STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E424	A. Building B. Wing	10/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sheridan County Hospital Ltcu	826 18th Street, Box 167 Hoxie, KS 67740

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 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. The facility had a census of 27 residents. The sample included 12 residents. Based on interviews and record review, the facility failed to provide Registered Nurse (RN) coverage for eight consecutive hours a day, seven days a week.Findings included:- The Payroll Based Journal (PBJ- a required detail of staffing information submitted by nursing homes, provided by the Centers for Medicare and Medicaid Services (CMS)) documented that the facility lacked RN eight-hour coverage for the following days: 04/19/25, 05/10/25, 05/17/25, and 05/24/25.On 10/21/25 at 04:00 PM, Administrative Nurse D verified on the above dates that there was no RN in the Long-Term Care Unit, but that there was an RN on call.On 10/22/25 at 07:55 AM, Administrative Staff A stated that a report was run after accounts payable received the timesheet. There had been times when they did not get the agency staff timesheets before submitting the PBJ, so that was probably the glitch. Administrative Staff A further stated they have since changed systems, and the agency staff can clock in to track their time better. Upon request, a policy for RN coverage was not provided by the facility.

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	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility had a census of 27 residents. The sample included 12 residents, with seven reviewed for unnecessary drugs. Based on observation, interview, and record review, the facility failed to ensure Resident (R) 25 was free from antipsychotic (a class of medications used to treat major mental conditions that cause a break from reality) medication use without an appropriate indication for use. Findings included: - R25?s Electronic Medical Record documented diagnoses of anxiety disorder (mental or emotional disorder characterized by apprehension, uncertainty and irrational fear), moderate dementia (progressive mental disorder characterized by failing memory, confusion) with psychotic disturbance (gross impairment in reality perception), restlessness, and agitation (feeling of aggravation or restlessness brought on by a provocation or a medical condition).R25?s Significant Change Minimum Data Set (MDS) dated [DATE] documented a Brief Interview for Mental Status (BIMS) score of 14, indicating intact cognition. The MDS documented no delusions (untrue persistent belief or perception held by a person, although evidence shows it was untrue) or verbal behaviors. The MDS documented R25 required moderate to dependent assistance of staff for activities of daily living (ADL) and received antianxiety (class of medications that calm and relax people) and antipsychotic medications (class of medications used to treat major mental conditions causing a break from reality).R25?s Psychotropic Care Area Assessment (CAA) dated 10/02/25 documented R25 had recently started olanzapine (antipsychotic medication) daily for agitation with dementia and delusional state (untrue persistent belief or perception held by a person although evidence shows it was untrue).R25?s Care Plan dated 07/02/25 documented R25 started taking olanzapine 2.5 milligrams (mg) every night for agitation with dementia, initiated 10/06/25. The care plan directed staff to monitor/document/report any changes in cognitive function. R25 did best when a family member tried to provide reassurance when R25 became anxious. The care plan initiated 10/20/25 directed staff to contact her son or granddaughter as needed. The Physician Order dated 09/09/25 directed staff to administer clonazepam (used to prevent and treat anxiety disorders, seizures, bipolar mania, agitation associated with psychosis), 0.5 mg, by mouth one time a day for a diagnosis of sedative (promoting calm or inducing sleep) or a diagnosis of intoxication (being under the influence of a sedative).The Physician Order dated 09/30/25 directed staff to administer olanzapine, 2.5 mg by mouth one time a day for agitation with dementia. On 10/21/25 at 08:33 AM, R25 was seated in her wheelchair at a dining table with staff present. She sat quietly, closing her eyes at times. On 10/20/25 at 04:15 PM, Administrative Nurse D stated R25 was having some off-and-on gradual dementia signs and some delusions (untrue persistent belief or perception held by a person although evidence shows it was untrue), which the family stated she had before her admission. On 10/22/25 at 09:05 AM, Administrative Nurse D stated the diagnosis of sedation for the use of clonazepam was not an approved diagnosis, and the olanzapine was a new order. She stated the resident had agitation with paranoia (a thought process believed to be heavily influenced by anxiety or fear to the point of irrational thinking). The facility's Psychotropic Medication Use policy, dated 10/23/17, stated the indication for any psychotropic medication would be thoroughly documented in the clinical record to include an appropriate supporting diagnosis and identification of behavioral symptoms being treated. The medical record must show documentation of adequate indication and diagnosed condition. As needed (PRN) orders for psychotropic medications would be limited to 14 days unless the provider specified the duration. If the provider believed the PRN order should be extended beyond the 14 days, the provider must document the rationale in the medical record.

