STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265164	A. Building B. Wing	04/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
West Vue Nursing and Rehabilitation Center	210 Davis Drive West Plains, MO 65775

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 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, the facility failed to store and distribute food under sanitary conditions, increasing the risk of cross-contamination and food-borne illness. This had the potential to affect all residents. The facility census was 119.Review of the facility's policy titled, Food Preparation and Service, revised April 2014, showed:- Food service employees shall prepare and serve food in a manner that complies with safe food handling practices;- All machines and equipment that require cleaning shall be cleaned after use and covered with a washable cover between uses;- Foods will not be thawed at room temperature, thawing procedures include thawing in the refrigerator in a drip-proof container;- Residents should be discouraged from saving anything from their meals for later consumption;- Snacks will not be left on trays or countertops beyond the established safe time and temperature requirements. Review of the facility's policy titled, Food Receiving and Storage, revised April 2014, showed:- Foods shall be received and stored in a manner that complies with safe food handling practices;- When food is delivered to the facility it will be inspected for safe transport and quality before being accepted;- Dry foods that are stored in bins will be removed from original packaging, labeled and dated (use by date), such foods will be rotated using a first in - first out system;- Uncooked and raw animal products and fish will be stored separately in drip-proof containers and below fruits, vegetables and other ready-to-eat foods. The facility did not provide a policy regarding water temperature in the kitchen. Observation on 04/13/26 at 10:53 A.M., and 04/16/26 at 12:07 P.M., of the kitchen showed:- The commercial dishwasher exterior with flaky white grime (dirt ingrained on the surface) build-up and scattered debris on the floor beneath;- Debris, an oily film build-up, and food debris on the floor beneath and behind the range; - The commercial gas range with an oily grime build-up around each burner, exterior surfaces, door handle, control knobs, oven interior, and scattered food debris on the floor beneath; - An oily grime build-up behind the gas range on the floor and wall surfaces;- An oily grime build-up on the steam table control knobs and exterior surfaces;- Bread shelving with dust and grime build-up;- Floor with white grime build-up in the dishwashing area;- Metal electrical junction box with exposed wiring below the dishwasher;- One approximately 24 inch (in.) x 36 in. wall diffuser (one of the few visible parts of an air conditioning system) with dust build-up and a brown substance on the front exterior surfaces near the walk in refrigerator;- The three-compartment sink with water temperature at 90 degrees Fahrenheit (ˆF) in the main kitchen area;- The dishwashing area sprayer sink at 65ˆF. During an interview on 04/16/26 at 12:07 P.M., Dietary Aide (DA) T said he/she asked about the stove and oven being pulled back so the backside area could be cleaned. There were cleaning logs, but the four-burner gas range still needed some deep cleaning, the steam table would need some cleaning also. A drip from the top created grease on the knobs and on the front of the steam table. During an interview on 04/16/26 at 12:31 P.M., DA U said the dishwasher had been delimed this week on Tuesday, but it did build up with grime in between cleanings. The water temperature should be warmer at the sink for dishes. It was warmer earlier today, but it didn't stay hot. Observation on 04/13/26 at 10:53 A.M., of the dry food storage area showed:- Three undated white bins of flour, white sugar, and brown sugar covered with clear tops and food debris on the tops; - One undated 3 quart (qt.) dented can of black eye peas;- One (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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	undated 3 qt. dented cans of tapioca pudding with a brown substance located on the dent;- Two undated 3 qt. dented cans of mild nacho cheese with a brown substance located on the dent;- Two 50 ounce (oz.) dented cans of New England clam chowder with white and brown food debris, dated best used by 04/10/27;- One 50 oz. dented can of cream of mushroom soup with white and brown food debris, dated best used by 09/16/27;- One 25 pound (lb.) opened bag of Japanese breadcrumbs, dated 07/09/25. Observation on 04/13/26 at 10:00 A.M., of the walk-in refrigerator showed:- Scattered food debris and shredded cheese lay on the floor below the food storage shelves. Observation on 04/13/26 at 10:05 A.M., of the walk-in freezer showed:- The floor with 1 in. thick ice formation below the food shelves;- One case of pork chops, one case of Italian vegetables, and three storage bags with ice lay on the floor;- Scattered food debris and paper trash below the food storage shelves. Observation on 04/14/26 at 5:19 A.M., of the Whispering Pine kitchen showed:- Scattered debris on the floor below the main refrigerator and the food shelves;- Refrigerator exterior handles with a sticky film build-up and the meat drawer with scattered food debris;- Ice machine exterior surfaces with a white substance and the top door seal section with scattered black debris;- Two clear glass baking dishes partially filled with apple dump cake and cherry delight cream dessert sat on the counter, dated 4/12/26;- Dishwasher interior with a 12 in. non-stick skillet; - An electric griddle sat on top of the electric range with a black carbon build-up along the edge of the top cooking surface; - Electric range oven handles with a sticky film build-up and interior lower surface with carbon build-up;- The utensil drawer divider tray with a scattered black substance and food debris; - Pantry area food bin with scattered food debris and hard textured hot dog buns, dated best by 02/17/26 and one bag of stuffing croutons, dated best by 11/06/25. During an interview on 04/14/26 at 5:30 A.M., DA V said he/she had a daily task paper that should be followed. The cleaning part was mainly done by the third shift staff that were here all night. Dayshift should clean up as needed after meals and the table was cleaned after two meals. During the night shift, staff should wipe the appliance handles and throw out the expired foods. Observation on 04/14/26 at 6:00 A.M., of the Dogwood kitchen showed:- Ice machine exterior surfaces with a white substance, the top door seal section with scattered black debris, and the upper interior section with a brown grime build-up;- Refrigerator exterior handles with a sticky film build-up and the meat drawer with