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 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 (continued on next page)

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

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F 0760 Level of Harm - Actual harm Residents Affected - Few	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, 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. (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few	The CMT's nurse should notify the pharmacy and ensure the 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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure all residents were treated in a dignified manner when staff observed a resident on the floor and failed to tell anyone, leaving the resident on the floor (Resident #183), and when staff left one resident without pants, leaving him/her exposed in the hallway (Resident #69). In addition, the facility failed to ensure the men and women's shower rooms on 3 Long Unit were in working order, preventing residents on that unit from using the shower room on their hall for an undetermined about of time, including one resident (Resident #147) who became aggressive due to his/her lack of access to showers. The sample was 47. The census was 166. Review of the facility's admission Agreement, dated, showed:-Right to a dignified existence: Be treated with consideration, respect, and dignity, recognizing each resident's individuality;-Freedom from abuse, neglect, exploitation, and misappropriation of property;-Freedom from physical or chemical restraints;-Quality of life is maintained or improved;-Exercise rights without interference, coercion, discrimination, or reprisal;-A homelike environment, and use of personal belongings when possible;-Equal access to quality care;-Security of possessions;-You have the right to be treated with dignity and respect, as well as make your own schedule and participate in the activities you choose. You have the right to decide when you go to bed, rise in the morning, and eat your meals. 1. Review of Resident #183's medical record, showed:-admitted to the facility on [DATE];-Diagnoses included difficulty swallowing, muscle weakness, diabetes, seizures and fall history. During an observation and interview on 1/13/26 at approximately 1:15 P.M., the surveyor walked past the resident's room. The resident was observed on the floor, on his/her buttocks with the wheelchair against his/her back. Housekeeper G observed in the resident's bathroom. The surveyor told Housekeeper G that the resident was on the floor, on his/her buttocks, and asked if he/she was going to tell anyone. Housekeeper G threw up his/her hands and said No and continued to spray cleanser on the toilet. During an interview on 1/13/26 at 11:59 A.M., the Housekeeping Supervisor said the housekeeper should have followed facility policy and reported the resident's fall to nursing staff immediately upon noticing the resident on the ground. The housekeeper should not have continued cleaning after becoming aware the resident was on the floor. During an interview on 1/13/26 at 1:50 P.M., the Administrator and Director of Nursing (DON) said if staff observe a resident on the floor, they are expected to immediately notify the nurse. Staff should not continue to work without notifying someone that a resident is on the floor. 2. Review of Resident #69's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 11/26/25, showed:-Diagnoses included Alzheimer's disease, diabetes, heart failure, and muscle weakness;-Moderately impaired cognition;-Dependent on staff for dressing his/her lower body. Observation on 1/13/26 at 6:56 A.M., showed the resident sat in his/her wheelchair in the hallway. He/She wore a shirt and brief. The brief was undone, exposing the resident's genitals. Another resident walked by the exposed resident in the hallway. During an interview on 1/13/26 at 7:51 A.M., Certified Nurse Aide (CNA) H said all residents should be clothed or at least covered when in public areas. The resident's genitals being exposed in the hallway was a dignity concern. During an interview on 1/13/26 at 10:08 A.M., Licensed Practical Nurse (LPN) I said the resident is unable to dress him/herself and requires assistance from staff. He/She expected for residents to be clothed and covered in public spaces. During an interview on 1/13/25 at 2:34 P.M., the Administrator and DON said residents' genitals should be covered in public spaces. 3. Review of Resident #147's medical record, showed: -admitted on [DATE];-Room on 3 Long Unit;-Diagnoses included hemiplegia (paralysis that affects one side of the body) and hemiparesis (one sided muscle weakness) following cerebral infarction (stroke) affecting left non-dominant side, heart failure, anxiety, and high blood pressure. Review of the resident's care plan, in use during survey, showed:-Focus: Resident has an (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Activities of Daily Living (ADL) self-care performance deficit related to left sided hemiparesis and hemiplegia;-Interventions included substantial/max assistance with bathing/shower. Observations during the survey from 1/6/26 through 1/12/26, showed the 3 Long Unit's men's and women's shower rooms with a taped piece of paper on each door that showed, This area is under construction. Do not enter. During an interview on 1/6/26 at 12:50 P.M., the resident said he/she cannot take a shower on his/her unit. His/Her shower days are Mondays and Thursdays. The men shower at night and the women during the day. Review of the resident's progress note, dated 1/8/26 at 4:27 P.M., showed the resident became increasingly agitated this shift and became verbally aggressive with several staff after requesting a shower. This writer offered to assist resident with shower and after several attempts from staff, resident refused, stating that the facility does not like men, and he/she is not sufficient enough to do the shower. This writer and Assistant Director of Nursing (ADON) educated resident that he/she would able to the get the assistance needed in the shower, and his/her next shower day is Monday. Resident continued to refuse, will continue to monitor for change in condition. During an interview on 1/8/26 at 5:03 P.M., the resident said he/she had one shower in the past five weeks. He/She never took a shower on 3 Short Unit because there were women taking their showers in the evening, even though it was supposed to be men in the evenings. He/She blew up at corporate staff who said he/she would receive a shower. He/She wants a shower. During an interview on 1/8/26 at 11:47 A.M., Housekeeper R said the 3 Long Unit shower rooms just went under construction due to a leak in the shower room on The Loop Unit. During an interview on 1/9/26 at 9:42 A.M., Licensed Practical Nurse (LPN) S said the men and women's shower rooms on 3 Long Unit had out of service signs for at least a couple of months. The residents from 3 Long Unit use the showers on 3 Short Unit, which are functioning properly. The residents on 3 Long Unit keep their same shower days. They go by the shower list, so it is not men at night or women during the day. The rooms on the units are divided up on the shower schedule. All residents are scheduled for showers twice a week. Resident #147 receives his/her showers in the evening. He/She becomes aggressive if he/she does not get his/her shower. To his/her knowledge, LPN S believed the resident receives his/her showers. During an interview on 1/12/26 at 3:07 P.M., the Administrator said he was not aware the men and women's shower rooms on the 3 Long Unit were of order. Observation and interview on 1/12/26 at 3:34 P.M., showed the Director of Maintenance removed the signs on the 3 Long Unit men's and women's shower rooms that read, This area is under construction. Do not enter. The Director of Maintenance said that the showers are working on 3 Long Unit. There was a flood on The Loop Unit and they recently repaired a crushed underground pipe. It was repaired the week before, with work completed on 1/2/26. He did not have a chance to inform staff the shower rooms were working. During an interview on 1/13/26 at 7:42 A.M., CNA P said the shower rooms on 3 Long Unit had been out of order since he/she worked at the facility. The residents on 3 Long Unit were using the showers on 3 Short Unit. He/She had not been informed the showers were working and the maintenance signs were removed. During an interview on 1/13/26 at 7:49 A.M., Certified Medication Technician (CMT) V said the showers on 3 Long Unit had been out of order for four years. He/She had not been informed the showers were working and the maintenance signs were removed. During an interview on 1/13/26 at 8:21 A.M., the resident said he/she had given up on receiving a shower. He/She did not receive a shower on Monday, 1/12/26. He/She believed the men are not able to shower and the facility is discriminating against men. He/She refused last week because the water was cold. Staff make residents feel guilty for wanting a shower and then they say, Wait until your next shower day. Observation and interview on 1/13/26 at 8:28 A.M., showed the Director of Maintenance walked into the men and women's shower rooms on 3 Long Unit to ensure they were not out of order. The sinks and showers were turned on and water came out of the spouts. The Director of Maintenance said that the showers are working. The reason some staff may not have been aware was because those shower rooms were out of order when he started working at the facility. During an interview on 1/13/26 at 12:37 P.M., the DON said she was not aware that the shower rooms on 3 (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Long Unit were no longer out of order. The residents on 3 Long Unit use the showers on 3 Short Unit. Staff can report needed repairs by completing a work order for Maintenance. They can also notify the Housekeeping Supervisor. She was not aware of Resident #147's issues with having access to a shower. During an interview on 1/13/26 at 1:50 P.M., the Administrator said he expected residents to be treated with dignity and respect. He was not aware of the showers not working or not being used. He expected maintenance staff to communicate with nursing staff when something is repaired. He expected maintenance staff to do rounds of the building.

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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 0576 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure residents have reasonable access to and privacy in their use of communication methods. Based on interview and record review, the facility failed to ensure residents received mail on Saturdays, a regular mail delivery day as identified by the United States Postal Service. The facility also failed to ensure mail was delivered timely. The sample was 47. The facility census was 166.During the resident council interview conducted with eight residents who represent the resident council, on 1/8/26 at 1:30 P.M., residents said mail is not delivered timely. It will sit in the activities room before they give it out. They have not had mail delivered this week. Some mail is time sensitive, that may have a due date or expiration date on it. One resident received his/her birthday card nearly one month late. He/She checked the postmark. He/She waited for the birthday card because there was $25 in there. He/She was upset it was delivered late. During an interview on 1/8/26 at 3:00 P.M., the Director of Activities said mail is delivered at the end of the day. After the facility receives the mail, the reception staff sort it out. He/She just got into the position, so he/she was not sure if there were issues with mail being delivered, but there are residents that keep track. Observation at this time of the Director of Activities desk showed a stack of envelopes with room numbers written on them. There were two letters with a visible post mark of 12/30/25 and 1/2/26. There was another large stack of mail on the second desk in the office. Observation on 1/13/26 at 7:54 A.M., showed the Director of Activities had a stack of envelopes on his/her desk. The post mark dated 1/9/26. The Director of Activities said mail came yesterday. He/She will write room numbers on the envelope and give them to the activity aides to deliver. During an interview on 1/13/26 at 10:39 A.M., Receptionist D said on the weekends, receptionist does not sort the mail. They do not know how to sort it properly, so they wait until Monday, so they go through it at that time. During an interview on 1/13/26 at 1:30 P.M., the Administrator said he would expect mail to be delivered timely and on Saturdays. He was not aware of staff waiting until Monday to sort mail delivered on Saturday.

