STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265001	A. Building B. Wing	01/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Athene Nursing and Rehabilitation	13995 Clayton Road Town and Country, MO 63017

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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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. Based on observation, interview and record review, the facility failed to follow acceptable nursing practice when facility staff left medication in one resident's room (Resident #135), who did not have a physician order for self-administration or medications to be left at the bedside. The sample was 47. The census was 166.Review of the facility's Resident Self Administration of Medications policy, last revised, 8/1/25, showed;-Policy: It is the policy of this facility to support each resident's right to self-administer medication; a resident may only self-administer medications after the facility's interdisciplinary team has determined which medications may be self-administered safely;-Policy explanation and Compliance Guidelines: -When determining if self-administration is clinically appropriate for a resident, the interdisciplinary team should at a minimum consider the following: -The medications appropriate and safe for self-administration; -The resident's physical capacity to swallow without difficulty, open medication bottles, administer injections; -The resident's cognitive status, including their ability to correctly name their medications and know what conditions they are taken for; -The resident's capability to follow directions and tell time to know when medications need to be taken; -The resident's comprehension of instructions for the medications they are taking, including the dose, timing, and signs of side effects, and when to report to facility staff; -The resident's ability to understand what refusal of medication is, and appropriate steps taken by staff to educate when this occurs; -The resident's ability to ensure that medication is stored safely and securely; -The results of the interdisciplinary team assessment are recorded for the medication self-administration assessment form, which is placed in the resident's medical record; -Upon notification of the use of bedside medication by the resident, the medication nurse records the self-administration on the medication administration record (MAR); -All nurses and aides are required to report to the charge nurse on duty any medication found at the bedside not authorized for bedside storage. Review of the Resident #135's physician order sheets dated, 1/7/26, showed:-An order dated, 12/16/25, Ofloxacin Ophthalmic solution 0.3% (eye medication to treat eye infections); one drop to both eyes four times a day for cataracts (cloudy film over eyes that is surgically removed);-An order dated, 12/17/25, Ketorolac Tromethamine solution 0.5 % (eye medication to treat inflammation and pain); one drop to both eyes four times a day for cataract;-An order dated, 12/17/25, Prednisolone acetate ophthalmic suspension 1 % (eye medication to treat inflammation); one drop to both eyes four times a day for cataract.-No order for self-administration of eye drops or that the eye medications can be left a bedside. Review of the resident medical record showed a no self-administration assessment completed. Observations on 1/6/26 at 10:15 A.M., 1/8/26 at 1:17 P.M. and 1/12/26 at 8:30 A.M., showed the resident had three eye drop bottles on his/her bedside table. The eye drops were Ofloxacin, Ketorolac, and Prednisolone. During an interview on 1/6/26 at 10:15 A.M., the resident said he/she administers the eye medications him/herself. During an interview on 1/13/26 at 11:39 A.M., Registered Nurse (RN) G said residents who want to administer their own medication need to be assessed by management to determine if they (continued on next page)

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

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

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	are safe and competent enough to do so. The assessment would be located in the medical record, and a physician order needs to be obtained stating that resident may self-administer medications and medications may be left at bedside. During an interview on 1/13/26 at 2:40 P.M., the Director of Nursing (DON) said she would expect staff to complete a self-administration assessment and obtain an order that the resident could self-administer the eye medication, and that the medication could be left at the bedside.

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F 0575 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Post a list of names, addresses, and telephone numbers of all pertinent State agencies and advocacy groups and a statement that the resident may file a complaint with the State Survey Agency. Based on observation and interview, the facility failed to post the Missouri Department of Health and Senior Services (DHSS) Elder Abuse and Neglect Hotline phone number and failed to provide contact information for the State Long-Term Care Ombudsman program (a statewide network of individuals who help residents in long-term care facilities by helping ensure their rights were preserved and respected) in a visible location. The sample was 47. The census was 166.Observation on 1/6/26 through 1/9/26, 1/12/26, and 1/13/26, showed: -No DHSS Abuse and Neglect hotline numbers or Ombudsman contact information on the facility's elevators;-The Corporate compliance contact information posted on the wall of Terrace 2. No DHSS Abuse and Neglect hotline number or Ombudsman contact information;-The Corporate compliance contact information posted on the double doors in the middle hall of Terrace 3. No DHSS Abuse and Neglect hotline number or Ombudsman contact information;-No DHSS Abuse and Neglect hotline number or Ombudsman contact information on 3 Short;-No DHSS Abuse and Neglect hotline number or Ombudsman contact information on 3 Long;-No DHSS Abuse and Neglect hotline number or Ombudsman contact information on the Loop. During an interview on 1/8/26 at 1:30 P.M., all eight residents present during the resident council meeting said they were not aware of the Ombudsman program and confirmed the information was not posted. One resident asked for the correct spelling of the advocacy agency. Observation on 1/8/26 at 2:52 P.M., showed a bulletin board on the wall in the front lobby, with typed up sign that showed, if you suspect any form of abuse and neglect, please contact the Administrator and provided the administrator's contact number. Observation on 1/8/26 at 2:55 P.M., showed a 12-inch x 18-inch Resident Rights poster outside of the Social Worker's office. At the bottom of the poster, a letter label, approximately 1 inch x 2 5/8 inches in size with the Ombudsman's contact number. There was a second sign on the door that showed Corporate's confidential reporting hotline for facility company. No observation of the hotline number for DHSS. During an interview on 1/13/26 at 1:30 P.M., the Administrator said there should be signs for the hotline number by the business office, by the stairwell near Terrace 2, and bird cages. He was only aware of those areas. He would have to see the print for the Ombudsman contact number, but he would expect the print to be large enough for residents to see. 1698646

