STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265142	A. Building B. Wing	04/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Chateau Girardeau	3120 Independence Street Cape Girardeau, MO 63703

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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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. Based on interview and record review, the facility failed to inform residents and/or their responsible parties, in advance of the risks and benefits of proposed care, before beginning psychotropic medications (medications that affect the mind, emotions, and behavior) for five residents (Residents #7, #8, #38, #55, and #66) out of five sampled residents. The facility census was 50. Review of the facility policy titled, Informed Consent for Treatment, undated, showed: - The facility is committed to honoring each resident's right to make informed decisions regarding their care. Informed consent will be obtained prior to initiating treatment, except in emergency situations, and will be documented in the resident's medical record; - Consent must be voluntary and free from coercion, based on clear, understandable information, and provided by the resident or legally authorized representative; - The practitioner obtaining consent must ensure that the resident or representative is informed of the nature and purpose of the proposed treatment, expected benefits and potential risks, reasonable alternatives, including the option to refuse treatment, and possible consequences of refusal; - The informed consent discussion, the name of the individual providing consent, the specific treatment or procedure consented to, date and time of consent, signature of the resident or representative (when required), and name and credentials of the practitioner obtaining consent must be documented in the medical record. 1. Review of Resident #7's medical record showed: - An admission date of 10/27/25; - Diagnoses of unspecified dementia (a disorder marked by memory loss, personality changes, and impaired reasoning that interferes with daily functioning) and anxiety disorder (persistent worry in daily life); - An order for aripiprazole (an antipsychotic – medications that treat psychosis, which include delusions, hallucinations, paranoia, or disordered thoughts) medications) 15 milligrams (mg) by mouth one time a day related to dementia, dated 10/03/25; - An order for sertraline (an antidepressant medication) 100 mg two tablets by mouth one time a day related to anxiety, dated 10/03/25; - No documentation of consents or education of risks and benefits were provided to the resident (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and/or their representative for the aripiprazole and sertraline medications. 2. Review of Resident #8's medical record showed: - An admission date of 04/26/23; - Diagnoses of major depressive disorder (MDD - a serious mental health condition characterized by at least two weeks of persistent, pervasive low mood, loss of interest, and low self-esteem) and dementia with psychotic disturbance; - An order for Cymbalta (an antidepressant medication) 30 mg by mouth one time a day related to MDD, dated 03/15/24; - An order for Effexor extended release (XR) (an antidepressant medication) 150 mg by mouth one time a day for depression, dated 07/07/23; - An order for lamotrigine (an anticonvulsant medication also used as mood stabilizer) 100 mg by mouth one time a day for mood stabilizer, dated 02/27/24; - An order for mirtazapine (an antidepressant medication) 30 mg by mouth at bedtime for depressive disorder, dated 05/18/24; - An order for trazodone (an antidepressant medication) 150 mg by mouth at bedtime for a sleep aide, dated 11/20/23; - An order for Vraylar (an antipsychotic medication) 1.5 mg two capsules by mouth one time a day for MDD, dated 11/07/24; - No documentation of consents or education of risks and benefits were provided to the resident and/or their representative for the Cymbalta, Effexor, lamotrigine, mirtazapine, trazodone, and Vraylar. 3. Review of Resident #38's medical record showed: - An admission date of 10/12/21; - Diagnoses of cerebral infarction (stroke), falls, dementia with behavioral disturbance, sedative/hypnotic (induces sleep)/anxiolytic (an antianxiety medication) dependence, anxiety disorder, MDD, and Alzheimer's disease (a progressive mental deterioration); - An order for clonazepam (an antianxiety medication) 0.5 mg by mouth four times a day related to anxiety until end of life, dated 11/06/24; - An order for escitalopram (an antidepressant medication) 10 mg by mouth one time a day related to anxiety until end of life, dated 11/07/24; - An order for lorazepam (an antianxiety medication) concentrate 2 mg/ milliliters 0.5 ml by mouth (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	every two hours as needed for anxiety/restlessness/shortness of breath, dated 09/10/25; - An order for Seroquel (an antipsychotic medication) 25 mg by mouth at bedtime for anxiety related to MDD, dated 08/06/24; - An order for Seroquel 25 mg two tablets by mouth one time a day for anxiety related to MDD, dated 08/06/24; - No documentation of consents or education of risks and benefits were provided to the resident and/or their representative for the clonazepam, escitalopram, lorazepam, and Seroquel. 