scattered food debris;- One 12 oz. refrigerated bottled tartar sauce, dated best by 03/13/26;- One 3.69 lb. beef brisket, dated 05/21/25, thawed inside the pantry area refrigerator on the top shelf;- Food debris lay in the pantry area floor below the food storage shelves. Observation on 04/14/26 at 6:14 A.M., of the Sleepy Oaks kitchen showed:- Two clear glass baking dishes partially filled with blueberry cream and peach dessert sat on the counter, dated 4/13/26;- Pantry area food bin with scattered food debris and three hard textured hot dog buns, dated received on 03/20/26;- Food debris lay in the pantry area floor below the food storage shelves;- One 12 oz. dented can of three bean salad, dated received on 02/21/26;- One 12 oz. dented can of tomato paste, dated received on 02/13/26;- One 12 oz. dented can of peaches, dated received on 01/17/26;- The pantry area freezer door bin partially splattered with an orange substance;- The pantry area refrigerator exterior handles with a sticky film build-up and the food shelves with scattered food debris and a dark spilled substance. During an interview on 04/14/26 at 6:30 A.M., DA W said he/she just started in the kitchen about a month ago and did not know there weren't supposed to be dented cans in the dry storage. During an interview on 04/13/26 at 10:53 A.M., the Dietary Manager said canned foods should at least have a use by date on the container, but some of the cans didn't. Normally she would not date the cans, but the staff went through the cans weekly when the truck delivered. She put a line on the front of a can to know which cans went first. Staff should place rusty and dented cans in the return cart, but some were on the rack. There should not be food boxes on the floor or trash under the shelves in the walk-in freezer. There should not be an opened bag of breadcrumbs under the sink that were out of date. During an interview on 04/16/26 at 1:30 P.M., the Administrator said the freezer and refrigerators should be clean. The wall vents should be clean and not have dust or grime build-up. All appliances, counter tops, and vents should be clean and work (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	properly. Dented cans should not be put on the racks, desserts should not be left out, and expired foods should be thrown away. Expectations were to follow the facility's kitchen policy and always keep the kitchen clean.

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the accuracy of a resident's advance directive regarding cardiopulmonary resuscitation (CPR - an emergency life-saving technique used when a person's heart stops beating or they stop breathing) code status for one resident (Resident #81) out of 24 sampled residents. The facility census was 119.The facility did not provide a policy regarding a resident's code status. 1. Review of Resident #81's [DATE] physician order sheet (POS) showed:- An admission date of [DATE];- No code status order. Review of the resident's face sheet, dated [DATE], showed:- No code status. Review of the resident's Outside the Hospital Do Not Resuscitate (OHDNR) form showed:- Code status of do not resuscitate (DNR) with the resident's signature, dated [DATE], and the physician's signature dated [DATE]. Review of the resident's care plan, undated, showed:- Did not address a code status. During an interview on [DATE] at 10:46 A.M., Licensed Practical Nurse (LPN) F said if a resident's code status was not in their medical record and he/she was unsure, he/she would treat them as a full code (wants CPR). He/She would look in the electronic health record (EHR) for the code status. During an interview on [DATE] at 3:27 P.M., the Director of Nursing said staff should check the code status in the EMR. If a resident's code status was not on their face sheet, staff would have to check further in the EHR. During an interview on [DATE] at 3:37 P.M., the Administrator said the resident code status should be indicated on the face sheet in the EHR.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to limit the use of as needed (PRN) psychotropic (medications that affect the mind, emotions, and behaviors) medication orders for 14 days for two residents (Residents #85 and #98) out of four sampled residents. The facility also failed to ensure an appropriate diagnosis for the use of an antipsychotic (medication that treats mental disorders characterized by a disconnection from reality) medication for one resident (Resident #108) and for the use of an antianxiety medication for one resident (Resident #10) out of four sampled residents. The facility census was 119.Review of the facility's policy titled, Psychotropic Medication Use, dated February 2025, showed:- Residents do not receive psychotropic medications that are not clinically indicated and necessary to treat a specific condition documented in the medical record;- Prior to initiating the use of, increasing the dose of, or switching to a different psychotropic medication, the staff and physician will review the following with the resident/representative prior to obtaining documented consent or refusal: non-pharmacological alternatives, the indications and rationale for the recommendation, the potential risks and benefits (including possible side effects, adverse consequences, and black box warnings), and the resident's/representative's right to accept or decline the treatment;- PRN orders for psychotropic medications are limited to 14 days;- For psychotropic medications that are not antipsychotics: if the prescriber or attending physician believes it is appropriate to extend the PRN order beyond 14 days, they will document the rationale for extending the use and include the duration for the PRN order. 1. Review of Resident #10's medical record showed:- Date of admission [DATE];- Diagnoses of Alzheimer's disease (a progressive brain disease that destroys memory, thinking skills, and eventually the ability to perform daily tasks), anxiety disorder (persistent worry and fear about everyday situations), bipolar disorder (a mental disorder that causes unusual shifts in mood), current episode manic (a period of abnormally high energy, elevated mood, or intense irritability) without psychotic (a loss of contact with reality) features, and insomnia (difficulty sleeping). Review of the resident's physician order sheet (POS), dated April 2026, showed:- An order for buspirone (an antianxiety medication) 5 milligram (mg) by mouth two times a day related to Alzheimer's disease, dated 10/01/25;- The facility failed to provide an appropriate diagnosis for the buspirone. 