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure the facility was clean and homelike. The facility failed to ensure two of 47 sampled residents had a clean room and clean medical equipment (Residents #135 and #72), failed to ensure the 3rd floor terrace had a clean shower room and fire extinguisher cabinet, failed to ensure the 3rd floor windows were free from cracks, failed to ensure the floors in room [ROOM NUMBER] were clean and failed to ensure the loop main hallway was clean and free from odors. The sample is 47. The census was 166. Review of the facility's cleaning policy, undated, showed: -Policy: The facility has employed team members of environmental service at the facility to ensure that all areas of the facility, including resident rooms, offices, and public areas, are clean and homelike; -Procedure: Walk through the assigned area checking for spills, debris, and unsafe items / situations to clean or remove immediately. The areas should be ready for residents, guests, and employees use ensuring professional first impression; -Trash and soiled linen removal: Safely load all hamper bags into soiled linen carts and safely transport to the nearest soiled linen utility. Replace linen where required. Environmental services are required to replace linen only on discharged resident beds; clinical staff replace linen on occupied beds. Review of the facility's cleaning and disinfection of resident care equipment policy, dated 8/1/25, showed: - Policy: Resident-care equipment can be a source of indirect transmission of pathogens. Reusable resident-care equipment will be cleaned and disinfected in accordance with current Centers for Disease Control and Prevention (CDC) recommendations in order to break the chain of infection; -For durable medical equipment, such as feeding pumps, staff shall store used/dirty equipment in soiled utility room. The central supply clerk shall be responsible for terminal cleaning/disinfection in designated locations, covering the equipment to prevent dust and other contamination, and storing in clean utility or other designated storage rooms. Verify the disinfectant is compatible with the equipment. 1. Review of Resident #135's medical record, showed; -admission date,12/16/25; -Diagnoses included osteomyelitis (infection of the bone) of left ankle and foot, muscle weakness, unsteady gait, and need for assistance with personal care. Observation of the resident's room on 1/6/26 at 10:15 A.M., 1/7/26 at 1:22 P.M., and 1/8/26 at 1:17 P.M., showed an intravenous (IV) pole had thick crusted yellow dried liquid on the bottom of the pole and wheel coverings. The resident's fitted sheets on his/her bed showed drops of maroon and dark (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	brown stains and smears. There were crumbs along the baseboards and behind the resident's dresser. The resident's clothing was stored in a clear trash bag. During an interview on 1/8/26 at 1:17 P.M., the resident said his/her sheets have never been changed since he/she had been there and thinks it's gross. The crusted liquid on the IV pole has been on the pole since they brought it into his/her room. The resident said his/her room is filthy. 2. Review of Resident #72's medical record, showed: -admission date, 12/15/25; -Diagnoses included cellulitis (skin infection) of left lower limb and lymphedema (swelling of extremities). Observation on 1/6/26 at 10:15 A.M., 1/7/26 at 1:22 P.M., and 1/8/26 at 1:17 P.M., showed used towels with stains, in the corner of the resident's room. In the bathroom, there were used washcloths and towels on the floor. The resident had a grocery bag full of trash tied to his/her nightstand. The resident's fitted bed sheet had brown smears and yellow stains. During an interview on 1/8/26 at 1:17 P.M., the resident said his/her sheets have never been change since he/she had been there. The resident said staff will say they will come in and change the sheets, but they never do. The washcloths in the bathroom are from when he/she took a shower. The towels in the corner of the resident's room were left from the Wound Nurse last week. The resident said he/she would clean the room him/herself because it is so dirty, but he/she is unable to do so. 3. During an interview on 1/13/26 at 9:40 A.M., Certified Nursing Assistant (CNA) U said resident sheets are changed on shower days. Towels and washcloths can be picked up housekeeping or nursing. Clothing should be placed in the closet, not in trash bags. 4. During an interview on 1/13/26 at approximately 11:30 A.M., Housekeeper BB said sheets are changed by nursing. Towels and trash should be removed by housekeeping when they clean the room. Housekeeper BB will usually ask the resident what they would like removed out of their room. Resident rooms are cleaned daily and furniture is moved to sweep or mop behind it. If there is something that housekeeping cannot clean, such as medical equipment, Housekeeper BB would notify his/her supervisor. 5. During an interview on 1/13/26 at 2:40 P.M., the Administrator and the Director of Nursing (DON) said residents' sheets should be changed twice a week. In resident rooms, linens should be picked up off the floor and their clothes stored in the closets. Any staff can clean a soiled IV pole. 6. Observations on 1/6/26 at 12:31 P.M., on 1/8/26 at 6:01 A.M. and on 1/12/26 at 7:58 A.M, of the fire extinguisher cabinet near room [ROOM NUMBER], showed a large, unidentifiable white stain covering the cabinet. Observations on 1/7/26 at 9:01 A.M. and on1/8/26 at 6:11 A.M., of the resident hall shower rooms on the 3rd Floor Terrace, showed: -Three wet towels on the floor and two stained washcloths left in the sink of the men's shower room; (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Two stained wash cloths in the second shower stall of the women's shower room. Observation of the [NAME] wing elevator, showed: -On 1/7/26 at 9:19 A.M., a scattering of dark, sticky stains on the floor of the elevator; -On 1/9/26 at 9:15 A.M., a scattering of dark, sticky stains on the floor of the elevator. Residents' and staff's shoes could be heard sticking to the elevator floor while entering and exiting the elevator; -On 1/12/26 at 8:24 A.M., a scattering of dark, sticky stains on the floor of the elevator. Residents' and staff's shoes could be heard sticking to the elevator floor while entering and exiting the elevator. Observation on 1/9/26 at 9:17 A.M. and on 1/12/25 at 8:17 A.M., of the wall opposite the elevator on the 3rd Floor Terrace level, showed an unidentified red splatter on the green wallpaper. Observation on 1/9/26 at 12:42 P.M. and on 1/12/26 at 8:22 A.M., of the artwork near the 3rd Floor Terrace elevator, showed a large, unidentifiable white stain covering the paintings on the wall. During an interview on 1/13/26 at 9:51 A.M. CNA L and Certified Medication Technician (CMT) M said housekeeping staff were responsible for cleaning the shower rooms on the hall, but all care staff should clean up after themselves when taking a resident to complete a shower in the shower room. Towels and wash cloths should be cleared and if a biologic spill needs to be cleaned up, housekeeping can be contacted for assistance. Shower rooms should be cleaned daily by housekeeping staff, but some housekeeping staff were more diligent about cleaning shower rooms than others. During an interview on 1/13/26 at 10:01 A.M., Registered Nurse (RN) G said housekeeping staff were responsible for cleaning the shower rooms on the hall, but all care staff should clean up after themselves when taking a resident to complete a shower in the shower room. If a biologic spill needs to be cleaned up, housekeeping can be contacted for assistance. During an interview on 1/13/26 at 1:41 P.M., the facility Director of Nurses (DON) and Administrator said any staff were able to clean up shower rooms on the resident halls, but housekeeping staff were primarily responsible for keeping these areas clean. Resident hall shower rooms should be cleaned daily and maintained in a clean and orderly fashion to promote a homelike environment. The facility elevators should be cleaned daily or as needed if spills or accidents occur. 7. Observation of the 3rd floor dining room on 1/6/26 through 1/9/26 and 1/12/26 through 1/13/26, showed double windows on both sides of the room, with 11 double windows on both sides. Several double windows were cracked, broken, or unable to close fully. There was a large piece of cardboard, 36 x 18 inches, that covered one half of a window. Observation on 1/9/26 at 12:05 P.M., showed a loose, small handrail outside of room [ROOM NUMBER] that moved down when touched. 8. Observation of room112, showed: -On 1/6/26 at 9:49 A.M., the floor was dirty with trash and a large dust like material splatter in (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the bathroom; -On 1/7/26 at 7:04 A.M., the floor was dirty with various trash wrappers and a large dust like material splatter in the bathroom; -On 1/12/26 at 7:29 A.M., the floor was dirty with trash wrappers in various areas of the room. 9. Observation of the loop main hallway, showed: -On 1/8/26 at 1:32 P.M., a strong odor of urine and sweat wafting in the hallway. The floor in the main hallway was sticky; -On 1/9/26 at 6:54 A.M., a strong odor of urine and sweat was wafting in the hallway. The floor in the main hallway was sticky. Various trash items were on the floor; -On 1/9/26 at 8:21 A.M., a strong odor of urine and bowel movement was wafting from the dirty linen cart positioned in the hallway. The lid was open; -On 1/13/26 at 6:55 A.M., a strong odor of bowel movement and urine was in the hallway. Bags of visibly dirty linens and depends were sitting on the ground in the main hallway. 10. During an interview on 1/13/26 at 12:49 P.M., the Director of Housekeeping said housekeepers were responsible for cleaning resident rooms. The floor technicians were responsible for cleaning the hallways and resident room floors. He expected floors to be clean and free from debris and trash. The machine used for cleaning the hallways was currently broken. 11. During an interview on 1/13/26 at 2:30 P.M., the Administrator and DON said they expected the floors on the loop hallway to be clean and free from trash. They expected dirty linen and depends to be stored properly in bins. They expected resident rooms to be clean. 260738 2566352 1698661 1698646 1698637 2712327