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility had a census of 27 residents. The sample included 12 residents. Based on observation, interview, and record review, the facility failed to develop a comprehensive care plan for two residents, Resident (R) 11 and R27, who received prophylactic antibiotics for urinary tract infections (UTI- an infection in any part of the urinary system).Findings included: - R11's Electronic Medical Record (EMR) documented diagnoses of retention of urine (lack of ability to urinate and empty the bladder), 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 paranoid schizophrenia (characterized by persistent delusions of persecution, grandeur, or jealousy, often accompanied by auditory hallucinations). R11's admission Minimum Data Set (MDS) dated [DATE] documented R11 had moderately impaired cognition. R11 was dependent upon staff assistance for toileting hygiene and was frequently incontinent of urine and always incontinent of bowel. The MDS recorded R11 had no UTIs and received an antibiotic (a class of medications used to treat infections). R11's Quarterly MDS dated 08/04/25 documented R11 had intact cognition. R11 was dependent upon staff assistance for toileting hygiene and was frequently incontinent of urine but continent of bowel. The MDS recorded R11 had no UTI and received an antibiotic medication. R11's Care Plan lacked documentation R11 had UTIs or received antibiotic medication. The Physician's Order dated 02/05/25 directed staff to administer Bactrim (an antibiotic) DS (double strength) 800-160 milligrams (mg), one tablet, by mouth, daily, prophylactic for the bladder. R11's ER lacked documentation R11 had a UTI since admission on [DATE]. The Consultant Pharmacist (CP) monthly medication reviews did not note the long-term antibiotic use and risks associated with ongoing administration from 03/2025 to 10/2025. On 10/22/25 at 01:25 PM, R11 sat in a wheelchair in his room. On 10/21/25 at 02:10 PM, Administrative Nurse E stated she did not monitor prophylactic antibiotics with her antibiotic stewardship program and would contact the physician for direction on the antibiotic use and if he would like R11 to continue the medication. At 03:00 PM, Administrative Nurse E stated that the CP verified that she did not monitor the use of the prophylactic antibiotic, only the renal function and dosage. On 10/21/25 at 03:36 PM, Certified Nurse Aide (CNA) M stated staff assisted R11 with toileting and personal care. On 10/22/25 at 03:59 PM, Licensed Nurse (LN) G stated R11 had not had any UTIs since he had been admitted and did not have any symptoms. On 10/22/25 at 10:35 AM, Administrative Nurse D stated the use of the antibiotic and what symptoms (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	staff should be aware of should be on R11's care plan. The facility's Minimum Data Set (MDS) and Comprehensive Care Plans policy dated 09/26/19, documented that the facility shall prepare an interdisciplinary comprehensive assessment of the resident's needs, strengths, goals, life history, and preferences, and information required by the Resident Assessment Instrument (RAI) using the Minimum Data Set (MDS). The information would be used to develop, with the input and participation and the resident representative would participate in the assessment process to the extent practicable. Each discipline's assessment would include the relevant resident's needs, strengths, life history, goals, and preferences as they related to the topic or area being assessed. - R27's Electronic Medical Record (EMR) included diagnoses of personal history of urinary tract infections (UTI- an infection in any part of the urinary system), diabetes mellitus (DM- when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin), chronic pain, congestive heart failure (CHF- a condition with low heart output and the body becomes congested with fluid), and anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear) disorder. R27's Quarterly Minimum Data Set (MDS), dated [DATE], documented that R27 had intact cognition, no delirium (sudden severe confusion, disorientation, and restlessness) or psychosis (any major mental disorder characterized by a gross impairment in reality perception), and did not exhibit behaviors. R27 had impaired functional range of motion of upper and lower extremities on both sides, and was dependent on staff for oral