STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175454	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLEARWATER NURSING & REHABILITATION CENTER	620 E WOOD STREET , CLEARWATER, Kansas, 67026

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	INITIAL COMMENTS The following citations represent the findings of extended survey and complaint investigations 2596308, 2599073, 2598824, 2591664, 2587692, 2581668, 2581611, 2573775, 2564610, 1575460, and 2613979. On 09/17/25 at 02:00 PM, Administrative Staff A and Consultant Staff II received a copy of the "Immediate Jeopardy [IJ] Template" and were notified that the facility failed to ensure residents remained free from physical and sexual abuse. The facility's failure to implement effective interventions to prevent physical and sexual abuse placed R2, R3, and R4 in IJ beginning on 06/28/25. On 06/28/25, R1 placed his hand on cognitively impaired R3's clothed genital area. The facility did not complete an investigation into the event or implement interventions to prevent further abuse. On 08/05/25, R1 grabbed R2's breast while R2 slept. Staff placed R1 on one-to-one for ten days, but failed to administer R1's physician-ordered medication to address his sexual behaviors. On 08/24/25, R1 put his hand inside cognitively impaired R4's brief while R4 slept in her bed. The facility's failure to implement effective interventions to prevent physical and sexual abuse placed R2, R3, and R4 in immediate jeopardy. The facility submitted an acceptable plan for removal of the IJ and on 09/17/25 at 05:05 PM, the surveyors verified implementation of the above corrective actions to address the immediacy as listed on the template. The scope and severity remained at a "G" to represent the actual psychosocial harm, using the reasonable person concept, since R2, R3, and R4 were cognitively impaired and unable to effectively communicate impact of the physical and sexual abuse experienced.	F0000		
F0558 SS = D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or	F0558		

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

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

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F0558 SS = D	Continued from page 1 other residents. This REQUIREMENT is NOT MET as evidenced by: The facility reported a census of 47 residents; the sample included 10 residents with three residents sampled for accommodation of preferences. Based on observation, interview, and record review the facility failed to ensure staff acknowledged and implemented Resident (R)6's preferences related to receiving his medications after his meals. Findings included: - R6's undated "Physician Orders," in the Electronic Health Record (EHR) included diagnoses of diabetes mellitus (DM-when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin) with hyperglycemia (elevated blood sugar content in the blood), long term use of insulin (hormone replacement medication that regulates blood sugar), cerebral infarction (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), chest pain, hypertension (high blood pressure), myocardial infarction (heart attack), atrial fibrillation (irregular heart rhythm), hemiplegia (paralysis of one side of the body) and hemiparesis (muscular weakness of one half of the body) following non-traumatic intracerebral (brain) hemorrhage (loss of a large amount of blood in a short period of time). R6's "Admission Minimum Data Set" (MDS) dated 08/26/25, documented a Brief Interview for Mental Status (BIMS) score of 13, indicating cognitively intact. The MDS noted he had functional limitations in the range of motion (ROM) on both sides of his lower extremities, and he used a wheelchair as an assistive mobility device. He received high-risk medications, which included insulin injections and anticoagulants (medication used to prevent the blood from clotting). R6's "Care Plan" dated 08/25/25 directed staff R6 has the potential to be physically and verbally aggressive related to anger and poor impulse control. The plan noted he was at risk for adverse reactions and side effects related to multiple medications and directed staff to review the medications with R6's physician and consulting pharmacist for timing, dosing, adverse reactions, supporting diagnoses, and frequency of administration, initiated 08/08/25. The plan lacked direction to staff related to R6's preference to have his medications administered 30 minutes to an hour	F0558		

