STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175513	A. Building B. Wing	08/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Kansas Soldiers Home	200 Custer, Unit 98 Fort Dodge, KS 67801

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility reported a census of 51 residents. The sample included 15 residents with five reviewed for unnecessary medications. Based on observations, interview and record review the facility failed to obtain a consent form for a psychotropic 9alters mood or thoughts) medication for Resident (R) 3. This placed the residents at risk for adverse side effects of the medications and uninformed decisions.Findings included: - R3's Physician Orders dated 07/18/25 revealed the following diagnosis: major depressive disorder (major mood disorder, which causes persistent feelings of sadness). R3's Annual Minimum Data Set(MDS) dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. The MDS indicated R3 received antidepressant medication (class of medications used to treat mood disorders).R3's Quarterly MDS dated [DATE] recorded a BIMS score of 14, which indicated intact cognition. The MDS documented R3 had no behaviors. The MDS noted R3 received an antidepressant medication. R3's Care Assessment Area dated 0/7/18/25 Psychotic Medication Use adverse effects (falls, sedation, and impaired balance) due to his daily use of psychotropic medication. R3's Care Plan documented the resident used antidepressant medication for depression and directed staff to monitor changes in behaviors, mood, cognition, suicidal thoughts, and social isolation. R3's Electronic Medical Record (EMR) revealed a Physician's Order for bupropion HCl (an antidepressant), give 150 mg (milligrams) by mouth one time a day, related to major depressive disorder. Observation on 08/06/25 at 08:10 AM, R3 sat in his wheelchair heading to the main dining room on the first floor. R3 had a device on the back of his wheelchair that alarmed if the resident tried to stand up without assistance. Observation on 08/0625 at 10:27 AM, R3 was in the commons area waiting for his shower. On 08/07/25 at 08:30 AM, Administrative Nurse D stated she only had consent forms for two other residents and confirmed there was no informed consent for R3's psychotropic medication. On 08/07/25 at 09:49 AM, Consultant Staff GG reported that the administrative nurse must have misunderstood regarding the informed consents for psychotropic medications. She said all psychotropic medication should have consent, and she had sent the form to the administrative nurse last month to complete. The facility did not provide a policy on informed consent.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility reported a census of 51 residents; the sample included 15 residents. Based on observation, interviews, and record review, the facility failed to ensure an environment free from physical restraints (any manual method or physical or mechanical device, material or equipment attached or adjacent to the resident's body that the individual cannot remove easily which restricts freedom of movement or normal access to one's body) when staff failed to assess and ensure safety regarding Resident (R) 28's use of a seatbelt on his motorized wheelchair. This deficient practice placed R28 at risk for complications related to restraints and impaired safety.Findings included:- Review of the Electronic Health Record (EHR) documented R28 had diagnoses which included chronic obstructive pulmonary disease (COPD- a progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing), and atrial fibrillation (rapid, irregular heartbeat).R28's 03/18/25 Annual Minimum Data Set (MDS) documented a Brief Interview of Mental Status (BIMS) of 15, which indicated intact cognition. The MDS documented R28 required moderate assistance for bathing, transfers, dressing, personal hygiene, bed mobility, and toileting. The MDS documented R28 was independent with wheelchair mobility and eating. The MDS documented R28 had impairment of both upper and lower extremities. The MDS documented R28 did not have a physical restraint.R28's 03/22/25 Functional Abilities (Self-Care and Mobility) Care Area Assessment (CAA) documented R28 required assistance from staff related to his limited range of motion and impaired balance. Staff were to encourage R28 to participate in his daily care as he is able.R28's 06/11/25 Quarterly MDS documented a BIMS score of 14, which indicated intact cognition. The MDS documented R28 required moderate assistance for transfers. The MDS documented R28 was independent with wheelchair mobility. The MDS documented R28 had impairment of both upper and lower extremities. The MDS documented R28 did not have a physical restraint.R28's EHR lacked evidence the facility assessed R28's ability to release his seatbelt.R28's Care Plan dated 08/06/25, documented R28 used a maroon electric wheelchair for