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure advance directive/code status forms (a legal document, often a Do Not Resuscitate (DNR) order, that tells medical professionals not to perform cardiopulmonary resuscitation (CPR) if the heart and breathing stop) were documented, updated, and reviewed annually, in accordance with the expectations of the Director of Nursing (DON) and Administrator, for 7 sampled residents (Residents #1, #6, #12, #17, #39, #55, and #176). The sample was 47. The census was 166.Review of the Residents' Rights Regarding Treatment and Advance Directives policy, revised [DATE], showed:-Policy: To support and facilitate a resident's right to request, refuse and/or discontinue medical or surgical treatment and formulate an advanced directive;-Definitions: Advance directive is written instruction, such as a living will or durable power of attorney for health care, recognized under state law (whether statutory or as recognized by the courts of the state), relating to the provision of health care when the individual is incapacitated;-Explanation and compliance guidelines:-On admission, the facility will determine if the resident has executed an advance directive, and if not, determine whether the resident would like to formulate an advance directive;-The facility will provide the resident or resident representative information, in a manner that is easy to understand, about the right to refuse medical or surgical treatment and formulate an advance directive;-Upon admission, should the resident have an advance directive, copies will be made and placed on the chart as well as communicated to the staff;-The facility will periodically assess the resident for decision making abilities and approach the health care proxy or legal representative if the resident is determined not to have decision making capacities;-The facility will identify or arrange for an appropriate representative for the resident to serve as primary decision maker if the resident is assessed as unable to make relevant health care decisions;-During the care planning process, the facility will identify, clarify and review with the resident of legal representative whether they desire to make any changes related to any advanced directives;-Decisions regarding advanced directives and treatment will be periodically reviewed as part of the comprehensive care planning process, the existing care instructions and whether the resident wishes to change or continue these instructions;-Any decision making regarding the resident's choices will be documented in the resident's medical record and communicated to the interdisciplinary team and staff responsible for the resident's care;-The facility will use the process as provided by state law for handling situations in which the facility and/or physician do not believe that they can provide care in accordance with the resident's advance directives or other wishes. 1. Review of Resident #1's request concerning life prolonging procedures form, dated [DATE], showed:-CPR: Yes;-Use of respirators or ventilators: Yes;-Blood transfusions: Yes;-Administration of medications other than those necessary to prevent infection, provide comfort or alleviate pain: Yes;-Signed by the resident and the physician. Review of the resident's medical record, showed:-re-admitted to facility on [DATE];-Diagnoses included irregular heartbeat, bipolar disorder (a chemical disorder that causes emotional highs and lows), heart disease, kidney disease, depression, muscle weakness, high blood pressure;-A physician order, dated [DATE], for full code. Review of the resident's care plan, revised [DATE], showed:-Focus: The resident has a full code status;-Goal: The resident/power of attorney (POA) will be informed of the right to complete advance directives to direct medical care and make treatment goals known;-Interventions: Advance directives and resident wishes will be honored. Further review of the resident's medical record, showed no updated signed code status election form since 2020. 2. Review of Resident #6's code status form, dated [DATE], showed:-Full resuscitation: I understand full resuscitation means that if my heart stops beating or if I stop breathing, all medical procedures to restart breathing or heart function will be initiated all measures will be taken including CPR, calling 911 (emergency services) and emergency intravenous (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

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	fluids and medications;-Signed by the resident and a registered nurse on [DATE]. Review of the resident's medical record, showed:-re-admitted to the facility on [DATE];-Diagnoses included diabetes, high blood pressure, depression, muscle wasting, schizophrenia (irregular thoughts), difficulty swallowing, and communication deficit. Review of the resident's care plan, revised [DATE], showed:-Focus: The resident has a full code status;-Goal: The resident and POA will be informed of the right to complete advance directive to direct medical care and make treatment goals known;-Interventions: Advance directives and resident wishes will be honored. Further review of the resident's medical record, showed no updated and reviewed signed code status form since 2023. 3. Review of Resident #12's electronic medical record (EMR), showed:-admitted to the facility on [DATE];-Diagnoses included diabetes, chronic kidney disease, heart disease, and heart failure;-A running ribbon at the top of the EMR included the resident's code status, listed as full code;-A physician order, dated [DATE], for full code;-A care plan, in use at the time of survey, showed the resident full code status;-A scanned copy of the resident's code status form showed DNR, signed by the resident and representative on [DATE]. Review of the 3rd Floor Terrace code status book on [DATE] at 10:18 A.M. showed a three-ring binder with copies of code statuses for residents on the hall. A DNR code status form signed by the resident's representative on [DATE] and signed by the hospice physician on [DATE] in the code status book. 4. Review of Resident #17's EMR, showed:-A scanned copy of the resident's code status form showed DNR, signed by the resident on [DATE], signed by the resident's representative on [DATE], and signed by the physician on [DATE];-admitted to the facility on [DATE];-Some cognitive impairment;-Diagnoses included unspecified dementia, neurocognitive disorder with Lewy Bodies (progressive brain disorder characterized by abnormal protein clumps affecting movement, behavior, and mood), schizophrenia, and Alzheimer's Disease;-A physician order, dated [DATE], for DNR. Review of the resident's care plan, in use during the survey, showed the resident had a DNR code status. Interventions included the resident completed a DNR advanced directive and had an active DNR physician order. Review of the 3rd Floor Terrace code status book on [DATE] at 10:18 A.M. showed a three-ring binder with copies of code statuses for residents on the hall. No code status for the located in the code status book. 5. Review of Resident #39's code status form, dated [DATE], showed:-Full resuscitation: I understand full resuscitation means that if my heart stops beating or if I stop breathing, all medical procedures to restart breathing or heart function will be initiated all measures will be taken including CPR, calling 911 (emergency services) and emergency intravenous fluids and medications;-Signed by the resident and a witness on [DATE]. Review of the resident's medical record, showed:-An order, dated [DATE] for full code;-re-admitted to the facility on [DATE];-Diagnoses included lack of coordination, abnormal gait, communication deficit, muscle weakness, neuropathy (loss of feeling in feet and legs), and heart failure. Review of the resident's care plan, revised [DATE], showed:-Focus: The resident has a full code status;-Goal: The resident will be informed of the right to complete advance directives to direct medical care and make treatment goals known;-Interventions: Advance directive and resident wishes will be honored, advance directives completed and placed in the front of the chart to ensure timely access and a copy placed in financial records, the resident will be informed of any changes in condition and benefits, risks, and possible choices of treatment, the physician will be notified of the resident's wishes and any needed physician order will be obtained. Further review of the resident's medical record, showed no current signed code status form. 6. Review of Resident #55's code status form, dated [DATE], showed: -DNR: I understand that DNR means that if my heart stops beating or if I stop breathing, no medical procedures to restart breathing or heart functioning will be initiated. No measures of resuscitation will be taken, including no CPR initiated and not calling 911; -Signed by the resident and a witness on [DATE]. Review of the resident's medical record, showed:-admitted to the facility on [DATE];-A physician order, dated [DATE], showed DNR code status;-Diagnoses included schizoaffective disorder, borderline personality disorder, bipolar disorder, dementia, depression, difficulty swallowing, and communication deficit. Review of the resident's care plan, revised [DATE], (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	showed:-Focus: The resident has a DNR code status;-Goal: The resident will be informed of the right to be complete advanced directive to direct medical care and make treatment goals known;-Interventions: The advance directive will be honored, advance directives completed and placed in the front of the chart to ensure timely access and a copy placed in financial records, the physician will be notified of the wishes and orders will be obtained. Further review of the resident's medical record, showed no signed code status form after [DATE]. 7. Review of Resident #176's medical record, showed:-Initially admitted to the facility on [DATE];-A physician order, darted [DATE], for full code;-A hospital Discharge summary, dated [DATE], showed code status listed as default full code, needs discussion;-re-admitted to the facility on [DATE];-Diagnoses included irregular heartbeat, protein-calorie malnutrition, diabetes, and muscle weakness. Review of the resident's care plan, revised on [DATE], showed:-Focus: The resident has a full code status;-Goal: The POA will be informed of the right to complete advance directives to direct medical care and make treatment goals known;-Interventions: Advance directive and wishes will be honored, advance directives completed and placed in the front of the chart to ensure timely access and a copy placed in the financial records and the physician will be notified of the resident wishes. Further review of the resident's medical record, showed no signed code status form. 8. During an interview on [DATE] at 9:51 A.M. Certified Nurse Aide (CNA) L said when looking for a resident's code status, staff first look in the EMR to see if a resident is a full code or DNR. DNR orders should be updated every six months or if there is a change in condition that necessitates a new code status order. Code statuses should be reflected accurately in residents' care plans, as front-line staff such as CNA's often consult resident care plans to determine care needs. 9. During an interview on [DATE] at 10:01 A.M. Registered Nurse (RN) P said staff are instructed to check the EMR to identify if a resident is a full code or DNR. If the EMR is unavailable or not working, a code status book is located at the desk with active code statuses for all residents on the hall. Advanced directives should be updated when a significant change happened. He/She expected code status orders to be accurately reflected in care plans. 10. During an interview on [DATE] at 9:21 A.M. RN N, the Infection Preventionist (IP), and Regional Nurse Consultant (RNC) O said staff should consult the EMR to determine a resident's code status. They should review the physical code status book located at each nurse's station if the medical record system is down. RN N and RNC O said resident code statuses should be accurately reflected in resident care plans, as the CNAs often review and consult the care plans to direct resident care. Code statuses should be updated when there is a change in condition or per company policy. 11. During an interview on [DATE] at 1:50 P.M., the Administrator and DON said at the time of admission, re-admission, and upon a change in condition, the admission nurse is responsible to ensure a current code status election is obtained, entered on the POS and added onto the care plan. The resident's code status should be reviewed yearly and at each care plan meeting and should be documented in the resident's medical record. The code status form should be signed yearly by the resident or responsible party and the physician.