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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** Based on interview and record review, the facility failed to ensure bed hold notices were provided for two of four residents investigated for discharge (Residents #166 and #177). The sample was 47. The census was 166. Review of the facility's Bed Hold Notice Upon Transfer policy, dated 8/1/25, showed:-Policy: at the time of transfer for hospitalization or therapeutic leave, the facility will provide to the resident and/or the resident representative written notice which specifies the duration of the bed-hold policy and addresses information explaining the return of the resident to the next available bed;-The facility will 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. 1. Review of Resident #166's medical record, showed: -Discharge to the hospital on [DATE];-No filled out and signed bed hold notice provided by the facility for the date of 10/16/25. 2. Review of Resident #177's, medical record, showed:-Discharge to the hospital on [DATE];-No filled out and signed bed hold notice provided by the facility for the date of 12/22/25. 3. During an interview on 1/13/26 at approximately 10:30 A.M., Licensed Practical Nurse (LPN) K, said the nurse discharging the resident should specifically document on the form whom they spoke with regarding the resident's discharge and the bed hold policy. The reason for the discharge should also be filled in on the bed hold form. The bed hold form should be completed in its entirety. 4. During an interview on 1/13/26 at 2:46 P.M., the Administrator said he would expect bed holds to be given to the resident or resident's representative before the resident leaves the facility. He would expect the form to be filled out and signed.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure services provided met professional standards when staff failed to obtain weights as ordered for two residents (Residents #175 and #177). The facility also failed to ensure physician's orders for hemodialysis (a life sustaining treatment for kidney failure that removes waste and extra fluids from the blood) assessments were obtained for one resident out of three residents sampled for hemodialysis (Resident #5). The sample was 47. The census was 166. Review of the facility's Weight Monitoring policy, revised 9/1/25, showed:-Policy: Based on the resident's comprehensive assessment, the facility will ensure that all residents maintain acceptable parameters of nutritional status, such as usual body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise;-Compliance guidelines: Weights should be recorded at the time obtained. Newly admitted residents are to be monitored weekly for four weeks. If clinically indicated, monitor weekly or daily as recommended by the dietician or physician. Review of the facility's Dialysis policy, revised 3/15/24, showed:-Guideline: Care required when a resident's disease trajectory requires hemodialysis may exceed the usual interventions provided to residents in long-term care setting. The following information will provide addition direction in assessment, planning, and provision of care to our residents requiring hemodialysis;-Post-dialysis protocol: Review transfer forms or user defined assessment documents for any pertinent information;-Remove fistula/graft-dressing evening of dialysis treatment or as instructed by dialysis center or physician order;-Check fistula for bruit (listening to fistula) or feel for a thrill (by touching the fistula). This must be done daily, best after dressing is removed. If you do not feel a pulse or hear a bruit, check again by placing your fingers gently over fistula and check for a thrill. Call thedialysis unit immediately. If the unit is closed, call the physician;-Daily fistula/graft check: Check for any signs of infection daily, these may appear as: redness, hardness, swelling pain, drainage, and elevated temperature and body chills. Call physician promptly;-Documentation on treatment sheets includes fistula checks daily and monitoring for presence of bruit and thrill;-Checks for signs/symptoms of infection daily. 1. Review of Resident #175's medical record, showed:-admission date 12/23/25;-Diagnosis included moderate protein calorie malnutrition (poor nutrition), dementia, seizures, and muscle weakness;-An order, dated 12/23/25, for weekly weights from admission for four weeks, then monthly. Review of the resident's care plan, in use at the time of survey, showed:-Focus: The resident has a nutritional problem or potential nutritional problem, moderate protein malnutrition and dysphagia (difficulty swallowing);-Interventions: Monitor weight as indicated. Review of the resident's weights, dated 12/23/25 through 1/12/26, showed:-On 12/26/25: 92.6 pounds (lbs.);-On 1/6/26: 89.2 lbs.;-No admission weight noted. 2. Review of Resident #177's medical record, showed:-Initial admission date 12/16/25;-discharge date [DATE];-readmission date 12/25/25;-Diagnosis included, dementia, muscle weakness, intellectual disabilities, schizoaffective disorder (mood disorder), moderate protein calorie malnutrition, dysphagia (difficulty swallowing), and difficulty walking;-An order, dated 12/16/25, for weekly weights from admission for four weeks, then monthly. Review of the resident's care plan, in use at the time of survey, showed:-Focus: The resident has a nutritional problem or potential nutrition problem;-Goal: The resident will maintain adequate nutrition status as evidence of maintaining weight;-Plan: Provide and serve diet as ordered. Review of the resident's weights, dated 12/16/25 through 1/8/25, showed:-On 12/16/25: 141.0 lbs.;-On 1/6/26: 109.4 lbs.;-On 1/8/26: 119.4 lbs.;-No readmission weight from 12/25/25 noted. 3. During an interview on 1/8/26 at 8:35 A.M., Nurse Practitioner (NP) J said he/she expected residents to be weighed (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	on admission and when re-admitted from the hospital, especially when they have a malnutrition diagnosis. He/She expected the resident to be weighed weekly from the admission date. During an interview on 1/13/26 at 9:42 A.M., Licensed Practical Nurse (LPN) K said it is a nursing team effort to get the weights on residents. Everyone is responsible for getting weights. Weights are to be completed on admission and then weekly for four weeks. The resident should be weighed when they return from the hospital to get a new baseline. During an interview on 1/13/26 at 2:40 P.M., the Director of Nursing (DON) said she expected staff to follow physician orders and obtain resident weights on admission and weekly for four weeks. She expected the residents to be weighed when readmitted from the hospital. 4. Review of Resident #5's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 12/3/25, showed:-Cognitively intact;-Diagnoses include anemia, heart failure, high blood pressure, kidney failure, diabetes, hyperlipidemia, anxiety, depression, bipolar, and asthma;-Dialysis received. Review of the resident's care plan, in use at the time of survey, showed:-Focus: Resident receives dialysis related to chronic kidney failure;-Goal: Resident will have minimized risk of complications related to dialysis;-Interventions included:--Check and change dressing daily at access site as ordered;--Monitor vital signs before and after dialysis. Notify physician of abnormalities;--Monitor/document/report new/worsening edema, weight gain;--Monitor/document/report as needed (PRN) any signs and symptoms of infection to access site: redness, swelling, warmth or drainage;--Monitor/document/report signs and symptoms of renal insufficiency. Review of the resident's Physician Order Sheet (POS), dated January 2026, showed:-An order, dated 9/6/25, for renal (kidney) care on Mondays, Wednesdays, and Fridays (chair time 8:25 A.M.);-An order, dated 10/16/25, to ensure dialysis dressing remains clean, dry, intact every shift, notify dialysis if not;-An order, dated 1/6/26, to monitor access site for bruising, bleeding and signs and symptoms of infection. If bleeding noted, apply direct pressure until bleeding is controlled and notify physician for further directions every shift for monitoring. Document progress note for any observed signs and symptoms of bruising, bleeding, and/or infections and notification of physician;-An order, dated 1/6/26, to assess dialysis site for thrill and bruit every shift for monitoring;-Review of the resident's order history showed no physician's orders to monitor assess site and assess dialysis site for thrill and bruit prior to 1/6/26. During an interview on 1/6/26 at 11:19 A.M. the resident said he/she goes to dialysis on Monday, Wednesday, and Friday at 5:00 A.M. He/She returns at 11:00 A.M. During an interview on 1/12/26 at 11:57 A.M., the resident said he/she returned from dialysis. Staff do not complete assessments on him/her after dialysis. They have never checked his/her bruit and thill. During an interview on 1/13/26 at 12:37 P.M., the DON said she expected the resident to have physician's orders to assess the resident's dialysis site and bruit and thill and for nursing staff to complete it. She was not sure why it was not ordered until 1/6/26, if it was previously discontinued or if something was caught during the auditing process. 2698569

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Athene Nursing and Rehabilitation	13995 Clayton Road Town and Country, MO 63017

