STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265149	A. Building B. Wing	12/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Four Seasons Living Center	2800 Highway Tt Sedalia, MO 65301

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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, facility staff failed to ensure the doors on the Tiger Medical Unit, a secured unit, were monitored during a fire alarm test which resulted in one resident (Resident #27) eloping from the facility at approximate 3:00 P.M. In addition, staff failed to complete hourly face checks for the resident, did not check on the resident after he/she missed dinner and smoke breaks, and did not notice the resident was missing until 9:00 P.M. Facility staff further failed to properly complete a thorough head count to ensure all residents were in the facility after the fire drill when staff were made aware two residents (Resident #116 and #112) had left the facility when the unit doors were left unattended and unlocked. Facility staff failed to properly store and lock medications to ensure resident safety for six residents (Resident #163, #211, #233, #74, #86, and #39) of a sample of 45 residents. The facility census was 231.The administrator was notified on 12/5/25 at 6:06 P.M., of an Immediate Jeopardy (IJ) which began on 12/4/25. The IJ was removed on 12/5/25, as confirmed by surveyor onsite verification. Review of the facility's Elopement policy, dated 06/12/24, showed residents who are at risk for elopement receive adequate supervision to prevent accidents, and receive care in accordance with their person-centered plan of care addressing the unique factors contributing to wandering or elopement risk. Elopement occurs when a resident leaves the premises or a safe area without authorization and/or any necessary supervision to do so. The facility is equipped with door locks/alarms. Alarms are not a replacement for necessary supervision. Review of the facility's Fire Drill Policy, dated 12/27/24, showed the policy did not contain staffing assignments during drills for secured units. Further review showed the policy did not address monitoring of doors during fire alarm drills or emergencies. 1.Review of Resident #27's Medicare 5-Day Minimum Data Set (MDS), dated [DATE], showed staff assessed the resident had verbal behaviors towards others, and required supervision or touch assistance with eating, walking, transfers, personal hygiene, and bathing. Diagnoses of Anxiety Disorder, Schizophrenia (a serious brain disorder causing abnormal reality interpretation, with symptoms like hallucinations (hearing voices), delusions (false beliefs), disorganized speech, and impaired thinking), Schizo-affective Disorder (Bipolar Type) (a serious mental illness blending symptoms of schizophrenia (psychosis like hallucinations/delusions) with bipolar disorder (manic highs and depressive lows), where psychotic symptoms occur alongside or even without significant mood episodes), Asthma, and Chronic Obstructive Pulmonary Disease (COPD). Review of the resident's care plan, dated 07/23/25, showed staff documented the resident had explosive anger, extreme emotional swings, fear of being left alone, impulsive, had self-destructive behaviors, concerns for self-harm, and skilled nursing to complete face checks. Review of the resident's Elopement Assessment, dated 11/14/25, showed the resident scored a zero, not at risk for elopement. Review of the facility's surveillance video showed on 12/4/25 at 2:53 P.M., staff for the Tiger Medical Unit could not be observed in the hallway or at the fire exit, during the fire drill. Resident #27 exited his/her room and walked straight out the fire exit door by the Business Office. At 2:53:44 P.M., the exterior camera footage showed the resident crossed the back parking lot of the facility and entered the woods behind the facility.Review of (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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Resident #116's care plan, dated 10/23/25, showed staff documented the resident has a history of behavioral challenges that require protective oversight in a secure setting; is at risk of elopement; and expresses a desire to leave facility. Eloped from his/her personal window on 10/23/25 at 12:24 P.M. Monitor resident's location frequently and initiate face-checks if/when necessary. Review of Resident #116's Quarterly Elopement Assessment, dated 11/5/25, showed staff assessed the resident as a high risk for elopement. Review of Resident 112's Quarterly Elopement Assessment, dated 10/16/25 showed staff assessed the resident as not a risk for elopement. Review of Resident #112's care plan, dated 11/3/25, showed staff documented staff should provide protective oversight and assist where needed. Observation on 12/4/25 at 3:00 P.M., showed Dietary Aide (DA) B yelled out the back dining room door Get back in here. Observation showed Resident #116 held open the exit door attached to the enclosed fence on Tiger Lane and Resident #112 outside the door and fence. Review of Resident #27's hourly face checks, dated 12/04/25, showed face checks were completed at the following times: 00:43 AM, 02:33 AM, 03:32 AM, 04:43 AM, 05:04 AM, and 19:50 (7:50 PM). Six hourly face checks were completed out of a possible 24 checks. One hourly check was documented as competed after the resident eloped from the facility. Review of the resident's Medication Administration Record (MAR), dated December 2025, showed the following for 12/04/25:- Melatonin Oral Tablet 10 milligrams (mg), Give 10 mg by mouth at bedtime related to insomnia, unspecified, at 8:00 P.M., ordered 11/18/25; not administered;- Vitamin D3 Oral Tablet (Cholecalciferol), give 1000 unit by mouth at bedtime for low vitamin D related to vitamin D deficiency, unspecified; at 8:00 P.M., ordered 11/18/25, not administered; - Antipsychotic medication - monitor for dry mouth, constipation, blurred vision, disorientation/confusion, difficulty urinating, hypotension, dark urine, yellow skin, nausea/vomiting, lethargy, drooling, tremors, disturbed gait, increased agitation, restlessness, involuntary movement of mouth or tongue; document every shift related to schizoaffective disorder, bipolar type, started 9/16/24; review showed staff documented the assessment was completed for the night shift;- Assess for pain every shift every shift, started 09/16/24, review showed staff documented the assessment was completed for the night shift;- Behaviors - monitor for the following: itching, picking at skin, restlessness (agitation), hitting, increase in complaints, biting, kicking, spitting, cussing, racial slurs, elopement, stealing, delusions, hallucinations, psychosis, aggression, refusing care, every day shift and night shift; review showed staff documented the assessment was completed for the night shift;- Check mouth after giving medications to observe for cheeking meds every shift, started 09/16/24; review showed staff documented the assessment was completed for the night shift. Review of the resident's progress notes, dated 12/4/25 at 9:12 P.M., showed staff reported the resident did not come to get his/her snack at 9:00 P.M., after a thorough check of the facility the resident could not be found. Another resident reported the resident walked out the door/fire exit around 3:00 P.M. when the fire alarm went off. Staff documented the Administrator, Director of Nursing (DON), Assistant DON, 911, and physician had been notified. Staff documented the guardian could not be reached. Review of the resident's progress notes, dated 12/4/25 at 10:00 P.M., showed staff documented the police were present when the DON arrived at the facility at 10:00 P.M., and confirmed by facility cameras the resident left the facility though the unlocked exit door at approximately 3:00 P.M. The police reported that a citizen called and said they had picked up a man/woman with the same name, who was walking, and gave him/her a ride to the public library. Review of the resident's progress notes, dated 12/5/25 at 1:43 A.M., showed staff documented the resident had been found at 1:33 A.M. and had been taken to the emergency room for psychiatric evaluation, as he/she reported he/she would not go back to the facility because Jesus had given his/her guardianship back. The DON instructed a Certified Nurse Aide (CAN) to take the resident's paperwork to the emergency room and sit with the resident per emergency room staff request. Review of the website https://forecast.weather.gov showed the temperature to be 19 Degrees Fahrenheit on 12/05/25 at 1:45 A.M. During an interview on 12/5/25 at 7:53 A.M., the DON said he/she found Resident #27 around 1:30 A.M. in the downtown area and had approached the resident to (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	get him/her back to the facility. The resident refused to return and was picked up by law enforcement around 1:45 A.M. and transported to the local hospital for psychiatric evaluation and is currently in the hospital. During an interview on 12/5/25 at 9:09 A.M., DA B said there had not been any staff assigned to the doors of the unit that the two residents went out of. He/She said the facility doesn't usually assign staff to the back door or the back gate during fire drills. The DA said he/she knows the doors are unlocked during fire drills. As far as he/she knows, when the fire drill occurred there was not a staff member assigned to watch the back door. He/she happened to be walking down the hall, when he/she heard the residents (#112 and #116) say let's go, and saw them go out the back door, so he/she opened the door and saw the two residents open the door to the fence and start to go through it. He/she yelled at the residents to get back in the building. The DA said a staff member did not come and talk to him/her after the fire drill. The DA said staff did not watch the exterior locked fence exit, just the inside doors. He/she said the administrative staff did not come talk to him/her about the two residents who tried to go through the back gate. The DA said he/she did not know another resident got out as well. He/she did not report to anyone the two residents got out, or that no staff watched the back exits. During an interview on 12/5/25 at 9:35 A.M., Resident #116 said it was him/her and Resident #112 that were at the open door during the fire drill. He/she knew the fence door would unlock during the fire drill. The resident said staff told him/her to come back in the door, so he/she did. The resident said there were not any staff at the dining room door, or at the exit door at the fence when the fire alarm went off. During an interview on 12/5/25 at 9:40 A.M., Resident #112 said it was him/her that went out the fence door when the fire alarm went off. He/she did not see any staff. During an interview on 12/5/25 at 9:45 A.M., Resident Care Coordinator (RCC) HH said the fire drill notification was sent by text and he/she knew about the drill before the alarm sounded. He/She didn't assign a staff member to monitor the exit doors before the alarm went off, but did ask staff to watch the doors while the alarm sounded. The RCC said he/she just started asking people to watch doors and had to use housekeepers and he/she did not assign anyone to watch the dining room door. There was not a staff member available to watch the exit door. The DON did not talk to him/her after the drill. The RCC was not aware Resident #27 was missing until 9:26 P.M., when staff told him/her they could not find the resident to give him/her a snack. Staff did not notify him/her the resident had missed his/her dinner or 8:00 P.M., medications. The RCC said the resident missed his/her smoke breaks last night which was not normal. It was cold last night when the resident walked down the highway without a shoulder. It can be difficult to create a safe and secure environment with two Nurse Aides (NAs) and one Certified Medication Technician (CMT). Staff should have completed hourly face checks on the resident. Staff documented the checks were completed, and they were not, because the resident was not there. During an interview on 12/5/25 at 10:46 A.M., the Receptionist said he/she announced the fire drill on the intercom at 2:45 P.M. on 12/4/25. During an interview on 12/5/25 at 11:00 A.M., the DON said as soon as the state surveyor came and reported the two residents (#112 and #116) outside to him/her, he/she looked at the Medical Records staff and told him/her to complete a head count on the unit. The DON said the medical records staff ran to the unit, completed head checks and told him/her all residents were accounted for. During an interview on 12/5/25 at 11:26 A.M., the Medical Record staff said he/she was not assigned to a door during the drill. The DON came and told him/her to contact the two other residents who tried to go out the back gate. The DON told him/her to lay eyes on the two residents and to do a bit of a count. He/She can't say that he/she went to each individual resident and he/she did not have any other staff count residents with him/her. He/She did not contact RCC HH or the aides on the floor, to see if they had completed a resident count and he/she did not see Resident #27. During an interview on 12/5/25 at 11:17 A.M., the Business Office Manager (BOM) thought he/she had been assigned to the door Resident #27 went out, but did not think he/she got there in time. He/She was not notified before the fire drill happened. Typically the aides on the hall monitor the doors. The BOM did not see any residents go out the doors, but was not down there exactly at that time. He/she got to the area after (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	the fire drill started. During an interview on 12/8/25 at 12:05 P.M., NA D said he/she was the staff over Resident #27's unit, the day of the resident's elopement. He/She went on lunch break and was not on the hall during the fire alarm test. He/She told CMT C and NA W he/she went to lunch, before the fire drill went off. During interviews on 12/5/25 at 11:50 A.M. and 12/8/25 at 12:46 P.M., CMT C said there should be staff by each exit door when a fire alarm drill/test is announced to ensure residents do not try to elope. CMT C said NA D came and asked to take a lunch on 12/4/25 and he/she told the NA to wait for NA W to get back. NA W should have been on the resident's unit if NA D was on break. During the fire drill he/she had to use housekeepers to watch the exits, because there was not enough nursing staff to monitor the exits. During an interview on 12/5/25 at 11:20 A.M., Resident #165 said Resident #27 was in the dining room on the Tiger Lane Medical unit when the fire alarm went off. He/She said after the alarm went off Resident #27 walked out the back door by the offices. The resident said there was not any staff by the exit door while the fire alarm sounded. During an interview on 12/5/25 at 5:21 P.M., the DON said during a true fire drill, staff should monitor the doors and complete a head count afterwards. He/She would have to check on the education provided during orientation, but he/she knows education regarding fire drills is provided throughout the year. The expectation would be to monitor the doors. He/She could understand why staff didn't during this experience. The DON said that since they were just testing to make sure the doors unlock it was not the same as when they run true fire drills where staff have to mock evacuate, get fire extinguishers, etc. He/She expected if the doors are unlocked, they should be monitored. During an interview on 12/5/2025 at 5:24 P.M., the administrator said he/she would expect if a door to a secured unit is unlocked a staff member would be present to monitor the door. He/She doesn't know why staff were not at the door. Staff receive education regarding fire drills, but he/she does not know if the education covers egress doors. He/She could not find a policy for locked secured doors. Staff are expected to ensure doors close, grab a fire extinguisher, evaluate the situation, monitor the doors and complete a head count to make sure everyone was safe. Staff should have gone downstairs and completed a head count and he/she does not know why they did not. The administrator said, We failed, we just failed. 2. Review of the facility's Medication Storage Policy, dated 05/18/25, showed it is the policy of this facility to ensure all medications housed on our premises will be stored in the medication rooms according to the manufacturer's recommendations and sufficient to ensure proper sanitation, temperature, light, ventilation, moisture control, segregation, and security. All drugs and biologicals will be stored in locked compartments (i.e., medication carts, cabinets, drawers, refrigerators, medication rooms) under proper temperature controls. Only authorized personnel will have access to the keys to locked compartments. During a medication pass, medications must be under the direct observation of the person administering medications or locked in the medication storage area/cart. Observation on 12/01/25 at 1:14 P.M., showed an unattended pill cup with several medications sat on the counter in Resident #163's room. Resident #211, #233, #74 & #86 wandered the hall outside the resident's room and Resident #74 and Resident #86 wandered into other residents' rooms. The unattended pill cup contained the following medications:-One 150 milligram (mg) Seroquel (antipsychotic medication);-Two tablets of melatonin three mg (used to induce sleep);-Two tablets of 500 mg Valproic Sodium (mood stabilizer);-One tablet of 200 mg Clozapine (antipsychotic medication);-One tablet of 300 mg Clindamycin (antibiotic);-One tablet of 50 mg Hydroxyzine (anti-anxiety medication);-Two tablets of 325 mg Acetaminophen. During an interview on 12/1/25 at 1:30 P.M., RCC 1 said the medications were from the night shift medication pass. CMT C was the CMT that administered the medications, and he/she documented the resident received them. During an interview on 12/1/25 at 1:43 P.M., CMT C said he/she gave the resident his/her medications last night. He/She never takes medications to the resident's room, he/she catches the resident when he/she goes out to smoke and gives him/her medications then. He/she must watch the resident, because he/she likes to cheek the medications. The CMT said he/she watches the resident swallow his/her medications. If the resident had night medications in his/her room, it was not from last night. (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 12/2/25 at 2:50 P.M., Resident #163 said CMT C left the medications on the sink in his/her room. He/She fell asleep before he/she could take them. During an interview on 12/05/25 at 12:14 P.M., NA I said three residents wander the unit where the pills were found, and two residents go in and out of residents' rooms. Observation on 12/8/25 at 10:37 A.M., showed medications sat on top of the 300 hall medication cart without staff present. Five unidentified residents were around the cart with the following medications:-Dulera (inhaler);-Albuterol (inhaler);-Flonase (nasal spray);-Duloxetine (antidepressant);-Ventolin (inhaler);-Fluticasone (nasal spray). During an interview on 12/8/25 at 10:38 A.M., Resident #39 said staff always leave those medications out for resident's that use inhalers as needed in case of an emergency. That way the residents do not have to wait on staff, and they can grab them themselves. During an interview on 12/8/25 at 10:40 A.M., CMT FF said the medications left out are from the morning medication pass, and he/she just forgot to put them up. During an interview on 12/8/25 at 1:28 P.M., CMT GG said it is important to never leave medications unlocked, because the residents will steal them. During an interview on 12/8/2025 at 2:44 P.M., RCC HH said staff should make sure residents swallow their medications. Staff should make sure the residents don't walk away from the medication cart with the medications. The unit has residents who wander in and out of rooms and it is dangerous to have unattended pills on the hall with residents who wander. During an interview on 12/8/25 at 4:29 P.M., the DON said staff should watch residents take their medications. There is a concern for other residents taking unattended medications. The DON said the unit has wanderers who go in and out of other residents' rooms. During an interview on 12/9/25 at 1:28 P.M., the administrator said he/she expected the CMTs to watch the residents take their medications. Staff should report immediately if they find medication that is unattended. The administrator said that unit does have residents that wander. NOTE: At the time of the survey, the violation was determined to be at the immediate 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 remove the IJ violation at the time. A final revisit will be conducted to determine if the facility is in substantial compliance with participation requirements. At the time of exit, the severity of the deficiency was lowered to the E level. This statement does not denote that the facility has complied with State law (Section 198.026.1 RSMo.) requiring that prompt remedial action to be taken to address Class I violation(s). Complaint 2685059

