STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265120	A. Building B. Wing	01/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St Sophia Health & Rehabilitation Center	936 Charbonier Road Florissant, MO 63031

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40290 Based on observation, interview and record review, the facility failed to ensure residents were treated with respect and dignity. One resident (Resident #214) required staff assistance with mobility and personal care needs. Staff left the resident's buttocks exposed while propelling the resident through common areas of the facility, and left the resident uncovered in bed with his/her genitals exposed and visible from the hallway outside of his/her room. Staff delivered a meal to the resident's room and failed to empty the resident's urinals, full of urine, leaving the urine in the resident's line of sight while he/she ate lunch. In addition, one employee made a video call on their personal cell phone while in a common area with one resident (Resident #22) in the background of the video. The sample was 33. The census was 166. Review of the facility's Resident Rights policy, last reviewed 4/26/23, showed: -Policy: The facility shall treat residents with kindness, respect, and dignity and ensure resident rights are being followed; -Resident rights included respect and dignity, and privacy and confidentiality. 1. Review of Resident #214's medical record, showed: -admitted [DATE]; -Diagnoses included morbid obesity (due to excess calories) and repeated falls. Review of the resident's baseline care plan, dated 1/11/25, showed dependent for toileting and personal hygiene. Review of the resident's Occupational Therapy evaluation, dated 1/11/25, showed: -Baseline level of performance for hygiene/grooming: Maximum; -Baseline level of performance for toileting: Moderate. Review of the resident's Physical Therapy evaluation, dated 1/13/25, showed: (continued on next page)

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

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Transfers: Minimal assistance; -Gait: 10 feet on level surfaces using two-wheeled walker. Observation on 1/22/25 at 11:40 A.M., showed the resident in bed. Two urinals hung on the front of the resident's walker next to his/her bed, one full with 1000 cubic centimeters (cc) of urine and the other with 600 cc of urine. During an interview, the resident said he/she was admitted to the facility for therapy following a hospitalization that left him/her unable to walk. He/She cannot get to the restroom on his/her own to empty his/her urinals. Observation on 1/22/25 at 12:57 P.M., showed the resident in bed, eating lunch. The two urinals remained full on the resident's walker. During an interview, the resident said staff brought him/her lunch but left his/her urine on the walker. The urine is not nice to look at while he/she is eating. Observation on 1/23/25 at 10:59 A.M., showed Employee EE propelled the resident down the hallway in a wheelchair. The resident wore a hospital gown that covered the front of his/her torso and waist. The resident's buttocks were uncovered and visible from both sides of the wheelchair. The employee propelled the resident down the hallway, past the nurse's station, through the reception area and lobby, and down the main hallway to the therapy gym at the end of the hallway. Other residents were in the hallway while the resident passed. Observation on 1/23/25 at 12:34 P.M., showed the door to the resident's room open. The resident lay on his/her back in bed with a hospital gown on that covered his/her torso and ended at the end of his/her stomach. His/Her groin area was uncovered and exposed, visible from the hallway outside of his/her room. During an interview, the resident said the hospital gown is too small to fully cover him/her and all of his/her skin was showing when staff brought him/her down the hall to the therapy gym earlier. He/She would have preferred to have been covered up before being transported across the facility. The therapist found him/her a bigger gown and it is on the couch in his/her room, but he/she cannot walk to get to it. He/She is currently waiting on staff to come back and help clean him/her up after he/she had a bowel movement. Observation on 1/23/35 at 1:10 P.M., showed three nursing staff passing out lunch trays on the hall. Observation on 1/23/25 at 1:43 P.M., showed the door to the resident's room open. The resident lay on his/her back in bed with a hospital gown on that covered his/her torso and ended at the end of his/her stomach. His/Her groin area was uncovered and exposed, visible from the hallway outside of his/her room. During an interview, the resident said he/she would like to be covered up with a sheet or something. Staff came in his/her room earlier to drop off lunch but did not help clean him/her or cover him/her. During an interview on 1/28/25 at 8:21 A.M., Certified Nurse Aide (CNA)/Certified Medication Technician (CMT) Q said the resident requires assistance from staff with toileting and hygiene. CNAs are responsible for emptying urinals when they are full. It would not be appropriate for staff to deliver a meal to the resident and leave the full urinals without emptying them. Staff should not transport the resident down the hall with his/her buttocks exposed because it is a dignity issue and he/she should be covered. If staff need to leave the room while providing personal care, they should make sure the resident is covered up before leaving for dignity reasons. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 1/28/25 at 9:59 P.M., Registered Nurse (RN) P said the resident is obese and requires two hospital gowns in order to be fully covered. He/She requires assistance from staff for personal hygiene and has limited mobility. Nursing staff is responsible for emptying urinals when they are full. When staff delivered the resident's lunch last week, they should have emptied the urinals for him/her when they were in the room. Nursing staff should ensure the resident is fully covered when transporting him/her throughout the facility and when providing personal care. If staff need to leave the room in the middle of providing care, they should ensure the resident is covered with a sheet or with the privacy curtain for dignity purposes. During an interview on 1/28/25 at 12:01 P.M., the Director of Nurses (DON) and Administrator said the resident requires assistance from staff with his/her personal care needs. Nursing staff should assist residents by emptying urinals when they are full. It was inappropriate for nursing staff to leave urinals full of urine on the resident's walker when they went in the room to deliver a meal tray. Staff should have provided the resident with a bariatric hospital gown instead of one regular size gown. If staff could not find a bariatric gown, they should have used two gowns or a sheet to ensure the resident was fully covered while being transported to therapy. If staff had to leave the room in the middle of providing care to the resident, they should have ensured he/she was fully covered for dignity and respect, by using a sheet, a privacy curtain, or closing the door. 2. Review of Resident #22's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 1/11/25, showed: -Diagnoses included dementia, anxiety, major depressive disorder and muscle weakness; -Severe cognitive impairment. Observation on 1/23/25 at 8:45 A.M., showed CNA K sat in a chair in the hallway. He/She was on his/her phone on a video facetime call. A male's face was observed on the phone screen talking to CNA K. He/She was holding up his/her phone close to his/her face. Resident #22 was propelling down the hallway in his/her wheelchair behind CNA K in view of the phone's camera. CNA continued to facetime on his/her phone until 8:47 A.M. During an interview on 1/28/25 at 7:44 A.M., CMT M said the facility's phone policy is that phones are only to be used in the break room or away from resident care areas. He/She said it is not appropriate to take a phone call in the hallway. He/She said video calls are not appropriate due to Health Insurance Portability and Accountability Act (HIPAA, protected privacy of resident's identifiable health information) violations. During an interview on 1/28/25 at 8:17 A.M., Licensed Practical Nurse (LPN) I said the facility's phone policy is that phones are only to be used in the break room or away from resident care areas. He/She said it is not appropriate to take a phone call in the hallway. He/She said video calls are not appropriate due to HIPAA violations. During an interview on 1/28/25 at 12:35 P.M., the Administrator and DON said the facility's phone policy is that phones are only to be used in the break room or away from resident care areas. They said it is not appropriate to take a phone call in the hallways or near resident rooms. They said video calls are not appropriate due to HIPAA violations. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	MO00241321 MO00241696 46888