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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 the bathroom; (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-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 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, 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, (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 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 (continued on next page)

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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	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. 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 (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 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 kempt. 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 (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. 260738016986371698634271232 7

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to implement a resident centered activities program that incorporated the resident's interests, hobbies and cultural preferences for two residents (Resident #153 and Resident #166) who resided on The Loop. In addition, the facility failed to provide one-to-one activities for one resident (Resident #177) who was unable to participate in group activities. The sample was 47. The census was 166. Review of the facility's Activities policy, date last revised, 8/1/25, showed:-Policy: it is the policy of this facility to provide an ongoing program to support residents in their choice of activities based on their comprehensive assessment, care plan, and preference of each resident. Facility sponsored group and individual activities and independent activities will be designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, as well as encourage both independence and interaction within the community;-Each resident's interest and needs will be assessed on a routine basis;-Activities may be conducted in different ways: Programs of activities to include a combination of large and small groups, one to one, and self-directed as the resident desires to attend;-A schedule of activities is posted in a prominent place in the facility;-Resident's are encouraged, but not mandated, to participate in scheduled activities;-Special considerations will be made for developing meaningful activities for residents with dementia and/or special needs; These may include but are not limited to considerations for: Residents who engage in behaviors not conducive to a therapeutic home-like environment. Residents who exhibit behaviors that require a less stimulating environment. Residents who excessively seek attention from staff or peers. Residents that lack awareness of personal safety. Resident who has delusional and hallucinatory behavior that is stressful to themselves;-Staff will assist the residents to and from activities when necessary;-Activities can occur at any time and are not limited to formal activities provided by the activities staff and can include other facility staff members, volunteers, visitors, residents, and family members. 1. Review of Resident #153's quarterly Minimum Data Set (MDS, a federally mandated assessment instrument completed by facility staff), dated 10/7/25, showed:-Diagnoses included Alzheimer's disease, chronic kidney disease, major depressive disorder, and Parkinson's disease;-Moderately impaired cognition. During an interview on 1/9/26 at 9:43 A.M., the resident said there are not enough activities and he/she would like more to do. Observation at this time, showed the resident resided on The Loop. 2. Review of Resident #166's quarterly MDS, dated [DATE], showed:-Diagnoses included dementia, major depressive disorder, anxiety, and chronic kidney disease;-Moderately impaired cognition. Review of the resident's care plan, in use at the time of the survey, showed:-Focus: The resident is very involved in activities. The resident enjoys trivia, bingo, church and helping out;-Goal: The resident will participate in activities of choice, including bingo, trivia, church, and helping out;-Interventions: Explain to the resident the importance of social interaction, leisure activity time. Encourage the resident's participation. Invite/encourage the resident's family members to attend activities with resident, to support participation. During an interview on 1/7/26 at 7:08 A.M., the resident said there are not enough activities and he/she is bored most of the time. Observation at this time showed the resident resided on The Loop. 3. Review of the facility's January 2025, activities calendar, showed:-On 1/8/26: 9am country hits, 10am Bible study, 11am boardgames, 2pm trivia, 4:30pm movie;-On 1/9/26: 9am morning worship, 10am chair Zumba, 11am trivia, 2pm happy hour, 4:30pm movies;-On 1/12/26: 9am jazz inspiration, 10am chair Zumba, 11am LRC/Uno, 2pm poker, 4:30pm movie;-The activity calendar did not indicate the location of the activities. Observations on The Loop, showed no activities in progress:-On 1/8/26 at 11:05 A.M., at 1:33 P.M., and at 1:41 P.M.;-On 1/9/26 at 8:00 A.M., at 9:01 A.M., at 9:30 A.M., at 10:00 A.M., and at 10:30 A.M.;-On 1/12/26 at 9:04 A.M., at 9:30 A.M., and at 9:40 A.M. During an interview on 1/13/26 at 7:51 A.M., Certified Nursing Assistant (CNA) H said there are not enough activities on The Loop. Activity staff do not even (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	take the residents off the hallway to do activities. The residents just sit around in the dining room all day. During an interview on 1/13/26 at 10:08 A.M., Licensed Practical Nurse (LPN) I said it depends on which activity aide comes to provide activities to The Loop on whether or not activities occur. He/She feels like more activities could be done and would be beneficial to the residents. During an interview on 1/13/26 at 2:40 P.M., the Administrator and the Director of Nursing (DON) said they would expect activities on The Loop to be meaningful and stimulate the residents. The activities in the hall need some work. 3. Review of Resident #177's, admission MDS, dated [DATE], showed:-Severe cognitive impairment;-It is very important for the resident to pick out his/her own clothing, listen to music he/she likes, to be around animal and pets, to do things with group of people, to do his/her favorite activities, to go outside and get fresh air when the weather is good, to participate in religious service or practices;-The primary respondent for the daily and activity preference: The resident. Review of the resident's medical record, showed diagnosis that included intellectual disabilities, dementia, Parkinsons disease, schizoaffective disorder (a mental disorder that causes disorganized thinking), muscle weakness, needs assistance with personal care, and cognitive communicative deficit, and bipolar disease (a mental disorder that causes extreme shifts in mood). Review of the resident's care plan, in use at the time of survey, showed:-Focus: The resident has little to no interest in activities;-Interventions: Establish and record the resident's prior level of activity involvement and interests by talking with the resident, caregivers, and family on admission and as necessary; Invite and encourage the resident's family members to attend activities with resident in order to support participation; Monitor and document impact of medical problems on activity level. Observation on 1/6/26 at 9:57 A.M., on 1/7/26 at 8:30 A.M., 9:04 A.M., 9:55 A.M., 10:24 A.M., and on 1/8/26 at approximately 9:00 A.M., showed the resident lay in bed with a green hospital gown on. The resident yelled very loudly and could be heard in the hallway. The resident's foot of his/her bed faced the door, and a privacy curtain was pulled to where the resident could not see out in the hall. The room was dark and the blinds on the window were closed. An activities calendar posted on the wall in the resident's room was dated December 2025. Review of the facility's one to one activities list, dated January 2026, did not list the resident. During an interview on 1/7/25 at 9:04 A.M. Speech Therapist (ST) F said the resident seems scared and anxious a lot of the time. The resident can answer some yes and no questions. During an interview on 1/8/26 at 8:45 A.M., Nurse Practitioner (NP) J said the resident would benefit from one-to-one activities due to his/her behaviors and anxiety. The resident should be placed in clothing other than a hospital gown and assisted out of bed and placed in the common area where the TV is. During an interview on 1/12/26 at 9:35 A.M., the Activities Director (AD) said she had never met the resident or assessed him/her for activities. Th AD is expected to do an assessment within 10 days of admission. For residents to meet the one-to-one criteria, the resident must be bed bound or if the resident requests it. One to one is good for residents exhibiting behaviors or anxiety that cannot participate in group. During an interview on 1/13/26 at 2:40 P.M., the Administrator and the DON said the resident is someone that should have been on one-to-one activities due to him/her yelling out and anxiety. 4. During the resident council interview on 1/8/26 at 1:30 P.M., residents said they stopped doing a lot of activities. They do chair yoga, but no one goes. One resident said he/she has therapy five times a week, so he/she did not want to do chair yoga. They used to play bingo four days a week, but it is now down to once a week. They used to give prizes, but now residents must draw a ticket for their prize. Other activities are watching The Price is Right and The Young and the Restless. The activities are not there anymore. The residents used to have happy hour, but the staff quit doing it every Friday. They changed it to every other Friday. Residents said activities like Country Hits were playing country music in the lobby and nothing else. Review of the activity calendar, dated 1/4/26 through 1/10/26, showed: -Chair Zumba was scheduled on 1/5/26, 1/7/26, and 1/9/26 at 10:00 A.M. -On 1/5/26 at 9:00 A.M., Jazz Inspiration was scheduled; -On 1/6/26 at 9:00 A.M., Classical music was scheduled;-On 1/7/26 at 9:00 A.M., R&B hits was scheduled;-On 1/8/26 at 9:00 A.M., Country hits was scheduled;-On 1/9/26 at 9:00 A.M., morning (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	worship was scheduled;-On 1/20/26 at 9:00 A.M., Classical music was scheduled. 5. Observation of the activity calendar dated 1/9/26 at 9:00 A.M., showed morning worship. The Director of Activities said the residents are not in the chapel. For morning worship, he/she will play gospel music on his/her phone on the patio. 6. During an interview on 1/13/26 at 7:54 A.M., the Director of Activities said there are three activities aides. One aide goes downstairs on the Loop for activities and the other two are conducting activities in the main hall. He/She believed there are enough supplies for activities to do what is needed.

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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 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 (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

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. 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. (continued on next page)

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

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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate foot care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure four of 47 sampled residents received foot care and were on the podiatry list as needed (Residents #133, #72, #69 and #177). The census was 166. Review of the facility's activities of daily living (ADL) policy, dated 9/1/25, showed:-Policy: 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;-A resident who is unable to carry out activities of daily living will receive the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. 1. Review of Resident #133's, quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 12/22/25, showed:-Cognitively intact;-The resident requires maximum assistance with bathing, lower body dressing, personal hygiene, and putting on and taking off footwear. Review of the resident's medical record, showed diagnoses that included cirrhosis of the liver (hardening of the liver resulting in dysfunction), left humerus (upper arm bone) fracture and difficulty walking. Observation and interview on 1/12/26 at 8:50 A.M., showed the resident lay in bed. The resident exposed his/her feet by pulling the bed sheet up. Both of the resident's feet appeared extremely dry, both of his/her big toes had nail polish chipped off. The resident's toenails on both feet were approximately half an inch long and appeared thick and jagged. The resident said he/she is a diabetic and normally goes to the salon to get a pedicure (nail care). The resident was tearful and said his/her toenails look like eagle talons. No staff member has provided any foot care and the resident was not aware that a podiatrist (foot doctor) visited the building. Review of the facility's podiatrist list dated 1/7/26, showed the resident not listed. 2. Review of Resident #72's admission MDS, dated [DATE], showed:-Cognitively intact;-The resident required supervision or touching assistance with bathing, lower body dressing, personal hygiene and putting on and taking off footwear. Review of the resident's medical record, showed diagnoses included cellulitis (skin infection) of the left lower limb and lymphedema (swelling of extremities). Observation and interview on 1/6/26 at approximately 10:00 A.M. and 1/7/26 at 1:28 P.M., showed the resident sat in his/her recliner in his/her room. The resident's feet were exposed. Both of the resident's feet had gray thick toenails that curled under approximately half an inch. The resident said he/she was so embarrassed and wished he/she could receive some foot care. Observation and interview on 1/13/26 at 10:05 A.M., showed the resident sat in his/her recliner in his/her room. The resident's feet were exposed. Both of the resident's feet had gray thick toenails that curled under approximately half an inch. Regional Resource Nurse B examined the resident's feet and said that the resident needed his/her toenails trimmed and that since the resident was not diabetic the nurse could trim and file the resident's toenails. Review of the facility's podiatrist list dated 1/7/26, showed the resident not listed. 3. Review of Resident #69's quarterly MDS, dated [DATE], showed:-Moderately impaired cognition;-Dependent on staff for dressing his/her lower body. Observation on 1/8/26 at 11:06 A.M., showed the resident sat in his/her wheelchair in his/her room. His/Her left foot had thick yellow toenails. The heel and ball of the resident's left foot had peeled dry skin. The resident's right foot had thick yellow toenails at various lengths. The heel and ball of the resident's right foot had peeled dry skin. Review of the facility's podiatrist list dated 1/7/26, showed the resident not listed. 4. Review of Resident #177's admission MDS, dated [DATE], showed:-Severe cognitive impairment;-Dependent on staff for bathing, lower body dressing, personal hygiene and putting on and taking off footwear. Review of the resident's care plan, in use at the time of survey, showed:-Focus: The resident has actual skin impairment due to immobility;-Plan: Use lotion on dry skin. Review of the resident's medical record, showed diagnoses included dementia, muscle weakness, intellectual disabilities, and difficulty walking. Observation on 1/7/26 at 9:04 A.M., showed the resident lay in bed. Physical Therapy Assistant (PTA) E and Speech Therapist (ST) F removed the resident's socks. The resident's right heel appeared dry and peeled. Both of the resident's feet (continued on next page)

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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	were extremely dry and flakes of skin fell off when the resident's socks were removed. Review of the facility's podiatrist list dated 1/7/26, showed the resident not listed. 5. During an interview on 1/13/26 at 11:39 A.M., Registered Nurse (RN) G said if the resident needs to be seen by the podiatrist, social services is informed and will place the resident on the podiatry list. Nurses normally do not trim toenails and will refer the resident to the podiatrist. Lotion can be applied to the resident's feet on their shower days and as needed. 6. During an interview on 1/13/26 at 2:32 P.M., the Director of Nursing (DON) and Administrator said they would expect residents to be on the list to see the podiatrist if they have skin/nail concerns or are diabetic. They would expect non-diabetic patients to have their nails trimmed by the nurse. They would expect dry skin to be treated.