2. Revew of Resident #85's POS, dated April 2026, showed:- Date of admission [DATE];- Diagnoses of senile degeneration of the brain (a neurological disorder that is tied to cognitive decline, memory impairment, and changes in behavior), not elsewhere classified, dementia (a disorder marked by memory loss, personality changes, and impaired reasoning that interferes with daily functioning) in other diseases classified elsewhere, moderate, with agitation;- An order for lorazepam (an antianxiety medication) 0.5 mg by mouth every eight hours PRN for anxiety, dated 02/03/26;- The facility failed to provide a 14-day stop-date order for the lorazepam. 3. Review of Resident #98's POS, dated April 2026, showed:- Date of admission [DATE];- Diagnoses of dementia in other diseases classified without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety; depression (a serious medical illness that negatively affects how you feel, the way you think and how you act); parkinsonism (a broad, umbrella term for a clinical syndrome featuring movement problems); and Parkinson's disease (a disease of the central nervous system that affects movement, often including tremors) with dyskinesia (a movement disorder characterized by involuntary, erratic, and uncontrollable body movements);- An order for lorazepam concentrate 2 mg/milliliter (ml) 0.25 ml sublingually (under the tongue) every four hours as needed for anxiety and for seizures may give 0.25 ml to 1 ml every four hours, dated 03/06/26, with no stop date;- The facility failed to provide a 14-day stop-date order for the lorazepam. 4. Review of Resident #108's medical record showed:- Date of admission [DATE];- Diagnosis of dementia in other diseases classified elsewhere, unspecified severity, with anxiety. Review of the resident's POS, dated April (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2026, showed:- An order for Zyprexa (an antipsychotic medication) 2.5 mg by mouth once daily for agitation and sundowning (a state of increased agitation, confusion, disorientation, and anxiety that typically occurs in the late afternoon or evening in some individuals affected with dementia), dated 01/21/26;- The facility failed to provide an appropriate diagnosis for the Zyprexa. During an interview on 04/16/26 at 8:50 A.M., the Medical Director said he would expect a 14-day stop-date order for psychotropic PRN medications. He would expect medications to have the correct diagnosis. During an interview on 04/16/26 at 3:40 P.M., the Director of Nursing (DON) said PRN psychotropic medications should have a stop date. If the physician did not include a stop date, the physician should be notified to clarify a stop date. She said sundowning and agitation were not acceptable diagnoses for an antipsychotic medication. During an interview on 04/16/26 at 4:26 P.M., the Administrator said sundowning and agitation were not acceptable diagnoses for an antipsychotic medication.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to include the bed-hold rate and complete the bed-hold policy upon transfer to the hospital and failed to identify the reason for the transfer/discharge and include the mailing and email address for the agency for protection and advocacy for residents with intellectual disabilities, and the mailing and email address and telephone number for the agency for protection and advocacy for residents with mental illness within the transfer and discharge notices for four residents (Residents #1, # 9, #11, and #124) out of four sampled residents. The facility census was 119.Review of the facility's policy titled, Bed-Holds and Returns, revised October 2022, showed:- All residents/representatives are provided written information regarding the facility and state bed-hold policies, which address holding or reserving a resident's bed during periods of absence (hospitalization or therapeutic leave);- Residents, regardless of payer source, are provided written notice about these policies at least twice, notice 1: well in advance of any transfer (e.g., in the admission packet); and notice 2: at the time of transfer (or, if the transfer was an emergency, within 24 hours);- The written bed-hold notices provided to the residents/representatives explain in detail the duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the facility; the reserve bed payment policy as indicated by the state plan (for Medicaid residents), the facility policy regarding bed-hold periods; the facility per-diem rate required to hold a bed (for non-Medicaid residents), or to hold a bed beyond the state bed-hold period (for Medicaid residents); and the facility return policy. Review of the facility's policy titled, Transfer or Discharge, revised March 2025, showed:- Once admitted to the facility, residents have the right to remain in the facility, transfers and discharges must meet specific criteria and require resident/representative notification, orientation, and documentation in the medical record;- When the facility transfers or discharges a resident, the following information is documented in the medical record and appropriate information is communicated to the receiving health care institution or provider, the basis for the transfer or discharge, that an appropriate notice was provided to the resident and/or legal representative, the date and time of the transfer or discharge, the new location of the resident, the mode of transportation, a summary of the resident's overall medical, physical, and mental condition, disposition of personal effects, disposition of medications, others as appropriate or as necessary, and the signature of the person recording the data in the medical record;- If the basis for the transfer or discharge is that the transfer or discharge is necessary for the resident's welfare, and the resident's needs cannot be met in the facility, the resident's physician (or provider) documents the specific resident needs that cannot be met, the facility's attempt to meet those needs, and the receiving facility's service(s) that are available to meet those needs;- Upon notice of transfer or discharge, the resident is provided with a statement of his or her right to appeal the transfer or discharge, including the name, address, email, and telephone number of the entity which receives such requests, information about how to obtain, complete, and submit an appeal form, how to get assistance completing the appeal process, and the facility bed-hold policy. 1. Review of Resident #1's medical record showed:- admitted on [DATE];- Transferred to the hospital on [DATE], and returned on 01/26/26;- Transferred to the hospital on [DATE], and returned on 02/18/26;- Transferred to the hospital on [DATE], and returned on 03/23/26. Review of the resident's Bed-Hold information, undated, showed:- No documentation the resident or resident representative elected to hold the bed;- No documentation of the daily bed hold rate;- No documentation of the resident's or resident representative's signature. Review of the resident's Notice of Transfer/Discharge forms, dated 01/26/26, 02/16/26, and 03/23/26, showed:- No documentation for the reason of the transfer/discharge;- No documentation of the agency contact information responsible for the protection and advocacy of individuals with developmental disabilities and the contact information for (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the agency for protection and advocacy of individuals with mental disorders. 