4. Review of Resident #55's medical record showed: - An admission date of 08/20/24; - Diagnoses of unspecified dementia unspecified severity with mood disturbance, unspecified dementia moderate with anxiety, and unspecified dementia moderate with agitation and insomnia; - An order for Cymbalta 30 mg by mouth one time a day for mood, dated 11/05/25; - An order for lorazepam oral concentrate 2 mg/ml 0.5 ml by mouth every four hours as needed for anxiety, dated 03/10/26; - An order for lorazepam 1 mg by mouth every eight hours, hold for sedation, may also use 0.5 ml liquid as well, dated 03/12/26; - An order for mirtazapine 7.5 mg by mouth at bedtime for agitation, dated 11/05/25; - An order for morphine sulfate (a narcotic medication used to treat pain) 10 mg/ml 0.25 ml by mouth every two hours as needed for shortness of breath/pain, dated 02/05/26; - An order for brexpiprazole (an antipsychotic medication) 2 mg by mouth one time a day for agitation, dated 11/05/25; - An order for trazodone 25 mg by mouth at bedtime for insomnia, dated 08/20/24; - No documentation of consents or education of risks and benefits were provided to the resident and/or their representative for Cymbalta, lorazepam, mirtazapine, morphine sulfate, brexpiprazole, or trazodone. 5. Review of Resident #66's medical record showed: - An admission date of 03/27/26; - Diagnoses of MDD, anxiety, and depression; - An order for duloxetine (an antidepressant medication) 60 mg by mouth one time a day for (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	depression, dated 03/28/26; - No documentation of consent or education of risks and benefits was provided to the resident and/or their representative for the duloxetine. During an interview on 04/10/26 at 3:58 P.M., Licensed Practical Nurse (LPN) B said he/she knew about psychotropic medication consents but did not think those were done at this facility. During an interview on 04/10/26 at 4:59 P.M., the Administrator and the Director of Nursing (DON) said they expected the residents and/or their representatives be informed of risks and benefits of psychotropic medications and to have informed consent of the psychotropic medications.

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to initiate an order for a code status for one resident (Resident #49) and failed to ensure an order for the code status was consistently documented throughout the medical record for one resident (Resident #24) out of 14 sampled residents. The facility census was 50. Review of the facility's policy titled, Advance Directives, dated 2026, showed: - Resident's medical record will have documentation indicating if a resident has an advance directive; - The facility honors residents' wishes as expressed in their Advance Directive. 1. Review of Resident #24's medical record showed: - admission date of [DATE]; - The face sheet, dated [DATE], showed a full code (if a person's heart stopped beating and/or they stopped breathing, cardiopulmonary resuscitation (CPR – an emergency lifesaving procedure performed when the heart stops beating or breathing ceases) procedures would be provided) status. Review of the resident's physician's order sheet (POS), dated [DATE], showed: - An order for full code status, dated [DATE]. Review of the resident's Do Not Resuscitate (DNR - does not want CPR) form, dated [DATE], showed: - The resident's code status was DNR; - Signed by the resident's responsible party and the physician on [DATE]. During an interview on [DATE] at 9:30 A.M., the resident was confused and did not know what his/her code status should be. During an interview on [DATE] at 9:40 A.M., the resident's responsible party/spouse was confused and did not know what the resident's code status should be. 2. Review of Resident #49's medical record showed: - admission date of [DATE]; - A code status sheet, undated, in the paper chart showed the resident was a full code; (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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- No order for a code status in the electronic medical record; - No code status documented on the resident's clinical dashboard (a snapshot of important resident information that remains at the top of the screen throughout the chart). During an interview on [DATE] at 3:11 P.M., Registered Nurse (RN) E said he/she looked at the residents' paper charts for their code status. The residents had blue and red stickers on the spine of the paper chart. A blue sticker meant a full code and a red sticker meant do not resuscitate (DNR - a medical order indicating that a person should not receive cardiopulmonary resuscitation (CPR) if that person's heart stops beating). There was a code status sheet in front of every resident's paper chart and listed at the top of the screen in every resident's EMR. During an interview on [DATE] at 1:25 P.M., Licensed Practical Nurse (LPN) B said that he/she looked at the front of the resident's paper chart for the code status because it was more accurate than the resident's EMR. During an interview on [DATE] at 1:30 P.M., the Director of Nursing (DON) said she would expect staff to look at the front of the resident's paper chart to find the resident's code status because it was most accurate. During an interview on [DATE] at 4:59 P.M., the Administrator and the DON said they would expect all residents to have an order for the code status and for the resident's code status to be documented consistently throughout the medical record. During an interview on [DATE] at 3:29 P.M., the DON said the nurse doing the resident's admission was responsible for getting an order for the code status or the nurse on duty at the time a code status was changed.

