STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175294	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 01/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEDICALODGES GODDARD	**501 EASY STREET , GODDARD, Kansas, 67052**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	INITIAL COMMENTS The following citations represent the findings of a Health Recertification Survey and complaint survey regarding allegations in 2697010, 2694991, 2680998, 2673282, 2596530, 2592546, 2574408, 2570842, 1423076.	F0000		
F0550 SS = D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility.	F0550		

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 reverse for further 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

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F0550 SS = D	Continued from page 1 §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is NOT MET as evidenced by: The facility reported a census of 45 residents; the sample included 13 residents. Based on interview, observation, and record review, the facility failed to protect the dignity of Resident (R) 33 when staff was argumentative and used foul language while speaking to R33. Findings included: - During an observation and interview on 01/13/26 at 12:10 PM, R33 sat in her wheelchair. R33 stated she had requested the staff to perform additional vaginal area cleaning due to itching and irritation, and one of the staff members started to argue with her and used foul language. R33 requested her to leave several times, and the staff member said R33 was not her mother and left. R33 said she has had issues with that Certified Nurse Aide (CNA) before. During an interview on 01/15/26 at 09:04 AM, Licensed Nurse (LN) G reported R33 had reported to her that an evening aide was not handling her gently during cares and was not speaking to her appropriately, and she had requested for the CNA to leave. LN G said the CNA did not leave, and R33 had to tell her several times to leave. LN G said the CNA told R33 that R33 was not her “mama,” and the CNA was argumentative with R33. LN G also said R33 reported the CNA was no longer allowed in her room. During an interview on 01/15/26 at 09:53 AM, Administrative Nurse D reported she had been informed about the CNA interaction with R33, and she had re-arranged the schedule so the CNA would not be part of R33's care, and then the problem had corrected itself when the CNA abruptly quit without notice before working again. The facility policy “Abuse, Neglect and Exploitation,” dated 10/2022, documented it was the policy of	F0550		

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F0550 SS = D	Continued from page 2 Medicalodges, Inc., to treat each resident with respect, kindness, dignity, and care, and to keep them free from abuse and neglect and to take swift and immediate action to investigate and adjudicate alleged abuse and neglect.	F0550		
F0552 SS = D	Right to be Informed/Make Treatment Decisions CFR(s): 483.10(c)(1)(4)(5) §483.10(c) Planning and Implementing Care. The resident has the right to be informed of, and participate in, his or her treatment, including: §483.10(c)(1) The right to be fully informed in language that he or she can understand of his or her total health status, including but not limited to, his or her medical condition. §483.10(c)(4) The right to be informed, in advance, of the care to be furnished and the type of care giver or professional that will furnish care. §483.10(c)(5) The right to be informed in advance, by the physician or other practitioner or professional, of the risks and benefits of proposed care, of treatment and treatment alternatives or treatment options and to choose the alternative or option he or she prefers. This REQUIREMENT is NOT MET as evidenced by: The facility reported a census of 45 residents; the sample included 13 residents. Based on interview, observation, and record review, the facility failed to inform Resident (R) 18 and/or his representative regarding the risks related to psychotropic (alters mood or thoughts) medications. Findings included: - Review of the Electronic Health Record (EHR) for R18 included diagnoses of depression (a mood disorder that causes a persistent feeling of sadness and loss of interest), insomnia (inability to sleep), anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), and chronic pain (persistent pain lasting over three months).	F0552		

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F0552 SS = D	Continued from page 3 R18's "Annual Minimum Data Set (MDS)," dated 01/02/26, documented a Brief Interview of Mental Status (BIMS) score of 15, which indicated intact cognition. The assessment documented R18's pain frequency was almost constant. The "Psychotropic Drug Use Care Area assessment (CAA)," dated 01/02/26, documented R18 had been administered antidepressant (a class of medications used to treat mood disorders) medications. The "Pain CAA," dated 01/02/26, documented R18 had reported pain almost constantly with a pain value of 7 to 10 on a numeric rating scale of zero to 10. R18's "Care Plan," dated 03/18/24, documented R18 had been taking medication to manage his chronic and acute pain. An intervention dated 12/19/25 included the administration of ordered Lyrica (an anticonvulsant and analgesic drug used for nerve pain) 50 milligrams (mg), one capsule three times a day for pain. R18's EHR revealed a psychotropic consent signed and dated 05/08/25 which listed Lyrica 50 mg to be given twice daily. R18's EHR documented a new order, dated 12/15/25, for Lyrica 50 mg, three times daily for pain related to chronic pain. R18's EHR lacked evidence R18 or his representative received education and/or informed consent regarding the Lyrica dose and frequency increase. During an interview on 01/15/26 at 10:34 AM, Licensed Nurse (LN) G stated psychotropic consent was for the purpose of informing the resident and/or legal representative of risk/benefits of medications and then to approve the medication. She then said she was unsure when those consents were done and unsure who was responsible for having them done. During an interview on 01/15/26 at 11:04 AM, Administrative Nurse D reported she and Administrative Nurse E were responsible for performing the	F0552		