care, toileting, personal hygiene, bathing, and upper and lower body dressing. R27 was also dependent on staff for bed mobility and transfers. The MDS further documented that R27 was on a toileting program and was frequently incontinent of urine and occasionally incontinent of bowel and had no UTIs in 30 days. R27 received insulin (a hormone that lowers the level of glucose in the blood) injections, an antianxiety (a class of medications that calm and relax people), an anticoagulant (a class of medications used to prevent the blood from clotting), an antibiotic (a class of medications used to treat infectious processes), a diuretic (a medication to promote the formation and excretion of urine), an opioid, and hypoglycemic (medication to lower the amount of glucose in the blood). The Urinary Incontinence Care Area Assessment (CAA) dated 01/20/25 documented that R27 was frequently incontinent of urine and bowel, did not always feel the urge to void, or know once she had gone. The CAA further documented that R27 was on a toileting schedule of every three hours during the day and checked once at 04:00 AM. R27's Care Plan dated 10/16/25 documented that R27 required assistance to perform most activities of daily living (ADL) and had a toileting schedule every three hours during the daytime and during the night at 04:00 AM. The care plan lacked including R27's history of UTIs or long-term use of antibiotics. The Physician Order dated 01/07/25, directed staff to administer Macrobid Oral Capsule (an antibiotic) 100 milligrams (mg) by mouth one time for the history of UTIs. The Progress Note dated 02/05/25 at 10:29 AM documented a urinary analysis (UA- lab analysis of urine). The Progress Note dated 02/05/25 at 06:11 PM documented that the staff received a physician order to hold the Macrobid (an antibiotic) and administer Cipro (an antibiotic) 500 mg by mouth twice a day (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	for five days, repeat a UA when the Cipro was completed, and restart Macrobid 100 mg by mouth daily. The Progress Note dated 07/21/25 at 04:31 PM documented a urine culture (lab test to determine specific microorganisms and antibiotic treatment) from 07/18/25 showing that the bacteria were resistant to Macrobid. The physician ordered to administer Cipro 500 mg twice a day for five days and then resume Macrobid. On 10/21/25 at 08:58 AM, staff assisted R27 from her wheelchair to her recliner using a sit-to-stand lift. Certified Nurse Aide (CNA) P asked the resident if she needed to use the bathroom prior to being placed in the recliner. R27 declined the offer. On 10/22/25 at 09:28 AM, Licensed Nurse (LN) I stated that she believed R27's prophylactic antibiotic was for the pressure ulcer on R27's heel, which was positive for Methicillin-resistant Staphylococcus Aureus (MRSA- a type of bacteria resistant to many antibiotics). On 10/22/25 at 10:40 AM, Administrative Nurse D verified that R27 received ongoing Macrobid for the history of UTIs and would discuss the matter with R27's physician. Administrative Nurse D verified R27's care plan lacked the ongoing use of antibiotic therapy related to R27's history of UTIs, which should have been included. The facility's Minimum Data Set (MDS) and Comprehensive Care Plans policy dated 09/26/19, documented that the facility shall prepare an interdisciplinary comprehensive assessment of the resident's needs, strengths, goals, life history, preferences, and information required by the Resident Assessment Instrument (RAI) using the Minimum Data Set (MDS). The information would be used to develop, with the input and participation and the resident representative would participate in the assessment process to the extent practicable. Each discipline's assessment would include the relevant resident's needs, strengths, life history, goals, and preferences as they related to the topic or area being assessed.