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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 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. Based on interview and record review, the facility failed to ensure the Quality Assessment and Assurance/Quality Assurance Performance Improvement (QAA/QAPI - a written plan containing the process that will guide the facility's efforts in assuring care and services are maintained at acceptable levels of performance and continually improved) committee developed and implemented an appropriate plan of action to correct identified quality deficiencies. This had the potential to affect all residents in the facility. The sample was 47. The facility census was 166.Review of the facility's 2025 QAPI Plan, showed:-Establish a facility-wide process to identify opportunities of improvement through continuous attention to quality of care, quality of life and resident safety;-Address gaps in systems or processes;-Ensure adequate provision of staffing, time, equipment and technical training resources;-Establish clear expectations around safety, quality, rights, choice and respect;-Continually improve the quality of care and services provided to our residents;-The facility conducts performance improvement plans (PIPs) to examine and improve care and/or services in specifically identified areas. PIPs are chosen based upon their importance and meaningfulness, in relation to the scope of services provided by the facility. The focus is on preventing problems and improving current systems and services. The facility seeks to prioritize projects in high risk, high frequency and/or problem prone areas that impact quality of care and quality of life for our residents and conducts one improvement project annually based on these areas;-Clinical data elements to monitor may include, but are not limited to falls, medication errors, polypharmacy, pressure injuries, infections, vaccination compliance, nutrition, physical/chemical restraints, unplanned hospitalizations, unexpected deaths, dementia care, abuse/neglect, and decline in functional status. Organizational data elements to monitor may include, but are not limited to, safety-related events, employee illnesses, functional status of alarms (such as door, fire, bed/chair, etc.), staff retention, regulatory survey outcomes, laundry services, dietary services, environmental services, recreational programming, staff education/training, employee immunization, and criminal background checks. During an interview on 1/12/26 at 12:37 P.M., the Administrator and Director of Nursing (DON) said they pull data in metrics to determine areas of concern. If there is a need for interventions for residents returning to the hospital, meal timeliness, and wounds, the facility will come up with interventions to increase a better outcome. They have not completed their QAPI for the month of December 2025, so until November 2025, they had not identified issues with obtaining labs timely. It had been a while since obtaining weights were discussed. A PIP was implemented to obtain weights upon admission and re-admission. They do not discuss showers in QAPI; it comes up in resident council or grievance process. Residents administered antibiotics are discussed during the clinical meeting or weekly risk meetings. The clinical team reviews the orders in the morning to ensure residents with orders from the hospital are followed. They did not identify pharmacy issues such as ordering medications timely. The DON said medications should be ordered before the medication runs out. During an interview on 1/13/26 at 1:50 P.M., the DON said she attended one QAPI meeting, at the end of December 2025. To her knowledge, re-ordering medication timely and pharmacy issues had not been identified as a concern. During her own audit, the DON identified there were concerns and did an in-service on 12/22/25 regarding documentation of medication on orders, steps needed to notify the pharmacy, and documenting in the medication administration record (MAR). Issues with ordering medication for residents re-admitted from the hospital was not identified. There were no issues regarding obtaining resident weights during the QAPI meeting. Showers and antibiotic issues were not identified as a concern.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement a program that monitors antibiotic use. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to follow current infection control best practices and facility infection control policy for three of 47 sampled residents who were receiving antibiotic therapy. Concerns were noted with the indications for use in the antibiotic orders for all three residents (Residents #69, #166 and #26). The facility census was 166. Review of the facility's Antibiotic Stewardship Program Policy, revised 7/2/25, showed:-The Antibiotic Stewardship Program leaders utilize existing resources to support antibiotic stewards' efforts by working with the Infection Preventionist (IP). The IP utilizes expertise and data to inform strategies to improve antibiotic use to include tracking of antibiotic starts, monitoring adherence to evidence-based published criteria during the evaluation and management of treated infections, and reviewing antibiotic resistance patterns in the facility to understand which infections are caused by resistant organisms;-The program includes antibiotic use protocols and a system to monitor antibiotic use. Antibiotic use protocols include nursing staff assessments of residents suspected to have an infection, the use of the CDC (Center for Disease Control and Prevention, a federal health agency designed to prevent the spread of resistant infections)'s Surveillance data and definitions, all prescriptions for antibiotics shall specify dose, duration, and indication for use;-Antibiotic orders obtained upon admission, whether new admission or readmission to the facility shall be reviewed for appropriateness;-Random audits of antibiotic prescriptions shall be performed to verify completeness and appropriateness. 1. Review of Resident #69's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 11/26/25, showed:-Diagnoses included Alzheimer's disease, diabetes, heart failure, and muscle weakness;-Moderately impaired cognition. Review of the resident's Physician's Order Summary (POS), dated 1/2026, showed:-An order, dated 11/22/25, Gentamicin Sulfate (antibiotic) external cream 0.1 %, apply to affected area topically at bedtime related to need for assistance with personal care;-The antibiotic medication did not have any indications for use. 2. Review of Resident #166's quarterly MDS, dated [DATE], showed:-Diagnoses included dementia, major depressive disorder, anxiety, and chronic kidney disease;-Moderately impaired cognition. Review of the resident's POS, dated 1/2026, showed:-An order, dated 12/9/25, Cefadroxil (antibiotic) oral capsule 500 milligram (mg), Give one capsule by mouth two times a day for antibiotic for three months;-The antibiotic medication did not have any indications for use. 3. Review of Resident #26's medical record, showed:-re-admitted : 11/15/25;-Suprapubic catheter (hollow tube placed through the abdomen into the bladder to drain urine) related to bladder dysfunction;-Diagnoses included amyotrophic lateral sclerosis (ALS, a terminal progressive neurodegenerative disease attacking motor neurons, causing gradual muscle weakness, twitching and loss of control), bipolar disease (emotions ranging from high to low), muscle wasting and atrophy (muscle loss), dysphagia (difficulty swallowing) and bladder dysfunction. Review of the electronic physician order sheet (ePOS), showed:-An order, dated 11/15/25: Doxycycline (antibiotic) 100 mg tablet. Take one tablet twice a day for urinary tract infection;-The order did not include an end or stop date. Review of the November and December 2025 MAR, showed:-An order, dated 11/15/25: Doxycycline (antibiotic) 100 milligram (mg) tablet. Take one tablet twice a day for urinary tract infection;-Noted administered as ordered November and December 2025;-The order did not include an end or stop date for the antibiotic. Review of the January 2026, MAR, showed:-An order, dated 11/15/25: Doxycycline (antibiotic) 100 mg tablet. Take one tablet twice a day for urinary tract infection;-Noted administered as ordered daily during the survey January 2026;-The order did not include an end or stop date for the antibiotic. During an interview on 1/13/26 at 12:15 P.M., Assistant Director of Nursing (ADON) Y said when the nurse received an antibiotic order, he/she should verify a stop/end date for the antibiotic use. Long term antibiotic use can result in antibiotic resistance. The facility has experienced management changes, and he/she is not sure who the infection preventionist is or how antibiotic tracking is occurring. 4. (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 1/13/26 at 10:01 A.M. Registered Nurse (RN) G said all residents on antibiotics are tracked by the facility IP, and should have orders that include a stop date, and an adequate indication for use of the antibiotic. Continuation of antibiotic therapy when an infection is not present or is not reacting to the antibiotic can promote the spread of drug-resistant organisms. 5. During an interview on 1/13/26 at 9:21 A.M. RN N, who serves as the facility IP, and Regional Nurse Consultant O said the facility has an antibiotic tracking log that ideally should be reviewed daily by the facility IP and the Interdisciplinary Team (IDT) during morning meetings. The infection control program also has facility mapping techniques identifying infections by organism. At the time of the interview, the facility IP and RN Consultant O were unaware of any residents receiving long term antibiotics. Antibiotic orders for all residents should have an adequate indication for use and a stop date. Currently, the facility IP and RN Consultant O are working on education with staff to ensure that antibiotic orders are transcribed accurately and with correct indications for use and listed stop date. It is important to ensure antibiotics orders are audited to prevent the spread of drug-resistant infections. 6. During an interview on 1/13/26 at 1:41 P.M. the facility Administrator and Director of Nursing (DON) said they would expect all residents on antibiotics in the facility to have both an adequate listed indication for use of the antibiotic and a stop date indicating when the resident should discontinue the antibiotic.