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F0552 SS = D	Continued from page 4 psychotropic medication consents. She stated the consents were done on admission if the resident was admitted on a psychotropic medication, before starting a psychotropic medication, and any time there was a change in the medication. She confirmed R18's consent was not accurate. The facility policy “Behavior Management & Psychotropic Medications,” dated 04/2025, documented informed consent was to be completed for the use of psychotropic medications and off-label use of medication which affects brain activity for the residents prior to initial administration of the medication and with a dose increase of psychotropic medication.	F0552		
F0607 SS = E	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(5)(ii)(iii) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, §483.12(b)(4) Establish coordination with the QAPI program required under §483.75. §483.12(b)(5) Ensure reporting of crimes occurring in federally-funded long-term care facilities in accordance with section 1150B of the Act. The policies and procedures must include but are not limited to the following elements. §483.12(b)(5)(ii) Posting a conspicuous notice of employee rights, as defined at section 1150B(d)(3) of the Act. §483.12(b)(5)(iii) Prohibiting and preventing	F0607		

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F0607 SS = E	Continued from page 5 retaliation, as defined at section 1150B(d)(1) and (2) of the Act. This REQUIREMENT is NOT MET as evidenced by: The facility reported a census of 45 residents. Five staff were reviewed for background checks. Based on interview and record review, the facility failed to implement their policy when facility failed to ensure background checks were completed for one staff. Findings included: - On 01/14/26 at 3:05 PM, Administrative Nurse D stated she was unable to locate the background check for Certified Nurse Aide (CNA) HH. She said she was aware it was a requirement for all staff to have a background check. On 01/15/26 at 10:23 AM, Administrative Staff A stated it was the expectation that all staff have background checks, per the facility's policy. The facility's policy "Abuse, Neglect, and Exploitation," dated 10/02/22, documented all new employees will be investigated prior to employment for a previous history of abuse, neglect, or exploitation.	F0607		
F0628 SS = D	Discharge Process CFR(s): 483.15(c)(2)(iii)(3)-(6)(8)(d)(1)(2); 483.21(c)(2) §483.15(c)(2) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider. (iii) Information provided to the receiving provider must include a minimum of the following: (A) Contact information of the practitioner responsible for the care of the resident. (B) Resident representative information including contact information	F0628		

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F0628 SS = D	Continued from page 6 (C) Advance Directive information (D) All special instructions or precautions for ongoing care, as appropriate. (E) Comprehensive care plan goals; (F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care. §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section;	F0628		

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F0628 SS = D	Continued from page 7 (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice.	F0628		

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F0628 SS = D	Continued from page 8 If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. §483.21(c)(2) Discharge Summary	F0628		

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F0628 SS = D	Continued from page 9 When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following: (i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results. (ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative. (iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter). This REQUIREMENT is NOT MET as evidenced by: The facility had a census of 45 residents. The sample included 13 residents with two residents reviewed for hospitalization. Based on interview and record review, the facility failed to provide a bed hold and written notification of transfer for Resident (R) 49 and failed to provide written notification of transfer for R33. The facility additionally failed to notify the Office of the Long-Term Care Ombudsman (LTCO). Findings included: 1. R49's "Progress Notes" dated 11/04/25 at 12:36 PM, documented another facility had arrived to pick up R49 to transport her to their facility for transfer. R49 would not wake up, and efforts to arouse R49 were ineffective. Staff notified Emergency Medical Service (EMS), and EMS transported R49 to the hospital. R49's Electronic Medical Record (EMR) lacked evidence the facility provided written notification of the transfer, and a bed hold notice to R49 and/or his representative. The facility was unable to provide evidence of notification to the LTCO for R49's transfer. 2. R33's “Transfer Note” dated 08/24/25 at 09:12 PM, documented R33 was not able to have a sensible	F0628		