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. Based on interview and record review, the facility failed to issue a Skilled Nursing Facility Advanced Beneficiary Notice (SNF ABN) when a resident's Medicare covered services had ended for one resident (Resident #70) out of three sampled residents. The facility census was 50.Review of the facility policy titled, Advance Beneficiary Notice, undated, showed:- It is the policy of the facility to issue an Advance Beneficiary Notice of Noncoverage (ABN) to Medicare beneficiaries in accordance with requirements established by the Centers for Medicare & Medicaid Services (CMS) when services are expected to be denied as not reasonable and necessary under Medicare guidelines;- An ABN must be issued before services are provided when services are likely to be denied due to lack of medical necessity, therapy services exceed coverage thresholds without sufficient documentation, maintenance therapy is not supported under current Medicare standards, or services are custodial rather than skilled. 1. Review of Resident #70's Notice of Medicare Non-Coverage (NOMNC) showed:- The resident discharged from skilled services on 10/13/25, and remained in the facility;- The facility failed to issue a SNF ABN. During an interview on 04/09/26 at 3:35 P.M., the Community Nurse Navigator said he/she was in charge of giving residents the SNF ABN and NOMNC forms. He/She just missed the SNF ABN for Resident #70. During an interview on 04/10/26 at 5:00 P.M., the Administrator said she would expect the appropriate SNF ABN and NOMNC forms be given to the resident or the resident's representative prior to the resident being discharged from Medicare skilled services in a timely manner.

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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 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. Based on interview and record review, the facility failed have an appropriate diagnosis for a psychotropic (medication that affect a person's mental state) medication for three residents (Residents #7, #8, and #55), failed to limit the use of a psychotropic as needed (PRN) medication order for 14 days for one resident (Resident #55), and failed to attempt gradual dose reductions (GDR) for one resident (Resident #8) out of five sampled residents. Facility census was 50. Review of the facility policy titled, Psychotropic Medication Use, last revised July 2022, showed: - Residents who have not used psychotropic medications are not prescribed or given these medications unless the medication is determined to be necessary to treat a specific condition that is diagnosed and documented in the medical record; - Residents on psychotropic medications receive gradual dose reductions (coupled with nonpharmacological interventions), unless clinically contraindicated, in an effort to discontinue these medications; - PRN orders for psychotropic medications are limited to 14 days, if a prescriber or attending physician believes it is appropriate to extend the PRN order beyond 14 days, he or she will document the rationale for extending the use and include the duration for the prn order. Review of the facility policy titled, Tapering Medications and Gradual Drug Dose Reductions, last revised July 2022, showed: - All medications shall be considered for possible tapering. Tapering that is applicable to psychotropic medications are referred to as gradual dose reductions; - Residents who use psychotropic medications shall receive gradual dose reductions and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; - The staff and practitioner will consider tapering under certain circumstances, including when the resident's clinical condition has improved or stabilized, the underlying causes of the original target symptoms have resolved, non-pharmacological interventions, including behavioral interventions, have been effective in reducing symptoms, or a resident's condition has not responded to treatment or has declined despite treatment; - Within the first year after a resident is admitted on a psychotropic medication or after the resident has been started on a psychotropic medication, the staff and practitioner shall attempt a GDR in two separate quarters (with at least one month between the attempts), unless clinically contraindicated. After the first year, the facility shall attempt a GDR at least annually, unless clinically contraindicated; - For any individual who is receiving a psychotropic medication to treat behavioral symptoms related to dementia (a disorder marked by memory loss, personality changes, and impaired reasoning that interferes with daily functioning), the GDR may be considered clinically contraindicated if the resident's target