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40290 Based on observation, interview and record review, the facility failed to ensure residents were appropriately assessed to self-administer medications, to obtain physician orders to self-administer medications, and to ensure staff adequately supervised residents during medication administration (Residents #20 and #214). The sample was 33. The census was 166. Review of the facility's Self-Administration of Medications policy, revised August 2014, showed: -Policy: In order to maintain the residents' high level of independence, residents who desire to self-administer medications are permitted to do so if the facility's interdisciplinary team (IDT) has determined that the practice would be safe for the resident and other residents of the facility and there is a prescriber's order to self-administer; -Procedures include: -If the resident desires to self-administer medications, an assessment is conducted by the IDT of the resident's cognitive (including orientation to time), physical, and visual ability to carry out this responsibility during the care planning process; -For those residents who self-administer, the IDT verifies the resident's ability to self-administer medications by means of a skill assessment conducted on quarterly basis or when there is a significant change in condition; -The results of the IDT assessment of resident skills and of the determination regarding bedside storage are recorded in the resident's medical record, on the care plan. For each medication authorized for self-administration, the label contains a notation that it may be self-administered; -If the resident demonstrates the ability to safely self-administer medications, a further assessment of the safety of bedside medication storage is conducted; -Bedside medication storage is permitted only when it does not present a risk to confused residents who wander into the rooms of, or room with, residents who self-administer. Conditions outlined in Bedside Medication Storage policy are met for bedside storage to occur. Review of the facility's Bedside Medication Storage policy, revised August 2014, showed: -Policy: Bedside medication storage is permitted for residents who wish to self-administer medications, upon the written order of the prescriber and once self-administration skills have been assessed and deemed appropriate in the judgment of the facility's IDT; -Procedures include: -A written order for the bedside storage of medication is present in the resident's medical record; (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Bedside storage of medications is indicated on the resident's Medication Administration Record (MAR) and in the care plan for the appropriate medications. Review of the facility's Medication Administration - General Guidelines policy, revised August 2014, showed: -Policy: Medications are administered as prescribed in accordance with good nursing principles and practices; -Procedures included: -When medications are administered by mobile cart taken to the resident's location (room, dining area, etc.) medications are administered at the time they are prepared; -Residents are allowed to self-administer medications when specifically authorized by the attending physician and in accordance with procedures for self-administration of medications (See Self-Administration of Medications policy); -The resident is always observed after administration to ensure that the dose was completely ingested. 1. Review of Resident #20's medical record, showed: -Diagnoses included schizophrenia (serious mental illness that affects how a person thinks, feels, and behaves), dysphagia (difficulty swallowing), and myasthenia gravis (neuromuscular disease causing muscle weakness); -Medication Self-Administration Safety Screen, dated 2/10/22, showed no pills listed as safe to self-administer, and Symbicort inhalation aerosol (used for treatment of airflow obstruction) 160-4.5 micrograms (mcg)/act (per actuation (inhalation) (budesonide-formoterol fumarate dihydrate) not listed as assessed for safety to self-administer; -No Medication Self-Administration Safety Screens completed after 2/10/22. Review of the resident's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 12/3/24, showed moderate cognitive impairment. Review of the resident's care plan, in use at the time of survey, showed: -Focus, initiated 8/26/20 and revised 2/15/22: Resident has requested to execute his/her right to self-administer medications with all prescribed medications, eye drops, and inhaler per physician orders. See physician's order to self-administer medications; -Interventions included: Assess resident's cognitive ability to appropriately and safely administer his/her medications. Reassess ability periodically or per policy and as needed; -The care plan did not indicate the resident was assessed to be able to safely administer his/her medications in pill form. (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the resident's Physician Order Summary (POS) and MAR for January 2025, showed: -An order, dated 4/14/24, for famotidine (used to prevent and treat heartburn) tablet 20 milligrams (mg), one tablet by mouth (PO) once daily. 7:00 A.M. dose for 1/22/25 and 1/23/25 initialed as administered by Certified Medication Technician (CMT) A; -An order, dated 12/30/22, for finasteride (used to treat enlarged prostate) tablet 5 mg, one tablet PO in the morning. 7:00 A.M. dose for 1/22/25 and 1/23/25 initialed as administered by CMT A; -An order, dated 12/20/22, for folic acid (supplemental vitamin) tablet 0.4 mg, one tablet PO in the morning. 7:00 A.M. dose for 1/22/25 and 1/23/25 initialed as administered by CMT A; -An order, dated 12/5/24, for metoprolol tartrate (used to treat high blood pressure and chest pain) tablet 12. 5 mg, one tablet PO once a day, every other day. 7:00 A.M. dose for 1/22/25 initialed as administered by CMT A; -An order, dated 5/22/22, for multivitamin tablet, one tablet PO in the morning. 7:00 A.M. dose for 1/22/25 and 1/23/25 initialed as administered by CMT A; -An order, dated 12/29/22, for pyridostigmine bromide (used to treat myasthenia gravis) 60 mg, give 30 mg PO three times a day. 7:00 A.M. dose for 1/22/25 and 1/23/25 initialed as administered by CMT A; -An order, dated 6/30/23, for hydroxyzine (antihistamine) hydrochloride (HCl) 10 mg tablet, one tablet PO three times a day. 7:00 A.M. dose for 1/22/25 and 1/23/25 initialed as administered by CMT A; -An order, dated 11/10/23, for simethicone (used to treat bloating) oral tablet chewable 80 mg, one tablet PO three times daily. 7:00 A.M. dose for 1/22/25 and 1/23/25 initialed as administered by CMT A; -An order, dated 11/7/24, for fluoxetine (antidepressant) 10 mg capsule, one capsule PO in the morning. 7:00 A.M. dose for 1/22/25 and 1/23/25 initialed as administered by CMT A; -An order, dated 12/30/22, for Vitamin B12 tablet, give 1000 mcg PO in the morning. 7:00 A.M. dose for 1/22/25 and 1/23/25 initialed as administered by CMT A; -An order, dated 7/6/22, for cetirizine (antihistamine) HCl 10 mg tablet, one tablet PO in the morning. 7:00 A. M. dose for 1/22/25 and 1/23/25, initialed as administered by CMT A; -An order, dated 12/29/22, for apixaban (blood thinner) 5 mg, one tablet PO twice daily. 7:00 A.M. dose for 1/22/25 and 1/23/25 initialed as administered by CMT A; -An order, dated 8/2/20, for calcium carbonate-vitamin D 500-200 mg-unit, one tablet PO twice daily. 7:00 A. M. dose for 1/22/25 and 1/23/25 initialed as administered by CMT A; -An order, dated 6/27/24, for vitamin C oral capsule, one capsule by mouth twice daily. 7:00 A.M. dose for 1/22/25 and 1/23/25 initialed as administered by CMT A; (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-An order, dated 1/10/25, for Symbicort inhalation aerosol 160-4.5 mcg/act, two puffs inhaled orally two times a day related to asthma. 7:00 A.M. dose for 1/22/25 and 1/23/25 initialed as administered by CMT A; -No physician orders to enable the resident to self-administer the above medications. Observation on 1/22/25 at 12:06 P.M., showed the resident in bed. One inhaler and a medicine cup containing pills were on the resident's bedside table. Observation on 1/22/25 at 1:03 P.M., showed the resident in bed. One inhaler and a medicine cup containing pills were on the resident's bedside table. During an interview, the resident said he/she will take his/her medication later. Observation on 1/22/25 at 5:54 P.M., showed the resident in bed. One inhaler was on the bedside table. During an interview, the resident said he/she took the pills from this morning. The resident said he/she just got the inhaler yesterday and has not tried it, yet. Observation on 1/23/25 at 10:55 A.M., showed CMT A prepared medications on the medication cart outside of the resident's room. He/She entered the resident's room and exited a minute later. Observation on 1/23/25 at 11:10 A.M. P.M., showed the resident in bed with eyes closed. One inhaler and a medicine cup containing pills were on the resident's bedside table. Observation on 1/23/25 at 1:37 P.M., showed the resident in bed. One inhaler and a medicine cup containing pills were on the resident's bedside table. During an interview, the resident said he/she can take his/her medication without supervision. The medications are for different issues, and he/she did not want to discuss all of them. During an interview on 1/28/25 at 9:59 A.M., Registered Nurse (RN) P said the resident's cognitive status fluctuates and goes back and forth between alert and oriented times one (to self) to three. He/She could probably self-administer his/her own inhaler but he/she cannot take medications in pill form without supervision. 2. Review of Resident #214's medical record, showed: -admitted [DATE]; -Diagnoses included asthma, shortness of breath, obstructive sleep apnea and heart failure. Review of the resident's POS, showed: -An order, dated 1/11/25 for Symbicort inhalation aerosol 160-4.5 mcg/act, two puffs inhaled orally two times a day related to asthma; -An order, dated 1/11/25, for Proventil HFA inhalation aerosol solution (used to treat asthma) 108 mcg/ACT (albuterol sulfate), two puffs inhaled orally every six hours as needed for shortness of breath, wheezing; (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-No physician orders for the resident to self-administer inhaler medications. Review of the resident's self-administration of medication assessment, dated 1/11/25, showed the resident fully capable of administering inhaler medications. Review of the resident's baseline care plan, dated 1/11/25, showed: -Medications resident is taking: Inhalers not listed; -Self-administer medications: Yes; -The baseline care plan did not specify what medications the resident self-administers. Observation on 1/22/25 at 11:40 A.M., showed the resident seated on the side of his/her bed. Two inhalers were on his/her bedside table. During an interview, the resident said he/she uses one inhaler twice a day, and the other as needed. He/She is able to use them without assistance or supervision. Observations on 1/22/25 at 12:57 P.M. and 6:03 P.M., showed two inhalers were on the resident's bedside table. Observation on 1/23/25 at 12:34 P.M., showed two inhalers were on the resident's bedside table. During an interview, the resident said he/she has not used either of his/her inhalers today. 3. During an interview on 1/28/25 at 8:21 A.M., CMT/Certified Nurse Aide (CNA) Q said he/she has never seen inhalers in Resident #214's room. He/She thinks Resident #20 might have an inhaler he/she can self-administer, but he/she is not sure. Any medication that is self-administered by a resident must have a physician order. If a resident does not have a physician order to self-administer their medication, the medication must be locked up on the cart. If a resident is asleep when staff go to pass their medication, staff should try to wake them. If the resident continues to sleep or is unavailable, staff should put the medication back on the cart or discard them. Medications cannot be left in a resident's room without staff observing the resident take the medication. Residents must be observed during medication administration for safety. During an interview on 1/28/25 at 9:43 A.M., Licensed Practical Nurse (LPN) O said in order for a resident to be able to self-administer their medications, they have to be assessed by the nurse for safety. If the assessment determines it is safe, physician orders must be obtained for the resident to self-administer their medication. Some residents have physician orders to self-administer inhalers or eye drops, but no residents in the facility can administer their medications in pill form. If the CMT or nurse prepares medications at the cart and brings the medications to the resident and the resident is sleeping or unavailable, the staff should write the resident's name on the medication cup and lock it up on the cart. Staff should not leave the cup of medications in the resident's room because the resident should be supervised when taking the medication for safety purposes. (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 1/28/25 at 9:59 A.M., RN P said in order for a resident to be able to self-administer their medications, the nurse has to complete a self-administration of medication evaluation. A physician order must be obtained for each medication that is safe to administer. Before preparing a resident's medication for administration, staff should make sure the resident is available and awake. If staff prepare the medications and find the resident is asleep, they should try to hold the medication for about ten minutes, then try again. If the medication cannot be administered, staff should discard the medication and mark it on the MAR. It is not acceptable to leave medications on a resident's bedside table because someone else could get to the medications and that is unsafe. During an interview on 1/28/25 at 12:01 P.M., the Director of Nurses (DON) and Administrator said it is only acceptable for medications to be left at bedside if the resident has been evaluated to be safe to self-administer medication, and a physician order has been obtained. Nurses are responsible for assessing residents for self-administration of medication. These assessments should be reassessed quarterly and as needed due to a potential change in cognitive status or capabilities. During medication administration, staff must watch the resident take their medication for safety purposes. If a resident is sleeping during an attempted medication administration, staff should try to wake them. Staff should not leave medications in a resident's room without watching the resident take their medication. MO00247998

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. 40290 Based on observation, interview and record review, the facility failed to ensure resident needs and preferences were accommodated for one resident (Resident #19) with communication and mobility impairments, when staff failed to ensure the resident's call light was within reach and when staff failed to transfer the resident back to bed, per the resident's request. The sample was 33. The census was 166. Review of the facility's Resident Rights policy, last reviewed 4/26/23, showed: -Policy: The facility shall treat residents with kindness, respect, and dignity and ensure resident rights are being followed; -Resident rights included exercise rights, planning and implementing care, making decisions/choices, and self-determination. Review of Resident #19's medical record, showed diagnoses included stroke, hemiplegia (paralysis to one side) affecting left nondominant side, acquired absence (amputation) of left leg above knee, aphasia (language impairment), frontal lobe and executive function deficit following cerebrovascular disease (conditions that affect blood flow to the brain), other speech and language deficits following cerebrovascular disease, morbid obesity due to excess calories, abnormal posture, unspecified abnormalities of gait and mobility, generalized muscle weakness and depression. Review of the resident's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 11/29/24, showed: -Rarely/never understood; -Unclear speech; -Usually makes self understood; -Substantial/maximum assistance required to roll left and right; -Dependent on assistance for sit to lying, lying to sitting on side of bed, sit to stand, and transfers. Review of the resident's care plan, in use at the time of survey, showed the care plan failed to identify the resident's communication difficulties, mobility limitations, and level of assistance needed to address his/her activities of daily living. The care plan did not indicate the resident must be up at certain times, or cannot be in bed when desired. (continued on next page)

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St Sophia Health & Rehabilitation Center	936 Charbonier Road Florissant, MO 63031