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility had a census of 27 residents. The sample included 12 residents, with seven reviewed for unnecessary medications. Based on observation, interview, and record review, the facility's Consultant Pharmacist (CP) failed to address with the facility the ongoing prophylactic (a medicine or course of action used to prevent disease) antibiotic (a class of medications used to treat infections) use for Resident (R) 11 and R27.Findings included: - R11's Electronic Medical Record (EMR) documented diagnoses of retention of urine (lack of ability to urinate and empty the bladder), 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 paranoid schizophrenia (characterized by persistent delusions of persecution, grandeur, or jealousy, often accompanied by auditory hallucinations). R11's admission Minimum Data Set (MDS) dated [DATE] documented R11 had moderately impaired cognition. R11 was dependent upon staff assistance for toileting hygiene and was frequently incontinent of urine and always incontinent of bowel. The MDS recorded R11 had no urinary tract infection (UTI- an infection in any part of the urinary system) and received an antibiotic. R11's Quarterly MDS dated 08/04/25 documented R11 had intact cognition. R11 was dependent upon staff assistance for toileting hygiene and was frequently incontinent of urine and continent of bowel. The MDS recorded R11 had no UTI and received an antibiotic medication. R11's Care Plan lacked documentation R11 had UTIs or received antibiotic medication. The Physician's Order dated 02/05/25 directed staff to administer Bactrim (an antibiotic) DS (double strength) 800-160 milligrams (mg), one tablet, by mouth, daily, prophylactic for bladder. R11's EMR lacked documentation R11 had a UTI since admission on [DATE]. The Consultant Pharmacist (CP) monthly medication reviews did not note the long-term antibiotic use or the risks associated with ongoing administration from 03/2025 to 10/2025. On 10/22/25 at 01:25 PM, R11 sat in a wheelchair in his room. On 10/21/25 at 02:10 PM, Administrative Nurse E stated she did not monitor prophylactic antibiotics with her antibiotic stewardship program and would contact the physician for direction on the antibiotic use and if he would like R11 to continue the medication. At 03:00 PM, Administrative Nurse E stated that the CP verified that she did not monitor the use of the prophylactic antibiotic, only the renal function and dosage. On 10/22/25 at 03:59 PM, Licensed Nurse (LN) G stated R11 had not had any UTIs since he had been admitted and did not have any symptoms. On 10/22/25 at 10:35 AM, Administrative Nurse D stated the use of the antibiotic and what symptoms staff should be aware of should be on R11's care plan. Administrative Nurse D verified she was unable to find any physician notes regarding the use of the Bactrim medication and would discuss the matter (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	with the physician. Administrative Nurse D stated the CP did not alert the facility of the antibiotic use due to the facility had a different program, and she did not have it on her radar to watch out for long-term antibiotic use. The facility's Consultant Pharmacist policy dated 10/15/17, documented that the pharmacy consultant would review antibiotic and psychotropic medication utilization and collaborate on the development of an action plan consistent with the best practices and regulatory requirements. The pharmacist would report any irregularities in a written report and give it to the Provider, the facility's medical director, and the director of nursing. The CP reports must be acted upon. Irregularities included, but not limited to: any unnecessary drug when used (1) in excessive dose (including duplicate therapy: or (2) for excessive duration: or (3) without adequate monitoring: or (4) without adequate indications for its use: or (5) in the presence of adverse consequences which indicate the dose should be reduced or discontinued: or (6) any combinations of the foregoing reasons. - R27's Electronic Medical Record (EMR) included diagnoses of personal history of urinary tract infections (UTI- an infection in any part of the urinary system), diabetes mellitus (DM- when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin), chronic pain, congestive heart failure (CHF- a condition with low heart output and the body becomes congested with fluid), and anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear) disorder. R27's Quarterly Minimum Data Set (MDS) dated [DATE] documented that R27 had intact cognition, no delirium (sudden severe confusion, disorientation, and restlessness) or psychosis (any major mental disorder characterized by a gross impairment in reality perception), and did not exhibit behaviors. R27 had impaired functional range of motion of upper and lower extremities on both sides, and was dependent on staff for oral