STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175130	A. Building B. Wing	09/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Meadowbrook Rehabilitation Hospital	427 W Main Street Gardner, KS 66030

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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Keep residents' personal and medical records private and confidential. The facility had a census of 109 residents. The sample included 22 residents. Based on observation, record review, and interview, the facility failed to keep Resident (R) 15, R12, R80, R13, and R54's protected health information (PHI) private on a medication cart parked in the main dining room. Findings included:- On 09/14/25 at 9:00 AM, an observation revealed a medication cart parked in the 800 hallway with a laptop computer open on the cart. There was no Licensed Nurse (LN) or Certified Medication Aide (CMA) around the cart. Nursing staff left the computer screen unlocked and open with R15's PHI on the screen, visible to all who passed by the medication cart. The information visualized included R15's medication, date of birth , allergy information, and code status. LN J locked the screen. On 09/14/25 at 09:05 AM, an observation revealed four medication carts parked in the commons room with a laptop computer opened on the medication cart. LN and CMA walked away from the medication carts and were in the dining room. The nursing staff, LN and CMA, left the computer screen unlocked and open, and the PHI of R12, R80, R13, and R54 were visible on the screen to all who passed by the medication cart. The information visualized included R12, R80, R13, and R54's medications, date of birth , allergy information, and code status. LN J locked all screens.On 09/16/25 at 11:30 AM, LN H stated the medication cart should be locked and the computer screen should be closed.On 09/16/25 at 11:45 PM, Administrative Nurse D stated she expected the nursing staff to close the computer screen before walking away from the medication cart. Administrative Nurse D stated the resident's PHI should never be left on the computer screen. The facility's HIPAA Sanctions policy dated 05/12/25 documented that it was the policy of this facility to apply sanctions against employees who fail to comply with all policies and procedures regarding the protection of our residents' personally identifiable health information. The facility, as a covered entity under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), would implement policies and procedures to prevent, detect, contain, and correct any HIPAA violations. All employees were expected to comply with all policies and procedures regarding the protection of personal identifiable health information of our residents. All employees would be educated on relevant policies and procedures for which they were expected to comply, including this sanctions policy.

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 identified a census of 109 residents. The sample included 22 residents, with six residents reviewed for unnecessary medications. Based on observation, record review, and interviews, the facility failed to ensure physician ordered laboratory tests to monitor antipsychotic medication (a class of medications used to treat major mental conditions that cause a break from reality) for Resident (R) 9 were completed. The facility also failed to ensure the physician had documented a rationale with the risk versus benefits for the continued use of an antipsychotic (class of medications used to treat mental disorders characterized by a gross impairment in reality testing) medication with no gradual dose reduction for R7.Findings included:- R9's Electronic Medical Record (EMR) from the Diagnosis tab documented diagnoses of anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), paranoid schizophrenia (characterized by persistent delusions and hallucinations, primarily involving themes of persecution, mistrust, and conspiracy), schizophrenia (a mental disorder characterized by gross distortion of reality, disturbances of language and communication, and fragmentation of thought), and major depressive disorder (major mood disorder that causes persistent feelings of sadness). The Annual Minimum Data Set (MDS) dated 04/08/25 documented a Brief Interview for Mental Status (BIMS) score of 15, which indicated intact cognition. The MDS documented R9 had received antidepressant (a class of medications used to treat mood disorders) medication, antianxiety (a class of medications that calm and relax people) medication, and antipsychotic (a class of medications used to treat major mental conditions that cause a break from reality) medication during the observation period. The Quarterly MDS dated [DATE] documented a BIMS score of 15, which indicated intact cognition. The MDS documented that R9 had received antidepressant medication, antianxiety medication, and antipsychotic medication during the observation period. R9's Psychotropic Drug Use Care Area Assessment (CAA) dated 04/09/25 documented she was at risk for adverse side effects related to the medication she had received. R9's Care Plan dated 06/27/22 documented the nursing staff would obtain the laboratory tests as ordered by the physician. The plan of care dated 04/18/24 documented her medications would be reviewed monthly by the physician and the pharmacist.R9's EMR under the Orders tab revealed the following physician orders: Complete Blood Count (CBC- laboratory blood test), complete metabolic panel (CMP- laboratory blood test), and Haldol (antipsychotic) level (laboratory test to monitor cat levels) every three months, dated 10/24/24. Haldol injection solution (haloperidol lactate) inject 150 milligrams (mg) intramuscularly one time a day every 28 days related to schizophrenia, dated 09/03/25. Review of R9's EMR under the Misc tab under Laboratory lacked test results, and the facility was unable to provide evidence of results for the following laboratory tests: Haldol level in March 2025 and June 2025. On 09/16/25 at 09:25 AM, R9 laid on her bed, covered with her quilt. On 09/15/25 at 11:26 AM, Licensed Nurse (LN) G stated she entered the order into the laboratory portal as ordered by the physician. LN G stated if the order was for an extended period, that could also be entered into the portal. On 09/16/25 at 11:45 AM, Administrative Nurse D stated she expected the nurse who obtained the lab order to enter the order into the laboratory provider portal to be drawn as it was ordered. Administrative Nurse D stated the lab order could be entered into the lab providers portal to be an ongoing order if that was what the physician had ordered. Administrative Nurse D stated the physician could review the lab in the provider's portal, and then the medical records person would download the results into the resident's EMR. The facility's Use of Psychotropic Medications policy, dated 02/05/25, documented it was the intent of this policy to ensure that residents only received psychotropic medications when other nonpharmacological (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	interventions are clinically contraindicated. Additionally, these medications would only be used to treat the resident's medical symptoms and not used for discipline or staff convenience, which would deem it a chemical restraint. Residents who used psychotropic drugs would receive gradual dose reductions, unless clinically contraindicated, in an effort to discontinue these drugs. - R7's Electronic Medical Record (EMR) from the Diagnosis tab documented diagnoses of posttraumatic stress disorder (PTSD- a mental disorder characterized by an acute emotional response to a traumatic event or situation involving severe environmental stress), anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), hypertension (HTN- high blood pressure), diabetes mellitus (DM- when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin), major depressive disorder (major mood disorder that causes persistent feelings of sadness), paranoid schizophrenia (characterized by persistent delusions and hallucinations, primarily involving themes of persecution, mistrust, and conspiracy), schizophrenia (a mental disorder characterized by gross distortion of reality, disturbances of language and communication, and fragmentation of thought), and Parkinson's disease (a slowly progressive neurologic disorder characterized by resting tremors, rolling of the fingers, masklike faces, shuffling gait, muscle rigidity, and weakness). The Significant Change Minimum Data Set (MDS) dated 07/14/25 documented a Brief Interview for Mental Status (BIMS) score of 12, which indicated moderately impaired cognition. The MDS documented R7 received antiplatelet (medication that helps prevent blood clots from occurring) medication, antipsychotic (a class of medications used to treat major mental conditions that cause a break from reality) medication, antidepressant (a class of medications used to treat mood disorders) medication, antianxiety (a class of medications that calm and relax people) medication, anticonvulsant (a medication that prevents or treats seizures and convulsions) medication, hypoglycemic (a class of medication used to lower blood sugar) medication, and opioid (a class of controlled drugs used to treat pain) medication during the observation period. The MDS documented a gradual dose reduction had not been attempted. The MDS lacked a date of a gradual dose reduction had been attempted in the past. The MDS documented there was no physician documentation that a gradual dose reduction was clinically contraindicated. R7's Psychotropic Drug Use Care Area Assessment (CAA) dated 07/28/25 documented she was at risk for adverse effects related to the medication she had received. R7's Care Plan dated 06/27/22 documented the physician and pharmacist would review her medication monthly. The plan of care documented the facility would discontinue or reduce her medications to keep them at the lowest dose possible. R7‘s EMR under the Orders tab revealed the following physician orders: buspirone hci (antianxiety) tablet 15 milligrams (mg), give one tablet by mouth three times a day for anxiety, dated 06/15/22. Olanzapine (antipsychotic) tablet 15 mg, give half of a tablet (7.5 mg) by mouth in the afternoon for schizophrenia, dated 02/17/25. Risperdal (antipsychotic) tablet 3 mg (risperidone), give one tablet by mouth two times a day related to schizophrenia, dated 08/04/25.trazodone hci (antidepressant) oral tablet 50 mg, give 1 tablet by mouth at bedtime for depression with targeted symptom of insomnia, dated 08/04/25.Xanax (antianxiety) oral tablet 1 mg (alprazolam), give one tablet by mouth three times a day for anxiety, dated 08/12/25. The facility was unable to provide physician documentation that a gradual dose reduction was clinically contraindicated. On 09/15/25 at 01:53 PM, R7 laid on her bed, she offered no concerns at that time. On 09/16/25 at 11:45 AM, Administrative Nurse D stated that medical records would help ensure the lab tests were obtained as ordered. Administrative Nurse D stated the nurse practitioner reviewed the resident's psychotropic medications. The facility's Use of Psychotropic Medications policy, dated 02/05/25, documented it was the intent of this policy to ensure that residents only received psychotropic medications when other nonpharmacological (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	interventions are clinically contraindicated. Additionally, these medications would only be used to treat the resident's medical symptoms and not used for discipline or staff convenience, which would deem it a chemical restraint. Residents who used psychotropic drugs would receive gradual dose reductions, unless clinically contraindicated, in an effort to discontinue these drugs.