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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 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 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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure resident care plans included revisions to address individual care needs for two of 47 sampled residents, when the facility included incorrect information about diet orders and code status on resident care plans (Residents #12 and #143). The facility census was 166.Review of the facility's Care Planning - Resident Participation Policy, revised 8/1/25, showed:-The care planning process should include an assessment of the resident's strengths and needs, and will incorporate the resident's personal and cultural preferences in developing goals of care;-The facility will encourage and assist the resident and/or representative to participate in choosing care and treatment options including: initial decisions about treatment, decisions about changes in treatment, and the right to refuse treatment;-If participation of the resident or resident's representative is determined not practicable for the development of a resident's care plan, an explanation will be documented in the resident's medical record. 1. Review of Resident #12's most recent quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 12/18/25, showed:-An admission date of 3/10/23;-The resident has some cognitive impairment;-Medical diagnoses included: Diabetes, Chronic Kidney Disease (CKD, a condition that involves impairment of the kidneys' ability to filter toxins from the blood), atherosclerotic heart disease (impairment of the myocardium caused by a blockage of the arteries), and heart failure. Observation of the 3rd Floor Terrace Code Status book on 1/7/26 at 10:18 A.M. showed a three-ring binder with copies of code statuses for residents on the hall. A Do Not Resuscitate (DNR, an advanced directive indicating life saving measures should be withheld in the event of a change in condition) code status signed by the resident's representative on 11/4/25 and signed by the hospice physician on 11/5/25, located in the code status book. Review of the resident's medical record, showed:-An active physician order for full code placed in the medical record on 11/3/25;-A scanned copy of the resident's DNR order;-A running ribbon at the top of the electronic medical record, included the resident's date of birth , physician, allergies and code status, which showed the resident was a full code. Review of the resident's care plan, in use at the time of survey, showed a focus that the resident was a full code. Interventions included ensuring the resident's advanced directives wishes were honored, and the resident had completed a full code directive. 2. Review of Resident #143's most recent quarterly MDS, dated [DATE], showed:-An admission date of 7/15/25;-The resident has no cognitive impairment;-Medical diagnoses including 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), congestive heart failure (CHF, a condition in which the lower chambers of the heart do not pump blood adequately to the rest of the body), and dysphagia (difficulty swallowing). Observation and interview on 1/6/26 at 9:42 A.M., showed the resident resting in bed with a hospital gown on. The resident stated he/she received a pureed order for breakfast. During an interview on 1/9/26 at 12:43 P.M., the resident said he/she was received a pureed texture lunch meal. Observation on 1/12/26 at 9:05 A.M., showed the resident had a pureed texture breakfast meal on his/her meal tray. Review of the resident's care plan, in use at the time of survey, showed:-A focus that the resident is at risk of aspiration due to noncompliance with NPO (nothing by mouth) status. Interventions included the resident had signed a risk acknowledgment form and was educated regarding the risks and benefits of an NPO diet status;-A focus that the resident requires tube feeding for nutrition. Interventions included checking for feeding tube placement, keeping the head of the bed elevated, and a quarterly consult from the Registered Dietician;-No further mention of the resident's diet orders or nutritional needs. Review of the resident's active physician orders, showed:-An active order for regular diet, pureed texture, placed on 12/17/2025;-An order for the resident to be NPO after midnight on 2/9/26;-No active order for tube (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	feeding. 3. During an interview on 1/13/26 at 9:51 A.M. Certified Nursing Assistant (CNA) L and Certified Medication Technician (CMT) N said care plans designed for residents should be individualized to each resident's needs. Diet orders should be included and accurate so front line care staff know which residents will require additional supervision or assistance with meals. Care plans should include active and accurate code status orders, as all code status orders in the medical record should be accurate in all areas of the record. 4. During an interview on 1/13/26 at 10:01 A.M. Registered Nurse (RN) G said care plans were designed on an individual basis to treat each resident's specific needs. Diet orders should be accurate so that the aides know which residents require assistance. Code status orders should be accurate and match in each part of the resident's medical record. 5. During an interview on 1/13/26 at 1:41 P.M. the facility Director of Nursing (DON) and Administrator said care plans should be individualized to each resident's needs so that staff are able to appropriately care for a resident. The facility DON did not know the answer as to whether or not diet orders should be included in a resident's care plan. The DON and Administrator said they would expect code status orders to be reflected accurately in each resident's care plan.

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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 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 (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure staff attempted to communicate with a resident, who was non-English dominate speaking resident, in in a form and manner that the resident can understand. The facility did not provide an activity calendar in his/her dominate language, a communication board, or use a translation application to communicate with the resident (Resident #176). The sample was 47. The census was 166.Review of the facility's Culturally Competent Care policy, revised 4/23/25, showed:-Policy: to provide culturally competent care in accordance with professional standards of practice. The facility has established a culture that treats each resident with respect and dignity as an individual, as well as addresses, supports and/or enhances his/her feelings of self-worth including personal control over choices and cultural preference;-Effective communication: describes a process of dialogue between individuals. The skills include speaking to others in a way they can understand and active listening and observation of verbal and non-verbal cues. Understanding what the resident is trying to communicate is essential to giving a response. Additionally, effective communication ensures that information provided to the resident is provided in a form and manner that the resident can access and understand, including in a language that the resident can understand;-Language assistance services is defined as language assistance to individuals who have limited English proficiency and/or other communication needs, at no cost to them, to facilitate timely access to all health care and services. This may include oral interpretation, written language translation, or both;-The facility will use the facility assessment to identify resident populations having unique cultural characteristics, such as language (including American Sign Language), religious or cultural practices, values, and preferences;-If the resident is non-English speaking, the facility will identify how communication will occur with the resident. If indicated, language assistance services will be arranged for the resident. The care plan will identify the language spoken and tools used to communicate;-If communication systems are used, all staff interacting with the resident will know where those materials are kept, will understand how to use them, and consistently implement use of those methods. Staff will demonstrate proficiency in communicating with the resident to assure that critical information can be conveyed, such as a change in condition, the presence of pain, explanation of routine care, and the ability to refuse care and services;-Resident-specific approaches will be developed and included in the resident's care plan. These interventions will be provided consistently, and supervising staff will monitor the delivery of care and staff interactions with the resident to assure they are implemented as written;-Residents will be informed in a language they can understand of their total health status, and will be provided notice of rights and services both orally and in writing in a language that they understand. This may involve facility staff evaluating how forms, including informed consent forms, are provided in the language used by the resident. Review of the Facility Assessment, dated 7/10/25, showed:-Ethnic, cultural or religious factors: the facility respects ethnic, cultural or religious factors and/or personal resident preferences that may potentially affect the care provided to residents. Examples include activities, food and nutrition services, languages, clothing preferences, access to religious services or religious-based advanced directives. The facility evaluates residents upon admission and periodically throughout the stay to determine any changes needed to maintain and/or improve socialization and overall physical, emotional, and spiritual well-being. Cultural, ethnic and spiritual preferences are heavily considered when integrating and/or developing facility programming and services;-Languages: use communication boards and Google translator to meet the needs of the resident;-Provide person centered directed care including psychosocial, spiritual support: the staff strive to develop a rapport with residents and families to understand the preferences. This allows the facility staff to determine preferences and routines, triggers, and recovery methods. This information will be incorporated into (continued on next page)

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Athene Nursing and Rehabilitation	13995 Clayton Road Town and Country, MO 63017

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the care plan to ensure staff caring the resident understand and are aware of necessary treatment and care preferences. Staff will provide culturally competent care, learn about the residents' preferences and practices, including about their culture and religion. Staff will remain open to requests and preferences and work to support those as appropriate. Staff will provide or support access to religious and spiritual preferences, as well as provide opportunities for social activities/life enrichment. Review of Resident #176's medical record, showed diagnoses included irregular heartbeat, altered mental status, protein calorie malnutrition, diabetes and muscle weakness; Review of the resident's hospital Discharge summary, dated [DATE], showed:-admitted following a change in condition. Patient received fluids for dehydration, and nutritional support;-Patient is Cantonese speaking, video translator used and able to obtain some response to questions;-Patient non-English speaking, long term care staff stated this is patient's baseline. Hospital staff left a message for patient daughter. Review of the resident's care plan, revised 1/6/26, showed:-Focus: The resident is sometimes understood and sometimes understands;-Goal: Needs will be met on a daily basis;-Interventions: Communication: allow adequate time to respond, repeat as necessary, do not rush, request clarification from the resident to ensure understanding, face the resident when speaking and make eye contact, turn off the TV/radio to reduce environmental noise, ask yes/no questions if appropriate, use simple brief words/cues, and use alternative communication tools as needed;-The care plan did not direct staff on how to communicate with the resident in a form and manner that the resident can access and understand. Observation on 1/6/25 at 10:15 A.M. and on 1/7/26 at 7:15 A.M. and 1:44 P.M., showed the resident's room noted to have a green Budda figurine and bamboo greenery on the bedside table. A facility February activity calendar in English text was present. Observation and interview on 1/8/26 at 10:15 A.M., showed the resident asleep in his/her bed. Certified Medication Technician (CMT) Z approached the resident's doorway with the medication cart. CMT Z entered the resident's room and said to the resident time to get up, sit on the side of the bed to take your medications. CMT Z obtained the resident's medication from the medication cart as the resident stood in the doorway. CMT Z administered the resident the medication and handed the resident his/her liquid nutritional supplement and told the resident drink. The resident entered his/her room and placed the supplement on the desk. CMT Z said the resident can understand some English. The resident does not have a communication board available. CMT Z had not attempted to use Google translate to explain medications or care to the resident. During an interview on 1/8/26 at 10:38 A.M., the resident sat at a table in the third-floor main dining room. The surveyor used a translation application to converse with the resident. The resident said the staff do not use a communication board to explain things to him/her. Staff point to items, or he/she would use hand gestures to understand. He/She enjoyed talking with the surveyor using the translation application because he/she could hear and read the Cantonese language. He/She cannot read the activity calendar in his/her room. Staff have called his/her family to explain care. During an interview on 1/8/26 at 1:13 P.M., Licensed Practical Nurse (LPN) AA said staff used hand gestures to communicate with the resident. He/She had not received training on the resident's dominate language, communication boards or the need for Google translate. During an interview on 1/13/26 at 1:50 P.M., the Administrator and Director of Nursing (DON) said a resident's language preferences should be assessed by nursing and social services at admission. Staff should use a communication board and/or translation application to communicate with non-English dominate speaking residents. Communication means should be in the care plan. Staff should notify nursing, management and social services if no communication board is located. The activity calendar should be printed in a manner the resident can read and understand.