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F0558 SS = D	Continued from page 2 after his food to prevent him from getting sick to his stomach. R6's "Physician's Orders" documented the resident received seven medications, which included an antibiotic, three cardiac medications (medications to regulate heart function), an anticonvulsant (to prevent seizures), an anticoagulant, insulin, and medication for indigestion. His medication orders lacked direction to administer any ordered medications with food or following food as the resident preferred. R6's "Medication Administration Record" (MAR) dated 08/01/25 through 09/15/25, revealed the resident refused his morning medications on 08/13/25, 09/01/25, 09/02/25, and 09/12/25. During an observation and interview on 09/16/25 at 11:04 AM, R6 self-propelled his wheelchair around his room during the interview. He used his right foot and hands to move his wheelchair. R6 stated he was his own person and should be able to make decisions about his care; no one was going to tell him what to do. R6 reported he got angry when he tried to get his meals on time, and he explained he had to have his food before he took his medications, or he would get sick. R6 stated that the staff did not listen to his requests, and he had to tell the staff over and over. R6 stated again that this made him angry. R6 stated he got tired of being sick in the bathroom and said he could not take his medications on an empty stomach, so he would just not take them. He stated he did not usually refuse his medications because he knew he needed them, but he could not take them unless he had eaten prior to taking them, so that is when he would refuse to take his medications. On 09/17/25 at 08:30 AM, CMA S entered the resident's room and informed the resident that she needed to check his vital signs and that she was giving him his medications. R6 replied in a loud voice that he would only tell them one more time that he could not take his medications because he had not eaten yet, and it would make him sick. He stated he needed to take his medication one-half hour to an hour after he ate to keep from being sick. R6 then asked CMA S how many times he had to tell them the same thing. He stated he was tired of having to spend time in the bathroom because he took his medications on an empty stomach. CMA S stated she would wait to give him his medications, but would take his vital signs to make sure his blood pressure was within range to give him his blood pressure medications. CMA S confirmed R6 had informed staff he would not take his medications unless	F0558		

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F0558 SS = D	Continued from page 3 he had eaten and confirmed R6's EHR lacked guidance to give R6 his medications with food, as he preferred. CMA S stated she informed the nurse when the resident refused his medications. On 09/17/25 at 08:45 AM, Certified Nurse Aide (CNA) M entered the resident's room and asked the resident if he wanted breakfast. The resident said yes, he had to eat before he could take his medications. CNA M left the room and then returned with the resident's breakfast tray. On 09/16/25 at 12:15 PM, Certified Medication Aide (CMA)/Social Service Staff (SSD) X stated the facility worked on R6's discharge plan back to the community, but his multiple transfers in and out of the hospital slowed the process down. CMA/SSD X stated she was not aware of the resident's concerns regarding his preference for staff to give his medications after he eats. CMA/SSD X confirmed that residents should be interviewed on admission and routinely throughout their stay regarding their preferences and that residents have the right to participate in decisions and provide input regarding their care. She stated that when a resident reported concerns to the staff, the concerns should be relayed to the supervisor, forwarded to social services, and then addressed with the appropriate department in a timely manner. CMA/SSD X stated that the concerns and grievances are followed up on, and changes are made to the care if indicated based on the resident's preferences. She confirmed R6's "Care Plan" had not been updated to direct staff regarding his preferences for mealtimes in relation to his medication administration. On 09/16/25 at 02:01 PM, Dietary Staff BB reported meals were served in the dining room at 08:00 AM for breakfast, 12:00 PM at lunch, and 05:00 PM at supper, but the residents who ate in their rooms received their trays approximately 30 to 45 minutes later. On 09/16/25 at 03:42 PM, CMA R confirmed she administered medications to R6 and that he had voiced his preference to have his medications after he ate or when he asked for them. CMA R said R6's medications were not ordered to be given with or after food On 09/17/25 at 02:30 PM, Administrative Nurse D confirmed that residents should have the opportunity to participate in decisions about their care, which included accommodation of their preferences regarding their medications. She stated residents' preferences and refusals of care and or services should be followed up by making the nurses aware and notifying the	F0558		

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F0558 SS = D	Continued from page 4 appropriate staff, and adjusting the resident's care as indicated to promote the resident's dignity and independence. She verified the resident's request for adjustment to meal service times and/or medication times had not been communicated as expected, and the facility had not followed up as they should. The facility did not provide a policy to address the reasonable accommodation of resident preferences.	F0558		
F0600 SS = SQC-J	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is NOT MET as evidenced by: The facility reported a census of 47 residents. The sample included 10 residents, with six residents reviewed for abuse. Based on observation, interview, and record review, the facility failed to ensure residents remained free from physical and sexual abuse. On 05/12/25 Resident (R) 1 admitted to the facility with a history of inappropriate behaviors. On 05/14/25, R1 grabbed and hit cognitively impaired R2 and staff placed R1 on one-to-one until he discharged to a behavioral health hospital on 05/15/25. R1 returned to the facility on 05/27/25, and the facility did not implement interventions for R1 to prevent further resident abuse. On 06/01/25, R1 bit R2's finger, causing it to bleed. R1 went to a behavioral health unit on 06/05/25 and returned to the facility on 06/18/25. On 06/21/25, R1 and R2 had an altercation where they slapped each other, and R1 grabbed R2's arm. On 06/28/25, R1 placed his hand on cognitively impaired R3's clothed genital area. The facility did not complete an investigation into the event or implement	F0600		