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility identified a census of 109 residents. The sample included 22 residents, with four sample residents reviewed for hospitalizations. Based on observation, record review, and interview, the facility failed to ensure Resident (R) 17, R87, and their representatives were provided bed hold and a written notification of transfer, as soon as practicable, upon their transfer to the hospital. The facility failed to ensure R76, and his/her representative was provided a bed hold, as soon as practicable, upon transfer from the facility. Findings included: - R17's Electronic Medical Record (EMR) included diagnoses of sleep apnea (a disorder of sleep characterized by periods without respirations), venous insufficiency (poor circulation), edema (swelling resulting from an excessive accumulation of fluid in the body tissues), heart failure, diabetes mellitus (DM- when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin), morbid obesity (excessive body fat) with alveolar hypoventilation (condition where the lungs do not adequately exchange carbon dioxide and oxygen), chronic obstructive pulmonary disease (COPD- a progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing), and encephalopathy (a broad term for any brain disease that alters brain function or structure). R17's Quarterly Minimum Data Set (MDS), dated [DATE], documented that R17 had intact cognition, required partial/moderate assistance with toileting hygiene, bathing, lower body dressing, rolling side to side in bed, and sitting to lying in bed. R17's MDS documented that R17 received a scheduled pain medication regimen, had pain that interfered with therapy activities, sleeping, and day-to-day activities. The MDS further documented that R17 experienced shortness of breath or trouble breathing when lying flat and used oxygen and a non-invasive mechanical ventilator (a method of delivering pressurized breathing support through a mask). R17's Discharge MDS, dated [DATE], recorded a Discharge Return Anticipated of unplanned short-term general hospital discharge status. On 07/24/25, R17's MDS recorded an entry into the facility. The Progress Note dated 07/20/25 at 02:48 PM documented R17's oxygen levels had been running lower than usual, with complaints of having a hard time catching her breath. Respiratory Therapy checked the carbon monoxide level, and the physician was notified of R17's condition. The Progress Note further documented that the physician ordered R17 to be sent to the emergency department. The Director of Nursing, along with the R17 family member, was notified of the transfer to the emergency department. The Progress Note dated 07/24/25 at 06:26 PM documented R17 returned to the facility from the hospital. On 09/15/25 at 09:09 AM, R17 ate breakfast in her bed, wearing oxygen via nasal canula. R17 reported the swelling in her legs had improved. R17 reported painful joints, but this was not new pain to her related to the joints wearing out due to her age. On 09/15/25 at 01:41 PM, Licensed Nurse (LN) I and LN H reported that the nurse filled out the Bed Hold Assessment in the resident's EMR when a resident was sent to the hospital. LN I and LN H stated that the nursing staff did not obtain a written form or have the resident or resident (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	representative sign a Bed Hold. On 09/16/25 at 08:31 AM, Social Service X stated that recently the facility owner corporation had given direction that a written bed hold was to be obtained from the resident or resident representative at the time of discharge, if possible, but due to the nature of emergencies, the bed hold could be given the next day. On 09/16/25 at 08:00 AM, Administrative Nurse E reported she was not aware of the facility's policy for who was responsible for the Bed Hold procedure, due to being new to the role of Administrative Nurse at this facility. The facility's Bed Hold Notice policy, dated 02/05/25, documented that it was the policy of the facility to provide written information to the resident and/or the resident representative regarding bed hold practices both well in advance and at the time of a transfer for hospitalization or therapeutic leave. In the event of an emergency transfer of a resident, the facility will provide written notice of the facility's bed-hold policies to the resident and/or the resident's representative within 24 hours. The facility would document multiple attempts to reach the resident's representative in cases where the facility was unable to notify the representative. The facility would keep a signed and dated copy of the bed-hold notice information given to the resident and or resident representative in the resident's file and/or medical record. - R87's Electronic Medical Record (EMR) documented diagnoses of transient cerebral ischemic attack (TIA- mini-stroke- is a temporary blockage of blood flow to the brain that causes stroke-like symptoms but resolves on its own, typically within minutes to hours and before permanent damage occurs), chronic obstructive pulmonary disease (COPD- progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing), heart failure (a chronic condition where the heart can't pump enough blood and oxygen to meet the body's needs), and pulmonary embolism (condition where a blood clot travels from another part of the body, usually the legs, and blocks one or more arteries in the lungs). R87's admission Minimum Data Set (MDS) dated [DATE] documented he had a Brief Interview for Mental Status (BIMS) score of 13, which indicated intact cognition. R87 had a functional limitation in range of motion of both upper and lower extremities on both sides. R87 was dependent on staff for all his activities of daily living (ADL) cares. R87 used a wheelchair to assist with mobility. R87's overall goal was to remain in the facility. R87 had active discharge planning occurring for the resident to return to the community. R87's Discharge MDS dated 07/15/25 documented an unplanned discharge to an acute hospital with a return anticipated. R87's Entry MDS dated 07/18/25 documented a re-entry to the facility from an acute hospital. Upon R87's transfer to the hospital on [DATE], the facility failed to provide R87 and or his representative with the bed hold policy and a written notification of transfer as required. R87's Functional Abilities Care Area Assessment (CAA) dated 03/27/25 documented that staff were to assist with ADL cares as needed, anticipating cares, so that care needs were effectively met. Therapy services were to be used as needed to help increase functional mobility. Staff to encourage R87 to participate in ADL cares as much as able and promote independence. (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R87's Care Plan, initiated on 03/08/25, revised on 07/18/25, directed staff that R87's discharge plan was to go home with home health services and family. The Care Plan directed staff to review R87's discharge plan quarterly in the care plan meetings. The Care Plan directed staff that therapy was to assist with R87's goal of going home. On 09/15/25 at 10:15 AM, R87 laid in his bed watching TV. On 09/16/25 at 08:15 AM, Administrative Nurse E stated there had been a lack of understanding on who was responsible for ensuring the bed hold was completed. Administrative Nurse E stated nursing thought it was social services' responsibility, and social services thought it was a nursing responsibility. On 09/16/25 at 08:22 AM, Social Services X stated she had thought that the bed hold was a nursing responsibility to complete, so the bed holds were not being completed as required. Social Services X stated she was unsure about the written notification upon transfer. On 09/16/25 at 08:31 AM, Administrative Staff B stated the bed hold had not been provided as required, but would be from here on out. Administrative Staff B stated she had been misinformed on what was required for the bed hold. Administrative Staff B stated the facility had not been providing the written notification of transfers to residents and their representatives, either, but would begin doing so as of today. The facility's Bed Hold Notice policy dated 02/05/25 documented it was the policy of the facility to provide written information to the resident and or the resident representative regarding bed hold practices, both well in advance and at the time of a transfer for hospitalizations or therapeutic leave. As part of the admission packet and at the time of a transfer to the hospital or therapeutic leave, the facility will provide the resident and/or the resident representative written information that specifies: The duration of the State bed-hold policy, if any, during which the resident was permitted to return and resume residence in the nursing facility; The reserve bed payment policy in the state plan policy, if any. The facility policies regarding bed-hold periods include allowing a resident to return to the next available bed. Conditions upon which the resident would return to the facility: The resident required the services which the facility provides; The resident was eligible for Medicare skilled nursing facility services or Medicaid nursing facility services. In the event of an emergency transfer of a resident, the facility will provide written notice of the facility's bed-hold policies to the resident and/or the resident representative within 24 hours. The facility would document multiple attempts to reach the resident's representative in cases where the facility was unable to notify the representative. The facility would keep a signed and dated copy of the bed-hold notice information given to the resident and/or resident representative in the resident's file and/or medical record. The facility would provide this written information to all facility residents, regardless of their payment source. The facility lacked a policy regarding written notification upon transfers. - R76's Electronic Medical Record (EMR) recorded diagnoses of diabetes mellitus (DM- when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin), non-pressure chronic ulcer of left foot, major depressive disorder (major mood disorder that causes persistent feelings of sadness), peripheral vascular disease (PVD- slow and progressive circulation disorder causing narrowing, blockage, or spasms in a blood vessel), heart failure, acquired absence of right leg below the knee, fracture (broken bone) of left femur (broken bone), sepsis (a life-threatening (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	systemic reaction that develops due to infections that cause inflammation throughout the entire body), and chronic obstructive pulmonary disease (COPD- a progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing). R76's Quarterly/Medicare 5 Day Minimum Data Set (MDS), dated [DATE], documented R76 had intact cognition, required substantial to maximal assistance with toileting hygiene, and sitting to lying and lying to sitting. The MDS documented R76 needed partial to moderate assistance with lower-body dressing. The MDS documented R76 had pain occasionally, which affected sleep, day-to-day activities, and interfered with therapy activities. The MDS further documented that R76 had one unstageable (depth of the wound is unknown due to the wound bed being covered by a thick layer of other tissue and pus) pressure ulcer (localized injury to the skin and/or underlying tissue usually over a bony prominence, as a result of pressure, or pressure in combination with shear and/or friction). R76's Discharge MDS dated [DATE] recorded a Discharge Return Anticipated of unplanned short-term general hospital status. On 06/11/25, R76's MDS recorded an entry into the facility. On 09/15/25 at 02:22 PM, R76 lay in bed, listening to music on his phone. R76 talked about his return to the facility from the hospitalization, reporting he was doing well. On 09/15/25 at 01:41 PM, Licensed Nurse (LN) I and LN H reported that the nurse filled out the Bed Hold Assessment in the resident's EMR when a resident was sent to the hospital. LN I and LN H stated that the nursing staff did not obtain a written form or have the resident or resident representative sign a Bed Hold. On 09/16/25 at 08:31 AM, Social Service X stated that recently, the facility owner corporation had given direction that a written bed hold was to be obtained from the resident or resident representative at the time of discharge, if possible, but due to the nature of emergencies, the bed hold could be given the next day. On 09/16/25 at 08:00 AM, Administrative Nurse E reported she was not aware of the facility's policy for who was responsible for the Bed Hold procedure, due to being new to the role of Administrative Nurse at this facility. The facility's Bed Hold Notice policy, dated 02/05/25, documented that it was the policy of the facility to provide written information to the resident and/or the resident representative regarding bed hold practices both well in advance and at the time of a transfer for hospitalization or therapeutic leave. In the event of an emergency transfer of a resident, the facility will provide written notice of the facility's bed-hold policies to the resident and/or the resident's representative within 24 hours. The facility would document multiple attempts to reach the resident's representative in cases where the facility was unable to notify the representative. The facility would keep a signed and dated copy of the bed-hold notice information given to the resident and or resident representative in the resident's file and/or medical record.

