STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265108	A. Building B. Wing	02/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Beth Haven Nursing Home	2500 Pleasant Street Hannibal, MO 63401

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32899 Based on observation, interview, and record review, the facility failed to ensure one wheelchair bound resident (Resident #7), had a proper fitting wheelchair for his/her height and weight which did not cause him/her pain. The facility also failed to ensure call lights were within reach for one resident (Resident #34). The census was 71. Review of the facility policy, Accommodation of Needs, last revised March 2021, showed the following: -The facility's environment and staff behaviors are directed toward assisting the resident in maintaining and/or achieving safe independent functioning, dignity and well-being. -The resident's individual needs and preferences are accommodated to the extent possible, except when the health and safety of the individual or other residents would be endangered. -The resident's individual needs and preferences, including the need for adaptive devices and modifications to the physical environment, are evaluated upon admission and reviewed on an ongoing basis. -In order to accommodate individual needs and preferences, adaptations may be made to the physical environment, including the resident's bedroom and bathroom, as well as the common areas in the facility. Examples of such adaptations may include: providing a variety of types (for example, chairs with and without arms), sizes (height and depth), and firmness of furniture in rooms and common areas so that residents with varying degrees of strength and mobility can independently arise to a standing position; -In order to accommodate individual needs and preferences, staff attitudes and behaviors are directed towards assisting the residents in maintaining independence, dignity and well-being to the extent possible and in accordance with the residents' wishes. For example, arranging personal items so that they are in easy reach of the resident. 1. Review of Resident #7's care plan, last revised 11/18/24, showed the following: -The resident wished to be physically comfortable while maintaining a sense of control; (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-He/She had a decline in activities of daily living (ADL) performance and mobility status related to diagnosis of multiple sclerosis (a chronic, autoimmune disease that affects the brain and spinal cord); -The resident will maintain highest level of functioning within limits of progressive multiple sclerosis. He/She will remain free of complications or discomfort related to multiple sclerosis. Review of the resident's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument to be completed by the facility, dated 1/10/25, showed the following: -admitted [DATE]; -Cognitively intact; -Dependent on staff for transfers; -Used a manual wheelchair. Observation on 2/2/25 at 11:40 A.M., showed the resident sat in a wheelchair in the common area. The resident was tall in stature and too large for his/her wheelchair. The seat of the chair was too short for the resident's legs forcing him/her to sit with his/her legs at an awkward angle, with his/her right knee pointed inward. The back of the wheelchair did not rise high enough to support the resident's back and only came up to the resident's lower to mid back. During an interview on 2/4/25 at 2:00 P.M., the resident said the following: -The only wheelchair he/she had to use was the one he/she was sitting in; -The chair was too small but was the only wheelchair the facility had for him/her; -The wheelchair caused him/her to sit awkwardly and caused pain in his/her right hip; -The facility was supposed to find him/her a more suitable wheelchair, but had not. During an interview on 2/5/25 at 10:35 A.M., the Care Plan/MDS Coordinator said the following: -He/She knew the resident's wheelchair was too small and that it caused the resident pain; -The resident should not be in pain due to the chair; -A wheelchair request was in the works for the last six months; -The process for getting the resident an appropriate chair started when their last therapy group was here (services ended in December 2024). The resident had a physician order, the last therapy group measured the resident and was working on finding him/her an appropriate wheelchair. However, when the therapy group left the facility, all of their records went with them; -He/She had not tried to retrieve the therapy group's records; (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-He/She had not tried to find the resident a more suitable chair within the facility; -The facility was responsible for ensuring the resident had a suitable sized chair. During an interview on 2/6/25 at 11:37 A.M., the Director of Nursing said the following: -The resident should have a proper fitting wheelchair that did not cause him/her pain; -The facility was responsible for ensuring residents had proper equipment, including wheelchairs; -There was no specific staff responsible for obtaining needed equipment for residents; -Since they did not have a therapy department, they only had access to spare equipment (wheelchairs). 2. Review of Resident #34's quarterly MDS, dated [DATE], showed the following: -Moderately impaired cognition; -Able to make self understood; -Required partial to moderate assistance with bed mobility and transfers. Review of the resident's care plan, last revised 12/12/24, showed the following: -Diagnoses included history of falling, muscle weakness and difficulty walking; -The resident had chronic pain. Anticipate the resident's need for pain relief and respond immediately to any complaints of pain. Observation on 2/2/25 at 11:00 A.M., showed the resident lay in his/her bed. One call light was wrapped around the wall outlet and the second call light in the room laid on the floor. Both call lights were not within the resident's reach Observation on 2/3/25 at 12:35 P.M., showed the resident sat on the side of his/her bed with his/her lunch tray. One call light lay on the floor between the bed and the wall and the other was wrapped around the wall outlet. Neither call light was in the resident's reach. Observations on 2/4/25 at 6:40 A.M. and 9:00 A.M., showed the resident lay in his/her bed. One call light lay on the floor between the bed and the wall and the other call light was wrapped around the wall outlet. Neither call light was in the resident's reach. During an interview on 2/4/25 at 7:55 A.M., Licensed Practical Nurse (LPN) S said call lights should be in the resident's reach at all times. During an interview on 2/4/25 at 1:25 P.M., CNA R said call lights should be in reach of the residents at all times. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 2/6/25 at 11:37 A.M., the Director of Nursing said call lights should be in reach of all residents at all times.

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F 0567 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to manage his or her financial affairs. 30813 Based on interview and record review, the facility failed to ensure residents had reasonable access to their personal funds. Residents were unable to gain access to their funds on the weekends including one resident (Resident #2) in a review of 18 sampled residents. The facility managed funds for 43 residents. The facility census was 71. Request was made of the facility for a facility policy regarding the Resident Trust Fund and no policy was provided. 1. During an interview on 02/02/25 at 2:44 P.M., Resident #2 said he/she was unable to access his/her resident funds on the weekends. Review of the facility log, listing residents the facility held resident funds for, showed Resident #2 was one of 43 residents that held funds in the resident trust fund account. During an interview on 02/03/25 at 2:49 P.M., the Admissions/Social Services staff said the following: -She handed out resident funds to residents; -The facility held funds for 43 residents; -The Business Office was not open on weekends; -The facility's banking hours were Monday through Friday, 8:00 A.M. to 4:00 P.M.; -The facility did not have banking hours on Saturday; -Residents have to ask ahead of time if they want money on the weekends. During email communication on 02/05/25 at 12:35 P.M., the administrator said she was not aware that residents should have access to resident funds for the same time a bank would be open.

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F 0570 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Assure the security of all personal funds of residents deposited with the facility. 30813 Based on interview and record review, the facility failed to maintain a surety bond (an amount equal to at least one and one half times the average monthly balance of the residents' personal funds) sufficient to ensure protection of all personal funds the facility held for 43 residents in the resident fund account. The facility census was 71. Request for a facility policy regarding Resident Trust Fund and/or Surety Bond was made with no policy provided. 1. Review of the facility log, listing residents the facility held resident funds for, showed 43 residents held funds in the resident trust fund account. Review of the facility surety bond, dated 02/06/13, showed the facility had an approved surety bond in the amount of $25,000.00. Review of the resident trust fund account for February 2024 to January 2025 showed an average monthly balance of $26,341.93. Calculation showed the facility required a bond in the amount of at least $39,000.00. The current ledger amount was $25,854.64. During an interview on 02/03/25 at 2:49 P.M., the Admissions/Social Services staff said she thought the administrator or Accounts Receivable (AR Business Office) staff was responsible for anything to do with the facility surety bond. During an interview on 02/04/25 at 12:15 P.M., Accounts Receivable staff said she was not responsible for the facility surety bond; she was not sure who was. During an interview on 02/04/25 at 3:30 P.M., the Administrative said the following: -She was not sure who was responsible for the resident trust fund and obtaining the surety bond for the trust; -She had not reviewed the bond to see if it was adequate.

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F 0577 Level of Harm - Potential for minimal harm Residents Affected - Some	Allow residents to easily view the nursing home's survey results and communicate with advocate agencies. 30813 Based on observation and interview, the facility failed to place the facility's most recent survey results in an area accessible to the residents and visitors, and failed to post signage of the location of the survey results in large enough print to be read and accessible to residents in wheelchairs. The census was 71. During an interview on 2/2/25 at 12:40 P.M., an unidentified resident's family member asked how they could find out the results of a survey. Observation on 2/2/25 at 3:10 P.M. showed a printed white paper (with black lettering) on the front hall bulletin board (located to the right of the front entrance) which read, Last three years survey certificates and complaint investigations available East and [NAME] nurses station, in binder, in filing cabinet, top drawer. The document was higher than eye level when standing. Observation on 2/2/25 at 3:12 P.M. showed the filing cabinets at the East and [NAME] nursing station were located behind the nurse's station where staff were usually present. There was no signage visible in this area to direct residents and staff to the survey results located in the cabinet. During the resident council meeting on 2/3/25 at 1:28 P.M., seven of seven residents in attendance said they did not know where the survey results were kept and were not aware of any signage directing them to the location of the survey results. During an interview on 2/6/25 at 12:50 P.M., the Administrator said the following: -The signage indicating the location of the survey results should be at an eye level so that all residents, including those in wheelchairs can see/read the sign; -The results should be kept in a public location where residents/visitors can review them privately. 32899 47008

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 30813 Based on observation, interview, and record review the facility failed to ensure reasonable care for the protection of resident property from loss, when two residents (Resident #59 and #67), and one additional resident (Resident #4), sent items to be laundered and not all items were returned, and failed to ensure one resident's (Resident #4), clothing was free from bleach stains upon return from the laundry department. The facility census was 71. Review of the facility's policy, Personal Property, revised August 2022, showed the following: -Facility staff will treat the residents' belongings with respect, regardless of perceived value; -The resident's personal belongings and clothing are inventoried and documented upon admission and updated as necessary. 1. Review of Resident #4's inventory list, dated 02/11/23, showed the resident had one gray undergarment. Review of the resident's inventory list, dated 02/01/24, showed the resident had one black pair of leggings. (Review showed no documentation of any other clothing items on the resident's inventory lists.) Review of the resident's annual assessment Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 01/31/25, showed the following: -The resident had moderate cognitive impairment; -He/She made himself/herself understood; -It was very important to the resident to take care of his/her personal belongings or things. During an interview on 02/02/25 at 2:35 P.M. and 02/04/25 at 1:37 P.M., the resident said the following: -He/She had 10 pair of gray socks, labeled with his/her name, that were missing for a long time; -He/She had a cover up missing; -He/She reported the missing items to a certified nurses aide (CNA); -He/She reported the missing items to laundry staff; -The facility had not found his/her missing items, and had not replaced the items that were missing from the laundry; (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-He/She had received items back from the laundry which had bleach stains on them; -He/She was upset because he/she felt his/her items were not taken care of appropriately and were being ruined when laundered at the facility. Observation on 02/04/25 at 1:37 P.M. showed the following: -The resident wore a pair of gray socks and had one pair of gray socks in his/her drawer; -The resident's last name was written on the bottom of the socks; -The resident had a bleach spot on the inside of a gray sport undershirt; -The resident had a bleached stained line on the back of the left leg and on the front waistband of one pair of black leggings. 2. Review of Resident #59's inventory list, dated 05/24/24, showed the following: -Two gray and black jogger pants; -One gray jogger, leg cut at bottoms; -Two black joggers. Review of the resident's admission assessment MDS, dated [DATE], showed the following: -He/She made himself/herself understood; -It was very important to the resident to take care of his/her personal belongings or things. During an interview on 02/02/25 at 10:52 A.M., the resident said the following: -The only pants he/she had were the black joggers he/she currently wore; -He/She was missing one pair of black joggers, one pair of gray joggers and two pair of gray and black joggers with a stripe running down the outside pant leg. The pants were labeled with his/her name; -The pants had been missing for over one month; -He/She told nursing staff he/she did not get his/her pants back from the laundry; -The facility did not find his/her pants and had not replaced his/her pants that were missing from the laundry. Observation on 02/02/25 at 10:52 A.M., showed the following: -An unknown CNA asked if the resident wanted to take a shower; (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The resident said he/she did not want to take a shower until he/she had a pair of clean pants; -The CNA left the resident's room; -The resident had four shirts on hangers in his/her closet and no pants. 3. Review of Resident #67's admission assessment MDS, dated [DATE], showed the following: -He/She made himself/herself understood; -It was very important to take care of his/her personal belongings or things. Review of the resident's undated inventory list, showed the resident had three gray t-shirts. During an interview on 02/03/25 at 7:55 A.M. and 10:24 A.M. and on 02/04/25 at 2:09 P.M., the resident said the following: -He/She was missing three gray t-shirts, labeled with his/her name; -His/Her t-shirts had been missing for approximately three to four months; -He/She told a CNA that he/she was missing t-shirts, -The facility had not found his/her t-shirts and had not replaced his/her t-shirts missing from the laundry. 4. During an interview on 02/04/25 at 2:27 P.M., Laundry Aide F said the following: -When a resident had missing items, staff would look in the laundry room to see if they could find them. If the item could not be found, a note was left for the resident which reported the item could not be found; -There was a lost and found room next to the laundry, where staff placed clothes if a item was not labeled or the label was faded and was no longer legible; -Sometimes staff delivered clothes to the wrong resident, so the clothes might be located in another resident's closet; -He/She was not aware Residents #4, #59 and #67 were missing clothing items; -He/She was not aware Resident #4 had bleach stains on his/her clothes; -The only way bleach could get on clothes was with a spray bottle or by sitting the item on top of another item with bleach on it; -The bleach line on the resident's clothing could have come from lying on the metal basket that may have been sprayed with bleach. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 02/04/25 at 2:27 P.M. in the laundry room showed a blue shirt lay on a metal basket with a bleach line running across the back of the shirt. During an interview on 02/04/25 at 3:10 P.M., the Housekeeping Supervisor said the following: -Normally staff marked a resident's clothes with the resident's name before they were laundered; -There were industrial machines that have bleach in the machines and have certain bleach cycles, for washing white sheets, towels, etc.; -No resident had mentioned having bleach stains on his/her clothes; -If a resident was missing a clothing item, staff checked the laundry room and storage room to see if the item could be located. During an interview on 02/04/25 at 3:30 P.M., the SSD said the following: -She did not have any open grievances related to clothing for Resident #4, #67 or #59; -She did not know any of the residents had any items missing or clothing items that were ruined in the laundry; -If a missing item was reported to the CNA, the CNA looked for the item and then should tell a charge nurse. The charge nurse would try to locate the missing item in the resident's room. If the item was not found, staff searched the laundry room and the lost and found. If staff were not able to locate the missing item, staff filled out a form for broken/missing items replacement authorization, and turned in the form to her and she who would start her own investigation. She would interview the resident, check the resident's room, and check with laundry. If she was unable to locate the missing item, then she would give the form with the investigation to the Administrator and the Administrator would inform her of what to do next; -Ultimately, if the items were not found or had been damaged, the facility would need to replace the items. During an interview on 02/06/25 at 11:40 A.M., the Director of Nurses (DON) said the following: -She expected residents to get all their clothing items back that were sent to be laundered at the facility; -If a resident had any missing items from laundry, staff should notify the SSD so an investigation could be performed and a value placed on the items that were not able to locate; -If items were returned to the resident with bleach stains, she would expect the facility to offer to replace the items. During an interview on 02/06/25 at 12:50 P.M., the Administrator said the following: (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-She expected residents to get all their clothing items back that were sent to be laundered at the facility; -If a resident had any missing items from laundry, staff would look for it in laundry. If staff did not find the item, they should notify the SSD so an investigation could be performed; -She expected the facility to replace lost items; -She would not expect a resident to receive items back from the laundry with bleach stains; -If a resident's clothes were damaged by bleach while in the laundry, she would expect the facility to replace the items. 47008