care, toileting, personal hygiene, bathing, and upper and lower body dressing. R27 was also dependent on staff for bed mobility and transfers. The MDS further documented that R27 was on a toileting program and was frequently incontinent of urine and occasionally of bowel, and had no UTIs in 30 days. R27 received insulin (a hormone that lowers the level of glucose in the blood) injections, an antianxiety (a class of medications that calm and relax people), an anticoagulant (a class of medications used to prevent the blood from clotting), an antibiotic (a class of medications used to treat infectious processes), a diuretic (a medication to promote the formation and excretion of urine), an opioid (a class of medication to alleviate pain), and hypoglycemic (medication to lower the amount of glucose in the blood). The Urinary Incontinence Care Area Assessment (CAA) dated 01/20/25 documented that R27 was frequently incontinent of urine and bowel, did not always feel the urge to void, or know once she had gone. The CAA further documented that R27 was on a toileting schedule of every three hours during the day and checked once at 04:00 AM. R27's Care Plan dated 10/16/25 documented that R27 required assistance to perform most activities of daily living (ADL) and had a toileting schedule every three hours during the daytime and during the night at 04:00 AM. The Physician Order dated 01/07/25 directed staff to administer Macrobid Oral Capsule (an antibiotic) 100 milligrams (mg) by mouth one time for the history of UTIs. The Progress Note dated 02/05/25 at 10:29 AM documented a urinary analysis (UA- lab analysis of urine). (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Progress Note dated 02/05/25 at 06:11 PM documented that the staff received a physician order to hold the Macrobid (an antibiotic) and administer Cipro (an antibiotic) 500 mg by mouth twice a day for five days, repeat a UA when the Cipro was completed, and to restart Macrobid 100 mg by mouth daily. The Progress Note dated 07/21/25 at 04:31 PM documented a urine culture (lab test to determine specific microorganisms and antibiotic treatment) from 07/18/25 showing that the bacteria were resistant to Macrobid. The physician ordered to administer Cipro 500 mg twice a day for five days and then resume Macrobid. On 10/21/25 at 08:58 AM, staff assisted R27 from her wheelchair to her recliner using a sit-to-stand lift. Certified Nurse Aide (CNA) P asked R27 if she needed to use the bathroom prior to being placed in the recliner. R27 declined the offer. On 10/21/25 at 02:15 PM, Administrative Nurse E, the Infection Preventionist (IP), reported not monitoring the prophylactic antibiotics use with the antibiotic stewardship surveillance. Administrative Nurse E reported she was not aware whether the Consultant Pharmacist (CP) reviewed the prophylactic (preventative in nature) antibiotic use, either. On 10/22/25 at 09:28 AM, Licensed Nurse (LN) I stated that she believed R27's prophylactic antibiotic was for the pressure ulcer on R27's heel, which was positive for Methicillin-resistant Staphylococcus Aureus (MRSA- a type of bacteria resistant to many antibiotics). On 10/22/25 at 10:40 AM, Administrative Nurse D verified that R27 received ongoing Macrobid for the history of UTIs and would discuss the matter with R27's physician and the CP. Administrative Nurse D reported the CP had not alerted the facility to the prophylactic antibiotic used on the monthly medication reviews, and the CP did not have it on her radar to watch for long-term antibiotic use. The facility's Consultant Pharmacist policy dated 10/15/17, documented that the pharmacy consultant would review antibiotic and psychotropic medication utilization and collaborate on the development of an action plan consistent with the best practices and regulatory requirements. The pharmacist would report any irregularities in a written report and give it to the Provider, the facility's medical director, and the director of nursing. The CP reports must be acted upon. Irregularities included, but not limited to: any unnecessary drug when used (1) in excessive dose (including duplicate therapy: or (2) for excessive duration: or (3) without adequate monitoring: or (4) without adequate indications for its use: or (5) in the presence of adverse consequences which indicate the dose should be reduced or discontinued: or (6) any combinations of the foregoing reasons.

