STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E071	A. Building B. Wing	11/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Greeley County Hospital Ltcu	506 3rd Street Tribune, KS 67879

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 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)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility had a census of 15 residents. The sample included eight residents, with five 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 unsuccessful attempts for nonpharmacological symptom management and risk versus benefits for the continued use for Resident (R) 12's antipsychotic (a medication used to treat any major mental disorder characterized by a gross impairment testing). Findings included: - R12's Electronic Medical Record (EMR) documented the resident had diagnoses of dementia (a progressive mental disorder characterized by failing memory and confusion), major depressive disorder (major mood disorder that causes persistent feelings of sadness), and Parkinson's disease (a slowly progressive neurologic disorder characterized by resting tremors, rolling of the fingers, masklike faces, shuffling gait, muscle rigidity, and weakness).R12's admission Minimum Data Set (MDS) dated [DATE] recorded R12 had a Brief Interview for Mental Status (BIMS) of seven, indicating moderately impaired cognition. The MDS recorded the resident used a walker and wheelchair for mobility and required substantial to maximal assistance with sit-to-stand, chair/bed to chair transfer, and toilet transfer. The MDS recorded R12 required partial to moderate assistance to walk ten feet once standing. The MDS recorded the resident received antipsychotic medications during the observation period.The Psychotropic Drug Use Care Area Assessment (CAA) dated 11/04/25 recorded R12 had a history 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). The CAA recorded R12 received an antipsychotic, antidepressant (a class of medications used to treat mood disorders), and a sedative (a medication that induces sedation by reducing irritability or excitement).R12's Care Plan dated 07/09/25 recorded R12 had impaired cognitive function, dementia, or impaired thought process due to dementia. The care plan documented R12 used psychotropic (a medication that alters mood or thoughts medication Seroquel (an antipsychotic medication) due to depression and dementia. The care plan directed staff to monitor for side effects and effectiveness every shift, and monitor for side effects such as unsteady gait, tardive dyskinesia (an abnormal condition characterized by involuntary repetitive movements of the muscles of the face, limbs, and trunk), shuffling gait, rigid muscles, shaking, 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 and vomiting, and behavior symptoms not usual to that person. The care plan documented the staff would monitor and record occurrences of targeted behaviors, symptoms, and document per facility protocol. The care plan did not document the targeted behaviors for Seroquel.The Physician's Order initial order date of 06/11/25 and 10/23/25 directed the staff to administer Seroquel 25 milligrams (mg), one time a day, related to major depressive disorder and anxiety.On 11/05/25 at 08:30 AM, observation revealed R12 sat in a wheelchair in her room. Continued observation revealed Certified Medication Aide (CMA) R administered the resident's morning medications. On 11/05/25 at 10:00 AM, Administrative Nurse D verified the resident received Seroquel, an antipsychotic medication, when R12 first received the medication that was ordered 12/29/23 with a diagnosis of dementia with behaviors, which the admitting nurse chose that diagnosis for the medication use. Administrative Nurse D stated the resident returned from her recent hospital stay, and on 10/23/25, the nurse apparently chose the diagnosis of major depressive disorder and anxiety. Administrative Nurse D stated she would speak with the physician and get an appropriate diagnosis for the use of Seroquel.The facility's Antipsychotic Medication policy, dated 04/28/25, documented any resident who used an antipsychotic medication receives a gradual dose reduction and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs to ensure the resident does not receive unnecessary medications and at the lowest possible dose is administered for the shortest amount of time. The policy documented all physician orders for antipsychotic medications would be clear and accurate and would include a diagnosis, condition, or indication for use, and the consultant pharmacist would review the appropriateness of all medication orders for medications to be administered by clinical staff. The policy documented each resident who had a new order for an antipsychotic medication would be assessed and periodically reassessed during their stay to determine the effectiveness of the medication. The policy documented the staff would revise the care plan as indicated and report to the physician any findings that indicated a change in medication regimen may be