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident when there is a significant change in condition **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility identified a census of 109 residents. The sample included 22 residents. Based on observation, record review, and interviews, the facility failed to identify the significant change in Resident (R) 54's condition and complete a comprehensive Significant Change Minimum Data Set (MDS) with the discontinuance of hospice services. Findings included: - R54's Electronic Medical Record (EMR) from the Diagnosis tab documented diagnoses of major depressive disorder (major mood disorder that causes persistent feelings of sadness), chronic obstructive pulmonary disease (COPD- a progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing), age related cognitive (relates to the processes of the mind, such as thinking, learning, remembering, and understanding) decline, hypertension (HTN- elevated blood pressure), lack of coordination, muscle weakness, congestive heart failure (CHF- a condition with low heart output and the body becomes congested with fluid), peripheral vascular disease (PVD- slow and progressive circulation disorder causing narrowing, blockage, or spasms in a blood vessel), and schizophrenia (a mental disorder characterized by gross distortion of reality, disturbances of language and communication, and fragmentation of thought).The Quarterly MDS dated 11/23/23, documented R54 received hospice services.The Quarterly MDS dated 02/23/24, documented R54 received hospice services.The Annual MDS dated 05/23/24, documented R54 did not receive hospice services.The Quarterly MDS dated 08/23/24, documented R54 did not receive hospice services. The Quarterly MDS dated 02/23/25, documented R54 received hospice services.The Annual MDS dated 04/25/25, documented R54 received hospice services. The Quarterly Minimum Data Set (MDS) dated [DATE] documented a Brief Interview for Mental Status (BIMS) score of 99, which indicated severely impaired cognition. The MDS documented R54 was dependent on staff for all activities of daily living (ADL). The MDS documented R54 received hospice services. R54's Cognitive Loss/Dementia (a progressive mental disorder characterized by failing memory and confusion) Care Area Assessment (CAA) dated 04/24/25 documented R54's cognition would be addressed in R54's care plan with her goals. The CAA documented staff would monitor for signs and symptoms of acute mental status changes and treat the underlying condition. The CAA documented staff would communicate using short and simple sentences to allow adequate time for R54 to understand others and for her to communicate her needs. The CAA documented staff were to approach R54 in a calm and non-threatening manner to help R54 to feel calm and unhurried, and her BIMS was to be completed quarterly and as needed to help monitor for trends in cognition. R54's Care Plan dated 11/02/24 documented R54's Hospice Services were discontinued, and R54 received palliative care, starting 11/02/24, with a diagnosis of senile degeneration of the brain (a progressive decline in cognitive function that occurs with aging). The plan of care for R54 documented symptoms would be managed with current interventions through the next review date, as evidenced by no signs and symptoms of air hunger (unable to get air), pain, agitation, and restlessness. The plan of care for R54 documented staff would assess for pain, restlessness, agitation, constipation, and other symptoms of discomfort, give medication as ordered, and evaluate effectiveness. Bereavement service provided by the palliative team as needed to help with grief and loss; provide R54 and my family support, including caregivers and other residents, before and after death.A review of R54's clinical record lacked evidence the facility completed a Significant Change MDS to address the resident's discontinuance of hospice services. On 09/14/25 at 09:42 AM, R54 laid in her bed, in her room.On 09/15/25 at 10:50 AM, R54 laid in her bed, in her room.On 09/16/25 at 11:45 AM, Administrative Nurse D stated she was unaware that a Significant Change MDS needed to be done, going off hospice services or going on palliative care services. The facility's Maintaining Minimum Data Set Assessments dated 09/18/24, documented the (continued on next page)

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Meadowbrook Rehabilitation Hospital	427 W Main Street Gardner, KS 66030

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	facility would maintain all resident assessments completed within the previous 15 months in the resident's active clinical record. The form of storage may be electronic or hard copy. The facility would maintain all MDS records for 15 months after the completion date, including: Comprehensive Assessment Records, Quarterly Assessment Records, CAA Summary, Entry, Reentry, and Death Tracking Records, Discharge Assessment Records - planned and unplanned Correction Request Forms (including signed attestation), and payment assessments.

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident’s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility identified a census of 109 residents. The sample included 22 residents, with one resident reviewed for quality of care. Based on observation, record review, and interviews, the facility failed to consistently follow a physician's order for daily weight monitoring for fluid overload and further failed to ensure Resident (R) 2's fluid restriction was monitored per the physicians' orders. Findings included:- R2's Electronic Medical Record (EMR) from the Diagnosis tab documented diagnoses of fluid overload (a condition where the body has too much fluid), edema (swelling resulting from an excessive accumulation of fluid in the body tissues), major depressive disorder (major mood disorder that causes persistent feelings of sadness), difficulty in walking, diabetes mellitus (DM- when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin), venous insufficiency (poor circulation), hypertension (HTN- high blood pressure), and acquired absence of left leg below knee. R2's Quarterly Minimum Data Set (MDS) dated [DATE] recorded a Brief Interview for Mental Status (BIMS) score of 15, which indicated intact cognition. The MDS documented R2 was dependent on staff for toileting and needed set up or clean up assistance from staff for eating, and substantial to maximal staff assistance with bathing and dressing. The MDS documented R2 had renal insufficiency (a condition where the kidneys are unable to function properly, leading to a decrease in their ability to filter waste products from the blood and maintain fluid balance), heart failure, and hypertension. R2's Functional Abilities (Self-Care and Mobility) Care Area Assessment (CAA) dated 03/30/25 documented R2's functional mobility would be addressed in R2's care plan. The CAA documented staff were to assist with activities of daily living (ADL) care as needed and anticipate care. The CAA for R2 documented therapy services would be used as needed to help increase functional mobility, and staff were to encourage R2 to participate in ADL care as much as able to promote independence.R2's Care Plan revised on 05/18/25 documented R2 had potential for dehydration/potential fluid deficit related to physician-ordered fluid restriction and history of infections. R2's care plan documented R2 required dialysis (a procedure where impurities or wastes are removed from the blood). R2's plan of care documented that nursing staff would administer medications as ordered, obtain daily weights, and call the physician if R2 gained more than three pounds in one day or five pounds in a week. R2's plan of care documented staff were to monitor and document intake and output as per facility policy. R2's EMR under the Orders tab revealed the following physician orders:Daily weights, call the physician if the patient gains more than three pounds in one day or five pounds in a week, dated 06/09/25. Fluid restriction: 1500 milliliters (ml) per day. Meals: 240 ml breakfast; 240 ml lunch; 240 ml dinner (total 720 ml). Nursing 180 ml night shift medication passes: 150 ml per medication pass for morning, noon, evening, and overnight medication pass every shift for fluid restriction related to fluid overload, dated 06/29/25.R2's EMR under the weights and Vitals tab documented weights were obtained every Monday, Wednesday, and Friday only. R2's EMR lacked weights for Tuesday, Thursday, Saturday, and Sunday.R2's EMR under the Treatment Administration Record (TAR) documented a signature by nursing for fluid restriction. R2's EMR lacked documentation of meals consumed daily. On 09/14/25 at 12:12 PM, R2 laid in her bed asleep.On 09/15/25 at 03:00 PM, R2 laid in her bed with her eyes shut.On 09/16/25 at 11:10 AM, Certified Nurse's Aide (CNA) M stated that nursing would make a list of anyone who needed to be weighed. She stated the aides obtained the weights and returned the list to the nurse. She stated she looks at the resident's care plan and communicates with her nurse to see if there were any changes with any of the residents. On 09/16/25 at 11:27 AM, Licensed Nurse (LN) G stated the nurses gave the CNA staff a list of residents needed weighted for the day. LN G stated the nurse should follow (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	up to ensure the weights were done and call the physician if needed. LN G stated if a resident was on fluid restriction, the staff would give the resident what fluids the resident asked for, and the nurse would educate the resident on how much fluid the resident could consume for the day.On 09/16/25 at 11:45 PM, Administrative Nurse D stated nursing was to ensure weights were obtained. Administrative Nurse D said nurses would then report to the physician or follow the orders as prescribed. Administrative Nurse D stated that the fluid restrictions were hard to obtain accurate intake, and she stated R2 was not compliant with her fluid restriction. The facility's Fluid Restrictions policy dated 03/26/25 documented it was the policy of this facility to ensure that fluid restrictions would be followed in accordance with the physician's orders. Fluid restrictions were basically the restriction of fluid intake. This may be due to underlying medical conditions that may cause fluid buildup, such as congestive heart failure (CHF- a condition with low heart output and the body becomes congested with fluid), or end-stage renal disease (ESRD- a terminal disease of the kidneys). In addition to electrolyte imbalance disorders such as hyponatremia (insufficient sodium in the blood), fluid restriction amounts can vary according to the resident's condition and the physician's judgment.The facility's Weight Monitoring policy dated 10/30/24 documented based on the resident's comprehensive assessment, the facility would ensure that all residents maintain 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's preferences indicated otherwise.