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. 47008 Based on observation, interview, and record review, the facility failed to evaluate one resident (Resident #375's) in the use of a power recliner chair as a restraint, in a review of 18 sampled residents. The motorized recliner which staff sat the resident was positioned so the resident's legs were in front of him/her (horizontal with the floor). The resident was mentally and physically incapable of using power chair remote to put his/her own feet to the floor. The facility census was 71. Review of the facility's policy, Use of Restraints, revised April 2017, showed the following: -Restraints shall only be used for the safety and well-being of the resident(s) and only after other alternatives have been tried unsuccessfully; -Restraints shall only be used to treat the resident's medical symptom(s) and never for discipline or staff convenience, or for the prevention of falls; -When the use of restraints is indicated, the least restrictive alternative will be used for the least amount of time necessary, and the ongoing re-evaluation for the need for restraints will be documented; -Physical Restraints are defined as any manual method or physical or mechanical device, material or equipment attached or adjacent to the resident's body that the individual cannot remove easily, which restricts freedom of movement or restricts normal access to one's body; -The definition of a restraint is based on the functional status of the resident and not the device. If the resident cannot remove a device in the same manner in which the staff applied it given that a resident's physical condition (i.e., side rails are put back down, rather than climbed over), and this restricts his/her typical ability to change position or place, that device is considered a restraint; -Practices that inappropriately utilize equipment to prevent resident mobility are considered restraints and are not permitted, included placing a resident in a chair that prevented the resident from rising; -Prior to placing a resident in restraints, there shall be a pre-restraining assessment and review to determine the need for restraints. Review of the facility's policy, Identifying Involuntary Seclusions and Unauthorized Restraint, revised in September 2022, showed the following: -Sometimes the use of restraints is not intentional, but this does not absolve the staff of responsibility to recognize and report the unauthorized use of restraints. Examples of physical restraints (intentional or unintentional) included placing a resident in a chair, such as a beanbag or recliner, that prevents a resident from rising independently; (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Beth Haven Nursing Home	2500 Pleasant Street Hannibal, MO 63401

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Restraints that are used as a last resort to protect the safety of the resident and others must be accompanied by an order from the practitioner and documentation reflecting the circumstances that led up to the decision to restrain him or her (See policy on Use of Restraints). 1. Review of Resident #375's care plan, revised 01/20/25, showed the following: -The resident was resistive to care at times related to his/her cognitive deficits. He/She may also have anxiety or agitation as part of his/her disease process; -He/She had impaired activities of daily living (ADL) performance and mobility status related to multiple disease processes; -He/She cannot ambulate independently. He/She needed staff to walk with him/her with a gait belt. He/She had to wear a gait belt at all times because he/she was very impulsive would attempt to get up quickly to walk on his/her own; -The resident had actual difficulty with communication related to unclear speech/very little talking; -Monitor him/her for physical/nonverbal indicators of discomfort or distress, and follow-up as needed; -He/She have an actual problem with cognition. He/She had found it difficult to feed him/herself, learn new information, understand reasoning, make decisions, recognize objects, or communicate effectively. This alteration in thought process is related to a traumatic brain injury; -No documentation reflecting medical symptoms or underlying problems that might support the need for a restraint. Review of Resident #375's admission Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 01/29/25, showed the following: -He/She was severely cognitively impaired; -He/She had unclear speech and usually understood others; -He/She had physical and verbal behavioral symptoms directed toward others and these behaviors put the resident at significant risk for physical illness or injury and significantly interfered with the resident's care; -He/She required partial/moderate assistance from staff for bed mobility, transfers and sitting to lying in bed, lying to sitting in bed and chair/bed-to-chair transfers, toilet transfer, tub/shower transfer, walk ten feet, walk 50 feet with two turns, and walk 150 feet; -He/She was dependent on staff to pick up items from the floor. Review of the resident's physician orders summary, dated February 2025, showed the following: (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Diagnoses included aphasia (a language disorder that affects a person's ability to communicate), traumatic brain injury (brain injury), history of falling, intellectual disabilities, and mood disorder (a mental health condition that causes long-lasting changes to a person's emotional state). -Documentation showed no order for physical restraint. Review of the resident's medical record showed no evaluation or assessment of restraining properties of a power reclining chair for the resident. Observation on 02/02/25 at 3:24 P.M. showed the resident sat reclined in a recliner chair with his/her feet on the chair's elevated foot rest (horizontal to the floor). The resident became restless and attempted to get up out of the chair. Observation on 02/02/25 at 4:10 P.M., showed the resident began to holler. The resident sat reclined in a reclining chair with one foot caught in the foot rest; the foot rest was raised and horizontal to the floor. Observation on 02/04/25 at 6:27 A.M., showed the resident sat in the recliner. The foot rest was down, and the resident's feet were on the floor. The resident stood up from the recliner without assistance. Observation on 02/04/25 at 9:18 A.M., showed the resident sat reclined in a recliner chair with his/her feet on the chair's elevated foot rest (horizontal to the floor). The resident yelled, kicked and tried to get up out of the chair. Staff redirected the resident to listen to a song on a cell phone. During an interview on 02/04/25 at 2:22 P.M., Certified Nurse Aide (CNA) Y said staff raised and lowered the resident's feet in the recliner using the electric recliner control. He/She had never observed the resident put his/her own feet down while in the recliner. During an interview on 02/04/25 at 3:18, CNA H said staff raised the resident's feet up (horizontal to the floor) using the recliner control. He/She did not think the resident could lower his/her feet to to the floor using the recliner control. He/She had never witnessed the resident using the recliner control to lower his/her feet to the floor by himself/herself. During an interview on 02/04/25 at 3:20 P.M., CNA G said the resident could not use the recliner control to put his/her feet down. The resident did not have the manual dexterity or the mental capacity to lower his/her own legs when his/her legs were raised in the air. The resident had tried to get up from the recliner with the foot rest in the raised position. The resident did not understand to stay out of other residents' rooms when walking and he/she always needed staff when he/she was not sitting in the recliner with his/her feet up (horizontal to the floor). During an interview on 02/04/25 at 3:25 P.M., Licensed Practical Nurse (LPN) E said he/she had never seen the resident use the remote to lower his/her feet to the ground when in the recliner. He/She did not think the resident was mentally capable of putting his/her feet down. If the resident wanted to get up from the recliner when his/her feet were up (horizontal to the floor), he/she would have to crawl out of the recliner. (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 02/05/25 at 8:00 A.M., CMT D said the resident could not get up from the recliner by himself/herself if the feet were raised (horizontal to the floor). During an interview on 02/05/25 11:15 A.M., the Social Service Director said the resident could not get out of the recliner without staff assistance if his/her feet were raised (horizontal to the floor). The resident could not use the chair remote to get himself/herself up out of the chair if his/her feet were raised (horizontal to the floor). She would consider the recliner to be an unintentional restraint. During an interview on 02/06/25 at 11:40 A.M., the Director of Nursing said the resident could not get his/her feet down by himself/herself when raised in the recliner (horizontal to the floor). The recliner had been used as an unintentional restraint because the resident could not get out of a chair by himself/herself with his/her feet raised (horizontal to the floor). She did not believe the resident had the mental capacity or the manual dexterity in his/her hands to control the remote to the recliner. If the resident could not get up from the recliner by himself/herself when his/her feet were raised (horizontal to the floor), it would be considered a restraint. It was not appropriate for a restraint to be used in the facility. She would not expect a restraint to be used in the facility. During an interview on 02/06/25 at 12:50, the Administrator said she did not know the resident very well and did not know if he/she was capable of lowering his/her feet to the floor if in the raised position. She expected there to be no restraints used in the facility.

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. 30813 Based on interview and record review, the facility failed to review the Nurse Aide Registry for a Federal Indicator (which would disqualify an individual from working in the facility) for two of ten newly hired employees reviewed. The facility census was 71. 1. Review of the Receptionist's employee file showed the following: -Date of hire 04/10/24; -No documentation the facility completed a Nurse Aide Registry check. 2. Review of Certified Medication Technician (CMT) BB's employee file showed the following: -Date of hire 01/26/24; -No documentation the facility completed a Nurse Aide Registry check. During an interview on 02/04/24 at 1:58 P.M., Human Resources staff she was responsible for completing the Criminal Background and Employee Disqualification List checks but was not aware she was to be completing the Nurse Aide Registry checks on newly hired staff. During an interview on 02/04/25 at 3:20 P.M., the administrator said the following: -She was aware that all employees should be checked against the Nurse Aide Registry; -It would be the responsibility of Human Resources to see that this was completed.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 32899 Based on observation, interview, and record review, the facility failed to develop a plan of care consistent with resident's specific conditions, needs, and risks for four residents (Residents #47, #68, #14 and #10), in a review of 18 sampled residents. The facility census was 71. Review of the facility policy, Care Plans, Comprehensive Person-Centered, dated 3/2022 showed the following: -A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident; -The care plan interventions are derived from a thorough analysis of the information gathered as part of the comprehensive assessment; -The comprehensive, person-centered care plan that includes measurable objectives and timeframe's, and describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. 1. Review of Resident #47's quarterly Minimum Data Set (MDS), a federally mandated assessment completed by facility staff, dated 12/20/24, showed the following: -Diagnosis included heart failure, high blood pressure, end stage renal disease (a permanent condition in which the kidneys can no longer filter waste, excess fluids, and electrolytes from the blood. It's also known as kidney failure, and diabetes; -No documentation the resident received dialysis. Review of resident's Physician Order Summary (POS) dated February 2025 showed an order for follow up with nephrologist during dialysis days with a start date 01/28/25. Review of resident's Care Plan, revised 12/05/24, showed no focus, goal or intervention for his/her dialysis care. Interview with resident on 02/05/25 at 8:39 A.M. showed the following: -He/She had been on dialysis for about three years; -He/She goes to dialysis treatment three times weekly. 2. Review of Resident #68's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument to be completed by the facility and dated 1/24/25 showed the following: -Severely impaired cognition; (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Dependent for bed mobility, transfers and sitting to lying in bed, lying to sitting in bed and chair/bed-to-chair transfers; -Side rails not used. Review of the resident's care plan, last revised 1/24/25 showed the following: -Impaired ADL performance and mobility status; -Transfer with sit to stand or hoyer (mechanical lift for persons who can not bear weight) lifts; -High risk for falls due to cognitive impairment, history of falls and lack of safety awareness; -Place a fall mattress next to my bed when i am in it; -The care plan did not address the use of side rails. Observation on 2/4/25 at at 6:30 A.M. showed the resident lay on his/her back in the bed with bilateral 1/4 rails (on the top half) of his/her bed. The side rails were in the upright position. Observation on 2/4/25 at 8:11 A.M. showed the resident remained in his/her bed with the 1/4 rails in the upright position. 3. Review of Resident #14's quarterly review MDS, dated [DATE], showed the following: -The resident was cognitively intact; -He/She was independent with rolling left and right; -He/She required substantial assistance with rolling from left to right, sitting to lying, and lying to sitting on the side of bed. Review of the resident's care plan, last reviewed 12/30/24, showed the following: -Diagnoses included: orthostatic hypotension (a condition where blood pressure drops significantly when a person stands up from a sitting or lying position), muscle weakness, difficulty walking, unsteadiness on feet, spinal stenosis (a narrowing of the spinal canal in the lower part of the back), history of falling, and repeated falls; -He/She was at risk for falls; -The care plan did not address the use of bed mobility bars. Observation on 02/02/25 at 10:29 A.M., showed the resident lay in his/her bed with mobility bars on both sides of the resident's bed. Observation on 02/04/25 at 7:45 A.M., showed the resident lay in his/her bed with mobility bars on both sides of the resident's bed. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4. Review of Resident #10's quarterly review MDS, dated [DATE], showed the following: -The resident was cognitively intact; -He/She could feed him/herself; -He/She was dependent on staff for all other cares and bed mobility. Review of the resident's care plan, last reviewed 01/28/25, showed the following: -Diagnoses included osteoarthritis, joint pain, history of falling, ataxic gait (uncoordinated, awkward way of walking that's caused by poor balance and muscle control), and neuropathic arthropathy (a condition that causes progressive joint destruction and bone weakening); -He/She was at risk for falls; -The care plan did not address the use of bed mobility bars. Observation on 02/02/25 at 11:40 A.M., showed the resident lay in his/her bed with mobility bars on both sides of the resident's bed. Observation on 02/03/25 at 8:03 A.M., showed the resident lay in his/her bed with mobility bars on both sides of the resident's bed. Observation on 02/04/25 at 8:35 A.M., showed the resident lay in his/her bed with mobility bars on both sides of the resident's bed. During a phone interview on 02/06/25 at 11:23 A.M., the Care Plan/MDS Coordinator said the following: -She was responsible for updating the care plans; -Care plans should be updated at minimum quarterly and as needed with changes; -When updating a resident's care plan, information was gathered from the IDT, medical records, family and floor staff; -The care plan should reflect the care needs of the resident; -If a resident was receiving dialysis, it should be included on the care plan. The care plan should reflect how often the resident are receiving dialysis and what should be monitored for the resident. During a phone interview on 02/06/25 at 11:40 A.M., the DON said the following: -The care plan should reflect the care needs of the resident; (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-If a resident had assist bars on their bed to help with bed mobility, she would expect to see it listed on the resident's care plan; -If a resident was receiving dialysis, she would expect to see it listed on the resident's care plan; -If a resident was receiving dialysis, she would expect to see where the resident was receiving dialysis and monitoring for the residentincluding edema, lung sound assessments; any assessment to monitor fluid overload should be listed on the resident's care plan. During an phone interview on 02/06/25 at 12:50, the Administrator said the following: -If a resident had assist bars on their bed, she would expect the information to be listed on the resident's care plan; -If a resident was receiving dialysis, she would expect the information to be listed on the resident's care plan. 47008