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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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)

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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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility had a census of 15 residents. The sample included eight residents, including one resident reviewed for accidents. Based on observation, interview, and record review, the staff failed ensure fall interventions were implemented to prevent a fall which resulted in transport to a local hospital and subsequent hip fracture and hematoma (collection of blood trapped in the tissues of the skin or in an organ, resulting from trauma) for Resident (R) 12. Findings included: - R12's Electronic Medical Record (EMR) documented the resident had diagnoses of atrial fibrillation (rapid, irregular heartbeat), dementia (a progressive mental disorder characterized by failing memory and confusion), major depressive disorder (major mood disorder that causes persistent feelings of sadness), Parkinson's disease (a slowly progressive neurologic disorder characterized by resting tremors, rolling of the fingers, masklike faces, shuffling gait, muscle rigidity, and weakness), and nondisplaced subtrochanteric fracture of right femur (broken thigh bone). R12's Quarterly Minimum Data Set (MDS) dated [DATE] recorded R12 had a Brief Interview for Mental Status (BIMS) score of seven, indicating severely impaired cognition. The MDS recorded the resident used a walker and wheelchair for mobility and required substantial to maximal staff assistance with sit-to stand, and chair/bed-to-chair transfer, toilet transfer. The MDS documented R12 required staff supervision or touch assistance to walk ten feet, once standing.R12's admission MDS dated [DATE] recorded R12 had a BIMS of seven. The MDS recorded the resident used a walker and wheelchair for mobility, required substantial to maximal staff assistance with sit-to-stand, and chair/bed-to-chair transfer, and toilet transfer. The MDS documented R12 required partial to moderate staff assistance to walk ten feet, once standing. R12's Fall Care Area Assessment (CAA) dated 11/04/25 documented R12 fell more than once during the quarter, received an antidepressant medication daily, and required staff assistance with transfers and activities of daily living (ADL) due to safety concerns and ADL assistance.R12's Fall Care Plan dated 07/09/25 documented R12 was a high fall risk, related to poor balance, unsteady gait, and the fall assessments. A 06/07/24 intervention noted R12 had a chair sensor alarm, used to notify staff when the resident tried to get out of bed on her own. The care plan included a staff intervention to make sure the alarm was moved between the recliner and the wheelchair. The care plan documented staff would ensure the floor was dry, clear of clutter, call light was within reach, needed items were within reach, and the resident had on appropriate footwear. The care plan documented staff would make sure sensor alarms were working and connected when in use and remind the resident to use the call light before standing or when assistance was needed. R12's ADL Care Plan dated 07/09/25 revealed one staff to assist R12 with transfers with a gait belt and walker and the resident may use a wheelchair if needed. The ADL care plan documented staff would check on the resident at midnight, 04:00 AM, and 08:00 AM. If the resident was incontinent the staff would assist the resident with cares and offer to assist R12 to the bathroom if R12 was not incontinent. The TRIPS - Fall Risk assessment dated [DATE] recorded a score of 85 (a score of 45 or higher indicated a high fall risk).The TRIPS - Fall Risk Assessment dated 10/30/25 recorded a score of 75. The Nurses Note dated 09/27/25 at 12:45 PM documented staff found R12 lying on the floor in front of her bathroom, positioned on her right side. R12 was alert, holding the back of her head and stated her head hurt. Upon assessment of R12'as head, staff noted a raised area to the back of her head, approximately 2.0 centimeter (cm) with no bleeding or bruising present. The nurse documented R12's range of motion was within normal limits and R12 denied pain or injury to any other area. R12 had on regular socks and her shoes were in front of her recliner, where she previously sat, and her call light was attached to the recliner. The staff assisted the resident to a wheelchair without difficulty, toileted R12, and pushed her to the dining room for lunch. The resident did not express distress and neuro checks were initiated. At approximately 12:30 PM, the hematoma to back of her head was larger and measured 4.0 cm. R12 was in the dining room eating lunch, alert and oriented per baseline. The staff sent the resident to the emergency room for evaluation of the hematoma and gave report to the emergency department nurse. The staff notified the Durable Power of Attorney (DPOA). The Nurse's Notes dated 09/27/25 at 03:07 PM documented R12 had a fractured left hip and transported a local hospital for surgery.The Nurse's Notes dated 10/10/25 at 02:56 PM documented R12 admitted back to the facility from the hospital at 11:05 AM (13 days after her fall). The Fall Investigation Report dated 10/03/25 documented: following assessment, staff interviews, and review of the environment, the facility could not determine what directly led to R12's fall, as it was unwitnessed. The investigation noted the resident was found alert, on the floor, in front of her bathroom, wearing plain socks