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview and record review, facility staff failed to perform hand hygiene as often as necessary using approved techniques to prevent cross-contamination. Facility staff failed to allow sanitized dishes to air dry to prevent the growth of foodborne pathogens. Facility staff failed to ensure two ice machines, used to supply ice to residents, drained through an air gap to prevent cross-contamination. Facility staff failed to store moist cleaning clothes in sanitizing solution between uses to prevent the growth of bacteria and cross-contamination. Facility staff also failed to maintain kitchen equipment and surfaces in two of two kitchens and one kitchenette in a clean sanitary manner to prevent cross-contamination and the growth of food-borne pathogens. These failures have the potential to affect all residents. The facility census was 231. 1. Review of the facility's policy titled Dietary-Sanitary Procedures, revised 11/06/23, showed: -Hand washing is a priority for infection control;-Hands must be washed prior to beginning work, when working with different food substances, and after contact with any unsanitary surface; -The policy directed staff to place enough hand soap or detergent to build a good lather on a fingernail brush and palms of hands, vigorously scrub and lather both hands and then rinse the lather and soap from hands in flowing warm water when they washed their hands. Observations on 12/03/25 at 6:55 A.M., 7:22 A.M., 7:23 A.M., and 7:28 A.M., showed Dietary Aide (DA) NN washed soiled dishes in the mechanical dishwashing station. Observation showed, without performing hand hygiene, the DA then put away sanitized dishes from the clean side of the station. During an interview on 12/03/25 at 7:28 A.M., DA NN said staff should wash their hands after they touch anything dirty. The DA said he/she rinsed his/hands after he/she put the soiled dishes into the machine, and he/she thought that was good enough. The DA said he/she was trained on proper handwashing procedures and proper handwashing includes the use of soap. The DA said he/she got in a hurry. During an interview on 12/03/25 at 7:30 A.M., the dietary manager (DM) said staff should wash their hands between handling dirty and clean dishes. The DM said DA NN had worked at the facility for a year, was trained on proper hand hygiene procedures upon hire, and he/she had provided the DA with multiple reminders since hire. Observation on 12/03/25 at 11:05 A.M., showed [NAME] PP used his/her cellular phone in the kitchen with his/her bare hands and then washed his/her hands at the handwashing sink. Observation showed the cook scrubbed his/her hands with soap under running water for three seconds and after he/she washed his/her hands, he/she set up meal trays for service to residents at the lunch meal. Observation on 12/03/25 at 11:06 A.M., showed DA OO washed his/her hands at the handwashing sink, he/she scrubbed his/her hands with soap for three seconds, rinsed, and then served food to residents in the Main Street dining room. Observation on 12/03/25 11:20 A.M., showed [NAME] PP lifted the trash can lid with his/her bare hands to dispose of trash and then washed his/her hands at the handwashing sink. Observation showed the cook scrubbed his/her hands with soap under running water for three seconds and after he/she washed his/her hands, he/she continued to prepare food for service to residents at the lunch meal. During an interview on 12/04/2025 at 2:03 P.M., the DM said staff should wash their hands after they touch anything dirty, which would include trash can lids, dirty dishes, and personal items like their cellular phones. The DM said when staff wash their hands, they should scrub their hands with soap, out of the running water, for 20 to 30 seconds. The DM said all staff are trained on proper hand hygiene procedures upon hire and at least annually. During an interview on 12/03/25 at 3:00 P.M., the administrator said staff should perform hand hygiene after they touch anything dirty, which would include trash can lids, dirty dishes, and personal items like their cellular phones. The administrator said when staff wash their hands, they should scrub their hands with soap, out of the running water, for 30 seconds and all staff are trained on proper hand hygiene procedures upon hire. 2. Review of the facility's policy titled Dietary-Equipment Operations, Infection Control, and Sanitation Policy, revised 02/02/24, showed the policy directed staff to air dry dishes after they are properly (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	washed and sanitized. Review of the facility's Daily Dietary Checklist/Cleaning Schedules, dated 12/01/25 through 12/03/25, showed the A.M. and P.M. dietary aides are directed to put dishes away clean and dry. Review showed staff did not document they put the dishes away as directed for the dates of 12/01/25 through 12/03/25. Observation on 12/01/25 at 9:54 A.M., showed 11 metal food service pans stacked together wet on the storge rack in the kitchen. Observations on 12/03/25 at 6:55 A.M., showed 24 plastic service trays, eight black dessert plates and five dessert bowls stacked together wet on the storage rack in mechanical dishwashing station. Observation on 12/03/25 at 7:00 A.M., showed DA NN removed sanitized plates from the clean side of the mechanical dishwashing station while wet, stacked them together and placed them in the plate warmer storage cart. Observation showed five additional plates stacked together wet in the plate warmer storage cart. During an interview on 12/03/25 at 7:15 A.M., the DM said staff should allow clean dishes to air dry before they are put away and staff are trained on this requirement. During an interview on 12/04/25 at 3:03 P.M., the administrator said staff should allow clean dishes to air dry before they are put away and staff are trained on this requirement during their orientation to the dietary department. The DM should monitor for this daily. 3. Review of the facility's policy titled Dietary-Equipment Operations, Infection Control, and Sanitation Policy, revised 02/02/24, showed the policy directed staff to see the manufacturer's instructions for operation of ice machines. Review showed the policy did not contain information related to drain air gaps. Observation on 12/03/25 at 8:00 A.M., showed the drain line to the ice machine in the Main Street dining room beverage station ended inside the floor drainpipe and the machine did not contain an air gap to prevent the backflow of sewage and other contaminates into the ice machine. Observation on 12/03/25 at 9:00 A.M., showed the drain line to the ice machine in the 100 hall clean utility room ended inside the floor drainpipe and the machine did not contain an air gap to prevent the backflow of sewage and other contaminates into the ice machine. During an interview on 12/03/25 at 9:00 A.M., the maintenance director said the facility's contracted service company is responsible for the installation and maintenance of the ice machines and he/she did not know ice machines needed to drain through air gaps. During an interview on 12/04/25 at 2:15 P.M., the DM said the ice machines in the Main Street dining beverage station and 100 hall clean utility room are used to supply ice to residents. The DM said the facility's contracted service company and maintenance staff are responsible for the maintenance of the ice machines and ice machines should drain through an air gap to ensure nothing goes into the machine if the drain backs up. The DM said he/she did not know the ice machine drains did not have an air gap. During an interview on 12/04/25 at 3:17 P.M., the administrator said the maintenance director is responsible to ensure the ice machines drain through an air gap and he/she did not know the ice machines did not drain through air gaps. 4. Review of the facility's policy titled Dietary-Equipment Operations, Infection Control, and Sanitation Policy, revised 02/02/24, showed the policy directed staff to store sanitizing cloths in sanitizing buckets, filled with an appropriate sanitizing solution, when not in use. Observation on 12/03/25 from 7:50 A.M. to 8:05 A.M., showed two wet cleaning clothes on the countertop by the sink in the Main Street dining beverage station. Observation showed staff entered and exited the beverage station multiple times. Observation on 12/03/25 from 10:50 A.M. to 12:45 P.M., showed a wet cleaning cloth on the countertop by the food processor as staff prepared food in the area. Observation on 12/04/25 from 2:15 P.M. to 2:30 P.M., showed a wet cleaning cloth on the countertop by the food processor as staff prepared food in the area. During an interview on 12/04/25 at 2:30 P.M., the DM said staff are to store cleaning cloths in buckets of sanitizer when not in use and staff are trained on this requirement. During an interview on 12/04/25 at 3:14 P.M., the administrator said staff should store wet cleaning cloths in buckets of sanitizer between uses and staff are trained on this requirement. 5. Review of the facility's policy titled Dietary-Equipment Operations, Infection Control, and Sanitation policy, revised on 02/02/24, showed: -The dietary staff shall maintain the sanitation of the dietary department through compliance with written, comprehensive cleaning schedules developed for the facility by the dietary manager;-The dietary manager shall record all cleaning and (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	sanitation tasks for the dietary department;-A cleaning schedule shall be posted with tasks designated to specific positions in the department;-All tasks shall be addressed as to the frequency of cleaning; -The dietary employees should complete the tasks assigned for the day and shift and they should check off tasks as they are completed. If the employee does not accomplish a task, they need to communicate with the dietary manager and place the task on the list for the following day;-The policy directed staff to clean and sanitize:*The insides of tray, dish and utility carts after each meal;*The exterior of the dishwasher after each meal and clean the interior and exterior of the machine with de-liming solution weekly;*The exterior of the ice machine daily;*The steamtables after each meal. Review showed the policy directed staff to remove food from the wells when they clean the steamtables;*The floors daily. Review showed the policy directed staff to dust mop or sweep and mop the floors when they clean them; *Walls and ceilings at least twice a year, but heavily soiled surfaces must be cleaned more frequently and as required;*Equipment daily. 6. Review of the facility's Daily Dietary Checklist/Cleaning Schedules, dated 12/01/25 through 12/03/25, showed the record did not include direction to clean the exterior of the mechanical dishwasher. Observations on 12/01/25 at 9:46 A.M. and 12/03/25 at 8:08 A.M., showed a thick accumulation of yellow and white substances dried on the exterior bottom half of the mechanical dishwasher. Observation showed the dried on substances came off the dishwasher when scraped with a fingernail. During an interview on 12/03/25 at 8:09 A.M., the DM said staff are directed to clean the dishwasher daily and delime the dishwasher weekly. The DM said they had not been able to find a product that would remove the calcium and lime deposits from the dishwasher. The DM said he/she did not think about trying to scrape the deposits off the surfaces. 7. Review of the facility's Daily Dietary Checklist/Cleaning Schedules, dated 12/01/25 through 12/03/25, showed the A.M. and P.M. aide is directed to sweep and mop the floors. Review showed staff did not document they swept and mopped the floors in the main kitchen and Main Street dining beverage station for the dates of 12/01/25 through 12/03/25. Review showed the staff who worked in the Tiger Lane kitchen documented they swept and mopped the floors after each meal for the dates of 12/01/25 through 12/03/25. Observations on 12/01/25 at 9:46 A.M. and 12/03/25 at 8:08 A.M., showed a thick accumulation of a white substance dried on the floor beneath the mechanical dishwasher in the main kitchen. Observation showed the dried on substance came off when scraped with a fingernail. During an interview on 12/03/25 at 8:09 A.M., the DM said staff are directed to clean the floors daily. The DM said they had not been able to find a product that would remove the calcium deposits from the floor. The DM said he/she did not think about trying to scrape the deposits off the floor. Observation on 12/03/25 at 7:59 A.M., showed the Main Street dining beverage station contained an excessive accumulation of dirt, trash and food debris on the floor under and around the ice machine and refrigerator and in the cabinet beneath the sink. Observation on 12/03/25 at 8:21 A.M., showed an accumulation of brown and black substances dried along the perimeter of the floor, which extended approximately three to five inches from the baseboards, in the Tiger Lane kitchen. 8. Review of the facility's Daily Dietary Checklist/Cleaning Schedules, dated 12/01/25 through 12/03/25, showed the A.M. and P.M. aide is directed to clean the kitchen doors and to clean the door frames and walls if needed in the main kitchen and to clean the walls in the Tiger Lane kitchen. Review showed staff did not document they cleaned the doors and walls as directed for the dates of 12/01/25 through 12/03/25. Observation on 12/01/25 at 9:46 A.M. and 12/03/25 at 8:09 A.M., showed the wall by the door to the main kitchen's mechanical dishwashing station covered with dried food debris and brown liquid stains. Observations on 12/03/25 at 8:18 A.M., showed an accumulation of dried food debris on the wall behind the steamtable in the Tiger Lane kitchen. Observation also showed an accumulation of black stains, dried liquid stains and food debris on the interior side of the two doors to the kitchen. During an interview on 12/04/25 at 2:21 PM., the DM said the person who scrapes the dishes after meals is responsible to clean the walls daily, but it did not look like they had done so. 9. Observation on 12/01/25 at 9:50 A.M. and 12/03/25 at 8:07 A.M., showed a thick accumulation of dust and debris on the two ceiling vents and the ceiling in the food (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	preparation and service area by the steamtable in the main kitchen. Observation showed debris hung from the side of the left facing vent. Observation on 12/03/25 at 8:18 A.M., showed an accumulation of dirt on the two vents and surrounding ceiling in the Tiger Lane kitchen. During an interview on 12/04/25 at 2:21 P.M., the DM said maintenance staff are responsible to clean vents and ceilings weekly, but they do not clean them unless he/she puts an order in the computerized maintenance portal. The DM said he/she had put in an order for them to be cleaned a while ago and they had not cleaned them yet. During an interview on 12/04/25 at 3:00 P.M., the administrator said maintenance staff are responsible to clean vents monthly and as needed. During an interview on 12/04/25 at 3:55 P.M., the maintenance director said maintenance staff is responsible to clean the vents and ceilings in the kitchens, but there is not a routine schedule to do so, and staff should put a work order in the computerized maintenance portal when maintenance is needed. The maintenance director said the maintenance department has been short staffed, they complete the work orders when they can, and he/she could not recall if he/she received a work order to clean the vents and ceilings in the kitchens. 10. Review of the facility's Daily Dietary Checklist/Cleaning Schedule, dated 12/01/25, showed the A.M. and P.M. cooks are directed to wipe the steamtables after each meal. Review showed staff did not document they cleaned the steamtables in the Main Street dining room as directed on 12/01/25. Observation on 12/01/25 at 10:20 A.M., showed food debris, which included pieces of chicken and green beans, floated in the water of the wells to the steamtable in the Main Street dining room and a slimy white substance on the bottom of the wells. During an interview on 12/04/25 at 2:21 P.M., the DM said serving staff are responsible to clean the steamtables, which would include the removal of any debris in the wells of the steamtable, after each meal. 11. Review of the facility's Daily Dietary Checklist/Cleaning Schedules, dated 12/01/25 through 12/03/25, showed the record did not include direction to clean the ice machines. Observation on 12/03/25 at 7:59 A.M., showed an excessive accumulation of dirt and an unidentifiable red substance on the exterior of all the water lines to the ice machine and on the outlet behind the ice machine in the Main Street dining beverage station. Observation showed the interior surfaces of the ice machine, filled with ice, contained an accumulation of dirt and an unidentifiable black substance. Observation also showed the scoop to dispense the ice hung uncovered from the side of the ice machine in a metal rack. Observation showed brown stains on the scoop and the rack with an accumulation of dust and rust spots. During an interview on 12/03/25 at 9:00 A.M., the maintenance director said the facility's contracted service company is responsible for the maintenance of the ice machines. During an interview on 12/04/25 at 2:15 P.M., the DM said the ice machine in the Main Street dining beverage station is used to supply ice to residents. The DM said the facility's contracted service company and maintenance staff are responsible for the maintenance of the ice machines, but dietary staff should wipe the exterior of the ice machine and ensure the scoop is cleaned daily. The DM said he/she did not know about the condition of the ice machine or that the ice scoop was not stored properly. 12. During an interview on 12/04/25 at 2:21 P.M., the DM said all staff are responsible for cleaning the kitchens daily and are expected to move equipment that can be moved to clean behind and under it. The DM said they have cleaning schedules for staff to follow and document on every day. The DM said some are not completed and some have signed that they completed the tasks but would say they have not done all the tasks. During an interview on 12/04/25 at 3:00 P.M., the administrator said the dietary staff is responsible to clean the kitchens daily, including the doors, walls, floors and equipment. The administrator said staff should follow the cleaning schedules and document the tasks as completed. The DM is responsible to ensure the kitchens are clean and in good repair and that staff have completed the daily cleaning schedules as assigned.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. Based on observation, interview and record review, facility staff failed to develop and implement complete policies and procedures for the inspection, testing and maintenance of the facility's water systems to inhibit the growth of waterborne pathogens and reduce the risk of an outbreak of Legionnaire's Disease, a serious type of pneumonia (lung infection) caused by Legionella bacteria. Facility staffs' failure to develop and implement complete policies and procedures for the inspection, testing and maintenance of the facility's water systems has the potential for the failure of staff to identify and mitigate the presence of waterborne pathogens, which places all residents of the facility at risk of exposure which could lead to illness. The facility census was 231 with a capacity of 239. 1. Review of the Centers for Medicare and Medicaid Services (CMS), QSO-17-30, dated 06/02/17 and revised 07/06/18, showed:-CMS expects Medicare and Medicare/Medicaid certified healthcare facilities to have water management policies and procedures to reduce the risk of growth and spread of Legionella and other opportunistic pathogens in building water systems.-Facilities must have water management plans and documentation that, at a minimum, ensure each facility:--Conducts a facility risk assessment to identify where Legionella and other opportunistic waterborne pathogens (e.g. Pseudomonas, Acinetobacter, Burkholderia, Stenotrophomonas, nontuberculous mycobacteria, and fungi) could grow and spread in the facility water system;--Develops and implements a water management program that considers the ASHRAE industry standard and the CDC toolkit;--Specifies testing protocols and acceptable ranges for control measures and document the results of testing and corrective actions taken when control limits are not maintained;--Maintains compliance with other applicable Federal, State and local requirements; --Note: CMS does not require water cultures for Legionella or other opportunistic water borne pathogens. Testing protocols are at the discretion of the provider. Review of the facility's Identifying and Investigating Legionnaire's Disease policy and procedure, dated 06/06/18, showed facilities must have water management plans and documentation that, at a minimum, ensure each facility:-Conducts a facility risk assessment;-Implements a water management program that includes control measures such as physical controls, temperature management, disinfectant level control, visual inspections and environmental testing;-Specifies testing protocols and acceptable ranges for control measures and document the results of testing and corrective actions taken when control limits are not maintained. Review of the facility's Environmental Water Testing for Legionnaire's Disease policy and procedure, dated 06/06/18, showed testing of the building's hot and cold-water distribution systems must be performed at least quarterly. Review showed water samples from at least five outlets on the hot water system and at least five outlets on the cold-water system should be taken for each quarterly testing cycle. Review of the facility's Building Water System Description, undated, showed:-In warm climates, water pipes that typically carry cold water may reach a temperature that allows for growth of Legionella;-Decorative fountains and devices such as cooling towers and ice machines may contain areas where cold water can be heated to temperatures that allow Legionella to grow;-If hot water is allowed to sit in pipes (stagnation), it might reach a temperature where legionella can grow and could encourage sediment to accumulate or biofilm to form. Review of the facility's Water Management Program documentation showed the documentation did not contain:-A facility specific risk assessment;-Control measures related to identified risk areas;-Corrective actions to take if control measures are not within specified ranges;-Documentation of quarterly water system testing. Observations on 12/02/25 and 12/03/25 during the Life Safety Code tour showed the facility equipped with a cooling tower, multiple ice machines and multiple water sources throughout the (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	facility. Observation showed all water sources were not in regular use. During an interview on 12/04/2025 at 11:57 A.M., the maintenance director said the facility should have a water management plan, but he/she did not know who was responsible for the plan. The maintenance director said any area with hot water would be a risk area. The maintenance director said he/she took a single Legionella water sample twice a year and he/she was unaware of the facility policy directing ten samples quarterly. The maintenance director he/she flushed water heaters twice a year but did not document the flushes. The maintenance director said he/she cleaned the facility cooling tower but did not document the cleaning. The maintenance director said he/she was not aware of any facility specific water management policies related to control measures or corrective actions. During an interview on 12/04/2025 at 4:13 P.M., the administrator said the facility water management program should include monitoring water temperatures, risk areas, Legionella sample testing and corrective measures for any issues identified. The administrator said he/she was not familiar with facility specific water sampling procedures or control measures. The administrator said he/she was not aware the water management program did not contain facility specific control measures or corrective actions.