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30813 Based on observation, interview, and record review, the facility failed to follow professional standards of practice for three residents (Residents #55, #46, and #19), in a review of 18 sampled residents, and one additional resident (Resident #65). The facility failed to obtain lab work as ordered for one resident (Resident #55), failed to document treatments and medication administration as completed for three residents (Residents #55, #46 and #19), and failed to ensure staff observed one additional resident (Resident #65) take his/her medications during a medication pass. The census was 71. Review of the facility's policy, Administering Medications, dated 2001 and last revised April 2019, showed the following: -Individual administering the medication initials the resident's medication administration record (MAR) on the appropriate line after giving each medication and before administering the next ones; -Residents may self-administer their own medications only if the attending physician, in conjunction with the interdisciplinary care planning team, has determined that they have the decision-making capacity to do so safely. 1. Review of Resident #55's Physician Order Sheet (POS), dated January 2025, showed the following: -Diagnoses included diabetes mellitus (uncontrolled blood glucose), coronary artery disease (heart blood vessel damage) and hyperlipidemia (high levels of fat in blood); -Hemoglobin A1c (HbA1c-lab to check average blood glucose over last three months) every four months (original order dated 7/7/23); -Complete Blood Count (CBC-measurement of blood cells) and Complete Metabolic Panel (CMP-blood test measuring various substances) yearly; -Calmoseptine external ointment (0.44020.6% menthol zinc oxide) (moisture barrier), apply topically to buttocks two times daily for wound (original order dated 12/21/24); -Accucheck (blood glucose check) fasting, early in the morning related to Type II DM. Contact physician if blood glucose is less than 60 or greater than 400. Review of the resident's Treatment Administration Record (TAR), dated January 2025, showed the following: -Calmoseptine external ointment (0.44020.6% menthol zinc oxide) apply topically to buttocks two times daily for wound care. Cleanse noted stage II (partial thickness loss of dermis presenting as a shallow open ulcer with a red or pink wound bed, without slough. May also present as an intact or open/ruptured blister) wound (0.5 cm x 0.5 cm) to left buttocks with normal saline, pat dry, and apply Calmoseptine two times daily (12/21/24); (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Review showed no documentation staff completed the resident's wound care treatment on 1/2, 1/10, 1/12, 1/24, 1/25,1/26 and 1/30/25. Review of the resident's Medication Administration Record (MAR), dated 1/2025, showed no documentation staff completed an accucheck as ordered on 1/8, 1/11, 1/16, 1/25 or 1/31/25. Review of the resident's electronic medical record showed no documentation the facility obtained the HbA1c, CBC or CMP as ordered. During an interview on 02/06/25 at 11:23 A.M. and 12:46 P.M., the Care Plan/MDS coordinator said the following: -She would expect an HbA1C to be completed every four months as ordered; -She was just assigned the task of tracking labs the beginning of last week; -She had just recently started looking at labs; -She had assessed all current lab orders and a report was given to the Director of Nurses (DON). 2. Review of Resident #46's POS, dated December 2024, showed the following: -Tylenol (pain medication) 500 milligrams (mg) two tablets three times daily for pain; -Clonazepam (an anti-anxiety medication) 0.5 mg twice daily for anxiety; -Medi-honey wound and burn dressing external paste (a topical wound dressing made from medical-grade manuka honey used for the treatment of various types of wounds) apply to coccyx BID for open area, cleanse with normal saline, pat dry, apply Medi-honey and cover with border foam; -Diagnoses included osteoarthritis, anxiety, and low back pain. Review of the resident's MAR, dated December 2024, showed the following: -No documentation the resident received the morning dose of clonazepam on 12/7/24, 12/20/24, and 12/22/24; -No documentation the resident received the evening dose of clonazepam on 12/2/24, 12/3/24, 12/6/24, 12/7/24, 12/8/24, 12/17/24, 12/20/24, 12/22/24 and 12/25/24; -No documentation the resident received bedtime dose of Tylenol on 12/4/24; -No documentation the resident's wound care treatment was completed on 12/24/24 (bedtime), 12/27/24 (bedtime). 12/28/24 (morning and bedtime), 12/29/24 (morning and bedtime) and 12/30/24 morning scheduled times. Review of the resident's care plan, last revised 1/15/25, showed the following: (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-The resident received an antianxiety medication; -Potential for pain related to arthritis; -The resident had orders for Tylenol to help with his/her pain. -Administer pain medications as ordered per physician; -The resident had a sacral wound. Treat according to current orders. Review of the resident's POS, dated January 2025, showed the following: -Tylenol 500 mg two tablets three times daily for pain; -Clonazepam 0.5 mg twice daily for anxiety; -Medi-honey wound and burn dressing external paste apply to coccyx twice daily for open area, cleanse with normal saline, pat dry, apply Medi-honey and cover with border foam. Review of the resident's MARs, dated January 2025, showed the following: -No documentation the resident received morning dose of clonazepam on 1/4/25, 1/8/25, 1/9/25, and 1/23/25; -No documentation the resident received evening dose of clonazepam on 1/4/25, 1/5/25, 1/8/25, 1/9/25, 1/17/25, 1/18/25, and 1/22/25; -No documentation the resident received bedtime dose of Tylenol on 1/16/25 and morning doses on 1/22/25, 1/25/25, 1/26/25 and 1/27/25; -No morning wound care documented as completed on 1/1/25 1/2/25, 1/6/25, 1/16/25, 1/20/25, 1/24/25, 1/25/25 and 1/28/25; -No bedtime wound care documented as completed on 1/1/25, 1/2/25, 1/3/25, 1/6/25, 1/7/25, 1/10/25, 1/11/25, 1/12/25, 1/14/25, 1/15/25, 1/16/25, 1/17/25, 1/20/25, 1/21/25, 1/24/25, 1/25/25, 1/26/25, 1/27/25, 1/28/25, 1/29/25 and 1/30/25. 3. Review of Resident #19's care plan, last reviewed 12/12/24, showed the following: -The resident had a diagnosis of depression and anxiety; -Administer medications as ordered. Review of the resident's POS, dated December 2024, showed the following: -Lorazepam (a medication used to treat anxiety) 0.5 mg every morning; -Lorazepam 0.5 mg every afternoon; (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Diagnosis of anxiety. Review of the resident's MARs, dated December 2024, showed the following: -No documentation the resident received morning dose of Lorazepam on 12/20/24 and 12/22/24; -No documentation the resident received afternoon dose of Lorazepam on 12/3/24, 12/7/24, 12/17/24, 12/20/24 and 12/22/24. Review of the resident's POS, dated January 2025, showed the following: -Lorazepam 0.5 mg every morning; -Lorazepam 0.5 mg every afternoon. Review of the resident's MARs, dated January 2025, showed the following: -No documentation the resident received morning dose of Lorazepam on 1/4/25, 1/5/25, 1/8/25, 1/8/25, 1/18/25, and 1/23/25; -No documentation the resident received afternoon dose of Lorazepam on 1/4/25, 1/8/25, 1/9/25 and 1/23/25. During interview on 2/5/25 at 2:01 P.M., LPN C said staff should sign the MAR when they give medications. He/She was not sure why there were days on the MARs/TARs without a signature. 4. Review of Resident #65's annual MDS, dated [DATE], showed the following: -Severely impaired cognition; -Diagnoses included atrial fibrillation, atherosclerotic heart disease (ASHD), Alzheimer's disease and dementia. Review of the resident's POS, dated February 2025, showed the following: -Aspirin 81 mg every morning for high blood pressure; -Metoprolol 25 mg every morning for high blood pressure; -Diagnoses included hypertension (high blood pressure), atrial fibrillation (irregular heart rhythm), atherosclerotic heart disease (a chronic disease which cause arteries to narrow and harden), Alzheimer's disease and dementia; -No order to self-administer medications. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 2/3/25 at 8:06 A.M., showed LPN B prepared the resident's aspirin 81 mg and metoprolol 25 mg. LPN B went to the resident in the dining room and handed the resident the medication cup that contained the medications. LPN B then walked back to the medication cart which was located behind the nurses station and did not observe the resident take his/her medications. During interview on 2/4/25 at 2:55 P.M., LPN B said staff should stay and watch the resident take his/her medications to ensure they take them. 5. During an interview on 2/6/25 at 11:37 A.M., the Director of Nursing said the following: -She expected staff to follow physician orders; -She expected staff to obtain labs as ordered. She recently appointed the MDS/Care Plan Coordinator to track labs to ensure they were completed; -She expected staff to complete treatments as ordered and to measure wounds weekly; -Staff were to document when all medications were administered and treatments were completed on the MAR and TAR; -She was not aware of missing documentation in the MARs/TARs; -If something was not documented, she would assume it was not completed; -She was not aware of anyone monitoring the MARs/TARs for documentation; -She expected staff to stay and observe residents take their medication to ensure they took the medication. She did not believe the facility had any residents who were able to self administer medications. 47008

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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** 30813 Based on observation, interview, and record review, the facility failed to provide the necessary care and services for incontinence care for three residents (Residents #43, #46, and #5), in a review of 18 sampled residents, and for one additional resident (Resident #175), who required assistance with their activities of daily living. Staff failed to provide oral care for three residents (#43, #46 and #5). The facility census was 71. Review of the facility's policy, Perineal Care, dated 2001 and revised February 2018, showed the following: -The purpose of this procedure is to provide cleanliness and comfort to the resident, to prevent infections and skin irritation and to observe the resident's skin condition; -For a female resident wet washcloth and apply soap or skin cleansing agent; wash perineal area, wiping from front to back; Separate labia and wash area downward from front to back. (Note: If the resident has an indwelling catheter, gently wash the juncture of the tubing from the urethra down the catheter about three inches. Gently rinse and dry the area.); Continue to wash the perineum moving from inside outward to and including thighs, alternating from side to side, and using downward strokes. Do not reuse the same washcloth or water to clean the urethra or labia; Rinse perineum thoroughly in same direction, using fresh water and a clean washcloth. (Note: If the resident has an indwelling catheter, hold the tubing to one side and support the tubing against the leg to avoid traction or unnecessary movement of the catheter.); Gently dry perineum; Instruct or assist the resident to turn to on her side with her top leg slightly bent, if able; Rinse wash cloth and apply soap or skin cleansing agent; Wash the rectal area thoroughly, wiping from the base of the labia towards and extending over the buttocks. Do not reuse the same washcloth or water to clean the labia; Rinse thoroughly using the same technique; Dry area thoroughly; -For a male resident wet washcloth and apply soap or skin cleansing agent; wash perineal area starting with urethra and working outward. (Note: If the resident has an indwelling catheter, gently wash the juncture of the tubing from the urethra down the catheter about three inches. Gently rinse and dry the area.); Retract foreskin of the uncircumcised male; Wash and rinse urethral area using a circular motion; Continue to wash the perineal area including the penis, scrotum, and inner thighs. Do not reuse the same washcloth or water to clean the urethra; Thoroughly rinse perineal area in same order, using fresh water and clean washcloth. (Note: If the resident has an indwelling catheter, hold the tubing to one side and support the tubing against the leg to avoid traction or unnecessary movement of the catheter.); Gently dry perineum following same sequence; Reposition foreskin of uncircumcised male; Instruct or assist the resident to turn to on her side with her top leg slightly bent, if able; Rinse wash cloth and apply soap or skin cleansing agent; Wash the rectal area thoroughly, including the area under the scrotum, the anus and the buttocks; Dry area thoroughly. Review of the facility's policy, Mouth Care, dated 2001 and last revised February 2018, showed the following: -The purpose of this procedure is to keep the resident's lips and oral tissues moist, to cleanse and freshen the resident's mouth and to prevent oral infection; (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-The facility policy did not address when staff were to provide mouth care to residents. 1. Review of Resident #43's annual Minimum Data Set (MDS), a federally mandated assessment instrument required to be completed by facility staff, dated 12/6/24, showed the following: -Severely impaired cognition; -Required moderate assistance of staff for oral hygiene, personal hygiene, and dressing; -Resident was dependent on staff for toileting; -Occasional incontinent of bowel and bladder; -Diagnoses included Alzheimer's disease and dementia. Review of the resident's undated Care Plan showed the following: -The resident had impaired activities of daily living (ADL) performance and mobility related to dementia. He/She was incontinent of bowel and bladder; -Help him/her to set-up his/her morning/evening care supplies and encourage him/her to do what he/she can for himself/herself, then help him/her with the rest; -Help him/her with each incontinence episode; -He/She needed reminded to perform oral care. Please help him/her if needed. Observation on 2/4/25 at 7:33 A.M. showed the following: -The resident lay in bed; -Certified Nurse Assistant (CNA) A entered the resident's room, put on gloves, retrieved the resident's clothes from the closet and hung them in the bathroom; -CNA A assisted the resident to walk to the bathroom; -CNA A pulled down the resident's pants and soiled incontinence brief and the resident sat on the toilet; -The resident was incontinent and soiled with urine and feces; -CNA A removed the resident's pants, socks and slippers; -CNA A ran the resident's legs through the leg openings of a clean brief and pants; -CNA A assisted the resident to stand and cleaned the resident's rectal and gluteal crease area; -CNA A pulled up the resident's incontinence brief and pants and repositioned the resident's shirt; (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-CNA A picked up the resident's hair brush, wet the brush with water and combed the resident's hair; -CNA A assisted the resident to the dining room; -CNA A did not clean the resident's front genital area or offer/assist the resident with oral care. 2. Review of Resident #46's annual MDS, dated [DATE], showed the following: -Severely impaired cognition; -Dependent on staff for oral hygiene, toileting and personal hygiene; -Always incontinent of bowel and bladder; -Diagnoses included Alzheimer's disease and dementia. Review of the resident's care plan, last reviewed 12/27/24, showed the following: -The resident was at risk for decline in his/her ADLs and mobility status related to a recent left hip fracture and other comorbid conditions; -He/She needed extensive assistance with toileting; -He/She was occasionally incontinent of bladder and needed assistance with toileting; -He/She had his/her own teeth. He/She needed assistance with brushing his/her teeth. Observation on 2/4/25 at 8:15 A.M., showed the following: -The resident lay in bed; -CNA A and Licensed Practical Nurse (LPN) B entered the resident's room and selected the resident's clothes for the day; -LPN B assisted the resident to sit on the side of the bed; -The resident's incontinence brief was visibly saturated with urine; -CNA A and LPN B assisted the resident to walk to the bathroom; -LPN B left the resident's room; -CNA A pulled down the resident's soiled incontinence brief and assisted the resident to sit on the toilet; -CNA A removed the urine soaked incontinence brief; (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-CNA A ran the resident's legs through the leg openings of a new incontinence brief and pants; -CNA A changed the resident's shirt; -CNA A assisted the resident to stand, cleaned the resident's gluteal crease with disposable wipes; -CNA A pulled up the resident's clean incontinence brief and pants, opened the door to his/her room and walked with the resident to the dining room; -CNA A did not clean the resident's front genitalia and did not provide oral care. During interview on 2/4/25 at 2:48 P.M., CNA A said the following: -When performing peri care, staff should clean any area of the skin that was soiled; -He/She didn't provide oral care because he/she was working by himself/herself and was just trying to get everyone to breakfast. 3. Review of Resident #5's annual MDS, dated [DATE], showed the following: -Cognitively intact; -Dependent on staff for toileting and personal hygiene; -Always incontinent of bowel and bladder. Review of the resident's care plan, last revised 1/15/25, showed the following: -At risk for skin breakdown related to impaired mobility and incontinence; -Inspect skin during AM/PM cares; -Change after incontinent episodes. Observation on 2/4/25 at 7:45 A.M. showed the following: -CNA Q and CNA R entered the resident's room to perform morning cares; -The resident lay in bed and was incontinent of urine; -CNA Q washed the resident's frontal genitalia with a wash cloth but did not cleanse all areas of the resident's skin in contact with the urine; -CNA Q and CNA R dressed the resident and transferred him/her to a chair and pushed him/her to breakfast; -The resident was edentulous and did not wear dentures; (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Staff did not offer or perform oral care for the resident. 4. Review of Resident #175's admission MDS, dated [DATE], showed the following: -Cognitively intact; -Partial to moderate assist with bed mobility; -Supervision to touch assist with personal hygiene; -Substantial to maximum assist with toileting; -Frequently incontinent of bladder. Review of the resident's care plan, last revised 1/30/25, showed the following: -Incontinent of bladder; -Provide preventative skin care as needed; -Cleanse skin as needed. Observation on 2/4/25 at 8:06 A.M. showed the following: -CNA Q and CNA R entered the room; -The resident lay in bed on a bed pan; -CNA R removed the urine filled bed pan and emptied it in the bathroom; -CNA Q assisted the resident to his/her left side. CNA R washed the resident's buttocks with a wash cloth and dried the area with toilet paper; -CNA R did not clean the resident's front perineal area. During an interview on 2/4/25 at 1:15 P.M., CNA Q said the following: -Staff should clean the perineal area, upper thighs, buttocks and any area contaminated by urine or feces when providing incontinent care; -Staff should provide oral care after every meal; -Some residents refused oral care, but staff should offer. 5. During an interview on 2/5/25 at 7:55 A.M., LPN S said the following: -Staff should clean all areas contaminated with urine or feces during perineal care, including front and back perineal areas and thighs (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Staff should offer oral care with morning cares, after meals and at bedtime; -If a resident did not have teeth, staff should use a moistened toothette when providing oral care. During an interview on 2/6/25 at 11:37 A.M., the Director of Nursing said the following: -She expected staff to provide oral care in the morning, after meals, and at bedtime; -Staff should offer oral care anytime a resident's teeth were visibly soiled; -If a resident was edentulous, she expected staff to use a toothette to clean the mouth/gumline; -Staff should clean the front and back perineal areas when providing incontinence care; -If a resident urinated on the bedpan, staff should cleanse the frontal perineal area as well as the resident's backside. 32899