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F0600 SS = SQC-J	Continued from page 5 interventions to prevent further abuse. On 08/05/25, R1 grabbed R2's breast while R2 slept. Staff placed R1 on one-to-one for ten days, but failed to administer R1's physician-ordered medication to address his sexual behaviors. On 08/24/25, R1 put his hand inside cognitively impaired R4's brief while R4 slept in her bed. The facility's failure to implement effective interventions to prevent physical and sexual abuse placed R2, R3, and R4 in immediate jeopardy. Findings Included: - R1's Electronic Health Record (EHR) revealed diagnoses of dementia (progressive mental disorder characterized by failing memory, confusion) and depression (a mood disorder that causes a persistent feeling of sadness and loss of interest). R1's 06/02/25 "Admission Minimum Data Set" (MDS) documented a Brief Interview for Mental Status (BIMS) score of seven, which indicated severely impaired cognition. R1's MDS documented he had no depression and no behaviors. The MDS documented R1 required supervision assistance with transfers and was independent with wheelchair mobility. The MDS documented R1 received antidepressant (a class of medications used to treat mood disorders) and antipsychotic (a class of medications used to treat major mental conditions that cause a break from reality) medications. R1's 06/05/25 "Cognitive Loss/Dementia Care Area Assessment" (CAA) triggered secondary to orientation, memory, and recall deficits noted during the BIMS interview. The CAA recorded contributing factors included dementia, change in mental status, and short-term/long-term memory loss; risk factors included self-care deficits, falls with injuries, incontinence, decreased socialization, skin breakdown, weight loss, and fluid imbalance. The CAA noted a care plan would be initiated and reviewed to improve and/or maintain current cognitive status, activities of daily living (ADL) status, continence status, mobility, as well as to encourage active participation in facility functions, maintain communication, decrease fall and pressure ulcer risk, and maintain dietary intake and hydration status. R1 did not trigger for "Behavioral Symptoms CAA" as R1's behaviors were not captured on the MDS. R1's "Behavioral Symptoms Tasks" in the EHR dated 05/07/25 through 06/02/25 documented R1 wandered on 05/29/25, and R1 was sexually inappropriate on	F0600		

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F0600 SS = SQC-J	Continued from page 6 05/30/25. R1's 06/04/25 "Quarterly MDS" documented a BIMS score of seven, which indicated severely impaired cognition. The MDS recorded R1 had no depression or behaviors during the lookback period. The MDS documented R1 received antipsychotic and antidepressant medications. R1's "Baseline Care Plan" dated 05/12/25 lacked mention or interventions related to R1's history of behaviors. R1's "Care Plan" dated 06/06/25 documented R1 had a behavior problem, physical and verbal aggression, and sexually inappropriate verbalizations and actions. Staff were educated to monitor R1's agitation, intervene before agitation escalated, and guide away from the source of distress. The plan directed staff to engage R1 calmly in conversation, and if his response was aggressive, staff were to walk calmly away and approach him later. The plan directed staff to obtain behavioral health consults as needed. R1's "Care Plan" on 06/12/25 documented staff were educated to intervene as necessary to protect the rights and safety of others. Staff were instructed to approach R1 and speak in a calm manner; divert R1's attention and remove him from the situation; take him to an alternate location as needed. Staff were instructed to minimize the potential for R1's disruptive behaviors by offering tasks that divert attention, such as activities of interest. R1's "Care Plan" on 08/05/25 documented R1's Paxil (antianxiety medication) was increased related to behaviors. Staff were to ensure medication compliance for Depo-Provera (a medication primarily known as a contraceptive for women but used in males as a method to reduce sexual drive and manage sexually offensive behavior) intramuscular (given directly into a muscle) suspension prefilled syringe 150 milligrams (mg)/milliliter (ml). Staff were to provide one-to-one sessions related to behaviors until R1's medication review with possible changes. R1's "Care Plan" on 08/27/25 documented R1's Seroquel (antipsychotic medication) was increased to 25 mg three times a day per medication review related to R1's increased sexual behaviors. R1's EHR, under the "Misc" tab revealed a scanned document provided from R1's previous facility upon admission, which included a "Progress Note" dated 04/29/25 that noted R1 continued to try to grab female staff during cares and noted he tried to work his way	F0600		