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on observation, interview, and record review, facility staff failed to maintain resident dignity, when residents were required to line up for medication administration outside of the nurse's station door, and required two residents to communicate with staff through a three-inch hole in the enclosed nurse's station glass. Additionally, residents were required to stand in line to get their meal trays and were unable to eat in the dining room due to lack of chairs. The facility census was 231. Review of the facility's policy titled, Resident Rights, dated 07/5/23, showed each resident shall be treated with consideration, respect and full recognition of his/her dignity and individuality including privacy in treatment. Review of the facility's policy titled Promoting/Maintaining Resident Dignity, dated 09/21/25, showed every resident has a right to be treated with dignity and respect. All staff will speak to and treat all residents with dignity and respect. The resident's former lifestyle and personal choices will be considered when providing care and services to meet the resident's needs and preferences. All staff members are involved in providing care to residents to promote and maintain resident dignity and respect resident rights. 1. Observation on 12/2/25 at 8:33 A.M., showed Certified Medication Technician (CMT) CC in the enclosed nurse's station at the medication cart. The CMT had pre-popped 18 cups of medications. Residents stood in a line at the closed nurse's station door to receive their medications. CMT CC would take one pill cup off the medication cart at a time, open the nurse's station door, hand the medication cup to the resident at the front of the line, close the door to the nurse's station and return to the medication cart. Resident Care Coordinator (RCC) HH went in and out of the nurse's station door during the medication administration. 2. Observation on 12/2/25 at 10:25 A.M., showed CMT CC and RCC HH in the enclosed nurse's station with the door closed. An unidentified resident bent over to talk to the CMT through an approximately three-inch circular hole in the plexiglass, at the front of the nurse's station. The resident stuck his/her ear to the hole in the glass to hear the CMTs responses to his/her questions. Observation on 12/3/25 at 12:06 P.M., showed CMT CC sat in the enclosed nurse's station with Resident #89 bent over at the waist to talk to him/her through the small circular hole in the plexiglass. During an interview on 12/2/25 at 10:29 A.M., Resident #58 said the residents having to talk to staff through the hole at the nurse's station, That is pretty much jail. During an interview on 12/2/25 at 11:12 A.M., Resident #165 said the nurse's station was completely closed in with glass and they must talk to staff through a small hole. The resident said he/she has been in other nursing homes and those homes do not have enclosed nurse's stations. The resident said, It is not homelike, to be honest it is more prison like. During an interview on 12/8/25 at 11:55 A.M., Nursing Assistant (NA) A W said residents talking through the hole at the nurse's station is not dignified. During an interview on 12/8/25 at 12:46 P.M., CMT C said it is not dignified for residents to have to speak to nursing staff through the small hole on the nurse's station glass. During an interview on 12/8/25 at 2:44 P.M., RCC HH said it's not dignified for staff to talk to resident through hole in nurse's station glass. 3. During an interview on 12/8/25 at 4:29 P.M., the Director of Nursing (DON) said it not dignified for residents to have to talk through hole in nurse's station to staff. The DON said staff should not be passing resident's medications from the nurse's station. During an interview on 12/9/25 at 1:28 P.M., the administrator said it is not dignified for residents to talk through the hole in the nurse's station glass. He/She said staff should not be administering medications from behind the nurse's station. 4. Observation on 12/3/25 at 12:17 P.M., showed six unidentified residents stood in a line in the Tiger Lane dining room as they waited for staff to serve their lunch trays from a kitchen window. There were not any staff in the dining room to serve the residents at the tables. Observation on 12/3/25 at 12:29 P.M. showed six unidentified residents in the Tiger Lane dining room stood in a line waiting for food. During an interview on 12/3/25 at 12:39 P.M., Resident #216 said there is not enough chairs in the Tiger Lane dining room for staff to serve residents during meals and that was why they must wait in line. The resident said even (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	if there were enough chairs there are not enough staff to serve the residents at the dining room tables. Observation on 12/4/25 at 12:14 P.M., showed Residents # 72, #183, #216, and seven unidentified residents stood in a line in the Tiger Lane dining room as they waited for staff to serve their lunch trays from the kitchen window. Further observation at 12:40 P.M., showed the same 10 residents continued to stand in a line at the kitchen window, waiting to be served lunch. During an interview on 12/4/25 at 12:42 P.M., Resident #183 said it bothers him/her to stand in line for food, he/she would rather be served at the table, but there are not enough chairs in the dining room. He/She said it was frustrating standing in line, and it puts everyone in a mood. He/She said sometimes they wait a long time in line before they are given their tray. During an interview on 12/4/25 at 12:44 P.M., Resident #72 said there was not enough chairs in the dining room. The resident said he/she can't even sit down and wait for his/her food. Observation on 12/5/25 at 11:50 A.M., showed 44 residents on Tiger Lane and showed nine dining room chairs in the Tiger Lane dining room. During an interview on 12/8/25 at 11:55 A.M., NA W said residents having to stand in line to get their food was not dignified. During an interview on 12/5/25 at 12:14 P.M., NA I said he/she does not think it is dignified to have residents stand in line to get their food, it was just easier to have the residents stand in line than to serve them. During an interview on 12/8/25 at 12:46 P.M., CMT C said some residents prefer to sit at a table and be served their food. The CMT said the facility used to serve all the residents at the tables. CMT C said residents shouldn't have to line up to get their meals but said it would take at least two staff to serve the residents, and they don't have enough staff to do that. During an interview on 12/8/2025 at 2:44 P.M., RCC HH said all the residents stand in a line to get their food and since he/she started this past February, there has always been a lack of chairs in the dining room. The RCC said some residents will pull up chairs, because they can't stand in that line that long. During an interview on 12/8/25 at 4:29 P.M., the DON said he/she thinks the residents prefer standing in line because they get their food faster. The DON said the facility would have to order more chairs, and the dietary department would need to send staff to assist, for residents to be able to sit and be served. During an interview on 12/9/25 at 1:28 P.M., the administrator said residents should not have to stand in line, it should be a choice for them, if they wanted to go get their tray. The administrator said staff should serve residents, if the residents want to sit down. The administrator said the facility would have to get more staff down there to serve the residents at the tables.

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Reasonably accommodate the needs and preferences of each resident. Based on observation, interview, and record review, facility staff failed to provide reasonable accommodations for residents when they failed to provide sufficient dining room chairs in four dining rooms to ensure residents were able to sit down and eat their meals. The facility census was 231. Review of the facility's policy titled Promoting/Maintaining Resident Dignity, dated 09/21/25, showed each resident will be provided equal access to quality care regardless of diagnosis, severity of condition or payment source. The resident's former lifestyle and personal choices will be considered when providing care and services to meet the resident's needs and preferences. 1.Observation on 12/2/25 at 11:15 A.M., showed 17 residents residing on the Tiger Medical Unit. The dining room contained two tables and three chairs. Observation on 12/3/25 at 12:47 P.M., showed the Tiger Medical Unit dining room with three tables and one chair at each table occupied. Observation showed dietary staff delivered a cart with lunch trays. Observation showed Resident #149 stood in the hallway with his/her food tray in one hand and ate his/her meal because there were no available chairs. Observation showed Resident #133 left the dining room table and Resident #74 sat down. Observation showed Resident #165 placed his/her lunch tray at the end of an occupied table and stood to eat because there were no available chairs. Observation on 12/4/25 at 12:37 P.M., showed the Tiger Medical Unit dining room with three tables and one chair at each table occupied. Observation showed Resident #74 placed his/her lunch tray at a dining room table and ate as he/she stood because there were no available chairs. During an interview on 12/3/25 at 12:39 P.M., Resident #216 said there was not enough chairs in the Tiger Lane dining room, and he/she thinks it's because residents take the chairs to their rooms. Observation on 12/5/25 at 11:50 A.M., showed 44 residents on Tiger Lane and showed nine dining room chairs in the Tiger Lane dining room. During an interview on 12/5/25 at 12:03 P.M., Resident #19 said there are not a lot of chairs in the Tiger Lane dining room. He/She likes to eat in the dining room, but there are not always enough chairs. During an interview on 12/5/25 at 11:46 A.M., Resident #115 said he/she would like more chairs in the Tiger Lane dining room. He/She used a wheelchair and would like to transfer from his/her wheelchair into a regular dining room chair to eat, but there were not enough chairs. During an interview on 12/5/25 at 11:52 A.M., Resident #195 said he/she eats in his/her room due to the lack of chairs in the Tiger Lane dining room. During an interview on 12/5/25 at 12:08 P.M., Resident #171 said the lack of chairs in the Tiger Lane dining room was a problem and he/she had seen residents standing to eat. Resident #171 said he/she usually ate in his/her room, but if the dining room had more chairs, he/she could eat in the dining room. He/she said it was not an option now. During an interview on 12/5/25 at 12:14 P.M., nursing assistant (NA) I said there are only three dining room chairs in the Tiger Medical dining room, because residents take the chairs to their rooms. The NA said it was not dignified for residents to have to stand and eat. Observation on 12/5/25 at 12:20 P.M., showed all nine dining room chairs occupied and all other residents carried their meal tray to their rooms. During an interview on 12/8/25 at 12:05 P.M., NA D said he/she noticed only three chairs in the Tiger Medical dining room, he/she does not know where the chairs are going, and he/she has not reported the missing chairs to anyone. The NA said he/she could use a few extra chairs for residents to eat. During an interview on 12/8/25 at 12:45 P.M., CMT C said some of the dining room chairs in Tiger Lane and Tiger Medical were broken and he/she thought the facility was supposed to be ordering more chairs but said that was around three to four months ago. 2. Observation on 12/8/25 at 1:41 P.M., showed seven chairs in the men's behavioral dining room. During an interview on 12/8/25 at 1:42 P.M., certified nursing assistant (CNA) DD said there are only seven chairs on the men's unit for 20 residents, he/she said because there are not enough chairs it causes residents to not eat, or they go to their room to eat, and it causes cleanliness issues. 3. Observation on 12/8/25 at 1:43 P.M., showed five chairs in the women's behavioral dining room. During an interview on 12/8/25 at 1:43 P.M., CNA T said there are five chairs in the women's dining room with 16 residents. He/She said there are not enough chairs and (continued on next page)

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Four Seasons Living Center	2800 Highway Tt Sedalia, MO 65301