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F 0678 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident's advance directives. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47008 Based on observation, interview, and record review, the facility failed to ensure the medical record accurately and consistently indicated the resident's code status for three residents (Residents #7, #31, and #46), in a review of 18 sampled residents. The facility census was 71. Review of the facility policy, Advance Directives, last revised [DATE], showed the following: -Advance directives are honored in accordance with state law and facility policy; -Do Not Resuscitate (DNR) - indicates that in case of respiratory or cardiac failure, the resident, legal guardian, health care proxy, or representative (sponsor) has directed that no cardiopulmonary resuscitation (CPR) or other life-sustaining treatments or methods are to be used; -Physician Orders for Life-Sustaining Treatment (or POLST) paradigm form - a form designed to improve patient care by creating a portable medical order form that records patient's treatment wishes so that emergency personnel know what treatments the patient wants in the event of a medical emergency, taking the patients current medical condition into consideration. A POLST paradigm form is not an advance directive; -Prior to or upon admission of a resident, the social services director or designee inquires of the resident, his/her family members and/or his or her legal representative, about the existence of any written advance directives; -The resident or representative is provided with written information concerning the right to refuse or accept medical or surgical treatment and to formulate an advance directive if he/she chooses to do so; -Written information about the right to accept or refuse medical or surgical treatment, and the right to formulate an advance directive is provided in a manner that is easily understood by the resident or representative; -The facility policy did not address ensuring the code status of all residents matched in all areas of the medical record and in all areas which list the resident's code status. 1. Review of Resident #7's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument to be completed by the facility, dated [DATE], showed the following: -Cognitively intact; -No short or long-term memory loss; -Able to understand others. Review of the resident's face sheet showed he/she was his/her own responsible party. (continued on next page)

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F 0678 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the resident's Physician Order Sheet (POS), dated February 2025, showed the resident's code status was Full Code. Observation on [DATE] at 10:16 A.M. showed a purple heart sticker (indicating the resident's code status was Do Not Resuscitate (DNR)) on the resident's name plate, located next to the door frame outside of his/her room. Review of the facility's code status binder on [DATE], [DATE], [DATE] and [DATE] showed it contained an out of hospital DNR dated [DATE] and signed by the physician. Review of the resident's care plan, dated [DATE], showed the resident was a DNR. Review of the resident's Electronic Medical Record (EMR) on [DATE] at 2:20 P.M. showed the following: -The dash board read, code status (advanced directive) Full Code; -The face sheet showed the resident's code status was Full Code. (The resident's physician's orders and documents in the EMR showed the resident was Full Code and were not consistent with the resident's wishes to be DNR.) During an interview on [DATE] at 4:50 P.M., the resident said he/she wanted his/her code status to be a DNR. He/She did not want Cardio Pulmonary Resuscitation (CPR) performed in the event his/her heart stopped beating. 2. Review of Resident #31's face sheet showed the following: -No code status was shown; -The resident's family member was listed as his/her responsible party. Review of the resident's care plan, dated [DATE], showed no documentation of code status. Review of the resident's quarterly MDS, dated [DATE], showed the following: -Moderately cognitively impairment; -Made self understood; -Able to understand others. Review of the resident's Physician Order Sheet (POS), dated February 2025, showed no order for code status. Observation on [DATE] at 3:50 P.M. showed a purple heart sticker (indicating DNR code status) on the resident's name plate, located next to the door frame outside of his/her room. (continued on next page)

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F 0678 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility's code status binder on [DATE], [DATE], [DATE] and [DATE] showed it contained an out of hospital Do Not Resuscitate (DNR) dated [DATE] and signed by the physician. During an interview on [DATE] at 1:35 P.M the resident said he/she wanted his/her code status to be a DNR. He/She did not want CPR performed in the event his/her heart stopped beating. During an interview on [DATE] at 4:21 P.M., the resident's Power of Attorney (POA) said the resident was a DNR. (Review showed the resident's POS and care plan did not contain information to show the resident's code status was DNR.) 3. Review of Resident #46's annual MDS, dated [DATE], showed the following: -Severely impaired cognition; -Able to understand others. Review of the resident's face sheet showed his/her family member was his/her durable power of attorney (DPOA). Review of the resident's POS, dated February 2025, showed no documentation of the resident's code status. Observation on [DATE] at 3:31 P.M. showed a purple heart sticker (indicating DNR code status) on the resident's name plate, located next to the door frame outside of his/her room. Review of the facility's code status binder on [DATE], [DATE], [DATE] and [DATE] showed it contained an out of hospital Do Not Resuscitate (DNR) signed by the physician. Review of the resident's care plan dated [DATE] showed the resident was a DNR. Review of the resident's Electronic Medical Record (EMR) on [DATE] at 2:20 P.M. showed the following: -The dashboard showed no documentation of the resident's code status; -The face sheet showed no documentation of the resident's code status; -Scanned copy of the resident's DNR form was located in the miscellaneous tab. (Review of the resident's POS, face sheet and dashboard, did not contain information to show the resident's code status was DNR.) (continued on next page)

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F 0678 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4. During interview on [DATE] at 6:05 A.M., Certified Medication Technician (CMT) said the green heart meant a resident was a full code and a purple heart on a resident's name plate indicated a DNR. He/She would also look on the resident's face sheet for a resident's code status. There used to be a binder at the nurses' station which included all the residents' code status but it was relocated downstairs about a month ago to be uploaded in the EMR. During interview on [DATE] at 3:35 P.M. and on [DATE] at 8:24 A.M., Licensed Practical Nurse (LPN) B said he/she would first check the resident's code status in the code status binder located at the nurses' station. If unable to locate the code status binder, he/she would look in the EMR to see if the full code/DNR form was scanned into the resident's record. During an interview on [DATE] at 5:00 P.M., CMT W said the following: -The hearts on the residents' name plates indicated their code status; -The code status was also in a binder at the desk and on the kardex/face sheet on the computer; -He/She would look at the resident's name plate to find the resident's code status and would look at the binder if he/she was not sure of the code status. During an interview on [DATE] at 5:08 P.M., LPN P said the following: -He/She would look at the heart sticker on the door to identify code status; -He/She would verify the code status on the physician's orders; -If there was a discrepancy, he/she would initiate CPR. During an interview on [DATE] at 10:15 A.M., the Social Service Director (SSD) said the following: -The admissions person was responsible for obtaining the resident's code status; -If there were a discrepancy in a code status, she would double check with the physician and the resident; -Either she or the Care Plan Coordinator would change the code status in the care plan as needed; -All necessary areas would be updated/corrected: door name plate, code status binder, POS, and face sheet; -The admissions person or the nurse were responsible for changing the code status in the EMR. During an interview on [DATE] at 11:21 A.M., the Care Plan Coordinator said the following: -The care plan should reflect and match the resident's correct code status; -He/She obtained the code status information from the interdisciplinary team, the family, the direct care staff, and the medical record; (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0678 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-He/She would correct a discrepancy in the care plan by checking the code status binder, discussions with staff and social services would let him/her know of changes. During an interview on [DATE] at 3:00 P.M., the Admissions staff said the following: -She was responsible for obtaining and adding the status to the code status book, the resident's door and the face sheet; -Either she or nursing would add the code status to the EMR; -She was not aware of any discrepancies regarding residents' code status. During an interview on [DATE] at 11:37 A.M., the Director of Nurses (DON) said the following: -A care plan should include a resident's code status; -Admissions staff and the SSD were responsible for obtaining resident's code status, obtaining necessary signatures, faxing the physician and ensuring the resident's code status was documented in all of the necessary places; -The code status should be documented in the code status binder, on the POS, in the care plan, in the electronic medical record and on the name plate outside the residents' rooms and they should all match; -The POS should contain the resident's code status; -If there was an emergency, he/she expected staff to look in the code status binder for the most accurate code status. During an interview on [DATE] at 12:10 P.M., the Administrator said the following: -Admissions staff was responsible for obtaining the code status and placing the code status in code status book, the sticker system (heart on door) and entering the code status in the electronic medical record; -The code status in all these areas should match with no discrepancies; -The SSD was responsible for updating and checking with residents annually to see if they wanted to change their code status; -She expected the code status to be on the physician's orders; -She expected staff to refer to the code status book for a resident's code status.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 32899 Based on observation, interview, and record review, the facility failed ensure harmful chemicals were kept in locked cabinets and not accessible to residents. The census was 71. 1. Observation on 2/3/25 from 1:35 P.M. to 2:37 P.M., during the dietary and sanitation tour of the facility, showed the following: -One unlabeled cup containing a pink paste substance, one unlabeled cup containing a blue liquid with a spoon in the liquid, and three cans of heavy duty cleaning spray located in an unlocked lower cabinet in the Gardens Special Care Unit (SCU - an area of the facility dedicated to care for residents with dementia who are generally ambulatory) dining room kitchenette. The label on the cans of cleaning spray read 'Keep out of reach of children'; -One gallon jug of concentrated descaler and delimer located on the open bottom shelf of the Gardens SCU dining room steam table. The label on the jug read 'Danger: causes severe skin burns and eye damage. Store locked up'; -One can of disinfectant and sanitizing spray located in an unlocked lower cabinet in the west dining room. The label on the can read 'Caution: keep out of reach of children'; -One can of stainless steel cleaner and polish located in an unlocked lower cabinet in the west kitchenette. The label on the can read 'Warning: keep out of reach of children'; -One can of furniture polish spray located in an unlocked lower cabinet in the Helping Hands dining room. The label on the can read 'Keep out of reach of children.' During an interview on 2/4/25 at 4:49 P.M., the Administrator said she expected cleaning supplies and other chemicals to be secured and inaccessible to residents. 44665

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. 32899 Based on observation and interview, the facility failed to post daily staffing for four out of the four days of the survey. The facility census was 71. Review of the facility policy, Posting Direct Care Daily Staffing Numbers, last revised August 2022, showed the following: -Within two hours of the beginning of each shift, the number of licensed nurses (registered nurses (RNs), licensed practical nurses (LPNs), and licensed vocational nurses (LVNs)) and the number of unlicensed nursing personnel (certified nursing assistants (CNAs) and nurse assistants (NAs)) directly responsible for resident care is posted in a prominent location (accessible to residents and visitors) and in a clear and readable format. -Shift staffing information is recorded on a form for each shift. The information recorded on the form shall include the following: -The name of the facility; -The current date (the date for which the information is posted); -The resident census at the beginning of the shift for which the information is posted; -Twenty-four (24)-hour shift schedule operated by the facility; -The shift for which the information is posted; -Type (RN, LPN), LVN, or CNA) and category (licensed or non-licensed) of nursing staff working during that shift who are paid by the facility (including contract staff); -The actual time worked during that shift for each category and type of nursing staff; -Total number of licensed and non-licensed nursing staff working for the posted shift. -Within two hours of the beginning of each shift, the charge nurse or designee computes the number of direct care staff and completes the Nurse Staffing Information form. The charge nurse completes the form and posts the staffing information in the location(s) designated by the administrator. -The form may by typed or handwritten. If the information must be written so that staffing data can be easily seen and read by residents, staff, visitors or others who are interested in our facility's daily staffing information. (continued on next page)