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 1/22/25 at 10:03 A.M., showed the resident seated in bed. His/Her call light was pinned to the privacy curtain on his/her left side, not within reach. During an interview, the resident had some difficulty speaking but was able to respond appropriately using one to several words and by nodding and shaking his/her head. The resident said he/she cannot reach his/her call light. He/She had a stroke and cannot move his/her left hand. He/She has no way to call staff for help. Observations on 1/22/25 at 10:52 A.M., 11:36 A.M., and 12:05 P.M., showed the resident in bed and his/her call light in the same position on the privacy curtain. Observation on 1/24/25 at 7:26 A.M., showed the resident seated in a geri-chair (reclining wheeled chair) at the nurse's station. The resident told Certified Nurse Aide (CNA) G he/she wanted to go back to bed. CNA G said no, the resident cannot go back to his/her room because he/she needs to be up for breakfast, and walked away. During an interview, the resident said he/she thought it was his/her choice if he/she wanted to be in his/her room or not. He/She is not happy. During an interview on 1/24/25 at 7:29 A.M., CNA FF said the resident probably can't go back to his/her room right now because they just got him/her up and he/she requires a Hoyer (mechanical) lift, so they need more staff to get the resident back down to bed. The resident will probably go back to his/her room after breakfast. Observation on 1/24/25 at 8:37 A.M., showed the resident seated in a geri-chair to the right side of his/her bed. The call light was placed in the middle of the bed on the resident's left side, not within reach. During an interview, the resident said he/she cannot reach his/her call light. He/She cannot ask for help when he/she wants it. He/She is not feeling great today and wants to get back in bed, but they told him/her no and he/she does not understand why. Observation on 1/24/25 at 9:11 A.M., showed CNA FF brought a breakfast tray to the resident's room and continued passing trays on the hall. The resident remained seated in the geri-chair next to his/her bed with his/her call light in the middle of the bed, not within reach. Observation on 1/24/25 at 11:29 A.M., showed the resident seated in a geri-chair to the right side of his/her bed. The call light was placed in the middle of the bed on the resident's left side, not within reach. Observation on 1/24/25 at 1:04 P.M , showed the resident seated in a geri-chair to the right side of his/her bed. The call light was placed in the middle of the bed on the resident's left side, not within reach. During an interview, the resident said he/she is frustrated. He/She wants to lay back down and the staff will not put him/her in the bed. During an interview on 1/24/25 at 1:10 P.M., CNA G said the resident is paralyzed on his/her left side due to a stroke. He/She can make his/her needs known and is a two-person assist for transfers. He/She wants to be in bed all day, and does not want to be up. The nursing management put a stop to that. They want the resident up now so he/she doesn't get pressure ulcers (injury to the skin and/or underlying tissue usually over a bony prominence, as a result of pressure or friction). The resident has to be up in the morning and gets back to bed after lunch. (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 1/28/25 at 9:59 A.M., Registered Nurse (RN) P said the resident is alert and oriented times three and can make his/her needs known. He/She is paralyzed on his/her left side and requires a Hoyer lift for transfers. Staff should ensure the resident's call light is placed on his/her right side, within his/her reach. The resident refuses to get out of bed sometimes. When this occurs, staff should compromise with him/her by offering a soda or something he/she might like. They should try to negotiate a timeframe and educate the resident about maintaining skin integrity. If he/she refuses to get out of bed, staff should try again for a total of three times. If he/she wants to go back to bed, staff should honor his/her request and assist him/her back to bed. The resident's care plan should include information related to the resident's care needs and preferences. During an interview on 1/28/25 at 12:01 P.M., the Director of Nurses (DON) and Administrator said the resident is alert and oriented times two. He/She has delayed communication but can make his/her needs known. He/She is paralyzed on one side and staff should ensure his/her call light is within reach on his/her functional side, before leaving the resident's room. The resident is dependent on staff to assist him/her with transfers. While it is ideal for him/her to be out of bed at times, he/she has the right to go back to bed when desired. Staff could first try to offer an activity instead, give him/her something to do, or reposition him/her. If the resident continues to request to be put back in bed, staff should honor the request.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40290 42795 46888 Based on observation, interview and record review, the facility failed to ensure eight of 33 sampled residents were provided a homelike environment by failing to ensure resident toilets were clean (Residents #8 and #119), resident rooms had clean floors (Residents #8, #119, #38, #62, and #15), soap dispensers in resident rooms were full (Residents #20 and #140) and residents had clean bedding (Resident #119). The facility also failed to ensure residents' furniture and medical equipment were in working order and clean (Residents #62, #105, and #15), and that the 400 hallway dining room had clean floors. The census was 166. Review of the facility's safe homelike environment policy, dated 4/28/22, showed: -Policy: In accordance with residents' rights, the facility will provide a safe, clean, comfortable and homelike environment; -Procedure: Housekeeping and maintenance services will be provided as necessary to maintain a sanitary, orderly and comfortable environment. The facility will provide and maintain bed and bath linens that are clean and in good condition. Minimize odors by disposing of soiled linens promptly and reporting lingering odors and bathrooms needing cleaning to housekeeping department. 1. Review of Resident #8's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 11/15/24, showed: -Moderate cognitive impairment; -Makes self understood; -Diagnoses included lack of coordination and weakness. Observation and interview on 1/22/25 at 12:31 P.M., showed a gray film of grime along the surface of the floor throughout the resident's room with two oval-shaped areas of a dried red liquid on the floor by the doorway to the room. In the resident's bathroom, fecal material was splattered along the inside of the toilet bowl. During an interview at that time, the resident said staff were not keeping his/her room clean. They don't mop or clean his/her room as often as they should. Observation and interview on 1/23/25 at 8:05 A.M., showed a gray film of grime along the surface of the floor throughout the room with two oval-shaped areas of a dried red liquid on the floor by the doorway to the room. In the resident's bathroom, fecal material remained splattered along the inside of the toilet bowl. During an interview at that time, the resident said the staff came in and cleaned up a little, but they barely did anything, and it still looks dirty to him/her. The toilet is still dirty and they didn't mop. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observations on 1/23/25 at 1:54 P.M. and on 1/24/25 at 1:00 P.M., showed the same gray film of grime along the surface of the floor throughout the room and two-oval shaped areas of a dried red liquid on the floor by the doorway to the room. In the bathroom, fecal material remained splattered along the inside of the toilet bowl. 2. Review of Resident #119's quarterly MDS, dated [DATE], showed: -Diagnoses included dementia, cognitive communication deficit, anxiety, and schizophrenia (a disorder that affects the ability to think, feel and behave clearly); -Moderately impaired cognition. Observation on 1/22/25 at 10:10 A.M., showed dirty floors with trash and food debris by the resident's bed. The resident's sheets and blanket were dirty with a brown substance. A strong fecal odor was in the room. Observation on 1/23/25 at 8:48 A.M., showed dirty floors with trash and food debris by the resident's bed. The resident's sheets and blanket were dirty with a brown substance. A strong fecal odor was in the room. Observation on 1/24/25 at 7:22 A.M., showed dirty floors with trash and food debris by the resident's bed. The resident's sheets and blanket were dirty with a brown substance. A strong fecal odor was in the room. Observation on 1/27/25 at 7:37 A.M., 10:05 A.M., and 11:40 A.M., showed dirty floors with trash and food debris by the resident's bed. The resident's sheets and blanket were dirty with a brown substance. A strong fecal odor was in the room. In the resident's bathroom, the bowl and toilet seat were covered with brown fecal substance. 3. Review of Resident #38's admission MDS, dated [DATE], showed: -Diagnoses included dementia, anxiety, and disruptive mood dysregulation disorder; -Moderately impaired cognition. Observation on 1/22/25 at 10:01 A.M., showed there was dust accumulation on the air conditioning unit under the resident's window. Observation on 1/23/25 at 8:49 A.M., showed there was dust accumulation on the air conditioning unit under the resident's window. Trash and food debris were on the ground surrounding the resident's bed. Observation on 1/24/25 at 7:24 A.M., showed there was dust accumulation on the air conditioning unit under the resident's window. Trash and food debris were on the ground surrounding the resident's bed. 4. Review of Resident #62's quarterly MDS, dated [DATE], showed: (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Diagnoses included dementia, muscle wasting, and cognitive communication deficit; -Moderately impaired cognition. Observation on 1/22/25 at 11:38 A.M., showed the resident's dresser door hanging off. Food and trash debris were on the ground next to the resident's bed. Observation on 1/23/25 at 12:34 P.M., showed the resident's dresser door hanging off. Food and trash debris were on the ground next to the resident's bed. Observation on 1/24/25 at 7:21 A.M., showed the resident's dresser door hanging off. Food and trash debris were on the ground next to the resident's bed. 5. Review of Resident #15's quarterly MDS, dated , 1/14/25, showed: -Cognitively intact; -Diagnoses include: Chronic obstructive pulmonary disease (COPD) (a lung disease that restricts the lung passages, making it difficulty to breathe) and anxiety. During observation and interview on 1/22/25 at 12:42 P.M. and 1/24/25 at 9:32 A.M., the resident was sitting in his/her wheelchair in his/her room. The floor next to and behind the resident's bed had dust, crumbs, and dried red splatters. The resident's bed frame had dried red splattered stains. The resident said the stains and overall stains on the floor around his/her bed had been there a week or two. He/She did not like it and he/she would clean it him/herself if someone could help him/her. During an interview on 1/28/25 at 9:07 A.M., Housekeeper AA said he/she wasn't sure what he/she could clean in the resident's room due to the resident having oxygen equipment. He/She was afraid to move anything because he/she didn't want to dislodge or break any equipment. He/She should probably ask nursing staff what he/she can move in the resident's room. The dirty floor and stains on the bed frames were not homelike. During an interview on 1/28/25 at 10:00 A.M., the Housekeeping Supervisor said the resident's room needed to be deep cleaned. He was not sure when the last time the resident's room was deep cleaned. Housekeeping staff are responsible to clean the bed frames. Dirty floors and bed frames are not homelike for the resident. He said resident rooms are deep cleaned annually and he oversees the cleaning to make sure it is done correctly. 6. Review of Resident #20's quarterly MDS, dated [DATE], showed: -Moderate cognitive impairment; -Makes self understood; -Diagnoses included myasthenia gravis (chronic neuromuscular disease that causes weakness) and lack of coordination. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation and interview on 1/22/25 at 12:06 P.M., showed no soap in the empty dispenser next to the resident's sink. During an interview, the resident said he/she has not had soap for a while. He/She tells staff, but they don't listen. Observations on 1/23/25, showed: -At 1:08 P.M., Housekeeper S positioned a housekeeping cart outside of the resident's room. He/She entered and exited the room several times, bringing cleaning supplies in and out of the room. At 1:11 P.M., he/she exited the room and moved the housekeeping cart down the hall; -At 1:37 P.M., there was no soap in the empty dispenser next to the resident's sink. Observations on 1/24/25 at 11:29 A.M. and 1/28/25 at 8:37 A.M., showed no soap in the dispenser next to the resident's sink. 7. Review of Resident #140's quarterly MDS, dated [DATE], showed: -Cognitively intact; -Makes self understood; -Diagnoses included disruption of external surgical wound not elsewhere classified. Observation and interview on 1/22/24 at 12:10 P.M., showed no soap in the empty dispenser next to the resident's sink. During an interview, the resident said there is no soap for him/her to use. He/She has been telling staff the dispenser has been empty for months, but it doesn't do any good. He/She cannot wash his hands with just water. Observations on 1/22/25 at 5:53 P.M., 1/23/25 at 7:47 A.M. and 11:08 A.M., 1/24/25 at 9:30 A.M. and 1:05 P. M., and 1/28/25 at 8:35 A.M., showed no soap in the empty dispenser next to the resident's sink. 8. Review of Resident #105's, quarterly MDS, dated , 11/25/24, showed: -Resident is rarely or never understood; -Diagnoses include, aphasia (inability to speak), stroke, and seizure disorder; -Receives nutrition via tube feeding. Observation on 1/22/25 at 9:50 A.M., 1/24/25 at 7:55 A.M., and 1/28/25 at 9:07 A.M., showed the resident lay in bed with a tube feeding pump and tubing connected to the resident. The bottom of the pole, that held the tube feeding and tube feeding pump, had multiple layers of dry, thick, flaky matter on the legs of the pole. During an interview on 1/28/25 at 9:07 A.M., Housekeeper AA said anyone in housekeeping can use a cleaner and remove the white crusted matter. He/She did not think the dirty equipment pole was homelike. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 1/28/25 at 7:45 A.M., Assistant Director of Nursing (ADON) said the person that made the tube feeding spill onto the equipment pole should have wiped it up. Any nursing personnel or housekeeper can clean the bottom of the poles. During an interview on 1/28/25 at 10:00 A.M., the Housekeeping Supervisor said the house keeping staff are expected to clean any type of debris or spill that is present on the equipment poles. If the poles are too soiled, then the pump can be switched out and a new one obtained from central supply. 9. Observations of the 400 hallway, showed: -On 1/22/25 at 11:48 A.M., the floors in the 400 hallway dining room were sticky and had food debris; -On 1/23/25 at 12:45 A.M., the floors in the 400 hallway dining room were sticky and had food debris; -On 1/24/25 at 7:26 A.M., the floors in the 400 hallway dining room were sticky and had food debris; -On 1/27/25 at 7:40 A.M., the floors in the 400 hallway dining room were sticky and had food debris. 10. During an interview on 1/28/25 at 8:46 A.M., Housekeeper S said housekeeping is responsible for cleaning resident rooms at least once a day. When cleaning rooms, housekeeping should clean the toilets, mirrors, sinks, floor boards, and floors. If they see soap is missing from the dispensers by the sink, they should notify the Housekeeping Supervisor. He/She is only aware of one room missing soap. He/She was not aware of soap missing in the rooms of Residents #140 and #20. He/She would expect residents' furniture and medical equipment to be clean and in working order. He/She said if staff notice furniture that is broken, they can put in a work order to the maintenance department. He/She would expect the 400 hallway dining room floors to be cleaned after each meal service. During an interview on 1/28/25 at 10:21 A.M., the Housekeeping Supervisor said he expects housekeeping staff to clean resident rooms daily. Housekeeping staff should follow the room cleaning checklist. Toilets and floors are included in the room cleaning checklist. He expects housekeeping staff to fill soap dispensers when empty. He would expect for residents to have clean bedding. He would expect staff to inform the maintenance department if air conditioning units are dusty so they can be cleaned. He would expect residents' furniture and medical equipment to be clean and in working order. He would expect the 400 hallway dining room floors to be cleaned after each meal service. He follows up once a day to ensure cleaning is done. During an interview on 1/28/25 at 12:06 P.M., the Administrator said she would expect for residents to have a clean, homelike environment. She would expect housekeeping to clean the residents' rooms and bathrooms daily. She would expect residents to have soap in their rooms. She would expect for residents' furniture and medical equipment to be clean. She would expect for maintenance to be checking residents' rooms for broken furniture and dirty air conditioning units. She would expect for dietary staff, housekeeping, and nursing staff to be cleaning the 400 hallway dining room floors after each meal service.