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility had a census of 27 residents. The sample included 12 residents, with one reviewed for Hospice (specialized end-of-life) services. Based on observation, interview, and record review, the facility failed to provide thorough care planning instruction for Resident (R) 7, who received Hospice services. Findings included:- R7?s Electronic Medical Record documented a diagnosis of Huntington's disease (rare abnormal hereditary condition characterized by progressive mental deterioration, a disabling central nervous system movement disorder).R7?s Quarterly Minimum Data Set (MDS) dated [DATE] documented the Brief Interview for Mental Status (BIMS) without a score and documented R7 had severely impaired cognition. The MDS documented R7 was dependent on staff for all activities of daily living and received Hospice services. R7?s Care Plan dated 10/13/25 stated his family had elected Hospice services. R7's weight would be obtained monthly for Hospice to monitor. The care plan included the hospice phone number but lacked the name of the hospice. The care plan directed staff to work cooperatively with the hospice team, initiated 07/14/25.The care plan lacked the name of the Hospice company, what supplies would be provided, and how often Hospice staff would assess and provide care for R7. On 10/21/25 at 07:40 AM, R7 sat in a specialized wheelchair in the commons area. R7 was awake, alert, and looking around. He displayed some involuntary movements.On 10/21/25 at 03:00 PM, Certified Nurse Aide (CNA) O verified R7 received Hospice services, but she did not know the name. She thought the nurse came to see R7 twice weekly. She was unsure if any hospice aides came. CNA O stated hospice staff brought in briefs, but she did not know what else they might have supplied. On 10/22/25 at 09:20 AM, Administrative Nurse D stated the facility only used one Hospice. She stated the hospice nurse came one to two times per week and the visits depended on the resident's needs, family questions, or if there were any changes. She verified the care plan lacked the Hospice name, visit frequency, and supplies. Upon request, 10/22/25, the facility did not provide a Hospice policy.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement a program that monitors antibiotic use. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility had a census of 27 residents. The sample included 12 residents, with seven reviewed for unnecessary medications. Based on observation, interview, and record review, the facility failed to implement antibiotic use protocols to avoid unnecessary and/or inappropriate antibiotic use to reduce the risk of adverse effects, including antibiotic resistance, when the facility failed to monitor effectiveness and evaluate appropriateness for the extended administration of prophylactic (preventative in nature) antibiotics for Residents (R) 11 and R27.Findings included:- R11's Electronic Medical Record (EMR) documented diagnoses of retention of urine (lack of ability to urinate and empty the bladder), 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 paranoid schizophrenia (characterized by persistent delusions of persecution, grandeur, or jealousy, often accompanied by auditory hallucinations). R11's admission Minimum Data Set (MDS), dated [DATE], documented R11 had moderately impaired cognition. R11 was dependent upon staff assistance for toileting hygiene and was frequently incontinent of urine and always incontinent of bowel. The MDS recorded R11 had no urinary tract infection (UTI- an infection in any part of the urinary system) and received an antibiotic (a class of medications used to treat infections). R11's Quarterly MDS, dated 08/04/25, documented R11 had intact cognition. R11 was dependent upon staff assistance for toileting hygiene and was frequently incontinent of urine and continent of bowel. The MDS recorded R11 had no UTI and received an antibiotic medication. R11's Care Plan lacked documentation R11 had UTIs or received antibiotic medication. The Physician's Order, dated 02/05/25, directed staff to administer Bactrim (an antibiotic) DS (double strength) 800-160 milligrams (mg), one tablet, by mouth, daily, prophylactic for bladder. R11's ER lacked documentation R11 had a UTI since admission on [DATE]. The Consultant Pharmacist (CP) monthly medication reviews did not note the long-term antibiotic use and risks associated with ongoing administration from 03/2025 to 10/2025. On 10/22/25 at 01:25 PM, R11 sat in a wheelchair in his room. On 10/21/25 at 02:10 PM, Administrative Nurse E stated she did not monitor prophylactic antibiotics with her antibiotic stewardship program and would contact the physician for direction on the antibiotic use and if he would like R11 to continue the medication. At 03:00 PM, Administrative Nurse E stated that the CP verified that she did not monitor the use of the prophylactic antibiotic, only the renal function and dosage. On 10/21/25 at 03:36 PM, Certified Nurse Aide (CNA) M stated staff assisted R11 with toileting and personal care. On 10/22/25 at 03:59 PM, Licensed Nurse (LN) G stated R11 had not had any UTIs since he had been admitted and did not have any symptoms. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E424	A. Building B. Wing	10/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sheridan County Hospital Ltcu	826 18th Street, Box 167 Hoxie, KS 67740

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/22/25 at 10:35 AM, Administrative Nurse D stated the use of the antibiotic and what symptoms staff should be aware of should be on R11's care plan. Administrative Nurse D verified she was unable to find any physician notes regarding the use of the Bactrim medication and would discuss the matter with the physician. Administrative Nurse D stated the CP did not alert the facility of the antibiotic use due to the facility had a different program, and she did not have it on her radar to watch out for long-term antibiotic use. The facility's Antimicrobial Stewardship policy, reviewed on 11/25/24, documented that all antimicrobials would be evaluated for appropriateness of therapy as soon as possible. The committee would comply with all state, federal, and local laws and regulations to follow evidence-based practice regarding antimicrobial use. The committee would provide reliable, consistent methods of surveillance and documentation regarding appropriate antibiotic usage for patients. The antimicrobial stewardship committee ensured that patients received the appropriate antibiotic therapy needed based on laboratory results and post-visit follow-ups on findings. - Resident (R) 27's Electronic Medical Record (EMR) included diagnoses of personal history of urinary tract infections (UTI- an infection in any part of the urinary system), diabetes mellitus (DM- when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin), chronic pain, congestive heart failure (CHF- a condition with low heart output and the body becomes congested with fluid), and anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear) disorder. R27's Quarterly Minimum Data Set (MDS) dated [DATE] documented that R27 had intact cognition, no delirium (sudden severe confusion, disorientation, and restlessness) or psychosis (any major mental disorder characterized by a gross impairment in reality perception), and did not exhibit behaviors. R27 had impaired functional range of motion of upper and lower extremities on both sides, and was dependent on staff for oral care, toileting, personal hygiene, bathing, and upper and lower body dressing. R27 was also dependent on staff for bed mobility and transfers. The MDS further documented that R27 was on a toileting program and was frequently incontinent of urine and occasionally of bowel and had no UTIs in 30 days. R27 received insulin (a hormone that lowers the level of glucose in the blood) injections, an antianxiety (a class of medications that calm and relax people), an anticoagulant (a class of medications used to prevent the blood from clotting), an antibiotic (a class of medications used to treat infectious processes), a diuretic (a medication to promote the formation and excretion of urine), an opioid, and hypoglycemic (medication to lower the amount of glucose in the blood). The Urinary Incontinence Care Area Assessment (CAA) dated 01/20/25 documented that R27 was frequently incontinent of urine and bowel, did not always feel the urge to void, or know once she had gone. The CAA further documented that R27 was on a toileting schedule of every three hours during the day and checked once at 04:00 AM. R27's Care Plan dated 10/16/25 documented that R27 required assistance to perform most Activities of Daily Living (ADL) and had a toileting schedule every three hours during the daytime and during the night at 04:00 AM. The Physician Order dated 01/07/25 directed staff to administer Macrobid Oral Capsule (an antibiotic) 100 milligrams (mg) by mouth one time for the history of UTIs. The Progress Note dated 02/05/25 at 10:29 AM documented a urinary analysis (UA- lab analysis of (continued on next page)