2. Review of Resident #9's medical record showed:- admitted on [DATE];- Transferred to the hospital on [DATE], and returned on 01/18/26;- Transferred to the hospital on [DATE], and returned 02/26/26;- Transferred to the hospital on [DATE], and returned on 03/25/26. Review of the resident's Bed-Hold information, undated, showed:- No documentation the resident or resident representative elected to hold the bed;- No documentation of the daily bed hold rate;- No documentation of the resident's or resident representative's signature. Review of the resident's Notice of Transfer/Discharge forms, dated 01/19/26, 02/26/26, and 03/21/26, showed:- No documentation for the reason of the transfer/discharge;- No documentation of the agency contact information responsible for the protection and advocacy of individuals with developmental disabilities and the contact information for the agency for protection and advocacy of individuals with mental disorders. 3. Review of Resident 11's medical record showed:- admitted on [DATE];- Transferred to the hospital on [DATE], and returned on 10/04/25;- Transferred to the hospital on [DATE], and returned 10/26/25;- Transferred to the hospital on [DATE], and returned on 02/09/26. Review of the resident's Bed-Hold information, undated, showed:- No documentation the resident or resident representative elected to hold the bed;- No documentation of the daily bed hold rate;- No documentation of the resident's or resident representative's signature. Review of the resident's Notice of Transfer/Discharge forms, dated 09/30/25, 10/27/25, and 02/09/26, showed:- No documentation for the reason of the transfer/discharge;- No documentation of the agency contact information responsible for the protection and advocacy of individuals with developmental disabilities and the contact information for the agency for protection and advocacy of individuals with mental disorders. 4. Review of Resident #124's medical record showed:- admitted on [DATE];- Transferred to the hospital on [DATE], and did not return. Review of the resident's Bed-Hold information, undated, showed:- No documentation the resident or resident representative elected to hold the bed;- No documentation of the daily bed hold rate;- No documentation of the resident's or resident representative's signature. Review of the resident's Notice of Transfer/Discharge forms, dated 01/26/26, showed:- No documentation for the reason of the transfer/discharge;- No documentation of the agency contact information responsible for the protection and advocacy of individuals with developmental disabilities and the contact information for the agency for protection and advocacy of individuals with mental disorders. During an interview on 04/16/26 at 1:05 P.M., the Social Services Designee (SSD) said she was unaware the Transfer/Discharge notice needed to be signed by the resident or the resident representative and returned to the facility, needed to identify the reason for the transfer/discharge, and include the mailing and email address for the agency for the protection and advocacy for residents with intellectual disabilities and the mail and email address and the telephone number for the agency for the protection and advocacy for residents with mental illness within the transfer and discharge notices. She also wasn't aware the resident or resident representative had the right to elect to hold the bed and the daily bed-hold rate needed to be documented on the form. During an interview on 04/16/26 at 4:02 P.M., the Administrator said she was not aware the Bed-Hold form had to have the daily rate along with the resident's or resident representative's signature. She also was unaware the Transfer/Discharge notice had to include the agency contact information responsible for protection and advocacy of individuals with developmental disabilities and contact information for the agency for protection and advocacy of individuals with a mental disorder.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to develop and implement care plans with specific interventions to meet individual needs for two residents (Residents #4 and #7) out of 24 sampled residents. The facility census was 119.Review of the facility's policy titled, Care Plans-Comprehensive, undated, showed:- An individualized comprehensive care plan that includes measurable objectives and timetables to meet the resident's medical, nursing, mental, and psychological needs is developed for each resident;- Each resident's comprehensive care plan has been designed to: incorporate identified problem areas, incorporate risk factors associated with identified problems, reflect treatment goals and objectives in measurable outcomes;- Care plans are revised as changes in the resident's condition dictate. Care plans are reviewed at least quarterly. 1. Review of Resident #4's medical record showed:- admitted [DATE];- Diagnoses of stroke affecting the left side, persistent atrial fibrillation (irregular heartbeat), major depressive disorder (persistent sadness, loss of interest, and low energy lasting at least two weeks), muscle weakness, lack of coordination, and weakness. Review of the resident's Smoking Assessment, dated 09/15/25, showed:- Cognitively intact;- Educated on the smoking policy, including the designated areas;- Able to safely utilize a lighter;- Demonstrated safe smoking behavior while interacting with other residents. Review of the resident's care plan, revised 02/16/26, showed:- Did not address smoking with person-centered interventions. 2. Review of resident #7's medical record showed:- admitted [DATE];- Diagnoses of chronic respiratory failure (impaired lung function), diabetes mellitus (metabolic disease), atrial fibrillation (irregular rhythm), congestive heart failure (impaired heart function), chronic obstructive pulmonary disease (COPD - a lung disease), and paroxysmal (a sudden, intense, and temporary onset of symptoms) atrial fibrillation;- An order for Eliquis (a blood thinner) 2.5 milligram (mg) by mouth two times a day, dated 11/26/25. Review of the resident's care plan, revised 03/04/26, showed:- Did not address the Eliquis with person-centered interventions. During an interview on 04/16/26 at 3:27 P.M., the Director of Nursing (DON) said she would expect blood thinner medications and smoking to be addressed on a resident's care plan. She would expect person-centered interventions to be on the care plan as well. During an interview on 04/16/26 at 4:02 P.M., the Administrator said she would expect smoking, blood thinner medications, and individualized interventions to be on a resident's care plan.