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F 0620 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Not require residents to give up Medicare or Medicaid benefits, or pay privately as a condition of admission; and must tell residents what care they do not provide. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42795 Based on observation, interview and record review, the facility failed to maintain records of residents' personal possessions for four residents (Resident #97, Resident #38, Resident #15 and Resident #265) The sample was 33. The census was 166. Review of the facility's admission agreement, revised June, 2023, showed: -Resident rights: -To keep and use your personal belongings and property as long as they don't interfere with the rights, health, or safety of others; -Personal items: -All personal property must be clearly and permanently labeled with the resident's name; -All food, liquids, medications, and personal effects brought to the resident must be brought to the nurses' station and checked with the nurse in charge before delivery to the resident; -The policy did not address how they would document and maintain personal property inventory sheets. 1. Review of Resident #97's medical record showed: -An admitted [DATE]; -A personal property inventory sheet, dated 8/28/24, showed: -No clothes, just a hospital gown; -One cell phone without the charger; -One royal blue blanket; - No added personal items listed since admission. Observation on 1/27/24 at 2:28 P.M., showed in the resident's room was a stuffed gnome, a Bat Man bag with a black coat, a blue and white knit hat, one pair of black and olive colored sweat pants, a multicolored striped scarf, and multiple personal hygiene items. 2. Review of Resident #38's medical record showed: -An admitted [DATE]; (continued on next page)

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F 0620 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-A personal property inventory sheet, dated 11/21/24, showed: -The resident admitted to the facility with a hospital gown, one pair of glasses, and a cell phone; -No further documentation of new items or clothing has been added; -The inventory sheet was not signed by the resident or the staff member who filled out the inventory sheet. Observation on 1/27/25 at 2:03 P.M., showed the resident had three shirts, five pairs of pants, and two sweaters in his/her dresser. None of the clothing had the resident's name on the tags. During an interview on 1/27/25 at 2:05 P.M., the resident said the items currently on his/her inventory list were all he/she had when he/she admitted to the facility. He/She said the clothing he/she owns was provided by the facility from the lost and found. He/She said staff have not written his/her name in his/her new clothing. 3. Review of #15's medical record showed: -An admitted [DATE]; -A personal property inventory sheet, undated, not signed by the resident, responsible party, or person completing the inventory sheet. 4. Review of Resident #265's medical record showed: -An admitted [DATE]; -A personal property inventory sheet dated, 1/15/25, showed: -The resident was admitted with no belongings; -The sheet was not signed by the staff member that completed the form; -No added personal items listed since admission. During observation and interview on 1/27/25 at 12:08 P.M., Family Member GG said the resident is missing a black night shirt and one light blue night gown with cherries on it and was not aware of any type of inventory sheet the facility had. The resident had one Care Bear t-shirt, one Tu Pac (musician) shirt, one gray shirt, two blue pairs of knit pants with the price tag on them, one black pair of knit pants, a plaid red and black pair of pajama pants, a tie-dyed night shirt, and one night shirt with swans on it. The resident also had six pair of socks in an unopened package and a pair of Muk [NAME] (brand name) of socks. 5. During a group meeting on 1/23/25 at 1:11 P.M., six residents, whom the facility identified as alert and oriented, said clothing items go missing frequently when brought to the laundry department. (continued on next page)

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F 0620 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 1/27/25 at 11:05 A.M., Certified Nursing Assistant (CNA) CC said he/she completed the resident's inventory list on a blank sheet of paper and gives it to the nurse. He/She wasn't sure what the process was when resident brings in more personal items. During an interview on 1/27/25 at 11:40 A.M., Licensed Practical Nurse (LPN) HH said there were forms to fill out for residents' personal belongings at the nurses' desk. The nurses and the nurse aides are responsible for filling out the sheets on admission and as new belongings are brought in for the resident. The completed forms are kept in the Concierge's (customer service) office. During an interview on 1/27/25 at 11:45 A.M., Concierge II said he/she will fill out the inventory list on admission and have the resident or the resident's responsible party sign the completed inventory sheet. The nursing staff will inform Concierge II if new items are brought in for the resident and he/she will add the new items for the list. If he/she is not in the office, the nursing staff can fill out another inventory sheet as needed. During an interview on 1/28/25 at 12:04 A.M., the Administrator and the Director of Nursing (DON) said they expected staff and the Concierge to complete the inventory sheets on admission and as needed when the resident brings in addition personal items. The inventory sheet should be dated, signed by the resident or responsible party and the staff member completing the inventory. A resident's clothing should have his/her name in them and should be added to the resident's inventory list. MO00241696 MO00247119 46888

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident when there is a significant change in condition **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40290 Based on interview and record review, the facility failed to ensure a significant change in status assessment was completed within 14 days after the determination was made a significant change occurred for one of one residents sampled for hospice (Resident #45). The facility identified three residents who received hospice services. The census was 166. Review of the facility's Minimum Data Set (MDS, a federally mandated assessment instrument completed by facility staff) policy, revised 4/26/23, showed: -Policy: The MDS is a standardized comprehensive assessment of all residents in Medicare or Medicaid certified facilities mandated by federal law to be completed and electronically transmitted to Centers for Medicare & Medicaid Services (CMS) in compliance with the guidelines in the MDS 3.0 Resident Assessment Instrument (RAI) User's Manual. Review of the resident's medical record, showed the resident was admitted to hospice on 5/15/24, with a primary diagnosis of cerebrovascular disease. Review of the resident's MDS records, showed: -A quarterly MDS, dated [DATE]; -A quarterly MDS, dated [DATE]; -No significant change MDS assessment completed within 14 days after the resident's admission to hospice. During an interview on 1/27/25 at 8:30 A.M., the MDS Coordinator said she is the only employee who completes MDS assessments for all residents in the facility at this time. A significant change MDS must be completed when a resident enters hospice. She is notified of changes to a resident's status, such as entering hospice, in the department head risk meetings. The resident's admission to hospice is not listed on his/her electronic physician order sheet, which may be the reason why the MDS Coordinator missed it. During an interview on 1/27/25 at 8:59 A.M., the Administrator said a significant change MDS should be completed within 14 days of a significant change, such as a resident entering hospice. She expected the MDS Coordinator to ensure significant change MDS assessments are completed timely.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40290 Based on interview and record review, the facility failed to ensure residents received an accurate assessment, reflective of the residents' status at the time of assessment, by failing to identify one resident's (Resident #45) hospice status with life expectancy of less than six months, and one resident's (Resident #19) fall within the assessment review period. The sample was 33. The census was 166. Review of the facility's Minimum Data Set (MDS, a federally mandated assessment instrument completed by facility staff) policy, revised 4/26/23, showed: -Policy: The MDS is a standardized comprehensive assessment of all residents in Medicare or Medicaid certified facilities mandated by federal law to be completed and electronically transmitted to Centers for Medicare & Medicaid Services (CMS) in compliance with the guidelines in the MDS 3.0 Resident Assessment Instrument (RAI) User's Manual. 1. Review of Resident #45's medical record, showed: -admitted to hospice on 5/15/24 with primary diagnosis of cerebrovascular disease; -Certification of terminal illness signed by physician to certify resident is terminally ill with life expectancy of six months or less. Review of the resident's quarterly MDS, dated [DATE], showed: -Life expectancy less than six months: No; -Hospice received: No. 2. Review of Resident #19's medical record, showed: -Diagnoses included acquired absence (amputation) of left leg above knee, hemiplegia (paralysis to one side) and hemiparesis (weakness to one side) following stroke affecting left non-dominant side, abnormal posture, generalized muscle weakness, and unspecified abnormalities of gait and mobility; -Incident note, dated 11/20/24, the resident laying face down on floor. Resident assessed, no injuries noted. Assisted back to bed with mechanical lift and assist of five staff members. Review of the resident's quarterly MDS, dated [DATE], showed no falls since last assessment. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. During an interview on 1/27/25 at 8:30 A.M., the MDS Coordinator said she is the only employee who completes MDS assessments for all residents in the facility at this time. When a resident enters hospice, hospice should be indicated in Section O of the MDS. Resident #45's admission to hospice is not listed on his/her electronic physician order sheet, which may be the reason why the MDS Coordinator missed adding hospice to the resident's MDS. The MDS Coordinator was not aware that a life expectancy of less than six months should be indicated on the MDS. The MDS Coordinator reviewed the incident note for Resident #19's fall on 11/20/24 and agreed the fall should have been indicated on the resident's quarterly MDS. During an interview on 1/27/25 at 8:59 A.M., the Administrator said if a resident is on hospice, it should be indicated on their MDS, as well as a life expectancy of less than six months. Falls that occur during the review period should be included on the MDS. She expected a resident's MDS to accurately reflect the resident's status at the time of assessment.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42795 Based on observation, interview and record review, the facility failed to ensure services provided met professional standards of practice by failing to transcribe two residents' (Residents #105 and #49) physician orders correctly to the Medication Administration Record (MAR). In addition, the facility administered medications to one resident (Resident #72) who did not have orders for crushed medications. The sample was 33 The census was 166. Review of the facility's Physician Orders policy, reviewed, 9/28/22, showed: -Purpose to provide guidance and ensure physician orders are transcribed and implemented in accordance with professional standards, state and federal guidelines; -Physician orders must be documented clearly in the medical record; The required components of a complete orders are: -Date and item of order; -Name of practitioner; -Name and strength of medication and treatment; -Quantity and duration; -Dosage and frequency; -Route of administration; -Indication or diagnosis; -Stop date if indicated; -Physician orders that are missing required components, are illegible or unclear must be clarified prior to implementation; -Physician orders will be transcribed to the appropriate administration record, the MAR or treatment administration record (TAR). Review of the facility's Medication Administration - General Guidelines policy and procedures, dated 12/2017, showed: -Medications are administered in accordance with written orders of the prescriber; -Table crushing/capsule opening: Crushing tablets may require a physician's order per facility policy. If it is safe to do so, education tablets may be crushed or capsules emptied out when a resident has difficulty swallowing or is tube-fed, using the following guidelines: (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The need for crushing medications should be indicated on the resident's orders and the MAR so that all personnel administering medications are aware of this need and the consultant pharmacist can advise on safety issues and alternatives, if appropriate, during medication regimen reviews. 1. Review of Resident #105's, quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 11/25/24, showed: -Resident is rarely or never understood; -Diagnoses included, aphasia (inability to speak), stroke, and seizure disorder; -Receives parenteral tube feeding liquid nutrition delivered through a tube in the abdomen). Review of the resident's care plan, in use at the time of survey, showed: -Focus: The resident requires alternative intake via tube feeding tube related to dysphagia (difficulty swallowing); -Interventions: Assist with tube feedings and water flushes. See physician orders for current feeding orders. Review of the resident's Physician's Order Sheet (POS), dated January, 2025, showed an order, dated 12/7/25; Start date, 12/7/25; Osmolyte 1.2 Cal (liquid nutrition); Give 75 milliliters (mls) per hour, via gastrostomy tube (g-tube, a tube that is surgically inserted into the abdomen) for 18 hours; Off at 12:00 A.M.; On at 6:00 A.M. Review of the resident's MAR, dated 1/1 through 1/22/25, showed: -An order, dated, 12/7/25, start date, 12/7/25, Osmolyte 1.2 Cal (liquid nutrition); Give 75 mls per hour, via g-tube, for 18 hours; Off at 12:00 A.M.; On at 6:00 A.M.; -The time for the administration was listed as 7:00 A.M. and 7:00 P.M.; -The MAR did not reflect the specific time of 12:00 A.M. to stop the tube feeding; -The MAR did not reflect the specific time of 6:00 A.M. to start the tube feeding. 2. Review of Resident #49's annual MDS, dated [DATE], showed: -The resident is rarely or never understood; -Diagnosis include seizure disorder and traumatic brain injury; -Receives parenteral tube feeding; Review of the resident's care plan, in use at the time of survey, showed: -Focus: The resident receives all nutrition and hydration via feeding tube; (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Intervention: The resident is dependent with tube feeding and water flushes. See MAR for current feeding rates. Review of the resident's physician order sheets (POS), dated January 2025, showed: -An order, dated, 1/2/25; start date, 1/3/25; Jevity 1.5 Cal (liquid nutrition); Give 60 mls per hour via g-tube. Tube feeding to run 6:00 A.M. to 10:00 P.M. Review of the resident's MAR, dated 1/1 through 1/27/25, showed: -An order, dated, 1/2/25; Start date, 1/3/25; Jevity 1.5 Cal (liquid nutrition); Give 60 mls per hour via g-tube; Tube feeding to run 6:00 A.M. to 10:00 P.M.; -The time for the administration showed 6:00 A.M.; -The MAR did not reflect the time to remove the tube feeding at 10:00 P.M. During an interview on 1/24/25 at 8:50 A.M., Registered Nurse (RN) Z said tube feeding orders that have specific times of being turned on and off should have the same times on the MAR. Even though the order was on the MAR, the times should be clear to what the order says to prevent any confusion. During an interview on 1/28/25 at 8:17 A.M., the Assistant Director of Nursing (ADON) V said tube feeding orders that include specific orders for times when the tube feeding was to be applied and removed are expected to have those exact times reflected on the MAR. The ADON was responsible for checking the orders to ensure that they are entered in correctly. The ADON said he/she had been off from work and they were not checked recently. During an interview on 1/28/25 at 12:04 P.M., the Administrator and Director of Nursing (DON) said they would expect the resident's physician order to be transcribed to the MAR with the correct and specific time the tube feeding should be turned on and off. 3. Review of Resident #72's MDS, dated [DATE], showed: -Diagnoses included, dysphagia oropharyngeal phase (difficulty swallowing food or liquid in the mouth and throat), Parkinsonism (a chronic and progressive nervous system disorder that causes nerve cells in the brain to die), dementia, and Alzheimer's disease; -Receives a mechanically altered diet. Review of the resident's care plan, last updated 1/13/25, showed: -No plan of care for dysphagia; -No care plan for mechanical soft diet. Review of the resident's order summary sheet, dated 1/24/25 showed: (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-An order dated, 9/14/2021, for mechanical soft diet, soft texture (soft, easy-to-chew foods that are mashed, ground, blended, or chopped into small, manageable pieces); -No physician order for the resident's medications to be crushed; -No consultation from pharmacist for advice on safety issues and alternatives related to crushed medications. Review of the resident's MAR, dated 1/1/25 through 1/24/25, showed no order to crush medications. Observation on 1/24/25 at 7:50 A.M., showed Certified Medication Tech (CMT) H placed eight tablets into a pill crusher pouch and then crushed the medications. He/She then opened two capsules and placed the contents into applesauce, added the crushed medications from the crusher pouch and mixed everything together. CMT H then administered the mixture to the resident with a spoon. During an interview on 1/24/25 at 12:00 P.M., CMT H said residents who receive crushed medications and opened capsules had a physician order in their chart and the MAR had a notation for crushed medications. If no physician order and no notation in the MAR existed, the CMT would not crush medications. There must be an order from the physician to crush medications. CMT H pulled up the resident's physician orders and the MAR and said there were not orders to crush medications. CMT H said there was a list of residents with comments on how the residents take their medications in the narcotic record binder inside the medication cart. That was what he/she had used since March 2024. He/She retrieved the list from the narcotic binder. The list did not have a title on the top. The bottom showed confidential with the date 8/11/2024. He/She said he/she did not know who was responsible to update the list. Staff should go off the physician orders and MAR for orders to crush medications and open capsules. CMT H said he/she should have seen there were not physician orders or notation in the MAR and notified the nurse. During an interview on 1/28/25 at 9:18 A.M., ADON V said an order was required from the physician prior to crushing medications. This order was found under resident orders and the MAR. Nursing staff were responsible to receive and document orders. If there were any concerns or questions with orders they should verify with the physician. The information for crushed medications was manually entered into the MAR. The nurse who entered the order was responsible to enter this. He/She also said the list of how residents took their medications was not an order and not a facility policy. ADON V did not know where it came from. He/She would remove the list from the narcotic binder. Medications could not be crushed or capsules opened if an order did not exist. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 1/28/25 at 12:48 P.M., The DON and Administrator said an order to crush medications was required by the physician prior to medications being crushed and capsules opened. They did not expect staff to crush medications and open capsules without a physician order. The crush medication order was located in the resident physician orders, plan of care, and MAR. Nurses were responsible to make sure orders were correct and entered into the resident's chart. If the orders were not correct or if there were questions about resident care, the nurses were responsible to call the physician to clarify. The ADON was responsible to check all physician orders, plan of care, and make sure the MAR noted if medications were to be crushed and capsules opened. The notation in the MAR was there so the CMT's and those administering medications could see it. The DON and Administrator were not aware of the list in the narcotic binder and said it was not part of the facility orders or policies. Crushed medication and capsule opening under physician orders signaled the pharmacist to review and advise on safety issues and alternatives to medications prior to crushing and opening capsules. The facility followed the crush medication list from Therapeutic Research Center. 50366