locomotion, date initiated 08/2024.R28's Physician Orders dated 08/06/25 did not address R28's seatbelt on the motorized wheelchair.R28's Progress Notes reviewed from 08/06/24 through 08/05/25 lacked mention of the seatbelt.During an observation on 08/04/25 at 01:21 PM, R28 had an engaged seatbelt on his electric wheelchair placed over his upper thighs. R28 reported that he could not undo the seatbelt independently as he could not reach it. R28 attempted to reach down with his right arm and could not reach the seatbelt. R28 reported that the staff would apply and release the seatbelt.During an observation on 08/05/25 from 01:20 PM through 03:45 PM, R28's seatbelt remained intact with no release until 03:45 PM. R28 was in bingo, then he independently went outside to sit in his wheelchair. R28 reported he had the electric wheelchair for about a year, and it has always had a seatbelt on it. R28 reported that he was told he had to wear the seatbelt. R28 said he did not have a choice to wear the seatbelt and reported that the staff was strict about the seatbelt.During an observation and interview on 08/05/25 at 03:42 PM, Certified Medication Aide (CMA) S reported R28 had to wear a seatbelt in the type of electric wheelchair he had, as it made R28 a high risk for injury. CMA S reported that not all residents required a seatbelt. CMA S verified that R28 was not able to undo his seatbelt independently. CMA S said it would be documented on the care plan if a resident required a seatbelt and went on to say it was ok to leave the seatbelt on longer than two hours. At 03:45 PM, CMA S entered R28's room and assisted R28 to the bathroom. CMA S released the seatbelt and assisted R28 to a standing position without a gait belt. R28 struggled to stand up independently, and CMA S pulled under R28's forearm to assist him up. During an interview on 08/05/25 at 03:50 PM, Licensed Nurse (LN) G reported that it was policy for the residents to wear a seatbelt in an electric wheelchair. LN G reported she was unaware who evaluated the seatbelt to see if a resident could release the seatbelt independently. LN G reported the seatbelt was a restraint if not released every two hours.During an interview on 08/05/25 at 04:32 PM, Administrative Nurse D and Administrative Nurse E reported that if a resident preferred to have the seatbelt on, the resident should be able to unbuckle the seatbelt, and it would be documented on the care plan. Administrative Nurse E reported that there were no residents currently who wore a seatbelt. Administrative Nurse D reported that the facility did not have a seatbelt safety assessment that would be completed.During an interview on 08/05/25 at 05:20 PM, Administrative Staff A reported that no resident had a seatbelt safety assessment completed, and no residents had a seatbelt care plan.The facility's policy Nursing Standards, Guidelines, Protocols, Procedures, and Position Statements, dated 10/10/24, the latest edition of Lippincott Nursing Procedure shall be used. Obtain a practitioner's order for a

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility reported a census of 51 residents; the sample included 15 residents. Five residents were reviewed for unnecessary medications. Based on observation, interview, and record review, the facility failed to ensure an appropriate indication, or a documented physician rationale which included the multiple unsuccessful attempts for nonpharmacological symptom management and risk versus benefits for the continued use of an antipsychotic (class of medications used to treat mental disorder characterized by a gross impairment in reality testing) for Resident (R) 1. This deficient practice placed R1 at risk for adverse effects associated with the use of psychotropic (alters mood or thoughts) medications.Findings included:- R1 's Electronic Health Record (EHR) revealed diagnoses of depression (a mood disorder that causes a persistent feeling of sadness and loss of interest) and anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear).R1's 10/22/24 Annual Minimum Data Set (MDS) documented the resident had a Brief Interview for Mental Status (BIMS) score of nine, which indicated moderately impaired cognition. R1 required supervision for bathing and was independent for all other activities of daily living (ADL). The MDS documented R1 had no behaviors. The MDS recorded R1 received antipsychotic and antidepressant (class of medications used to treat mood disorders) medication on a routine basis. The MDS documented no gradual dose reduction.R1's 10/25/25 Psychotropic Drug Use Care Area Assessment (CAA) recorded R1 was at risk for adverse effects (falls, sedation, impaired balance, side effects outlined in the black box warning) due to his daily use of a psychotropic medication. Staff would monitor for signs and symptoms. The facility would review for possible gradual dose reduction