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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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility had a census of 15 residents. The sample included eight residents. Based on observation, interview, and record review, the facility failed to ensure the Consultant Pharmacist (CP) identified the lack of specific parameters for Resident (R) 1's use of as-needed (PRN) opioid (a class of drug used to reduce moderate to severe pain) and diuretic (a medication to promote the formation and excretion of urine) use and R12's unapproved diagnosis for the use of an antipsychotic (a class of medications used to treat major mental conditions that cause a break from reality).Findings included: - R1's Electronic Medical Record (EMR) included diagnoses of constipation (difficulty passing stools), pain, functional dyspepsia (indigestion), major depressive disorder (major mood disorder that causes persistent feelings of sadness), acquired absence of right leg above the knee, pain in the left leg, and polyneuropathy (a condition that affects multiple peripheral nerves). R1's Quarterly Minimum Data Set (MDS) dated [DATE] documented that R1 had intact cognition and rejection of care behavior that occurred one to three days during a seven-day look-back period. R1 had a functional range of motion to lower extremity on one side, required substantial to maximal assistance with toileting hygiene, chair-to-bed transfers, and bed-to-chair transfers. R1 required partial to moderate assistance with upper body dressing and personal hygiene. R1 had occasional incontinence of urine and bowel. The MDS further documented that R1 had not received scheduled pain medication regimen but received PRN pain medication and non-medication interventions for pain. R1 had frequent pain, which occasionally affects sleep, and the pain level score of eight out of ten. (Pain scale rating zero for no pain and ten being the worst pain felt). R1 received a diuretic and an opioid. The Pain Care Area Assessment (CAA) dated 04/16/25 documented that R1 had pain frequently, utilized PRN medication daily, had polyneuropathy, and chest pain. R1's Care Plan dated 10/28/25 documented that R1 was on pain medication therapy related to complaints of chronic pain, polyneuropathy, and depression. The Care Plan directed staff to administer pain medication as ordered by the physician and oxycodone (opioid medication) five milligrams (mg) PRN every three hours for pain. The Black Box Warning (BBW- the highest safety-related warning that medications can have assigned by the Food and Drug Administration) for documented Bumetanide (diuretic medication) was a potent diuretic that could lead to diuresis with water and electrolyte (minerals that help keep the body's fluid levels in balance, necessary to help the muscles, heart, and other organs work properly) depletion. Therefore, careful medical supervision is required, and the dose and dosage schedule have to be adjusted to the individual patient's needs. The Physician Order dated 09/23/24 directed staff to administer oxycodone (opioid) five mg by mouth every three hours as needed for pain. Take one to three tablets every three hours PRN. The order lacked parameters related to specifics for the level or type of pain and how many tablets to give based on the level or type of pain. The Physician Order dated 08/26/25 directed staff to administer bumetanide 0.5 mg by mouth every 24 hours as needed for edema. The order lacked specific guidelines related to edema. (continued on next page)

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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 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Physician Order dated 09/17/25 directed staff to administer bumetanide one mg by mouth one time a day for a diuretic. The September 2025 Medication Administration Record (MAR) revealed R1 received five to ten mg of oxycodone three to six times a day. The October 2025 MAR revealed R1 received ten mg of oxycodone two to six times a day. The Progress Note dated 09/15/25 documented that R1 informed the nurse that bumetanide two mg was making her cramp all over and wanted the physician notified that she wanted the dose decreased back to one mg. R1 stated she would refuse the two mg dose if the dose was not lowered. The Monthly Medication Regimen Review dated 12/17/24 through 09/24/25 lacked a recommendation or clarification on the specific parameters related to the PRN use of oxycodone and bumetanide. On 11/04/25 at 04:19 PM, R1 was sitting in the dining room for another resident's birthday celebration. On 11/05/25 at 04:44 