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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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure residents received appropriate activity of daily living (ADL, daily care) care to meet the needs of residents, including showers, personal hygiene, and nail care (Residents #15, #26, #143, #133, #153, #11, #21, #137, and #177). The sample was 47. The census was 166.Review of the facility's Activity of Daily Living policy, revised 4/23/25, showed:-Policy: The facility will, based on the comprehensive assessment and consistent with the resident's needs and choices, ensure a resident's abilities in ADLs do not deteriorate unless deterioration is unavoidable;-Care and services will be provided for the following ADLs:--Bathing, dressing, grooming and oral care;--Transfer and ambulation;--Toileting;-Explanation and compliance guidelines: -Conditions which may demonstrate unavoidable decline in ADLs include:--Natural progression of the resident's disease state with known functional decline;--Deterioration of the resident's physical condition associated with the onset of an acute physical or mental disability while receiving care to restore or maintain functional abilities;--Refusal of care and treatment by the resident or his/her representative to maintain functional abilities after efforts by the facility to inform and educate about the benefits/risks of the proposed care and treatment, counsel and/or offer alternatives to the resident or representative;-A resident who is unable to carry out ADLs will receive the necessary services to maintain good nutrition, grooming and personal and oral hygiene; -The facility will identify resident triggers through the Care Area Assessment (CAA) process to assess causal factors for the decline, potential decline of lack of improvement;-Terminology for ADL evaluation and documentation will follow definitions from the State's Resident Assessment Instrument (RAI) manual:--Independent: If the resident completes the activity by themselves with no assistance from a helper;--Setup or clean up assistance: If the helper sets up or cleans up, resident completes activity. Helper assists only prior to or following the activity, but not during the activity;--Supervision/touching assistance: If the helper provides verbal cues or touching/steadying/contact guard assistance;--Partial/moderate assistance: If helper does less than half the effort;--Substantial/maximal assistance: If the helper does more than half the effort;--Dependent: If the helper does all the effort and resident does none of the effort to complete the activity. 1. Review of Resident #15's admission Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 12/23/25, showed:-Cognitively intact;-Required supervision or touch assistance with bathing, personal hygiene, and toileting hygiene. Review of the resident's medical record, showed:-admission date 12/16/25;-Diagnosis included osteomyelitis (infection of the bone) of left ankle and foot, diabetes, abnormalities with gait, and muscle weakness. Review of the resident's shower and skin condition report for December 2025, showed on 12/19/25, 12/23/25, 12/30/25, and 1/2/26/25, staff documented the resident received a shower. Observation on 1/6/26 at 10:15 A.M., showed the resident sat on the side of the bed with a foot and ankle dressing on his/her left foot and a tall surgical boot on his/her left foot. He/She had a peripherally inserted central catheter (PICC, a long thin tube inserted into the vein used for medications and blood draws) line in his/her right upper arm. The resident had long facial hair, approximately one inch long. During an interview, the resident said he/she liked to be clean shaven. He/She had an odor and was embarrassed how he/she looked. He/She had never received a shower because no staff member would assist him/her with removing his/her dressing to his/her left foot and staff would not cover his/her PICC line with plastic to protect it from getting wet. 2. Review of Resident #26's quarterly MDS, dated [DATE], showed:-Cognitively intact;-Functional limitation in range of motion to upper and lower extremities, both sides;-Required full staff care for bed mobility, (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	transfers, oral care, bathing, personal hygiene and dressing;-Diagnoses included amyotrophic lateral sclerosis (ALS, a terminal progressive neurodegenerative disease attacking motor neurons, causing gradual muscle weakness, twitching and loss of control, leading to difficulty walking, speaking, swallowing and breathing), bipolar disorder (emotions ranging from high to low), muscle wasting and atrophy (muscle loss), need for assistance with personal care, dysphagia (difficulty swallowing), and bladder dysfunction. Review of the resident's care plan, in use during the survey, showed:-Focus: The resident has ADL self-care performance deficit related to diagnoses of disease process;-Goal: The resident will maintain current level of ADL function;-Interventions: Dependent on staff for ADL care and mobility. Review of the Certified Nurse Aide (CNA) assignment and shower book on the resident's hall, showed the resident scheduled to have a shower every Wednesday and Saturday. Observations and interviews, showed:-On 1/9/16 at 9:08 A.M., the resident awake in bed. Using a visual communication tablet, he/she said he/she had not had a shower the month of January. He/She felt dirty. He/She wanted his/her hair washed;-On 1/12/26 at 9:24 A.M., the resident asleep in bed. His/Her hair appeared oily;-On 1/13/26 at 9:45 A.M., the resident awake in bed. Using a visual communication tablet, he/she said he/she wanted a shower. He/She wanted his/her hair washed, and he/she stank. He/She had not had a shower in weeks, and he/she would like a shower before his/her wound care appointment. He/She appeared tearful and requested surveyor to inform management of the shower request. During an interview on 1/13/26 at 9:59 A.M., CNA U said the resident's hallway required heavy care and sometimes showers did not get completed. 3. Review of Resident #143's quarterly MDS, dated [DATE], showed:-admitted : 7/15/25;-Cognitively intact;-Diagnoses included gastrostomy placement (a surgical opening into the stomach used to administer nutrition and/or medications), history of sepsis (a potentially fatal infection in the bloodstream), heart failure, and dysphagia (difficulty swallowing). Review of the resident's care plan, in use at the time of survey, showed:-Focus: The resident had an ADL care deficit requiring staff assistance with bathing and showering;-Interventions included providing total assistance with bathing and showering activities, checking nail length on bath days, and providing a bed bath when a shower is not possible. Review of the resident's December 2025 shower sheets, showed:-A shower sheet, dated 12/3/25 on day shift, showed staff documented a bed bath completed;-No completed shower sheets between 12/3/25 and 12/21/25, a period of 18 days;-A shower sheet, dated 12/22/25 on evening shift, showed staff documented a bed bath completed;-No completed shower sheets between 12/22/25 and 12/28/25, a period of six days;-A shower sheet, dated 12/29/25 on evening shift, showed staff documented a shower completed;-No completed shower sheets between 12/29/25 and 1/7/26, a period of nine days. Observation on 1/6/25 at 9:42 A.M., showed the resident in bed with a hospital gown on. He/She had oily skin and disheveled hair. During an interview, the resident said he/she had not received a shower in weeks and staff routinely told him/her a shower could not be provided due to equipment not working or shower rooms unavailable. Review of the resident's shower sheet, dated 1/7/26, showed staff documented a shower completed. Observation on 1/8/25 at 6:01 A.M, showed the resident in bed with a hospital gown on. He/She had oily skin and disheveled hair. During an interview, the resident said he/she asked for a shower yesterday afternoon and staff told him/her they could not transfer him/her because the Hoyer lift was not charged. Review of the resident's shower sheet, dated 1/9/26, showed staff documented a shower completed. Observation on 1/9/25 at 12:43 P.M., showed the resident in bed with a hospital gown on. During an interview, the resident stated he/she had not received a shower in the month of January 2026. He/She had a visitor on 1/8/26, and the visitor told him/her that he/she smelled. The resident felt the staff do not care about him/her, and he/she is forgotten about. Review of the resident's progress notes, showed no documentation of any care or (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	shower refusals for the month of January. During an interview on 1/13/25 at 9:51 A.M. CNA L and Certified Medication Technician (CMT) N said residents should receive showers or bed baths at least twice per week or if a resident requests one. CNA L and CMT N were unaware of any non-functioning Hoyer lifts on the floor and were unable to say when the resident had last received a shower. During an interview on 1/13/25 at 10:01 A.M. Registered Nurse (RN) G said a period of 18 days without a shower was unacceptable. 4. Review of Resident #133's quarterly MDS, dated [DATE], showed:-Cognitively intact;-Required maximum assistance with bathing, personal hygiene, and toilet hygiene. Review of the resident's care plan, in use at the time of survey, showed:-Focus: The resident has an ADL self-care deficit;-Plan: Use short simple instructions to promote independence and avoid scrubbing and pat dry sensitive skin. Review of the resident's medical record, showed:-admission date, 11/25/25;-discharge date , 12/2/25;-readmission date,12/4/25.-Diagnosis included cirrhosis of the liver (hardening of the liver resulting in dysfunction) and encephalopathy (brain disease or damage). Review of the resident's shower sheets and skin condition report, showed:-The resident received a shower on 12/3/25, 12/17/25, 12/20/25, 12/24/25, and 12/27/25;-No shower sheets provided for January 2026. Observation on 1/6/26 at approximately 10:30 A.M., showed the resident in bed. His/Her arms and upper chest were very dry. His/Her hair was oily and stringy. During an interview, the resident said he/she had never received a shower or hair wash since he/she had been at the facility. His/Her skin was itchy and dry. Staff wipe him/her down but he/she wouldn't consider it a bath. A staff member promised the resident that they were going to get him/her into the shower using the Hoyer lift and a shower chair. Observation on 1/12/26 at 8:50 A.M., showed the resident in bed. His/Her arms and upper chest were very dry, and his/her hair was oily and stringy. During an interview, the resident said he/she had not received a shower. He/She was told by staff that there was no shower chair available. During an interview on 1/12/26 at approximately 9:00 A.M., CNA U said there was a shower chair on the third floor that could be used for the resident's shower. 5. Review of Resident #153's quarterly MDS, dated [DATE], showed:-Diagnoses included Alzheimer's disease, chronic kidney disease, major depressive disorder, and Parkinson's disease;-Moderately impaired cognition;-Required moderate staff assistance for personal hygiene. Review of the resident's care plan, in use at the time of the survey, showed:-Focus: The resident has an ADL self-care performance deficit;-Goal: The resident will maintain current level of ADL function through the review date;-Interventions: Personal hygiene requires partial or moderate assistance from staff. Observation on 1/6/26 at 9:56 A.M., showed the resident in the doorway to his/her room. His/Her nails were long and uneven. During an interview, the resident said his/her nails are too long and he/she wanted a nail file. Observation on 1/8/26 at 8:24 A.M., showed the resident in the dining room for breakfast. His/Her fingernails were long and jagged. During an interview, the resident said he/she wanted his/her nails trimmed. During an interview on 1/13/26 at 7:46 A.M., CNA I said the nurse is responsible for trimming the resident's fingernails. He/She was unsure where to find nail files for the resident. 6. Review of Resident #11's quarterly MDS, dated [DATE], showed:-Moderate cognitive impairment;-Diagnoses included stroke, dementia and anxiety;-Dependent on staff for personal hygiene, toilet hygiene and bathing;-Received hospice care. Review of the resident's care plan, in use at the time of survey, showed:-Focus: The resident has an ADL self-care performance deficit due to immobility;-Plan: The resident is dependent on staff for bathing, personal hygiene, toilet hygiene. Review the resident's hospice communication form, showed:-Visit date: 12/31/25, bed bath given and assisted with personal care and ADLs;-Visit date: 1/5/26, bed bath given and assisted with personal care and ADLs;-Visit date: 1/7/26, bed bath given and assisted with personal care and ADLs;-Visit date: 1/12/26, bed bath given and assisted with personal care and ADLs. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 1/6/26 at 9:50 A.M., 1/8/26 at 8:22 A.M., and 1/9/26 at 8:14 A.M., showed the resident with an unshaven face with approximately one-inch-long facial hair. The resident's fingernails on both hands were approximately one half an inch long with dark matter underneath. The resident's face was oily with large white flakes in the resident's neck skin folds. Observation on 1/13/25 at approximately 10:00 A.M., showed the resident's face with a partial shave. His/Her cheeks were shaved and had he/she had approximately one inch of hair on his/her neck and mouth. The resident's fingernails on both hands were approximately one half an inch long with dark matter underneath. 7. Review of Resident #21's quarterly MDS, dated [DATE], showed:-Diagnoses included Alzheimer's disease, major depressive disorder, and muscle weakness;-Moderately impaired cognition;-Required maximum staff assistance for personal hygiene. Review of the resident's care plan, in use at the time of the survey, showed:-Focus: The resident has an ADL self-care performance deficit;-Goal: The resident will maintain current level of ADL function through the review date;-Interventions: The resident is dependent on staff for showering and hygiene. Observation on 1/6/26 at 11:47 A.M., showed the resident had long jagged nails with matter underneath. Observation on 1/8/26 at 9:10 A.M., showed the resident in the dining room eating breakfast. The resident's nails were long and jagged with matter underneath. Observation on 1/9/26 at 9:57 A.M., showed the resident seated in the dining room after breakfast. The resident's nails were long and jagged. During an interview on 1/13/26 at 7:46 A.M., Certified Nurse Aide (CNA) I said the nurse is responsible for trimming the resident's fingernails. He/She said the resident's hospice nurse can also trim the resident's nails. 8. Review of Resident #137's quarterly MDS, dated [DATE], showed:-Diagnoses included Parkinson's disease (a neurological disease causing weakness), dementia, and muscle weakness;-Severe cognitive impairment;-Required full staff assistance for care needs. Review of the resident's care plan, in use at the time of the survey, showed:-Focus: The resident has an ADL self-care performance deficit;-Goal: The resident will maintain/improve level of functioning;-Interventions: Bathing required substantial/maximum assistance from staff, personal hygiene required substantial/maximum assistance from staff. Observations on 1/6/26 at 9:51 A.M., 1/8/26 at 7:28 A.M., and 1/9/26 at 9:02 A.M., showed the resident with long, oily hair and an unkempt beard. His/Her nails were uneven and dirty with matter underneath. 9. Review of Resident #177's admission MDS, dated [DATE], showed:-admission date 12/16/25;-Severe cognitive impairment;-Dependent on staff for bathing, personal hygiene, oral hygiene, and toileting hygiene. Review of the resident's medical record, showed diagnoses included dementia, muscle weakness, intellectual disabilities, schizoaffective disorder (mood disorder), Parkinsonism (movement disorder) and difficulty walking. Review of the resident's care plan, in use at the time of survey, showed:-Focus: The resident has ADL self-performance deficient related to Parkinson's disease;-Plan: Provide sponge bath when a full bath cannot be tolerated. Review of the resident's shower sheets and skin condition report, showed:-On 12/2/26, 12/5/26, 12/9/26, and 12/12/25, staff documented bathing as completed;-No shower sheets were provided dated January 2026. Observations on 1/6/26 at 9:57 A.M. and 1/7/26 at 8:30 A.M., showed the resident in bed with a hospital gown on. His/Her teeth were caked with yellow matter. His/Her fingernails on both hands had brown matter underneath. 10. During an interview on 1/12/26 at approximately 9:00 A.M., CNA U said that residents receive baths twice a week and the showers and baths are assigned daily by the nurse. Bathing includes shaving and nail trimming and cleaning and oral care. Shower sheets are filled out by the person providing the shower and the charge nurse signs off on them. During an interview on 1/13/26 at 9:59 A.M., CNA U said at times, residents received a bed bath instead of a shower. CNAs should document the care provided on the shower sheets and in the resident's electronic medical record. The charge nurse reviews the shower sheet and turns it in. 11. During an (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	interview on 1/13/26 at 7:46 A.M., CNA H said the nurse is responsible for setting up hair appointments for the residents. The nurse is responsible for trimming resident's fingernails. 12. During an interview on 1/13/26 at 10:05 A.M., Licensed Practical Nurse (LPN) I said the Social Worker is responsible for setting up hair appointments for the residents. He/She expected residents' hair and beards to be kept. CNAs are responsible for trimming the resident's nails unless the resident is diabetic; then the responsibility is on the nurse. 13. During an interview on 1/13/25 at 10:01 A.M., RN G said residents should receive showers or bed baths twice a week or when requested by a resident. Nurses on the hall were responsible for ensuring shower sheets are signed and checked off. Nursing staff could and should assist residents in bathing and hygiene activities. 14. During an interview on 1/13/26 at 9:56 A.M., Regional Nurse DD said CNAs were assigned daily showers and shower sheets should be completed for each resident. If a resident refused a shower, staff should document on the shower sheet, the resident should sign the shower sheet, and staff should also document in the progress notes of missed or refused showers. 15. During an interview on 1/13/26 at 2:31 P.M., the Director of Nursing (DON) said she expected resident nails to be trimmed and clean. She expected residents' hair and beards to be kept and cut according to the resident's wants/needs. 16. During an interview on 1/13/25 at 1:41 P.M. the DON and Administrator said residents should receive bed baths or showers twice per week or when requested. Nursing staff were responsible for ensuring showers or bed baths are completed. The charge nurse assigned daily showers to the CNAs. The aides were responsible to complete the shower and document on the shower sheet. If a resident refused a shower, the aide should notify the nurse, and the nurse should document the refusal in the progress note. 26073801698637169863427123 27