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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** 46888 Based on observation, interview and record review, the facility failed to ensure Activities of Daily Living (ADL) care was provided to four of 33 sampled residents. The facility failed to ensure one resident was free from unwanted facial hair (Resident #22), failed to ensure one resident had clean hands and hair (Resident #32), failed to ensure one resident had clean hair and nails (Resident #62), and failed to ensure two residents had clean clothing to wear (Residents #62 and #71). The sample was 33. The census was 166. Review of the facility's nail care policy, dated 7/21/22, showed: -Policy: The purpose of nail care is to clean the nails, trim nails, and prevent infection; -Key points: Nails may be cleaned during bathing. Nail care includes daily cleaning and regular trimming. Review of the facility's ADL care bathing policy, dated 7/21/22, showed: -Policy: Nursing staff will assist in bathing residents to promote cleanliness and dignity; -Procedure: Assist resident with dressing/grooming as needed. 1. Review of Resident #22's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 1/11/25, showed: -Diagnoses included dementia, anxiety, major depressive disorder, and muscle weakness; -Severe cognitive impairment. Review of the resident's care plan, dated 1/17/25, showed: -Focus: Resident requires extensive to full staff assistance with ADLs due to previous traumatic brain injury; -Goal: Resident will maintain current functional level and will be appropriately groomed, dressed, and bathed with assist; -Interventions: Extensive assist with grooming. Observation on 1/22/25 at 10:24 A.M., showed the resident in his/her bed awake. He/She had a thick patch of chin hair. Observation on 1/23/25 at 8:39 A.M., showed the resident in the dining room eating breakfast. He/She had a thick patch of chin hair. During an interview on 1/24/25 at 7:40 A.M., the resident said he/she does not want chin hair. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Review of Resident #32's annual MDS, dated [DATE], showed: -Diagnoses included dementia, major depressive disorder, and Chronic Obstructive Pulmonary Disease (COPD, lung disease); -Severe cognitive impairment. Review of the resident's care plan, dated 1/13/25, showed: -The resident was not care planned for ADL care. Observation on 1/22/25 at 1:38 P.M., showed the resident had greasy hair. Observation on 1/24/25 at 7:29 A.M., showed the resident seated at the nurse's station. The resident had greasy hair and his/her shirt had food debris on the front. Observation on 1/27/24 at 9:55 A.M., showed the resident in the hallway. He/She had dirty hands with food debris and food matter on his/her arms. 3. Review of Resident #62's quarterly MDS, dated [DATE], showed: -Diagnoses included dementia, muscle wasting, and cognitive communication deficit; -Moderately impaired cognition. Review of the resident's care plan, dated 1/13/25, showed: -Focus: Resident has the potential of ADL self care performance deficit. Resident needs encouragement with oversight and minimum to moderate assistance with bathing to complete task and compliance; -Goal: Resident will maintain current level of function through the review date; -Interventions: Monitor resident for any changes with his/her abilities to perform ADL task and assist him/her as needed. Resident requires staff oversight to monitor him/her for dressing. Observation on 1/22/25 at 12:16 P.M., showed the resident in the dining room waiting for lunch. He/She had on white pants and a gray shirt with the words There is always hope written on the front. His/Her hair was oily and his/her nails were long with matter underneath. Observation on 1/23/25 at 8:41 A.M., showed the resident in the dining room eating breakfast. He/She had the same gray shirt on as the day before and plaid pajama pants. His/Her hair was oily. He/She was eating his/her breakfast with his/her hands. His/Her nails were long at various lengths and had dark matter underneath. Observation on 1/24/25 at 7:27 A.M., showed the resident sat in the dining room. He/She had on the same plaid pajama pants as the day before along with the same gray shirt with the words There is always hope written on the front. His/Her hair was oily and his/her nails had dark matter underneath. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 1/24/25 at 9:22 A.M., the resident said he/she does not have any other clothing so he/she has to wear the same shirt. Observation on 1/27/25 at 4:38 P.M., showed the resident had on the same plaid pajama pants as the week before along with the same gray shirt with the words There is always hope written on the front. His/Her hair was oily and his/her nails had dark matter underneath. During an interview on 1/28/25 at 8:18 A.M., Licensed Practical Nurse (LPN) I said staff did not get to the resident's shower the day before due to behaviors on the hallway. He/She would expect residents to get their showers at least twice a week. 4. Review of Resident #71's quarterly MDS, dated [DATE], showed: -Diagnoses Alzheimer's disease, muscle wasting, and insomnia; - Severe cognitive impairment. Review of the resident's care plan, dated 1/13/25, showed: -The resident is not care planned for ADL or hygiene care. Review of the resident's shower sheet, showed: -The shower sheet was dated for 1/21/25 and was not completed. Observation on 1/22/25 at 11:33 A.M., showed the resident walking in the hallway. He/She was wearing a short sleeve blue shirt. Observation on 1/23/25 at 12:41 P.M., showed the resident in the dining room eating lunch. He/She had on the same blue short sleeved shirt as the day before. Observation on 1/24/25 at 7:25 A.M., showed the resident wearing the same blue short sleeve shirt as the day before and a red jacket. Observation on 1/27/25 at 8:32 A.M., showed the resident walking in the hallway wearing the same blue short sleeved shirt. 5. During an interview on 1/28/25 at 7:47 A.M., Certified Medication Technician (CMT) M said he/she would expect residents' nails to be trimmed and clean and for residents' hands to be clean. He/She would expect residents to have clean clothing. He/She said if a resident does not have clothing, staff can get the resident clothing from lost and found or the donated clothing. He/She would expect for residents' hair to be clean and not oily. All nursing staff are in charge of shaving residents' facial hair. He/She would expect nursing staff to ask residents if they want their facial hair. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 1/28/25 at 8:18 A.M., LPN I said he/she would expect residents to have clean hands with trimmed and cleaned nails. He/She would expect residents to have clean clothing to change into. He/She said if a resident does not have any clothing, staff can get the resident clothing from the donated clothing. He/She would expect residents to have clean hair. Staff should be asking residents if they want their facial hair and assisting the residents with shaving. He/She would expect residents' care plans to reflect the level of ADL assistance required. During an interview on 1/28/25 at 12:42 P.M., the Director of Nursing (DON) and Administrator said they would expect for residents to have clean hands with trimmed nails. They would expect staff to wash residents' hands frequently. They would expect staff to be changing residents' clothing every day. They said if the residents do not have clothing, staff can get the residents clothes from the donated clothing. They would expect residents to receive their showers. They would expect nursing staff to be asking residents if they want facial hair and assisting residents with removal of hair. They would expect residents' care plans to reflect the level of ADL assistance required.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265120	A. Building B. Wing	01/28/2025