symptoms returned or worsened after the most recent attempt at a GDR within the facility and the physician has documented the clinical rationale for why any additional attempted dose (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	reduction at that time would be likely to impair the resident's function or increase distressed behavior; - Attempted tapering of sedatives and hypnotics shall be considered as a way to demonstrate whether the resident is benefiting from a medication or might benefit from a lower or less frequent dose. 1. Review of Resident #7's medical record showed: - An admission date of 10/27/25; - Diagnoses of unspecified dementia and other specified anxiety disorders (persistent worry in daily life); - An order for aripiprazole (an antipsychotic (medications used to manage psychosis, particularly hallucinations, delusions, and severe agitation) medication) 15 milligrams (mg) by mouth one time a day related to dementia, dated 10/03/25; - No appropriate diagnosis for the aripiprazole medication. 2. Review of Resident #8's medical record showed: - An admission date of 04/26/23; - Diagnoses of major depressive disorder (MDD - a serious mental health condition characterized by at least two weeks of persistent, pervasive low mood, loss of interest, and low self-esteem) and dementia with psychotic disturbance; - An order for Cymbalta (an antidepressant medication) 30 mg by mouth one time a day related to MDD, dated 03/15/24; - An order for Effexor extended release (XR) (an antidepressant medication) 150 mg by mouth one time a day for depression, dated 07/07/23; - An order for lamotrigine (an anticonvulsant medication also used to treat mood disorders) 100 mg by mouth one time a day for mood stabilizer, dated 02/27/24; - An order for mirtazapine (an antidepressant medication) 30 mg by mouth at bedtime for depressive disorder, dated 05/18/24; - An order for trazodone (an antidepressant medication) 150 mg by mouth at bedtime for a sleep aide, dated 11/20/23; - An order for Vraylar (an antipsychotic medication) 1.5 mg two capsules by mouth one time a day for MDD, dated 11/07/24; - No documented pharmacy recommendation for an appropriate diagnosis for the trazodone medication; (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- No documented pharmacy recommendation for GDRs for the Cymbalta, mirtazapine, lamotrigine, trazodone, and Vraylar medications. Review of the resident's quarterly Minimum Data Set (MDS – a federally mandated assessment instrument completed by facility staff), dated 03/03/26, showed: - Intact cognition; - Received antipsychotic medications on a routine basis; - Received antidepressant medications on a routine basis; - Received hypnotic (medications that induce sleep) medications on a routine basis; - GDR not attempted and not documented as contraindicated. During an interview on 04/10/26 at 3:35 P.M., the Director of Nursing (DON) said Resident #8 saw an outpatient counseling/psychiatric provider for counseling/psychiatric care. The facility had been unable to get records or information from the other provider regarding the status and care for Resident #8. During a phone interview on 04/14/26 at 8:50 A.M., the outpatient counseling/psychiatric office provider for Resident #8 said there was no release of information signed on the resident and would not be able to provide any information. 3. Review of Resident #55's medical record showed: - An admission date of 08/20/24; - Diagnoses of unspecified dementia unspecified severity with mood disturbance, unspecified dementia moderate with anxiety, and unspecified dementia moderate with agitation and insomnia; - An order for lorazepam (an antianxiety medication) concentrate 2 mg/milliliter (ml) 0.5 ml by mouth every four hours PRN for anxiety, dated 03/10/26 and no stop date; - An order for mirtazapine 7.5 mg by mouth at bedtime for agitation, dated 11/05/25; - No appropriate diagnosis for the mirtazapine; - No pharmacy recommendations regarding a stop date for the lorazepam PRN and for an appropriate diagnosis for the mirtazapine medications. During an interview on 04/10/26 at 3:58 P.M., Licensed Practical Nurse (LPN) B said Resident #55 had not had any behaviors recently. The resident had behaviors in the past but none in the last couple (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	of months. During an interview on 04/10/26 at 4:59 P.M., the Administrator and the Director of Nursing said they would expect psychotropic medications to have an appropriate diagnosis and PRN psychotropic medications should have a 14-day stop date. During an interview on 4/15/26 at 4:57 P.M., the Medical Director (MD) said dementia was not an appropriate diagnosis for aripiprazole and the diagnosis should be mood disorder.