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure residents received care consistent with professional standards by not obtaining dressing change orders for one resident that had a recent toe amputation (Resident #135) and by not changing one resident's leg wound dressing as scheduled and when it was saturated with fluid and dislodged (Resident #72). In addition, the facility failed to obtain a urinalysis (UA, a urine test to check for infection and obtain the results) as ordered for one resident (Resident # 3). The sample was 47. The census was 166.Review of the facility's Wound Treatment Management policy, revised, 9/1/25, showed:-Policy: To promote wound healing of various types of wounds. It is the policy of this facility to provide evidence-based treatments in accordance with current standards of practice and physician orders;-Policy explanation and compliance guidelines:-Wound treatments will be provide in accordance with physician order, including the cleansing method, type of dressing, and frequency of dressing change;-In the absence of treatment orders, the licensed nurse will notify the physician to obtain treatment orders. This may be the treatment nurse, or the assigned licensed nurse in the absences of the treatment nurse;-Dressing changes may be provided outside the frequency parameters in certain situations, including when the dressing has dislodged or the dressing is soiled or is wet;-Treatments will be documented on the treatment administration record (TAR). Review of the facility's Laboratory Services and Reporting policy, revised 8/1/25, showed:-Policy: The facility must provide or obtain services when ordered by a physician, physician assistant, nurse practitioner, or clinical nurse specialist in accordance with state law;-Policy explanation and compliance guidelines:-The facility must provide or obtain laboratory service sit meet the needs of its residents;-The facility is responsible of the timeliness of the services;-All laboratory reports will be dated and contain the name and address of the testing laboratory and will be filed in the resident's clinical record;-Promptly notify the ordering physician, physician assistant, nurse practitioner, or clinical nurse specialist of laboratory results that call outside the clinical reference range. 1. Review of Resident #135's admission Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 12/23/25, showed:-admission date: 12/16/25;-Cognitively intact;-Diagnoses included peripheral vascular disease (PVD, a decreased blood flow in the legs cause by narrowed blood vessels) and diabetes. Review of the resident's care plan, in use at the time of survey, showed;-Focus: The resident has an infection to his/her left foot and ankle;-Intervention: Administer antibiotics as ordered. Review of the resident's electronic physician order sheet (ePOS), showed no orders for wound dressing changes to the resident's left foot from 12/16/25 to 1/5/26. Observation on 1/6/26 at 10:15 A.M., showed the resident sat on the side of the bed with a dressing on his/her left foot and ankle, and a tall surgical boot on his/her left foot. During an interview, the resident said he/she had all of his/her toes removed on his/her left foot due to osteomyelitis (bone infection). He/She always has to ask staff to change his/her dressing. During an interview on 1/6/26 at 11:30 A.M., Licensed Practical Nurse (LPN) C said there were no physician orders for the resident's foot dressing and that he/she changes it when the resident asks him/her to. LPN C said he/she will reach out to the physician to obtain orders. Review of the resident's medical record, showed an order, dated 1/6/26, start date, 1/7/26, for left foot, cleanse toes with wound cleaner, apply abdominal pad (a type of dressing), and wrap with Kerlix (a specialized wrap dressing) every two days. Observation on 1/8/26 at 1:17 P.M., showed the resident sat on the side of the bed with a leg and foot brace on. The resident removed his/her leg and foot brace. His/Her left foot was wrapped with Kerlix and Coban dressing (a specialized wrap) and dated 1/3/26. During an interview on 1/13/26 at (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2:40 P.M., the Director of Nurses (DON) said she expected the staff to have reached out to the surgeon to get orders for dressing changes for the resident's foot and not to just ask the resident. 2. Review of Resident #72's medical record, showed:-admission date: 12/15/25;-Diagnoses included cellulitis (skin infection) of left lower limb and lymphedema (swelling of the extremities);-A physician order, dated 12/24/25, to cleanse left calf with normal saline or wound cleanser, apply methylene blue (a specialized dressing) foam and cover with abdominal pads, wrap with gauze roll and secure with tape, Change three times a week and as needed (PRN) if saturated, soiled or dislodged. Review of the resident's admission MDS, dated [DATE], showed the resident cognitively intact. Review of the resident's care plan, in use at the time of survey, showed;-Focus: The resident has potential for impairment to skin integrity related to lymphedema;-Intervention: Weekly treatment documentation to include measurement of skin breakdown. Review of the resident's medical record, showed:-On 1/12/26, the resident's calf dressing change not documented as completed as scheduled;-No PRN dressing changes documented as completed from 1/10/26 through 1/12/26. Observation on 1/12/26 at approximately 8:30 A.M., showed the resident in a recliner chair with his/her left leg exposed. An undated dressing on the resident's leg, saturated with serous (yellow fluid), with the dressing wrap falling off the resident's leg. A bed pad was located on the floor underneath the resident's left foot. During an interview, the resident said his/her dressing was leaking so bad that he/she placed a bed pad underneath his/her foot to contain the moisture. His/Her dressing had been wet for the last two days. Observation on 1/13/26 at 9:32 A.M., showed the resident in a recliner chair with his/her left leg exposed. An undated dressing on the resident's leg, saturated with serous drainage, with the dressing wrap falling off the resident. A pillowcase underneath the resident's left foot with rings of yellow serous drainage on it. During an interview, the resident said he/she replaced the bed pad underneath his/her foot with a pillowcase because the bed pad was wet with drainage. During an interview on 1/13/26 at 11:39 A.M., Registered Nurse (RN) G said staff should complete all treatments and wound care before leaving their shift. If a resident's dressing is soiled or loose, the nurse should change the dressing. Dressing change orders need to be obtained on admission and staff should not wait for the resident to request their dressing to be changed. During an interview on 1/13/26 at 9:45 A.M., Regional Resource Nurse B said it is expected that staff change the dressing when it is scheduled and as needed, including when it is wet or dislodged. During an interview on 1/13/26 at 11:16 A.M., Wound Physician II said he/she expected staff to change the dressings when ordered and as needed. 3. Review of the Resident #3's quarterly MDS, dated [DATE], showed:-Cognitively intact;-Diagnoses included anemia, heart failure, hypertension (high blood pressure), orthostatic hypotension (low blood pressure), renal failure, diabetes, hyponatremia (electrolyte imbalance), non-Alzheimer's dementia, anxiety, depression, post-traumatic stress disorder, and asthma;-Required partial/moderate assistance with toileting hygiene;-Occasionally incontinent with bladder. Review of the resident's care plan, in use during survey, showed:-Focus: Resident has an Activities of Daily Living (ADL) self-care performance deficit related to small bowel obstruction (SBO) and hypotension;-Intervention: Staff intervention to the extent needed to accomplish task;-Focus: Resident has an ADL self-care performance deficit limited mobility;-Interventions: Personal hygiene: Supervision/touch assist for personal hygiene. Partial/moderate assistance for toilet hygiene. Review of the resident's ePOS, showed:-An order, dated 1/6/26, for please obtain STAT (immediately) UA with reflex (automatically performing a second test on the same patient sample when the initial test yields a specific result) to culture;-An order, dated 1/7/26, for please obtain STAT UA with reflex to culture. Observation on 1/8/26 at 4:20 P.M., showed the resident in bed. During an interview, the resident said he/she had not completed a urine test yet. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	He/She was verbally unable to explain the reason. When asked if there was pain and if there is pain during urinating, the resident said yes. He/She denied blood in the urine. He/She had been in pain for weeks. He/She had not urinated today. During an interview on 1/8/26 at 4:23 P.M., LPN AA said they had not obtained urine from the resident. The resident is not refusing: it was just not obtained. The resident had only been to the bathroom once since he/she had been here. Further review of the resident's ePOS, showed:-An order, dated 1/9/26, for comprehensive metabolic panel (CMP, routine blood test), complete blood count (CBC, blood test that analyzes white and red blood cells and platelets) culture, urine one time only. A note showed, Send to lab on 1/9/26 2:02 P.M. Central time);-An order, dated 1/9/26, for CMP, CBC culture, urine one time only. A note showed, Waiting to be sent. During an interview on 1/9/26 at 8:22 A.M., the resident said he/she did not give a urine sample. He/She did not have pain when urinating; however, he/she had lower abdomen pain that made it feel like he/she had to urinate, but he/she did not. During an interview on 1/9/26 at 9:42 A.M., LPN S said he/she was in the process of putting in the resident's labs right now. The resident was supposed to get lab work today. LPN S was in the process of collecting it now. They notified the doctor that they did not collect the resident's urine. Normally a STAT UA should come with orders to straight catheterize (insert a catheter into the bladder to drain urine), if necessary. That is what LPN S would have done. Observation on 1/9/26 at 12:06 P.M., showed a lab tech from a lab company entered the resident's room. The resident was overheard saying, I just went, as the lab tech entered and closed the door. At 12:15 P.M., the lab tech exited the resident's room and left the unit. During an interview on 1/12/26 at 11:54 A.M., the resident said he/she had pain during urination, but it is at night when trying to sleep. He/She continued to have pain to the lower left abdomen.Review of the resident's acute care note, dated 1/12/26, showed:-History: Following up on the patient, ordered UA on Monday;--Was advised patient still pending UA 2/2 needing a hat;---Advised on straight catheterization if it takes more time;-Assessment/plan: Frequency of micturition (frequency of urination). Will check urine for infection and empiric (initial antibiotics to treat a suspected bacterial infection before the specific germ is identified) antibiotic if symptoms worse/continue. Review of the resident's UA results, dated 1/12/26, showed:-Please indicate urine source: Urine - clean catch;-Report date/time: 1/12/26 at 4:09 P.M.;-Culture Observation: Urogenital flora (normal bacteria from the genital area that contaminated the sample) isolated. No further testing performed. Further review of the resident's ePOS, showed:-An order, dated 1/11/26, for sodium chloride solution (saline) 0.9%, use 50 milliliters (ml.) per (/) hour (hr.) intravenously (IV, into the vein) one time a day for hyponatremia for one day;-An order, dated 1/11/26, for place an IV for IVF (intravenous fluids);-An order, dated 1/12/26, for IV peripheral - type 22 gauge (diameter of catheter), location in right antecubital fossa (AC, crease of inner elbow) one time only for two days;-An order, dated 1/12/26, for IV peripheral flush with 10 ml. saline before and after medication infusion (use 10 ml. syringe) every shift for two days until finished. During an interview on 1/13/26 at 10:44 P.M., LPN S said the resident's UA was completed, but he/she was unable to see results. The blood work came back and the resident's sodium level was low. The physician was here and ordered sodium chloride. Staff went into the emergency kit and pulled all of what was needed for the order. The resident received the sodium chloride yesterday. During an interview on 1/13/26 at 12:37 P.M., the DON said there was a UA completed on the resident, but she was unable to log into the system to check the results. If staff could obtain urine from a resident as ordered by the physician, she expected staff to notify the physician within 24 hours. If staff were unable to obtain a urine sample, she expected staff to relay the information to the next shift, so they can obtain the sample. She was not aware of the resident's hydration issues. At (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1:50 P.M., the DON said staff should notify the Nurse Practitioner if labs were missed. 2702576