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility identified a census of 109 residents. The sample included 22 residents, with six residents reviewed for treatment/services to prevent/heal pressure ulcers (localized injury to the skin and/or underlying tissue usually over a bony prominence, because of pressure, or pressure in combination with shear and/or friction). Based on observation, record review, and interviews, the facility failed to monitor the low-air-loss (a special type of medical mattress that uses microscopic holes to provide a constant, slow airflow) mattress for Resident (R) 54 and further failed to provide a pressure-reducing device for R16's wheelchair. Findings Included - R54's Electronic Medical Record (EMR) from the Diagnosis tab documented diagnoses of major depressive disorder (major mood disorder that causes persistent feelings of sadness), chronic obstructive pulmonary disease (COPD- a progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing), age related cognitive (relates to the processes of the mind, such as thinking, learning, remembering, and understanding) decline, hypertension (HTN- elevated blood pressure), lack of coordination, muscle weakness, congestive heart failure (CHF- a condition with low heart output and the body becomes congested with fluid), peripheral vascular disease (PVD- slow and progressive circulation disorder causing narrowing, blockage, or spasms in a blood vessel), and schizophrenia (a mental disorder characterized by gross distortion of reality, disturbances of language and communication, and fragmentation of thought). The Quarterly Minimum Data Set (MDS) dated [DATE] documented a Brief Interview for Mental Status (BIMS) score of 99, which indicated severely impaired cognition. The MDS documented R54 was dependent on staff for all activities of daily living (ADL). The MDS was at risk for pressure injury and had a pressure-reducing cushion in her chair and a pressure-reducing mattress on her bed. R54's Pressure Ulcer/ Injury Care Area Assessment (CAA) dated 04/24/25 documented pressure ulcers would be addressed in R54's care plan. The CAA documented nursing staff would assist with repositioning per protocol and as needed to help maintain skin integrity. Licensed Nurse (LN) staff were to monitor skin integrity every week. The CAA documented incontinence creams were to be used as needed to help maintain skin integrity. The CAA documented pressure redistributing surface in place to R54's bed and to her wheelchair to help maintain skin integrity. R54's Care Plan dated 02/06/23 documented R54 was at risk for skin Integrity related to incontinence and impaired mobility. R54's plan of care dated 08/08/23 documented staff were to do daily visual skin checks during routine cares and bathing and report abnormal findings to the nurse. R54's plan of care dated 05/27/25 documented that the staff were to check the low air loss mattress and pump function every shift to ensure settings were correct, and staff were to compare R54's weight to the settings on the pump to check for accuracy. R54's EMR under the Orders tab documented the following physician's order: Check the low air loss mattress and pump function to ensure proper working order and check to ensure correct settings in place per label on pump (setting based on weight/or per manufacturer guidelines) every shift, dated 01/27/25. R54's Weekly Skin Assessment dated 09/11/25 documented previously identified areas, various healing bruises to the bilateral upper extremities. The resident was encouraged to wear long sleeves/Geri sleeves (a type of protective sleeve). (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R54's EMR under the Weight and Vitals tab documented R54's weighed 128.6 pounds (lbs.) on 09/01/25. R54's low air loss mattress 6000 ProAir set at 50-pound increments, was set at 240 lbs. R54's Braden Scale for Prediction Pressure Sore Risk dated 07/23/25 documented a score of 13, indicating a moderate risk for pressure ulcers. On 09/14/25 at 09:42 AM, R54 laid in her bed, in her room. On 09/15/25 at 10:50 AM, R54 laid in her bed, in her room. On 09/16/25 at 02:17 PM, Certified Nurse's Aide (CNA) M stated all staff checked the low air loss mattresses to ensure the mattress was in working order, plugged in, and set at the correct weight. She stated normally there would be a piece of tape with the correct settings on the monitor of the mattress. On 09/16/25 at 02:31 PM, Licensed Nurse (LN) G stated it was on the nursing Treatment Administration Record (TAR) to monitor the settings of all low air loss mattresses. She stated the nurses documented the mattress was set at the correct settings. On 09/16/25 at 04:31 PM, Administrative Nurse D stated there was a quality team that checked mattresses every day. She stated it was also on the nursing TAR to ensure the low-air-loss mattresses were set at the correct settings. Administrative Nurse D stated the machines were set by weight. The facility's Pressure Injury Prevention Management policy, dated 12/03/24, documented the facility was committed to the prevention of avoidable pressure injuries, unless clinically unavoidable, and to provide treatment and services to heal the pressure ulcer/injury, prevent infection, and the development of additional pressure ulcers/injuries. The facility shall establish and utilize a systematic approach for pressure injury prevention and management, including prompt assessment and treatment; intervening to stabilize, reduce, or remove underlying risk factors; monitoring the impact of the interventions; and modifying the interventions as appropriately needed. - R16's Electronic Medical Record (EMR) from the Diagnosis tab documented diagnoses of dementia (a progressive mental disorder characterized by failing memory and confusion), muscle weakness, contracture (abnormal permanent fixation of a joint or muscle) of right hand, hemiparesis/hemiplegia (weakness and paralysis on one side of the body), and cerebrovascular accident (CVA- stroke- sudden death of brain cells due to lack of oxygen caused by impaired blood flow to the brain by blockage or rupture of an artery to the brain). The Annual Minimum Data Set (MDS) dated 03/14/25 documented a staff interview, which documented moderately impaired cognition. The MDS documented R16 had limited range of motion (ROM- the full movement potential of a joint, usually its range of flexion and extension) on his upper and lower extremities on one side of his body. The MDS documented R16 required substantial to maximum assistance with oral hygiene, bathing, toileting, and application of footwear. The MDS documented R16 was at risk for development of pressure-related injuries. The MDS documented the facility placed pressure-reducing devices on R16's bed and in the wheelchair. The Quarterly MDS dated [DATE] documented a staff interview, which documented moderately impaired cognition. The MDS documented R16 had limited ROM in his upper and lower extremities on one side of (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	his body. The MDS documented R16 required substantial to maximum assistance with oral hygiene, bathing, toileting, lower extremity dressing, and application of footwear. The MDS documented R16 was at risk for development of pressure related injuries. The MDS documented the facility placed pressure-reducing devices on R16's bed and in the wheelchair. R16's Pressure Ulcer Care Area Assessment (CAA) dated 03/17/25 documented he was at risk for skin breakdown. R16's Care Plan, dated 09/13/24 documented pressure redistribution devices placed on the bed and wheelchair. On 09/14/25 at 10:12 AM, R16 laid asleep on his bed. R16's wheelchair was next to the bed and lacked a cushion on the chair. No wheelchair cushion was noted in R16's room. On 09/15/25 at 07:24 AM, R16 laid on the bed with the head of his bed elevated. R16's wheelchair sat next to his bed and lacked a cushion in the wheelchair. On 09/16/25 at 07:58 AM, R16 propelled his wheelchair from his room to the dining room. R16 lacked a cushion in his wheelchair. R16's right hand was tightly closed and lacked his right-hand splint. R16's right foot slid along the floor under the wheelchair as he propelled himself with his left hand. On 09/16/25 at 11:10 AM, Certified Nurse Aide (CNA) M stated the direct care staff are responsible to ensure there was a cushion in a resident's wheelchair if it had been on the resident's plan of care. On 09/16/25 at 11:26 AM, Licensed nurse (LN) G stated the nurse was the person who was responsible to ensure the cushion was in the resident's wheelchair if it was on their plan of care. LN G stated she felt the residents who used a wheelchair for transportation should have a cushion in the wheelchair to prevent skin breakdown. On 09/16/25 at 11:45 AM, Administrative Nurse D stated she expected everyone who worked with the residents to ensure the equipment they were care planned to be available and in place. Administrative Nurse D stated she expected any resident who triggered to be at risk of skin breakdown to have their pressure-reducing devices in place. The facility's Pressure Injury Prevention Management policy dated 12/03/24 documented this facility was committed to the prevention of avoidable pressure injuries, unless clinically unavoidable, and to provide treatment and services to heal the pressure ulcer/injury, prevent infection, and the development of additional pressure ulcers/injuries. The facility shall establish and utilize a systematic approach for pressure injury prevention and management, including prompt assessment and treatment; intervening to stabilize, reduce, or remove underlying risk factors, monitoring the impact of the interventions, and modifying the interventions as appropriate.