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to complete a comprehensive Minimum Data Set (MDS - a federally mandated assessment instrument completed by the facility staff) within the required time frames for three residents (Residents #8, #38, and #55) out of 14 sampled residents. The facility's census was 50.Review of the facility policy titled, MDS Completion and Submission Timeframes, revised July 2017, showed: - The facility will conduct and submit resident assessments in accordance with current federal and state submission timeframes; - Timeframes for completion and submission of assessments are based on the current requirements published in the Resident Assessment Instrument (RAI) Manual. Review of the Resident Assessment Instrument Manual, dated October 2025, showed: - For the admission assessment, the MDS completion date must be no later than 13 days after the entry date; - The assessment reference date (ARD) of an assessment drives the due date of the next assessment. The next comprehensive assessment is due within 366 days after the ARD of the most recent comprehensive assessment; - For the admission assessment, the care area assessment (CAA) completion date must be no later than 14 days after the entry date; - For the annual assessment, the CAA completion date must be no later than 14 days after the ARD. 1. Review of Resident #8's medical record showed:- admitted on [DATE];- A comprehensive annual MDS assessment with an ARD of 08/17/24, and a completion date of 08/26/24; - A quarterly MDS assessment with an ARD of 11/17/24, and a completion date of 11/26/24; - A quarterly MDS assessment with an ARD of 02/17/25, and a completion date of 02/18/25; - A quarterly MDS assessment with an ARD of 05/20/25, and a completion date of 05/21/25;- A quarterly MDS assessment with an ARD of 08/20/25, and a completion date of 08/25/25;- A quarterly MDS assessment with an ARD of 11/20/25, and a completion date of 12/02/25;- A quarterly MDS assessment with an ARD of 02/20/26, and a completion date of 03/03/26;- No comprehensive MDS assessment within 366 days of the last comprehensive MDS assessment. 2.Review of Resident #38's medical record showed: - An admission date of 10/12/21; (continued on next page)

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- A comprehensive annual MDS assessment with an ARD of 12/15/24, and a completion date of 12/18/24; - A quarterly MDS assessment with an ARD of 03/17/25, and a completion date of 03/24/25; - A quarterly MDS assessment with an ARD of 06/17/25, and a completion date of 06/19/25; - A quarterly MDS assessment with an ARD of 09/17/25, and a completion date of 09/17/25;- A quarterly MDS assessment with an ARD of 12/18/25, and a completion date of 12/31/25;- A quarterly MDS assessment with an ARD of 03/20/26, and a completion date of 04/03/26; - No comprehensive MDS assessment within 366 days of the last comprehensive MDS assessment. 3. Review of Resident #55's medical record showed:- admitted on [DATE];- A comprehensive admission MDS assessment with an ARD of 08/26/24, and a completion date of 08/29/24; - A quarterly MDS assessment with an ARD of 11/26/24, and a completion date of 12/04/24; - A quarterly MDS assessment with an ARD of 02/26/25, and a completion date of 02/28/25; - A quarterly MDS assessment with an ARD of 05/29/25, and a completion date of 05/30/25;- A quarterly MDS assessment with an ARD of 08/29/25, and a completion date of 09/03/25;- No comprehensive MDS assessment within 366 days of the last comprehensive MDS assessment. During an interview on 04/10/26 at 4:59 P.M., the Administrator said she would expect the MDS assessments to be done timely and reflect the resident's current condition at the time of the assessment. During an interview on 04/15/26 at 12:09 P.M., the MDS Coordinator said he/she was new to the job, was still learning what to do, had never done the job before, and never used the computer system at the facility before. He/She was taking classes, learning what all was required from the MDS timeframes, and when to do assessments. He/She knew some MDS assessments had been missed recently or were completed late.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Chateau Girardeau	3120 Independence Street Cape Girardeau, MO 63703