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F0600 SS = SQC-J	Continued from page 7 into elder females' space; R1 required constant supervision when up from bed and 15 minute checks when he was in bed. R1's EHR recorded an order for "Physician Order Behavior Monitoring" that documented staff monitored the resident for behaviors including itching, picking at skin, restlessness, agitation, hitting, increase in complaints, biting, kicking, spitting, cussing, racial slurs, elopement, stealing, delusions, hallucinations, psychosis, aggression, and refusing care. Staff would document: 'N' if monitored and none of the above was observed. Staff would document 'Y' if monitored and any of the above was observed, select chart code 'Other/ See Nurses Notes' and document progress note findings every day and night shift for psychotropic (alters mood or thought) medication use, date ordered 05/12/25. R1's "Progress Note" on 05/14/25 at 09:45 AM documented staff arrived at the nurses' station and reported R1 just hit and grabbed another resident; the residents were separated, and R1was placed on one-to-one supervision as an intervention. The facility's 05/14/25 "Incident Report" at 09:45 AM documented that staff intervened appropriately to separate the residents with close monitoring provided to R1to ensure safety for other residents until a physician-ordered intervention was obtained. This incident lacked further investigation details and outcomes. R1's "Physician Order" documented administer Depo-Provera intramuscular suspension prefilled syringe 150 mg/ml inject 2 ml intramuscularly in the morning every two weeks on Thursdays for behaviors, date ordered 05/15/25. R1's "Progress Note" on 05/27/25 at 05:25 PM documented R1 readmitted from a behavioral health unit on one-to-one. R1's "Progress Note" on 06/01/25 at 01:57 AM documented, at approximately 11:15 AM staff heard a female resident yelling "Help" in the dining room. All staff members ran to the dining room and observed a female resident [R2] standing in front of R1 with the female resident's finger in R1's mouth. R1 was biting down with his teeth, and there was blood dripping from the female resident's hand. The noted documented staff members intervened immediately and removed both residents from the dining room. Staff placed R1 on one-to-one observation.	F0600		

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F0600 SS = SQC-J	Continued from page 8 The facility's 06/01/25 "Incident Report" at 11:15 AM documented staff intervened appropriately to separate the residents, with close monitoring provided to R1 to ensure safety for other residents until a physician-ordered intervention was obtained. R1's "Progress Note" on 06/18/25 at 04:05 PM documented R1 returned to the facility around 02:10 PM via facility transport in a wheelchair. R1's "Progress Note" on 06/21/25 at 03:08 AM documented staff witnessed R1 in the dining room with a female resident [R2]. The noted recorded staff witnessed both residents slapping each other on the arms, R1 grabbed the female resident's arm, and staff immediately intervened and separated the residents. The facility could not provide an investigation related to the 06/21/25 incident. R1's "Physician Note" on 06/23/25 at 05:50 PM documented a physician saw R1 after admission to the behavioral health unit again. The note documented R1 had a recent admission twice for inappropriate physical and sexual behaviors. The note documented R1 was primarily redirectable and noted the physician would follow up for changes in mood. R1's "Progress Note" on 06/28/25 at 11:03 AM, documented staff notified R1's representative that staff observed R1 touching a female resident in the genital area and R1 would be monitored on a one-to-one basis. The note recorded R1's representative stated they did not know how staff would stop R1 from doing that. The facility could not provide an investigation related to the 06/28/25 incident. R1's "Progress Note" on 07/03/25 at 05:31 AM, documented R1 tried to grab at a staff member's private area three times that day. R1's "Physician Note" on 08/04/25 at 10:13 AM, documented the provider saw R1 on 07/28/25 and issued new orders to decrease R1's Seroquel to 25 mg twice a day to attempt a gradual dose reduction, and increase Paxil to 30 mg daily for mood-behaviors; continue all other medications as ordered. R1's "Progress Note" on 08/05/25 at 03:36 PM documented staff witnessed R1 inappropriately touching a female resident's [R2] right breast in the television room. The note recorded the female resident was asleep when	F0600		