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 40290 Based on observation, interview and record review, the facility failed to ensure one resident (Resident #45), assessed to be at risk for aspiration, was served pureed meat and thickened liquids in accordance with physician's orders. The resident recently returned from a hospitalization after aspirating at the facility, resulting in aspiration pneumonia (an infection caused by inhaling something other than air into your lungs) for which he/she received intravenous antibiotics. The facility staff failed to monitor the resident in the dining room, as assessed in the Minimum Data Set (MDS), which showed the resident required supervision and touching assistance for eating. Observation showed the resident chewing on a milk-soaked paper napkin without staff intervention, which could have resulted in choking. The resident's care plan failed to identify the resident's risk of aspiration and the level of assistance and supervision required for eating. The sample was 33. The census was 166. The administrator was notified on 1/27/25 at 1:09 P.M. of an Immediate Jeopardy (IJ) which began on 1/23/25. The IJ was removed on 1/27/25, as confirmed by surveyor onsite verification. Review of the facility's policy, entitled Physician Orders, dated 9/28/22, showed: -Policy: To provide guidance and ensure physician orders are transcribed and implemented in accordance with professional standards, state and federal guidelines. Review of the facility's Tray Identification and Tray Cards policy, revised 3/20/24, showed: -Policy: Physician diet orders may be communicated to the Dietary Manager by nursing staff upon admission, using electronic medical record Nutrition Management or otherwise communicated by Nursing. A tray card shall be printed to be used by the personnel as tray identification during meal service. Changes in dietary orders shall be communicated in the same manner. All additions and changes shall be updated in a timely manner; -Procedure: -A tray card shall be printed in a timely manner and provide to the nutritional services personnel. Tray card to include but not limit to name of resident, type of diet, texture of diet, type of liquids; -The Dietary Manager shall audit tray cards/diet orders against the medical records as needed. Review of Resident #45's medical record, showed: -Diagnoses included history of transient ischemic attack (TIA, temporary blockage of blood flow to the brain), unspecified sequelae (aftereffects) of cerebral infarction (stroke), hemiplegia (a neurological condition that causes paralysis or weakness on one side of the body) and hemiparesis (a condition characterized by weakness or paralysis on one side of the body) following cerebral infarction affecting left non-dominant side; frontal lobe and executive function deficit, other symptoms and signs involving cognitive functions and awareness; (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-An order, dated 8/31/23, for mechanical soft texture diet. Review of the resident's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 12/4/24, showed: -Severe cognitive impairment; -Able to make self understood; -Supervision or touching assistance required for eating. Review of the resident's care plan, revised 1/24/25, showed: -Focus: Impaired cognitive function/dementia or impaired though process; -Focus: Activities of daily living (ADLs) self-care performance deficit; -Focus: History/potential for behavior problem. Update on 1/24/25: Resident chews on linens; -Interventions included: Encourage and redirect patient from chewing on linens; -Focus: The resident has nutritional problem or potential nutritional problem and is on a supplement; -Interventions included: Provide, serve diet as ordered. Monitor intake and record every meal; -The care plan did not identify the resident's risk of aspiration and the level of assistance and supervision required for eating. Review of the resident's nurse's note, dated 1/18/25 at 11:30 P.M., showed Licensed Practical Nurse (LPN) E documented during report, the resident had emesis (vomiting) multiple times. In the middle of report, resident was heard gurgling, lung sounds mirrored crackling, oxygen declining. Reached out to physician and hospice. Was told by hospice to send resident to emergency room (ER) for aspiration. Resident left facility at 7:55 P.M. to hospital. Review of the resident's nurse's note, dated 1/19/25 at 1:50 A.M., showed LPN E documented the resident arrived back via Emergency Medical Services (EMS). Resident was still gurgling with audible breathing and per EMS, resident threw up multiple times on the way to facility. Hospice notified of status and agreed resident needs to go back out to hospital. Resident vomited a large piece of what appeared to be meat. Resident's oxygen still low, but no longer loud audible breathing. EMS took resident back to hospital at 2:54 A.M. During an interview on 1/29/25 at 8:50 A.M., LPN E said after the resident returned to the facility from the hospital on 1/18/25, he/she had an episode of emesis and threw up a chunk of meat. LPN E could tell the meat was ground up, but it was stuck together in a ball. The resident was on a mechanical diet at the time of the incident. He/She requires assistance and supervision while eating. Someone should be sitting down next to him/her while he/she eats. The resident has confusion and will put anything in front of him/her in his/her mouth. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the resident's hospital discharge summary, dated 1/21/25, showed: -Presenting history: Patient initially aspirated on evening of 1/18/25 on a hamburger patty at the nursing home. Chest x-ray showed bilateral lower lobe infiltrates (increased density in the lower lobes of both lungs, which can be caused by various conditions including infection (like pneumonia), fluid buildup (pulmonary edema), blood clots, or inflammation). Patient was given intravenous antibiotics and fluids and admitted for further medical management; -Clinical swallow evaluation, dated 1/20/25, showed recommendations of mechanically altered diet/minced and moist/nectar thick (mildly thick) liquids. Patient is at risk for aspiration due to recent aspiration event, stroke with history of dysphagia (swallowing disorder) and results observed during this assessment; -Discharge diagnosis: Aspiration pneumonia; -Precaution orders: Aspiration precautions. Review of the resident's physician order summary, showed an order, dated 1/21/25, for mechanical soft texture diet/pureed meat texture, nectar consistency liquids. Observation on 1/23/25 at 1:28 P.M., showed the resident seated by the nurse's station, chewing on a towel. Certified Medication Technician (CMT) A gave the resident a cup of un-thickened water. The resident took a couple sips of water and began coughing. CMT A waited until the resident stopped coughing, then gave the resident another sip of un-thickened water. During an interview on 1/23/25 at 1:52 P.M., CMT A said the resident chews on things like towels as a behavior and it seems to soothe him/her. He/She used to receive a mechanical-soft diet, but went out to the hospital last week for aspiration. He/She returned to the facility on a pureed diet. He/She still receives thin liquids. Observation on 1/24/25 at 8:05 A.M., showed Dietary Aide (DA) F poured un-thickened 2% milk into the resident's cereal and left the carton of milk on the table. The resident knocked over the carton of milk, which spilled all over the paper napkin on the table. No staff was observed to supervise the resident. At 8:18 A.M., the resident picked up the milk-soaked napkin and put the napkin in his/her mouth. The resident began chewing on the napkin and made swallowing gestures. Staff were not aware the resident was chewing on the napkin until the surveyor notified Registered Nurse (RN) B at 8:21 A.M. Upon being made aware the resident had something in his/her mouth, RN B approached the resident and asked him/her what he/she had in his/her mouth. The resident looked at RN B and did not verbally respond while he/she continued to chew on the napkin in his/her mouth. RN B did not ask the resident to open his/her mouth. As Certified Nurse Aide (CNA) C was walking by, RN B asked CNA C what the resident had in his/her mouth. CNA C said the resident was eating breakfast. RN B told the surveyor the resident was chewing his/her food. The surveyor asked RN B to look inside the resident's mouth. RN B asked the resident to open his/her mouth and observed the napkin inside his/her mouth, then removed it. CNA C said the resident does this all the time. At 8:23 A.M., CNA C brought the resident a breakfast plate consisting of mechanical-soft sausage. CNA C fed the resident the mechanical-soft sausage. Review of the resident's dietary slip showed mechanical soft diet, with no documentation regarding pureed meat or nectar thick liquids. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 1/24/25 at 8:27 A.M., CNA C said the resident requires feeding assistance and reaches for things he/she should not have. He/She receives a mechanical soft diet so he/she can chew his/her food. He/She does not require pureed food and can have regular liquids. During an attempted interview on 1/24/25 at 9:08 A.M., the resident was unable to respond to specific questions related to his/her recent hospitalization or medical condition. During an interview 1/27/25 at 8:23 A.M., RN B said he/she does not know the resident, and does not know his/her cognitive status, dietary orders, or level of assistance required for eating. On 1/24/25, after being made aware the resident had something in his/her mouth, RN B assumed the CNA saw what he/she had in his/her mouth and assumed he/she was chewing on cereal. During an interview on 1/24/25 at 1:10 P.M., CNA G said the resident is confused. He/She recently had an incident where he/she choked on his/her food and was sent out to the hospital. He/She can feed him/herself but needs to be supervised at all times while eating because he/she will put things in his/her mouth that he/she shouldn't. During an interview on 1/27/24 at 7:53 A.M., the Dietary Manager (DM) said the resident has always required feeding assistance. He/She has been on a mechanical diet for a while now. Last week, the resident just kept choking and choking during breakfast, possibly on sausage. Assistant Director of Nurses (ADON) T made an executive decision to give the resident pureed meat at that meal, instead of mechanical. The order for pureed meat and thickened liquids is new and happened after the incident last week. Thickened liquids include all liquids served to the resident, such as milk, coffee, and water. The kitchen has thickened milk cartons that can be given to residents who should have nectar-thick liquids, and this is what should have been used for the resident at breakfast on 1/24/25. Residents with orders for thickened liquids should receive liquids as ordered because of choking risk. Dietary slips are generated from the physician orders entered by nursing in the electronic medical record (EMR). When there is a change to a resident's diet orders, nursing gives her a form. She cannot find a form to notify her of the changes to the resident's diet, but the orders are in the EMR. The diet slip observed with the resident's breakfast on 1/24/25 must have been an old slip. Dietary and nursing staff should check the diet slips to ensure residents are served the correct foods. During an interview on 1/27/25 at 8:10 A.M., ADON T said he/she may have recently made a nursing judgment to downgrade the resident's diet to pureed meat one day because he/she was pocketing his/her food. He/She cannot remember the exact day this occurred. The resident should receive the correct diet in accordance with physician orders due to risk of choking. He/She puts things other than food in his/her mouth all the time and needs a lot of supervision. On 1/24/25, the staff should have been paying attention to the resident, keeping a close eye on him/her. When the nurse was notified the resident had the napkin in his/her mouth, the nurse should have checked the resident's mouth because the resident is confused. During an interview on 1/27/25 at 8:30 A.M., the MDS Coordinator said he/she does not know the resident well. When asked to define supervision for eating, as indicated on the resident's MDS, the MDS Coordinator said supervision means staff need to be there to guide the resident, encourage them, and assist to a certain point. Staff should make sure the resident is safe with eating and not exhibiting behaviors. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 1/27/25 at 7:23 A.M., the Medical Director said the resident just came back from the hospital. He believes the facility made him aware of the hospital's new orders for the resident to receive a mechanical soft diet and nectar-thick liquids. He is not sure if the instruction for pureed meat on the current physician order came from hospice or the hospital's speech therapist, but he expected the orders to be followed. Pureed meat could be helpful with the resident's swallowing. Nectar-thick liquids means all liquids should be thickened, including water. The resident is confused and has poor safety awareness. He/She should be supervised while eating. It would be fine for staff to just be in the dining room with the resident, if they are keeping an eye on him/her. When given a description of the observations made on 1/24/25, the Medical Director said it was problematic for the resident to have put the napkin in his/her mouth, whether he/she has a swallowing issue or not. When the nurse was notified of the behavior, the nurse should have checked the resident's mouth, without prompting. Staff should have had a more watchful eye on the resident. The resident should have received thickened liquids and pureed meat at his/her meal. During an interview on 1/27/25 at 8:59 A.M., the Administrator said the resident is confused and recently went out to the hospital for aspiration pneumonia. Before the hospitalization , the resident received a mechanical diet. When he/she returned to the facility, the admitting nurse should have reviewed the orders from the hospital, verified them with the physician, then entered the orders into the EMR. The EMR is integrated so new dietary orders would have gone to the dietary department, and the new orders would have been generated on the dietary slips. Sometimes dietary staff will generate bulk slips at one time to be used throughout the week, but the dietary slips should be printed daily so the current orders are reflected on the dietary slips. Changes to a resident's diet should be communicated to the floor staff from daily huddles and the report sheets. Nectar-thick liquids applies to all liquids given to a resident. Nectar-thick liquids allow for more time to go down to prevent aspiration because thin liquids can go down too fast. The resident should have received thickened liquids with meals and pureed meat at breakfast, not mechanical-soft sausage. The resident needs supervision while eating. He/She has poor safety awareness. He/She can pick up his/her utensil but needs encouragement and at times, staff may have to pick up his/her utensil for him/her to get started eating. He/She chews on his/her tongue and the behavior of putting things in his/her mouth is recent. Because he/she has this behavior, staff should be around at meals to keep an eye on him/her. When informed of the observations made on 1/24/25, the Administrator said she expected staff to be supervising the resident. When the nurse was made aware of the resident having something in his/her mouth, the nurse should have checked his/her mouth right away. NOTE: At the time of the survey, the violation was determined to be at the immediate and serious jeopardy level J. Based on observation, interview and record review completed during the onsite visit, it was determined the facility had implemented corrective action to address and lower the violation at the time. At the time of exit, the severity of the deficiency was lowered to the D level. This statement does not denote that the facility has complied with State law (Section 198.026.1 RSMo.) requiring that prompt remedial action be taken to address Class I violation(s).