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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 Based on interview and record review, the facility failed to complete a comprehensive Minimum Data Set (MDS - a federally mandated assessment instrument to be completed by facility staff) assessment after a significant change for one resident (Resident #55) out of two sampled residents who received hospice services. The facility census was 50.Review of the facility policy titled, MDS Completion and Submission Timeframes, dated July 2017, showed:- The assessment coordinator or designee is responsible for ensuring that resident assessments are submitted to the Centers for Medicare and Medicaid Services (CMS) in accordance with current federal and state guidelines;- Timeframes for completion and submission of assessments are based on the current requirements published in the Resident Assessment Instrument (RAI) Manual. Review of RAI 3.0 Version 1.20.1, dated October 2025, showed:- The assessment must accurately reflect the resident's status;- A significant change in status assessment must be completed no later than 14 days from the determination date of the significant change;- If a nursing home resident elects the hospice benefit, the nursing home is required to complete an MDS Significant Change in Status Assessment (SCSA);- It is a CMS requirement to have an SCSA completed every time the hospice benefit has been elected, even if a recent MDS was done and the only change is the election of the hospice benefit;- Comprehensive or quarterly assessments are due every quarter unless the resident is no longer in the facility. There must be no more than 92 days between assessments;- A comprehensive assessment is due every year unless the resident is no longer in the facility. There must be no more than 366 days between comprehensive assessments. 1. Review of Resident #55's medical record showed:- An admission date of 08/20/24;- Diagnoses of moderate unspecified dementia with anxiety (a moderate cognitive decline and significant, documented anxiety symptoms such as restlessness, excessive worry, or panic episodes where the specific type of dementia is not determined), moderate unspecified dementia with agitation (a middle-stage cognitive decline where the specific cause is unknown, accompanied by behavioral disturbances), and chronic obstructive pulmonary disease (COPD - a lung disease);- An order to admit to hospice, dated 02/04/26;- A quarterly MDS assessment completed on 03/01/26;- No significant change in condition assessment was completed within 14 days of admission to hospice. During an interview on 04/10/26 at 4:59 P.M., the Administrator and Director of Nursing (DON) said they would expect the MDS assessments to be done timely and reflect the resident's condition at the time of the assessment. During an interview on 04/15/26 at 12:09 P.M., the MDS Coordinator said he/she was new to the job, was still learning what to do, had never done the job before, and never used the computer system at the facility before. He/She was taking classes, learning what all was required from the MDS timeframes, and when to do assessments. He/She knew some MDS assessments had been missed recently or were completed late.

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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. Based on observation, interview, and record review, the facility failed to follow physician's orders for one resident (Resident #22) and failed to obtain urinary catheter orders for one resident (Resident #67) out of five sampled residents. The facility census was 50. Review of the facility policy titled, Catheter Care, Urinary, dated September 2014, showed: - The purpose of this procedure is to prevent catheter-associated urinary tract infections; - Cleansing of the catheter insertion site during daily bathing or showering is appropriate; - Empty collection bag at least every eight hours. 1. Review of Resident #22's medical record showed: - An admission date of 09/25/25; - Diagnoses of chronic obstructive pulmonary disease (COPD – a lung disease) and respiratory failure (lungs not working like they should); - An order for daily weights one time a day, dated 10/28/25. Review of the resident's weights, dated October 2025 - April 2026, showed: - October weights not completed on 10/28/25, 10/30/25, and 10/31/25, with three out of four opportunities missed; - November weights not completed for 11/01/25 – 11/30/25, with 30 out of 30 opportunities missed; - December weights not completed on 12/01/25 - 12/04/25, 12/06/25, and 12/08/25 - 12/31/25 for 29 out of 31 opportunities missed; - January weights not completed on 01/01/26 - 01/25/26 and 01/27/26 - 01/31/26 for 30 out of 31 opportunities missed; - February weights not completed on 02/01/26 - 02/21/26, 02/24/26, and 02/28/26 for a total of 23 out of 28 opportunities missed. During an interview on 04/10/26 at 1:15 P.M., Certified Nurse Aide (CNA) F said night shift staff performed the weights. If they did not get to them, then day shift did them. Weights were obtained upon admission and charted on the sheet that had the resident's preferences. Night shift weights were written on the board behind the nurse's station and the nurses put the weight results in the charts. Nurses wrote on