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility identified a census of 109 residents. The sample included 22 residents, with two residents reviewed for positioning and mobility. Based on observation, record review, and interviews, the facility failed to ensure Resident (R) 16 received services and treatment for his right-hand contracture (abnormal permanent fixation of a joint or muscle) to prevent an avoidable reduction of range of motion (ROM - the full movement potential of a joint, usually its range of flexion and extension). Findings included:- R16's Electronic Medical Record (EMR) from the Diagnosis tab documented diagnoses of dementia (a progressive mental disorder characterized by failing memory and confusion), muscle weakness, contracture of right hand, hemiparesis/hemiplegia (weakness and paralysis on one side of the body), and cerebrovascular accident (CVA- stroke- sudden death of brain cells due to lack of oxygen caused by impaired blood flow to the brain by blockage or rupture of an artery to the brain). The Annual Minimum Data Set (MDS) dated 03/14/25 documented a staff interview, which indicated moderately impaired cognition. The MDS documented R16 had limited ROM in his upper and lower extremities on one side of his body. The MDS documented R16 required substantial to maximum assistance with oral hygiene, bathing, toileting, and application of footwear. The MDS documented R16 was at risk for the development of pressure-related injuries. The MDS documented the facility placed pressure-reducing devices on R16's bed and in the wheelchair. The Quarterly MDS dated [DATE] documented a staff interview, which documented moderately impaired cognition. The MDS documented R16 had limited ROM in his upper and lower extremities on one side of his body. The MDS documented R16 required substantial to maximum assistance with oral hygiene, bathing, toileting, lower extremity dressing, and application of footwear. The MDS documented R16 was at risk for the development of pressure-related injuries. The MDS documented the facility placed pressure-reducing devices on R16's bed and in the wheelchair. R16's Functional Abilities (Self-Care and Mobility) Care Area Assessment (CAA) dated 03/17/25 documented he required staff assistance with activities of daily living. R16's Care Plan dated 04/04/25 documented he was to wear a hand brace during the morning, and it would be removed at bedtime as tolerated. R16's EMR under the Orders tab revealed the following physician orders: Apply the right-hand splint in the morning and remove it at bedtime every day, dated 04/03/25. On 09/16/25 at 07:58 AM, R16 propelled his wheelchair from his room to the dining room. R16 lacked a cushion in his wheelchair. R16's right hand was tightly closed and lacked his right-hand splint. R16's right foot slid along the floor under the wheelchair as he propelled himself with his left hand. On 09/16/25 at 11:10 AM, Certified Nurse Aide (CNA) M stated the direct care staff could place a brace or hand splint on a resident. CNA M stated she would ask the nurse if there were any questions or problems with the brace or splint. On 09/16/25 at 11:26 AM, Licensed nurse (LN) G stated the nurse was the person responsible for ensuring the splint or brace was on the resident. LN G stated the order for the brace or splint was listed on the Treatment Administration Record (TAR). On 09/16/25 at 11:45 AM, Administrative Nurse D stated she expected the charge nurse to ensure the resident was wearing their brace or splint. Administrative Nurse D stated the nurse would have to sign that the brace or splint was applied as ordered.The facility's Restorative Nursing Programs policy dated 10/14/24 documented it was the policy of this facility to provide maintenance and restorative services designed to maintain or improve a resident's abilities to the highest practicable level. Residents who were identified during the comprehensive assessment process would receive services from restorative aides when they are assessed for restorative nursing services. These services may include Splint or brace assistance.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. The facility identified a census of 109 residents. The sample included 22 residents, with two reviewed for accidents. Based on observation, interview, and record review, the facility failed to prevent avoidable accidents when direct care staff used the incorrect sling size while attempting to transfer Resident (R) 112, a quadriplegic (inability to move the arms, legs, and trunk of the body below the level of an associated injury to the spinal cord) resident with a history of traumatic brain injury. On 08/04/25 at 08:00 PM, Certified Nurse Aide (CNA) N and CNA O attempted to transfer R112 from her wheelchair to her bed, used the wrong sling size, the mechanical lift tipped over, and R112 fell to the floor from the lift's highest position. The facility's failure to ensure staff used the correct sling size while transferring R112 with the full mechanical lift placed R112 in immediate jeopardy to their health and safety and at risk for injury. Findings Included:- The Electronic Medical Record (EMR) included R112 had the following diagnoses: quadriplegia (inability to move the arms, legs, and trunk of the body below the level of an associated injury to the spinal cord), muscle weakness, and traumatic brain injury (TBI-an injury to the brain caused by external forces). The 05/11/25 Quarterly Minimum Data Set (MDS) indicated R112 had a Brief Interview for Mental Status (BIMS) score of zero, indicating severe cognitive impairment. The MDS indicated she had bilateral impairment of her upper and lower extremities, was dependent on staff for transfers, used a wheelchair for mobility, and had no falls.The 09/09/25 Cognitive Loss/Dementia Care Area Assessment (CAA) indicated R112 was at risk for acute mental status changes. The CAA instructed staff to use short and simple sentences and allow adequate time for her to understand others and to communicate her needs. The 09/04/24 Care Plan indicated R112 required a Hoyer lift with two staff present for transfer to her bed and chair. The plan instructed staff to use a medium-sized sling for Hoyer transfer (09/04/24). The plan instructed staff to use the Hoyer sling (09/04/24). Review of the 08/04/25 Facility Investigation #1822 revealed the Hoyer lift fell over, and R112 fell to the floor during the transfer. The note revealed staff assessed R112 with no injuries and sent the resident to an acute medical facility for further assessment. The investigation concluded staff used the wrong size sling to transfer R112 with the mechanical lift. The 08/04/25 Witness Statement by Certified Nurse Aide (CNA) N revealed on 08/04/25 at approximately 08:00 PM she assisted CNA O. CNA N noted she prepared R112 for a mechanical lift transfer by removing the wheelchair's headrest and positioning her next to the mechanical lift. CNA N noted R112's sling was attached to the mechanical lift, and staff raised R112 in the air with the lift. CNA N indicated the lift sling became stuck on R112's wheelchair as she was lifted. The statement revealed staff stopped and fixed her sling positioning. CNA N noted the staff lifted R112 as high as the mechanical lift would go, but R112 did not clear the armrest of her chair. CNA N noted staff attempted to lower the back of her wheelchair but could not get R112 to clear the chair's armrest upon transfer. CNA N stated she attempted to pull the wheelchair out as CNA O attempted to lift R112 up in the sling. The statement revealed the mechanical lift began to tilt as staff attempted to reposition R112, while the lift was in the highest position. The statement indicated both the resident and the mechanical lift fell over to the ground. The 08/04/25 Witness Statement by CNA O revealed on 08/04/25 she assisted CNA N with transferring residents. CNA O noted when they raised R112 all the way up in the mechanical lift, they realized the sling was too big. CNA O documented they could not get R112 over the wheelchair's armrest and attempted to maneuver her (R112) around the chair. CNA O's statement revealed R112 fell to the floor when the mechanical lift tilted and fell over. An observation on 09/15/25 at 10:01 AM, revealed the facility had three mechanical lifts. The supply area revealed several small, medium, and large transfer slings for the Hoyer (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Meadowbrook Rehabilitation Hospital	427 W Main Street Gardner, KS 66030

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	lifts.During an interview on 09/15/25 at 10:15 AM, CNA P stated each care plan should indicate the size of sling required for each resident. CNA P stated using the wrong size sling could hurt the resident or cause them to fall. CNA P stated the facility held annual training related to transfers and accident prevention.During an interview on 09/15/25 at 10:30 AM, Licensed Nurse (LN) H stated the facility had multiple sling sizes and she expected staff to verify which sling each resident required by looking at their care plan. LN H stated staff were trained to verify the sizes. LN H stated staff should never attempt to reposition or maneuver a resident while lifted in the air.During an interview on 09/15/25 at 02:30 PM, Administrative Nurse E stated she expected staff to verify the sling size required for transfers and use the mechanical lifts per facility training. Administrative Nurse E stated the care plans contained the appropriate sling size for transfers for each resident. She stated the facility trained all staff upon hire and annually regarding mechanical lift use.On 09/15/25 at 02:30 PM, Administrative Staff A stated the facility completed verbal education to the two staff members involved, replaced and provided extra slings, updated affected residents, and placed cheat sheets in the sling closets that contained the mechanical lift sling measurements, immediately after the incident on 08/04/25. Administrative Staff A stated the facility started a facility-wide re-education for all care staff on 09/15/25 related to mechanical lift transfers.The facility's Incidents and Accidents policy 07/01/25 indicated the facility was expected to ensure the appropriate interventions are implemented to prevent potential accidents and injuries. The policy indicated the facility ensured all residents were screened for potential risks. The policy indicated staff were to use the appropriate techniques and equipment designated by the facility to minimize the risks related to falls and accidents. On 09/15/25 at 02:30 PM, Administrative Staff A was provided the IJ template and notified of the facility's failure to ensure R112 remained free from accidents in immediate jeopardy. The facility provided an acceptable plan for the removal of the immediacy on 09/16/25 at 08:30 AM, which included the following: The facility provided verbal education with CNA N and CNA O on 08/04/25. The facility's slings were replaced to ensure proper sizes on 08/04/25. The facility provided documentation of mechanical lift observations completed by their administrative team from 08/05/25 to 09/17/25. All affected residents who required mechanical lift transfers were reviewed, and care plans were updated as needed on 08/05/25. The administrative nursing team would audit three mechanical lift transfers weekly, starting on 09/15/25. Facility-wide re-education was started on 09/15/25 related to safe mechanical lift transfers. The surveyor verified the implementation of the IJ removal plan while on-site on 09/16/25 at 09:00 AM. The deficient practice remained at a D scope and severity, upon removal of the IJ immediacy.