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure safety and adequate monitoring were provided during meals for two residents who had recommendations from Speech Therapy regarding proper positioning, type of required assistance during meals and/or monitoring during meals (Resident #109 and #11). The resident sample was 47. The census was 166.Review of the facility's Activities of Daily Living (ADLs) policy, revised 4/23/25, showed:-The facility will, based on the resident's comprehensive assessment and consistent with the resident's needs and choices, ensure a resident's abilities in ADLs do not deteriorate unless deterioration is unavoidable.-Care and services will be provided for the following activities of daily living: Eating to include meals and snacks;-Terminology for ADL evaluation and documentation will follow definitions from the State's Resident Assessment Instrument Manual: Partial/moderate assistance: if the helper does LESS THAN HALF the effort. Helper lifts, holds, or supports trunk or limbs, but provides less than half the effort;-Dependent: if the helper does ALL of the effort. Resident does none of the effort to complete the activity; or the assistance of two or more helpers is required for the resident to complete the activity. Review of the facility's Assisted Nutrition and Hydration policy, revised 8/1/25, showed:-The facility will: Provide nutritional and hydration care and services to each resident, consistent with the resident's comprehensive assessment;-Recognize, evaluate, and address the needs of every resident, including but not limited to, the resident at risk or already experiencing impaired nutrition and hydration;-Provide a therapeutic diet taking into account the resident's clinical condition and preferences;-Based on the resident's comprehensive assessment, the facility will ensure each resident: Maintains acceptable parameters of nutritional and status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise;-Is offered sufficient fluid intake to maintain proper hydration and health;-Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet;-Documentation for nutrition and hydration services to include consent and risks vs benefits will be found in the resident's chart. 1. Review of Resident #109's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 11/19/25, showed:-Mild Cognitive impairment;-Diagnoses included neurogenic bladder (lacks bladder control due to brain, spinal cord, or nerve damage), malnutrition, other hereditary ataxias (genetic disorders causing progressive loss of balance and coordination), cerebellar ataxia (a movement disorder caused by damage to the cerebellum (motor control and cognitive function), muscle weakness, muscle wasting and atrophy, abnormal posture, dysphagia (difficulty swallowing), and cognitive communication deficit;-Dependent with eating;-Therapy services administered at least 15 minutes a day on one or more days in the last seven days: Speech language pathology and audiology services. Review of the resident's care plan, in use during survey, showed:-Focus: Resident likes to roll on his/her stomach and lay on the floor;--Goal: Resident will remain safe;--Interventions: Anticipate and meet the resident's needs. Monitor behavior episodes and attempt to determine underlying cause. Consider location, time of day, persons involved, and situations. Document behavior and potential causes;-Focus: Resident has nutritional problem or potential nutritional problem. He/She is on a regular diet and has thin liquids. Resident likes finger foods;--Goal: Resident will maintain adequate nutritional status as evidenced by maintaining weight, no signs and symptoms of malnutrition;--Interventions: Monitor/document/report as needed (PRN) any signs and symptoms of dysphagia. Monitor/record/report to physician PRN signs and symptoms of malnutrition. Provide, serve diet as ordered. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Monitor intake and record every meal. Registered Dietician (RD) to evaluate and make diet change recommendations PRN. Review of the resident's Speech Therapy (ST) evaluation, dated 12/30/25, showed:-Diagnoses: Cerebellar ataxia, cognitive communication deficit, and dysphagia;-Reason for referral/current illness: Referred to speech therapy for evaluation of cognitive communicative abilities and swallowing abilities;-How often does patient require supervision/assistance at mealtime due to swallow safety: 91-100% of the time;-Patient was observed with regular texture and thin liquids this date. Patient was unable to feed him/herself this date, requiring 1:1 feeding assistance. Recommending regular textures with thin liquids. Patient requires skilled ST to ensure consistent oral care, as well as, to implement compensatory swallowing strategies and educate nursing. Patient warranted for ST three times a week/45 days. Review of the resident's electronic Physician's Orders Sheet (ePOS), dated January 2026, showed:-An order dated 12/1/25, frozen/thickened nutritional supplement, two times a day magic cup meals (nutrition supplement);-An order dated 12/1/25, health shake (dietary) with meals;-An order dated 12/22/25, regular diet, regular texture, regular/thin liquids consistency for small/bite size soft;-An order dated 12/30/25, ST clarification order: SLP completed eval this date. Patient requires skilled ST 3x a week/45 days to target communicative deficits and swallowing abilities. Observation on 1/6/26 at 12:50 P.M., showed the resident lay in bed on his/her stomach. The resident had a meal tray underneath him/her. The resident ate his/her meal while he/she lay on his/her stomach. The resident had chicken tetrazzini and green beans, juice and a health shake. The resident used a spoon to feed him/herself without assistance. No staff were in the room monitoring the resident. At 1:05 P.M., staff entered room and asked the resident if he/she was finished with his/her meal. The resident said done and the staff member removed the tray from underneath the resident, leaving pieces of pasta and green beans on the bed under the resident. Observation on 1/7/26 at 8:50 A.M., showed the resident lay in bed on his/her stomach. He/she fed him/herself breakfast and consumed most of the meal. The resident continued to feed him/herself without assistance or staff monitoring. Observation on 1/9/26 at 8:27 A.M., showed the resident lay in bed on his/her stomach. He/She had bacon, French toast, cream of wheat, oatmeal cream pie, a health shake and orange juice. The resident fed him/herself without assistance. He/She coughed a couple of times during the meal. The cough was loud and harsh. The resident spit out food. During an interview on 1/12/26 at 1:13 P.M., the Director of Therapy confirmed that the resident eats meals on his/her stomach. He/She would expect the resident to have oversight while eating. During an interview on 1/12/26 at 1:20 P.M., Speech Therapist F said the instructions were for staff to have the resident up in his/her chair at meals. Sometimes the resident refuses, and he/she rolls on his/her stomach. He/She cannot tolerate being on his/her back. If the resident refuses and eats in his/her room, staff are expected to provide oversight if he/she is eating on his/her stomach. During an interview on 1/12/26 at 1:50 P.M., the Administrator and Director of Nursing (DON) said they would expect staff to provide protective oversight during meals if the physician ordered it. 2. Review of Resident #11's quarterly MDS, dated [DATE], showed:-Moderate cognitive impairment;-Requires partial to moderate assistance with eating;-Diagnoses included stroke, dementia and anxiety. Review of the resident's care plan, in use at the time of survey, showed:-Focus: The resident has a potential nutritional problem related to dementia;-Plan: Provide assistance with dining, such as set up tray, cutting up food, identifying items on tray, and feeding residents as needed. Observation on 1/8/26 at 8:22 A.M., showed in the resident's room, a sign posted on the wall near the resident's bed that read: Swallowing Strategies: Assist the resident in cutting up food and tray set up, supervision at mealtimes, upright position at mealtimes, small bites and sips, slow rate, alternate food and liquids every couple of bites. Observation showed the resident lay (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	in bed with his/her meal tray positioned in front of him/her on a bedside table. The resident slumped down in bed and ate ground sausage with his/her fingers. No staff member supervised the resident while eating. Observation on 1/9/26 at 8:14 A.M., showed Assistant Director of Nursing (ADON) X and Certified Nursing Assistant (CNA) T positioned the resident up in the bed, placed the resident's food in front of him/her on a bedside table, and assisted the resident with opening containers. The ADON and CNA then left the room, and the resident began to eat his/her breakfast with his/her fingers. The resident's swallowing strategies sign was posted on the wall near the resident's bed. No Staff member supervised the resident eating. During an interview on 1/12/26 at 9:05 A.M., CNA U said he/she was aware of the resident's swallowing strategies sign. The resident should be up out of bed for meals and supervised in the dining room so that the resident does not choke on food. During an interview on 1/13/26 at 1:20 P.M., ST F said staff is expected to follow the swallowing strategies sign posted in the resident's room and the resident is to be supervised during meals and in an upright position. During an interview on 1/13/26 at 2:40 P.M., the DON said she would expect staff to follow speech therapy recommendations and have the resident sit upright and supervise the resident during meals. 2702576