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F0600 SS = SQC-J	Continued from page 9 staff observed R1 groping her and attempting to reach under her shirt. Staff immediately intervened and separated both residents. The facility's 08/05/25 "Incident Report" at 10:00 AM documented staff immediately separated both residents, completed skin assessments, and updated R1's family and provider. The report noted medication changes were made on 08/05/25 (decrease of Seroquel and increase of Paxil), and R1 was on one-to-one from 08/05/25. R1's "E-Medication Administration Record" (eMAR) on 08/07/25 at 11:20 AM documented staff could not administer R1's injection of Depo-Provera for behavioral reasons because the medication was not in stock; staff re-ordered medications. The August 2025 eMAR documented the 08/07/25 dose was never administered, and R1 did not receive the Depo-Provera until the next scheduled dose on 08/21/25 (14 days later). R1's EHR lacked evidence staff notified the physician R1's Depo-Provera was not administered on 08/07/25 as ordered. On 08/10/25, the EHR revealed R1's one-to-one supervision was discontinued. R1's "Progress Note" on 08/24/25 at 01:06 PM documented staff observed R1 in a female resident's [R4] room with his hand in her brief while the female resident lay in her bed. Staff initiated one-to-one monitoring. The facility's 08/24/25 "Incident Report" at 12:00 PM documented staff removed R1 from a female resident's [R4] room and initiated one-to-one for R1. The report noted staff monitored both residents closely for behavioral or psychological changes, and R1 remained one-to-one until 08/31/25. R1's "Physician Note" on 08/26/25 at 08:23 PM documented R1 continued with one-to-one with no behavior issues observed or reported during that shift. R1's "Progress Note" on 08/27/25 at 02:08 PM documented R1 continued with one-to-one for inappropriate sexual behaviors. The note recorded staff spoke with the provider for a medication review as R1 recently had a gradual dose reduction (GDR) for Seroquel; the GDR attempt failed, and staff received a new order to increase R1's Seroquel 25 mg to three times a day. During an observation on 09/16/25 at 12:15 PM, R1 sat in the dining room waiting for lunch.	F0600		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0600 SS = SQC-J	Continued from page 10 During an observation on 09/17/25 at 08:45 AM, staff pushed R1 in a wheelchair from the shower room to the dining room. R1 sat at a table alone and fed himself breakfast. During an interview on 09/16/25 at 03:04 PM, Social Service Designee (SSD) X reported R1 admitted from a facility after they received the referral. SSD X reported she was not sure who evaluated R1 for admission and said she was unaware that R1 had behaviors at the prior facility. SSD X reported R1's behaviors and interventions should have been documented on the baseline care plan with appropriate interventions and said nursing staff was responsible for completing the baseline care plan. During an interview on 09/16/25 at 12:29 PM, Licensed Nurse (LN) G reported R1's one-to-one was discontinued a couple of weeks ago, as R1 had an increase in the Seroquel medication, and that helped with R1's behaviors. LN G reported R1 had several inappropriate sexual behaviors towards other female residents and staff. LN G reported that when a resident was placed on a one-to-one, it would only be for a short period of time. During an interview on 09/16/25 at 03:19 PM, Administrative Nurse E reported she worked as a floor nurse when R1 admitted in May 2025. She reported the floor nurse would complete the baseline care plan upon admission after assessments and a review of documentation from the admitting facility was completed. Administrative Nurse E reported the floor staff would not see the referral paperwork and reported she was unaware R1 had a history of sexual behaviors when he admitted. Administrative Nurse E reported R1's behaviors and interventions should have been documented on his care plan. Administrative Nurse E reported the facility would generally keep a resident on a one-to-one for about three days after an incident and then review. She reported staff should have removed the one-to-one from R1's "Care Plan" when it was discontinued on 08/31/25. During an interview on 09/16/25 at 05:00 PM, LN G reported if a medication was not available for administration, the nurse would check the emergency medication kit to see if that medication was available, and if it was not, the staff would notify the pharmacy. LN G reported the pharmacy would deliver the medication if it were an emergency. LN G reported medication was ordered once or twice a month, and the physician should be notified when the medication is not available.	F0600		