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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. 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 (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 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 (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. Based on observation, interview and record review, the facility failed to ensure one resident that had a gastrostomy tube (g-tube, a tube that is surgically inserted into the abdomen to administer fluids, liquid nutrition, and medications) received the correct water flush during medication administration (Resident # 178). The sample was 47. The census was 166. Review of the facility's policy for Medication Administration via Enteral tube (feeding tube), date last revised 5/1/25, showed:-Policy: It is the policy of this facility to ensure the safe and effective administration of medications via enteral feeding tubes by utilizing best practice guidelines;-Procedure: Verify physician orders for medication and enteral tube flush amount; Flush enteral tube with at least 15 milters (ml) of water prior to administering medications unless otherwise ordered by prescriber; Dilute the solid or liquid medication as appropriate and administer using a clean oral syringe greater than 30 ml in size; Flush the tube again with at least 5 ml of water takin into account resident's volume status; Repeat with the next medication if appropriate; Flush the tube with a final flush of at least 15 ml of water to ensure drug delivery and clear the tube. Review of Resident #178's medical record, showed diagnoses that included seizures, brain injury, and dysphagia (difficulty swallowing). Review of the resident's care plan, in use at the time of survey, showed:-Focus: The resident requires a feeding tube;-Intervention: Check tube for gastric contents and tube placement per facility protocol and record; Provide g-tube care: Keep head of bed elevated 45 degrees, 30 minutes after feeding. Review of the resident's physician order sheet, showed:-An order dated 1/5/26, Enteral feed order every 4 hours flush feeding tube with 120 ml of water every 4 hours, and with 120 ml of water before and after medication administration;-An order dated, 1/5/26, Valproic acid (medication used to treat seizures) 250 milligrams (mg) per 5 ml. Give 20 ml per g-tube, twice a day;-An order dated 1/5/26, Metoprolol Tartrate (used to treat high blood pressure) 25 mg, give one tablet per g-tube, twice a day;-An order dated 1/5/26, Sodium chloride (supplement) give 1000 mg per g-tube three times daily;-An order dated 1/5/26, Amlodipine (used to treat high blood pressure) 5 mg, give one tablet per g-tube, once a day;-An order dated 1/5/26, Levothyroxine (used to treat low thyroid levels) 75 micrograms (mcg), give one tablet, per g-tube, once a day;-An order dated 1/5/26, Glycopyrrolate (used to treat excess acid and saliva) 1 mg, give one tablet twice daily per g-tube. Observation and interview on 1/7/26 at 10:07 A.M., showed Licensed Practical Nurse (LPN) FF prepared the resident's ordered medication by diluting the medications in 30 ml of water each, in individual medicine cups. The resident had two ports on his/her g-tube labeled medications and feeding. LPN FF flushed the resident's g-tube with 120 ml of water through the medication port prior to administering medications. LPN FF administered the resident's medications and after each medication LPN FF administered 120 ml of water. LPN FF said the order read to give the medications then flush after each medication with 120 ml of water. During an interview on 1/7/26 at 1:50 P.M., LPN FF and LPN C said the resident's flush order was confusing. LPN C thought 120 ml water flush was to be administered after the entire medication pass not after each medication. LPN FF interpreted the order as 120 ml water flush after each medication. During an interview on 1/7/26 at 3:28 P.M., Regional Nurse DD said the order needed clarification and the order was flush the tube with 120 ml of water before and after entire medication pass and give 5 ml in between medications as per their policy. Regional Nurse DD said he/she would expect staff to get clarification on the order before administering medications or flushes.

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. Based on observation, interview and record review, the facility failed to provide the necessary behavioral health care and services to attain or maintain the highest practicable physical, mental and psychosocial well-being for one resident's' behavior (Resident #177). The sample was 47. The census was 166.Review of the facility's Behavior Management policy, last revised, 8/1/25, showed:-Policy: Residents who exhibit behavioral concerns may require a behavioral management care plan to ensure they are receiving appropriate service sand interventions to meet their needs; The interdisciplinary team, including the family member, should develop a behavioral plan for each resident with identified behaviors; The plan should reflect the resident' personal preferences and usual routine, to the extent possible; the plan should include the recreation schedule, non-pharmacological interventions, and environment adjustments needed to help the resident meet his or her highest practicable well-being;-Policy explanation and compliance guidelines: -Upon admission of a new resident, the Unit Coordinator or designee will determine if the resident's behaviors warrant a behavioral management plan; -The Unit Coordinator or designee should develop an interim behavioral management plan for use by staff, until the comprehensive assessment and care plan is completed; -Information regarding the resident's usual routine can be gathered from the from the pre-screening tool, from the resident and family members and or the comprehensive assessment; -Behaviors should be identified and documented by facility staff, and approaches for modifications or redirection should be included in the comprehensive care plan. Review of the facility's Activities policy, date last revised, 8/1/25, showed:-Policy: It is the policy of this facility to provide an ongoing program to support residents in their choice of activities based on their comprehensive assessment, care plan, and preference of each resident; Facility sponsored group and individual activities and independent activities will be designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, as well as, encourage both independence and interaction within the community;-Definition: Activities refer to any endeavor, other than routine activities of daily living (ADL), in which a resident participates that is intended to enhance his/her sense of well being and to promote or enhance physical cognitive, and emotional health;-Policy explanation and compliance guidelines: -Each resident's interest and needs will be assessed on a routine basis; This assessment may include, but not limited to an assessment to include the resident's interest, preferences and needed adaptations; Social history: and discharge information if applicable; -Activities will be designed with the intent to: -Enhance the resident's sense of well-being, belonging, and usefulness; -Promote or enhance physical activity; -Promote or enhance cognition; -Promote or enhance emotional health; -Promote self-esteem, dignity, pleasure, comfort, education, creativity, success and independence; -Reflect resident's interests and age; -Reflect cultural and religious interests of the residents; -Reflect choices of the residents; -ADL related activities, such as manicures (nail care), pedicures (foot care) hairstyling, make overs, may be considered part of activities program; -Activities may be conducted in different ways; -One to One program; -Person appropriate to promote self-esteem, dignity, pleasure, comfort, education, creativity, success and independence; -Programs of activities to include a combination of large and small groups, one to one, and self-directed as the resident desires to attend; -A schedule of activities are posted in a prominent place in the facility; -Resident's are encouraged, but not mandated, to participate in scheduled activities; -Activities may include individual , small and large group activities such as: -Indoor and outdoor activities; -Activities away from the facility; -Religious programs; -Exercise programs; -Community activities; -Social activities; -In-room activities; -Individualized activities; -Educational programs; -Special considerations will be made for developing meaningful activities for residents with dementia and/or special needs; These may include, but are not limited to considerations for: -Residents who exhibit unusual amounts of energy or walking without a purpose; -Residents who engage in behaviors not conducive with a therapeutic home like (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	environment; -Residents who exhibit behaviors that require a less stimulation environment to discontinue behaviors not welcomed by others sharing their social space; -Residents that go through others' belongings; -Residents who have withdrawn from previous activity interest, customary routines, and isolates self in room or bed most of the day; -Residents who excessively seek attention from staff or peers; -Residents that lack awareness to personal safety; -Resident who have delusional and hallucinatory behavior that is stressful to themselves; -Staff will assist resident to and from activities when necessary; Activities can occur at any time and are not limited to formal activities provided b the activities staff and can include other facility staff members, volunteers, visitors, residents , and family members. Review of the Facility's Assessment, dated, 7/10/25, showed:-Mental health and behaviors: Specific practices: Manage the medical conditions and medication-related issues causing psychiatric symptoms and behavior, identify and implement interventions to help support individuals with issues such as dealing with anxiety, care of someone with cognitive impairment, care of individuals with depression, trauma, or other psychiatric diagnosis, intellectual or developmental disabilities. Review of Resident #177's admission Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated, 12/30/25, showed:-Severe cognitive impairment;-It is very important for the resident to pick out his/her own clothing, listen to music he/she likes; to be around animal and pets; do things with group of people; to do his/her favorite activities; to go outside and get fresh air when the weather is good; to participate in religious service or practices;-The primary respondent for the daily and activity preference: The resident.- The resident exhibits no physical or verbal behaviors. Review of the resident's medical record, showed diagnoses that included: Intellectual disabilities, dementia, Parkinson's disease (progressive neurological disease that affects movement), schizoaffective disorder (a mental disorder that causes disorganized thinking), muscle weakness, needs assistance with personal care, and cognitive communicative deficit, and bipolar disease (a mental disorder that causes extreme shifts in mood). Review of the resident's care plan, in use at the time of survey, showed:-Focus: The resident has a communication problem related to dementia and anxiety;Goal: The resident will have his/her needs met every day;-Interventions: Anticipate and meet needs; Monitor and document for physical non-verbal indictors of discomfort or distress; Monitor and document the resident's ability to express and comprehend, memory, reasoning ability, problem solving, and ability to attend. -Focus: The resident has little or no interest in activities;-Interventions: Establish and record the resident's prior level of activity involvement and interests by talking with the resident, caregivers, and family on admission and as necessary; Invite and encourage the resident's family members to attend activities with resident in order to support participation; Monitor and document impact of medical problems on activity level. Review of the resident's skilled nursing note dated 1/3/26, showed:-Level of consciousness: Alert and restless;-Mood: Tearful and anxious. Review of the resident's treatment administration record, dated 1/1 through 1/8/26 showed:-An order dated, 12/18/25, record behaviors and number of episodes; on day and night shift; 0= no behaviors, 1= verbal threatening and screaming at others ; 2 = physical hitting, scratching and kicking; 3 = continuous yelling and screaming; 4= distressing hallucinations; 5= Paranoia (suspicion of others); 6= distressing delusions (false beliefs); 7= Disrobing; 8= smearing or throwing food; 9= combative with care; 10= injury to self or others; 11= experiencing inconsolable fear; 12= Other, see progress notes;-On 1/1 through 1/7/26, day and night shifts, and on 1/8/26, day shift, staff documented the resident had no behaviors. Review of the resident's physician order sheets, dated 1/7/26, showed no psychiatric consultation.Review of the resident's progress notes, showed no psychiatric visits. Observation on 1/6/26 at 9:57 A.M., showed the resident lay in bed with a green hospital gown on. The resident yelled loudly and could be heard in the hallway on 400 hall. The foot of his/her bed faced the door, and a privacy curtain was pulled to where the resident could not see out in the hall. The room was dark and the blinds on the window were closed. An activities calendar was posted on the wall in the resident's room, dated December 2025. Multiple staff members walked past the resident's room and did not enter the resident's room to (continued on next page)

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Athene Nursing and Rehabilitation	13995 Clayton Road Town and Country, MO 63017