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F0628 SS = D	Continued from page 10 conversation with caregivers, was not able to voice her pain levels, and was not able to wheel herself in her wheelchair as normal. R33 was sent out to the emergency room (ER) for further checkup. The “Admission Progress Note,” dated 08/29/25 at 09:00 PM, documented R33 was readmitted to the facility from the hospital. R33's EMR lacked evidence R33 or her legal representative was provided written notification, and lacked evidence the LTCO was notified of her transfer to the hospital on 08/24/25. During an interview on 01/14/26 at 10:13 AM, Social Services X stated the nurse on duty would provide the bed hold when a resident transferred to the hospital. Social Services X also said there should have been a bed hold provided when R49 transferred to the hospital, and the nurse should have provided the written reason for transfer. Social Services X also stated the LTCO was notified monthly of transfers and discharges via email. Social Services X confirmed there was no bed hold provided, and the written notification was not provided to the R$9 or his legal representative, or to the LTCO regarding his transfer or discharge. During an interview on 01/14/26 at 10:30 AM, Licensed Nurse (LN) I stated she was unsure about who provided a bed hold and had never been informed about who provided a bed hold. LN I said she believed the business office or social services designee (SSD) provided bed holds and written notification. During an interview on 01/14/26 at 11:00 AM, Administrative Nurse G stated the bed hold notification was kept at the nurse’s station, and it was sent with the resident and EMS when the resident was transferred to the hospital. Administrative Nurse G then said the business office provided follow-up within 24 hours of transfer or discharge. She further stated a progress note was also done, which documented a notification was provided and sent. During an interview on 01/14/26 at 04:02 PM, Social Services X said there was no written notification provided to R33 or her legal representative about her transfer to the hospital, and there was no evidence the	F0628		

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F0628 SS = D	Continued from page 11 LTCO was notified of R33's transfer to the hospital. The facility policy “Notice of Bed Hold Policy and Returns,” dated 12/14/17, documented it was the policy in all Medicalodges, Inc. facilities to provide a written notice to residents, family members, or legal representatives of the facilities bed hold policies at the time of admission and again at the time of transfer of a resident to a hospital or for therapeutic leave.	F0628		
F0688 SS = D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is NOT MET as evidenced by: The facility identified a census of 45. The sample included 13 residents with one resident reviewed for mobility or range of motion (ROM - the full movement potential of a joint, usually its range of flexion and extension). Based on observation, record review, and interviews, the facility failed to implement an assistive program to help maintain ROM and prevent a potential decrease in ROM/mobility for Resident (R) 22. Findings included: - R22's Electronic Medical Record (EMR) from the "Diagnosis" tab documented diagnoses of dementia (a progressive mental disorder characterized by failing memory and confusion), cognitive communication deficit	F0688		

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MEDICALODGES GODDARD	501 EASY STREET , GODDARD, Kansas, 67052

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0688 SS = D	Continued from page 12 (an impairment in organization, sequencing, attention, memory, planning, problem-solving, and safety awareness) and a paralytic gait (a walking pattern characterized by stiffness, decreased coordination, and muscle weakness). R22's "Significant Change Minimum Data Set" (MDS) documented a Brief Interview of Mental Status (BIMS) score of 99, which indicated R22 was unable to complete the interview. Per staff interview, he had short-term and long-term memory deficits. The MDS documented R22 had an impaired ability to make himself understood through verbal and non-verbal expression of ideas and/or wants because he was rarely or never understood. The MDS documented R22 had received antidepressant (a class of medications used to treat mood disorders) and antipsychotic (a class of medications used to treat major mental conditions which cause a break from reality) medications. R22's "Care Plan," created on 01/22/21 and revised on 11/26/25, documented the nursing staff would monitor for tearful behavior. R22's "Care Plan," created on 01/22/21 and revised on 04/03/24, documented R22 was dependent with all activities of daily living (ADLs) except eating, for which he required maximum assistance. R22's EMR, including under the "Tasks" section, lacked evidence active or passive ROM or restorative care was provided. Observation on 01/13/26 at 09:30 AM revealed R22 sat in the television room in a high-backed wheelchair. His hands were curled inwards with fingers extended and held close to his chest. Observation on 01/13/26 at 11:25 AM revealed R22 remained in the television room. His hands were in the same position as in the previous observation. The television showed only a blue screen. On 01/14/26 at 11:55 AM, observation revealed R22 sat in his wheelchair at a table in the dining room. His hands were underneath a blanket was pulled up to his elbows. His eyes were closed, and he had a facial grimace.	F0688		