the CNA assignment sheets who needed weighed. (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 04/10/26 at 3:55 P.M., CNA A said both the nurses and CNAs got weights. There was a paper list at the nurse's station that had residents that needed weighed. Once the resident was weighed, the result was given to the nurse to chart. During an interview on 04/10/26 at 3:58 P.M., Licensed Practical Nurse (LPN) B said the order entered into the electronic medical record should flow over into the administration record to let the nurse know a weight needed to be done. Both the nurses and CNAs got weights, but he/she normally did his/her residents. There was a list with highlighted residents for the CNAs to get weights on. The CNAs did not chart the weights. The nurse's charted the weights. During an interview on 04/10/26 at 4:00 P.M., Registered Nurse (RN) C said Resident #22 was a daily weight and he/she did not refuse to be weighed. 2. Review of Resident #67's medical record showed: - An admission date of 04/07/26; - Diagnoses of urinary tract infection (UTI - a bacterial infection of the urinary system that causes burning pain, frequent urges to urinate, and cloudy or foul-smelling urine), pseudomonas (a group of bacteria commonly found in the environment that can cause infections in the blood, lungs, urinary tract, or other parts of the body), and benign prostatic hyperplasia (BPH - enlargement of the prostate); - No order for a urinary catheter; - No order for urinary catheter care. Review of the resident's baseline care plan, dated 04/07/26, showed: - The resident had a urinary catheter (a sterile tube inserted into the bladder to drain urine). Review of the resident's progress note, dated 04/08/26, showed: - Fax sent to the urologist (a physician specializing in diagnosing and treating diseases of the urinary tract) office for urinary catheter care. During an interview on 04/07/26 at 7:56 P.M., the resident said his/her urinary catheter was inserted before coming to the facility. During an interview on 04/10/26 at 4:59 P.M., the Administrator and Director of Nursing (DON) said they would expect an order for a urinary catheter and catheter care for all residents with urinary catheters. (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 04/15/26 at 3:29 P.M., the DON said the admitting nurse was responsible for getting urinary catheter orders from the physician.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, interview, and record review, the facility staff failed to implement enhanced barrier precautions (EBP - precautions for use during high-contact resident care activities for residents infected with a multidrug-resistant organism (MDRO -microorganisms that are resistant to one or more classes of antimicrobial agents) or any resident who has a chronic wound and/or indwelling medical device) for two residents (Residents #24 and #67) out of four residents sampled. The facility also failed to use proper infection control techniques during incontinent care for one resident (Resident #24) out of two sampled residents. The facility census was 50. Review of facility policy titled, Enhanced Barrier Precautions, dated January 2026, showed: - EBP will be implemented for residents who have a known colonization of MDROs, presence of indwelling medical devices, chronic wounds, and non-intact skin; - Staff must wear gown and gloves during high-contact care activities; - High-contact care activities include dressing, bathing, grooming, transferring, repositioning, toileting, incontinence care, wound care, and device care or use; - Personal protective equipment (PPE - gloves, gowns, masks, respirators, and face shields designed to protect workers and patients from infectious materials) must be put on before the activity and removed immediately after, followed by hand hygiene. Review of the facility's policy titled, Handwashing/Hand Hygiene, revised October 2023, showed: - Hand hygiene is indicated: a. immediately before touching a resident; b. before performing an aseptic task (for example, placing an indwelling device or handling an invasive medical device); c. after contact with blood, body fluids, or contaminated surfaces; d. after touching a resident; e. after touching the resident's environment; f. before moving from work on a soiled body site to a clean body site on the same resident; and g. immediately after glove removal. Review of the facility's policy titled, Catheter Care, Urinary, revised September 2014, showed: - Use standard precautions when handling or manipulating the drainage system; (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- PPE (e.g. gowns, gloves, mask, etc., as needed) are necessary when performing urinary catheter care; - Cleanse the catheter from insertion site to approximately four inches outward. 