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	17E424	A. Building B. Wing	10/22/2025

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Sheridan County Hospital Ltcu	826 18th Street, Box 167 Hoxie, KS 67740

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	urine). The Progress Note dated 02/05/25 at 06:11 PM documented that the staff received a physician order to hold the Macrobid (an antibiotic) and administer Cipro (an antibiotic) 500 mg by mouth twice a day for five days, repeat a UA when Cipro was completed, and to restart Macrobid 100 mg by mouth daily. The Progress Note dated 07/21/25 at 04:31 PM documented a urine culture (lab test to determine specific microorganisms and antibiotic treatment) from 07/18/25 showing that the bacteria were resistant to Macrobid. The physician ordered to administer Cipro 500 mg twice a day for five days and then resume Macrobid. On 10/21/25 at 08:58 AM, staff assisted R27 from her wheelchair to her recliner using a sit-to-stand lift. Certified Nurse Aide (CNA) P asked the resident if she needed to use the bathroom prior to being placed in the recliner. R27 declined the offer. On 10/21/25 at 02:15 PM, Administrative Nurse E, the Infection Preventionist (IP), reported not monitoring the prophylactic antibiotics use with the antibiotic stewardship surveillance. Administrative Nurse E reported she was not aware whether the Consultant Pharmacist (CP) reviewed the prophylactic (preventative in nature) antibiotic use, either. On 10/22/25 at 09:28 AM, Licensed Nurse (LN) I stated that she believed R27's prophylactic antibiotic was for the pressure ulcer on R27's heel, which was positive for Methicillin-resistant Staphylococcus aureus (MRSA- a type of bacteria resistant to many antibiotics). On 10/22/25 at 10:40 AM, Administrative Nurse D verified that R27 received ongoing Macrobid for the history of UTIs and would discuss the matter with R27's physician. Administrative Nurse D reported the CP had not alerted the facility to the prophylactic antibiotic used on the monthly medication reviews, and the CP did not have it on her radar to watch for long-term antibiotic use. The facility's Antimicrobial Stewardship policy, reviewed on 11/25/24, documented that all antimicrobials would be evaluated for appropriateness of therapy as soon as possible. The committee would comply with all state, federal, and local laws and regulations to follow evidence-based practice regarding antimicrobial use. The committee would provide reliable, consistent methods of surveillance and documentation regarding appropriate antibiotic usage for patients. The antimicrobial stewardship committee ensured that patients received the appropriate antibiotic therapy needed based on laboratory results and post-visit follow-ups on findings.

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F 0851 Level of Harm - Potential for minimal harm Residents Affected - Many	Electronically submit to CMS complete and accurate direct care staffing information, based on payroll and other verifiable and auditable data. The facility had a census of 27 residents. Based on observation, interview, and record review, the facility failed to submit complete and accurate staffing information through Payroll Based Journaling (PBJ- a required detail of staffing information submitted by nursing homes, provided by the Centers for Medicare and Medicaid Services (CMS)).Findings included:- The PBJ report provided by the Centers for Medicare and Medicaid Services (CMS) for Medicare & Medicaid Services (CMS) Fiscal (YR) 2025, Quarter (Q) 2, indicated no licensed nurse coverage for four dates: 01/04/25, 02/08/25, 03/01/25, and 03/22/25.The PBJ for FY Q3 recorded no licensed nurse coverage on three dates: 04/12/25, 05/03/25, and 05/24/25.Review of the facility's licensed nurse payroll data for the dates listed above revealed a licensed nurse was on duty for 24 hours a day, seven days a week.On 10/21/25 at 04:00 PM, Administrative Nurse D stated they would never be without a licensed nurse in the facility. The Nurses were scheduled for 12-hour shifts and had the availability of agency nurses also.On 10/22/25 at 07:55 AM, Administrative Staff A stated a report was run after accounts payable received the timesheet. There had been times when they did not get the agency staff timesheets before submitting the PBJ, so that was probably the glitch. Administrative Staff A further stated they have since changed systems, and the agency staff can clock in to track their time better.Upon request, a policy for PBJ was not provided by the facility.