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	265164	A. Building B. Wing	04/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
West Vue Nursing and Rehabilitation Center	210 Davis Drive West Plains, MO 65775

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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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure placement of the urinary indwelling catheter (a sterile tube inserted into the bladder to drain urine) drainage bag was maintained for one resident (Resident #3) out of two sampled residents. The facility census was 119.Review of the facility's policy titled, Urinary Catheter Care, dated 02/03/15, showed:- The purpose of this procedure is to prevent infection of the resident's urinary tract;- Be sure the catheter tubing and drainage bag are kept off the floor. 1. Review of Resident #3's medical record showed:- admitted on [DATE];- Diagnoses of chronic kidney disease (impaired kidney function) and urinary retention (inability to completely or partially empty the bladder). Review of the resident's physician order sheet (POS), dated April 2026, showed:- An order to change the 16 French (Fr. - size of the catheter) with 10 milliliter (ml) bulb suprapubic (a sterile tube insert3ed into the bladder through the abdominal wall to drain urine) catheter every month on the 12th related to chronic kidney disease stage three, dated 03/12/26;- An order to change the urinary catheter drainage bag every month starting on the 12th and ending on the 13th, dated 02/12/26; - An order to cleanse the suprapubic catheter insertion site with normal saline (salt water), pat dry, and apply a split sponge (a type of dressing) daily and as needed, dated 01/28/26;- An order for urinary catheter care every shift for urinary retention, dated 01/22/26. Review of the resident's admission Minimum Data Set (MDS - a federally mandated assessment instrument completed by facility staff), dated 01/29/26, showed:- Used a suprapubic catheter. Review of the resident's care plan, dated 02/11/26, showed:- Resident with a suprapubic catheter;- Cover the drainage bag when up to promote privacy;- Encourage fluids and monitor character of the urine;- Catheter care every shift. Observations on 04/14/26 at 5:15 A.M., and 9:22 A.M., of the resident showed:- The resident lay in bed and the catheter drainage bag lay on the floor. The bottom of the catheter drainage bag rested on the floor due to the privacy flap was intact and did not cover the bottom of the drainage bag. During an interview on 04/16/26 at 2:44 P.M., Certified Nursing Assistant (CNA) O said a catheter drainage bag should not touch the floor. During an interview on 04/16/26 at 1:30 P.M., Registered Nurse (RN) G said a catheter drainage bag should not touch the floor. During an interview on 04/16/26 at 2:50 P.M., CNA J said a catheter drainage bag should not be on the floor. During an interview on 04/16/26 at 2:53 P.M., CNA K and Nursing Assistant (NA) L said a catheter drainage bag should not touch the floor. During an interview on 04/16/26 at 2:58 P.M., RN M and Licensed Practical Nurse (LPN) N said a catheter drainage bag should not touch the floor. During an interview on 04/16/26 at 4:30 P.M., the Director of Nursing (DON) and the Administrator said they would expect staff to keep a resident's catheter drainage bag off of the floor.

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to identify, assess, and provide supportive interventions for one resident (Resident #8) out of one sampled resident and one resident (Resident #88) outside the sample, whom the facility indicated on the facility's matrix (a form that is used to identify pertinent care categories for newly admitted residents in the last 30 days who are still residing in the facility and for all other residents) with a diagnosis of post-traumatic stress disorder (PTSD - a mental health condition triggered by a terrifying event - either experiencing it or witnessing it; symptoms may include flashbacks, nightmares, and severe anxiety, as well as uncontrollable thoughts about the event) or trauma (the lasting emotional response that often results from living through a distressing event) within the facility. The facility census was 119.Review of the facility's policy titled, Trauma Informed Care and Culturally Competent Care, revision date August 2022, showed:- Trauma results from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual well-being;- Trauma-informed care is an approach to delivering care that involves understanding, recognizing, and responding to the effects of all types of trauma. A trauma-informed approach to care delivery recognizes the widespread impact and signs and symptoms of trauma in residents, and incorporates knowledge about trauma into care plans, policies, procedures, and practices to avoid re-traumatization;- Trigger is a psychological stimulus that prompts recall of a previous traumatic event, even if the stimulus itself is not traumatic or frightening;- Traumatic events which may affect residents during their lifetime include: - physical, sexual and emotional abuse; - neglect; - interpersonal or community violence; - serious injury or illness; - bullying; - forced displacement; - racism; - war, and; - generational or historical trauma;- Triggers are highly individualized. Some common triggers may include: - experiencing a lack of privacy or confinement in a crowded or small space; - exposure to loud noises, or bright/flashing lights; - certain sights, such as objects; and/or; - sounds, smells, and physical touch;- Include trauma-informed care as part of the quality assurance and performance improvement process, so that needs and problem areas are identified and addressed;- Develop individualized care plans that address past trauma in collaboration with the resident and family, as appropriate;- Identify and decrease exposure to triggers that may re-traumatize the resident. 