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F0688 SS = D	Continued from page 13 On 01/14/226 at12:03 PM, staff fed R22 his meal while the resident's arms and hands remained under a blanket. On 01/15/26 at 07:49 AM, R22 sat in his wheelchair in the television room/. His right hand was clenched shut and rested in his lap. R22 had very limited ability to open and close his right hand, and he nodded yes when asked if it was difficult to open and close his hands. On 01/14/26 at 11:02 AM, Certified Nurse Aide (CNA) P said she felt all residents should have a restorative program. On 01/14/26 at 11:04 AM, CNA N stated she felt residents should have a restorative program which included ROM, mobility, and stretching. On 1/14/26 at 02:12 PM, CNA M revealed R22 was not able to utilize a call light due to the limited range of motion of his hands. On 01/15/26 10:09 AM, License Nurse (LN) G revealed R22 does not have any restorative or specific care areas to prevent contractures (abnormal fixation of a joint or muscle) or prevent a decline in his ROM or mobility care. LN G revealed R22 had restricted ROM in all his extremities. LN G stated staff assessed R22 every two hours for positioning. LN G confirmed a passive ROM plan would be a good idea for R22. LN G also stated due to R22's limited mobility and ROM restriction in his hands, a soft-touch call light might be more appropriate for the resident than a regular push-button call light. On 01/15/26 at 10:20 AM, LN J stated the facility no longer had a restorative program. On 01/15/26 at 11:40 AM, Administrative Nurse D revealed restorative services, or a passive ROM program, would be expected for R22. Administrative Nurse D verified there was no documentation in the resident's clinical record or tasks which indicated ROM services to prevent further decline were provided. The facility's Restorative Program policy dated	F0688		

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F0688 SS = D	Continued from page 14 03-2014; Rev. 12-2018; 12-2022 documented restorative programs will be provided to each resident based on their individual needs to maintain their highest level of functioning in the areas of physical, mental, and psychosocial well-being.	F0688		
F0689 SS = D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is NOT MET as evidenced by: The facility reported a census of 45 residents; the sample included three residents reviewed for accidents. Based on observation, interview, and record review, the facility failed to follow an intervention to prevent further falls after a fall for Resident (R) 6. This placed the residents at risk for further falls and related injuries. Findings included: - R6's Electronic Medical Records (EMR) documented diagnoses which included anxiety (a mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), dialysis (a procedure where impurities or wastes are removed from the blood), and hyperextension (movement at a joint to a position beyond the joint's normal maximum extension). R6's 03/25/25 "Admission Minimum Data Set (MDS)" documented a Brief Interview for Mental Status (BIMS) score of 14, indicating intact cognition. The MDS documented R6 had no falls within the last six months or while admitted. R6's "Falls Care Area Assessment" documented R6 was at risk for falls.	F0689		

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F0689 SS = D	Continued from page 15 R6's "Care Plan" documented she was at risk for falls related to confusion; initiated on 03/19/25. Staff were to place R6's wheelchair by her bed, and anti-roll back brakes were attached on 02/07/24. A bed alarm was placed on 09/01/24. Staff were to frequently check on R6, initiated on 12/10/24, and lower the bed to the lowest position, initiated on 06/04/25. R6's "Care Plan" directed staff to ensure her fall mat was in place, initiated on 03/25/25. R6's "Fall Risk Assessment V1.0," dated 01/05/26, documented she had a high risk of falls. On 01/13/26 at 09:43 AM, R6 laid in bed with the wheelchair beside her bed. She had a large bruise on the left side of her face from her forehead to her neck. R6 was lying toward the side of the bed closest to the wheelchair. There was no fall mat on the floor beside her bed. On 01/13/26 at 03:54 PM, R6 was sleeping on the side of the bed. There was no fall mat in place. On 01/14/26 at 08:47 AM, Certified Nurse Aide (CNA) M assisted R6 to her room and assisted her to her bed. CNA M placed the wheelchair in the bathroom and did not place the fall mat on the floor beside her bed. On 01/14/26 at10:15 AM, R6 laid in bed. No floor mat was on the floor beside the bed. On 01/14/26 at 03:42 PM, CNA N stated R6 was a high risk for falls. CNA N stated staff were to put a fall mat on the floor on the side of the bed. On 01/15/26 at 11:42 AM, Administrative Nurse D stated R6's interventions for falls include a fall mat next to bed, assisting R6 to her room after meals, assisting R6 to the bathroom, placing a stop sign, leaving a bathroom light on at night, checking oxygen level at night, proper footwear, and a call light. Administrative Nurse D said she expected R6's interventions be followed. The facility's undated policy "Electronic Care Plan"	F0689		