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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 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. The facility identified a census of 109 residents. The sample included 22 residents. Based on interviews and record reviews, the facility's direct care staff failed to verify and utilize the appropriate Hoyer lift sling while transferring Resident (R) 112, resulting in a non-injury fall from the Hoyer lift. Findings included:- The Medical Diagnosis section within R112's Electronic Medical Records (EMR) included diagnoses of Quadriplegia (inability to move the arms, legs, and trunk of the body below the level of an associated injury to the spinal cord), muscle weakness, and traumatic brain injury (TBI- an injury to the brain caused by external forces). R112's Quarterly Minimum Data Set (MDS) completed 05/11/25 indicated a Brief Interview for Mental Status (BIMS) score of zero, indicating severe cognitive impairments. The MDS indicated she was dependent on staff for transfers, bathing, dressing, personal hygiene, bed mobility, and oral hygiene. The MDS indicated she used a wheelchair and had no falls. The MDS noted she had bilateral impairments of her upper and lower extremities. R112's Cognitive Impairment Care Area Assessment (CAA) completed 09/09/25 indicated she was at risk for acute mental status changes and nutritional impairments related to her cognitive impairments. The CAA instructed staff to use short and simple sentences and allow adequate time for her to understand and to communicate her needs. R112's Falls or Functional Abilities CAA was not triggered. R112's Care Plan initiated 09/04/24 indicated she required assistance from two staff for bathing, bed mobility, dressing, personal hygiene, and footwear (09/04/24). The plan indicated she required a Hoyer lift with two staff present for transfers to her bed and chair (09/04/24). The plan instructed staff to use a medium-sized sling for Hoyer transfer (09/04/24). The plan instructed staff to use the Hoyer sling (09/04/24). The plan noted she used a specialized wheelchair for mobility (11/18/24). A review of Facility Investigation #1822 completed on 08/04/25 revealed that the on-duty nurse was notified by direct care staff that the Hoyer lift tilted during an attempted transfer of R112. The note revealed that the lift and R112 fell to the floor during transfer from her wheelchair to her bed. The note revealed that other staff were called to assist with removing the Hoyer and her wheelchair. The note revealed R112 was assessed with no injuries. The note revealed R112 was sent to an acute medical facility for further assessment. The investigation's root-cause analysis revealed that staff used the wrong size sling to transfer R112 with the Hoyer lift. A Witness Statement completed by Certified Nurse's Aide (CNA) N on 08/04/25 revealed on 08/04/25 at about 08:00 PM that she assisted CNA O with getting residents prepared for bed. CNA N noted she prepared R112's for a Hoyer Lift transfer by removing her wheelchair's headrest and positioning her next to the Hoyer lift. CNA N noted R112's sling was then hooked up to the Hoyer lift. The statement revealed that the staff raised R112 in the air with the lift. CNA N indicated the lift sling became stuck on R112's wheelchair as she was lifted in the Hoyer Lift. The statement revealed that the staff stopped and fixed her sling positioning. CNA N noted R112 was lifted as high as the Hoyer lift would go, but R112 did not clear the armrest of her chair. CNA N noted staff attempted to lower the back of the wheelchair, but could not get R112 to clear the Chair's armrest upon transfer. CNA N stated she attempted to pull the wheelchair out as CNA O attempted to lift R112 up in the sling. The Statement revealed that the Hoyer lift began to tilt as staff attempted to reposition R112 while the lift was in the highest position. The statement indicated that both the resident and Hoyer fell over to the ground. A review of a Witness Statement completed on 08/04/25 by CNA O noted on 08/04/25 that she assisted CNA N with transferring the residents to their beds. CNA O stated that when they raised R112 all the way up in the Hoyer lift, they realized the sling was too big. The statement revealed they could not get R112 over the wheelchair's armrest and attempted to maneuver her around the (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	chair. The statement revealed R112 fell to the floor when the Hoyer lift tilted and fell over. On 09/15/25, CNA N and CNA O were not available for an interview. On 09/15/25 at 10:15 AM, CNA P stated that each care plan should indicate the size of sling required for each resident. She stated that using the wrong size could hurt the resident or cause them to fall. She stated the facility held annual training related to transferring and accident prevention. She stated that all staff were given training on Hoyer lifts and proper transfer techniques. On 09/15/25 at 10:30 AM, Licensed Nurse (LN) H stated the facility had multiple sling sizes and staff were expected to verify which sling each resident required by looking at their care plan. She stated that staff have been trained to verify the sizes and know the specific sling loops in use. She stated that if staff had questions related to issues with transfers, they were expected to stop the transfer and get help. She stated staff should never attempt to reposition or maneuver a resident while lifted in the air. On 09/15/25 at 02:30 PM, Administrative Nurse E stated that staff were expected to verify the size required for transfers and use the lifts as they have been trained to do. She stated that the care plans contained the appropriate sling size for transfers for each resident. She stated all staff were trained to use the Hoyer lifts upon hire and annually. Administrative Nurse E stated. On 09/15/25 at 02:30 PM, Administrative Staff A stated the facility started a facility-wide re-education plan for all care staff on 09/15/25 related to safe Hoyer lift transfers. The facility's Competent Staff policy dated 02/2025 indicated the facility was to ensure staff had sufficient competencies and skill sets to provide nursing services to ensure resident safety.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility identified a census of 109 residents. The sample included 22 residents, with six residents reviewed for unnecessary medications. Based on observation, record review, and interviews, the facility failed to ensure the Consultant Pharmacist (CP) recommendations had been reviewed and addressed by the physician within 30 days for Residents (R) 15 and R9. The facility also failed to ensure the CP had identified and reported the physician-ordered laboratory tests had not been followed for R15 and R9. Findings included:- R15's Electronic Medical Record (EMR) from the Diagnosis tab documented diagnoses of major depressive disorder (major mood disorder that causes persistent feelings of sadness), anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), epilepsy (brain disorder characterized by repeated seizures), congestive heart failure (CHF- a condition with low heart output and the body becomes congested with fluid), and dementia (a progressive mental disorder characterized by failing memory and confusion). The Annual Minimum Data Set (MDS) dated 08/27/25 documented a Brief Interview for Mental Status (BIMS) score of seven, which indicated severely impaired cognition. The MDS documented R15 had received an anticonvulsant (a medication that prevents or treats seizures and convulsions) medication, antidepressant (a class of medications used to treat mood disorders) medication, antiplatelet (medication that helps prevent blood clots from occurring) medication, antipsychotic (a class of medications used to treat major mental conditions that cause a break from reality) medication, and a diuretic (a medication to promote the formation and excretion of urine) medication during the observation period. R15's Psychotropic Drug Use Care Area Assessment (CAA) dated 08/27/25 documented he was at risk of adverse effects related to the medication he had received. R15's Care Plan, dated 06/27/22, documented the nursing staff would obtain lab work as ordered by the physician. The plan of care documented the physician, and the CP would review the medications monthly. R15‘s EMR under the Orders tab revealed the following physician orders: Complete Blood Count (CBC- laboratory test) with differential laboratory test every three months, dated 06/16/22.complete metabolic panel (CMP- laboratory blood test) every three months, dated 06/16/22. Vitamin B12 level (laboratory test) yearly, dated 06/16/22.Vitamin D level (laboratory test) yearly, dated 06/16/22. Valproic Acid level (laboratory test to monitor for medication levels) quarterly, dated 12/15/22.Keppra level (laboratory test to monitor for medication levels) quarterly, dated 07/06/23.Continue Vitamin B12, Hemoglobin A1C, T4, TSH, and Vitamin D every 12 months, dated 10/24/24. Keppra, CBC, CMP, and Valproic acid every three months, dated 10/24/24. Review of the Monthly Medication Review (MMR) from September 2024 to August 2025 lacked documentation or recommendations for the lack of physician-ordered laboratory test. Review of R15's EMR under the Misc tab lacked MMRs from October 2024 and December 2024. The facility was able to provide the MMR's on 09/16/25, which were reviewed by the physician and dated 09/16/25. Review of R15's EMR under the Misc tab under Laboratory lacked test results, and the facility was unable to provide evidence of results for the following laboratory tests, CBC and CMP, from May 2025 and August 2025. R15's EMR also lacked the Keppra levels and Valproic acid level lab test from April 2025 and July 2025. R15's EMR also lacked results from yearly lab work. On 09/15/25 at 03:36 PM, R15 propelled his wheelchair in the common area. R15's oxygen tank was attached to the back of his wheelchair. On 09/15/25 at 11:26 AM, Licensed Nurse (LN) G stated she did not work with the pharmacy MMRs. LN G stated the administrative nurses took care of the MMRs. On 09/16/25 at 11:45 AM, Administrative Nurse D stated she expected the CP to identify and report any irregularities monthly during the monthly reviews. Administrative Nurse D stated R15's laboratory tests should have (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	been discontinued in February 2025 when he was admitted to hospice services. The facility's Pharmacy Services policy dated 04/09/25 documented it is the policy of this facility to ensure that pharmaceutical services, whether employed by the facility or under an agreement, are provided to meet the needs of each resident, are consistent with state and federal requirements, and reflect current standards of practice. - R9's Electronic Medical Record (EMR) from the Diagnosis tab documented diagnoses of anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), paranoid schizophrenia (characterized by persistent delusions and hallucinations, primarily involving themes of persecution, mistrust, and conspiracy), schizophrenia (a mental disorder characterized by gross distortion of reality, disturbances of language and communication, and fragmentation of thought), and major depressive disorder (major mood disorder that causes persistent feelings of