1. Review of Resident #8's medical record showed:- admitted on [DATE];- Diagnoses of bipolar disorder (a mood disorder that can cause intense mood swings), unspecified anxiety disorder (a mental health condition that cause fear, dread and other symptoms that are out of proportion to the situation), and paranoid personality disorder (a psychiatric condition distinguished by a pervasive distrust and suspicion of others, leading to impairments in psychosocial functioning);- No documented trauma informed consent assessment. Review of the facility's matrix, dated 04/13/26, showed:- Resident diagnosed with PTSD/trauma. Review of the resident's level one Preadmission Screening and Resident Review (PASRR - a federal requirement to help ensure that individuals are not inappropriately placed in nursing homes for long term care), dated 07/10/24, showed:- No history of PTSD or trigger indicators. Review of the resident's quarterly Minimum Data Set (MDS - a federally mandated assessment instrument completed by facility staff), dated 01/21/26, showed:- Cognition intact;- No diagnosis of PTSD. Review of the resident's Traumatic Event Assessment, dated 07/26/24, showed:- Positive screen for a traumatic event;- No triggers identified for the positive screen and no developed plan of care to minimize/avoid the triggers. Review of the residents' care plan, dated 04/16/26, showed:- Potential for a history of past trauma;- Will receive care based on the resident's past experiences and preferences to avoid triggers leading to re-traumatization;- Did not address the resident's past trauma or any triggers that would cause the resident trauma;- Did not address how the facility would address behaviors if they occurred or how (continued on next page)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the facility would provide support to the resident. During an interview on 04/16/26 at 12:15 P.M., the Administrator said trauma and/or PTSD should be addressed on Resident #8's care plan. The resident wanted the details of his/her trauma to be confidential and did not want people talking about what happened related to his/her trauma). The family had told the Administrator what had happened. In the past, the resident had requested a female counselor to treat him/her. During an interview on 04/16/26 at 3:20 P.M., Resident #8 said he/she used to see a counselor. Visiting and talking to others to keep his/her mind off things would help, but he/she had no one to talk to because the staff were busy. Maybe one-to-one visits in his/her room or playing cards might help when thoughts of his/her trauma occurred. 2. Review of Resident #88's medical record showed:- admitted on [DATE];- Diagnoses of pneumonia (infection and inflammation of the lung), acute kidney failure, and left femur fracture. Review of the facility's matrix, dated 04/13/26, showed:-The resident diagnosed with PTSD. Review of the resident's PASRR, dated 12/15/25, showed:- No history of PTSD or trigger indicators. Review of the resident's Trauma Informed Consent Assessment, dated 01/08/26, showed:- Experienced a traumatic event;- Had nightmares and unwanted thoughts about the event;- No triggers addressed. Review of the resident's care plan, revised 05/06/25, showed:- Did not address the resident's past trauma or any triggers that would cause the resident trauma;- Did not address how the facility would address behaviors if they occurred or how the facility would provide support to the resident. Review of the resident's Behavioral Notes, dated April 2026, showed:- No behaviors. During an interview on 04/14/26 at 8:14 A.M., Resident #88 said he/she was in a war and lots of men and women lost their lives during that time. The resident did not want to continue to talk about the war. During an interview on 04/15/26 at 2:00 P.M., the Social Services Director (SSD) said he/she completed the Trauma Informed Care screenings, but when he/she completed it, Resident #88 shut down and did not want to keep talking. He/She was not sure when the resident was diagnosed with PTSD but thought he/she came to the facility with the diagnosis. During an interview on 04/15/26 at 3:25 P.M., the Director of Nursing (DON) said if the resident had a diagnosis of PTSD, the care plan should include what triggered the behaviors with interventions. If no triggers were indicated at the time of the assessment, it should be documented on the resident's care plan as well. She said the trauma informed care assessment should be completed quarterly. During an interview on 04/15/26 at 3:48 P.M., the Administrator said the trauma informed care assessment was completed on every admission. If a resident had a diagnosis of PTSD, triggers and interventions should be addressed on the care plan. If the trauma informed care assessment showed no triggers, it should be addressed on the care plan for no triggers indicated and followed up on the next scheduled assessment.