if indicated. Staff would notify the physicians of any adverse reactions noted.R1's 06/30/25 Quarterly MDS documented a BIMS score of four, which indicated severely impaired cognition. The MDS documented R1 had no behaviors. R1 required maximal assistance for bathing. R1 required moderate assistance for toileting and lower body dressing. The MDS recorded R1 received antipsychotic and antidepressant on a routine basis with no gradual dose reduction.R1's Care Plan dated 11/07/23 documented R1 used psychotropic medications, including aripiprazole (atypical antipsychotic medication), for major depressive disorder. The plan noted an intervention dated 11/07/23, which directed staff to administer medications as ordered; monitor and document for side effects and effectiveness. The plan further directed staff to consult with the pharmacy and physician to consider dosage reduction when clinically appropriate; discuss with the physician and family regarding the ongoing need for use of medication. The plan directed staff to review behaviors, interventions, and alternate therapies attempted and their effectiveness per policy. The plan directed staff to provide education to the resident, family, and caregivers about risks, benefits, and the side effects and/or toxic symptoms of aripiprazole. Staff were instructed to monitor, document, and report any adverse reactions of psychotropic medications including unsteady gait, tardive dyskinesia (an abnormal condition characterized by involuntary repetitive movements of the muscles of the face, limbs, and trunk), frequent falls, refusal to eat, difficulty swallowing, dry mouth, depression, suicidal ideations, social isolation, blurred vision, diarrhea, fatigue, insomnia, loss of appetite, weight loss, muscle cramps nausea, vomiting, and behavior symptoms not usual to the person.R1's Physician's Orders documented an order for mirtazapine oral tablet (an antidepressant), give 30 milligrams (mg) by mouth one time a day for depression and sleep date ordered 11/08/22.R1's Physician's Orders documented an order for aripiprazole oral tablet, give 1 mg tablet by mouth daily for depression, date ordered 06/11/25.R1's Medication Regimen Review reviewed from 08/31/24 through 07/30/25, lacked evidence that Pharmacy Consultant GG identified the aripiprazole diagnosis of depression or the lack of documentation for what symptoms the antipsychotic medication was being administered for.During an observation on 08/06/25 at 08:00 AM, R1 was in his room eating his breakfast, with no concerns noted.During an interview on 08/07/25 at 08:30 AM, Administrative Nurse D reported she did not know if depression was an acceptable diagnosis for R1's aripiprazole. Additionally, she reported that the managed symptoms of R1's behaviors should be in order. During an interview on 08/07/25 at 09:49 AM, Pharmacy Consultant Staff GG reported that depression was not an acceptable diagnosis for R1's antipsychotic medication, and the order was missing some components of managed symptoms of R1's behaviors.The facility did not provide a policy on psychotropic medications.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. The facility had a census of 51 residents. The sample included 12 residents. Based on observations, interviews, and record review, the facility failed to provide services to meet professional standards of care related to medication administration. This placed the residents at risk for medication-related complications and ineffective medication regimes. Findings included:- During an observation on 08/05/25 at 08:45 AM, Certified Medication Aide (CMA) R was at the medication cart on the third floor. Observation revealed CMA R reviewed the computer screen with several residents' names highlighted in pink, indicating overdue medications. CMA R prepared medications without using the electronic Medication Administration Record (MAR) to verify the medication orders. CMA R stated she had prepared Resident (R)8's medications. Upon inquiry about the 14 residents that were highlighted pink and the preparation of the medications without looking at the MAR, CMA R shrugged her shoulders and walked away. During an observation and interview on 08/05/25 at 08:50 AM, Licensed Nurse (LN) H accessed the MAR in the Electronic Health Record (EHR) and noted 14 residents highlighted in pink; LN H reported the residents orders were all 07:30 AM scheduled medications and since it was just a little past 08:30 AM, the medications were not that late. LN H reported that the residents were independent, and it was hard to always administer medications on time. LN H reported the staff did not have time to chase after the residents. LN H reported that the medications were scheduled for a specific time, and if the MAR was pink, it meant the medications were late. LN H verified the facility did not have a liberalized mediation pass (allows