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. Based on observation, interview, and record review, the facility failed to ensure residents with urinary catheters (tube that drains the urine from the bladder) had physician orders to include catheter care instructions, for two of three residents sampled with indwelling urinary catheters (Residents #182 and #10). The facility identified 12 residents with indwelling urinary catheters. The sample was 47. The census was 166.Review of the facility's Catheter Care policy, revised 8/1/25, showed:-It is the policy of this facility to ensure that residents with indwelling catheters receive appropriate catheter care and maintain their dignity and privacy when indwelling catheters are in use;-Catheter care will be performed every shift and as needed by nursing personnel;-Empty drainage bags when bag is half-full or every three to six hours;-Ensure drainage bag is located below the level of the bladder to discourage backflow of urine. 1. Review of Resident #10's electronic Physician's Orders Sheet (ePOS), dated November 2025, showed:-An order dated 11/22/25, to discontinue order for change foley catheter and drainage bag monthly and as needed (PRN);-An order dated 11/22/25, to discontinue order for catheter care;-An order dated 11/22/25, to discontinue order for catheter to remain covered for privacy every shift. Review of the resident's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 12/31/25, showed:-Mild cognitive impairment;-Diagnoses included high blood pressure, kidney failure, and neurogenic bladder (lack of bladder control);-Used a wheelchair;-Limitation in range of motion: Impairment on both sides of the lower extremity;-Required substantial/maximal assistance with toileting hygiene;-Indwelling urinary catheter. Review of the resident's care plan, in use during survey, showed:-Focus: Resident has a Foley catheter (brand of indwelling urinary catheter) related to bilateral (both sides) lower extremity amputation and skin impairment;-Goal: Resident will remain free from catheter-related trauma;-Interventions: Provide catheter care every shift. Observation on 1/6/26 at 12:21 P.M., 1/7/26 at 12:42 P.M., 1/8/26 at 1:30 P.M., and 1/9/26 at 8:30 A.M., showed the resident in his/her electric wheelchair. The catheter positioned on the right side of his/her wheelchair. The catheter drainage bag hung on the right arm rest of the wheelchair. Review of the resident's ePOS, dated January 2026, showed:-An order, dated 11/25/25, Foley catheter to gravity drain. Catheter size 16 Fr. (size) Balloon size 30 milliliter.-An order, dated 1/6/26, catheter care every shift; -An order, dated 1/6/26, change catheter anchor weekly and as needed if soiled;-An order, dated 1/6/26, Foley catheter to leg bag when out of bed if ambulatory. During an interview on 1/13/26 at 12:37 P.M. and 1:50 P.M., the Director of Nursing (DON) said they recently went through an auditing process so she was not sure if the orders for catheter care was changed or if it was caught during the auditing process. Catheter orders and care orders are expected to be in the POS at the time of re-admission. 2. Review of Resident #182's medical record, showed diagnoses included benign prostatic hyperplasia (an enlarged prostate gland that causes difficulty in urination) with lower urinary tract symptoms. Review of the resident's care plan, in use while the resident was admitted to the facility, showed:-Focus: The resident has a urinary catheter;-Plan: Provide catheter care every shift. Review of the resident's physician order sheets dated, 12/31/25 through 1/3/26, showed no order related to urinary catheter care. During an on 1/13/26 at 11:39 A.M., Registered Nurse (RN) G said all residents that have urinary catheters are expected to have orders for catheter care. During an interview on 1/13/26 at 2:40 P.M., the DON said she would expect staff to place catheter care orders on all the residents that have catheters. She would expect the orders to be placed on admission. 2713484