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide ongoing monitoring, supervision, and routine maintenance of the beds with the side rails in use and failed to ensure a bed rail was not used as a restraint for two residents (Residents #6 and #12) out of two sampled residents. The facility's census was 119.Review of the facility's policy titled, Bed/Side Rails, undated, showed:- Bed/Side rails may pose unwarranted hazards to patient safety and will only be used after careful evaluation for requested use by resident/family, for aid in mobility or to provide a sense of comfort and security. Safety is paramount and an evaluation is needed to assess the relative risk of using the bed/side rail compared to not using it for an individual resident. The decision to use or to discontinue use should be made in the context of an individual patient assessment with input from the resident or the legal guardian;- Side rail evaluations are completed by nursing to determine any risks associated with the use of bed/side rails;- Physician order obtained;- Resident bed/side rail consent explaining risks and alternatives is reviewed and signed by the resident or guardian;- Work order requesting bed rail installation sent to maintenance;- Bed/side rails installed after review of all forms by nursing;- Bed/side rail(s) installed. Review of the facility's policy titled, Use of Restraints, undated, showed:- Restraints shall never be used for the prevention of falls;- Physical restraints are defined as any manual method or physical or mechanical device, adjacent to the resident's body that the individual cannot remove easily, which restricts freedom of movement;- The definition of a restraint is based on the functional status of the resident and not the device. If the resident cannot remove a device in the same manner in which the staff applied it given the resident's physical condition (i.e. side rails are put back down, rather than climbed over) and this restricts his/her typical ability to change position or place, that device is considered a restraint;- Practices that inappropriately utilize equipment to prevent resident mobility are considered restraints and are not permitted, including using bedrails to keep a resident from voluntarily getting out of bed as opposed to enhancing mobility while in bed;- Restrained individuals shall be reviewed regularly (at least quarterly) to determine whether they are candidates for restraint reduction, less restrictive methods of restraints, or total restraint elimination. 1. Review of Resident #6's medical record showed:- admitted on [DATE];- Diagnoses of heart failure (impaired heart function), chronic obstructive pulmonary disease (COPD - a lung disease), stroke, seizures (a sudden burst of electrical activity in the brain), atrial fibrillation (irregular heart rhythm), and repeated falls;- No order for the bilateral (both sides) quarter siderails;- No documentation of any attempts made with alternative methods prior to the side rail use;- No documentation of routine maintenance of the side rails. Review of the resident's Side Rail Evaluation, dated 03/27/26, showed:- No interventions trialed before considering the use of the side rails;- Resident used the assist rails on both sides;- Resident requested to use the side rails while in bed;- No cause/medical symptom justified the use. Review of the resident's significant change Minimum Data Set (MDS-a federally mandated assessment instrument completed by the facility), dated 04/01/26, showed:- Cognition severely impaired;- Maximum assistance from staff for bed mobility;- No side rail use. Review of the resident's care plan, dated 03/24/26, showed:- Did not address the bilateral quarter side rail use with goals and interventions. Observations on 04/13/26 at 11:12 A.M., 04/14/26 at 6:31 A.M., and 04/16/26 at 11:46 A.M., of the resident showed:- The resident lay in bed with the head of the bed elevated and the bilateral quarter side rails in the upward position and the left side of the bed up against the wall closest to the door. 2. Review of Resident #12's medical record showed:- admitted on [DATE];- Diagnoses of stroke, dysphagia (difficulty swallowing), high blood pressure, peripheral vascular disease (poor circulation), macular degeneration (eye disease affecting a person's central vision), anxiety (fear, unease, or worry about future events), (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and depression (persistent low mood, loss of interest and reduced energy);- An order for a quarter side rail for a positioning aid and for safety and security of the resident, dated 09/29/25;- No documentation of any attempts made with alternative methods prior to the side rail use;- No documentation of a side rail assessment completed;- No documentation of routine maintenance of the side rails. Review of the resident's quarterly MDS, dated [DATE], showed:- Cognition severely impaired;- Maximum assistance from staff for bed mobility;- No side rail use. Review of the resident's care plan, dated 03/19/26, showed:- Used a quarter side rail as an enabler for repositioning;- Required a Hoyer lift (a mechanical lift used to transfer residents from one position to another) for transfers, and a Geri chair (a medical reclining chair) for mobility. Be aware the resident has poor sitting balance, leans to the left, may need pillows to prop and for comfort. Observations on 04/14/24 at 12:32 P.M., and 04/16/26 at 12:17 P.M., of the resident's bed showed:- The bilateral quarter side rails in the upward position with the left side of the bed up against the wall closest to the door. Observation on 04/16/26 at 12:11 P.M., of the resident during incontinent care showed:- The resident did not utilize the bilateral side rails due to required max assistance from the staff with turning; - Certified Nurse Assistant (CNA) B put the right side rail in the downward position and the top of the side rail height remained approximately four inches above the top of the mattress. During an interview on 04/16/26 at 10:15 A.M., the Director of Nursing (DON) said the side rail inspections were completed by maintenance when the side rails were placed on the bed and if the resident ever changed beds or the mattress was changed. The side rail assessments for the need for a side rail should be completed quarterly and if the resident's condition changed. The side rails were not to be used for preventing a resident from moving or rolling out of the bed. Side rails were used as enablers. During an interview on 04/16/26 at 12:24 P.M., CNA B said the quarter side rails were placed in the lowered position which prevented Residents #6 and #12 from rolling out of bed due to the top of the rails sat above the mattress. Both residents had fallen, and the side rails were used to prevent the residents from falling out of bed. During an interview on 04/16/26 at 1:46 P.M., CNA C said the side rails were placed in the lowered position to keep Residents #6 and #12 in bed. Both residents had an incident a few months ago, where the residents landed on the floor. The side rails were used to keep them from falling out of bed. During an interview on 04/16/26 at 1:47 P.M., Licensed Practical Nurse (LPN) X said that when the quarter side rails were in the lowered position, they kept Resident #12 from rolling out of the bed due to the top of the side rail sat up above the mattress. During an interview on 04/16/26 at 4:02 P.M., the Administrator said side rails were used to promote independence and aid in turning. Side rails were not to be used to keep the residents in bed. Side rails assessments were completed initially and evaluated with care plans quarterly.