long-term care residents to choose when they receive their medications, within a designated window, based on their individual schedules and preferences, rather than adhering strictly to a fixed schedule). During an observation on 08/06/25 at 09:52 AM, CMA T administered the 07:30 AM scheduled medications to R2. R2 received 18 late oral medications and one late inhaled medication. R2 declined the nasal spray.During an interview on 08/05/25 at 09:44 AM, Administrative Nurse D verified that the medications were scheduled for 07:30 AM and confirmed the facility did not have a liberalized medication pass time. Administrative Nurse D said she expected all medications to be administered on time; she expected staff to locate the residents to make sure all medications were passed on time. During an interview on 08/06/25 at 09:52 AM, CMA T stated he was trained by another certified medication aide and was told medications were only considered late after 10:00 AM. The facility policy Medication Administration dated 10/19/18 states that all administration of medications, the nurse shall keep in mind the following. Right drug, right dose, right time, right route, right indication, and right documentation.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	The facility identified a census of 51 residents. The sample included 12 residents, including one resident reviewed for pressure ulcers (localized injury to the skin and/or underlying tissue usually over a bony prominence, as a result of pressure, or pressure in combination with shear and/or friction). Based on observation, interview, and record review, the facility failed to address and implement measures consistent with professional standards of practice to prevent the development of and promote the healing of pressure ulcers for Resident (R) 32 when staff failed to ensure R32 received pressure reducing interventions, repositioning, and physician involvement at the time the initial changes were identified. The resident developed Stage 3 pressure ulcers and was at risk for the development of new pressure ulcers, delayed healing, and worsening of existing ulcers. Findings included:- R32's Electronic Health Record (EHR) revealed diagnoses of cerebral palsy (a progressive disorder of movement, muscle tone, or posture caused by injury or abnormal development in the immature brain, most often before birth), abnormalities of gait and mobility, and pain. R32's 07/25/25 admission Minimum Data Set (MDS) documented a Brief Interview of Mental Status (BIMS) of 15, which indicated intact cognition. The MDS documented R32 required maximal assistance for toileting, oral care, personal hygiene, bed mobility, and transfers. The MDS documented R32 had impairment of both lower extremities. The MDS documented R32 was at risk for pressure ulcer development and documented no existing pressure ulcers or skin concerns. The MDS documented R32 did not have a pressure-reducing mattress, pressure-reducing cushion for his wheelchair, or a repositioning program. R32's 07/29/25 Pressure Ulcer/Injury Care Area Assessment (CAA) documented R32 was at risk for pressure injury based on his Braden Scale score (a tool used to assess a patient's risk for developing a pressure injury) of 15 (07/18/25), which indicated a mild risk. The CAA noted R32 received psychotropic (alters mood or thoughts) medication use and limited mobility. Nursing would perform weekly skin assessments and assist as needed with repositioning for comfort. The CAA noted R32 would have a pressure reduction mattress, wheelchair cushion, and barrier cream in place for preventive measures. Review of R32's Braden Scale documented on 07/15/25 indicated R32 was at mild risk for pressure injury development with a score of 16. The assessment performed on 07/18/25 and 08/01/25 indicated R32 was at mild risk with a score of 15. R32's Care Plan dated 07/19/25 recorded he had an activities of daily living (ADL) deficit related to fatigue and limited mobility. The plan recorded an intervention dated 07/19/25, which instructed staff to know R32 required limited assistance from staff for bed mobility to turn and reposition. R32's 07/29/25 Care Plan documented R32 had the potential for pressure injury based on a Braden score of 15, limited mobility, and a Foley catheter (tube inserted into the bladder to drain urine). The plan instructed staff to provide education to the resident, family, and caregivers as to the causes of skin breakdown, including transfer and positioning requirements, importance of taking care during ambulating and mobility, good nutrition, and frequent repositioning. The plan instructed staff to follow facility policies and protocols for the prevention and/or treatment of skin breakdown. The plan instructed staff to inform the resident, family, and caregivers of any new area of skin breakdown and alert the family, interdisciplinary