1. Review of Resident #24's medical record showed: - admission date of 12/10/25; - An order to ensure EBP is being utilized with direct contact care, dated 04/08/26. Observation on 04/09/26 at 3:37 P.M., of the resident's gait belt transfer and incontinent and urinary catheter (a sterile tube inserted into the bladder to drain urine) care showed: - EBP signage on the resident's door; - Licensed Practical Nurse (LPN) H and Certified Medication Technician (CMT) D entered the resident's room, performed hand hygiene, put on gloves, and did not put on gowns; - LPN H and CMT D assisted the resident to transfer to the bed; - LPN H and CMT D removed the resident's pants and brief soiled with fecal matter, did not change gloves, and did not perform hand hygiene; -CMT D cleaned the resident's catheter tubing and wiped toward the insertion site instead of away, did not change gloves, and did not perform hand hygiene; - LPN H assisted the resident to turn to his/her left side; - CMT D cleaned the resident's buttocks; - LPN H and CMT D changed gloves, did not perform hand hygiene, positioned the resident on his/her right side, and adjusted the blankets; LPN H and CMT D performed hand hygiene and exited the room. During an interview on 04/09/26 at 4:30 P.M., LPN H said gowns and gloves should be worn for residents on EBP, and hand hygiene should be performed before and after incontinent and catheter care. 2. Review of Resident #67's medical record showed: - admission date of 04/07/26; - Diagnoses of urinary tract infection (UTI - a bacterial infection of the urinary system that causes (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	burning pain, frequent urges to urinate, and cloudy or foul-smelling urine) and pseudomonas (a group of bacteria commonly found in the environment that can cause infections in the blood, lungs, urinary tract, or other parts of the body); - An order to ensure EBP is being utilized with direct contact care, start date of 04/08/26 with no end date. Observation on 04/10/26 at 9:52 A.M., of the resident's urinary catheter care showed: - EPB signage and PPE hung on the resident's door; - Certified Nursing Assistant (CNA) F put on a gown, performed hand hygiene, and put on gloves; - CNA F performed the resident's urinary catheter care; - CNA F removed the gown, performed hand hygiene, changed gloves, dumped the soiled water out of the resident's water basin into the resident's toilet; - CNA F performed hand hygiene and changed gloves; - CNA F threaded the urinary catheter bag through the resident's underwear and pant leg and put the resident's feet through his/her underwear and pants; - CNA F pulled the resident's underwear and pants up to his/her thighs, removed gloves, and performed hand hygiene; - CNA F assisted the resident to a standing position; - CNA F placed the urinary catheter bag into a privacy bag that hung on the resident's walker, adjusted the resident's pants and shirt with his/her bare hands, and did not perform hand hygiene; - CNA F assisted the resident to sit in his/her recliner with his/her bare hands; - CNA F gathered the resident's used sheets and towels, placed them in a laundry bag, and tied up the laundry bag with his/her bare hands; - CNA F performed hand hygiene, picked up the dirty laundry bag with his/her bare hands, and exited the room. During an interview on 04/10/26 at 1:15 P.M., CNA F said a gown and gloves should be worn when dressing a resident or assisting with transfers for residents on EBP. During an interview on 04/10/26 at 1:18 P.M., LPN G said residents with wounds, catheters, and intravenous medications (IV – administered into a vein) were on EBP. Even residents with surgical wounds. He/She said a gown and gloves should be worn for all care. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 04/10/26 at 1:25 P.M., LPN B said EBP should be used for residents with chronic wounds or indwelling lines and gowns, masks, and gloves should be worn during high contact care for residents on EBP. He/She said hand hygiene should be performed before and after incontinent care. During an interview on 04/10/26 at 1:30 P.M., the Director of Nursing (DON) said EBP should be used for residents with open wounds or indwelling devices, and gowns and gloves should be worn during high contact care for residents on EBP. She said hand hygiene should be performed before, after, and when going from dirty to clean tasks during incontinent care. During an interview on 04/10/25 at 2:30 P.M., the Administrator said EBP should be used for residents with open wounds or indwelling devices, and gowns and gloves should be worn during high contact care for residents on EBP. She said hand hygiene should be performed before, after, and when going from dirty to clean tasks during incontinent care.