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Daily observations on 2/2/25 through 2/5/25 of the facility vestibule, front hall, common areas, [NAME] and East nursing stations, outside all office doors, and the unit showed the facility did not post a daily staffing sheet. A binder with facility staffing lay on the desk in the locked special care unit (SCU), however nothing was posted on the wall and visible to all residents and visitors. The staffing sheets in the binder included the number of each RN, LPN, CNAs for each shift, the actual hours worked, the facility name, date and census. During an interview on 2/2/25 at 4:00 P.M., LPN C, who was a charge nurse in the SCU, said the charge nurse of the SCU was responsible to fill out the staffing sheet and to place the paper in a binder. He/She didn't think staff posted the staffing sheet anywhere else in the facility. During an interview on 2/6/25 at 11:37 A.M., the Director of Nursing said the following: -She expected staff to post the daily staffing for residents and families to view; -The daily staffing should be posted outside the Social Services door; -The document should include the facility name, number of licensed nurses, certified medication technicians, CNAs, and NAs, the date, shifts and hours worked; -The charge nurse in the special care unit was responsible for posting daily staffing. During interview on 2/5/25 at 1:59 P.M., the Administrator said SCU staff were responsible for filling out the staffing sheet and to post it by the Social Service office.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 30813 Based on observation, interview, and record review, the facility failed to ensure inventories of schedule II controlled substance medication (substances in this schedule have a high potential for abuse which may lead to severe psychological or physical dependence. Schedule III and IV medications have a lower potential for abuse) and schedule III through IV controlled substance medication, were reconciled by at least two qualified staff to ensure accountability. The facility census was 71. Request for a facility policy regarding Controlled Substances or Narcotic Reconciliation was requested with no policy provided. 1. Review of the [NAME] Unit, Team 1 facility Narcotic Count Sheet, on 02/03/25 at 1:02 P.M. showed the following shift-to-shift documentation: -01/29 (no year), 7:00 A.M., no signature for the on-coming nurse and no signature for the off-going nurse, indicating a shiftly narcotic count had not been completed; -01/29 (no year), 7:00 P.M., no signature for the on-coming nurse and no signature for the off-going nurse, indicating a shiftly narcotic count had not been completed; -01/30 (no year), 7:00 A.M., no signature for the on-coming nurse and no signature for the off-going nurse, indicating a shiftly narcotic count had not been completed; -01/30 (no year), 8:00 A.M., staff signature for the on-coming nurse but no signature for the off-going nurse, indicating a shiftly narcotic count by two qualified staff had not been completed; -01/30 (no year), 3:00 P.M., no signature for the on-coming nurse but a signature for the off-going nurse, indicating a shiftly narcotic count by two qualified staff had not been completed; -01/30 (no year), 7:00 P.M., staff signature for the on-coming nurse but no signature for the off-going nurse, indicating a shiftly narcotic count by two qualified staff had not been completed; -02/03 (no year), 7:00 A.M., no signature for the on-coming nurse and but a signature for the off-going nurse, indicating a shiftly narcotic count by two qualified staff had not been completed. 2. Review of the [NAME] Unit, Team 1 facility Narcotic Count Book, on 02/03/25 at 1:05 P.M. showed the narcotic bin of the medication cart held the following narcotic medications: -Morphine sulfate (a schedule II narcotic controlled substance for pain); -Hydrocodone (a schedule II narcotic controlled substance for pain); -Alprazolam (a schedule IV narcotic controlled substance for anxiety); -Clonazepam (a schedule IV narcotic controlled substance for anxiety); (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Ativan (a schedule IV narcotic controlled substance for anxiety). During an interview on 02/03/25 at 1:15 P.M., Licensed Practical Nurse (LPN) P said the following: -Staff are to write the date and time, along with their signature, of each shift change narcotic count; -Without the documentation, there was no way to know if the counts had been completed or not; no documentation meant the count was not done. During an interview on 02/04/25 at 3:18 P.M., the Director of Nursing (DON) said the following: -Two staff should do the shift to shift narcotic count to confirm the inventories of narcotic medications; -Those two staff members were responsible for signing their name in the appropriate spots on the count sheet to acknowledge/document that the narcotic count had been completed at shift change. During an interview on 02/04/25 at 3:20 P.M., the administrator said the following: -She expected narcotic medication to be accounted for between each shift; -Two qualified staff should be doing the narcotic counts together at shift change and immediately signing the count sheet.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. 30813 Based on observation, interview and record review, the facility failed to administer insulin according to manufacturers' recommendations to ensure staff administered the prescribed insulin dose for two residents (Resident #20 and #22) in a review of 18 sampled residents. The facility census was 71. Review of the facility policy, Insulin Administration, revised September 2014, showed no direction to staff regarding the use of insulin pens. Review of the Lispro Insulin (fast-acting insulin to treat diabetes) Pen manufacturer's instructions for use showed the following: -Priming your pen: -Prime before each injection; -Priming your pen means removing the air from the needle and cartridge that may collect during normal use and ensures that the pen is working correctly; -If you do not prime before each injection, you may get too much or too little insulin; this step also makes sure you avoid injecting air and ensures proper dosing; -To prime your pen, turn the dose knob to select two units; -Hold the pen with the needle pointing up. Tap the cartridge gently with your finger a few times to make any air bubbles collect at the top of the cartridge and keep the needle pointing upwards; -Press the push-button all the way in. The dose selector returns to 0. A drop of insulin should appear at the needle tip; check and make sure the dose selector is set at 0; hold the dose knob in and count to five slowly; - Select the dose you are to administer by turning the dose selector to the number of units you need to inject; -Giving your injection: -Choose your injection site; -Prepare the injection site as directed by your healthcare professional; -Insert the needle into your skin; push the dose knob all the way in; continue to hold the dose knob in and slowly count to five before removing the needle. Review of the Humalog 75/25 Insulin (mixture of fast-acting and longer-acting insulin to treat diabetes) Pen manufacturer's instructions for use showed the following: (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Priming your pen before each injection; -Priming your pen means removing the air from the needle and cartridge that may collect during normal use and ensures that the pen is working correctly; -If you do not prime before each injection, you may get too much or too little insulin; this step also makes sure you avoid injecting air and ensures proper dosing: -To prime your pen, turn the dose knob to select two units; -Hold the pen with the needle pointing up. Tap the cartridge gently with your finger a few times to make any air bubbles collect at the top of the cartridge and keep the needle pointing upwards; -Press the push-button all the way in. The dose selector returns to 0. A drop of insulin should appear at the needle tip. Check and make sure the dose selector is set at 0, hold the dose knob in and count to five slowly; - Select the dose you are to administer by turning the dose selector to the number of units you need to inject. 1. Review of Resident #22's facility diagnoses page showed the resident had diagnoses that included diabetes. Review of the resident's February 2025 Physician Order Sheet (POS) showed the resident had an order for Humalog 75/25 Insulin, 40 units (U) subcutaneously (subq) in the evening. Observation on 02/03/25 at 4:50 P.M. showed the following: -Licensed Practical Nurse (LPN) P, removed a Humalog 75/25 insulin pen and needle cap from the medication cart. -Without priming the insulin pen, LPN P prepared 40 U of insulin and administered the insulin to the resident. During an interview on 02/03/25 at 5:00 P.M., LPN P said he/she had not primed the resident's insulin pen before preparing his/her ordered dose of insulin; he/she had forgotten to do so. 2. Review of Resident #20's facility diagnoses page showed the resident had diagnoses that included diabetes. Review of the resident's February 2025 POS showed the resident had an order for Lispro seven U sub three times daily. Observation on 02/03/25 at 5:15 P.M. showed the following: -Certified Medication Technician (CMT) W, removed a Lispro insulin pen and needle cap from the medication cart; (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Without priming the insulin pen, CMT W prepared 40 U of insulin and administered the insulin to the resident, holding the pen against the resident's skin briefly and not for five seconds as instructed by the manufacturer. During an interview on 02/03/25 at 5:20 P.M., CMT W said he/she was unaware that an insulin pen needed to be primed with two units of insulin prior to preparation of the resident's ordered. She was not aware he/she needed to hold the pen against the resident's skin for any specific length of time. During an interview on 02/04/25 at 3:05 P.M., the Director of Nursing (DON) said the following: -Insulin pens should be primed with two units of insulin prior to preparing the ordered dose; -The pen needs to be dialed to a two, wasted and then dialed to the dose to administer; -If the pen was not primed, the resident might not get the full dose of insulin; -A pen should be held against the resident's skin at the time of administration for five seconds.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30813 Based on observation, interview and record review, the facility failed to ensure discontinued medications for one resident (Resident #52), and medications for two discharged residents (Resident #301 and #300), were destroyed or returned to the pharmacy timely. The facility census was 71. 1. Review of Resident #52's physician orders, dated September 2024, showed the resident had an order for Lantus (long-acting injectable medication used to treat diabetes) 24 units subcutaneously in the morning. The order was discontinued 09/04/24. Observation on 02/03/25 at 1:30 P.M. of the [NAME] Unit Team 2 medication cart showed a Lantus insulin pen, labeled for the resident. During an interview on 02/03/25 at 1:31 P.M., Certified Medication Technician (CMT) W said the resident no longer used the insulin because he/she had an insulin pump and that the pen should have been removed from the medication cart and destroyed as soon as the order was discontinued because he/she no longer used the insulin pens. (The medication remained in the medication cart 153 days after the medication was discontinued) 2. Review of Resident #301's physician orders, dated November 2024, showed the resident had an order for Pneumococcal 20-Valent Conjugate Vaccine, Inject 0.5 ml intramuscularly one time only for vaccine. Observation on 02/03/25 at 1:50 P.M. of the East Unit medication storage room refrigerator showed a vial of Prevnar20 labeled for the resident. During an interview on 02/03/25 at 1:40 P.M., CMT DD said the resident had discharged home. He/She did not know why the medication had not been sent back to the pharmacy. During an interview on 02/03/25 at 1:45 P.M., Licensed Practical Nurse (LPN) E said he/she did not know why the immunization was still in the refrigerator. The resident had discharged , so the medication should have been sent back to the pharmacy. When someone discharges or medications are discontinued or changed, nursing staff should destroy them immediately or send them back to the pharmacy. Review of the facility clinical census showed the resident discharged from the facility on 01/01/25. (The medication remained in the medication room [ROOM NUMBER] days after the resident had discharged) 3. Review of Resident #300's physician orders, dated January 2025, showed the resident had orders for the following: (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Ipratropium Bromide/Albuterol Sulfate nebulizer treatment (inhaled lung medication) one vial every four hours as needed for cough or shortness of breath; -Miralax 17 grams every morning for constipation. Observation on 02/03/25 at 1:37 P.M., of the [NAME] Unit medication storage room showed the following: -Two boxes of 90 vials each of Ipratropium Bromide/Albuterol Sulfate nebulizer treatment vials labeled for the resident; -One 29.6 ounce bottle of Miralax labeled for the resident. During an interview on 02/03/25 at 1:40 P.M., CMT W said the resident had discharged home. He/She did not know why the medications had not been sent home with the resident or sent back to the pharmacy. Review of the facility clinical census showed the resident discharged from the facility on 01/17/25. (The medication remained in the medication room [ROOM NUMBER] days after the resident had discharged) During an interview on 02/04/25 at 3:22 P.M., the Director of Nursing (DON) said nursing staff was responsible for destroying or returning medications that were no longer in use as soon as the occurrence happened.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. 30813 44665 Based on observation, interview, and record review, the facility failed to ensure staff served meals to meet the nutritional needs of the residents when staff failed to prepare and serve food according to the facility's diet spreadsheet menu. The facility census was 71. 1. Review of the Diet Orders, printed 2/3/25, showed the following: -43 residents with a physician-ordered regular diet; -Ten residents with a physician-ordered consistent carbohydrate (CCHO) (low concentrated sweets (LCS)) diet; -Seven residents with a physician-ordered heart healthy diet; -Four residents with a physician-ordered large portion diet; -Six residents with a physician-ordered pureed diet. Review of the Diet Spreadsheet, for 2/4/25 (Day 24, Tuesday) Lunch, showed the following: -Staff were to serve residents on regular, pureed, CCHO (LCS), heart healthy, mechanical soft, and large portion diets a dinner roll with margarine. (The roll/margarine was to be pureed for the pureed diet orders and a soft dinner roll for the mechanical soft diet orders); -Staff were to serve residents on pureed diets a piece of pureed frosted chocolate cake. Observation on 2/4/25 at 10:18 A.M., showed [NAME] L prepared pureed cake in the food processor and placed the pureed cake in the reach-in cooler in the kitchen. Observation on 2/4/25 from 12:14 P.M. to 12:29 P.M., in the kitchen at the steam table, showed [NAME] L and [NAME] Z prepared residents' plates of mechanical soft and pureed diet food items and placed the items onto trays on carts to go to the upstairs dining rooms. Staff did not serve dinner rolls, soft dinner rolls, pureed dinner rolls, or pureed frosted chocolate cake on the residents' trays. During an interview on 2/4/25 at 12:32 P.M., [NAME] Z said he/she thought the pureed dessert was located on the cart of regular dessert items that was sent up to the east dining room. Observation on 2/4/25 at 12:34 P.M., in the east dining room, showed the following: -Residents on a mechanical soft and pureed diet received plates on trays from a cart that were brought up from the kitchen; (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Beth Haven Nursing Home	2500 Pleasant Street Hannibal, MO 63401

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Residents with a pureed diet did not have a dessert on their tray; -The residents on regular, mechanical soft and pureed diets did not receive a dinner roll or margarine. During an interview on 2/4/25 at 12:38 P.M., Certified Nurse Aide (CNA) G said pureed desserts should already be on the trays of residents with a pureed diet. These items were prepared and served on plates in the kitchen and brought up to the dining rooms on carts from the kitchen. A cart of regular dessert items was brought up from the kitchen to the east dining room and CNA G confirmed there were no pureed dessert items on the cart. During an interview on 2/4/25 at 2:26 P.M., Direct Service Aide J (who was responsible to help serve meals) said the following: -Dietary staff brought food from the kitchen to each of the dining rooms for him/her and other staff to serve residents' meals; -He/She was unaware of what items each resident should receive for their diet type; -He/She didn't have a diet spreadsheet menu; -No rolls or pureed frosted chocolate cake were brought up to the east dining room for him/her to serve to residents for the 2/4/25 lunch meal. During interview on 2/4/25 at 2:49 P.M., the Dietary Manager said he expected staff to follow physician-ordered resident diet orders, recipes, and the diet spreadsheet menus.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 30813 32899 Based on observation, interview, and record review, the facility failed to provide food items at a safe and appetizing temperature and taste. The facility census was 71. 1. Review of the Diet Orders, printed 2/3/25, showed the following: -13 residents with a physician-ordered mechanical soft diet; -Two residents who preferred to receive a mechanical soft diet; -Six residents with a physician-ordered pureed diet. Review of the facility's recipe binders, located on the food preparation counter and in a rack by the dietary manager's office, showed no recipes (or associated temperature guidelines) for the following food items: -Mechanical soft or pureed potato salad; -Pureed or chopped (mechanical soft) spinach; -Mechanical soft or pureed pork loin. Review of the facility's food substitution log for the lunch meal on 2/4/25 showed pork loin was substituted for pork schnitzel with sour cream dill sauce. German potato salad was substituted for potato salad. Review of temperature logs, located in the kitchen, showing the temperature of the items prior to serving the lunch meal on 2/4/25 showed the following: -Cooking Temperature Log: pork loin 185 degrees F, potato salad 45 degrees F, spinach salad 40 degrees F, cooked spinach 177 degrees F; -Mechanical Soft Temperature Log: meat 170 degrees F, starch 166 degrees F, vegetable 165 degrees F, bread 160 degrees F, dessert RT (room temperature); -Puree Temperature Log: meat 170 degrees F, starch 167 degrees F, vegetable 166 degrees F, bread 160 degrees F, dessert RT. Observation on 2/4/25 from 12:14 P.M. to 12:29 P.M., in the kitchen at the steam table, showed [NAME] L and [NAME] Z served mechanical soft and pureed diet food items onto residents' plates, added a plate cover to each plate, and placed the food items onto trays. Staff then placed the meal trays onto metal tray carts to go to the upstairs dining rooms. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 2/4/25 at 12:32 P.M., in the kitchen at the steam table, showed [NAME] Z plated a test tray of mechanical soft and pureed food items after all residents had been served. He/She placed the test tray on the cart staff took to the east dining room. Observation on 2/4/25, in the east dining room, at 12:34 P.M., showed staff served trays off the meal tray cart (that arrived from the kitchen) to residents with mechanical soft and pureed diets. At 12:39 P.M., staff finished serving all resident from the cart. Observation at 12:40 P.M., of the temperature of the food items on the test tray showed the following: -Mechanical soft potato salad was 61.2 degrees Fahrenheit (F) and tasted warm; -Pureed potato salad was 89.1 degrees F and tasted lukewarm; -Pureed spinach was 108.7 degrees F and tasted cool; -Chopped (mechanical soft) spinach was 105.8 degrees F and tasted cool; -Mechanical soft pork loin was 110.7 degrees F and tasted cool; -Pureed pork loin was 111.2 degrees F and tasted cool. During an interview on 2/4/25 at 2:35 P.M., Resident #36 said he/she preferred to eat in his/her room. About three times a week, the food was medium in temperature. He/She preferred hot foods to be hot and cold foods to be cold. During interview on 2/4/25 at 2:49 P.M., the Dietary Manager said the following: -He expected hot foods to be served to residents at a temperature of at least 135 degrees F and cold foods at less than 40 degrees F; -He expected staff to take temperatures of food items during and after cooking, before and during serving food, and to log the temperatures in the food temperature log books. 44665