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	sometimes the residents are upset because they all want to eat together. 4. During an interview on 12/8/25 at 2:44 P.M., residential care coordinator (RCC) HH said there always has been a lack of chairs in the dining rooms, at least since he/she started in February. The RCC said occasionally residents have said things about not getting to sit in the dining room, because there aren't enough chairs. The RCC said sometimes he/she has seen residents stand and eat, the residents will put their tray on a table and stand, due to a lack of chairs. RCC HH said he/she thought the facility ordered more chairs a few months ago and doesn't know why they have not arrived. During an interview on 12/8/25 at 4:29 P.M., the director of nursing (DON) said property damage by residents is probably a big part of not having many chairs. The DON said he/she was not aware; residents were standing to eat. The DON said it is not dignified for the residents to stand and eat. He/She said the residents should be able to sit down and eat their meals. The DON said he/she believes the administrator has put in an order, but it has not been approved. During an interview on 12/9/25 at 1:28 P.M., the administrator said a lot of chairs have been broken, and he/she put in a capital expense request for new chairs around four to five months ago and had it had not been approved yet. The administrator said it is not dignified for residents to have to stand and eat.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, facility staff failed to provide a comfortable and homelike environment for residents, when staff failed to clean and maintain resident room and common area walls, doors, windows, floors, toilets, air conditioning (A/C) units, bathroom vents, and furniture. Facility staff failed to ensure residents had access to clean clothes and linens in a timely manner and failed to assist residents with laundry as needed. The facility census was 231 with a capacity of 239. 1.Review of the facility policy titled Safe and Homelike Environment Policy, dated 06/5/24, showed the facility will provide a safe, clean, comfortable and homelike environment. The facility will create and maintain, to the extent possible, a homelike environment that deemphasizes the institutional character of the setting. Housekeeping and maintenance services will be provided as necessary to maintain a sanitary and comfortable environment. The facility will provide and maintain bed and bath linens that are clean and in good condition, the facility will provide sufficient individual closet space in each resident room. General considerations include to minimize odors by disposing of soiled linens promptly and reporting lingering odors and bathrooms needing cleaning to Housekeeping Department; report any furniture in disrepair to Maintenance promptly; and report any unresolved environmental concerns to the Administrator. Review of the facility policy titled Housekeeping - Deep Cleaning, dated 06/29/23, showed deep cleaning is to be completed as scheduled, this includes complete pull outs of furniture in rooms, wall cleaning, floor cleaning (scrubbing and waxing included), restrooms to be cleaned and disinfected, cob webs removed, beds and rails to be cleaned, sprinkler heads to be cleaned, windows to be cleaned. All areas should be monitored daily, and all resident living areas and non-living areas should be clean and odor free. Daily cleaning includes dust mop or sweep floor; surfaces are to be cleaned including wall smudges, side tables, and windows; and clean shower rooms inside the shower, around the shower, and the base boards in the room. All resident rooms will be deep cleaned once monthly or more often if needed, as in the case of heavy care rooms. Bathroom floors will be swept and mopped, and any dirt, grime or stains will be hand scrubbed with stiff brush or other equipment suitable for removing surface dirty from the entire floor; if the stain is not removable then housekeeper will notify Maintenance department with a Maintenance Request Form; and necessary wall washing to remove smudges and spots will be done with disinfectant cleaner. Review of the facility's policy titled Exhaust Fan Maintenance, revised 02/3/25, showed maintenance is responsible for repair and testing of the ventilation systems. Maintenance employees shall inspect the ventilation system including the vent covers, ductwork and fan operation during quarterly preventive maintenance room audits. Observation on 12/2/25 and 12/3/25 during the Life Safety Code tour showed:-Bathrooms adjacent to resident rooms 104, 408, 417, 424, and 505 did not contain covers to the bathroom exhaust fans;-Bathrooms adjacent to resident rooms 122, 129, 412, and 518 did not contain toilet tank lids;-The bathroom adjacent to resident room [ROOM NUMBER] contained a bowed ceiling tile and a two- and one-half inch gap which exposed the space above the ceiling;-The bathroom adjacent to resident room [ROOM NUMBER] contained a bowed ceiling tile and a four-inch gap which exposed the space above the ceiling;-Resident room [ROOM NUMBER] had large holes in the wall which exposed the wall cavity;-The bathroom adjacent to resident room [ROOM NUMBER] had a rusted baseboard heater;-The corridor handrails near resident rooms 102, 412 and 415 were missing end caps, which exposed sharp metal edges;-Resident room [ROOM NUMBER] was missing hallway door trim; -Resident room [ROOM NUMBER] had torn bathroom door trim and the bathroom door did not contain a doorknob; -Resident room [ROOM NUMBER] contained a broken hallway door frame which caused the door to stick which prevented the door from latching; -Resident room [ROOM NUMBER] was missing hallway door trim on the left side of the door. During an interview on 12/4/25 at 11:57 A.M., the maintenance director said all staff, residents, and visitors can enter work orders (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	when issues are identified. Facility staff completed 99 work orders this week and they still have 25 open work orders. He/She was not aware of every wall issue since they were so frequent. He/She was not aware of the missing handrail end caps. The maintenance director said toilet tanks should have lids, and he/she was not sure why they were missing. He/She needed more staff to keep up with building maintenance and repairs. Observation on 12/01/25 at 11:40 A.M., showed the following around the Tiger Lane dining and nurse's station areas: -Exterior exit door missing paint and covered in dirt and debris;-Handrails in the dining room between columns have peeled and missing paint on four handrails;-Missing base trim and exposed unpainted drywall; -Missing paint and drywall on corners of columns and metal brackets on corners of columns exposed; -Four drywall patches on dining room walls, sanded and not painted;-A/C wall unit had broken vents, covered in thick dirt and debris, and missing trim around unit; -500 Hall nurses station missing paint and drywall on corners, one large drywall patch, unpainted;-Door to the vending machine room with a crack across the bottom of the door. Observation on 12/1/25 at 11:42 A.M., showed the handrails by resident rooms [ROOM NUMBERS] with chipped and missing paint. Observation on 12/1/25 at 11:58 A.M., showed the Tiger Lane hallway light fixture by the dry utility room without a cover. Observation on 12/1/25 at 12:47 P.M., showed resident occupied room [ROOM NUMBER] with the bed not made, belongings piled on the bed and on the floor under the bed, a laundry basket, and an open box of prepackaged noodles. Observation on 12/2/25 at 9:09 A.M., showed resident occupied room [ROOM NUMBER] in the same condition, bed was not made, personal belongings piled on the bed and on the floor under the bed, and an open box of prepackaged noodles. Observation on 12/1/25 at 12:49 P.M., showed resident occupied room [ROOM NUMBER] with a rolled-up, stained blanket in front of the dresser by the sink and under the sink; missing/damaged floor tiles under the sink, and the nightstand between the resident beds had the two top drawers broken. Observation on 12/1/25 at 12:52 P.M., showed resident occupied room [ROOM NUMBER]'s bathroom with a brown stain and water leakage around the base of the toilet. During an interview on 12/1/25 at 12:52 P.M., the resident said his/her toilet had been leaking for a month. Staff were aware and it had not been fixed yet. It was not sanitary and posed a fall risk. Observation on 12/3/25 at 3:46 P.M., showed resident occupied room [ROOM NUMBER]'s bathroom with a brown stain and water leakage around the base of the toilet. Observation on 12/4/25 at 9:05 A.M., showed resident occupied room [ROOM NUMBER]'s bathroom with a brown stain and water leakage around the base of the toilet. During an interview on 12/5/25 at 11:27 A.M., housekeeper BB said he/she had not noticed the resident's toilet leaking in room [ROOM NUMBER] and said it did not appear to be leaking when he/she cleaned the bathroom. Housekeeper BB said if he/she had noticed it leaking he/she would notify maintenance to repair it because it could be a fall risk to residents. Observation on 12/1/25 at 12:53 P.M., showed the dresser in resident occupied room [ROOM NUMBER] A missing the front of the top drawer and exposed nails. The floor was dirty with scattered trash. Observation on 12/01/25 at 12:54 P.M., showed a strong odor of urine when entering the Tiger Medical unit. Observation showed the handrails on both sides of the hall on Tiger Medical unit with missing paint and two large drywall patches on the wall between resident rooms [ROOM NUMBERS] that were not sanded or painted. Observation on 12/01/25 at 12:59 P.M., showed 13 cracked tiles in the Tiger Medical dining room floor and showed the A/C unit had broken vents and the A/C unit cover hanging forward of off the unit. Observation on 12/01/25 at 1:00 P.M., showed resident occupied room [ROOM NUMBER] had debris scattered around the bed and a dark substance on the floor in front of and went under the bed. Observation on 12/02/25 at 2:30 P.M., showed resident occupied room [ROOM NUMBER] with debris scattered around the bed and a dark substance on the floor in front of and went under the bed. Observation on 12/03/25 at 9:38 A.M., showed resident occupied room [ROOM NUMBER] with debris scattered around the bed and a dark substance on the floor in front of and went under the bed. Observation on 12/04/25 at 2:40 P.M., showed resident occupied room [ROOM NUMBER] with debris scattered around the bed and a dark substance on the floor in front of and went under the bed. Observation on 12/05/25 at 11:42 A.M., showed (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	resident occupied room [ROOM NUMBER] with debris scattered around the bed and a dark substance on the floor in front of and went under the bed. Observation on 12/01/25 at 1:04 P.M., of resident occupied room [ROOM NUMBER] showed bed B missing a mattress and the wire frame exposed with visible rust. Further observation showed unpainted drywall patches on the wall next to the room sink, damaged drywall at bed height across the back of the wall where the beds are located along the length of the wall. The left side window of the double window had three screws through the window frame and unable to open the window, and the screen was missing; the right-side window was cracked open, unable to be fully closed, with a torn screen on the bottom edge; with a few leaves on the inside of window frame. Also on the wall near bed A was large letters scribbled on the wall spelling Howdy with a brown and black waxy like substance. Observation on 12/02/25 at 9:27 A.M., showed resident occupied room [ROOM NUMBER] remained without a mattress on bed B, left side window remained screwed shut with missing window screen; right side window remained cracked open along bottom edge, unable to shut with moderate amount of force. During an interview on 12/8/25 at 12:53 P.M., Licensed Practical Nurse (LPN) E said he/she did not notice the windows in room [ROOM NUMBER] and tried to report an issue when he/she sees it. LPN E said he/she was not sure how long the unoccupied bed did not have a mattress. During an interview on 12/8/25 at 1:04 P.M., Certified Nurse Aide (CNA) H said he/she did not notice the window in room [ROOM NUMBER], he/she tries to report every concern he/she sees and was not sure how long the bed has not had a mattress. Observation on 12/01/25 at 1:05 P.M., showed resident occupied room [ROOM NUMBER] with debris on the floor and in the windowsills. The floors and walls have a dark substance on them and the sheets and bedding were dirty. Observation on 12/02/25 at 2:40 P.M., showed resident occupied room [ROOM NUMBER] with the same debris on the floor and in the windowsills. Resident bed A's floor and wall had a dark substance splattered on it and dirty linens on the bed. Observation on 12/03/25 at 9:45 A.M., showed resident occupied room [ROOM NUMBER] with the same debris on the floor and resident bed A's floor and wall had a dark substance splattered on it and dirty linens on the bed. Observation on 12/04/25 at 2:50 P.M., showed resident occupied room [ROOM NUMBER] with the same debris on the floor and resident bed A's floor and wall had a dark substance splattered on it and dirty linens on the bed. Observation on 12/05/25 at 11:50 A.M., showed resident occupied room [ROOM NUMBER] with the same debris on the floor and resident bed A's floor and wall had a dark substance splattered on it and dirty linens on the bed. During an interview on 12/05/25 at 11:53 A.M., the resident said the toilet has been broken for about a week. Staff have been in and out of the room looking at the toilet all week and was unsure what the dirty linens are on the bathroom floor. He/She was unsure how they got there and who was supposed to take care of them. Observation on 12/01/25 at 1:06 P.M., showed a large area of peeled paint that exposed the drywall by the emergency eye wash kit at the end of the 400 hall. Observation on 12/01/25 at 1:25 P.M., showed resident occupied room [ROOM NUMBER]'s bathroom showed the vent without a cover and approximately three sheets of toilet paper in the vent. Observation on 12/05/25 at 9:43 A.M., showed the floor in resident occupied room [ROOM NUMBER] dirty with debris. Observation on 12/01/25 at 1:30 P.M., showed the bathroom in room [ROOM NUMBER] with the vent uncovered and showed the bathroom floor dirty with a black substance in front of the toilet. Observation on 12/01/25 at 1:32 P.M., showed occupied room [ROOM NUMBER] B with a dirty and stained privacy curtain. Observation showed the headboard attached to the resident's bed broken and without approximately one-fourth of the headboard. Observation on 12/01/25 at 1:38 P.M., showed a crack in the oxygen storage room door by room [ROOM NUMBER]. Observation on 12/01/25 at 2:15 P.M., showed resident occupied room [ROOM NUMBER]'s bathroom floor with brownish stains on the left side of the toilet. Observation showed a black substance around the base of the toilet, and a flat piece of wood stuck out from under the toilet. Further observation showed cracked, chipped, and stained floor tiles along the baseboard and underneath the resident's bed. Observation on 12/01/25 at 2:20 P.M., showed the inner door frame of resident occupied room [ROOM NUMBER] had missing trim that exposed the (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	space between the door frame and dry wall. The bathroom floor had a chipped tile in front of the toilet and one missing tile two tiles away from the front of the toilet. Observation on 12/01/25 at 2:25 P.M., showed resident occupied room [ROOM NUMBER] with approximately three feet of missing paint on the wall. The bathroom floor had a black substance on the floor tiles close to the toilet. Observation on 12/01/25 at 3:22 P.M., showed resident occupied room [ROOM NUMBER] with bed frame A with a thick layer of dirt and debris. Observation on 12/03/25 at 7:40 P.M., showed resident occupied room [ROOM NUMBER] A with two large pieces of feces and urine on the floor in front of the resident's dresser and showed areas of feces on the front of the dresser. Observation on 12/03/25 at 8:07 P.M., showed two large pieces of feces remained on the floor in resident occupied room [ROOM NUMBER] visible from the hallway. Further observation showed certified medication technician (CMT) C walked into Tiger Lane Medical and tried to get the resident back into his/her room, but did not do anything to address the two large pieces of feces on the resident's floor. Observation on 12/03/25 at 8:40 P.M., showed two large pieces of feces remained on the floor in resident room [ROOM NUMBER] visible from the hallway. Observation on 12/04/25 at 8:35 A.M., showed resident room [ROOM NUMBER] room smelled of urine and the floor was sticky and had a brown outline of where the feces had been. Dried feces remained on the front of the resident's dresser. Observation on 12/02/25 at 8:48 A.M., showed resident occupied room [ROOM NUMBER] with a brown substance splattered on the window blinds and showed the floors around the baseboard trim with a black thick unknown substance. The bathroom door had gouges and the A/C unit was covered in dirt and debris. The bathroom had missing baseboards that exposed damaged drywall. During an interview on 12/02/25 at 8:52 A.M., the resident said he/she was not sure how often housekeeping cleans his/her room and said the floors are stained. Maintenance was very limited on the time they had to fix holes in the walls, as they have a lot of stuff to fix on other halls in the facility. Observation on 12/02/25 at 9:05 A.M., showed resident occupied room [ROOM NUMBER] had unpainted patched drywall under the bathroom vent. Observation on 12/02/25 at 9:11 A.M., showed resident occupied room [ROOM NUMBER] had food debris and dirt in the middle of the room and under bed A. Observation on 12/02/25 at 9:30 A.M., showed resident occupied room [ROOM NUMBER] A had brown splatter on the walls around the bed and showed dirt and debris on the floors. Observation showed damage to the drywall by the bed's headboard, a buildup of black grime around the rubber of the baseboard trim and showed white splatter on the privacy curtain. Observation on 12/02/25 at 10:29 A.M., showed the shower room on Tiger Lane with a black unknown substance scattered on the ceiling. Further observation showed the walk-in shower had a thick black unknown substance on the tile along the base boards. During an interview on 12/08/25 at 3:49 P.M., the environmental supervisor said the facility previously had issues with mold build up in the Tiger Lane shower room and had painted the ceiling at that time but recently noticed the areas on the ceiling coming back. Observation on 12/02/25 at 10:35 A.M., showed resident occupied room [ROOM NUMBER]'s bathroom vent had a large accumulation of dust. Observation on 12/02/25 at 2:33 P.M., showed a resident on Tiger Lane medical urinated on the floor, pulled his/her pant leg up and dropped feces on the floor. Observation showed housekeeper M came to the unit picked up the feces and did not clean up the urine or mop/sanitize the floor where the feces was. Observation on 12/02/25 at 2:35 P.M., showed resident occupied room [ROOM NUMBER] had a broken dirty toilet and dirty linens on the bathroom floor. Resident bed C had clothes and shoes all over his/her floor around the bed, and a plate of food on the bed side table. Observation on 12/03/25 at 9:40 A.M., showed resident occupied room [ROOM NUMBER]'s toilet consistently running and had dirty linens on the bathroom floor. Resident bed C had clothes and shoes all over his/her floor around the bed and a plate of food on the bed side table. Observation on 12/04/25 at 2:45 P.M., showed resident occupied room [ROOM NUMBER] had dirty linens on the bathroom floor. Resident bed C had clothes and shoes all over his/her floor around the bed and a plate of food on the bed side table. Observation on 12/05/25 at 11:46 A.M., showed resident occupied room [ROOM NUMBER] had dirty linens on the bathroom floor. Resident bed C had clothes and shoes all over his/her floor around (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the bed and a plate of food on the bed side table. During an interview on 12/05/25 at 11:53 A.M., the resident said the toilet has been broken for about a week. Staff had been in and out of the room looking at the toilet all week and was unsure what the dirty linens are on the bathroom floor. The resident said he/she doesn't know why the staff haven't picked them up. The resident said it was his/her responsibility to keep things picked up in his/her own space. During an interview on 12/05/25 at 11:55 A.M., Certified Medication Technician (CMT) LL said there was only one staff member on the unit. The residents do all their own cleaning, sweeping, mopping and linen changes. CMT LL said staff should encourage residents to do these things and help if needed. CMT LL said residents are told to aim for having these things done by 10 o'clock in the morning so they have the rest of the day free. The CMT said he/she is unsure if room checks are done but thinks maybe the upper management might do it. Observation on 12/02/25 at 3:10 P.M., showed the floor in resident occupied room [ROOM NUMBER] dirty with dirt and debris. Observation on 12/02/25 at 3:13 P.M., showed the Tiger Lane hallway floor by room [ROOM NUMBER] and room [ROOM NUMBER] with various black stains. Observation on 12/02/25 at 2:46 P.M., showed resident occupied room [ROOM NUMBER]'s right side of the bathroom door frame was missing trim and had exposed nails between the door frame and drywall and the bathroom door handle was missing. Observation showed the floor was dirty with dirt and debris and showed the A/C unit covered in dirt and debris. The tiles around the toilet were stained and discolored and had missing caulk around base of the toilet. The window did not have blinds and showed the resident's bedsheet was stained and had brown debris. Observation on 12/03/25 at 11:20 A.M., showed the floor in resident occupied room [ROOM NUMBER] was dirty and had dirt and debris and had brown splatter on the walls around the resident's bed and door. Observation on 12/04/25 at 8:40 A.M., showed the floor in occupied room [ROOM NUMBER] was sticky and covered with dirt and debris. During an interview on 12/02/25 at 2:50 P.M., the resident said his/her bathroom door had been like that for approximately three months when he/she first moved into the room. Observation on 12/03/25 at 11:12 A.M., showed the Tiger Medical hallway light fixture by room [ROOM NUMBER] without a cover. Observation on 12/04/25 at 11:53 A.M., showed resident occupied room [ROOM NUMBER] with a broken PTAC unit and showed it would not turn on, and the PTAC vents were covered in dirt and debris. During an interview on 12/04/25 at 11:55 A.M., the resident said his/her PTAC unit did not work and it had not worked for over a week. He/She did not want to be cold and said all he/she had to keep warm was his/her blanket. He/She told staff the PTAC unit was not working but could not remember which staff he/she told. Observation on 12/04/25 at 12:23 P.M., showed the outlet on the right side of the Tiger Lane kitchen service window did not have a cover and a light switch in the Tiger Lane dining room did not have a cover. Observation on 12/05/25 at 9:10 A.M., showed the double windows in the 100-hall dining room leaked cold air. The frame of the double windows was screwed into the window casing; a sheet of glass was attached/glued by a white substance to the window frame. Observation on 12/05/25 at 9:40 A.M., showed the privacy curtain in resident occupied room [ROOM NUMBER] B with various brownish stains. Observation on 12/08/25 at 1:38 P.M., showed multiple ceiling tiles in the hallway near rooms [ROOM NUMBERS] with small to large brown stains and some areas of the tiles were missing and the corners of the tiles appeared torn, with the brown core exposed. During an interview on 12/08/25 at 12:05 P.M., nursing assistant (NA) D said the resident rooms on Tiger Medical were not in good condition because residents tear up their rooms to get back at staff if they don't feel like staff are treating them well. NA D said staff can get on the radio and request extra cleaning for resident rooms and said there was scheduled deep clean days. The NA said there are Quick Response Codes (QR Code - a matrix barcode sorting data like URLs (Uniform Resource Locator -a web address that functions like a physical address) on the back of doors to resident rooms that staff can scan for maintenance requests. During an interview on 12/08/25 at 12:31 P.M., housekeeper KK said housekeeping staff are assigned to a hall to clean every day and said they are expected to clean the resident's toilets, sinks, floors, change linens, and whatever else is needed. The housekeeper said the (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	housekeeping department had been short staffed for a while, but they now have five housekeepers, although they are supposed to have six, and said most of the housekeeping staff are new. During an interview on 12/08/25 at 12:46 P.M., CMT C said the facility has been short housekeepers and maintenance is not doing anything. There was a form on the computer for staff to fill out for maintenance requests. The housekeeping supervisor was on leave the last few months and the housekeeping went downhill. CMT C said sometimes residents urinate on the floors. During an interview on 12/8/25 at 12:53 P.M., LPN E, said for any maintenance concerns he/she calls the maintenance director directly. A few months ago the facility started using a code he/she had to scan with his/her personal phone, and he/she does not like to do that, so he/she will just call. There used to be a maintenance book staff could put requests in, but they do not have that anymore. He/She did not notice the windows in room [ROOM NUMBER] and tries to report an issue when he/she sees it. He/She will also notify housekeeping if there is something that needs to be cleaned, but sometimes he/she is focused on caring for residents and does not notice. During an interview on 12/8/25 at 1:04 P.M., CNA H said there is a QR code that he/she must scan with his/her personal phone to submit a maintenance request. He/she said there used to be a maintenance book but switched to the QR code a couple of months ago. He/she does not like using his/her personal phone as they are not supposed to be on their phones while working and if someone does not have a smart phone, they can't scan it. He/She did not notice the window in room [ROOM NUMBER] and he/she tries to report every concern he/she sees. Staff will fix things, but then it gets broken again. Sometimes he/she is focused on resident care and may not notice things. CNA H said rooms should be clean and in good repair because it is the residents' home. During an interview on 12/8/25 at 2:44 P.M., Residential Care Coordinator (RCC) HH said there has been a lack of housekeepers. If an NA sees a room not cleaned appropriately, they can come to him/her and he/she would go to the environmental supervisor. The RCC said the NA's also know where to find the cleaning supplies. During an interview on 12/8/25 at 3:48 P.M., the environmental supervisor said he/she had been on leave the last few months and supervising the housekeepers was an issue. He/She expects the housekeeping staff to thoroughly clean all resident rooms and common areas and said each housekeeping staff is supposed to deep clean one resident room each day. Maintenance staff are responsible to clean and maintain A/C units and said he/she has noticed how dirty some of them are. During an interview on 12/9/25 at 1:28 P.M., the administrator said the housekeeps call in, and there is a lot of turnover which makes it difficult to adequately train new staff. They had a period when the housekeeping supervisor was on leave, and they were all trying to cover his/her position. If staff finds things that need to be fixed, they are supposed to put in work orders and maintenance is supposed to follow up with those orders. He/She was not sure why staff are doing that. The facility was also down a maintenance staff and he/she does not have an answer for why staff are not putting in work orders. The administrator said he/she is responsible to make sure maintenance is maintaining the building and said they do a weekly environmental round and go in each room. Maintenance is responsible for cleaning the air conditioners and should check the units monthly and at a minimum twice a year. During an interview on 12/17/25 at 11:22 A.M., the maintenance director said staff members and residents can use the QR code in the rooms to report maintenance issues. Maintenance staff is responsible to sand and repaint repaired areas, but it's been difficult to keep up due to not enough maintenance staff. Maintenance staff is responsible to clean and maintain the air conditioning units and said the units are cleaned at least annually and typically in nicer weather. He/She had replaced a lot of floor tiles in the last few months, but didn't realize there were more areas that were chipped and broken. Covers should be on all the overhead light fixtures and said all the outlets and light switches should have covers. Maintenance is also responsible to address broken furniture and he/she was not aware there were broken headboards or dressers. He/She was not aware of any resident rooms with missing door trim and said he/she expects staff to report these issues because he/she has a stock of materials and supplies on hand for these issues. 2. Review of the facility's policy titled Handling Clean and Dirty Linen Policy, (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	dated 06/26/24, showed it is the policy of the facility to handle, store, process and transport clean and soiled linen in a safe and sanitary method to prevent contamination of the linen, which can lead to infection. Linen can become contaminated with pathogens from contact with intact skin, body substances, or from environmental contaminants. Linen should not be allowed to touch the uniform or floor and should be handled as little as possible, with minimum agitation to avoid contamination of air, surfaces, and persons; and used or soiled linen shall be collected at the bedside (or point of use, such as dining room) and placed in a linen bag or designated lined receptacle. Soiled linen shall not be kept in the resident's room or bathroom. Observation on 12/02/25 at 3:03 P.M., showed a medium sized pile of clothes in the corner of Resident #19's room. During an interview on 12/02/25 at 3:05 P.M., Resident #19 said the washer on the Tiger Lane unit has been broken for a while and staff did not get clean clothes back to the residents timely. The resident said he/she currently did not have any clean pants, underwear, or socks. During an interview on 12/08/25 at 12:03 P.M., Resident #19 said it can take around two to three weeks to get clean clothes back from laundry. He/She said he/she did not have enough clothes to wait that long, so he/she has had to wear dirty clothes. Observation on 12/02/25 at 10:20 A.M., showed a large pile of cloths on the floor by Resident #26's bed and showed the resident's bed without a bed sheet or a pillowcase on the pillow. During an interview on 12/02/25 at 10:22 A.M., Resident #26 said if his/her bed sheet gets dirty he/she was supposed to go get a clean one from the linen closet but said there was usually not any clean sheets available. He/She would like to sleep with a bed sheet and pillowcase. Observation on 12/03/25 at 10:57 A.M., showed a large pile of clothes on the floor by Resident #26's bed and showed the resident's bed without a bed sheet and without a pillowcase. Observation on 12/05/25 at 9:43 A.M., showed a large pile of clothes on the floor by Resident #26's bed and showed the resident without a bed sheet and without a pillowcase. During an interview on 12/05/25 at 9:45 A.M., Resident #26 said he/she did not know what to do with his/her dirty laundry and said he/she was tired of wearing dirty clothes. He/She has not had a bed sheet or pillowcase all week and staff have not checked to see if he/she wants one. Observation on 12/01/25 at 1:30 P.M., showed Resident #38's room with a large pile of clothes on the floor in front of the bed. During an interview on 12/01/25 at 1:32 P.M., Resident #38 said his/her dirty clothes have been piled up like that for four to five days. The resident said it can take laundry at least a week to get clean clothes back to residents. During an interview on 12/05/25 at 12:22 P.M., Resident #38 said he/she still does not have any clean clothes and said he/she had to wear dirty clothes. Observation on 12/02/25 at 9:27 A.M., showed Resident #46 wore a hospital gown. During an interview on 12/02/25 at 9:30 A.M., Resident #46 said he/she was wearing the hospital gown until he/she can get a clean shirt. He/She did not have any clean underwear or socks and said the items have been in laundry a long time. During an interview on 12/03/25 at 12 P.M., Resident #177 said it can take two to three weeks to get clean clothes back from the laundry. During an interview on 12/02/25 at 2:47 P.M., NA D said the washer in Tiger Lane was broken. NA D said the new washer had been installed about a month ago but broke after a couple of days. Residents are supposed to put their dirty clothes in the laundry bin and staff takes the bin to the main laundry room. It has been a while since he/she has seen laundry bring the residents clean clothes, he/she cannot remember the last time they brought clean clothes. He/She must go upstairs to get clean clothes for the residents. During an interview on 12/08/25 at 10:40 A.M., the laundry lead said he/she was the only staff working in laundry during the day. The washer in Tiger Lane has been broken for a month or two. Staff are supposed to put the resident's dirty clothes in a bag, label the bag with the resident's name and bring it to the laundry room, but staff are not consistently doing it. He/She only has two functioning washing machines in the main laundry room and the other two are curre