sadness). The Annual Minimum Data Set (MDS) dated 04/08/25 documented a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. The MDS documented R9 had received antidepressant (a class of medications used to treat mood disorders) medication, antianxiety (a class of medication that calms and relaxes people) medication, and antipsychotic (a class of medications used to treat major mental conditions that cause a break from reality) medication during the observation period. The Quarterly MDS dated [DATE] documented a BIMS score of 15, which indicated intact cognition. The MDS documented that R9 had received antidepressant medication, antianxiety medication, and antipsychotic medication during the observation period. R9's Psychotropic Drug Use Care Area Assessment (CAA), dated 04/09/25, documented she was at risk for adverse side effects related to the medication she had received. R9's Care Plan, dated 06/27/22, documented the nursing staff would obtain the laboratory tests as ordered by the physician. The plan of care dated 04/18/24 documented her medications would be reviewed monthly by the physician and the pharmacist.R9's EMR under the Orders tab revealed the following physician orders: Continue Vitamin B12 level (laboratory test to monitor medication level), Hemoglobin A1C (laboratory test to monitor blood sugar level), LIPID panel (laboratory test to monitor medication level), T4 (laboratory test to monitor medication level), TSH (laboratory test to monitor medication level), and Vitamin D (laboratory test to monitor medication level) yearly, dated 10/24/24.Complete Blood Count (CBC- laboratory blood test), complete metabolic panel (CMP- laboratory blood test), and Haldol (antipsychotic) level (laboratory test to monitor cat levels) every three months, dated 10/24/24. Review of the Monthly Medication Review (MMR) from September 2024 to August 2025 lacked documentation or recommendations for the lack of physician-ordered laboratory tests. Review of R9's EMR under the Misc tab lacked MMRs from December 2024 and April 2025. The facility was able to provide the MMRs on 09/16/25, which were reviewed by the physician and dated 09/16/25. Review of R9's EMR under the Misc tab under Laboratory lacked test results, and the facility was unable to provide evidence of results for the following laboratory tests: Vitamin B12, T4, TSH, and Vitamin D level from yearly lab work in April 2025. R9's EMR also lacked evidence of results from the Haldol level in March 2025 and June 2025. R9's EMR also lacked evidence of results for a CBC and CMP from March 2025. On 09/16/25 at 09:25 AM, R9 laid on her bed covered with her quilt. On 09/15/25 at 11:26 AM, Licensed Nurse (LN) G stated she did not work with the pharmacy MMRs. LN G stated the administrative nurses took care of the MMRs. On 09/16/25 at 11:45 AM, Administrative Nurse D stated she expected the CP to identify and report any irregularities monthly during the monthly reviews. Administrative Nurse D stated the medical records would ensure the MMRs were reviewed by the physician, and the administrative nurses would enter the physician's orders into the resident's EMR. The facility's Pharmacy Services policy dated 04/09/25 documented it is the policy of this facility to ensure that pharmaceutical services, whether employed by the facility or under an agreement, are provided (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	to meet the needs of each resident, are consistent with state and federal requirements, and reflect current standards of practice.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility identified a census of 109 residents. The sample included 22 residents, with six residents reviewed for unnecessary medications. Based on observation, record review, and interviews, the facility failed to ensure physician-ordered laboratory tests were obtained as ordered for Resident (R) 15 and R9. The facility also failed to consistently take and record blood pressures and pulse for R5's beta blocker (a medication to slow down your heart rate and reduce the force of your heart's contraction). Findings included:- R15's Electronic Medical Record (EMR) from the Diagnosis tab documented diagnoses of major depressive disorder (major mood disorder that causes persistent feelings of sadness), anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), epilepsy (brain disorder characterized by repeated seizures), congestive heart failure (CHF- a condition with low heart output and the body becomes congested with fluid), and dementia (a progressive mental disorder characterized by failing memory and confusion). The Annual Minimum Data Set (MDS) dated 08/27/25 documented a Brief Interview for Mental Status (BIMS) score of seven, which indicated severely impaired cognition. The MDS documented R15 had received an anticonvulsant (a medication that prevents or treats seizures and convulsions) medication, antidepressant (a class of medications used to treat mood disorders) medication, antiplatelet (medication that helps prevent blood clots from occurring) medication, antipsychotic (a class of medications used to treat major mental conditions that cause a break from reality) medication, and a diuretic (a medication to promote the formation and excretion of urine) medication during the observation period. R15's Psychotropic Drug Use Care Area Assessment (CAA) dated 08/27/25 documented he was at risk of adverse effects related to the medication he had received. R15's Care Plan, dated 06/27/22, documented the nursing staff would obtain lab work as ordered by the physician. The plan of care was documented the physician, and the CP would review the medications monthly. R15's EMR under the Orders tab revealed the following physician orders: Complete Blood Count (CBC- laboratory test) with differential laboratory test every three months, dated 06/16/22. complete metabolic panel (CMP- laboratory blood test) every three months, dated 06/16/22. Vitamin B12 level (laboratory test) yearly, dated 06/16/22.Vitamin D level (laboratory test) yearly, dated 06/16/22. Valproic Acid level (laboratory test to monitor for medication levels) quarterly, dated 12/15/22. Keppra level (laboratory test to monitor for medication levels) quarterly, dated 07/06/23. Continue Vitamin B12, Hemoglobin A1C, T4, TSH, and Vitamin D every 12 months, dated 10/24/24. Keppra, CBC, CMP, and Valproic acid every three months, dated 10/24/24. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of R15's EMR under the Misc tab under Laboratory lacked test results, and the facility was unable to provide evidence of results for the following laboratory tests CBC and CMP, from May 2025 and August 2025. R15's EMR also lacked the Keppra levels and Valproic acid level lab test from April 2025 and July 2025. R15's EMR also lacked results from yearly lab work. On 09/15/2025 at 03:36 PM, R15 propelled his wheelchair in the common area. R15's oxygen tank was attached to the back of his wheelchair. On 09/15/25 at 11:26 AM, Licensed Nurse (LN) G stated she entered the order into the laboratory portal as ordered by the physician. LNG stated if the order was for an extended period, that could also be entered into the portal. On 09/16/25 at 11:45 AM, Administrative Nurse D stated she expected the nurse who obtained the lab order to enter the order into the laboratory provider portal to be drawn as it was ordered. Administrative Nurse D stated the lab order could be entered into the lab providers portal to be an ongoing order if that was what the physician had ordered. Administrative Nurse D stated the physician can review the lab in the provider's portal, and then the medical records person would download the results into the resident's EMR. Administrative Nurse D stated the medical records would help ensure the lab test were obtained as ordered. The facility's Laboratory Services and Reporting policy dated 12/11/24 documented the facility must provide or obtain laboratory services when ordered by a physician, physician assistant, nurse practitioner, or clinical nurse specialist in accordance with state law. - R9's Electronic Medical Record (EMR) from the Diagnosis tab documented diagnoses of anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), paranoid schizophrenia (characterized by persistent delusions and hallucinations, primarily involving themes of persecution, mistrust, and conspiracy), schizophrenia (a mental disorder characterized by gross distortion of reality, disturbances of language and communication, and fragmentation of thought), and major depressive disorder (major mood disorder that causes persistent feelings of sadness). The Annual Minimum Data Set (MDS) dated 04/08/25 documented a Brief Interview for Mental Status (BIMS) score of 15, which indicated intact cognition. The MDS documented R9 had received antidepressant (a class of medications used to treat mood disorders) medication, antianxiety (a class of medications that calm and relax people) medication, and antipsychotic (a class of medications used to treat major mental conditions that cause a break from reality) medication during the observation period. The Quarterly MDS dated [DATE] documented a BIMS score of 15, which indicated intact cognition. The MDS documented that R9 had received antidepressant medication, antianxiety medication, and antipsychotic medication during the observation period. R9's Psychotropic Drug Use Care Area Assessment (CAA) dated 04/09/25 documented she was at risk for adverse side effects related to the medication she had received. R9's Care Plan, dated 06/27/22, documented the nursing staff would obtain the laboratory tests as ordered by the physician. The plan of care dated 04/18/24 documented her medications would be reviewed monthly by the physician and the pharmacist. R9's EMR under the Orders tab revealed the following physician orders: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175130	A. Building B. Wing	09/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Meadowbrook Rehabilitation Hospital	427 W Main Street Gardner, KS 66030