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 30813 32899 44665 Based on observation, interview, and record review, staff failed to store, prepare, and serve food in accordance with professional standards for food service safety. Staff did not securely seal, label, date, store per manufacturer's instructions, or properly thaw food items in order to prevent potential contamination. Staff did not practice proper hand and glove hygiene, hair restraint usage, and consumption of personal food and beverage items. Staff did not maintain surfaces and equipment to be free from a buildup of grease and debris or demonstrate proper surface sanitization procedures and knowledge of chemical sanitizer levels. Staff did not ensure dishes and utensils were stored and handled in a sanitary manner. Staff failed to ensure an air gap was present at the facility's ice machine drains to prevent possible backflow from the drain back into the ice machines. The facility census was 71. 1. Observation on 2/3/25 at 10:38 A.M., in the kitchen reach-in freezer, showed a box of catfish nuggets did not have the inner plastic securely sealed around the nuggets. Observation on 2/4/25 at 8:29 A.M., on the kitchen spice shelf, showed the following: -An open, unrefrigerated bottle of lemon juice, with a label that read 'Refrigerate after opening'; -An open, unrefrigerated bottle of chocolate syrup, with a label that read 'Refrigerate after opening'. Observation on 2/3/25 at 1:34 P.M., near the kitchen, showed the following: -Four pork loins thawed in a tray in the walk-in cooler. The pork loins hung over the sides of the tray by 2 inches on one side and were not completely contained in the tray; -A box of chocolate chips in the walk-in freezer had the inner bag not securely sealed. Observation on 2/4/25 at 8:35 A.M., in a reach-in cooler in the kitchen, showed a box of sausage patties did not have the inner plastic sealed and the box flaps were open. Observation on 2/3/25 at 1:56 P.M., in the Gardens Special Care Unit (SCU) kitchenette refrigerator, showed the following: -An undated pan of mixed fruit; -An undated stack of approximately 30 cheese slices; -An unlabeled and undated unknown food item wrapped in foil; (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-An undated grease stained fast food bag of unknown food items with the first name of a person written on the bag. During an interview on 2/4/25 at 2:49 P.M., the Dietary Manager said food items should be stored in a safe and sanitary manner. Food should be sealed, labeled, dated, and stored per label instructions. Raw meats should thaw in a large enough container so as not to overhang over the edge of the container. During an interview on 2/4/25 at 4:49 P.M., the Administrator said she expected food to be stored, served, and prepared in a safe and sanitary manner. 2. Observation on 2/3/25 at 10:42 A.M., showed Dietary Aide K finished using the food processor to prepare resident food items for the lunch meal service. When he/she moved the food processor machine, an approximate 6-inch by 6-inch area of black oily substance remained on the preparation counter. Dietary Aide N wiped the area with a cloth and placed the soiled cloth in the red bucket of sanitizing solution. Approximately 75% of the cloth was soiled with the black residue. Observation on 2/4/25 at 10:13 A.M., showed a red bucket of sanitizing solution with a cloth inside was discolored brown across 25% of the cloth's surface and was not fully submerged in the solution. A green bucket sat next to the red bucket and a moist cloth lay resting between the two buckets and was not submerged fully in either solution. During an interview on 2/4/25 at 1:09 P.M., Dietary Aide N said cloths in the sanitizer solution in the red bucket should be fully submerged. Staff should change the sanitizing solution every 1.5 hours and test the solution with a chemical test strip. He/She was unsure what the chemical level of the sanitizer should be. During an interview on 2/4/25 at 2:49 P.M., the Dietary Manager said the red buckets in the kitchen contained sanitizing solution and the green buckets contained soapy water. Staff should change the sanitizing solution every two hours, or as needed, test the chemical level of the solution, and record the value in the sanitizer log book. Sanitizer cloths should be fully submerged in the solution and changed when visibly soiled. Record review of the Sanitizing Bucket Chemical Log, located on the preparation counter by the spice shelf in the kitchen, showed the following: -A log sheet indicated values of 100 PPM for July 25, July 29-31, August 1-5, and August 18-22 of an unidentified year. No entries were completed for July 26-28 or August 6-17 on the sheet; -A second log sheet indicated a value of 300 PPM (lunch) and 400 PPM (dinner) for 3/5/24. Values of 400 PPM were filled in for lunch and dinner on 3/7/24. No entries were completed for breakfast for 3/5/24 or 3/7/24. No other entries for March 2024 were completed; -No documentation showing sanitizer chemical levels were logged for 3/8/24 to current date. 3. Observation on 2/3/25 at 1:34 P.M., near the kitchen, showed the walk-in cooler and walk-in freezer had an excess accumulation of a brownish-red residue, trash, and dried food debris on the floor underneath the shelves. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Observation on 2/3/25 at 11:46 A.M., in the kitchen, showed two of the eight range hood baffle filters, located above the fryer had a heavy accumulation of yellow grease with fuzzy debris. Observations on 2/3/25 from 1:35 P.M. to 2:37 P.M., during the dietary and sanitation tour of the facility, showed the following: -In the Gardens SCU, sticky brown residue and bits of yellow food debris were visible on the bottom interior of the kitchenette refrigerator. A white residue coated 25% of the ice machine's interior surface and a brown residue was visible along the outer edge of the door opening of the ice machine. Heavy dust and debris was visible on the front lower vent of the ice machine. Discarded cups, paper towels, and a brown residue were visible on the floor behind and below the ice machine. In the cabinet drawer next to the ice machine, there was an ice cream scoop with bits of brown dried debris on the food contact surface of the scoop. The scoop lay on the surface of the drawer which was speckled black; -In the Helping Hands Dining Room, brown sticky residue was on the floor by the refrigerator and the refrigerator's interior bottom surface had a dried pink and yellowish residue on it; -In the [NAME] dining room, the floor was sticky. Observations on 2/4/25 at 8:14 A.M., in the kitchen, showed a heavy accumulation of black fuzzy debris on a 2-foot by 3-foot wall vent located by the upright warming oven. The floor behind and under the convection oven, fryer, stoves, and steamers had a heavy accumulation of food debris, trash, wadded foil, a thermometer, paper towels, and an oily residue coated the floor and legs of cooking appliances in this area. The upright warming oven had approximately 75% of the glass surface coated with dried food drips and the door seal was warped and missing pieces of the seal across 25% of the seal's surface. The interior and exterior metal surfaces and glass doors of the convection oven had a moderate accumulation of dried brown and black residue. Grease and food debris speckled the surface of the convection oven by the fryer. Three of six burners on the 6-burner stove had a heavy black encrusted debris buildup and one of two burners on the 2-burner stove/griddle unit had a heavy black encrusted debris buildup. Observations on 2/4/25 at 9:26 A.M., in the east dining room, showed dried food debris and splatters on the floor and cove base trim by the steam table. In the nearby kitchenette, cabinets contained loose cereal, dead insects resembling cockroaches, dried black and brown stains on the interior bottom and sides of the cabinets. One upper shelf contained a thick pink residue on the shelf's surface. A plastic bag, cups, straws, and various items sat on a heavily soiled lower cabinet. Inside the ice machine there was a moderate accumulation of white and light brown staining. Below and behind the ice machine, there was an excess accumulation of trash and debris including cup lids, spoons, cups, paper towels, and plates. During an interview on 2/4/25 at 2:49 P.M., the Dietary Manager said the following: -He expected the range hood baffle filters to be free from an excess buildup of grease and debris. A company came to clean the filters every six months and they were due to come soon; -Dietary staff did not clean the filters because the company said the filters were very sharp and not easily able to be removed without a special tool; (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-Staff swept and mopped the middle walkways of the walk-in cooler and freezer but it had probably been awhile since the floors under the shelves in the walk-in units had been cleaned; -The floors under the stoves and cooking appliances were last cleaned in September when a company came to clean them. 4. Observation on 2/3/25 at 9:00 A.M., in the kitchen, showed Dietary Aide K drank from his/her personal beverage then wiped his/her hands on a paper towel and put on gloves. He/She did not wash his/her hands prior to putting on gloves and served fruit crisp for the lunch meal into bowls on the food preparation counter. Observation on 2/3/25 at 9:10 A.M., in the kitchen, showed Dietary Aide N put a glove on his/her left hand and used his/her right bare hand to move spices, a jug of oil, and a bag of bread. Without washing his/her hands or changing his/her gloves, he/she donned a glove on his/her right hand and used his/her right gloved hand to grasp shredded lettuce from a bag and place the lettuce into bowls. Observation on 2/3/25 from 9:13 A.M. to 9:30 A.M., in the kitchen, showed the following: -Cook L washed his/her hands and turned off the faucet handle with his/her clean hands; -He/She wore a hat and had 3-inch long hair on his/her head that was exposed and not covered by the hat and had approximately 1-inch long facial hair that was not covered with a hair restraint; -He/She removed his/her hat, put his/her hat back on, scratched his/her elbow, rubbed the bottom of his/her neck, and touched his/her necklace and shirt with his/her clean hands; -Without washing his/her hands, he/she went to the dry storage room and brought back a bag of macaroni and laid it on the food preparation counter; -He/She poured a cup of coffee, walked across the kitchen drinking the coffee, and sat the coffee down on the food preparation counter; -He/She picked up and drank from the cup of coffee on the food preparation counter, took a soiled cutting board to the dish room, touched his/her shirt, and opened a utensil drawer to obtain a spoon which he/she used to stir food that was cooking on the stove; -He/She went into the dry storage room, removed and replaced his/her hat, obtained a new box of food service film, and returned with the film to the kitchen food preparation counter; -He/She washed his/her hands for approximately 10 seconds and turned off the faucet with his/her clean hands and pulled up his/her pants as he/she walked around the kitchen; -He/She stood by three trays, containing approximately 15 bowls each, of uncovered fruit crisp and five trays, containing approximately 10 bowls each, of uncovered lettuce. All of his/her hair was not covered with a proper hair restraint. Observation on 2/3/25 at 9:32 A.M., in the kitchen, showed the following: (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-Cook L used his/her bare hands to pick pieces of raw meat left in the three-compartment sink, placed them in a tub and carried it to the dishwashing room; -He/She washed his/her hands, turned off the faucet with his/her clean hands, and used the paper towels from drying his/her hands to wipe the food preparation counter located by the food processor; -He/She went into the dietary manager's office, touched his/her shirt, donned gloves, and opened the cooler door, obtained three eggs, and placed the eggs on a box of open disposable gloves on the food preparation counter; -He/She opened the cooler door and obtained two slices of bacon and placed them on the griddle; -He/She washed his/her hands and turned off the faucet with his/her clean hands and used his/her bare hands to move one of the eggs from the box of disposable gloves and placed the egg on a roll of blank food labels; -Without washing his/her hands, he/she put a glove on his/her right hand and use his/her right gloved hand to obtain slices of bread from a bag and put the slices on the griddle; -He/She removed and replaced his/her hat on his/her head and drank from the coffee cup on the preparation counter and continued to prepare food at the griddle for the breakfast meal service. Observation on 2/3/25 at 10:25 A.M., in the kitchen showed Dietary Aide K used his/her gloved hands to touch the inside portion of a trash bag (located in a trash can) and swept food debris into the trash can. He/She removed his/her gloves, did not wash his/her hands, and used a cloth from a green bucket of soapy water and wiped the food preparation counter. He/She carried his/her phone and personal drink to the food preparation area and put his/her phone upside down on the food preparation counter and played music. He/She went to the hand washing sink, turned on the faucet and used his/her hands to put water on his/her facial hair and wiped his/her facial hair with a paper towel. He/She did not wash his/her hands, went to the food preparation counter, and rested his/her palm on the surface of the food preparation counter. Observation on 2/3/25 at 10:36 A.M., in the kitchen, showed Dietary Aide O obtained a carton of chocolate milk from the cooler, walked to the food preparation counter, and drank the milk while leaning on the food preparation counter. Observation on 2/4/25 at 8:10 A.M., showed the Dietary Manager and Dietary Aide N prepared plates of food for residents during the breakfast meal service at the food preparation and serving area in the kitchen. Both the Dietary Manager and Dietary Aide N had approximately 3-inch long facial hair and were not wearing hair restraints as they served food from the steam table and griddle. During an interview on 2/4/25 at 12:59 P.M., [NAME] Z said staff should wash their hands by wetting their hands, applying soap, singing the happy birthday song three times, and using a paper towel to turn off the faucet handle. Staff should wash their hands when they remove their gloves, touch themselves, and after completing dirty tasks. During an interview on 2/4/25 at 1:09 P.M., Dietary Aide N said staff should eat and drink personal food and beverage items in the break room. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 2/4/25 at 2:49 P.M., the Dietary Manager said the following: -Staff should not eat, drink, or use their cell phones in food preparation areas; -Staff should wash their hands after touching dirty items such as trash cans; after touching their self, clothing, or hair restraint; after changing their gloves; and before conducting clean tasks; -Staff changing their gloves did not substitute the need for them to wash their hands; -After washing their hands, staff should use a paper towel rather than their clean hands to turn off the faucet handle; -Staff should not handle ready-to-eat (RTE) food items with soiled gloves and should protect RTE food from contamination; -Staff should wear hair restraints properly with all hair secured to prevent potential contamination of food. He was unsure of what beard length required a hair restraint but head hair that went below the ears should be covered. 5. Observation on 2/3/25 at 10:02 A.M., in the kitchen, showed Dietary Aide O washed his/her hands, put on one glove, rubbed his/her nose, and put on the other glove. He/She put clean trays on a three-tiered cart and pushed the cart of trays to the preparation counter where he/she touched meal tickets, clean napkins, and clean silverware by the eating surface of the silverware and placed the silverware on napkins on the trays. Observation on 2/3/25 at 10:59 A.M., in the kitchen, showed Dietary Aide N pureed food for the lunch meal service at the food processor machine located near the three compartment sink. He/She used the spray nozzle at the three-compartment sink to spray out the food processor container after pureeing green beans. He/She then used the container to puree milk and slices of bread. Observation on 2/4/25 at 8:14 A.M., in the kitchen, showed the clean dish and pan storage areas located under the food preparation tables had dried white residue and several bits of food debris and encrusted debris visible. The clean container storage area, located on a three-tier metal wire shelf, showed four containers that were not inverted or covered. A large fan had a moderate accumulation of dust and debris on the wire guard and fan blade and was pointed towards the clean dish storage area. In the utensil drawers, there were dried bits of food debris in the bottom of the drawers. Multiple utensils and food scoops had dried, crusted food debris and white residue on the food surface of the utensils and scoops. During an interview on 2/4/25 at 2:49 P.M., the Dietary Manager said the following: -He expected dishware and utensils to be in good condition, stored clean, and for staff to handle them by the non-eating surfaces of those items; -Staff should properly clean and sanitize dishes and should not just spray them off in the three-compartment sink. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	5. Review of the Food and Drug Administration Food Code, dated 2013, showed an air gap between the water supply inlet and the flood level rim of the plumbing fixture or equipment shall be at least twice the diameter of the water supply inlet and may not be less than one inch. Observation on 2/3/25 at 2:05 P.M., of the Gardens SCU ice machine, showed the machine's drain did not contain an air gap. A 3-foot long 1-inch diameter PVC pipe connected to the ice machine drain and continued through the wall to an adjoining resident room (it was not visible when viewed from the resident room side). Approximately 6 inches from the ice machine drain, a 3-foot vertical 1-inch diameter PVC pipe extended upward and was located along the 3-foot horizontal drain PVC pipe. Observation on 2/4/25 at 9:26 A.M., of the east kitchenette ice machine, showed there was no air gap at the drain. A 1-inch diameter 3-foot long flexible drain hose went from the ice machine drain to a 1-inch diameter 3-foot long PVC pipe that that went to another flexible pipe through the wall and was not visible on the other side of the wall. During an interview on 2/5/25 at 10:08 A.M., the Maintenance Supervisor said the following: -The ice machines at the facility were rented from a company; -The rental company preferred to maintain the ice machines including the ice machine drains; -He expected the ice machines to have an appropriate drain air gap and assumed they did. During an interview on 2/4/25 at 9:50 A.M., the Administrator said she expected there to be an air gap at the drain to prevent potential back flow from the drain back into the machine and was unaware that the ice machines did not contain an air gap.

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Beth Haven Nursing Home	2500 Pleasant Street Hannibal, MO 63401

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Dispose of garbage and refuse properly. 30813 44665 Based on observation and interview, the facility failed to ensure lids on outdoor garbage and grease collection containers remained closed or covered when not in use. The census was 71. Observations on 2/3/25 at 3:38 P.M., during the outside sanitation tour near the basement service hall area, showed the following: -A dumpster, approximately 25% full of trash, did not have a lid on the top and front of the dumpster; -A grease container, approximately 90% full of grease, had a lid that hung off to the side of the container. The lid read Grease only. Close lid. A water bottle floated on the surface of the grease in the container. Black and light gray residue was visible on the grass in an approximate 4-foot by 20-foot area around and downhill of the grease container; -No staff were present or actively working in the area where the dumpster and grease container were located. During interview on 2/4/25 at 2:49 P.M., the Dietary Manager said the outside dumpster never had lids. He was unaware the outside grease collection container lid was not covering the opening of the container. During an interview on 2/4/25 at 4:49 P.M., the Administrator said the facility changed garbage disposal companies and received a new dumpster. She was unaware the new dumpster did not have the ability to close the top and front openings of the dumpster. A contracted company came periodically to empty the grease collection container.