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	determine if he/she required assistance. Observation on 1/7/26 at 8:30 A.M., 9:04 A.M., 9:55 A.M., and 10:24 A.M., showed the resident lay in bed with a green hospital gown on. The resident yelled very loudly and could be heard in the hallway on 400 hall. The foot of his/her bed faced the door, and a privacy curtain was pulled to where the resident could not see out in the hallway. The room was dark and the blinds on the window were closed. Multiple staff members walked past the resident's room and did not enter the resident's room to determine if he/she required assistance. Observation on 1/8/26 at approximately 9:00 A.M., showed the resident lay in bed with a green hospital gown on. The resident yelled very loudly and could be heard in the hallway on 400 hall. The resident's foot of his/her bed faced the door and a privacy curtain was pulled to where the resident could not see out in the hallway. The room was dark and the blinds on the window were closed. Multiple staff members walked past the resident's room and did not enter the resident's room to determine if he/she required assistance. During an interview on 1/7/26 at 8:35 A.M., the resident's roommate, Resident #159, said Resident #177 yells out all night. During an interview on 1/7/26 at 9:04 A.M., Speech Therapist (ST) F said the resident seemed scared and anxious a lot of the time. The resident could answer some yes or no questions. During an interview on 1/8/26 at 8:45 A.M., Nurse Practitioner (NP) J said the resident would benefit from one-to-one activities due to his/her behaviors and anxiety. The resident should be placed in clothing other than a hospital gown. The resident should be gotten out of bed and positioned in the common area where the TV is located. The resident should have a psychiatrist consult due to his/her behaviors of yelling out and to have his/her medications reviewed. The resident could answer some yes or no questions. During an interview on 1/12/26 at 9:15 A.M., the Social Service Director (SSD) said she was not aware of the resident's behaviors of his/her yelling out. She expected staff to let her know that the resident was experiencing some psychiatric problems. The resident came from a group home prior to coming to the facility. The facility had a care plan meeting with the resident's guardian, but the guardian did have much information on the resident. She expected staff to engage with the resident, get him/her out of bed, and encourage the resident participate in activities. The resident needed to have a psychiatric consult. The resident's transition to the facility was not a smooth one. During an interview on 1/12/26 at 9:35 A.M., the Activities Director (AD) said she had never met the resident or assessed him/her for activities. Th AD is expected to do an assessment within 10 days of admission. For residents to meet the one-to-one criteria, the resident has to be bed bound or if the resident requests it. One to one is good for residents having behaviors or anxiety who cannot participate in groups. During an interview on 1/12/26 at 9:55 A.M., Licensed Practical Nurse (LPN) GG said when residents are constantly yelling out, the staff were expected to see if their needs were met; ensuring they are not soiled, if they need medications, or if they are hungry or thirsty. If the behaviors continue, the resident may require some redirection, a non-pharmacological intervention, a task to complete or companionship. Activities are always a distraction to residents who have behaviors, and the residents have fun. The nurse was expected to document accurately on resident behaviors so when the resident is seen by psychiatry, they can review the behavior notes. If nursing is having difficulty redirecting or the resident is having repetitive behaviors, the SSD and the Director of Nursing (DON) should be notified. During an interview on 1/13/26 at 9:40 A.M., Certified Nursing Assistant (CNA) U and CNA HH said the resident always was anxious. They would try to meet his/her needs by making sure he/she was dry or needed repositioning. CNA U and CNA HH said they normally let the nurse know if the resident could not be calmed down. During an interview on 1/13/26 at 2:40 P.M., the Administrator and the DON said staff were expected to ensure the resident's needs were met when the resident was experiencing behaviors and anxiety. Interventions by staff included but not limited to: Have the resident participate in activities, getting the resident out of bed, determine if they need water or they if they are hungry. Staff should have obtained a psychiatric consult for the resident. Staff were expected to document accurately about the resident's behaviors and their interventions.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview, and record review the facility failed to ensure a narcotic medication was under a double lock and counted when a resident admitted and destroyed when the resident discharged from the facility (Resident #179). The sample was 47. The census was 166. Review of the facility's medication administration policy, dated 2/7/24, showed: -Policy: medications are administered by licensed nurses, or other staff who are legally authorized to do so in this state, as ordered by the physician and in accordance with professional standards of practice, in a manner to prevent contamination or infection. Review of Resident #179's admission Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 11/27/25, showed: -Diagnoses included chronic kidney disease, muscle weakness, and dementia; -Moderately impaired cognition. Review of the resident's progress notes, showed: -A note, dated 12/18/25, resident discharged with all personal belongings, escorted to long term care facility in personal vehicle by his/her son. Discharge paperwork given to son, no questions or concerns at this time. Observation on 1/8/26 at 11:10 A.M., of the nurse's medication cart on the loop hallway, showed the bottom drawer contained a grocery bag with a ziplock bag of medication bottles labeled with the resident's name. The medication was not behind a double lock. Review on 1/8/26, of the loop medication cart narcotic count sheet, showed the resident's Tramadol was not included. Observation on 1/8/26 at 11:42 A.M., of the medication storage room on the loop hallway, showed a grocery bag with the ziplock bag of medication labeled for the resident was on the counter top (not double locked). Observation on 1/8/26 at 12:00 P.M., of the grocery bag of medication stored in the medication storage room, showed one bottle of Tramadol (narcotic pain medication). The bottle was dated 4/6/25, labeled with the resident's name and contained 16 Tramadol pills. During an interview on 1/8/26 at 11:40 A.M., the Loop Unit Manager EE said he/she moved the medication to the medication storage room where it should have been. He/She said the medication was left over from a resident who had discharged home. During an interview on 1/8/26 at 11:55 A.M., Certified Medication Technician (CMT) CC identified the medication as the narcotic, Tramadol. He/She said it belonged to a resident who discharged from the facility two weeks prior. The Tramadol was brought to the facility when the resident admitted . The medication should have been counted every shift and documented on a narcotic count sheet, but it (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	was not. During an interview on 1/13/26 at 2:34 P.M., the Director of Nursing (DON) said left over medication should be given to the resident or destroyed upon the resident's discharge from the facility. She would expect narcotic medication to be stored behind a double lock. If medication is brought from home, it should be counted on a narcotic count sheet.

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F 0808 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure therapeutic diets are prescribed by the attending physician and may be delegated to a registered or licensed dietitian, to the extent allowed by State law. Based on observation, interview and record review, the facility failed to assure that residents receive meals with appropriate nutritive content as prescribed by a physician to support the resident's treatment and plan of care, in accordance with his/her goals and preferences by failing to assure one resident received an appropriate substitute for starches (Resident #5). The sample was 47. The census was 166.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. 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 included anemia (low red blood cell count), heart failure, high blood pressure, renal (kidney) failure, diabetes, and hyperlipidemia (high cholesterol);-Required set-up or clean-up assistance with eating;-Weight 209 pounds;-Receives a therapeutic diet;-Receives dialysis (procedure that filters out the blood for individuals in kidney failure). Review of the resident's care plan, in use during survey, showed:-Focus: Resident has potential for alteration in nutritional status due to diabetes, chronic kidney disease (CKD), and congestive heart failure;-Goal: The resident will maintain adequate nutritional status as evidenced by maintaining weight, no signs or symptoms of malnutrition;-Interventions: Monitor tolerance and acceptance of diet. Provide diet and serve diet as ordered. Review of the resident's annual nutritional assessment, dated 9/6/25, showed:-Therapeutic diet: Regular - heart healthy precautions. Regular-sodium precautions. Fluid restrictions;-Assessment/Intervention/Goals: Resident weight in hospital at 238 pounds. Will clarify diet order and change to regular liberal renal CCHO (controlled carbohydrate diet) with 180 ml fluid restriction;-Goals: healthy weight loss, fluid balance, adequate by mouth intake. Review of the resident's electronic Physician's Orders Sheet (ePOS), dated January 2026, showed:-An order dated 9/6/25, for CCHO/liberal renal diet, regular texture, regular/thin liquids consistency, 1800 milliliter (ml) fluid restriction, 120 ml every med pass, 360 ml at breakfast and 480 ml at lunch and dinner for diet;-An order, dated 1/7/26, CCHO/no added salt (NAS) diet, regular texture, regular/thin liquids consistency, no orange juice, bananas, tomato products, 1800 ml fluid, restriction, 120 ml every med pass, 360 ml at breakfast and 480 ml at lunch and dinner for diet. Review of the resident's nutrition progress notes, showed:-On 9/8/25: Certified Dietary Manager (CDM) met with resident regarding food preferences. Resident was asking about having broth and sandwiches at lunch and dinner every day. CDM educated resident on salt content in these food items. Resident wanted information on other options. Resident would like to have lower sodium foods more appropriate with diet. Resident is currently on CCHO liberal renal diet. Residents want lower sodium protein, fruit - no citrus, vegetables and fresh lettuce salads. Dietary Manager updated tray card with preferences. Will continue to monitor weight and intakes. Registered Dietician (RD) to see as needed (PRN);-On 1/7/26: Resident wanting more liberal diet. Will liberalize diet order to Regular CCHO, no added salt (NAS) with no orange juice, bananas, tomato products with 1800 ml fluid restriction. During an interview on 1/6/26 at 11:19 A.M., the resident said he/she was supposed to have a high protein diet. He/She receives potatoes instead of carrots or other vegetables. If the other (continued on next page)