team, and resident of treatment refusals to determine why and try to find alternative methods. R32's Care Plan, revised 08/05/25, noted R32 had actual skin impairment on his buttock and directed staff to administer medications as ordered, including Arginaid (a nonprescription nutritional drink that supplies the amino acid L-arginine along with vitamins C and E) twice daily. An 08/05/25 intervention directed staff to perform weekly treatment documentation, including measurements of the skin breakdown width, length, depth, tissue type, and whether exudate (drainage) was present. R32's Care Plan lacked interventions related to frequency of repositioning, barrier cream, or pressure-reducing devices. R32's Physician Orders documented the following:Weekly Braden Assessment every Friday for four weeks, ordered 07/28/25.Weekly skin assessments every Wednesday for prevention of wounds, ordered 07/29/25. R32's Tasks in the EHR lacked documentation related to turning and repositioning. R32's 07/27/25 Bath and Skin Monitoring Sheet documented chafing (skin irritation caused by friction, often resulting in soreness or rawness) to his buttocks, and noted barrier cream was applied. R32's Weekly Skin Assessment dated 07/30/25 at 05:38 PM documented R32 had a rash on his buttocks, right and left gluteal (pertaining to the buttocks or buttocks muscles) folds, and several discolored areas. The assessment lacked measurements. R32's EHR lacked evidence staff notified the resident's physician of the skin condition noted on 07/30/25 and lacked evidence of treatments implemented in response to the changes to the resident's skin noted on 07/30/25. R32's

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Observe each nurse aide's job performance and give regular training. The facility reported a census of 51 residents. The facility identified five Certified Nurse Aides (CNA) employed for over 12 months during the review period. Based on interviews and record review, the facility failed to complete an annual performance review at least once every 12 months for the five CNAs reviewed, to ensure adequate and appropriate care and services were provided to the residents of the facility. This placed the residents at risk for decreased quality of care. Findings included:- Review of employee files on 08/06/25 at 01:07 PM revealed a lack of performance evaluations signed by management for the five CNAs that had been employed over one year, that included CMA L date of hire 01/29/10, CMA R date of hire 05/08/23, CMA II date of hire 07/12/23, CMA JJ date of hire 05/28/15, and CMA KK date of hire 09/24/06. During an interview on 08/07/25 at 10:10 AM, Administrative Staff A reported he expected 100 percent compliance to have the annual performances evaluations completed annually.The facility did not provide a policy on annual performance evaluations.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. The facility reported a census of 51 residents. The sample included 12 residents with five residents reviewed for unnecessary medications. Based on observation, interview, and record review, the facility failed to act upon the pharmacist's monthly medication review (MRR) or document the rationale for Resident (R) 1. The deficient practice had the potential to lead to the residents receiving unnecessary medications.Findings included:- R1's Electronic Health Record (EHR) revealed diagnoses of depression (a mood disorder that causes a persistent feeling of sadness and loss of interest), anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), and pain.R1's 10/22/24 Annual Minimum Data Set (MDS) documented the resident had a Brief Interview for Mental Status (BIMS) score of nine, which indicated moderately impaired cognition. R1 required supervision for bathing and was independent for all other activities of daily living (ADL). The MDS documented R1 had no behaviors. The MDS recorded R1 received antipsychotic and antidepressant (class of medications used to treat mood disorders) medication on a routine basis.R1's 10/25/25 Functional Abilities (Self-Care and Mobility) Care Area Assessment (CAA) R1 triggered related to the resident's potential need for assistance with ADLs. The CAA noted R1 had diagnoses of anxiety disorder and pain. He may be screened by therapy for a potential increase in ADL status, strength, balance, and mobility. He was at risk for incontinence, falls, and skin impairments. The CAA noted the care plan would address the resident's need for assistance with ADLs.R1's 06/30/25 Quarterly MDS documented a BIMS score of four, which indicated severely impaired cognition. The MDS documented R1 had no behaviors. R1 required maximal assistance for bathing. R1 required moderate assistance for toileting and lower body dressing. The MDS recorded R1 received antipsychotic and antidepressant medications on a routine basis.R1's Care Plan documented on 08/29/23, staff instructed to administer Celebrex (medication commonly used to relieve pain and reduce inflammation)100 milligrams (mg) per order. The plan directed staff to monitor, record, and report to the nurse any resident complaints of pain or requests for pain treatment. R1's Physician's Orders documented an order for Celebrex oral capsule, one capsule, by mouth, one time a day for pain, date ordered 03/16/23.R1's Medication Regimen Review (MRR) on 09/10/24, documented a review was completed with no duplicate therapy or irregularities noted. The MRR noted R1 received Celebrex, and his creatinine (levels in the blood or urine can be measured to assess kidney function) was 1. 