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F 0851 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Electronically submit to CMS complete and accurate direct care staffing information, based on payroll and other verifiable and auditable data. 32899 Based on interview and record review, the facility failed to electronically submit to Centers for Medicare and Medicaid Services (CMS), a complete and accurate direct care staffing information to the Payroll Based Journal (PBJ) data from 07/01/24 through 09/30/24. The facility census was 71. 1. Review of the CMS PBJ Staffing Data Report, dated 1/28/25, showed the facility did not report staffing data for the period of 07/01/24 through 09/30/24. During an interview on 2/5/25 at 2:50 P.M., the Administrator said the following: -The facility had not been submitting their PBJ information; -The last person responsible for submission was the payroll clerk who had since left employment; -Their payroll service was responsible for submitting the PBJ for them once the contract began.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30813 Based on observation, interview, and record review, the facility failed to ensure staff washed their hands after each direct resident contact and when indicated by professional standard of practice during personal care for four residents (Residents #43, #66, and #5 and #175), and during medication pass for one resident (Resident #25), in a review of 18 sampled residents. The facility failed to ensure three different staff properly performed infection control procedures when they did not clean the tips of insulin pens prior to applying a needle cap and administering insulin to three residents (Residents #22, #20 and #4). The facility failed to complete, or have documentation of, a two step, or prior two step Tuberculin Skin Tests (TST) as required to rule out Tuberculosis (TB) (a communicable disease that affects the lungs characterized by fever, cough, and difficulty breathing), failed to complete annual TB testing as required and failed to document the results of that testing in the appropriate millimeters (mm) for eight of ten sampled employees before compensation. The facility failed to develop specific control parameters for addressing Legionella (a bacterium that can cause a serious type of pneumonia in persons at risk), based on Center for Disease Control (CDC) and American Society of Heating, Refrigerating, and Air Conditioning Engineers (ASHRAE) standards and failed to complete a facility assessment. The facility did not have an active water management team, detailed water flow map, and did not implement the facility's Legionnaire Disease (severe pneumonia like infection caused by contaminated water) policy that instructed staff how to monitor residents for Legionnaire's disease. The facility census was 71. Review of the facility's policy, Handwashing/Hand Hygiene, dated 2001 and revised August 2019, showed the following: -This facility considers hand hygiene the primary means to prevent the spread of infections; -All personnel shall follow the handwashing/hand hygiene procedures to help prevent the spread of infections to other personnel, residents and visitors; -Wash hands with soap (antimicrobial or non-antimicrobial) and water for the following situations: when hands are visibly soiled and after contact with a resident with infectious diarrhea including, but not limited to infections caused by norovirus, salmonella, shigella and C. difficile; -Use an alcohol-based hand rub containing at least 62% alcohol; or, alternatively, soap (antimicrobial or non-antimicrobial) and water for the following situations: before and after coming on duty; before and after direct contact with residents; before preparing or handling medications; before performing any non-surgical invasive procedures; before and after handling an invasive device (e.g., urinary catheters, IV access sites); before donning sterile gloves; before handling clean or soiled dressing, gauze pads, etc.; before moving from a contaminated body site to a clean body site during resident care; after contact with a resident's intact skin; after contact with blood or bodily fluids; after handling used dressings, contaminated equipment, etc.; after contact with objects (e.g., medical equipment) in the immediate vicinity of the resident; after removing gloves; before and after entering isolation precaution settings; before and after eating or handling food; before and after assisting a resident with meals and after personal use of the toilet or conducting your own personal hygiene; (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-Hand hygiene is the final step after removing and disposing of personal protective equipment; -The use of gloves does not replace hand washing/hand hygiene. Integration of glove use along with routine hand hygiene is recognized as the best practice for preventing healthcare-associated infections. Review of the facility policy, Personal Protective Equipment - Using Gloves, dated 2001 and revised July 2009, showed the following: -Gloves must be worn when handling blood body fluids, secretions, excretions, mucous membranes and /or non-intact skin; -Gloves shall be used only once and discarded into the appropriate receptacle located in the room in which the procedure is being performed; -The use of gloves will vary according to the procedure involved. The use of disposable gloves is indicated: when it is likely that the employee's hands will come in contact with blood, body fluids, secretions, excretions, mucous membranes, and/or non-intact skin [NAME] performing the procedure; when the employee has any cuts, wounds or scrapes on his or her hands; when the employee's hands are chapped or have a skin rash or skin condition; when handling soiled linen or items that may be contaminated; during instrumental examination of oropharynx, gastrointestinal tract and genitourinary tract; when examining abraded or non-intact skin or patients with active bleeding; during invasive procedures and during all cleaning of blood, body fluids and decontaminating procedures; -Wash your hands after removing gloves; -Remove gloves before removing the mask and gown and discard them into the designated waste receptacle inside the room. 1. Review of Resident #43's annual Minimum Data Set (MDS), a federally mandated assessment instrument, dated 12/6/24, showed the following: -Required moderate assistance of staff for personal hygiene and dressing; -Resident was dependent on staff for toileting; -Occasionally incontinent of bowel and bladder. Review of the resident's undated care plan showed the following: -He/She had impaired activities of daily living (ADL) performance related to dementia; -He/She was incontinent of bowel and bladder; -Help him/her with each incontinence episode. Observation on 2/4/25 at 7:33 A.M. showed the following: (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-Certified Nurse Assistant (CNA) A entered the resident's room, did not wash his/her hands, put on gloves, retrieved the resident's clothes from the closet and hung them in the bathroom; -CNA A assisted the resident to walk to the bathroom; -CNA A pulled down the resident's pants and soiled incontinence brief and the resident sat on the toilet; -The resident was incontinent of urine and feces; -CNA A removed the resident's pants, socks and slippers and placed them in a plastic bag; -CNA A pulled disposable wipes from the container and wiped feces from the back of the resident's lower left leg; -Without changing his/her gloves, CNA A ran the resident's legs through the leg openings of a clean incontinence brief and pants, changed the resident's shirt, pulled seven disposable wipes from the wipes container, laid them on top of the container, and assisted the resident to stand; -CNA A cleaned the resident's rectal and gluteal crease area with wipes; -Wearing the same gloves, CNA A pulled up the resident's incontinence brief and pants and adjusted the resident's shirt; -CNA A removed his/her gloves, and without washing his/her hands, picked up the resident's hair brush, wet the brush with water and combed the resident's hair, and assisted the resident to the dining room. 2. Review of Resident #46's annual MDS, dated [DATE], showed the following: -Dependent on staff for toileting and personal hygiene; -Always incontinent of bowel and bladder. Review of the resident's care plan, last reviewed 12/27/24, showed the following: -He/She was at risk for decline in his/her ADLs related to my recent left hip fracture and other comorbid conditions; -He/She needed extensive assistance with toileting; -He/She was occasionally incontinent of bladder. He/She needed assist with toileting. Observation on 2/4/25 at 8:15 A.M., showed the following: -CNA A entered the resident's room, did not wash his/her hands, put on gloves and selected the resident's clothes for the day; (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-CNA A walked with the resident to the bathroom; -CNA A pulled down the resident's urine-soaked incontinence brief, assisted the resident to sit on the toilet, and removed the soiled incontinence brief; -Wearing the same gloves, CNA A picked up a clean incontinence brief and pants and ran the resident's legs through the leg openings. CNA A changed the resident's shirt, assisted the resident to stand, cleaned the resident's gluteal crease with disposable wipes, pulled up the resident's clean incontinence brief and pants, opened the door to the resident's room and walked with the resident to the dining room. During interview on 2/4/25 at 2:48 P.M., CNA A said staff should change their gloves when going from front to back during peri care. He/She should wash hands between glove changes and when finished with providing care. 3. Review of Resident #5's annual MDS, dated [DATE] showed the following: -Dependent on staff for toileting and personal hygiene; -Always incontinent of bowel and bladder; -Diagnoses included dementia. Review of the resident's care plan, last revised 1/15/25, showed the following: -Impaired mobility and incontinence; -Change after incontinent episodes. Observation on 2/4/25 at 7:45 A.M. showed the following: -CNA Q entered the resident's room and without washing his/her hands, put on gloves; -CNA Q washed the resident's upper body with a washcloth and then picked up a clean incontinence brief and laid it on the bed; -CNA Q un-taped the resident's urine soiled incontinence brief and pulled it down. He/She washed the resident's front peri-area; -CNA Q wiped feces from the resident's rectum area, pulled the soiled incontinence brief from under the resident, and placed it in the trash; -Without removing his/her gloves, CNA Q touched the resident's hip and back and assisted the resident to roll in bed; -CNA Q removed his/her gloves and exited the room without washing his/her hands. During an interview on 2/4/25 at 1:15 P.M., CNA Q said the following: (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-He/She should wash his/her hands upon entering the resident's room, when his/her hands were soiled, when changing changes and after providing perineal care; -He/She should change his/her gloves when they were soiled. 4. Review of Resident #175's admission MDS, dated [DATE] showed the following: -Supervision to touch assist with personal hygiene; -Substantial to maximum assist with toileting; -Frequently incontinent of bladder. Review of the resident's care plan, last revised 1/30/25, showed the following: -Incontinent of bladder; -Cleanse skin as needed. Observation on 2/4/25 at 8:06 A.M. showed the following: -CNA R entered the resident's room and without washing his/her hands, put on gloves; -The resident lay in bed on a bed pan; -CNA R removed the urine filled bed pan, emptied it in the bathroom, and then cleaned urine from the resident's buttocks; -Without removing his/her gloves and performing hand hygiene, CNA R applied a gait belt around the resident and assisted the resident to his/her chair; -CNA R removed his/her gloves, and without washing his/her hands, made the resident's bed and exited the room. During an interview on 2/4/25 at 1:25 P.M., CNA R said the following: -He/She should wash before providing care, when he/she changed his/her gloves, after providing care and before exiting the room; -He/She should change gloves when they were soiled. During an interview on 2/6/25 at 11:37 A.M., the Director of Nursing (DON) said the following: -He/She expected staff to wash or sanitize their hands before providing care, when their hands were soiled, and when changing their gloves; -Staff should change their gloves when the gloves were visibly soiled, between tasks, when moving from dirty to clean areas/tasks, and in between residents; (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-She would not expect staff to touch clean surfaces/items with soiled hands/gloves. 5. Review of the facility's policy, Administering Medications, last revised April 2019, showed staff should follow the facility's established infection control procedures (e.g., handwashing, antiseptic technique, gloves, isolation precautions, etc.) for the administration of medications. 6. Review of Resident #25's Physician Order Sheet (POS), dated February 2025, showed the following: -Amlodipine besylate (a medication used to treat high blood pressure) 10 milligrams (mg) one-half tablet daily; -Coreg (a medication used to treat high blood pressure) 3.125 mg two times daily; -Losartan potassium (a medication used to treat high blood pressure) 50 mg daily; -Meloxicam (a medication used to relieve the symptoms of arthritis) 7.5 mg daily with food; -Myrbetriq (a medication used to treat overactive bladder) 25 mg daily; -Vitamin D (a dietary supplement) 50 micrograms (mcg) daily. Observation on 2/3/25 at 8:10 A.M., showed Licensed Practical Nurse (LPN) B prepared the resident's morning medications for administration. When removing the resident's Myrbetriq from the plastic strip packaging, the tablet fell on to the laptop computer on the medication cart. LPN B put a glove on his/her right hand, picked up the pill and placed the pill in the medication cup with the rest of the resident's morning medications. LPN B administered all the medications to the resident. During interview on 2/4/25 at 2:55 P.M., LPN B said the medication cart should be a clean surface. If a pill dropped on the medication cart, then he/she could pick it up wearing gloves and still administer it to the resident. LPN B said he/she did not clean the laptop computer prior to starting the medication pass. He/She should have destroyed the pill that fell on to the laptop. 7. Review of the facility policy, Insulin Administration, revised September 2014, showed staff was to disinfect the top of the vial with an alcohol wipe. There were no specific instructions for insulin pen use. 8. Review of Resident #4's February 2025 Physician Order Sheets (POS) showed the resident had orders for the following: -Lispro Insulin, six units (U) subcutaneously (subq) (injection to be given in the fatty tissue) three times daily; -Lispro per sliding scale (an amount of medication to be determined based on the blood glucose result), one unit for blood glucose readings of 150 - 199. Review of the manufacturer's instructions for Lispro Insulin (fast-acting insulin to treat diabetes) Pen showed the following: (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-Step 1: Pull the pen cap straight off; Wipe the rubber seal with an alcohol swab; -Step 3: Select a new needle; Pull off the paper tab from the outer needle shield; -Step 4: Push the capped needle straight onto the pen and twist the needle on until it is tight. Observation on 02/03/25 at 4:38 P.M. showed the following: -Certified Medication Technician (CMT) H removed a Lispro insulin pen and needle cap from the medication cart; -CMT H removed the insulin pen cap, did not clean the tip of the insulin pen with alcohol, and screwed the needle cap on the insulin pen; -CMT H checked the resident's Dexacom Continuous Glucose Monitoring Device (a wearable device that measures blood glucose levels) that showed the resident's blood glucose level was 170; -With bare hands, CMT H cleaned the resident's abdominal injection site with an alcohol pad, placed the insulin pen against the resident's abdomen to begin to administer the resident's ordered insulin; -The Infection Preventionist walked by and stopped CMT H from administering the insulin and instructed him/her to apply gloves. During an interview on 02/03/25 at 4:42 P.M., CMT H said he/she did not know he/she was to clean the tip of the insulin pen prior to applying the needle cap. He/She should always wear gloves when administering insulin. He/She just forgot to apply them. 9. Review of Resident #22's February 2025 POS showed the resident had an order for Humalog 75/25 Insulin, 40 U subq in the evening. Review of the Humalog 75/25 Insulin (mixture of fast-acting and longer-acting insulin to treat diabetes) Pen manufacturer's instructions for use showed the following: -Step 1: Pull the pen cap straight off; Wipe the rubber seal with an alcohol swab; -Step 5: Select a new needle; Pull off the paper tab from the outer needle shield; -Step 6: Push the capped needle straight onto the pen and twist the needle on until it is tight. Observation on 02/03/25 at 4:50 P.M. showed the following: -LPN P removed a Humalog 75/25 insulin pen and needle cap from the medication cart; -LPN P removed the insulin pen cap and without cleaning the tip of the insulin pen with alcohol, screwed the needle cap on the insulin pen; -LPN P then administered the resident his/her ordered insulin. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 02/03/25 at 5:00 P.M., LPN P said he/she knew to clean the tip of the insulin pen with alcohol before screwing the needle cap on; he/she had just forgotten to do so. 10. Review of Resident #20's February 2025 POS showed the resident had an order for Lispro (fast-acting insulin to treat diabetes) seven U sub three times daily. Observation on 02/03/25 at 5:15 P.M. showed the following: -CMT W removed a Lispro insulin pen and needle cap from the medication cart; -CMT W removed the insulin pen cap and without cleaning the tip of the insulin pen with alcohol, screwed the needle cap on the insulin pen; -CMT W then administered the resident his/her ordered insulin. During an interview on 02/03/25 at 5:20 P.M., CMT W said he/she did not usually clean the tip of the insulin pen prior to applying the needle cap. During an interview on 02/04/25 at 3:05 P.M., the DON said she expected staff to clean the tips of insulin pens with an alcohol pad prior to applying the needle cap and staff should wear gloves when administering injections. 11. Review of the Department of Health and Senior Services Tuberculosis Screening for Long-Term Care Facility Employees Flowchart (based on the requirements identified in the state regulation for administering TB testing), updated 03/11/14, showed the following: -Administer TST first step prior to employment. (Can coincide reading the results with the employee start date by administering TST two to three days prior to the employee start date); -Read results of first step TST within 48-72 hours of administration (results must be read and documented in millimeters (mm) induration prior to or on the employee start date); -If first TST is negative, administer second step within 1-3 weeks; -Read results within 48-72 hours of administration; -The employee cannot start work for compensation until the first step TST is administered and read. Review of the Missouri Department of Health Infection Control Guidelines for Long Term Care Facilities, dated January 2020, showed the following: -The following occupationally-exposed persons should be tested at least annually include, all employees, attending physicians and dentist, volunteers who spend more than 10 hours a week in the facility, and nursing and allied health personnel; -Provide a tuberculin skin test (PPD) to all employees during pre-employment procedures; (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-The Department of Health rule states employees will be skin tested on an annual basis as a means of surveillance within a facility. 12. Review of LPN I's employee file showed the following: -His/Her date of hire was 09/18/24 (compensation began on this date); -First step TST administered on 09/18/24 and read on 09/20/24. Staff documented the results as negative (-) and did not document in mm of induration; -Second step TST administered on 10/02/24 and read on 10/04/24. Staff documented the results as negative (-) and did not document the results in mm of induration; (The employee received compensation before the first step TST was administered and read and the results were not documented appropriately.) 13. Review of the Social Service Director's employee file showed the following: -His/Her date of hire was 01/24/24; -No documentation of a previous two step TST; -An annual TST was administered on 02/12/24 and read on 02/14/24. Staff documented the results as 0 and did not not document in mm of induration; -No documentation of an annual TST in January of 2025; (The employee received compensation without proof of a prior two step TST. Staff did not document the results of his/her 2024 annual TST properly, and did not ensure he/she received an annual TST in January 2025.) 14. Review of CNA Y's employee file showed the following: -His/Her date of hire was 05/25/23; -No documentation of a previous two step TST; -An annual TST was administered on 02/19/24 and read on 02/22/24. Staff documented the results as 0 and did not document in mm of induration; -No documentation of an annual TST in January of 2025; (The employee received compensation without proof of a prior two step TST. Staff did not document the results of his/her annual 2024 TST properly, and did not ensure he/she received an annual TST in January 2025.) 15. Review of Dietary Aide AA's employee file showed the following: (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-His/Her date of hire was 08/23/24; -First step TST administered on 08/23/24 and read on 08/26/24. Staff documented the results as negative (-) and did not document in mm of induration; -Second step TST administered on 09/10/24 and read on 09/12/24. Staff documented the results as negative (-) and did not document in mm of induration; (The employee received compensation before the first step TST was administered and read, and staff did not properly document the results in mm of induration.) 16. Review of the Housekeeping/Beautician Staff's employee file showed the following: -His/Her date of hire was 11/24/23; -No documentation of a first step or second step TST; -No documentation of an annual TST, previous or current; -The employee received compensation before TB testing. 17. Review of the Receptionist's employee file showed the following: -His/Her date of hire was 04/10/24; -First step TST administered on 04/10/24 and read on 04/12/24. Staff documented the results as negative (-) and did not document the results in mm of induration; -Second step TST administered on 04/18/24 and read on 04/20/24. Staff documented the results as negative (-) and did not document the results in mm of induration. (The employee received compensation before the first step TST was administered and read, and staff did not properly read the results in mm of induration.) 18. Review of the CMT W's employee file showed the following: -His/Her date of hire was 03/08/24; -No documentation of a first step or second step TST; -Annual TST administered on 03/05/24 and read on 03/07/24. Staff documented the results as 0 and did not document the results in mm of induration. (The employee received compensation without proof of a prior two step TST. Staff did not properly document the results on his/her 2024 annual TST and did not ensure he/she received an annual TST in January 2025.) 19. Review of the CMT BB's employee file showed the following: (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-His/Her date of hire was 01/26/24; -No documentation of a previous two step TST; -An annual TST was administered on 01/20/24 and read on 01/22/24. Staff documented the results as 0 and did not document in mm of induration; -No documentation of an annual TST in January 2025; (The employee received compensation without proof of a prior two step TST. Staff did not properly document the results on his/her 2024 annual TST, and did not ensure he/she received an annual TST in January 2025.) 20. During an interview on 02/04/25 at 3:05 P.M., the Administrator said the following: -The Infection Preventionist (IP) was responsible for administering, reading and reporting the TB test results and was also responsible for tracking the annual TB tests. Annual TB tests were normally given in January and July. There had been recent staff turnover for the IP position and things might be getting missed or not done; -She expected the facility to follow the regulation for TB screenings, administration and documentation; -She was aware the first-step TST should be administered and read prior to the first date of contact with residents. She did not know that this had to be done by the first time of compensation. Staff do not have contact with residents immediately, but they are paid for their orientation, which would be their date of hire. Staff are given their first step TST during orientation. 21. Review of the facility's policy, Legionella Water Management Program, dated 2001 and last revised September 2022, showed the following: -As part of the infection prevention and control program, our facility has a water management program, which is overseen by the water management team; -The water management team consists of at least the following personnel: the infection preventionist, the administrator, the medical director (or designee), the director of maintenance and the director of environmental services; -The purposes of the water management program are to identify areas in the water system where Legionella bacteria can grow and spread, and to reduce the risk of Legionnaire's disease; -The water management program used by our facility is based on the Centers for Disease Control and Prevention and ASHRAE recommendations for developing a Legionella water management program; -The water management program includes the following elements: -a. An interdisciplinary water management team (see above); (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-b. A detailed description and diagram of the water system in the facility, including the following: receiving, cold water distribution, heating, hot water distribution, and waste; -c. The identification of areas in the water system that could encourage the growth and spread of Legionella or other waterborne bacteria, including the following: storage tanks; water heaters; filters; aerators; showerheads and hoses; misters, atomizers, air washers and humidifiers; hot tubs; fountains; and medical devices such as CPAP machines, hydrotherapy equipment, etc; -d. The identification of situations that can lead to Legionella growth, such as: construction; water main breaks; changes in municipal water quality; the presence of biofilm, scale or sediment; water temperature fluctuations; water pressure changes; water stagnation; and inadequate disinfection; -e. Specific measures used to control the introduction and/or spread of Legionella (e.g., temperature, disinfectants); -f. The control limits or parameters that are acceptable and that are monitored; -g. A diagram of where control measures are applied; -h. A system to monitor control limits and the effectiveness of control measures; - i. A plan for when control limits are not met and/or control measures are not effective and -j. Documentation of the program; -The water management program is reviewed at least once a year, or sooner if any of the following occur: -a. The control limits are consistently not met; -b. There is a major maintenance or water service change; -c. There are any disease cases associated with the water system or -d. There are changes in laws, regulations, standards or guidelines. Review of the Centers for Disease Control and Prevention Legionella Environmental Assessment Form, undated, showed Legionella generally grow well between 77 degrees Fahrenheit (F) and 113 degrees F. The optimal growth range for Legionella is between 85 degrees F and 108 degrees F. Growth slows between 113 degrees F and 120 degrees F, and Legionella begin to die above 120 degrees F. Growth also slows between 68 degrees F and 77 degrees F, and Legionella become dormant below 68 degrees F. 22. Record review of the facility's water temperature log for November 2024 through February 2025 showed staff only checked the temperature of the hot water in areas of the facility. During an interview on 2/4/25 at 11:31 A.M., the Maintenance Director (MD) said the following: -He started as Maintenance Director at the facility in July 2024; (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-He checked water temperatures daily; -He only checked hot water temperatures; he did not check cold water temperatures; -He ensured water temperatures were between 105 degrees F and 120 degrees F; -He did not know anything about Legionella or other water-borne pathogens, or what to monitor to prevent water-borne pathogens; -The facility did not have a water flow map; -He was not aware of a water management team. During an interview on 2/4/25, at 12:17 P.M., the DON/Infection Preventionist (IP) said the following: -She was not aware of a water management team, but the team should consist of the IP and Maintenance Director; -She took over as DON in July 2024 as DON and was the interim IP since January 2025; -There used to be a water management flow map, but she was not sure where it was; -She has not talked to the Maintenance Director about water testing or the Legionella program; -She would have to review for the signs/symptoms to look for related to Legionella since the facility policy changed recently; -The facility had test kits at one time but she did not know where they were now. During an interview on 2/5/25, at 1:59 P.M., the Administrator said the following: -The facility did not officially have a water management team, but the team would include the Maintenance Director, IP, DON and Administrator; -The facility had test kits but was she was unsure where they were located or if the Maintenance Director was aware of them; -The Maintenance Director should test the cold water temperatures as well as the hot water temperatures; -She was not sure the Maintenance Director knew what he should do for the water management program. 32899