PM, R1 reported that the pain she experienced was leg pain. R1 also reported edema in her stump and could not follow orders to wear the stump shrinker to utilize the prosthesis (artificial body part). On 11/05/25 at 08:09 AM, Certified Medication Aide (CMA) R explained that the charge nurse on duty was notified if R1 needed or requested PRN medication, and the charge nurse determined what medication to administer to R1. On 11/06/25 at 09:05 AM, Licensed Nurse (LN) G reported that R1 determined what dose of oxycodone she wanted. LN G reported that R1 usually complained of pain all over her body when LN G asked about pain. LN G stated R1 had changes to the dose of bumetanide, and R1 would let staff know if she wanted the PRN bumetanide. LN G stated the order for oxycodone and bumetanide lacked parameters or specified edema (swelling) or pain levels related to their use. On 11/06/25 at 10:51 AM, Administrative Nurse D reported the physician's order lacked specific criteria for administration of PRN dosing. The facility's Pharmacy Services policy, dated 04/28/25, documented that it was the policy of the facility to provide pharmacy services in accordance with State and Federal Regulations. - R12's Electronic Medical Record (EMR) documented the resident had diagnoses of dementia (a progressive mental disorder characterized by failing memory and confusion), major depressive disorder (major mood disorder that causes persistent feelings of sadness), and Parkinson's disease (a slowly progressive neurologic disorder characterized by resting tremors, rolling of the fingers, masklike faces, shuffling gait, muscle rigidity, and weakness). (continued on next page)

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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 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R12 admission Minimum Data Set (MDS) dated [DATE] recorder R12 had a Brief Interview for Mental Status (BIMS) of seven, indicating moderately impaired cognition. The MDS recorded the resident used a walker and wheelchair for mobility and required substantial to maximal assistance with sit to stand, and chair/bed to chair transfer, toilet transfer, with partial to moderate assistance to walk ten feet once standing. The MDS recorded the resident received antipsychotic medications (class of medications used to treat major mental conditions which cause a break from reality) during the observation period. The Psychotropic Drug Use Care Area Assessment (CAA) dated 11/04/25 recorded R12 had a history 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). The CAA recorded R12 received an antipsychotic, antidepressant (a class of medications used to treat mood disorders) and a sedative (a medication that induces sedation by reducing irritability or excitement). R12's Care Plan, dated 07/09/25 recorded R12 had impaired cognitive function, dementia, or impaired thought process due to dementia. The care pan documented R12 used psychotropic (a medication that alters mood or thoughts) medication, Seroquel (antipsychotic medication), due to depression and dementia. The care plan directed staff to monitor for side effects and effectiveness every shift, and monitor for side effects such as unsteady gait, tardive dyskinesia (an abnormal condition characterized by involuntary repetitive movements of the muscles of the face, limbs, and trunk), shuffling gait, rigid muscles, shaking, 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 and vomiting, and behavior symptoms not usual to that person. The care plan documented the staff would monitor and record occurrences of targeted behaviors symptoms and document per facility protocol. The care plan did not document the targeted behaviors for Seroquel. The Physician's Order, initial order date 06/11/25 and 10/23/25, directed the staff to administer Seroquel 25 milligrams (mg), one time a day related to major depressive disorder and anxiety. On 11/05/25 at 08:30 AM, observation revealed R12 sat in a wheelchair in her room. Continued observation revealed Certified Medication Aide (CMA) R administered the resident's morning medications. On 11/05/25 at 10:00 AM, Administrative Nurse D verified the resident received Seroquel, an antipsychotic medication, when she first received the medication that was ordered 12/29/23 with a diagnosis of dementia with behaviors, which the admit nurse chose that diagnosis for the medication use. Administrative Nurse D stated the resident returned from her recent hospital stay and on 10/23/25 the nurse apparently chose the diagnosis of major depressive disorder and anxiety. Administrative Nurse D stated she would speak with the physician and get an appropriate diagnosis for the use of the Seroquel. Administrative Nurse D verified the pharmacist consultant did not address the physician's diagnosis for the Seroquel with his monthly reviews. (continued on next page)