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42795 Based on observation, interview and record review, the facility failed to follow physician orders, the oxygen administration storage policy, and proper infection control techniques for two of 33 sampled residents (Resident #15 and #315). The census was 166. Review of the facility's Oxygen Administration and Storage policy, dated, 1/1/14, showed: -Purpose: To ensure staff follow safety guidelines and regulation for storage and use of oxygen; -Tubing: Oxygen tubing should be changed weekly; Nasal cannula (NC, tubing that delivers oxygen through the nose) tubing may need to be changed more frequently; -Pulse Oximetry: Residents who have oxygen order should have oxygen saturation levels measured by oximetry (a device that is placed on the finger and measures oxygen levels); The physician should be notified of any concern identified with oxygen titration needs so the physician may determine a need to change the order to best meet the resident's oxygen needs. Review of the facility's Physician Orders policy, reviewed 9/28/22, showed: -Purpose to provide guidance and ensure physician orders are transcribed and implemented in accordance with professional standards, state and federal guidelines; -Physician orders must be documented clearly in the medical record; The required components of a complete orders are: -Date and item of order; -Name of practitioner; -Name and strength of medication and treatment; -Quantity and duration; -Dosage and frequency; -Route of administration; -Indication or diagnosis; -Stop date if indicated; -Physician orders that are missing required components, are illegible or unclear must be clarified prior to implementation; (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Physician orders will be transcribed to the appropriate administration record, the Medication Administration Record (MAR) or Treatment Administration Record (TAR). 1. Review of Resident #15's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 1/14/25, showed: -Cognitively intact; -Requires oxygen therapy. Review of the resident's face sheet, undated, showed his/her diagnoses included shortness of breath (SOB), wheezing, chronic obstructive pulmonary disease (COPD, a lung disease that restricts the lung passages, making it difficulty to breathe), atelectasis (complete or partial collapse of the lung), anxiety and tobacco use. Review of the resident's care plan, in use at the time of survey, showed: -Focus: The resident is on oxygen therapy related to COPD; -Interventions: The resident was educated on safety precautions related to increasing his/her oxygen; monitor signs and symptoms of respiratory distress and report to physician as needed; Monitor pulse, pulse oximetry, respirations, increased heart rate, sweating, use of accessory muscles (muscles used to assist with breathing), and lethargy (sleepiness), educate the resident and caregivers about the potential outcome of not complying with treatment and care; -Focus: The resident is resistive to care and will remove oxygen to smoke; -Interventions: Educate the effects of smoking on the lungs and body, encourage the resident to stop smoking; -Focus: The resident has COPD; -Intervention: Give oxygen therapy as ordered by the physician. Review of the resident's Physician Order Sheets (POS), dated January, 2025, showed: -An order, dated 11/27/24; Start date, 11/28/24; Oxygen 3 liters (L) NC continuously as tolerated, every shift, related to SOB; -An order, dated 11/23/24, no start date; Change the following as indicated, humidifier bottle on oxygen concentrator, humidifier tubing, oxygen tubing and water in the humidifier, no frequency listed; -An order, dated, 11/23/24; Start date, 11/23/24; Monitor pulse oximetry every shift. Review of the resident's Medication Administration Record (MAR), dated 1/1/25 through 1/23/25, showed: (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-An order, dated 11/27/24; Start date, 11/28/24; Oxygen 3 L NC continuously as tolerated, every shift; related to SOB; -Documented as completed at 7:00 A.M. and 7:00 P.M. -An order, dated 11/23/24, no start date, change the following as indicated, humidifier bottle, on oxygen concentrator, humidifier tubing, oxygen tubing and water in the humidifier, no frequency listed; -An X was noted in the documentation boxes. -An order, dated 11/23/24; Start date, 11/23/24, Monitor pulse oximetry every shift; -Documented as completed for 7:00 A.M. and 7:00 P.M. Review of the resident's pulse oximetry under the vital signs tab, dated 1/1/25 through 1/23/25, showed no documentation of the pulse oximetry result number. Review of the resident's progress notes, dated 1/1/25 through 1/25/25, did not show documentation of the result of the resident's oximetry or behaviors by the resident, such as refusing to wear the oxygen or the resident increasing the oxygen rate. During observation and interview on 1/22/25 at 12:42 P.M., the resident sat in his/her wheelchair in his/her room. The resident had a nasal cannula and oxygen tubing on, connected to an oxygen concentrator. The oxygen tubing was undated. The oxygen concentrator was set on 5L. The resident said he/she just walked out of the restroom and increased the oxygen to 5L NC because he/she was short of breath. The resident appeared to breathe rapidly and had difficulty speaking, but recovered during the conversation. The resident said the only time he/she used the oxygen was when he/she was moving around out of his/her wheelchair. During observation and interview on 1/24/25 at 9:32 A.M., the resident sat in his/her wheelchair in his/her room. The resident had a nasal cannula and oxygen tubing connected to the oxygen concentrator. The oxygen tubing was undated. The oxygen concentrator was set on 5 L. The resident said he/she was trying to change his/her shirt and pants and became short of breath and had applied the oxygen him/herself. The resident was pursed lip breathing (a method of breathing that includes exhaling through tight lips and inhaling through the nose) and the resident said he/she was trying to catch his/her breath. Observation on 1/24/25 at 9:50 A.M., and on 1/28/25 at approximately 11:00 A.M., showed the resident self-propelled his/her wheelchair, using his/her feet in the main hallway. The resident did not have on oxygen. Observation on 1/27/25 at 10:12 A.M., showed the resident at the nurses' station in his/her wheelchair, making a phone call. The resident did not have on oxygen. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with on 1/28/25 at 7:28 A.M., Registered Nurse (RN) P and Licensed Practical Nurse (LPN) W said they were not aware the resident changed the oxygen rate to 5 L. The resident removes his/her oxygen to smoke. RN P said the resident's order for oxygen means the resident is to have on oxygen at 3L via NC but has the right to remove the oxygen if he/she feels as though he/she cannot tolerate it. The oxygen tubing is to be changed every Sunday on night shift and should be labeled with the date. The pulse oximetry order should reflect the actual number and was probably placed in the system incorrectly and did not have an attachment added to reflect the resident's actual pulse oximetry number. It is important to check the resident's pulse oximetry, especially if the residents are on oxygen. During an interview on 1/28/25 at 8:17 A.M., Assistant Director of Nursing (ADON) V said the resident's oxygen order needed to be clarified as continuously or as needed with an accurate liter flow. The current order didn't make any sense. ADON V said the resident's pulse oximetry order and the oxygen tubing change order was placed in the computer incorrectly. The pulse oximetry order did not have the staff document the actual number and the X on the resident's MAR for the oxygen tubing change meant it was not completed. The way that the orders were currently in the computer failed to have the nurses document properly. The ADON is responsible for checking the orders to ensure they are entered in correctly. The ADON said he/she had been off from work and they were not checked recently. Any documentation that the resident is changing the oxygen rate or any type of refusals would be documented in the progress notes. During an interview on 1/28/25 at 12:04 P.M., the Administrator and the Director of Nursing (DON) said they expected the oxygen related orders to be clear, accurate and understandable. Physician orders are expected to be placed in the computer correctly for accurate documentation. The ADONs are responsible to check if the orders are in correctly. Any type of behaviors of refusing oxygen and changing the oxygen rate should be documented in the resident's progress notes. The oxygen tubing is expected to be changed on Sundays and labeled with a date. 2. Review of Resident #315's quarterly MDS, dated [DATE], showed: -Cognitively intact; -Requires intermittent oxygen therapy; -Diagnoses included COPD and chronic respiratory failure with hypoxia (failure of the organs and tissues to receive adequate oxygenation). Review of the resident's care plan, in use at the time of survey, showed: -Focus: The resident has SOB; -Interventions: Maintain a clear airway by encouraging resident to clear secretions with effective coughing; -No intervention regarding the resident's oxygen use or oxygen orders. Review of the resident's POS, dated January, 2025, showed: (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-An active order signed on 1/18/25, for the changeover of oxygen tubing, water in the oxygen concentrator, the humidifier bottle, and oxygen tubing as indicated; -An active order signed on 1/18/25, for the resident to have 4L of oxygen via nasal cannula continuously. During observation and interview on 1/22/25 at 9:36 A.M., the resident said he/she uses oxygen intermittently while in bed or while resting in the room. The resident said it is often difficult to retrieve his/her nasal cannula when he/she returns to his/her room, as it is often on the floor. Observation showed the resident's nasal cannula on the floor next to the resident's oxygen concentrator. The concentrator was running. Observation on 1/23/25 at 8:40 A.M., showed the resident entered his/her room via wheelchair while housekeeping staff cleaned the room. The housekeeping staff member finished cleaning the room and left, leaving the resident's nasal cannula on the floor next to the oxygen concentrator. The concentrator was left running. Observation on 1/24/25 at 8:04 A.M., showed the resident's nasal cannula laying on the floor next to the oxygen concentrator. The concentrator was left running. Observation on 1/24/25 at 9:20 A.M., showed housekeeping staff entered the resident's room to provide daily cleaning. At that time, the resident's nasal cannula was on the floor next to the resident's oxygen concentrator. The concentrator was running. At 11:05 A.M., the resident's nasal cannula was on the floor next to the oxygen concentrator with the concentrator left running. Observation on 1/28/25 at 7:51 A.M., showed the resident's nasal cannula laying on the floor next to the oxygen concentrator. The concentrator was running. At 9:52 A.M., the nasal cannula lay on the floor next to the oxygen concentrator. The concentrator was left running. During an interview on 1/28/25 at 9:17 A.M., Certified Nurse Aide (CNA) X said he/she was unsure of the resident's specific oxygen orders, but the resident only uses oxygen when in his/her room, either in bed or resting in his/her wheelchair. The facility expected staff to ensure the resident's nasal cannula and oxygen tubing are kept off the floor, and the concentrator turned off when not in use. Staff are expected to pick up and clean a resident's nasal cannula if seen on the floor during care or room cleaning, and the concentrator should be turned off when not in use. During an interview on 1/28/25 at 9:06 A.M., LPN Y said the resident's oxygen orders are as needed (PRN), and the resident uses oxygen when in his/her room or during times when the resident feels anxious. The facility expected staff to ensure the resident's nasal cannula is kept up off the floor and in a plastic bag attached to the concentrator. The concentrator should be turned off when not in use. All staff are expected to pick up a resident's nasal cannula off the floor during care or when cleaning. LPN Y said oxygen use and orders should be included on a resident's care plan to direct appropriate care. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 1/28/25 at 12:01 P.M., the Administrator and DON said the resident uses his/her oxygen intermittently when in his/her room or when resting in his/her chair. The oxygen tubing and nasal cannula should be kept off the floor and in a clean plastic bag when not in use to maintain proper infection control practices. The oxygen concentrator should be turned off when not in use. The Administrator and DON expected any staff member to retrieve a resident's nasal cannula from the floor if they were in the room providing care or daily cleaning. The Administrator and DON expected any resident with oxygen orders to have that information included on the resident's care plan. 44948