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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 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Regularly inspect all bed frames, mattresses, and bed rails (if any) for safety; and all bed rails and mattresses must attach safely to the bed frame. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32899 Based on observation, interview, and record review, the facility failed to complete inspections of bed frames, mattresses, and bed rails as part of regular maintenance program to identify areas of possible entrapment for three residents (Residents #68, #14, and #10), in a review of 18 sampled residents. The census was 71. Review of the Food and Drug Administration (FDA) document, Guide to Bed Safety Rails in Hospitals, Nursing Homes and Home Health Care: The Facts, revised April 2010, shows the potential risk of bed rails may include: -Strangling, suffocating, bodily injury or death when patients or part of their body are caught between rails or between the bed rails and mattress; -More serious injuries from falls when patient climb over rails; -Skin bruising, cuts and scrapes; -Inducing agitated behavior when bed rails are used as a restraint; -Feeling isolated or unnecessarily restricted; -And preventing patients, who are able to get out of bed, from performing routine activities such as going to the bathroom, or retrieving something from a closet. 1. Review of Resident #68's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument to be completed by the facility, dated 1/24/25, showed the following: -Severely impaired cognition; -Dependent on staff for bed mobility, transfers and sitting to lying in bed, lying to sitting in bed and chair/bed-to-chair transfers. Review of the resident's care plan, last revised 1/24/25, showed the following: -Impaired activity of daily living (ADL) performance and mobility status; -Transfer with sit-to-stand or mechanical lifts; -High risk for falls due to cognitive impairment, history of falls and lack of safety awareness; -Place a fall mattress next to my bed when in bed. (No documentation to show the resident had bed rails on his/her bed.) (continued on next page)

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F 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 2/4/25 at at 6:30 A.M. showed the resident lay on his/her back in the bed with 1/4 bed rails in the raised position on both sides of his/her bed. Review of the resident's medical record showed no evidence staff conducted an inspection of the resident's bed frame, mattress, or assist bars to identify areas of possible entrapment. 2. Review of Resident #14's quarterly MDS, dated [DATE], showed the following: -The resident was cognitively intact; -He/She required substantial assistance with rolling from left to right, sitting to lying, and lying to sitting on the side of bed. Review of the resident's care plan, last reviewed 12/30/24, showed the following: -Diagnoses included orthostatic hypotension (a condition where blood pressure drops significantly when a person stands up from a sitting or lying position), muscle weakness, difficulty walking, unsteadiness on feet, spinal stenosis (a narrowing of the spinal canal in the lower part of the back), history of falling, and repeated falls; -He/She was at risk for falls; (No documentation to show the resident had bed rails/mobility bars on his/her bed). Observations on 02/02/25 at 10:29 A.M. and on 02/04/25 at 7:45 A.M., showed the resident lay in his/her bed with mobility bars on both sides of the resident's bed. Review of the resident's medical record showed no evidence staff conducted an inspection of the resident's bed frame, mattress and mobility bars to identify areas of possible entrapment. 3. Review of Resident #10's quarterly MDS, dated [DATE], showed the following: -The resident was cognitively intact; -He/She was dependent on staff for bed mobility. Review of the resident's care plan, last reviewed 01/28/25, showed the following: -Diagnoses included osteoarthritis, joint pain, history of falling, ataxic gait (uncoordinated, awkward way of walking that's caused by poor balance and muscle control), and neuropathic arthropathy (a condition that causes progressive joint destruction and bone weakening); -He/She was at risk for falls; (No documentation to show the resident had bed rails/mobility bars on his/her bed). Observation on 02/02/25 at 11:40 A.M., 02/03/25 at 8:03 A.M., and on 02/04/25 at 8:35 A.M., showed the resident lay in his/her bed with mobility bars on both sides of the resident's bed. (continued on next page)

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F 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the resident's medical record showed no evidence staff conducted an inspection of the resident's bed frame, mattress and mobility bars to identify areas of possible entrapment. 4. During an interview on 2/5/25 at 8:10 A.M., the Maintenance Director said he did not currently measures beds for entrapments zones. During interviews on 02/06/25 at 11:40 A.M., the Director of Nursing said she the maintenance department was responsible to measure the entrapment zones. During a phone interview on 02/06/25 at 12:50 P.M. the Administrator said she expected the maintenance department to complete measurements for entrapment zones quarterly. 47008

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. 30813 44665 Based on observation and interview, the facility failed to maintain an environment to deter pests from entering the facility's kitchen, satellite dining rooms, kitchenettes, and food storage areas. The facility census was 71. 1. Observation on 2/3/25 at 10:49 A.M., in the kitchen above the three compartment sink, showed an approximate 1-foot by 3-foot window was open and did not contain a screen. Observation on 2/3/25 at 3:38 P.M., during the exterior and interior sanitation tour of the facility, showed the following: -Two approximately 1-foot by 3-foot windows were open to the kitchen and contained no screens on the windows; -An exterior door to the service hall, located near the outside dumpster and grease collection container, was propped fully open with a metal ramp. Both the dumpster and grease container were open. The dumpster was 25% full of garbage and did not have a lid on the top and front of the dumpster. The lid of the grease container hung off to the side of the container and the container was 90% full of grease; -Approximately 50 feet down the service hall into the facility (from the open exterior door), the door to the emergency food/water storage and dietary walk-in cooler and freezer room was propped open with a large can of food. Observation on 2/4/25 at 8:29 A.M., in the kitchen, showed a white laundry basket labeled 'Kitchen' sat near two bulk bins of rice and oats. Approximately 50 mouse droppings were located in the bottom of the laundry basket. Behind and along the wall, two boxes of fry oil sat on the floor. Mouse droppings were on the floor around the oil in this area. Observation on 2/4/25 at 8:42 A.M., showed the outside exterior door to the parking lot near the food service was chained open by the handle. No staff were around or actively working in the area. The door to the dry storage room that contained emergency food and water and paper products and the walk-in cooler and freezer had the self closer disconnected at the top of the door and was propped open with a can of food. Mouse droppings were on the floor. On the shelves in this room, multiple cups and food containers were not inverted and mouse droppings were scattered on the surface of the shelves, cups, and food containers. Observation on 2/4/25 at 9:26 A.M., in the kitchenette near the east dining room, showed the cabinets contained loose cereal and dead insects resembling cockroaches. During an interview on 2/4/25 at 2:49 P.M., the Dietary Manager said the following: (continued on next page)

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-The outside dumpster never had lids. He was unaware the outside grease collection container lid was not covering the opening of the container; -The exterior door to the service hall and the door to the emergency food/water storage and dietary walk-in cooler and freezer room should not be propped open when not in use; -The facility had mouse issues in the past and the pest control company gave him a stack of glue traps if he needed to use them. He also planned to put more items in plastic totes to protect them from mice in the dry storage room; -The kitchen windows that were open had been previously damaged and did not have screens. Maintenance staff planned to replace the windows but staff probably shouldn't open the windows until they had screens. During an interview on 2/4/25 at 4:49 P.M., the Administrator said the facility's pest control company maintained outside bait stations and had sticky traps available for mice.