78 milligram/deciliter (mg/dL) (Normal is 0.65-1.36 mg/dL) in May 2024 and the hemoglobin (Hgb-measure of blood that carried oxygen to the cells from the lungs and carbon dioxide away from the cells to the lungs) was 9.6 gram/dL. (Normal Hgb was 13.4-18.0 g/dL). R1's current creatinine was a little better but still elevated at 1.51. The consultant pharmacist recommended considering discontinuing the Celebrex 100 mg due to renal (kidney) or gastrointestinal involvement.R1's Physician Response to the 09/10/24 MRR, noted on 09/12/24, documented the physician's response of No to the recommendation but lacked a rationale. R1's Laboratory Results dated 05/13/25 noted R1's creatinine was 2.5 mg/Dl.During an observation on 08/06/25 at 08:00 AM, R1 was in his room eating his breakfast.During an interview on 08/07/25 at 08:30 AM, Administrative Nurse D reported she did not know if the physician was required to document a rationale for a pharmacy recommendation when not wanting to follow it.During an interview on 08/07/25 at 09:49 AM, Pharmacy Consultant Staff GG reported that the physician was not required to provide a rationale when not wanting to follow a recommendation, but only required one with gradual dose reductions for psychotropic medications.The facility's Drug Regimen Review dated October 10, 2024, documented to ensure residents at the Kansas Soldiers' Home maintain their highest practicable level of functioning and prevent or minimize adverse consequences related to medication therapy to the extent possible. Appropriate response from physician(s) concerning previous drug regimen review recommendations or drug irregularities.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. The facility reported a census of 51 residents. The sample included 15 residents. Based on observation, interview and record review the facility failed to ensure a medication error rate of less that five percent. 35 medication administration opportunities were observed, and 22 errors identified resulting in a medication error rate of 52.94 percent. This placed the residents at risk for medication related complications and ineffective medication regimes.Finding included:- Resident (R) 2's July Medication Administration Record/Treatment Administration Record (MAR/TAR) documented 18 oral medications scheduled at 07:30 AM, two nasal spray medications were scheduled at 07:30 AM, as well as one inhaled medication. On 08/06/25 at 09:52 AM, observation revealed Certified Medication Aide T administered the 07:30 AM scheduled medications to R2, outside of the one hour before or after protocol. R2 received 18 late oral medications and one late inhaled medication. R2 declined the nasal spray. On 08/06/25 at 09:52 AM, CMA T stated he was trained by another certified medication aide and was told medications were only considered late after 10:00 AM. On 08/05/25 at 09:44 AM, Administrative Nurse D verified that the medications were scheduled for 07:30 AM and confirmed the facility did not have a liberalized medication pass time. Administrative Nurse D said she expected all medications to be administered on time; she expected staff to locate the residents to make sure all medications were passed on time. The facility policy Medication Administration dated 10/19/18, all administration of medications, the nurse shall keep in mind the following. Right drug, right dose, right time, right route, right indication, and right documentation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175513	A. Building B. Wing	08/07/2025