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 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Continue Vitamin B12 level (laboratory test to monitor medication level), Hemoglobin A1C (laboratory test to monitor blood sugar level), LIPID panel (laboratory test to monitor medication level), T4 (laboratory test to monitor medication level), TSH (laboratory test to monitor medication level), and Vitamin D (laboratory test to monitor medication level) yearly, dated 10/24/24.Complete Blood Count (CBC- laboratory blood test), complete metabolic panel (CMP- laboratory blood test), and Haldol (antipsychotic) level (laboratory test to monitor cat levels) every three months, dated 10/24/24. Review of R9's EMR under the Misc tab under Laboratory lacked test results, and the facility was unable to provide evidence of results for the following laboratory tests: Vitamin B12, T4, TSH, and Vitamin D level from yearly lab work in April 2025. R9's EMR also lacked evidence of results for a CBC and CMP from March 2025. On 09/16/25 at 09:25 AM, R9 laid on her bed covered with her quilt. On 09/15/25 at 11:26 AM, Licensed Nurse (LN) G stated she entered the order into the laboratory portal as ordered by the physician. LN G stated if the order was for an extended period, that could also be entered into the portal. On 09/16/25 at 11:45 AM, Administrative Nurse D stated she expected the nurse who obtained the lab order to enter the order into the laboratory provider portal to be drawn as it was ordered. Administrative Nurse D stated the lab order could be entered into the lab providers' portal to be an ongoing order if that was what the physician had ordered. Administrative Nurse D stated the physician can review the lab in the provider's portal, and then the medical records person would download the results into the resident's EMR. Administrative Nurse D stated that medical records would help ensure the lab tests were obtained as ordered. The facility's Laboratory Services and Reporting policy dated 12/11/24 documented the facility must provide or obtain laboratory services when ordered by a physician, physician assistant, nurse practitioner, or clinical nurse specialist in accordance with state law. - R5's Electronic Medical Record (EMR) from the Diagnosis tab documented diagnoses of sleep apnea (a disorder of sleep characterized by periods without respirations), diabetes mellitus (DM- when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin), schizoaffective (a mental disorder characterized by gross distortion of reality, disturbances of language and communication, and fragmentation of thought), hypertension (HTN- high blood pressure), obesity (excessive body fat), bipolar disorder (a major mental illness that causes people to have episodes of severe high and low moods), congestive heart failure (CHF- a condition with low heart output and the body becomes congested with fluid), venous insufficiency (poor circulation), and chronic obstructive pulmonary disease (COPD- a progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing). The Quarterly Minimum Data Set (MDS) dated [DATE] documented a Brief Interview for Mental Status (BIMS) score of 15, which indicated intact cognition. The MDS documented R5 needed partial to moderate assistance with toileting, and setup or clean-up for eating, oral hygiene, bathing, and dressing. The MDS documented R5 had heart failure and hypertension. R5s Functional Abilities (Self-Care and Mobility) Care Area Assessment (CAA) dated 10/21/24 would be addressed in R5's care plan. The CAA documented staff were to assist with activities of daily living (ADL), as needed, and anticipate care. The CAA documented therapy services would be used as (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	needed to help increase functional mobility, and staff were to encourage R5 to participate in ADL care as much as able to promote independence. R5's Care Plan dated 10/17/24 documented R5 had hypertension related to lifestyle choices. R5's plan of care documented staff were to avoid taking the blood pressure reading after physical activity or emotional distress, and staff were to educate R5 about the importance of maintaining a normal weight for my height, the value of regular exercise, limiting salt intake, the adverse effects of tobacco and alcohol use, the importance of medication and diet compliance. R5 plan of care documented nursing was to give anti-hypertensive (medications to lower blood pressure) medications as ordered and monitor for side effects such as hypotension (low blood pressure), increased heart rate, and effectiveness. The care plan for R5 documented nursing staff would monitor for edema (swelling resulting from an excessive accumulation of fluid in the body tissues). R5's EMR under Orders revealed the following physicians' orders: Coreg (beta blocker) oral tablet 6.25 milligrams (mg) (Carvedilol), give 6.25 mg by mouth two times a day for HTN, hold for systolic blood pressure (SBP) less than 110 or heart rate (HR) less than 60. R5's EMR under the Treatment Administration Record (TAR) recorded the following dates, which lacked evidence the blood pressure was obtained: 09/01/25, 09/04/25, 09/07/25, 09/10/25, 09/12/25, 09/13/25, and 09/14/25. On 09/14/25 at 09:47 AM, R5 sat on the side of his bed, drinking from a brown cup. On 09/16/25 at 11:30 AM, Licensed Nurse (LN) G stated that the certified medication aides (CMA), or the nurses, should always obtain vitals if a medication has perimeters. On 09/16/24 at 11:45 AM, Administrative Nurse D stated she was unsure why the blood pressure and pulse were not obtained before a resident received a beta blocker. She stated quality checks were done by the assistant director of nursing to ensure medications that should have perimeters have the perimeters put in place. The facility's Documentation in the Medical Record policy dated 01/30/24 documented that each resident's medical record would contain an accurate representation of the actual experiences of the resident and include enough information to provide a picture of the resident's progress through complete, accurate, and timely documentation. Licensed staff and interdisciplinary team members would document all assessments, observations, and services provided in the resident's medical record in accordance with state law and facility policy. Documentation would be completed at the time of service, but no later than the shift in which the assessment, observation, or care service occurred. Documentation may be performed manually or as per the facility's specific electronic medical record software program.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. The facility identified a census of 109 residents. The sample included 22 residents, with three medication rooms. Based on observation, record review, and interviews, the facility failed to secure medication carts containing residents' insulin (a hormone that lowers the level of glucose in the blood) pens and needles, residents' scheduled medications, and over-the-counter medication. Findings included:- On 09/14/25 at 09:05 AM, at the facility walk-through, four medication carts sitting in the commons area room were unlocked and unsecured. The medication cart contained insulin pens, needles, residents scheduled medications, and over-the-counter medications. The Certified Medication Aides (CMA) and the Licensed Nurse (LN) secured the carts. LN J locked all the medication carts. On 09/14/25 at 09:15 AM, a medication cart in the 800 hallway was unlocked and unsecured. The medication cart contained scheduled medications and over-the-counter medications. The CMA secured the cart. LN J locked the cart. On 09/16/25 at 11:30 AM, Licensed Nurse (LN) G stated the medication carts should never be left unattended. She stated insulin pens and needles should be locked in the cart when staff are not within eyesight of the medication cart. On 09/16/25 at 11:45 AM, Administrative Nurse D stated medication carts should be locked and never left unattended. She stated the facility expected that medication carts be locked, and the keys be with the nurse or CMA. The facility's Medication Storage policy dated 04/09/25 documented it was the policy of this facility to ensure all medications housed on our premises would be stored in the pharmacy and/or medication rooms according to the manufacturer's recommendations and sufficient to ensure proper sanitation, temperature, light, ventilation, moisture control, segregation, and security. All drugs and biologicals will be stored in locked compartments (i.e., medication carts, cabinets, drawers, refrigerators, medication rooms) under proper temperature controls. Only authorized personnel will have access to the keys to locked compartments. During a medication pass, medications must be under the direct observation of the person administering medications or locked in the medication storage area/cart.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. The facility identified a census of 109 residents, six residents on a puree textured diet. One resident received a double portion of their pureed diet, so the facility prepared seven pureed servings. Based on observation, record review, and interviews, the facility failed to follow nutritionally approved recipes during the preparation of the facility's puree-based meals. Findings included:- On 09/15/25 at 11:25 AM, Dietary Staff CC placed cooked country fried steak and stated she had added one cup of beef broth into the food processor and then started the machine. Dietary Staff CC then added several spoons of thickener powder into the food processor. Dietary Staff CC checked the consistency of the country-fried steaks. Dietary Staff CC then placed the country-fried steak into a metal container. Dietary Staff CC cleaned the food processor bowl and then placed corn into the food processor, then stated she had added one cup of chicken broth into the food processor with the corn. Dietary Staff CC added several spoons full of thickener powder to the food processor with the corn. Dietary Staff CC placed the pureed corn into a metal pan. Dietary Staff CC cleaned the food processor bowl. Dietary Staff CC placed the cake into the food processor and stated she had added about a cup of milk to the food processor with the cake. Dietary Staff CC started the food processor, then checked the consistency of the cake, and she added more milk to the food processor. Dietary Staff CC then placed the pureed cake into a metal pan. Dietary Staff CC never had reviewed a recipe during the process. The facility provided the recipe for the pureed altered diet, which lacked the indication of the servings and the fluid measurement to be added to maintain the nutritional value for each serving of food. On 09/16/25 at 12:10 PM, Dietary Staff BB stated that Dietary Staff CC should reference the recipes. Dietary Staff BB stated the recipe should have the servings identified with the measurement needed to maintain the nutritional value. The facility's Therapeutic Diet Orders policy dated 03/26/25 documented the facility provided all residents with foods in the appropriate form and/or the appropriate nutritive content as prescribed by a physician, and/or assessed by the interdisciplinary team to support the resident's treatment/plan of care, in accordance with his/her goals and preferences.

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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 109 residents. The sample included 22 residents. Based on record review and interviews, the facility failed to submit complete and accurate staff information through Payroll-Based Journal (PBJ) as required.Findings included:- The PBJ report provided by the Centers for Medicare & Medicaid Services (CMS) for Fiscal Year (YR) 2024 Quarter (Q) 4 and FY 2025 Q1, Q2, Q3 indicated excessively low weekend staffing.A review of the facility's weekend and licensed nurse hours revealed appropriate weekend and licensed nurse coverage.On 09/16/25 at 11:32 AM, Administrative Staff A reported she was responsible for the PBJ submissions. Administrative Staff A reported the use of a software program to verify hours before submission and had made some changes related to removing ancillary staff from the total hours. Administrative Staff A stated the weekend staffing patterns for licensed nurses remained the same.The facility's Payroll Based Journal policy, dated 02/25/25, documented the facility to electronically submit timely to CMS complete and accurate direct care staffing information, including information for agency and contract staff, based on payroll and other verifiable and auditable data in a uniform format according to specifications established by CMS.