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F0689 SS = D	Continued from page 16 documented the resident's person-centered plan of care was an active working document that reflects the care needs and resident voice. The facility's undated policy "Falls Management" documented the facility strives to minimize the risk for resident falls and to reduce injuries associated with resident falls.	F0689		
F0692 SS = D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is NOT MET as evidenced by: The facility identified a census of 45 residents. The sample included 13 residents with three sampled for nutrition. Based on observation, interview and record review, the facility failed to promote Resident (R) 3's highest practicable nutritional status when staff failed to weigh the resident upon admission and readmission after hospitals stays in order to establish a baseline and/or identify weight loss. Findings included: - R3's Electronic Medical Record (EMR) revealed a	F0692		

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F0692 SS = D	Continued from page 17 diagnosis of paraplegia (paralysis characterized by motor or sensory loss in the lower limbs and trunk), osteomyelitis (local or generalized infection of the bone and bone marrow), right leg above-the-knee amputation (surgical removal of a body part), and left leg below-the-knee amputation. R3's 12/05/25 “Quarterly Minimum Data Set" (MDS) documented a Brief Interview for Mental Status (BIMS) of 15, indicating intact cognition. The MDS recorded R3 had a weight loss of five percent (%) or more in the last month or 10% or more in the last six months. R3's "Care Plan," dated 08/26/25, documented R3 was at risk of weight loss or gain due to the disease process and directed staff to weigh him as the physician ordered. R3's “Physician's Order” documented an order for a weekly weight with a start date on 09/01/25. R3's “Physician's Order” documented an order for a daily weight for three days with a start date on 10/04/25. R3's “Physician's Order” documented an order for a daily weight with a start date on 10/10/25. R3's “Physician's Order” documented an order for a weekly weight with a start date on 10/15/25. R3's “Physician's Order” documented an order for a weekly weight for four weeks with a start date on 11/2625. R3's EMR documented an admission date of 08/25/25. R3's EMR lacked an admission weight until 09/09/25. The weight recorded for 09/09/25 was 259.6 pounds (lbs). R3 was discharged from the hospital on 09/13/25. R3 was readmitted on 10/02/25 and discharged back to the hospital on 10/04/25 with no weight obtained during this time.	F0692		

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F0692 SS = D	Continued from page 18 R3 readmitted on 10/09/25. R3's EMR lacked evidence of a weight assessment at that time or for the next 19 days. R3's EMR recorded a weight dated 10/29/25 prior to discharge back to the hospital that day. R3's weight on 10/29/25 was 249.4 lbs., showing a 10 lb. weight loss. R3 readmitted on 11/19//25 and discharged on 11/23/25 with no weight obtained during the stay. R3 readmitted on 12/02/25. R3's EMR lacked evidence of a weight assessment at that time and did not record a weight until 12/11/25, when his weight was measured at 222.2 lbs. On 01/14/26 at 07:50 AM, R3 reclined in bed with his bedside table over him. He ate breakfast at that time. His eggs were partially eaten. R3 stated he was feeling a little better than the previous day. On 01/14/26 at 3:42 PM, Certified Nurse Aide (CNA) N stated R3 had been sick and had not been eating as much the last few days. CNA N reported R3 snacked a lot and had food delivered. CNA N stated the CNAs help get the residents' weights. On 01/14/26 at 03:58 PM, Licensed Nurse (LN) H stated staff weigh residents as ordered. The dietary manager and the CNAs weigh the residents, and Dietary BB entered the weights in the EMR. On 01/14/26 at 01:36 PM, Administrative Nurse D stated she expected staff to weigh a resident as ordered. The expectation was that when a resident was admitted or readmitted, staff would weigh the resident weekly for four weeks, then monthly unless otherwise ordered by the physician. The facility's policy "Weight Assessment and Intervention" documented the nursing staff will record the resident's weight the day they move in and once a week for four weeks. If no weight concerns are noted, the resident's weight will be recorded monthly.	F0692		