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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 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility's Antipsychotic Medication policy, dated 01/26/24, documented any resident who used an antipsychotic medication receives gradual dose reduction and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs to ensure the resident does not receive unnecessary medications and at the lowest possible dose is administered for the shortest amount of time. The policy documented all physician orders for antipsychotic medications would be clear and accurate and would include a diagnosis, condition or indication for use, and the consultant pharmacist would review the appropriateness of all medication orders for medications to be administered by clinical staff. The policy documented each resident who had a new order for an antipsychotic medication would be assessed and periodically reassessed during their stay to determine the effectiveness of the medication. The policy documented the staff would revise the care plan as indicated and report to the physician any findings that indicated a change in medication regimen may be indicated. The Pharmacy Services policy, dated 04/28/25, documented the facility would provide pharmacy services in accordance with State and Federal regulations. The facility would employ or obtain services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility, establishes a system of records of receipts and disposition all controlled drugs in sufficient detail to enable an accurate reconciliation. Determines that drug records are in order and that an account of all controlled drugs is maintained.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. (continued on next page)

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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 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility had a census of 15 residents. The sample included eight residents. Based on observation, interview, and record review, the facility failed to obtain parameters for as needed (PRN) medication related to opioid (a class of drug used to reduce moderate to severe pain) and diuretic (a medication to promote the formation and excretion of urine) use.Findings included:- R1's Electronic Medical Record (EMR) included diagnoses of constipation (difficulty passing stools), pain, functional dyspepsia (indigestion), major depressive disorder (major mood disorder that causes persistent feelings of sadness), acquired absence of right leg above the knee, pain in left leg, and polyneuropathy (a condition that affects multiple peripheral nerves).R1's Quarterly Minimum Data Set (MDS) dated [DATE] documented that R1 had intact cognition and rejection of care behavior that occurred one to three days during a seven-day look-back period. R1 had a functional range of motion to lower extremity on one side, required substantial to maximal assistance with toileting hygiene, chair-to-bed transfers, and bed-to-chair transfers. R1 required partial to moderate assistance with upper body dressing and personal hygiene. R1 had occasional incontinence of urine and bowel. The MDS further documented that R1 had not received scheduled pain medication regimen but received PRN pain medication and non-medication interventions for pain. R1 had frequent pain, which occasionally affected sleep, and the pain level score of eight out of ten. (Pain scale rating zero for no pain and ten being the worst pain felt). R1 received a diuretic and an opioid.The Pain Care Area Assessment (CAA) dated 04/16/25 documented that R1 had pain frequently, utilized PRN medication daily, had polyneuropathy, and chest pain.R1's Care Plan dated 10/28/25 documented that R1 was on pain medication therapy related to complaints of chronic pain, polyneuropathy, and depression. The Care Plan directed staff to administer pain medication as ordered by the physician and oxycodone (opioid medication) five milligrams (mg) PRN every three hours for pain. The Black Box Warning (BBW- the highest safety-related warning that medications can have assigned by the Food and Drug Administration) for documented Bumetanide (diuretic medication) was a potent diuretic that could lead to diuresis with water and electrolyte (minerals that help keep the body's fluid levels in balance, necessary to help the muscles, heart, and other organs work properly) depletion. Therefore, careful medical supervision is required, and the dose and dosage schedule have to be adjusted to the individual patient's needs.The Physician Order dated 09/23/24 directed staff to administer oxycodone (opioid) five mg by mouth every three hours as needed for pain. Take one to three tablets every three hours PRN. The order lacked parameters related to specifics for the level or type of pain and how many tablets to give based on the level or type of pain.The Physician Order dated 08/26/25 directed staff to administer bumetanide 0.5 mg by mouth every 24 hours as needed for edema. The order lacked specific guidelines related to edema.The Physician Order dated 09/17/25 directed staff to administer bumetanide one mg by mouth one time a day for a diuretic. The September 2025 Medication Administration Record (MAR) revealed R1 received five to ten mg of oxycodone three to six times a day.The