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, facility staff failed to provide written information to the resident and/or the resident's representative of the bed hold policy at the time of transfer to the hospital and failed to send a copy of the notice of transfer and/or discharge for eight residents (Resident #4, #7, #9, #12, #91, #93, #100, and #150) out of eight sampled to the representative of the Office of the State Long-Term Care (LTC) Ombudsman. The facility census was 231. 1. Review of the facility's policy titled Bed Hold, revised 06/12/2025, showed: -Before a resident is transferred or discharged , the facility must: -Notify the resident and the resident representative the reason for the transfer or discharge in writing in a manner they understand; --Notify a representative of the Office of the State Long-Term care Ombudsman; --A copy of the discharge/transfer notice shall be sent to the Ombudsman at least 30 days in advance of a discharge or as soon as possible; --In the case of an emergency or immediate discharge, copies shall be sent to the Ombudsman. This notice shall be sent when practicable and a monthly list is acceptable and should include if the resident's return is expected. 2. Review of Resident #4's medical record showed staff documented the resident discharged from the facility to the hospital on [DATE] and returned on 09/30/25. The medical record did not contain documentation staff issued a bed hold upon discharge to the resident or the resident's responsible party and did not notify the Ombudsman of the transfers/discharges. 3. Review of Resident #7's medical record showed staff documented the resident discharged from the facility to the hospital on [DATE] and returned on 08/18/25. The medical record did not contain documentation staff issued a bed hold upon discharge to the resident or the resident's responsible party and did not notify the Ombudsman of the transfers/discharges. 4. Review of Resident #9's medical record showed staff documented the resident discharged from the facility to the hospital and returned to the facility on the following dates: 10/07/25 through 10/09/25; 10/25/25 through 10/29/25 and 10/30/25 through 11/04/25. The medical record did not contain documentation staff issued a bed hold upon discharge to the resident or the resident's responsible party and did not notify the Ombudsman of the transfers/discharges. 5. Review of Resident #12's medical record showed staff documented the resident discharged from the facility to the hospital and returned to the facility on the following dates: 04/15/25 through 05/13/25; 05/27/25 through 06/04/25; 06/22/25 through 06/29/25, 09/14/25 through 09/20/25, and 11/04/25 through 11/05/25. The medical record did not contain documentation staff issued a bed hold upon discharge to the resident or the resident's responsible party and did not notify the Ombudsman of the transfers/discharges. 6. Review of Resident #91's medical record showed staff documented the resident discharged from (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the facility to the hospital on [DATE] and returned on 07/19/25. Review showed the resident discharged from the facility to the hospital on [DATE] and returned on 08/09/25. The medical record did not contain documentation staff issued a bed hold upon discharge to the resident or the resident's responsible party and did not notify the Ombudsman of the transfers/discharges. 7. Review of Resident #93's medical record showed staff documented the resident discharged from the facility to the hospital on [DATE] and returned on 02/24/25. Review showed the resident discharged from the facility to the hospital on [DATE] and returned on 11/13/25. The medical record did not contain documentation staff issued a bed hold upon discharge to the resident or the resident's responsible party and did not notify the Ombudsman of the transfers/discharges. 8. Review of Resident #100's medical record showed staff documented the resident discharged from the facility to the hospital on [DATE]. The medical record did not contain documentation staff issued a bed hold upon discharge to the resident or the resident's responsible party and did not notify the Ombudsman of the transfers/discharges. 9. Review of Resident #150's medical record showed staff documented the resident discharged from the facility to the hospital on [DATE] and returned on 11/24/25. The medical record did not contain documentation staff issued a bed hold upon discharge to the resident or the resident's responsible party and did not notify the Ombudsman of the transfers/discharges. 10. Review of email correspondence from the Ombudsman, dated 11/25/25, showed the Ombudsman said he/she had not received transfer/discharge logs since last year around this time. During an interview on 12/8/25 at 12:53 P.M., Licensed Practical Nurse (LPN) E said if the resident is their own responsible person, the nurse would give the bed hold to them, if it has to go to their guardian, he/she was not sure who would be responsible, maybe the Social Services Director (SSD), otherwise the nurse gives it to the resident on the way out of the door. LPN E said he/she was not sure if the bed holds were issued to the residents consistently. During an interview on 2/08/25 at 2:14 P.M., the SSD said the Administrator issues the bed holds; if it is on a weekend or night shift staff tells the Administrator, and he/she does not do them. The SSD said he/she had only been told one time since the previous SSD left at the end of October about notifying the Ombudsman of the transfers/discharges but was unclear on the frequency. He/she did not know that the Ombudsman was not being notified of the transfers/discharges. During an interview on 12/08/25 at 3:18 P.M., the Administrator said the charge nurse should issue the bed hold; if he/she is in the office, he/she will issue the paperwork, but the charge nurse should. The Administrator said he/she did not know staff were not doing them until the bed holds were requested. He/she said the team oversees they are being done, but the SSD and himself/herself should ensure they are completed. The Administrator said he/she would expect the Ombudsman notified at least monthly of transfers/discharges, and if an emergency discharge is completed, they should be notified as soon as possible. He/she did not know the Ombudsman notifications were not being done, and the SSD should be the one sending the notifications. During an interview on 12/08/25 at 4:29 P.M., the Director of Nursing (DON) said charge nurses are responsible for issuing the bed holds, and the SSD can assist within 24 hours if the resident is sent out emergently. The DON said when he/she looked at the system, he/she realized the process had changed six months or so ago and were not auto populated any longer in the system. The DON did not (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	know they were not being done until they were requested, and that is when he/she realized the issue. He/she said some of the bed holds did not even populate for completion. The DON said the SSD should send a monthly report to the Ombudsman, and he/she did not know it was not being done. He/she said the previous SSD was working until about a month ago, so they should have been sent.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, facility staff failed to review and revise the plan of care for ten residents (Resident #12, #19, #57, #58, #76, #82, #91, #117, #185, and #211) out of 45 sampled residents with changes in the resident's needs. The facility census was 231.1. Review of the facility policy titled Comprehensive Care Plans, dated 10/31/24, showed it is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident's rights, that includes measurable objectives and time frames to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment. The comprehensive care plan will describe resident specific interventions that reflect the resident's needs and preferences and will be prepared by an interdisciplinary team. The comprehensive care plan will be reviewed and revised by the interdisciplinary team after each comprehensive and quarterly Minimum Data Set (MDS – a federally mandated assessment tool) assessment. The comprehensive care plan will include measurable objectives and timeframes to meet the resident's needs as identified in the resident's comprehensive assessment. Qualified staff responsible for carrying out interventions specified in the care plan will be notified of their roles and responsibilities for carrying out the interventions, initially and when changes are made. 2. Review of Resident #12's Quarterly MDS, dated [DATE], showed staff assessed the resident as moderately cognitively impaired, at risk for pressure ulcers, one Stage III pressure ulcer (a bedsore that involves full-thickness skin loss, extending through the top layers into the fatty tissue), and diagnoses of high blood pressure, end stage renal failure with dialysis (the kidneys have permanently failed requiring dialysis to filter waste and fluid from the blood), and diabetes. Review of the resident's Physician Order Sheet (POS), dated December 2025, showed an order for Venelex bordered foam (a prescription topical ointment wound dressing) to coccyx every shift and as needed every day and night shift for abscess, effective 10/16/25. Review of the resident's progress notes, dated 12/02/25, showed the facility Nurse Practitioner identified the wound as a stage III pressure ulcer acquired on 10/13/25, and to cleanse wound with cleanser, apply Alginate (used to manage moderate to heavily draining wounds) to wound bed, cover wound with bordered foam dressing to be changed daily and for soiling and/or saturation. Review of the resident's care plan, dated 08/20/25, showed staff did not update the plan to include the resident's pressure ulcer or interventions. 3. Review of Resident #19's Quarterly MDS, dated [DATE], showed the resident with a diagnosis of Psoriasis (a chronic autoimmune disease causing rapid skin cell buildup, leading to itchy, scaly, red patches (plaques) on elbows, knees, scalp, and elsewhere). Review of the residents POS, dated December 2025, showed the following orders:- Ketoconazole Shampoo (a medicated shampoo to treat scalp conditions) 2% three times weekly;- Prednisone (used to help reduce inflammation) 10 milligram (mg) tablet one time daily to treat Psoriasis;- Revised order on 12/01/25 for dermatology consult for severe Psoriasis and need for medication change. Observation on 12/01/25 at 2:09 P.M., showed the resident's scalp, face, and neck area with a significant amount of dry and flakey skin. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the resident's care plan, dated 08/29/25, showed staff did not update the plan to include the resident's diagnosis of Psoriasis or interventions. 4. Review of Resident #57's Quarterly MDS, dated [DATE], showed staff assessed the resident as cognitively intact, no behaviors, and did not wander. Review of the resident's Quarterly Elopement Assessment, 09/26/25, showed staff assessed the resident at risk for elopement/wandering. Review of the resident's care plan, dated 08/29/25, showed staff documented diagnoses of dementia with behavioral disturbance, and history of traumatic brain injury (damage to the brain from an external force). Review showed staff did not update the plan to include the resident's elopement/wandering risk with interventions. 5. Review of Resident #58's Quarterly MDS, dated [DATE], showed staff assessed the resident as cognitively intact. Review of the resident's POS, dated 12/01/25, showed an order for Almond Milk (a dairy-free, plant-based milk made from ground almonds and water) instead of regular milk, due to intolerance of regular milk, started 04/28/25. Review of the resident's care plan, dated 06/25/25, showed staff did not update the plan to include the resident's dietary requirements with interventions. Observation on 12/03/25 at 12:47 P.M., showed staff did not provide an alternative to regular milk to the resident. The resident asked staff about his/her Almond Milk and staff said, you know the kitchen only has half of what they need down here on the unit. Observation on 12/08/25 at 12:35 P.M., showed staff did not provide an alternative to regular milk to the resident. During an interview on 12/01/25 at 3:51 P.M., the resident said he/she hasn't been getting his/her Almond Milk, he/she was lactose intolerant. During an interview on 12/03/25 at 9:48 A.M., the resident said staff try to give him/her regular milk and when he/she explains, he/she needs Almond Milk, the staff won't give it to him/her. During an interview on 12/08/25 at 12:05 P.M., Nurse Aide (NA) D said he/she knows the resident cannot drink regular milk, but not sure why the facility was not getting Almond Milk down here. During an interview on 12/08/25 at 4:29 P.M., the Director of Nursing (DON) said dietary interventions should be on a resident's care plan. During an interview on 12/09/25 at 1:28 P.M., the administrator said dietary restrictions and interventions should be on care plan. 6. Review of Resident #76's Quarterly MDS, dated [DATE], showed staff assessed the resident as cognitively intact, behaviors of rejection of care, had no hallucination, had no delusions, no physical behavior towards others, had no feelings of little interest or pleasure in doing things in the last two (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	weeks, had no feelings of down/depressed/hopelessness in the last two weeks. Review of the resident's health status note, dated 10/03/25, showed staff documented they responded to code green (a facility-specific emergency alert for a behavioral/mental health crisis) where they found the resident with a shirt tied around his/her neck. The staff reported it took three staff members to remove the shirt from his/her neck. Staff reported the resident stated he/she was homicidal/suicidal. The resident was sent out for psychiatric evaluation. Review of the resident's behavioral note, dated 10/27/25, showed staff reported that resident attempted to place items around his/her neck stated, I want to die and the voices are telling me to kill myself. Staff reported the resident said he/she needed to go to the hospital again and the last time he/she went he/she wasn't honest about how he/she was feeling. Staff reported the resident said the voices were getting worse and tell him to harm himself/herself and make him/her want to put things around my neck. The resident was sent out for psychiatric evaluation. Review of the resident's current care plan that was in use, dated 09/09/25, showed staff did not update the plan to include the resident's behavior of suicidal ideation with risks and interventions. During an interview on 12/08/25 at 4:29 P.M., the DON said suicidal ideation and attempts should be updated on the care plan, but it was not true suicidal ideation. He/She would expect the behaviors to be on the care plan. The DON said a new suicidal ideation assessment was not done because the resident denied suicidal ideation, did not want to harm himself/herself, and was just upset in the moment and the resident had some delusions involved. 7. Review of Resident #82's Significant Change in Status (SCSA) assessment, dated 10/01/25, showed staff assessed the resident as unable to assess cognitive status, short and long-term memory issues, received hospice services, and diagnoses of non-traumatic brain injury, high blood pressure, Alzheimer's Disease (dementia), seizure disorder, and depression. Review of the resident's POS, dated December 2025, showed an order for hospice consult, dated 09/4/25, and hospice services, dated 09/16/25. Review of the resident's care plan, dated 10/16/25, showed staff did not update the plan to include the resident's hospice with interventions. 8. Review of Resident #91's Annual MDS assessment, dated 10/01/25, showed staff assessed the resident as moderately cognitively impaired, had weight loss of five percent or more in the last month or ten percent or more in the last six months; not on physician prescribed weight-loss regimen, with diagnoses of high blood pressure, diabetes, Alzheimer's disease, dementia, anxiety, depression, psychotic disorder (a loss of contact with reality with symptoms like hallucinations, delusions, and unusual behavior), and schizophrenia (a serious, chronic brain disorder that disrupts how a person thinks, feels, and behaves). Review of the resident's monthly weights, showed on 05/05/2025, the resident weighed 183.2 lbs. On 11/08/2025, the resident weighed 160 pounds which was a 12.66% loss. Review of the resident's care plan, dated 11/03/25, showed staff did not update the plan to include the resident's recent significant weight loss. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	orders or requirements, pressure ulcers, elopement risks, suicidal ideation, behaviors and skin conditions such as psoriasis and edema should be on the care plan, especially if they are ongoing or more chronic issues. He/she said he/she is typically in the building on Tuesdays and Thursdays and covers the sister facility on Wednesdays and Fridays. During an interview on 12/09/25 at 10:28 A.M., the Administrator said the Care Plan Coordinator is primarily responsible for revising and updating the care plans, but said nursing staff can also update care plans as needed. He/she would expect hospice services, weight loss, pressure ulcers, elopement risk and actual elopements, skin conditions such as Psoriasis, and edema to all be included on the resident's care plan. The Administrator said he/she would also expect for significant behaviors to be included on resident care plans, such as suicidal ideation so staff understands the resident's behaviors and interventions.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review facility staff failed to provide care, to maintain personal hygiene, grooming, bathing and nail care for four residents (Residents #211, #233, #149, and #77) out of a sample of 45 residents. The facility census was 231.Review of the facility's policy titled Activities of Daily Living (ADLs), dated 05/18/24, showed a resident who is unable to carry out ADLs will receive the necessary services, to maintain good nutrition, grooming and personal hygiene. The facility will provide a maintenance and restorative program to assist the resident in achieving and maintaining the highest practicable outcome based on comprehensive assessment. The facility will maintain individual objectives of the care plan and periodic review and evaluation. 1. Review of Resident #233's Quarterly Minimum Data Set (MDS), a federally mandated assessment tool, dated 09/5/25, showed staff assessed the resident as:-Severe cognitive impairment;-Rejection of care not exhibited;-Required moderate assistance from staff members for personal hygiene, bathing, and toileting hygiene;-Required supervision or touch assistance from staff members for dressing and eating;-Diagnoses of Parkinson's Disease (a progressive nervous system disorder causing tremors, stiffness, slow movement (bradykinesia), and balance problems), Alzheimer's Disease and Dementia. Review of the resident's care plan, dated 06/10/25, showed staff documented the resident had an ADL self-care performance deficit due to Alzheimer's disease. When bathing staff should check nail length and trim and clean on bath day and as necessary. Report any changes to the nurse. When dressing staff should assist the resident to choose simple comfortable clothing that enhances the resident's ability to dress self. Review of the facility's Point of Care documentation, dated 12/1/25 through 12/5/25, showed staff documented the following:-12/1/25 nail care did not occur and staff did not document the resident refused nail care;-12/2/25 personal hygiene had been provided. -12/5/25 staff documented the resident had been offered a shower and refused. Staff did not document how or when the resident had been reapproached. Review of the facility's Staffing Schedule, dated 12/3/25, showed the night shift aide documented the resident refused a shower, the aide was the only documented staff on the locked unit with 17 residents with behaviors. Review of the resident's Progress Notes, dated 12/1/25 through 12/5/25, showed staff did not document the resident refused care. Observation on 12/2/25 at 9:24 A.M., showed the resident wore the same gray sweatshirt and blue sweatpants as he/she wore the previous day. The resident's hair was oily and unkempt, and he/she had a strong body odor. The resident's nails were long with debris under them. Observation on 12/3/25 at 12:55 P.M., showed the resident shuffled to the dining room with the same gray sweatshirt and blue sweatpants he/she had on the past three days with long dirty fingernails and the resident's hair was oily and unkempt. Observation on 12/4/25 at 11:50 A.M., showed the resident wore the same clothes as the previous three days, had jagged fingernails full of debris, with body odor and greasy unkempt hair. Observation on 12/5/25 at 8:06 A.M., showed the resident wore the same clothes as the previous four days. His/her hair was oily and unkempt, and his/her fingernails were long and had a build up black and brown debris under them. The resident had a strong body odor. (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 12/5/25 at 12:14 P.M., Nursing Aide (NA) I said the residents should not eat with fingernails that look like the resident's nails. The NA said he/she had not told the Resident Care Coordinator (RCC) or Certified Medication Technician (CMT) this week about the resident's fingernails. During an interview on 12/8/25 at 12:05 P.M., NA D said staff have a hard time getting the resident's clothes changed, because they have to go get another resident who speaks the resident's language to translate. The NA said he/she had to negotiate with the resident to get the resident to let him/her change his/her clothes. The NA said he/she does not remember the resident refusing showers this week. During an interview on 12/8/25 at 2:44 P.M., RCC HH said he/she doesn't know why the resident did not get a shower last week. The RCC said staff have not reported to him/her, the resident refused his/her shower. The RCC said staff have not come to him/her in the last week about this resident's fingernails. RCC HH said he/she tries to do residents nails and the CNA can if they are certified, just not for diabetics. The RCC said residents nails should be checked daily, nails should be cleaned before and after meals especially on the medical side, and no staff had come to him/her about the resident's fingernails. The RCC said staff should ask for help reapproaching residents for showers. 2. Review of Resident #149's Quarterly MDS, dated [DATE], showed staff assessed the resident as:-Moderate cognitive impairment;-Rejection of care not exhibited;-Required supervision or touch assistance from staff members for bathing, dressing and personal hygiene;-Diagnoses of Diabetes, Dementia, and Traumatic Brain Injury (TBI). Review of the resident's care plan, dated 11/3/25, showed staff documented the resident has an ADL self-care performance deficit due to TBI. When dressing resident, staff should assist the resident to choose simple comfortable clothing that enhances the resident's ability to dress self. Staff should monitor/document/report PRN (as needed) any changes, any potential for improvement, reasons for self-care deficit, expected course, declines in function. Review of the facility's Point of Care documentation, dated 12/1/25 through 12/5/25, showed staff documented the resident did not refuse nail care, bathing or personal hygiene. Staff documented the resident had been offered a bath. Review of the resident's Progress Notes, dated 12/1/25 through 12/5/25, showed staff did not document any refusals of ADL cares by the resident. Observation on 12/3/25 at 12:52 P.M., showed the resident wore stained clothing in the dining room. The resident's hair was unkempt and oily. The resident's fingernails were long and full of brown debris and the resident had a strong body odor. Observation on 12/4/2025 at 12:01 P.M., showed the resident wore the same clothes as the previous day that were stained. The resident's hair was oily and disheveled. The resident's fingernails were long and had brown debris under them. Observation on 12/5/25 at 8:11 A.M, showed the resident wore the same clothing the previous two days. The resident had strong body odor and long dirty fingernails. The resident's hair was oily and unkempt. During an interview on 12/5/25 at 12:14 P.M., NA I said the residents should not eat with fingernails that look like the resident's. The NA said he/she had not told the RCC or CMT this week about the resident's fingernails. During an interview on 12/8/25 at 2:44 P.M., RCC 1 said he/she doesn't know why the resident did not get a shower last week. The RCC said staff have not reported to him/her the resident refused his/her shower. The RCC said staff have not come to him/her in the last week about this resident's fingernails. 3. Review of Resident #211's Quarterly MDS, dated [DATE], showed staff assessed the resident as:-Moderate cognitive impairment;-Rejection of care not exhibited;-Required moderate assist from staff members for personal hygiene, bathing, toileting hygiene and oral hygiene;-Supervision of touching assistance from staff members for dressing;-Occasional incontinence of bowel and bladder;-Diagnoses of Dementia, Major Depressive Disorder, Adjustment (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Disorder, Antisocial Personality Disorder and TBI. Review of the resident's care plan, dated 11/20/25, showed staff documented the resident had impaired cognitive function/dementia, ADL self-care performance deficit due to disease process Hereditary Ataxia (a neurological symptom causing poor muscle coordination, leading to clumsy movements, balance issues, slurred speech, and difficulty with tasks like writing or eating), impaired balance and limited mobility. During showering staff should check nail length and trim and clean on bath day and as necessary. Required limited assistance from one staff to dress with personal hygiene and toileting. Review of the facility's Point of Care documentation, dated 12/1/25 to 12/5/25, showed staff documented the resident did not refuse nail care, bathing, or personal hygiene. Review showed staff did not document the resident had been offered a bath or shower. Review of the resident's Progress Notes, dated 12/01/25 through 12/05/25, showed staff did not document the resident refused cares. Observation on 12/1/25 at 3:22 P.M., showed the resident walked the hall in blue pants and blue shirt with stains on it. The resident had an odor of urine, his/her fingernails were long with brown debris, and the resident's hair was oily. Observation on 12/2/25 at 9:06 A.M., the resident wandered up and down the hall without shoes or socks and had long, thickened toenails which curled downwards over his/her toes and a thick layer of black substance on the bottoms of his/her feet. The resident's fingernails were long and full of brown debris and his/her hair was oily and disheveled. The resident wore the same light blue shirt with food debris down the front of it and the same stained blue sweatpants as the day before. Observation on 12/3/25 at 11:14 A.M., showed the resident in his/her bed. The resident wore the same blue shirt and sweatpants he/she had worn for three days. The resident's bare feet were covered in a thick black substance. The resident had a strong body odor and urine smell. His/her hair continued to be oily, and fingernails were long and full of brown debris. Observation on 12/3/25 at 1:02 P.M., showed Certified Medication Technician (CMT) N delivered a meal tray and placed it on the resident's two drawer dresser, then left room. The resident stood up from the bed and fed him/her self with his/her hands with long brown fingernails. The resident ate food off the tray with his/her fingers and placed his/her dirty fingers and fingernails in his/her mouth with the food. Observation on 12/3/25 at 7:40 P.M., showed the resident in bed, in the same soiled blue pants and shirt. The resident's fingernails were long and full of brown debris and the resident's hair was oily. Observation on 12/4/25 at 11:44 A.M., showed the resident in bed, with the same blue shirt and sweatpants on with a circular wet spot on the buttocks of his/her pants. The resident's fingernails were long and full of a brown substance. The resident had on yellow non-skid socks and the bottoms were covered in a black substance. Observation on 12/5/25 at 8:13 A.M., showed the resident in bed with a yellow non-skid sock on his/her left foot and a bare right foot covered in a black substance. The resident's hair was oily and unkempt. The resident's fingernails were long and full of brown debris. During an interview on 12/5/25 at 12:14 P.M., NA I said the resident had worn the same clothes all (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	week. The NA said the black substance on the resident's feet was from him/her walking around the unit bare foot. The NA said he/she worked the hall on 12/1/25 and 12/2/25 and did not shower the resident. The NA said sometimes the resident does smell of body odor. The NA said the resident's fingernails are a little long and crusty on the inside and the resident should not eat with his/her hands with fingernails that dirty. The NA said he/she has not told the CMT or RCC this week about the resident's fingernails. During an interview on 12/8/25 at 2:44 P.M., RCC HH said he/she doesn't know why the resident did not get a shower last week. The RCC said staff have not reported to him/her, the resident refused his/her shower. The RCC said staff have not come to him/her in the last week about this resident's fingernails. 4. Review of Resident #77's Quarterly MDS, dated [DATE], showed staff assessed the resident as:-Moderate Cognitive impairment;-Rejection of care not exhibited;-Range of Motion (ROM) impairment to both sides of lower extremities;-Used a wheelchair;-Required moderate assistance from staff members for personal hygiene, bathing and toileting hygiene;-Diagnoses of Alzheimer's Disease, Dementia and Psychotic Disorder. Review of the resident's care plan, dated 06/25/25, showed staff documented the resident required supervision and care assistance at all times related to vascular dementia. The resident was reliant on staff for meeting emotional, intellectual, physical, and social needs due to disease process and physical limitations. When bathing staff should check nail length and trim and clean on bath day and as necessary. Report any changes to the nurse. Staff should provide sponge bath when a full bath or shower cannot be tolerated. If possible, negotiate a time for ADLs so that the resident participates in the decision-making process. Return at the agreed upon time. If resident resists with ADLs, staff should reassure resident, leave and return five to ten minutes later and try again. Review of the facility's Point of Care documentation, dated 12/1/25 through 12/5/25, showed staff documented the resident did not refuse nail care, bathing, or personal hygiene. Review of the resident's Progress Notes, dated 12/1/25, showed staff did not document any refusals of ADL cares, by resident. Observation on 12/3/25 at 1:13 P.M., showed NA D stood by the resident as he/she ate at the dining room table. The resident's fingernails were long with debris and the resident ate with his/her fingers at times. The resident's hair was oily and unkempt and the resident had a foul body odor. Observation on 12/3/25 at 7:49 P.M., showed NA P entered the resident's room to provide incontinence care. Observation showed the resident's fingernails were long and with debris under them. The NA exited the resident's room after incontinence care and did not clean the resident's fingernails. Observation on 12/5/25 at 8:09 A.M., showed the resident's fingernails were long with brown debris under the nails, the resident's hair was oily and unkempt, and the resident had a foul body odor. During an interview on 12/5/25 at 12:14 P.M., NA I said the residents should not eat with fingernails that look like the resident's. The NA said he/she has not told the RCC or CMT this week about the resident's fingernails. NA I said it could be a risk for infection eating with dirty fingernails. During an interview on 12/08/25 at 2:44 P.M., RCC HH said he/she doesn't know why the resident did (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	not get a shower last week. The RCC said staff have not reported to him/her, the resident refused his/her shower. The RCC said staff have not come to him/her in the last week about this resident's fingernails. 5. During interviews on 12/2/25 at 10:39 A.M. and 12/5/25 at 12:14 P.M., NA I said he/she has 17 residents on his/her unit, and he/she is the only staff right now. The NA said CMTs usually trim and clean the residents fingernails, he/she does as much care as he/she can. NA I said it is usually him/her for staff on the unit, when he/she has to do ADL care for residents, he/she has to get the CMT or RCC from the other unit. The NA said he/she keeps the resident's shower schedule in his/her head. The NA said he/she knows not to cut any resident's fingernails. The NA said the foot doctor comes once a month and cuts the resident's nails. The NA said after working down on the unit, he/she has become nose blind. During an interview on 12/8/25 at 12:05 P.M., NA D said he/she needs another staff on the hall when he/she completes resident showers, that is the problem, the staff from the other side can't come over and watch the hall and if they do, it leaves a CMT on the other unit with forty something residents to monitor and administer medications. One CMT for forty something residents is not enough. The NA said if residents need their fingernails clipped, staff grab the clippers, if the resident is diabetic, staff tells the nurse. During an interview on 12/8/25 at 12:46 P.M., CMT C said the facility should have two staff members on the unit, so if a staff completes showers the unit is not left unsupervised. The CMT said there used to be a CNA down on Tiger and Tiger Medical that would do rounds and cut the residents fingernails every week. The RCC would cut the diabetic residents nails. The CMT said since that CNA changed positions five to six months ago, the facility has not had a CNA come down to these units and cut the residents' fingernails. The CMT said the staff should check the cleanliness of resident fingernails before the resident eats, but the staff do not. The CMT said if a resident refuses care it should be documented in the notes and on the resident's care plan. During an interview on 12/8/25 at 2:44 P.M., RCC 1 said sometimes residents can't shower because there are not any clean towels or washcloths. The RCC said the NA is responsible for assisting residents with changing clothes, if the resident needs it. The RCC said a NA should assist residents with showering, if they need the assistance. The RCC said staff can write in the system, if a resident refuses care. The RCC said he/she tries to clean and trim the residents' fingernails. The RCC said staff should ask for help with reapproaching residents for showers, if the resident refuses. The RCC said staff should check the residents' fingernails daily. The RCC said staff should clean the residents' fingernails before and after meals, especially on this unit. During an interview on 12/8/25 at 4:29 P.M., the Director of Nursing (DON) said staff did not document refusals for ADL cares for these residents. The DON said nail care should be on shower days and refusals should be documented and on the care plan. During an interview on 12/9/25 at 1:28 P.M., the administrator said he/she did not have a good answer for why these residents wore the same clothes, had body odors, and had dirty fingernails all week. The administrator said nursing staff should cut the residents' fingernails, unless they are diabetic, it would have to be a licensed nurse.