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F0692 SS = D F0732 SS = C	Posted Nurse Staffing Information CFR(s): 483.35(i)(1)-(4) §483.35(i) Nurse Staffing Information. §483.35(i)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(i)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (i)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents, staff, and visitors. §483.35(i)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(i)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater.	F0692 F0732		

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F0732 SS = C	Continued from page 20 This REQUIREMENT is NOT MET as evidenced by: The facility reported a census of 45 residents. Based on observation, interview, and record review, the facility failed to ensure the posted daily nurse staffing sheets included accurate and identifiable information to include actual staff hours, as required. Findings included: - During an observation on 01/14/26 at 11:27 AM, the daily staffing sheet hung on the wall near the nurse's station. The daily nurse staffing form for 01/13/26 and 01/14/26 was posted and lacked the actual hours worked per shift for licensed and unlicensed staff providing resident care. Review of the daily staffing sheets from September 2025 through January 14, 2026, revealed some of September's staff sheets were filled out correctly. There were no staffing sheets for October 2025. November's staffing sheets lacked actual hours. December's staffing sheets lacked actual hours. January 1 through 6 staffing sheets lacked actual hours worked. January 7 through 12 had actual hours worked. On 01/14/26 at 11:27 AM, Administrative Nurse E stated she filled out the staff sheet and did not put actual hours on the posted sheet; the business office completed it later. On 01/14/26 at 2:48 PM, Administrative Nurse D stated she was not aware of the requirement to have actual hours posted on the daily staff sheet. The business office took care of it later. The facility's "Benefits Improvement Protection Act (BIPA) Nurse Staff Posting," revised 12/2019, documented the total hours worked this shift will be completed by the charge nurse at the end of the shift. The actual hours worked will be verified by the business office.	F0732		
F0759 SS = E	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors.	F0759		

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F0759 SS = E	Continued from page 21 The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is NOT MET as evidenced by: The facility had a census of 45 residents; the sample included 13 residents. Twenty-nine medications administrations were observed with three errors identified resulting in a medication error rate of 10.34 %. Based on observation, record review, and interview, the facility failed to ensure a medication error rate below five percent. Findings included: - Review of the Electronic Health Record (EHR) for Resident (R) 46 revealed the following orders: 1. Citalopram (a medication used to treat depression) 10 milligrams (mg), give one tablet by mouth one time a day. 2. Folic acid (a supplemental vitamin) one mg, give one tablet by mouth once daily. 3. Senna (a medication used to treat constipation) 8.6 mg, give two tablets by mouth two times daily. R46's EHR lacked orders for medications to be crushed and mixed. Observed on 01/15/26 at 07:12 AM, Certified Medication Aide (CMA) R, crushed together citalopram 10 mg, folic acid one mg, and senna 8.6 mg, and then gave them to R46. During an interview on 01/15/26 at 07:15 AM, CMA R stated R46's medications were always crushed together and then given to R46. During an interview on 01/15/26 at 07:49 AM, CMA R stated there should have been an order to crush medications and an order allowing the medications to be	F0759		

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F0759 SS = E	Continued from page 22 mixed together. During an interview on 01/15/26 at 07:56 AM, Licensed Nurse (LN) G stated there should have been an order to crush and mix the medications; if this happened without an order, then it was a medication error. LN G verified R46 had no order to crush medications, and she was not listed as a resident who required medications to be crushed. During an interview on 01/15/26 at 08:00 AM, Administrative Nurse D stated there should have been an order to crush medications and if there are specific warnings about medications being crushed, then there should have been an order related to the specific medication. Administrative Nurse D also said if medications were crushed and given with no crush order, it was not a medication error. The facility's policy "Medication Administration General Guidelines," dated 01/24, documented the need for crushing medications was to be indicated on the resident's orders and the medication administration record (MAR) so all were aware of the need, and the consultant pharmacist could advise on safety and alternatives, if appropriate, during medication regimen reviews (MRR).	F0759		
F0880 SS = E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff,	F0880		

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F0880 SS = E	Continued from page 23 volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review.	F0880		