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F0600 SS = SQC-J	Continued from page 11 During an interview on 09/17/25 at 08:10 AM, Certified Nurse Aide (CNA) M reported he did not know about any hyper-sexual behaviors towards female residents by R1. CNA M reported he knew about sexual behaviors towards female staff, and he was asked numerous times by female staff to bathe R1 because they felt uncomfortable around him. CNA M further reported he was unaware of the location for information about R1's previous resident-to-resident abuse incidents or where to find the interventions to utilize if the incidents reoccurred. During an interview on 09/17/25 at 08:20 AM, CNA N reported he witnessed R1 attempt to grab or grope a female resident, but he immediately intervened and redirected R1. CNA N reported R1's information and interventions should be listed on his care plan. During an interview on 09/17/25 at 09:50 AM, Administrative Staff E reported she was unaware R1 had missed a Depo-Provera shot in August 2025. Administrative Staff E reported the facility orders the medication, receive multiple doses with each delivery, and when the nurse administered the last dose, the nurse would re-order the medication. Administrative Staff E reported she expected the floor nurses to perform a follow-up with this type of situation, and to communicate with the pharmacy, notify the provider that the medication was missed, and to chart progress notes related to the situation and follow-ups. During an interview on 09/17/25 at 10:25 AM, Administrative Staff A stated he expected all reportable incidents to be thoroughly investigated and the completed investigation to be submitted in the time frame allowable. Administrative staff A was unable to provide the completed investigations and confirmed he was not working in the facility at the time of the previous events on 06/21/25 and 06/28/25. The facility's policy "Abuse Prevention Program" dated May 2025 documented the residents had the right to be free from abuse, neglect, misappropriation of property, and exploitation. The community had zero tolerance for abuse, and to protect residents from abuse by anyone, the facility would implement measures to address factors that may lead to abusive situations. On 09/17/25 at 02:00 PM, Administrative Staff A and Consultant Staff II received a copy of the "Immediate Jeopardy [IJ] Template" and were notified that the facility failed to ensure residents remained free from physical and sexual abuse. The facility's failure to	F0600		

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F0600 SS = SQC-J	Continued from page 12 implement effective interventions to prevent physical and sexual abuse placed R2, R3, and R4 in IJ. The facility submitted an acceptable plan for removal of the IJ on 09/17/25 at 04:55 PM, which included the following: 1. Staff were in-serviced on the facility's "ANE P&P and De-Escalation Tool" completed by 09/17/25. Staff were not allowed to work until verification of the in-service training was obtained. 2. R1 was accepted to another facility with an estimated discharge date of 11/01/25 or sooner. 3. To ensure R1 received his Depo-Provera, the Director of Nursing added the administration date to her calendar as a reminder to ensure that the medication was on hand by the due date every two weeks. 4. All staff were educated on 09/17/25 regarding R1's specific behaviors that indicate that R1 might be escalating and the appropriate actions to take in response. 5. The facility had a recent change in Administrator and Director of Nursing staff, and the new staff were in-service on 09/17/25 to do a root cause analysis when a resident was placed on one-to-one monitoring, which included what led up to the incident, what behaviors led up to the incident, and what to look for after the resident was removed from one-to-one monitoring. The entire interdisciplinary Team (IDT) also received this in-service on 09/17/25. 6. The facility and corporate entity modified the current one-to-one policy to create ongoing monitoring once residents were removed from the one-to-one oversight, with regional support to monitor the effectiveness of interventions placed. 7. The facility conducted a Quality Assurance and Performance Improvement (QAPI) meeting on 09/17/25 to review. On 09/17/25 at 05:05 PM, the surveyors verified implementation of the above corrective actions to address the immediacy as listed on the template. The scope and severity remained at a "G" to represent the actual psychosocial harm, using the reasonable person concept, since R2, R3, and R4 were cognitively impaired and unable to effectively communicate impact of the physical and sexual abuse experienced.	F0600		
F0609 SS = D	Reporting of Alleged Violations	F0609		