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F 0728 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that nurse aides who have worked more than 4 months, are trained and competent; and nurse aides who have worked less than 4 months are enrolled in appropriate training. Based on interview and record review, facility staff failed to ensure nine Nurse Aides (NA) (NA D, NA I, NA P, NA V, NA W, NA X, NA Y, NA Z, and NA AA) out of nineteen sampled staff, completed the nurse aide training program within four months of his/her employment in the facility. The facility census was 233.1. Review of the facility's policies showed the facility did not provide a policy for NA qualifications.2. Review of NA D's CNA report showed a hire date of 04/28/25. Review showed the file did not contain documentation the NA completed a nurse aide training program.3. Review of NA I's CNA report showed a hire date of 08/26/24. Review showed the file did not contain documentation the NA completed a nurse aide training program.4. Review of NA P's CNA report showed a hire date of 07/15/25. Review showed the file did not contain documentation the NA completed a nurse aide training program.5. Review of NA V's CNA report showed a hire date of 06/16/25. Review showed the file did not contain documentation the NA completed a nurse aide training program.6. Review of NA W's CNA report showed a hire date of 07/21/25. Review showed the file did not contain documentation the NA completed a nurse aide training program.7. Review of NA X's CNA report showed a hire date of 02/24/25. Review showed the file did not contain documentation the NA completed a nurse aide training program.8. Review of NA Y's CNA report showed a hire date of 04/21/25. Review showed the file did not contain documentation the NA completed a nurse aide training program.9. Review of NA Z's CNA report showed a hire date of 07/22/25. Review showed the file did not contain documentation the NA completed a nurse aide training program.10. Review of NA AA's CNA report showed a hire date of 03/24/25. Review showed the file did not contain documentation the NA completed a nurse aide training program.During an interview on 12/12/25 at 8:19 A.M., NA V said he/she did work the week of survey as a NA. NA V said he/she was in the middle of Certified Nurse Assistant (CNA) classes when the instructor quit, he/she believes it was in October 2025. NA V said he/she has been waiting to find out what he/she was supposed to do next, but has not heard anything until recently when the facility got a new instructor. The NA said he/she continued to work as an NA, because the facility needed staff. During an interview on 12/05/25 at 3:45 P.M., the Director of Nursing (DON) said the CNA instructor was at a sister facility and quit abruptly so it left the NAs unable to complete the program. The DON said he/she was aware the NAs should be certified in 120 days, however there was no other option but to leave them working as NAs as the facility needed the coverage. During an interview on 12/08/25 at 12:30 P.M., the Administrator said he/she was aware of the 120-day time frame for NA training completion, however the instructor quit which delayed the process. The administrator said other than that he/she would not know why it would not be completed within the time frame. The administrator said the DON and Human Resources (HR) are responsible for making sure the time frames are met. During an interview on 12/10/25 at 3:30 P.M., HR said reason the NAs were not certified within the time frame is because the instructor quit. He/She said they would typically try to move the aides to a different position in the facility not related to nursing until they are able to become certified. However, the NAs continued to work as NAs due to shortage of staff.

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F 0741 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that the facility has sufficient staff members who possess the competencies and skills to meet the behavioral health needs of residents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, facility staff failed train their staff on how to adequately care for residents behavioral health needs and two residents, with behavioral health needs, were involved in a resident to resident altercation (Resident #22 and #44) and failed to educate staff on resident specific behaviors and interventions for seven residents (Resident #170, #19, #27, #116, #129, #163, and #211) of 35 sampled residents on two units, the women's behavioral health unit and Tiger Lane. The facility census was 231. 1. Review of the facility's Behavioral Health Services Policy, revised 10/31/24, showed it is the policy of the facility to ensure all residents receive necessary behavioral health services to assist them in reaching and maintaining their highest level of mental and psychosocial functioning. Behavioral health encompasses a resident's whole emotional and mental well-being, which includes, but is not limited to, the prevention and treatment of mental and substance use disorders, psychosocial adjustment difficulty, and trauma or post-traumatic stress disorders. The facility will consider the acuity of the resident population. All facility staff, including contracted staff and volunteers, shall receive education to ensure appropriate competencies and skill sets for meeting the behavioral health needs of residents. Education shall be based on the role of the staff member and resident needs identified through the facility assessment. This includes residents with mental disorders, psychosocial disorders, or substance use disorders (SUDs), and those with a history of trauma and/or post-traumatic stress disorder (PTSD), as reflected in the facility assessment. The facility will ensure that necessary behavioral health care services are person-centered and reflect the resident's goals for care, while maximizing the resident's dignity, autonomy, privacy, socialization, independence, choice, and safety. The facility will ensure that a resident who, upon admission was not assessed or diagnosed with a mental or psychosocial adjustment difficulty or a documented history of trauma and/or PTSD does not develop patterns of decreased social interaction and/or increased withdrawn, angry, or depressive behaviors while residing in the facility. Behavioral health care and services shall be provided in an environment that is conducive to mental and psychosocial well-being. Conditions that are frequently seen in nursing home residents and may require the facility to provide specialized services and support based upon residents' individual needs, include, but are not limited to:-Depression: It is not a natural part of aging, however, older adults in the nursing home setting are more at risk than older adults in the community; -Anxiety and Anxiety Disorders: There are many types of anxiety disorders, each with different symptoms. The most common types of anxiety disorders include Generalized Anxiety Disorder, Social Anxiety Disorder, Panic Disorder, Phobias and Post-Traumatic Stress Disorder; -Schizophrenia: Is a serious mental disorder that may interfere with a person's ability to think clearly, manage emotions, make decisions and relate to others. It is uncommon for schizophrenia to be diagnosed in a person younger than 12 or older than 40;-Bipolar Disorder: Is a mental disorder that causes dramatic shifts in a person's mood or energy and may affect the ability to think clearly.Assessment /Care Planning: The facility utilizes the comprehensive assessment process for identifying and assessing a resident's mental and psychosocial status and providing person-centered care. The assessment and care plan will include goals that are person-centered and individualized to reflect and maximize the resident's dignity, autonomy, privacy, socialization, independence, choice, and safety. Staff will: obtain history from medical records, the resident, and as appropriate the resident's family and friends, regarding mental, psychosocial, and emotional health; monitor the resident closely for expressions or indications of distress; evaluate whether the resident's distress was attributable to their clinical condition and demonstrate that the change in behavior was unavoidable; assess and develop a person-centered care plan for concerns identified in the resident's assessment; share concerns with the interdisciplinary team (IDT) to determine underlying causes of mood and behavior changes, (continued on next page)