October 2025 MAR revealed R1 received ten mg of oxycodone two to six times a day.The Progress Note dated 09/15/25 documented that R1 informed the nurse that bumetanide two mg was making her cramp all over and wanted the physician notified that she wanted the dose decreased back to one mg. R1 stated she would refuse the two mg dose if the dose was not lowered. On 11/04/25 at 04:19 PM, R1 was sitting in the dining room for another resident's birthday celebration.On 11/05/25 at 04:44 PM, R1 reported the pain she experienced was leg pain. R1 also reported edema in her stump and could not follow orders to wear the stump shrinker to utilize the prosthesis (artificial body part).On 11/05/25 at 08:09 AM, Certified Medication Aide (CMA) R explained the charge nurse on duty was notified if R1 needed/requested PRN medication, and the charge nurse determined what medication to administer to the resident.On 11/06/25 at 09:05 AM, Licensed Nurse (LN) G reported that R1 determined what dose of oxycodone she wanted. LN G reported that R1 usually complained of pain all over her body when LN G asked about pain. LN G stated R1 had changes to the dose of bumetanide, and R1 would let staff know if she wanted the PRN bumetanide. LN G stated the order for oxycodone and bumetanide lacked parameters or specified edema (swelling) or pain levels related to their use.On 11/06/25 at 10:51 AM, Administrative Nurse D reported the physician's order lacked specific criteria for administration of PRN dosing.The facility's Administration of PRN (As Needed) Medications policy, dated 11/06/25, documented that medication would be administered by qualified staff only and would be administered only as prescribed by a licensed practitioner in this State. All medications would be administered in a safe and effective manner. Due to the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E071	A. Building B. Wing	11/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Greeley County Hospital Ltcu	506 3rd Street Tribune, KS 67879

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. The facility had a census of 15 residents. Based on observation, interview, and record review, the facility failed to use appropriate barriers while sorting soiled laundry.Findings included:- On 11/06/25 at 08:37 AM, while on tour of the laundry department, Housekeeping Staff V stated the soiled laundry was sorted using only gloves for personal protective equipment (PPE) and said staff did not wear a gown or other barriers.On 11/06/25 at 09:48 AM, Housekeeping Staff U stated the laundry staff had not been using a clothing barrier while sorting soiled laundry, and there was the potential of transferring infectious material to the clean laundry while sorting and folding clean laundry.The facility's Laundry Washer Dryer Room Procedures, dated 10/02/24, documented to use of gloves when touching dirty/soiled laundry. The policy lacked the use of a PPE gown or apron barrier to prevent the transfer of potentially infectious material from sorting soiled laundry onto clean laundry for folding and sorting.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility had a census of 15 residents. Based on observation, interview, and record review, the facility failed to offer a pneumococcal (type of bacterial infection) PVC20 immunization for Residents (R) 6, R12, and R10 per the guidance from the Centers for Disease Control and Prevention (CDC).Findings included:- R6's Electronic Health Record (EHR) documented that R6 received one Pneumovax Prevnar 13 dose on 04/17/17. The facility lacked documentation that R6 had been offered or refused any further pneumococcal vaccinations. R12's EHR documented that R12 received one Pneumovax Prevnar 13 dose on 01/05/18. The facility lacked documentation that R12 had been offered or refused any further pneumococcal vaccinations.R10's EHR documented that R10 received one Pneumovax Prevnar 13 dose on 11/17/22. The facility lacked documentation that R10 had been offered or refused any further pneumococcal vaccinations. On 11/06/25 at 09:34 AM, Administrative Nurse E reported the facility had been working on the pneumonia immunizations and had been reviewing the pneumococcal status of the current residents, but had not offered the currently required pneumococcal vaccinations as required by the CDC. Administrative Nurse E reported updating the physician's standing orders to include the update for pneumococcal immunizations.The facility's Influenza and Pneumonia Immunization policy, dated 08/27/24, documented that the Advisory Committee on Immunization Practices recommends vaccinating persons who are at high risk for complications from influenza and/or pneumonia, including those [AGE] years of age and older, who are residents of nursing homes. Recognizing the major impact and mortality of influenza and/or pneumonia disease on residents of nursing homes, and the effectiveness of vaccines in reducing healthcare costs and preventing illness, hospitalization, and death, this facility has adopted the following policy statement: Pneumonia vaccines will be administered per CDC-recommended guidelines.