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. The facility reported a census of 51 residents, and one main kitchen. Based on observation, record review and interview the facility failed to prepare and serve food under sanitary conditions to prevent the potential for food borne bacteria. This placed the residents at risk for food borne illnesses.Findings included: - During a second tour of the kitchen on 08/5/25 at 10:30 AM, observation revealed three-barrel type trash cans that did not have a lid covering the trash cans. Dietary Staff DD did ask the staff to locate the lids to the trash cans, and all but one was found. On 08/0525 at 10:35 AM, observation revealed Dietary Staff DD washed her hands, then put on gloves, and pureed the food for five residents, which included country fried steak and asparagus. Dietary Staff DD followed the recipe. During the observation, Dietary Staff DD removed her soiled glove at the counter, put them in the trash barrel that did not have a lid, then reapplied new gloves without washing her hands. During the serving of the food on 08/06/25 at 11:00 AM, Dietary Staff CC removed her gloves, washed her hands, and donned new gloves. She then grabbed a plate with her gloved hands and then touched the hamburger buns package. Wearing the same gloves, she grabbed the breaded chicken with her gloved hand, turned, and then opened the tomato containers. Dietary Staff CC then removed her gloves, washed her hands, donned new gloves, and then proceeded to touch the tomatoes, plates, picked up a loaf of bread, and then went into the refrigerator for the prepared coleslaw. On 08/06/25 at 11:50 AM, Certified Dietary Manager BB stated the facility expected staff to provide food in a safe and healthy environment. CDM BB stated she provided training on food handling every year and met with her supervisors every Monday to discuss areas that staff needed to work on. The facility's policy Hand Washing, revised on 10/10/21, indicated staff will wash hands frequently as needed throughout the day, following proper hand washing procedure. After handling soiled equipment, during food preparation, as often as necessary to remove soil and contamination and to prevent cross-contamination when changing tasks.

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Dispose of garbage and refuse properly. The facility reported a census of 51 residents. Based on observations, interviews and record review, the facility failed to maintain and/or dispose of kitchen garbage and refuse properly. This placed facility residents at risk for insect or rodent infestation.Findings included: - During a second tour of the kitchen on 08/5/25 at 10:30 AM observation revealed three-barrel type trash cans which did not have a lid. Dietary Staff DD did ask the staff to locate the lids to the trash cans and all but one was found.On 08/06/25 at 03:15 PM observation of the outside garbage bins with Certified Dietary Manager (CDM) BB revealed eight trash bins against the fence and two of the bins had lids up. The wind at the time of the observation was calm breeze and there were no strong winds noted.On 08/06/25 at 03:15 PM CDM BB said the bins were usually closed but maybe the wind lifted the lids. CDM BB said he had no idea why the lids were open at that time.The facility's policy Waste Disposal revised on 10/10/24 all garbage will be disposed of daily and in needed throughout the day. Trash will be deposited into a sealed container outside the premises.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The facility reported a census of 51 residents. The sample included 15 residents. Based on interviews, observation and record review, the facility failed to establish and maintain a consistent infection prevention and control program. Additionally the facility failed to utilize Enhanced Barrier Precautions (EBP-infection control interventions designed to reduce transmission of resistant organisms which employ targeted gown and glove use during high contact care) when providing direct care to residents with catheters (a flexible tube inserted through a narrow opening into a body cavity, particularly the bladder, for removing fluid), wounds, and/or surgical artificial openings entering the body to prevent the spread of infection. The facility further failed to provide catheter care using aseptic technique and failed to implement measures to prevent the growth of Legionella (a serious type of lung infection caused by inhaling water droplets or mist contaminated with Legionella bacteria) and other opportunistic water borne pathogens in the facility's water systems to prevent the spread of infections. These deficient practices had the potential to spread infections to the residents in the facility.Findings included:- Review of the facility Matrix, dated 08/05/25 revealed 11 residents with indwelling catheters and three residents with wounds. Upon request, the facility was unable to provide documentation or evidence of a water management program to mitigate Legionella and other water born pathogens.During an observation on 08/04/25 at 11:00 AM, initial tour of the facility revealed no evidence of EBP set up nor signage to indicate residents that required EBP personal protective equipment (PPE).During an observation on 08/04/25 at 01:58 PM, Certified Nurse Aide (CNA) O emptied Resident (R)32's indwelling catheter drainage bag. She donned gloves but did not wear a gown. CMA O then accessed the outlet access port, drained the urine and reinserted the outlet access into the holder port with cleansing it