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F 0741 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	diagnosis: cursing, yelling, leg shaking, moving around in or frequently getting up and down from his/her chair, nail biting, nervousness, pacing on the unit, restlessness, shaky voice, sweating and toe tapping. Staff documented the resident's interventions were to watch for signs before the resident loses control, offer activities and offer medication before behavioral outburst. Review of Resident #44's nurses notes, dated 12/04/25 at 5:01 A.M., showed the resident continuously agitated and yelling out and struck in the head by another resident. Observation on 12/02/25 at 8:40 A.M., showed Resident #22 and Resident #44 in a verbal altercation. Both residents used profane language. While the residents continued to argue Certified Nurse Aid (CNA) T allowed the residents to go outside together to smoke and supervised the residents through a window. The residents continued to yell at each other outside as other residents became agitated over the arguments and verbalized their input. CNA T did not intervene or implement interventions from either resident's care plan to de-escalate the argument. Observation on 12/02/25 at 9:33 A.M., showed the residents' verbal argument escalated inside in the main hallway and CNA T stepped between the residents as Resident #44 struck Resident #22 over CNA T. Certified Medication Technician (CMT) GG radioed on his/her walkie talkie for the Residential Care Coordinator (RCC), but the RCC did not respond or come to the unit. CMT GG did not intervene or implement any interventions after he/she radioed for the RCC. CNA T placed Resident #22 in another resident's room to protect him/her from Resident #44. Resident #44 knocked medication cups of the medication cart and knocked over a soiled laundry bin cart in the hallway then flailed his/her arms and legs at CNA T and attempted to push CNA T out of the way to enter the room. CNA T stated to CMT GG he/she needed a break and left the unit. Resident #44 followed CNA T off the locked hall and through another locked unit and continued to yell and scream, CMT GG then called a code green (is a facility-specific emergency alert for a behavioral/mental health crisis). The DON took Resident #44 to his/her office to calm down. CNA T and CNA GG failed to implement any behavior interventions from either resident's care plan to de-escalate each resident's behaviors. Review showed facility staff did not provide an investigation regarding the incident between Resident #22 and Resident #44 on 12/2/25. Review of Resident #22's nurses notes, dated 12/02/25 through 12/5/25, showed staff did not document the incident that occurred on 12/2/25. Review of Resident #44's nurses notes, dated 12/02/25 through 12/5/25, showed staff did not document the incident that occurred on 12/2/25.During an interview on 12/05/25 at 11:27 A.M., Resident #22 said staff always wait until residents start fighting to do anything. He/She said, staff just let us yell and then we fight. During an interview on 12/05/25 at 11:32 A.M., CNA T said Resident #22 was not baseline because he/she was usually redirectable, but he/she was not this day. CMT GG should have helped him/her earlier and called a code green to help deescalate the situation because the residents ended up getting physical and Resident #44 walked through two locked units without permission. Code greens are subjective because they are different for different people, and it causes an issue because they are called too much or not in time. He/She was scared to call codes because management had gotten upset because the residents has behaviors every day. He/She was trained on de-escalation but not interventions for each resident. During an interview on 12/05/25 at 11:46 A.M., Resident #44 said staff refuse to keep us safe, none of us feel safe here. He/She said, I was told by staff to fend for myself when I was scared because fights continue to occur. During an interview on 12/08/25 at 1:28 P.M., CMT GG said a code green should have been called earlier that day, when the situation escalated but he/she did not because the RCC did not come to the unit. Resident #44 had behaviors of yelling at other residents which was not at his/her baseline so the code should have been called then. He/She does not know either resident's interventions only to call a code green. During an interview on 12/08/25 at 3:22 P.M., CMT GG said he/she sometimes looks at the care plans but had to figure out how because it was not a normal occurrence. He/She said staff are not provided training on how to access the care plans and management does not communicate when interventions are updated. He/She does not know Resident #22 or Resident #44's interventions for de-escalation. During an interview on 12/08/25 at 4:12 P.M., the Crisis Prevention Intervention (CPI) educator said he/she (continued on next page)

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F 0741 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	does not teach staff when to call codes he/she believed a code should be called when staff are fearful, or the situation is not deescalating. He/She said codes should be called prior to physical altercation, if it has gotten physical then the situation has gone too far. During an interview on 12/09/25 at 9:52 A.M., the Administrator said Code Green should be called when a resident is identified to be a threat to themselves or others, when the staff feels there is about to be a behavior crisis, or the resident is not at their baseline. Code greens should be called prior to the situation turning physical. In this situation a code green should have been called earlier because the resident's behavior was argumentative, physical, and not redirectable which is not Resident #44's and the situation had escalated and got physical. Any staff can call a code green and to his/her knowledge has not been reprimanded for calling a code green. 3. Review of Resident #170's admission MDS, dated [DATE], showed staff assessed the resident as cognitively intact with a diagnoses of schizophrenia - bipolar type, attention deficit disorder, mood disorder, bipolar disorder, anxiety and major depressive disorder.Review of the resident's care plan, revised 10/28/25, showed the resident had a history of behavioral challenges that required protective oversight on a secured unit. Staff documented the residents' interventions as staff one on one as needed and pharmaceutical interventions as needed. Review showed the resident was at risk for signs/symptoms related to the diagnoses of Schizoaffective disorder, bipolar type: aggression, anxiety, cannot make decisions, delusions (fixed false beliefs that can't be reasoned with, fearful, hallucinations (hearing, seeing, feeling, smelling things that are not there), hard time focusing or showing no interest in activities/projects, irritability, poor hygiene, self-isolation and talking to him/her self. Staff documented the resident's interventions were notifying charge nurse if you observe the resident experiencing any of the following signs/symptoms of Schizophrenia: hallucinations, delusions, hard time focusing or showing no interest in activities/projects, cannot make decisions, poor hygiene, fearful, stays to self, irritability, talks to self, mumbles, makes hand gestures as if having a conversation, eyes may dart back and forth, anxiety, and aggression. Respect the resident's personal space, resident's that hallucinate are often fearful of people coming near them. Watch resident closely for signs of anxiety and work with him/her to reduce anxiety. Hallucinations are often triggered by anxiety. Review of the resident's admission note, dated 10/17/25, showed staff documented the resident had a history of visual and auditory hallucinations. The resident believed spirits are after him/her, he/she was irritable and had poor insight. Review of the facility's investigation, dated 11/15/25, showed the resident became physical when he/she wanted another residents food. Review of the facility's investigation, dated 11/29/25, showed the resident became physical with another resident and the resident received treatment at the hospital. Review of the resident's progress notes, dated 11/30/25, showed staff documented the resident was the aggressor in the incident. Staff documented the resident feels safe and does not have any staff he/she feels safe to share his/her thoughts. Staff documented the resident said he/she had no after affects from the incident. Review of the facility's investigation, dated 12/04/25, showed the resident became physical with another resident and the resident received treatment at the hospital. Review of the resident's progress notes, dated 12/04/25 at 4:19 A.M., showed staff documented the resident assaulted Resident #44 and hit him/her in the head multiple times. Review of the resident's progress notes, dated 12/04/25 at 5:01 A.M., showed staff documented the resident struck another resident in the head four times. The resident had no apparent injuries or complaints. Officer arrived with EMS for Resident #44. Review of the resident's progress notes, dated 12/04/25 at 5:50 A.M., showed staff documented the resident was delusional and hallucinating about being tormented about demons/evil spirits. Verbally and physically aggressive towards others whom he/she believed are evil spirits. Extremely hard to redirect. PRN Thorazine 50mg given IM right deltoid. Per psych transported to hospital via facility van with a 1:1 escort.Observation on 12/02/25 at 9:26 A.M., showed the resident in his/her room alone. The resident yelled out multiple times about the demons getting him/her. Observation showed staff on the unit and they did not to assist the resident or implement any care planned interventions for the (continued on next page)

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F 0741 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	resident. Observation on 12/03/25 at 9:43 A.M., showed the resident in the dining room, using profanities and threatening staff and resident's because he/she wanted more juice. The resident had three cups of juice at table. Observation showed staff did not assist the resident or implement care planned interventions to address the resident's behaviors of yelling out. Observation on 12/05/25 at 11:22 A.M., showed the resident in the dining room, alone. The resident yelled out multiple times to get him/her the fuck away from me. Observation showed staff did not assist or implement care planned interventions for the resident. During an interview on 12/03/25 at 12:13 P.M., Resident #1 said he/she moved off the unit where Resident #170 resided because of the continuous fighting on the unit. He/She couldn't come out of his/her room because it was too chaotic, and he/she was becoming depressed and anxious. The residents are always fighting, yelling, and cussing and staff never intervene. Resident #170 sees and talks to demons and has had multiple altercations with other residents. Staff allow people to mouth each other and then acts surprised when it turns physical even though staff have watched it the whole time. During an interview on 12/05/25 at 11:22 A.M., an unidentified resident said residents and staff fear the resident, staff allow him/her to do whatever because they cannot control him/her. Residents are getting hurt because staff won't control the resident. During an interview on 12/05/25 at 11:32 A.M., CNA T said he/she feared the resident and was very intimidated by him/her. The resident was very aggressive and had hurt multiple residents. Staff cannot care for him/her here, residents and staff are not safe. CNA T said staff are not trained for his/her level of needs, staff are just trained on how to handle when residents when they get physical. He/She did not feel like he/she was trained on mental health, personal interventions, or how to deescalate situations before they turn physical. During an interview on 12/08/25 at 3:22 P.M., CMT GG said he/she does not know the residents care plan interventions for de-escalation. He/she knew how to look at care plans but had to figure out how because it was not a normal occurrence. He/She usually lets the resident use the phone when he/she was upset but did not know what other intervention to do if his/her contacts do not answer. During an interview on 12/09/25 at 9:52 A.M., the Administrator said the resident was very delusional and hears demons that tell him/her to do things. The interventions for the resident right now are that he/she was in a single room because privacy was very important to him/her and he/she enjoyed makeup and the facility had bought makeup. If staff cannot deescalate a residents behaviors, staff need to call a code green. He/She was not aware that residents and staff feel unsafe with the resident. He/She felt that facility staff could meet the resident's needs but will investigate further and find placement if staff felt they are scared of the resident. 4. Review of Resident #19's care plan, last revised on 08/29/25, showed the following diagnoses, behaviors, and staff interventions:-Diagnoses of Bipolar Disorder, Schizoaffective Disorder, Bipolar Disorder, Generalized Anxiety Disorder, and Post Traumatic Stress Disorder (PTSD);-Resident at risk for the following signs and symptoms related to diagnosis of Bipolar Disorder, which included changing clothes multiple times a day, displaying high and low emotions, and an increase in signs of symptoms of depression. Interventions include to assist resident with staying on tasks, avoid giving attention when the resident starts boasting, decrease stimulation around the resident when showing high anxiety, and use short and clear explanations or directions for the resident;- Resident at risk for the following signs and symptoms related to diagnosis of anxiety, which included cursing, leg shaking, moving around in or frequently getting up and down for the chair, nail biting, nervousness, pacing on unit, and restlessness. Interventions include to be aware of body stance and facial expressions when approaching the resident, watch closely for signs of anxiety and act before the resident loses control, do not argue with the resident when he/she becomes upset, offer activities to keep the resident from getting bored, and offer medication before the resident has a behavioral outburst;- Resident at risk for the following signs and symptoms related to diagnosis of Schizophrenia, which includes aggression, cannot make decisions, fearful, hallucinations, irritability, makes hand gestures as if having a conversation, mumbles, and talks to self. Interventions included to avoid arguing or getting defensive with the resident, be respectful at all times towards the (continued on next page)

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F 0741 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	residents, notify the charge nurse if the resident is experiencing any of the signs and symptoms of Schizophrenia, residents who hallucinate are often fearful of people coming near them, so be careful when using reassuring touch, and when talking about hallucinations, focus the resident on how the hallucination makes them feel rather than the content of the hallucination, and do not argue with the resident that their hallucinations are not real; - The resident had a history of PTSD and symptoms may flare up without any known trigger, and alterations in reactivity from the traumatic event including aggressiveness and self-destructive behavior. Interventions included remind the resident to use coping skills, move the resident to a quiet place, stay with the resident until calm, and talk to the resident in a calm and steady voice. 5. Review of Resident #27's care plan, dated 11/20/25, showed staff documented the following:-Diagnoses of Paranoid Schizophrenia, Paranoid Personality Disorder, Bipolar Disorder, Inhalant Abuse Uncomplicated, Brief Psychotic Disorder, Other Psychoactive Substance Abuse, Insomnia, Schizophrenia Unspecified, Schizoaffective Disorder Bipolar Type;-The resident was admitted to facility for long term care due to mental illness management. The resident had refused to take medications at times, causing psychosis to escalate, makes false statements that staff, family, police are molesting him/her;-History of hyperactive, suspicious, confused withdrawn and combative, causes management problems. Sexually inappropriate, non-compliant history of delusions and aggression, history of sexually inappropriate and requires structure, incapable of self-direction, required prompts incapable of self-care, fears God and hears angles, uses religion to justify his/her behaviors;-Non-Pharmaceutical interventions, one on one interventions as needed, Pharmaceutical Interventions as needed;-May have smoking privilege held due to negative behaviors at staff's discretion, per legal guardian;-The resident felt like his/her warning signs are, not listed; -His/her past crisis moments include, not listed;-The following are ways he/she can be distracted, or methods that comfort him/her, not listed;-The following worked well for him/her during his/her past crisis moments, not listed; -These are steps the resident wants to take to make his/her environment safer, not listed;-Be aware of your body stance and facial expressions when you approach the resident, closely watch the resident for signs of anxiety and act before he/she loses control, Do not argue or tell the resident that he/she is wrong when he/she upset, do not get into a power struggle with the resident, don't get to close and remember personal space, offer activities to keep the resident from getting bored and provide an opportunity to release energy in a healthy way, offer medication before the resident has a behavioral outburst, offer non-invasive coping mechanisms, first to try to reduce the resident's anxiety level, assist the resident with finding the cause of the anxiety;-Assist with helping resident stay on task, avoid giving attention to resident when he/she starts boasting about himself/herself. Selves, be consistent, keep routine as much as possible, calmly redirect the resident's inappropriate behavior, decrease stimulation around resident when he/she displays signs of anxiety, offer warm baths or soothing music to decrease restlessness;-Please notify charge nurse if you observe the resident experiencing any of thefollowing signs/symptoms of Schizophrenia: hallucinations, delusions, hard timefocusing or showing no interest in activities/projects, cannot make decisions, poorhygiene, fearful, stays to self, irritability, talks to self, mumbles, makes hand gestures as if having a conversation, eyes may dart back and forth, anxiety, and aggression;- Skilled nursing to increase frequency of assessment of behavior monitoring(aggressive/hostile behavior, harm to self or suicidal ideation), behavior monitoring will increase with frequency during the skilled timeframe;-Skilled Nursing to complete face checks, definition of skillednursing face checks are clinical symptom changes, respiratory assessment, sideeffects from medication administration, monitoring of adverse conditions, change in affect or changes in resident condition.6. Review of Resident #116's care plan, last revised on 09/29/25, showed the following diagnosis's, behaviors, and staff interventions:-Diagnosis of Schizoaffective Disorder, Bipolar Disorder, Anxiety Disorder, and abuse of other non-psychoactive substance;-The resident had a history of behavioral challenges that required protective oversight in a secure setting. Interventions included to use CALM technique if needed, implement plans to change inappropriate (continued on next page)

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F 0741 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	behavior, 1:1 intervention as needed;-The resident was at risk for the following signs and symptoms related to diagnosis of anxiety, which includes cursing, leg shaking, moving around in or frequently getting up and down for the chair, nail biting, nervousness, pacing on unit, and restlessness. Interventions included to be aware of body stance and facial expressions when approaching the resident, watch closely for signs of anxiety and act before the resident loses control, do not argue with the resident when he/she becomes upset, offer activities to keep the resident from getting bored, and offer medication before the resident has a behavioral outburst;-The resident was at risk for the following signs and symptoms related to diagnosis of Schizoaffective Disorder, which included aggression, cannot make decisions, fearful, hallucinations, irritability, made hand gestures as if having a conversation, mumbles, and talks to self. Interventions include to notify the charge nurse if you observe the resident experiencing any of these signs and symptoms, avoid arguing or getting defensive with the resident, be careful when using reassuring touch, and watch the resident closely for signs of anxiety due to hallucinations often triggered by anxiety;-The resident was at risk for the following signs and symptoms related to diagnosis of Bipolar Disorder, which included changing clothes multiple times a day, and displaying high and low emotions. Interventions included to assist resident with staying on tasks, avoid giving attention when the resident starts boasting, decrease stimulation around the resident when showing high anxiety, and use short and clear explanations or directions for the resident;-The resident was an elopement risk related to history of attempts and to monitor the resident's location frequently and initiate face checks when necessary. 7. Review of Resident #129's care plan, last revised on 06/17/25, showed the following diagnosis's, behaviors, and staff interventions:-Diagnosis of Anxiety Disorder, Extrapyramidal and Movement Disorder, Impulse Disorder, and Delusional Disorders;-The resident had a history of behavioral challenges that required protective oversight in a secure setting. Interventions included to use CALM technique if needed, implement plans to change inappropriate behavior, 1:1 intervention as needed;-The resident was an elopement risk related to history of attempts and to monitor the resident's location frequently and initiate face checks when necessary;-The resident was at risk for the following signs and symptoms related to diagnosis of Schizoaffective Disorder, which included aggression, cannot make decisions, fearful, hallucinations, irritability, makes hand gestures as if having a conversation, mumbles, and talks to self. Interventions included to notify the charge nurse if you observe the resident experiencing any of these signs and symptoms, avoid arguing or getting defensive with the resident, be careful when using reassuring touch, and watch the resident closely for signs of anxiety due to hallucinations often triggered by anxiety;-The resident was at risk for the following signs and symptoms related to diagnosis of anxiety, which includes cursing, leg shaking, moving around in or frequently getting up and down for the chair, nail biting, nervousness, pacing on unit, and restlessness. Interventions include to be aware of body stance and facial expressions when approaching the resident, watch closely for signs of anxiety and act before the resident loses control, do not argue with the resident when he/she becomes upset, offer activities to keep the resident from getting bored, and offer medication before the resident has a behavioral outburst. 8. Review of Resident #163's care plan, dated 04/8/25, showed staff documented the following:-Diagnoses of Undifferentiated Schizophrenia, Insomnia, Major Depressive Disorder, Borderline Personality Disorder, History of Traumatic Brain Injury, Mild Intellectual Disabilities;- Administer PRN medication for anxiety or hallucinations per physici