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. 44948 Based on observation, interview and record review, the facility failed to ensure drugs and biologicals were labeled and stored per acceptable standards of practice, in two of two facility medication rooms and in two of three medication administration carts. The facility census was 166. Review of the facility's Medication Storage in the Facility policy, revised 11/2018, showed: -Medications and biologicals are stored safely, securely and properly, following manufacturer's recommendations or those of the supplier. The medication supply is accessible only to licensed nursing personnel, pharmacy personnel, or staff members lawfully authorized to administer medications; -All expired medications will be removed from the active supply and destroyed in the facility, regardless of the amount remaining. The medication will be destroyed in the usual manner. Observation of the 300 hall medication storage room on 1/23/25 at 10:10 A.M., showed a plastic bag containing nine ESwab Liquid collection and preservation kits (used to collect liquid samples for laboratory examination) expired as of 9/20/24. Observation of a medication cart located on the 300 hall on 1/23/25 at 10:31 A.M., showed a box of CareAll Tetrahydrolozine HCl Eye Drops (used to help the eyes stay moist and clear) with 15 mL (milliliters) dropper expired as of 11/2024. Observation of the 200 hall medication storage room on 1/23/25 at 10:58 A.M., showed: -One bottle of ProCure Allergy Relief (loratadine antihistamine, a medication used to reduce nasal congestion, itchy nose, and other allergy symptoms) 10 mg (milligram) tablets expired as of 10/2024; -One box of CareAll Tetrahydrolozine HCl Eye Drops with 15 mL dropper expired as of 11/2024; -One box of Assure Dose Accucheck Control Solution (a liquid solution used to properly calibrate glucose meters) expired as of 10/6/2024. Observation of a medication cart located on the 100 hall on 1/23/25 at 12:21 P.M., showed one bottle of GeriCare Zinc Sulfate (a daily dietary and immune system supplement) 50 mg tablets expired as of 10/2024. During an interview on 1/28/25 at 9:09 A.M., Certified Medication Technician (CMT) DD said no single staff member was responsible for ensuring expired medications were removed from facility medication rooms and medication carts, but the CMTs and floor nurses went through them at least once per week. If an expired medication or biological was found in a facility medication room or medication cart, staff were expected to remove and waste those medications per facility policy. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During interview on 1/28/25 at 9:13 A.M., Licensed Practical Nurse (LPN) Y said there was no staff member directly responsible for auditing medication rooms and medication carts for expired medications, but the night nurses worked together to audit the carts once per week. If an expired medication was found on a floor's medication cart or in any of the facility medication rooms staff were expect to remove those items and waste them as appropriate per facility policy. During interview on 1/28/25 at 12:01 P.M. the Administrator and Director of Nursing (DON) said each floor's Assistant Director of Nursing (ADON) was in charge of ensuring medication rooms were audited for expired medications on a daily basis and medication carts were audited once a week on Fridays. Facility administration expected any staff member who found expired medications or biologicals in a medication room or medication cart in the facility to be disposed of per facility policy.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 46888 Based on observation, interview and record review, the facility failed to ensure the kitchen floors, bulk bins, and appliances were free from food and trash debris. The facility failed to ensure the ceiling above a meal preparation station was free from dust build up, and failed to ensure the walk in- refrigerator and freezer floors were free from food and trash debris. The facility census was 166. Review of the facility's daily kitchen cleaning checklist, undated, showed: -Daily or after each use: all freezers and refrigerators are cleaned, floors swept and mopped daily. Review of the facility's weekly kitchen cleaning checklist, undated, showed: -Clean all freezers and refrigerators interior and exterior, deep clean oven, polish all stainless-steel surfaces, vents cleaned and free of dust, deep fryer cleaned and oil changed weekly. 1. Observation on 1/22/25, of the kitchen, showed: -At 9:25 A.M., the walk-in refrigerator had a pink liquid spill under the first rack and trash and food debris in various areas on the floor; -At 9:28 A.M., the walk-in freezer had trash and food debris in various areas of the floor; -At 9:38 A.M., the floor next to the dishwashing sink had dark matter build up, dead bugs, and liquid spilled; -At 9:40 A.M., the vent and ceiling above the main food preparation station had dust build up and cobwebs. Ground meat was being prepared at the station; -At 9:41 A.M., the bulk bin lids had food debris and white powder build up; -At 9:44 A.M., the deep fryer had a sticky liquid substance on the right and left sides. The oil was dark brown and had food particles; -At 9:44 A.M., the oven doors had food debris. The side next to the deep fryer had a sticky liquid buildup. 2. Observation on 1/23/25, of the kitchen, showed: -At 7:44 A.M., the walk-in freezer had food debris and trash on the ground; -At 7:56 A.M., the walk-in refrigerator had food debris and trash on the ground; (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-At 7:58 A.M., the floor under the clean end of the dishwashing station had trash and bowls; -At 8:00 A.M., the ceiling and vent above the main meal preparation station had dust accumulation; -At 8:02 A.M., the deep fryer had a sticky liquid substance on the right and left sides. The oil was dark brown; -At 8:02 A.M., the oven doors had food debris and caked-on substance. The side of the oven closest to the deep fryer had a caked sticky substance; -At 8:04 A.M., the bulk bin lids had white powder build up and food debris; -At 8:05 A.M., the floor by the pots and pans storage rack had a white powder spill by the drain; -At 8:05 A.M., the floors under and around the dishwashing sinks had matter build up, dead bugs and liquid spilled. 3. Observation on 1/27/25, of the kitchen, showed: -At 7:53 A.M., the deep fryer had a sticky liquid build up on the right and left sides; -At 7:54 A.M., the oven had food build up on the doors and front and liquid build up on the side closest to the deep fryer; -At 7:54 A.M., the ceiling and one vent above the main meal preparation station had dust build up and cobwebs. Unwrapped food was on the preparation station; -At 7:55 A.M., the 6 bulk bins had food debris and white powder build up on the lids; -At 7:55 A.M., the floor in front of the pots and pans storage rack had a white powder splatter; -At 7:57 A.M., the floors under and around the dishwashing sinks had matter build up, dead bugs and liquid spilled; -At 7:58 A.M., the floors under the clean end of the dishwashing station had trash and bowls -At 7:59 A.M., the walk-in refrigerator had a pink liquid spill under the first rack and trash and food debris on various areas on the floor. 4. During an interview on 1/28/25 at 9:01 A.M., [NAME] L said the kitchen floors should be cleaned after every meal service. He/She expected the ceiling and ceiling vents to be free from dust build up. He/She expected kitchen appliances and bulk bins to be cleaned after each use and deep cleaned once a week. He/She expected the walk-in refrigerator and freezer to be free from trash and debris. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 1/28/25 at 9:21 A.M., the Dietary Supervisor said she expected the ceiling and ceiling vents to be free from dust build up. She said maintenance comes in and cleans the ceilings once a week. She expected the bulk bin lids to be free from food debris. She expected kitchen appliances to be clean. She said the deep fryer and oven are to be cleaned twice a week. She said the frying oil is changed once a week. She expected the floors in the entire kitchen to be clean and free from food and trash debris. She said the cooks are responsible for cleaning the the kitchen appliances and food preparation stations. Dietary Aides are responsible for cleaning the floors in the kitchen and the walk-ins and the bulk bins. She said when she is not at the facility, the cooks are in charge of oversight of cleaning in the kitchen. During an interview on 1/28/25 at 12:29 P.M., the Administrator said she expected dietary staff to ensure the kitchen and kitchen appliances were cleaned per the kitchen cleaning check lists.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42795 Based on observation, interview and record review, the facility failed to follow acceptable infection control standards by not implementing Enhanced Barrier Precautions (EBP, an infection control intervention designed to reduce the transmission of multidrug-resistant organisms (MDROs) that employs targeted gown and glove use during high contact resident care activities) as recommended by the Centers for Disease Control and Prevention (CDC) and required by the Centers for Medicare and Medicaid Services (CMS) for residents with central lines to include dialysis (a treatment that helps remove waste products and excess fluid from the blood when the kidneys are not working properly) access sites, residents with gastrostomy tubes (g-tube, a tube that is surgically inserted into the abdomen and is used for liquid nutrition and medications) and wounds requiring treatments, for three residents (Resident # 97, #105, and #265) The sample was 33. The census was 166. Review of the facility's Enhanced Barrier Precautions (EBP), reviewed 5/15/24, showed: -Policy: The facility may expand the use of personal protective equipment (PPE, isolation gowns and gloves) and refer to the use of gowns and gloves during high contact resident care activities that provides opportunities for transfer of MDROs to hands or clothing. The use of gowns and gloves for high contact care activities is indicated, when contact precautions do not otherwise apply, for facility residents with wounds and/or indwelling medical devices regardless of MDRO colonization (organisms are present but not causing any symptoms) as well as for residents with MDRO infection or colonization; -Procedure: Examples of high contact resident care activities requiring gown and glove use for EBP include: dressing, bathing or showering, transferring providing hygiene, changing lines, changing briefs or toileting, central line care (a flexible tube that is inserted into the vein) urinary catheter (a tube that is inserted into the bladder to drain urine) enteral tube (a surgical inserted tube in the abdomen that is used for liquid nutrition and medications), tracheostomy (a tube inserted into the windpipe that assists with breathing), wound care that requires a dressing; -Steps: Post signage on the door or wall outside the resident's room indication the use of EBP; EBP signage should include information on high contact resident care activities that require the use of gown and gloves; PPE should be available inside of the resident's room; Alcohol based hand rub should be available for hand hygiene; Incorporate periodic monitoring/evaluation of adherence to infection prevention practices to determine the need for addition training/ education. 1. Review of Resident #97 's, quarterly minimum data set (MDS), a federally mandated assessment tool completed by facility staff, dated, 12/4/24, showed: -Cognitively intact; -Diagnosis include: Diabetes, kidney failure, heart disease, heat failure, and respiratory failure; -Receives dialysis. Review of the resident's care plan, in use at the time of survey, did not address EBP. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the resident's physician order sheets (POS), dated, January, 2025, showed: -An order, dated, 1/22/25; Check the resident's catheter site for dislodgement, signs and symptoms of infection, and spontaneous bleeding; -An order, dated, 12/30/24; Cleanse the resident's stump (a part of the limb that remains after an amputation) with soap and water, apply dressing and wrap with Kerlix (a specialized mesh dressing), once daily; -No order for EBP. Observation and interview on 1/22/25 at 10:29 A.M., showed an EBP sign that read Stop, EBP was posted on the resident's door frame outside the resident's room. On the inside of the resident's room a caddy was located hanging on the door that contained PPE. The resident lay in bed and said he/she had a recent right leg amputation. The resident also said he/she received in house dialysis and his/her dialysis access was a catheter in his/her right groin. The resident raised his/her hospital gown and exposed his/her stump to show a dressing dated, 1/21/24, and a dialysis catheter to his/her right groin. At 10:40 A.M., Certified Nursing Assistant (CNA) CC entered the room and explained to the resident he/she was going to change the resident's incontinence brief. CNA CC applied gloves and provided perineal care (peri-care, cleansing of the genitals and rectal area) to the resident. At 10:45 A.M., CNA BB entered the room with a Hoyer lift (a specialized lift for residents that cannot stand). CNA BB applied gloves and assisted CNA CC with applying the Hoyer lift pad by turning the resident side to side. When the resident was turned to his/her right side, the resident held onto CNA BB by grasping CNA BB's waist. CNA BB and CNA CC transferred the resident into a chair with the assistance of the Hoyer lift. CNA CC and CNA BB did not wear a gown while providing care to the resident. 2. Review of Resident #105's, quarterly MDS, dated , 11/25/24, showed: -Resident is rarely or never understood; -Diagnosis include, aphasia (inability to speak), stroke, and seizure disorder; -Receives parenteral tube feeding (liquid nutrition administered through a tube that is surgically inserted into the abdomen). Review of the resident's care plan, in use at the time of survey, showed: -Focus: The resident is on EBP related to g-tube; -Interventions: Gown and glove use for all high contact resident care. Incorporate periodic monitoring and evaluation of adherence to infection control practices to determine need for additional training or education. Review of the resident's POS, dated, January, 2025, showed no order for EBP. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 1/22/25 at 2:50 P.M., showed an EBP sign that read Stop, EBP on the door frame outside the resident's door. A caddy was located hanging on the door inside of the resident's room, and contained PPE . The resident lay in bed with a tube feeding pump connected to his/her g-tube. CNA BB entered the resident's room and applied gloves. CNA BB removed the resident's brief and performed peri-care on the resident. CNA BB rolled the resident side to side as he/she changed the resident's incontinence brief. CNA BB's uniform top frequently touched the resident's body while turning the resident. CNA BB did not wear a gown while providing care to the resident. 3. Review of the Resident #265's face sheet, undated, showed: -An admitted [DATE]; -Diagnosis include: diabetes, aphasia (inability to speak), stroke and hemiplegia (paralysis to one side of the body). Review of the resident's baseline care plan, dated, 1/15/25, did not address EBP for the resident. Review of the resident's POS, dated, January, 2025, showed no order for EBP. Observation on 1/24/25 at 1:32 P.M., showed an EBP sign that read Stop, EBP on the door frame outside the resident's door. A caddy was located hanging on the door inside of the resident's room and contained PPE. CNA C entered the room and applied gloves. CNA C raised the resident's hospital gown and the resident had a g-tube located in his/her abdomen. CNA C removed the resident's incontinence brief and provided peri-care. Certified Medication Technician (CMT) H entered the room and applied gloves. CMT H assisted CNA C with turning the resident side to side and repositioning the resident. CNA C and CMT H did not wear gowns during resident care. 4. During an interview on 1/28/25 at 7:32 A.M., Registered Nurse (RN) P said EBP was for residents who had MDRO or a history of MDRO, dialysis catheters, g-tubes, urinary catheters and wounds. Residents who required EBP required staff to wear a gown and gloves and possibly a mask if indicated when providing care. Resident #95, Resident #107, and Resident #265 required staff to wear gown and gloves when providing care. During an interview on 1/28/25 at approximately 9:00 A.M., CNA R said there should be an EBP sign on the door and PPE inside the resident's room. Residents who had the EBP sign, required staff to wear a gown and gloves when providing care. Care included bathing the resident, changing the resident's clothing, during transfers and when providing peri-care. CNA R thought EBP were for residents who had wounds and urinary catheters. During an interview on 1/28/25 at 9:30 A.M., Assistant Director of Nursing U, said he/she was the Infection Preventionist (IP) for the facility. He/She expected staff to use PPE when the EBP sign was on the door. EBP was used when staff dressed the resident, bathed the resident or basically providing any type of care to the resident. Residents who required EBP had MDRO, a dialysis catheter, wounds that required dressings, tracheostomy tubes, g-tubes, drains, and urinary catheters. Residents with EBP were expected to have physician orders and be included in the resident's care plan. (continued on next page)

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 1/28/25 at 12:04 P.M., the Administrator and the Director of Nursing said they expected staff to wear PPE when residents required EBP. Residents with EBP were expected to have physician orders and it be included on the resident's care plan.