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F 0760 Level of Harm - Actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure physician-ordered prescription medications were received timely from the pharmacy and administered as ordered, affecting one resident who did not receive an antipsychotic medication for one month and had documented increased behaviors, including a resident-to-resident incident (Resident #173), and another resident who did not receive an antibiotic medication (Resident #133). The sample was 47. The census was 166.Review of the Medication Reordering policy, revised 8/1/25, showed:-Policy: To accurately and safely provide or obtain pharmaceutically services including the provision of routine and emergency medication and biologicals in a timely manner to meet the needs of reach resident;-Explanation and compliance guidelines:--The facility will utilize a systematic approach to provide or obtain routine and emergency medications in order to meet the needs of each resident;--Acquisition of medications should be completed in a timely manner to ensure medication are administered in a timely manner;--Each time a nurse is administering medication and observes six of less doses left of one kind, that nurse will reorder the medication, time permitting;--In the event of new orders, the facility is allowed 24 hours to begin a medication unless otherwise specified by the physician. 1. Review of Resident #173's closed medical record, showed:-re-admitted to the facility on [DATE];-Diagnoses included lung disease, schizophrenia (a brain disorder causing distorted reality with symptoms including hallucinations, delusions and disorganized thinking/speech and unusual behavior), anxiety, bipolar disorder (mental disorder including emotional highs and lows), insomnia (difficulty sleeping) and depression. Review of the resident's progress note, dated 1/24/25 at 5:28 P.M., showed the resident re-admitted to the facility. The physician notified, medications verified and faxed to the pharmacy. Review of the resident's care plan, in use at the time of survey, showed:-Focus: The resident used psychotropic medications for behavior management;-Goal: The resident will be/remain free of complications;-Interventions: Administer medications as ordered and monitor effectiveness, discuss with the physician regarding the ongoing need for the medications, monitor and record behaviors. Review of the resident's physician order sheet (POS), showed an order, dated 1/24/25, for cariprazine (used to treat schizophrenia) 4.5 milligram (mg.). Take one capsule once daily. Review of the resident's progress notes, showed:-On 1/25/25 at 8:28 A.M., administration note, cariprazine 4.5 mg for schizophrenia, drug on order;-On 1/26/25 at 6:05 A.M., behavior note, the resident used the call light all night, requested medication he/she had already received of melatonin (used to help sleep). The resident yelled out and disturbed other residents and was asked to lower voice. The resident not easily redirected. The resident requested to assistance to be changed. Resident threatened to call emergency services to report he/she could not sleep;-On 1/26/25 at 9:00 A.M., an administration note, cariprazine 4.5 mg, on order;-On 1/27/25 at 9:30 A.M., an administration note, cariprazine 4.5 mg, on order;-On 1/28/25 at 9:18 P.M., an administration note:, cariprazine 4.5 mg, on order;-On 1/29/25 at 9:54 A.M., an administration note, cariprazine 4.5 mg, on order;-On 1/30/35 at 8:12 A.M., an administration note, cariprazine 4.5 mg, unavailable;-On 1/31/25 at 8:25 A.M., an administration note, cariprazine 4.5 mg, on order. Review of the resident's January 2025 Medication Administration Record (MAR), showed the order for cariprazine 4.5 mg. missed 7 out of 7 missed medication administration opportunities. Further review of the resident's progress notes, showed:-On 2/1/25 at 9:59 A.M., an administration note, cariprazine 4.5 mg, unavailable pharmacy contacted;-On 2/1/25 at 8:02 A.M., an administration note, cariprazine 4.5 mg, on order;-On 2/2/25 at 9:59 A.M., an administration note, cariprazine 4.5 mg, on order;-On 2/3/25 at 9:56 A.M., an administration note, cariprazine 4.5 mg, unavailable;-On 2/4/25 at 9:44 A.M., an administration note, cariprazine 4.5 mg, (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Athene Nursing and Rehabilitation	13995 Clayton Road Town and Country, MO 63017

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 0760 Level of Harm - Actual harm Residents Affected - Few	unavailable;-On 2/5/25 at 11:05 A.M., an administration note, cariprazine 4.5 mg, unavailable;-On 2/6/25 at 9:17 A.M., a behavior note, the resident reviewed for resident-to-resident altercation. Interventions put in place for psychology and psychiatry consult for coping skills;-On 2/6/25 at 10:30 A.M., an administration note, cariprazine 4.5 mg, unavailable;-On 2/7/25 at 7:28 A.M., an administration note, cariprazine 4.5 mg, unavailable;-On 2/9/25 at 10:27 A.M., and administration note, cariprazine 4.5 mg, unavailable;-On 2/11/25 at 8:58 A.M., an administration note, cariprazine 4.5 mg, unavailable;-On 2/13/25 at 10:31 A.M., an administration note, cariprazine 4.5 mg, unavailable;-On 2/14/25 at 10:27 A.M., an administration note, cariprazine 4.5 mg, drug unavailable;-On 2/15/25 at 9:27 A.M., an administration note, cariprazine 4.5 mg, drug on order;-On 2/16/25 at 10:40 A.M., an administration note, cariprazine 4.5 mg, unavailable;-On 2/19/25 at 9:05 A.M., an administration note, cariprazine 4.5 mg, unavailable;-On 2/20/25 at 10:32 A.M., an administration note, cariprazine 4.5 mg, unavailable;-On 2/22/25 at 10:37 A.M., an administration note, cariprazine 4.5 mg, unavailable;-On 2/23/25 at 9:31 A.M., an administration note, cariprazine 4.5 mg, unavailable;-On 2/24/25 at 10:00 A.M., an administration note, cariprazine 4.5 mg, unavailable;-On 2/25/25 at 9:57 A.M., an administration note, cariprazine 4.5 mg, unavailable;-On 2/26/25 at 10:42 A.M., an administration note, cariprazine 4.5 mg, unavailable;-On 2/27/25 at 11:02 A.M., an administration note, cariprazine 4.5 mg, unavailable;-On 2/28/25 at 10:16 A.M., an administration note, cariprazine 4.5 mg, unavailable;-No documented notifications to the physician regarding missed doses of cariprazine. Review of the resident's February 2025 MAR, showed the order for cariprazine 4.5 mg. missed 24 out of 28 missed medication administration opportunities. During an interview on 1/12/26 at 12:15 P.M., Pharmacy Representative W said the pharmacy last dispensed the medication on 3/13/25 as a 14-day supply. The medication is expensive and that is why a 14-day supply is sent. The facility did not send in a prescription for the medication to the pharmacy in January 2025, following the resident's re-admission. The facility did not send an order until March 2025, and that is when a 14-day supply was sent routinely. 2. Review of Resident #133's medical record, showed diagnoses included alcoholic cirrhosis of the liver (hardening of the liver resulting in dysfunction) and hepatic encephalopathy (brain disease or damage caused by liver failure). Review of the resident's December 2025 MAR, showed:-An order, dated 12/6/25, for rifaximin (an antibiotic use to treat hepatic encephalopathy) 550 mg, give one tablet twice a day for 14 days;-Rifaximin not documented as administered 12/6/25 through 12/19/25. During an interview on 1/12/26 at 11:56 A.M., Pharmacy Representative W said the resident's rifaximin was not sent because it required an out-of-pocket expense of $1600.00. The pharmacy needed either payment from the facility or from the resident because it was not covered by the resident's health plan. During an interview on 1/12/26 at 12:01 P.M., Nurse Practitioner (NP) J said he/she was notified by nursing staff that the resident's Rifaximin was not covered by the resident's health plan and was asked if there was an alternative that was less expensive. NP J informed the nursing staff member that all the liver medications are expensive and that the rifaximin needed to be dispensed. NP J was not informed that the medication was not administered to the resident. During an interview on 1/13/26 at approximately 12:15 P.M., the Administrator said he was not aware that the resident did not receive his/her rifaximin. Generally, if a medication is expensive, the facility will reach out to the physician and pharmacy to see if there is an alternative that is less expensive. The Administrator said the facility would have paid for the resident's rifaximin. 3. During an interview on 1/13/25 at 11:32 A.M., Certified Medication Technician (CMT) Z said if a medication is not present in the medication cart, staff should check the bottom drawer for overflow medication. If the medication is not available, the charge nurse should be notified. The CMT's nurse should notify the pharmacy and ensure the (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265001	A. Building B. Wing	01/13/2026

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F 0760 Level of Harm - Actual harm Residents Affected - Few	medication will be delivered. If the medication is not delivered, the pharmacy and physician should be notified within 48 hours. 4. During an interview on 1/13/26 at approximately 12:15 P.M., the Administrator said he would expect staff to reach out to himself or the Director of Nurses and inform them of a resident's missing medication and not continue to document that it was not administered. 25663522713484