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F0609 SS = D	Continued from page 13 CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is NOT MET as evidenced by: The facility reported a census of 47 residents. The sample included 10 residents, with six residents reviewed for abuse. Based on interview, and record review, the facility failed submit a completed investigation for allegations of resident-to-resident abuse to the State Agency within five working days as required for allegations involving Resident (R) 1 and R2 on 06/21/25 and R1 and R3 on 06/28/25. Findings Included: - The facility provided an initial report to the SA for a resident-to-resident involving R1 and R2 in Incident KS00196132 and for R1 and R3 in Incident KS00196270. R1's "Progress Note" on 06/21/25 at 03:08 AM documented staff witnessed R1 in the dining room with a female resident [R2]. The noted recorded staff witnessed both residents slapping each other on the arms, R1 grabbed	F0609		

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F0609 SS = D	Continued from page 14 the female resident's arm, and staff immediately intervened and separated the residents. R1's "Progress Note" on 06/28/25 at 11:03 AM, documented staff notified R1's representative that staff observed R1 touching a female resident in the genital area and R1 would be monitored on a one-to-one basis. The note recorded R1's representative stated they did not know how staff would stop R1 from doing that. The facility could not provide an investigation related to the 06/21/25 and 06/28/25 incidents. The facility was unable to provide evidence the completed investigations were submitted to the SA within five working days. During an interview on 09/17/25 at 10:25 AM, Administrative Staff A stated he expected all reportable incidents to be thoroughly investigated and the completed investigation to be submitted in the time frame allowable. Administrative staff A was unable to provide the completed investigations and confirmed he was not working in the facility at the time of the previous events on 06/21/25 and 06/28/25 so he was not sure if anything was submitted to the SA or when. The facility's policy "Abuse Prevention Program" dated May 2025 documented the Administrator, or his/her designee, will provide the appropriate agencies or individuals listed above with a written report of the findings of the investigation within five (5) working days of the occurrence of the incident.	F0609		
F0610 SS = D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated	F0610		

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F0610 SS = D	Continued from page 15 representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is NOT MET as evidenced by: The facility reported a census of 47 residents. The sample included 10 residents, with six residents reviewed for abuse. Based on interview, and record review, the facility failed to thoroughly investigate allegations of abuse for allegations involving Resident (R) 1 and R2 on 06/21/25 and R1 and R3 on 06/28/25. Findings Included: - The facility provided an initial report to the SA for a resident-to-resident involving R1 and R2 in Incident KS00196132 and for R1 and R3 in Incident KS00196270. R1's "Progress Note" on 06/21/25 at 03:08 AM documented staff witnessed R1 in the dining room with a female resident [R2]. The noted recorded staff witnessed both residents slapping each other on the arms, R1 grabbed the female resident's arm, and staff immediately intervened and separated the residents. The facility could not provide an investigation related to the 06/21/25 incident. R1's "Progress Note" on 06/28/25 at 11:03 AM, documented staff notified R1's representative that staff observed R1 touching a female resident in the genital area and R1 would be monitored on a one-to-one basis. The note recorded R1's representative stated they did not know how staff would stop R1 from doing that. The facility could not provide an investigation related to the 06/28/25 incident. During an interview on 09/17/25 at 10:25 AM, Administrative Staff A stated he expected all reportable incidents to be thoroughly investigated and the completed investigation to be submitted in the time frame allowable. Administrative staff A was unable to provide the completed investigations and confirmed he was not working in the facility at the time of the previous events on 06/21/25 and 06/28/25 so he was not sure if anything was completed. The facility's policy "Abuse Prevention Program" dated May 2025 documented if an actual incident, suspected	F0610		

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F0610 SS = D	Continued from page 16 incident or allegation of resident abuse, mistreatment, neglect or injury of unknown source or reasonable suspicion of a crime was reported, the Administrator would assign the investigation to an appropriate individual. and provide any supporting documents relative to the alleged incident to the person in charge of the investigation. The Administrator would keep the resident, and his/her representative (sponsor) informed of the progress of the investigation and suspend immediately any employee who has been accused of resident abuse, pending the outcome of the investigation. The Administrator would ensure that any further potential abuse, neglect exploitation or mistreatment as prevented. The Administrator will inform the resident and his/her representative of the status of the investigation and measures taken to protect the safety and privacy of the resident.	F0610		