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F0880 SS = E	Continued from page 24 The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is NOT MET as evidenced by: The facility reported a census of 45 residents. The sample included 13 residents with four residents reviewed for accident. Based on observation, interview and record review, the facility failed to clean reusable shared equipment between residents and failed to use proper 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) for R1 who had an indwelling catheter (tube placed in the bladder to drain urine into a collection bag) and wounds. Findings included: - On 01/14/26 at 07:55 AM, Certified Nurse Aide (CNA) N and CNA O entered Resident(R)1's room to transfer him with a mechanical lift. There was no visible EBP notification on the door. R1 had an indwelling catheter visible, with the tubing visible. CNA P and CNA O did not wear gowns during the care. On 01/14/26 at 10:17 AM, Certified Medication Aide (CMA) S finished a glucose check for Resident (R) 26 using a glucometer (instrument used to assess blood glucose levels) and proceeded to the cart. CMA S wrote down the number but did not clean the glucose monitor. CMA S pushed the cart to R1's room. CMA S obtained a test strip and placed it in the glucometer and obtained gloves. CMA S entered the room and uncovered R1 per his request. CMA S laid the glucometer and gloves on the overbed table, then washed her hands. CMA S applied gloves, started the monitor, cleaned R1's finger with alcohol, poked R1's finger to get a drop of blood, and checked the blood glucose level. CMA S threw trash away, then washed her hands. CMA S went to the hall and started to proceed to the next resident. Administrative Nurse E walked up to get dressing supplies out of the cart. Administrative Nurse E saw what CMA S was doing and left and returned with Sani-cloths. Administrative Nurse E cleaned the glucometer and wrapped it up, then got out another glucometer so they could have two in use, one to use while the other was sanitized. Administrative Nurse E told CMA S the glucometer should be cleaned between uses.	F0880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175294	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 01/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F0880 SS = E	Continued from page 25 On 01/14/26 at 10:40 AM, CMA S stated she was not aware that the glucometer was to be cleaned between residents. She has not been doing it and said she was never taught it needed to be done. On 01/15/26 at 10:58 AM, Administrative Nurse D stated she expected the CNAs to utilize EBP every time a resident with a wound or artificial opening was present. On 01/15/26 at 11:58 AM, Administrative Nurse D and Administrative Nurse E stated they expected staff to clean glucometers between each use. The facility's "ML Skills Check-Blood Glucose Monitoring – Cloned 3/20/201" documented that the glucometer was to be cleaned after use, wrap the meter inside a wipe, and place a new clean field. Review of the facility provided policy "Summary of Personal Protective Equipment [PPE] Use and Room Restrictions When Caring for Residents in Nursing Homes," EBP was to be used for all residents with wound or indwelling medical devices (such as catheters) regardless of MDRO infection or colonization.	F0880		
F0947 SS = F	Required In-Service Training for Nurse Aides CFR(s): 483.95(g)(1)-(4) §483.95(g) Required in-service training for nurse aides. In-service training must- §483.95(g)(1) Be sufficient to ensure the continuing competence of nurse aides, but must be no less than 12 hours per year. §483.95(g)(2) Include dementia management training and resident abuse prevention training. §483.95(g)(3) Address areas of weakness as determined in nurse aides' performance reviews and facility assessment at § 483.71 and may address the special needs of residents as determined by the facility staff.	F0947		

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F0947 SS = F	Continued from page 26 §483.95(g)(4) For nurse aides providing services to individuals with cognitive impairments, also address the care of the cognitively impaired. This REQUIREMENT is NOT MET as evidenced by: The facility reported a census of 45 residents. Based on interview and record review, the facility failed to develop, implement, and permanently maintain an in-service training program for Certified Nurse Aide (CNAs) with the required topics and no less than 12 hours per year. Two of the five nurse aides sampled lacked the required training topics. Two of five nurse aides sampled lacked the required 12 hours per year of in-service training. Findings included: - On 01/14/26 at 03:05 PM, review of training records for five CNAs employed by the facility for more than one year revealed two CNAs had less than 12 hours of documented in-service training for the previous 12 months. CNA HH had one hour of documented training, and CNA II had eight hours of documented training. On 01/14/26 at 03:05 PM, review of training records for five CNAs employed by the facility for more than one year revealed CNA HH and CNA II did not have the required topics for in-service training for the previous 12 months. On 01/14/26 3:05 PM, Administrative Nurse D confirmed the CNAs were required to have 12 hours of training annually and stated there were no records of additional training for those CNAs. Administrative Nurse D added that the staff members were working to complete the training. The facility did not provide a policy.	F0947		