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, facility staff failed to document the administration of controlled substance medications in the facility's Control Drug Record book (used to reconcile narcotic medications) at time of administration for three residents (Resident #166, #189 and #116) out of 45 sampled residents. The facility census was 231. 1.Review of the facility's Controlled Substance Administration and Accountability Policy, dated 05/14/24, showed the following:-It is the policy of this facility to promote safe, high quality patient care, complaint with state and federal regulations regarding monitoring the use of controlled substances. The facility will have safeguards in place in order to prevent loss, diversion or accidental exposure;-All controlled substances obtained from a non-automated medication cart or cabinet are recorded on the designated usage form. Written documentation must be clearly legible with all applicable information provided;-The Controlled Drug Record (or other specified form) serves the dual purpose of recording both narcotic disposition and patient administration;-The Controlled Drug Record is a permanent medical record document and in conjunction with the medication administration record (MAR) is the source for documenting any patient-specific narcotic dispensed from the pharmacy;-For areas without automated dispensing systems, two licensed nurses account for all controlled substances and access keys at the end of each shift;-Any discrepancy in the count of controlled substances or disposition of the narcotic keys is resolved by the end of the shift during which it is discovered;-Resolution can be achieved by review of dispensing and administration records and consulting with all staff with access;-Any discrepancies which cannot be resolved must be reported immediately to the director of nursing (DON), charge nurse, or designee and pharmacy. 2.Review of Resident #166's Annual Minimum Data Set (MDS), a federally mandated assessment tool, dated 09/23/25, showed staff assessed the resident as follows:-Diagnoses of Anxiety Disorder, Bipolar (a serious mental illness causing extreme mood swings, from manic highs (euphoria, energy, irritability, impulsivity) to depressive lows (sadness, fatigue, hopelessness), affecting energy, thinking, sleep, and behavior), Schizophrenia (a severe brain disorder causing a disconnect from reality, leading to hallucinations (like hearing voices), delusions (false beliefs), disorganized thinking, and impaired functioning), Diabetes Mellitus, and Arthritis;-Received an as needed pain medication or was offered and declined within last five days. Review of the resident's care plan, dated 11/20/25, showed the resident had acute pain and to monitor/record/report to nurse if resident complains of pain or requests for pain treatment. Review of the resident's physician order sheet (POS), dated October 2025, showed an order for Tramadol (a Schedule IV controlled substance to treat pain) HCL 50 milligrams (mg), give two tablets by mouth every six hours as needed. Review of the resident's medication administration record (MAR), dated October 2025, showed staff documented the resident's Tramadol HCL was administered one time on 10/04/25. Review of the resident's individual patient narcotic record, undated, showed staff did not document the Tramadol administered on 10/04/25.Observation on 12/01/25 at 10:37 A.M., showed certified medication technician (CMT) U was unable to find the Tramadol card during the narcotic count. The resident's individual patient narcotic record in the Control Drug Record book showed one tablet remained. 3.Review of Resident #189's Quarterly MDS, dated [DATE], showed staff assessed the resident as follows:-Diagnoses of Anxiety Disorder, Depression, Bipolar, and Schizophrenia;-Received anti-psychotic medication in the past seven days. Review of the resident's care plan, dated 11/20/25, showed the resident uses psychotropic medications (drugs that alter brain chemistry to manage mental health conditions like depression, anxiety, bipolar disorder, schizophrenia, and ADHD by affecting neurotransmitters) related to diagnosis of schizoaffective disorder, bipolar disorder, and depression. Review of the resident's POS, dated October 2025, showed an order for Clonazepam (a Schedule IV controlled substance to treat anxiety) 0.5 mg, give one tablet (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	by mouth twice daily. Review of the resident's MAR, dated October 2025, showed staff documented the resident's Clonazepam was administered two times on 10/16/25 and two times on 10/19/25. Review of the resident's individual patient narcotic record, dated 10/16/25, showed staff did not document the Clonazepam was administered two times on 10/16/15 and did not document it was administered in the morning on 10/19/25. Observation on 12/01/25 at 10:19 A.M., showed CMT U unable to find the Clonazepam card during the narcotic count. The resident's individual patient narcotic record in the Control Drug Record book showed three tablets remained. 4.Review of Resident #116's Quarterly MDS, dated [DATE], showed staff assessed the resident as follows:-Diagnoses of Anxiety Disorder, Depression, Bipolar Disorder, Schizophrenia, Oppositional Defiant Disorder, and Abuse of other non-psychoactive substances;-Received an opioid medication in the past seven days. Review of the resident's care plan, dated 11/21/25, showed the resident has a history of alcohol and drug abuse (methamphetamine). Review of the resident's POS, dated November 2025, showed an order for Suboxone (a Schedule III controlled substance used to treat opioid addiction) sublingual film 4 mg /1 mg, give one film twice daily. Review of the resident's MAR, dated November 2025, showed staff documented the resident's Suboxone was administered two times on 11/30/25. Review of the resident's individual patient narcotic record, undated, showed staff did not document the Suboxone was administered two times on 11/30/25. Observation on 12/03/25 at 11:41 A.M., showed Resident Care Coordinator (RCC) HH counted 51 doses of Suboxone remained. The resident's individual patient narcotic record in the Control Drug Record book showed 53 doses remained. During an interview on 12/03/2025 at 11:45 A.M., RCC HH said they just completed a narcotic count during the morning shift change. The resident's Suboxone film count reconciled this morning and was not sure why it was not reconciling. He/She said two staff are expected to reconcile the narcotic medications upon shift change and anytime staff are transferring the medication cart keys to another staff member. The RCC HH said if they identify an issue with the narcotic counts not reconciling, staff are expected to try and figure out why there was an issue and report it to the DON. 5.During an interview on 12/02/25 at 11:27 A.M., CMT U said two staff are expected to reconcile the narcotic medications upon shift change and anytime staff are transferring the medication cart keys to another staff member. He/she did not realize the two residents had individual patient narcotic records in the Control Drug Record book that they did not have medication cards and said he/she was not sure how that happened. CMT U said staff are expected to figure out any discrepancies of why the narcotic medication counts are not correct and if they cannot figure it out, staff are expected to report it to the DON. He/she was not sure if the DON has been made aware of the narcotic medication count discrepancies for Resident #166 and Resident #189. CMT U said staff are expected to document the administration of a narcotic medication in the Control Drug Record book at the time the medication is being administered. During an interview on 12/05/2025 at 9:53 A.M., RCC HH said staff are expected to document the administration of a narcotic medication in the Control Drug Record book at the time the medication is being administered. During an interview on 12/05/2025 at 4:31 P.M., the DON said he/she expects staff to document the administration of a narcotic medication in the Control Drug Record book in real time and at the time it is being administered. Two staff members are expected to reconcile the narcotic medications in the medication carts upon shift change and anytime staff are transferring the medication cart keys to another staff member. If staff forgets to document the narcotic medication in the Control Drug Record book, he/she would expect the staff member to go back and sign off in the book. If staff identifies a discrepancy with the narcotic medication counts while reconciling the medications, he/she would expect for staff to try and identify how the discrepancy occurred and to notify him/her if the narcotic counts are not correct. The DON said he/she was not aware the three resident's narcotic counts were incorrect. He/She would expect staff to notify him/her so he/she can complete a review of the discrepancies found. During an interview on 12/08/25 at 10:28 A.M., the Administrator said he/she expects staff to sign the Control Drug Record book at the time a narcotic medication is being administered. He/She expects for staff to reconcile the narcotic medications in the medication carts each shift and expects staff to report any discrepancies to the DON.

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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. Based on observation, interview, and record review, facility staff failed to ensure drugs used in the facility were labeled in accordance with currently accepted professional principles when unpackaged, loose medications were found in five of seven medication carts observed. The facility census was 231.1.Review of the facility's, Medication Storage Policy, dated 05/18/24, showed the policy did not provide guidance regarding loose medications in the medication carts. Observation on 12/01/2025 at 9:55 A.M., showed the 200 hall medical unit medication cart with one crushed pill and one blue and yellow capsule loose in the cart. Observation on 12/01/2025 at 10:19 A.M., showed the 100 hall medical unit medication cart with two white tablets, one pink tablet, and one white tablet in the narcotic box all loose in the cart. Observation on 12/01/2025 at 10:37 A.M., showed the woman's behavior unit medication cart with three white tablets and one yellow tablet loose in the cart. Observation on 12/01/2025 at 10:50 A.M., showed the men's behavior unit medication cart with one purple and pink capsule loose in the cart. Observation on 12/01/2025 at 10:57 A.M., showed the 300 hall medication cart with one red and white capsule and one yellow capsule loose in the cart.During an interview on 12/01/2025 at 11:27 A.M., CMT U said he/she usually tries to check the medication carts weekly for loose medications. The CMT said he/she is not sure if the facility has a set schedule on when to go through the medication carts to look for loose medications and said he/she was not trained on how often staff should be going through the medication carts to check for loose medications.During an interview on 12/05/2025 at 2:44 P.M., RCC HH said he/she is not sure if the facility has a policy about how often to go through medication carts regarding loose medications but said he/she thinks the CMT's should be checking the medication carts weekly.During an interview on 12/05/2025 at 4:31 P.M., the DON said he/she believes the facility's policy instructs staff to check the medication carts for loose medications each shift and for staff to complete a full check each week. The DON said he/she would expect staff to follow the policy and expects for the medication carts to not contain loose medications.During an interview on 12/08/2025 at 10:28 A.M., the Administrator said he/she is uncertain about what the facility's policy says about how often to check the medication carts for loose medications but said he/she would expect staff to check frequently and for the medication carts to not contain loose medications.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. Based on observation, interview and record review, facility staff failed to ensure prepared food items were served at a safe and appetizing temperature to residents who ate in the Main Street and 400 hall dining rooms. Facility staff failed to ensure the internal temperature of hot food held in the steam table measured at least 140 degrees Fahrenheit (dF) and failed to ensure the internal temperature of hot food measured at least 120 dF upon service to the residents. The facility census was 231. 1. Review of the facility's policy titled Dietary Food Preparation, revised 07/05/23, showed:-Foods will be served at the proper temperature to ensure food safety;-Staff are to check the internal temperature of foods to be served with a probe-type thermometer at the beginning of the service and during service;-The acceptable serving temperature for hot food is 135 dF, but preferably 160-175 dF;-If the food temperatures do not meet acceptable serving temperatures, reheat the product to the proper temperature;-If temperatures are not at acceptable levels and cannot be corrected in time for meal service, make an appropriate substitution and discard the out of temperature range foods. 2. Observation on 12/03/25 at 7:45 A.M., showed Dietary Aide (DA) MM served residents food, which included sausage gravy, from the steam table in the Main Street dining room. Observation showed the internal temperature of the sausage gravy in the steam table measured 92 dF. During an interview on 12/03/25 at 7:50 A.M., DA MM said he/she pulled the pan of sausage gravy from the oven in the kitchen and, without checking the internal temperature of the gravy, transported it to the Main Street dining room and put in the steam table for service. The DA said when he/she checked the internal temperature of the gravy after he/she put it in the steam table, it measured 90 dF. The DA said hot food should be at least 140 dF while in the steam table and if it is not, it should be taken back to the kitchen. He/she did not send the gravy back to the kitchen to be reheated because the steam table usually heats it up before service. The DA said he/she did not check the temperature of the gravy again before he/she served it to the residents. During an interview on 12/03/25 at 8:15 A.M., the dietary manager (DM) said hot food should be at least 140 dF while in the steam table to prevent the growth of bacteria and staff are trained on this requirement. Staff should check the internal temperature of food items before served and if a hot food does not measure at least 140 dF, staff should send it back to be reheated or throw it away. During an interview on 12/04/25 at 3:06 P.M., the administrator said staff should check the internal temperature of food before it is served and the temperature of hot food held in the steam table should be at least 140 dF. If the internal temperature of hot food is not at least 140 dF, staff should not serve it until it is brought up to the proper temperature and staff should be trained on that requirement during their orientation to the dietary department. 3. Observation on 12/03/25 from 8:30 A.M. to 9:00 A.M., showed DA B prepared breakfast trays for residents on the 400 hall in the Tiger Lane kitchen. Observation showed the DA placed hot food, which included scrambled eggs and hashbrowns, from the steam table on room temperature plates, covered the plates with insulated plate covers, and placed the trays on an open wheeled bakery rack cart. Observation showed an empty green insulated food cart in the hallway just outside the door of the Tiger Lane kitchen. During an interview on 12/03/25 at 9:00 A.M., DA B said the food trays for the residents on the 400 hall are supposed to be put in the green insulated food cart for delivery, but he/she decided not to use it. The DA said the insulated food cart is to be used so the food stays hot, but staff usually pass the trays quickly so he/she did not think it would be an issue. Observation on 12/03/25 at 9:00 A.M., showed staff delivered the open wheeled bakery cart of food trays to the 400 hall dining room and staff served the first tray from the cart at 9:05 A.M. Observation on 12/03/25 at 9:12 A.M., showed the internal temperature of the scrambled eggs and hashbrowns on the breakfast tray for Resident #149 measured 95 dF. Observation showed the internal temperature of the scrambled eggs and hashbrowns on the breakfast trays for Residents #25 and #163 measured 100 dF. Observation on 12/03/25 at 9:20 A.M., showed staff served the breakfast trays to Residents #25, #149 and #163. During an interview on 12/04/25 at 2:15 P.M., the DM said the internal temperature of (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	hot food should be at least 140 dF when served to the residents and staff are trained on this requirement. The DM said staff are trained to put the trays for residents on the 400 hall in the insulated food cart to keep the food hot and he/she did not know why staff did not use the food cart at breakfast on 12/03/25. During an interview on 12/04/25 at 3:06 P.M., the administrator said the internal temperature of hot food should be at least 120 dF upon service to the residents and dietary staff are trained to deliver the food trays for the residents in the 400 hall in the insulated food cart and to check the internal temperature of the food on the first tray before it is served.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265149	A. Building B. Wing	12/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Four Seasons Living Center	2800 Highway Tt Sedalia, MO 65301

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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 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. Based on observation and interview, facility staff failed to post the required nurse staffing information, which included the total number of staff and the actual hours worked by both licensed and unlicensed nursing staff directly responsible for resident care, per shift, daily in an area readily accessible to all residents and visitors. The facility census was 233.Review of the facility's policy titled Nurse Staffing Posting Information Policy, reviewed 06/26/24, showed the nurse Staffing Sheet will be posted on a daily basis and will contain: -Facility Name;-Current date;-Facility current resident census;-The total number and actual hours worked by the following categories of licensed and unlicensed nursing staff directedly responsible for resident care per shift:-Registered nurses;-Licensed Practical Nurses (LPN)/Licensed Vocational Nurses (LVN);-Certified nurse aides (CNAs). The facility will post the Nurses Staffing Sheet at the beginning of each shift. The information posted will be:-Presented in a clear and readable format;-In a prominent place readily accessible to residents and visitors. 1. Observation on 12/1/25 at 12:00 P.M., showed facility staff did not display the nurse staff posting sheet in an area readily accessible to residents and visitors on the 200 hall. Observation on 12/2/25 at 11:55 A.M., showed facility staff did not display the nurse staff posting sheet in an area readily accessible to residents and visitors on the 200 hall. Observation on 12/3/25 at 12:48 P.M., showed facility staff did not display the nurse staff posting sheet in an area readily accessible to residents and visitors on the 200 hall. Observation on 12/4/25 at 10:15 A.M., showed facility staff did not display the nurse staff posting sheet in an area readily accessible to residents and visitors on the 200 hall. Observation on 12/5/25 at 9:35 A.M., showed facility staff did not display the nurse staff posting sheet in an area readily accessible to residents and visitors on the 200 hall. 2. Observation on 12/5/25 at 3:15 P.M., showed facility staff did not display the nurse staff posting on the 100 hall medical unit. Observation on 12/5/25 at 3:16 P.M., showed no daily nurse staff posting visible on 100 hall behavioral unit. Observation on 12/8/25 at 10:13 A.M., showed no daily nurse staff posting visible on 100 hall medical unit.3. Observation on 12/1/25 at 2:45 P.M., showed facility staff did not display the nurse staff posting sheet in an area readily accessible to residents and visitors on the 300 hall.Observation on 12/2/25 at 12:15 P.M., showed facility staff did not display the nurse staff posting sheet in an area readily accessible to residents and visitors on the 300 hall.Observation on 12/3/25 at 10:30 P.M., showed facility staff did not display the nurse staff posting sheet in an area readily accessible to residents and visitors on the 300 hall.Observation on 12/4/25 at 3:20 P.M., showed facility staff did not display the nurse staff posting sheet in an area readily accessible to residents and visitors on the 300 hall.Observation on 12/5/25 at 9:00 A.M., showed facility staff did not display the nurse staff posting sheet in an area readily accessible to residents and visitors on the 300 hall.Observation on 12/8/25 at 11:00 A.M., showed facility staff did not display the nurse staff posting sheet in an area readily accessible to residents and visitors on the 300 hall.4. Observation on 12/3/25 at 10:30 A.M., showed facility staff did not display the nurse staff posting in an area readily accessible to residents and visitors on the Alzheimer's Unit. Observation on 12/8/25 at 10:26 A.M., showed facility staff did not display the nurse staff posting in an area readily accessible to residents and visitors on the Alzheimer's Unit. 5. During an interview on 12/8/25 at 9:07 A.M., Certified Medication Technician (CMT) EE said he/she takes a picture of the nurse staff posting up front and uses it to fill out the one on the unit he/she works, but it was not always completed. He/She said he/she wrote the names of the staff scheduled, but did not write the hours worked. During an interview on 12/08/25 at 3:17 P.M., CMT U said the nurse staff posting on the 100 behavioral unit and the 100 medical unit have not been filled out for months. He/She said he/she does not know who was responsible to complete the posting. He/She said he/she did not fill it out because he/she does not have dry erase markers. During an interview on 12/08/25 at 4:34 P.M., the Director of Nursing (DON) said the nurse staff posting was posted daily, in the front lobby. He/She said the Resident Care Coordinators (RCCs) oversee the nurse staff positing on each unit. He/She said he/she (continued on next page)

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	265149	A. Building B. Wing	12/08/2025

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	does not know why it was not being done. During an interview on 12/09/25 at 12:35 P.M., the Administrator said staff are to write the staff posting on the white board in each unit every day. It should include the name of staff that work that shift, and their hours worked. The administrator said she did not know staff were not doing this daily.