first. CNA O reported she did not know what EBP were. Observation revealed there was no signage regarding EBP or readily accessible PPE in or around the resident's room. CNA O confirmed the resident's door lacked signage to indicate the need for staff to wear PPE and the lack of assessable PPE in the room other than gloves.During an observation on 08/05/25 at 11:20 AM, R33 laid in the bed with an indwelling urinary catheter collection bag placed inside of a dignity bag. Further observation revealed there was no signage to inform those entering the room of required PPE, or gowns available in the room or surrounding area to be used when providing direct care and/or contact.On 08/06/25 at 01:24 PM, Administrative Nurse F confirmed the above findings. She stated she was not aware of the 04/01/2024 Center of Medicare and Medicaid Service (CMS) requirement for EBP to prevent infections for residents that had catheters, wounds and/or artificial openings in their body as noted above. Administrative Nurse F said catheter care should be provided each shift using aseptic technique to prevent cross contamination and the spread of infection. Administrative Nurse F reported she had not completed the July or August Infection Control Log. She stated she normally completed the documentation at the end of each month and did not track or trend infections more frequently to identify trends and patterns. She said she expected staff to clean the spout with an alcohol wipe before replacing the outlet when providing catheter care.On 08/07/25 at 10:46 AM, Administrative Nurse D, confirmed the above findings and stated she was not aware of the 04/01/2024 directive for the use of enhanced barrier precautions for residents with catheters, wounds, and/or artificial openings into their bodies. She stated catheter care should be provided each shift and should include cleaning the outlet tube with an alcohol wipe after emptying the drainage bag of urine and before replacing the tube in the sleeve to prevent cross contamination and the spread of infection. Administrative Nurse D said the infections in the facility should be tracked at the time the infection is identified to ensure timely interventions are implemented, not at the end of the month.The undated facility policy Infection Control, Program documentation included the function of the infection Control Program includes but is not limited to a system of surveillance designed to identify possible communicable disease or infection, tracking and trending infections before they can spread to another person in the facility and monitor the use of antibiotics. Staff providing direct care to residents should follow hand hygiene procedures.The facility did not have a policy related to prevention of Legionella.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Implement a program that monitors antibiotic use. The facility reported a census of 51 residents; the sample included 15 residents. Based on interview and record review, the facility failed to establish and infection prevention and control program which included an antibiotic stewardship program with antibiotic use protocols and a system to monitor antibiotic use. This placed the residents at risk for infectious diseases.Findings included: - The facility Matrix, dated 08/05/25, noted seven residents who received antibiotics. Review of the infection control surveillance log dated 07/01/25 through 08/06/25 revealed the facility lacked documentation of tracking and trending of Resident (R) 33, with a diagnosis of recurrent urinary tract infection (UTI), who received gentamycin (antibiotic) bladder irrigations for prevention of urinary tract infection. The log lacked documentation of tracking and trending of R4, with diagnosis of UTI, for receiving amoxicillin (antibiotic), ordered 7/31/25, for seven days.On 08/06/25 at 01:24 PM, Administrative Nurse F confirmed the above findings. She stated R33 and R4 received antibiotics, which she failed to include on the Infection Control Log, dated 07/01/25 through 08/06/25. Administrative Nurse F reported she had not completed the July Infection Control Log to include antibiotic use in the facility. She stated she normally completed the documentation at the end of each month and did not track/trend antibiotic use daily. She reported the facility used McGeer's Criteria to determine the appropriateness of prescribed antibiotics. Upon Inquiry, she reported that the physician prescribed antibiotics, and the facility did not conduct formal reviews or audits to determine the appropriateness or effectiveness of the use of each antibiotic in the facility. On 08/07/25 at 10:46 AM, Administrative Nurse D stated the infections and antibiotics in the facility should be tracked when prescribed and reviewed for appropriate use.The undated facility policy Infection Control lacked address of the identified areas of concern.