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F 0808 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	residents are served baked chicken, he/she is served ground beef and some bread or something similar. There is no dessert or juice. It's mostly lunch and dinner that is the issue. Observation and interview on 1/6/26 at 12:35 P.M., showed the resident was served his/her meal of grilled cheese, one serving of green beans, and apple sauce. The resident said he/she was disgusted. He/She is served something different from the other residents. He/She did not request the grilled cheese as an alternate. Review of the resident's 1/6/26 lunch meal ticket, showed:-Diet: Liberal renal, CCHO;-Menu: Chicken tetrazzini, low salt green beans, and diced pears;-Notes: Protein, vegetables, and fruit only each meal. No starch (breads). No orange juice, bananas, tomato products. Review of the facility's Lunch menu, dated 1/6/26, showed:-Regular: Chicken tetrazzini, green beans, and diced pears;-CCHO: chicken tetrazzini, green beans, and diced pears;-Liberal renal: chicken tetrazzini, low salt green beans, and diced pears. Observation on 1/8/26 at 4:26 P.M., showed hall trays served on 3 Long. At 4:38 P.M., the resident's tray was set on the table outside his/her room. The resident was not in his/her room. At 5:01 P.M., the resident was not in his/her room. The tray sat on the table outside of the room. The tray contained a plate with a small piece of baked chicken and one serving of broccoli. Review of the facility's Dinner menu, dated 1/8/26, showed:-Regular: Turkey burger patty, lettuce and tomato, cornbread stuffing, broccoli, and mandarin oranges;-CCHO: Turkey burger patty, lettuce and tomato, cornbread stuffing, broccoli, and mandarin oranges;-Liberal renal: Turkey burger patty, lettuce, seasoned pasta, broccoli, and mandarin oranges. Observation on 1/9/26 at 12:17 P.M., showed the resident was served baked fish, one serving of carrots, and pudding for lunch. The resident said it was not the same as the other residents. Review of the facility's Lunch menu, dated 1/9/26, showed:-Regular: Fried fish, wild rice pilaf, glazed carrots, and banana pudding;-CCHO: Baked whitefish with dill and lemon, wild rice pilaf, glazed carrots, and banana pudding;-Liberal renal: Baked whitefish with dill and lemon, steamed white rice, glazed carrots, and renal fruit cup (no citrus, apricots, or prunes). Review of the resident's progress notes, dated 1/9/26, showed: Writer spoke with resident regarding diet order. Resident is happy with current diet order. Diet explained to resident. Resident is choosing to restrict bread. Resident wants protein, fruit, and vegetables at meals. Weight loss noted as desired. During an interview on 1/12/26 at 11:57 A.M., the resident said over the weekend, dinner was terrible. On Friday, he/she was served some kind of white meat and vegetables. It was terrible and he/she did not eat it. He/She was served the same thing on Saturday. Observation and interview on 1/12/26 at 12:11 P.M., showed staff served the resident chicken with a white sauce on top, spinach, and tri colored pasta. The resident said he/she was surprised he/she received all of this and believed it was because the surveyors were in the facility. Review of the resident's meal ticket, showed:-Diet: CCHO (LCS), NAS;-Menu: Baked chicken with onion gravy, buttered tri colored pasta, chopped spinach, and vanilla pudding;-Notes: Protein, vegetables, and fruit only each meal. No starch (breads). No orange juice, bananas, tomato products. Review of the facility's lunch menu, dated 1/12/26, showed:-Regular: Baked chicken with onion gravy, buttered tri colored pasta, chopped spinach, and vanilla pudding;-CCHO: Baked chicken with onion gravy, buttered tri color, chopped spinach, and vanilla pudding. During an interview on 1/13/26 at 10:45 A.M., the Registered Dietician (RD) said the resident had not had any issues with meals he/she is served. He/She has a few restrictions, but he/she is not on a full renal diet. Right now, he/she has no added salt, CCHO, no orange juice, banana, or tomato products. He/She changes his/her mind often. The RD tries to meet with the resident often when he/she is at the facility. The resident was also on a liberal renal diet. There are more strict options. Sometimes they change the higher sodium options. They would change a potato or noodles to something else. The resident requested a restricted diet with protein and vegetables only. He/She asked for limited starches and bread. If they want vegetables, they will receive an extra vegetable. The RD was asked if the resident should have received an extra vegetable instead of nothing at all. The RD would have to speak with the resident to see if he/she would want an extra to replace the starch. If the resident wants another vegetable, they will add it. The RD was not sure if the food served was enough food to meet his/her caloric needs. The RD did (continued on next page)

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F 0808 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	not know why the resident was served grilled cheese and green beans if he/she did not ask for it. During an interview on 1/13/26 at 11:02 A.M., the Dietary Manager said the resident requested grilled cheese and green beans on 1/6/26. They talk often. He/She would ask for no rice, but they will replace it with vegetables or double vegetables. During an interview on 1/13/26 at 1:50 P.M., the Administrator and Director of Nursing (DON) said they would expect appropriate substitutes for residents who decline to have starches or other carbohydrates. They expect staff to discuss the options with the resident and to ensure the resident receives adequate number of calories to meet her medical and health needs as well as his/her person preferences.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, interview and record review, the facility failed to follow current CDC (Centers for Disease Control and Prevention) guidelines and the facility's infection control policies for two of 47 sampled residents. Staff failed to use an adequate disinfectant on reusable medical equipment during a resident's dressing change (Resident #9). Staff failed to use adequate Enhanced Barrier Precaution (EBP, precautions requiring the use of additional protective equipment by staff when providing care to reduce the spread of certain infections) interventions when providing direct care to a resident with a catheter (thin flexible tube) (Resident #135). The facility census was 166. Review of the facility's Enhanced Barrier Precautions policy, revised 4/23/25, showed: -The policy is designed to implement enhanced barrier precautions for the prevention of transmission of multidrug-resistant organisms (MDROs); -An order for Enhanced Barrier Precautions will be placed for residents with any of the following conditions: wounds, wounds such as chronic pressure ulcers, diabetic foot wounds, surgical wounds, any indwelling medical device (including urinary catheters and dialysis catheters) even if the resident is not known to be colonized with an MDRO; -Implementation of Barrier Precautions: Make gowns and gloves available immediately near or outside of the resident's room; -The Infection Preventionist will incorporate periodic monitoring and assessment of adherence to determine the need for additional training and education; -Enhanced Barrier Precautions should be used for the duration of the affected resident's stay in the facility or until resolution of the wound or discontinuation of the indwelling medical device that placed them at higher risk. Review of the facility's Infection Prevention and Control Program, revised 4/23/25, showed: -All staff shall assume a resident is potentially infected or colonized with an organism that could be transmitted during the course of providing resident care services; -Environmental cleaning and disinfection shall be performed according to facility policy; -All reusable items requiring special cleaning, disinfection, or sterilization shall be cleaned in accordance with our current procedures governing the cleaning and sterilization of soiled or contaminated equipment; -Non-sterile supplies are stored as clean and maintained until prior to use; -All staff shall receive training, relevant to their specific roles and responsibilities, regarding the facility's infection prevention and control program, including policies and procedures related to their job function; -All staff shall demonstrate competence in relevant infection control policies. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Cleaning and Disinfection of Resident Care Equipment policy, last revised 8/1/25, showed: -Policy: Resident care equipment can be a source of indirect transmissions of pathogens. Reusable resident care equipment will be cleaned and disinfected in accordance with current CDC recommendations in order to break the chain of infection; -Definitions: Reusable multiple resident items are items that may be used multiple times for multiple residents; -Policy explanation and compliance guidelines: Staff shall follow established infection control principles for cleaning and disinfection reusable, non-critical equipment; Each user is responsible for routine cleaning and disinfection of multi-resident items after each use, particularly before use of another resident; Multiple-resident use equipment shall be cleaned and disinfected after each use; Verify the disinfectant is compatible with the equipment; Follow manufacturer recommendations for cleaning equipment. 1. Review of Resident #9's most recent quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, completed on 1/5/26, showed: -An admission date of 2/4/25; -The resident is cognitively intact; -Medical diagnoses including chronic atrial fibrillation (a-fib, a condition in which the upper chambers of the heart beat less efficiently than normal), history of sepsis, hydronephrosis with ureteral calculus obstruction (abnormal swelling of the kidney due to a blockage in the ureter caused by a kidney stone), and history of digestive system surgery. Observation on 1/6/26 at 9:13 A.M. showed the resident resting in his/her wheelchair with a urinary catheter bag hanging from the wheelchair. A sign on the resident's door indicated to staff that Enhanced Barrier Precautions should be used when providing care. A small storage caddy with Personal Protective Equipment (PPE) was located outside the resident's door. Observation on 1/12/26 at 9:02 A.M., showed the resident resting in his/her wheelchair while staff emptied the resident's urinary catheter with no PPE on. No signage was noted at the resident's door indicating staff should follow Enhanced Barrier Precautions when providing care. No storage caddy with PPE was located at the resident's door. Observation on 1/13/26 at 10:27 A.M., showed the resident resting in his/her wheelchair with a urinary catheter bag hanging from the wheelchair. No signage was noted at the door indicating staff should follow Enhanced Barrier Precautions when providing care. No storage caddy with PPE was located at the resident's door. During an interview on 1/13/26 at 9:21 A.M. Registered Nurse (RN) N who serves as the facility Infection Preventionist, and Regional Nurse Consultant O said a resident with a urinary catheter should be placed on EBP orders for the duration of the catheter's necessity, and staff should wear PPE when providing care for residents on EBP orders. EBP orders should be placed at admission or when the resident has a new medical condition such as the acquisition of a wound or the necessity of (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

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.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	an indwelling medical device. Residents with active orders should have signage at the door and a storage caddy with PPE nearby. The facility has identified the need for additional storage caddies and would expect staff to put signage back up if it falls off a resident's door. During an interview on 1/13/26 at 1:41 P.M. the Director of Nursing (DON) and Administrator said orders for EBP should be placed upon admission or when a condition requiring EBP orders is noted by staff. Signage should be placed at the door of any resident on EBP orders, and storage caddies with PPE should be easily available to staff. 2. Review of Resident #135's medical record, showed: -Diagnoses included osteomyelitis (infection of the bone) of left ankle and foot; -An order, dated 1/6/26, start date, 1/7/26, left foot, cleanse toes with wound cleaner, apply abdominal pad (a type of dressing), and wrap with Kerlix (a specialized wrap dressing). Observation on 1/8/26 at 1:17 P.M., showed Regional Resource Nurse B prepared the resident's wound treatment at the nurses' cart. The resident sat at the side of the bed with a leg and foot brace on. The resident removed his/her leg and foot brace. The resident's right foot was wrapped with Kerlix and Coban dressing (a specialized wrap). Regional Resource Nurse B placed the wound care supplies on a towel on the resident's bed. Regional Resource Nurse B placed a blue handled pair of scissors directly on the resident's bedside table, without cleaning the bedside table or placing a barrier on the bedside table. Regional Resource Nurse B opened a packaged of gauze dressings with gloved hands and then removed the blue scissors off the resident's bedside table. Regional Resource Nurse B then cleaned the blue handled scissors by applying hand sanitizer to the gauze and spraying wound cleaner directly onto the scissors. Regional Resource Nurse B wiped the excess wound cleaner off of the blue handled scissors and then cut the resident's Kerlix and Coban dressing off. During an interview on 1/13/26 at 9:40 A.M., Regional Resource Nurse B said he/she should have cleaned the scissors with disinfecting cleansing wipes that are approved for cleaning multi-resident medical equipment and should not have used hand sanitizer and wound cleaner. He/She should have disinfected the scissors with the disinfecting wipes prior to cutting the resident's dressing. During an interview on 1/13/26 at 9:21 A.M. RN N, who serves as the facility Infection Preventionist, and Regional Nurse Consultant O said equipment should be cleaned per the manufacturer's recommendation or CDC guidelines. The facility has purple-top container wipes that provide the appropriate germicidal content to satisfy both facility policy and CDC guidelines, and should be used to clean medical equipment that is reused by staff. During an interview on 1/13/26 at 1:41 P.M., the DON and Administrator said staff should follow facility policy when disinfecting reusable medical equipment. The DON said the facility provides germicidal wipes in purple-top containers for staff to use in the event of needing to disinfect reusable medical equipment.