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on interview and record review, the facility failed to ensure staff reconciled narcotics (a process that allows one staff to reconcile the exact narcotic inventory on hand with another staff) at each shift change for two out of two sampled medication carts. This practice had the potential to affect all residents. The facility census was 113.Review of the facility's policy titled, Controlled Substances, revised November 2022, showed:- Controlled substance inventory is monitored and reconciled to identify loss or potential diversion in a manner that minimizes the time between loss/diversion and detection/follow-up;- Nursing staff count controlled medication inventory at the end of each shift, using these records to reconcile the inventory count;- The nurse coming on duty and the nurse going off duty make the count together and document and report any discrepancies to the Director of Nursing (DON) services. 1. Review of the Licensed Practical Nurse (LPN)/Registered Nurse (RN) Narcotic Count records for the 200 Hall medication cart, dated 02/01/26 - 02/28/26, showed:- No signature and/or initials by the on-coming and off-going nurse on the shift verification of controlled substance count sheet for 12 missed opportunities out of 144 opportunities. Review of the LPN/RN Narcotic Count records for the 200 Hall medication cart, dated 03/01/26 - 03/31/26, showed:- No signature and/or initials by the on-coming and off-going nurse on the shift verification of controlled substance count sheet for 15 missed opportunities out of 158 opportunities. Review of the LPN/RN Narcotic Count records for the 200 Hall medication cart, dated 04/01/26 - 04/16/26, showed:- No signature and/or initials by the on-coming and off-going nurse on the shift verification of controlled substance count sheet for 10 missed opportunities out of 80 opportunities. 2. Review of the LPN/RN Narcotic Count records for the 400 Hall medication cart, dated 02/01/26 - 02/28/26, showed:- No signature and/or initials by the on-coming and off-going nurse on the shift verification of controlled substance count sheet for nine missed opportunities out of 120 opportunities. Review of the LPN/RN Narcotic Count records for the 400 Hall medication cart, dated 03/01/26 - 03/31/26, showed:- No signature and/or initials by the on-coming and off-going nurse on the shift verification of controlled substance count sheet for eight missed opportunities out of 144 opportunities. Review of the LPN/RN Narcotic Count records for the 400 Hall medication cart, dated 04/01/26 - 04/16/26, showed:- No signature and/or initials by the on-coming and off-going nurse on the shift verification of controlled substance count sheet for two missed opportunities out of 80 opportunities. During an interview on 04/16/26 at 10:20 A.M., LPN N said every shift should have two staff members count narcotics at each shift change. During an interview on 04/16/26 at 11:28 A.M., the DON said she expected the on-coming and off-going staff to count to reconcile the narcotics in the medication cart every shift and sign the narcotic count verification form. During an interview on 04/16/26 at 12:15 P.M., the Administrator said staff were to count the narcotics on the medication cart every shift. Two staff, the on-coming and off-going staff, should also sign the narcotic count verification form on each cart after performing the narcotic count together to ensure no discrepancies occurred on the prior shift.

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, interview, and record review, the facility failed to follow enhanced barrier precautions (EBP - precautions for use during high-contact resident care activities for residents infected with a multidrug-resistant organisms (MDRO - microorganisms that are resistant to one or more classes of antimicrobial agents) or any resident who has a chronic wound and/or indwelling medical device) for three residents (Residents #7, #14, and #29) out of six sampled residents. The facility also failed to provide proper infection control techniques for hand hygiene and glove changes for six residents (Residents #1, # 5, #7, #13, #24, and #29) out of seven sampled residents. The facility census was 119.Review of the facility's policy titled, Enhanced Barrier Precautions, dated December 2024, showed:- Enhanced barrier precautions apply when a resident is not known to be infected or colonized with any MDROs, has a wound or indwelling medical devices, and does not have secretions or excretions that are unable to be covered or contained;- Indwelling medical devices include central lines, urinary catheters (a sterile tube inserted into the bladder to drain urine), feeding tubes, and tracheostomies;- Examples of secretions or excretions include wound drainage, fecal incontinence or diarrhea, or other discharges from the body that cannot be contained and pose an increased potential for extensive environmental contamination and risk of transmission of a pathogen;- EBPs employ targeted gown and glove use in addition to standard precautions during high-contact resident care activities when contact precautions do not otherwise apply;- Gloves and gowns are applied prior to performing the high-contact resident care activity (as opposed to before entering the room);- Personal protective equipment (PPE) is changed before caring for another resident;- Face protection may be used if there is also a risk of splash or spray;- Examples of high-contact resident care activities requiring the use of gown and gloves for EBPs include: changing briefs or assisting with toileting; device care or use (central line, urinary catheter, feeding tube, etc.); and wound care (any opening requiring a dressing). Review of the facility's policy titled, Handwashing/Hand Hygiene, dated 04/22/14, showed:- This facility considers hand hygiene the primary means to prevent the spread of infections;- Employees must wash their hands for 10 to 15 seconds using antimicrobial or non-antimicrobial soap and water under the following conditions: before and after direct contact with residents; when hands are visibly dirty or soiled with blood or other body fluids; after contact with blood, body fluids, secretions, mucous membranes, or non-intact skin; after removing gloves; after handling items potentially contaminated with blood, body fluids, or secretions;- In most situations, the preferred method of hand hygiene is with an alcohol-based hand rub. If hands are not visibly soiled, use an alcohol-based hand rub containing 60-95% ethanol or isopropanol for all the following situations: before and after direct contact with residents; before handling clean or soiled dressings, gauze pads, etc.; before moving from a contaminated body site to a clean body site during resident care; after contact with a resident's intact skin; after handling used dressings, contaminated equipment, etc.; after contact with objects (e.g., medical equipment) in the immediate vicinity of the resident; and after removing gloves;- Hand hygiene is always the final step after removing and disposing of personal protective equipment;- The use of gloves does not replace handwashing/hand hygiene. Review of the facility's policy titled, Personal Protective Equipment - Gloves, revised April 2014, showed:- All employees must wear gloves when touching blood, body fluids, secretions, excretions, mucous membranes, and/or non-intact skin;- The use of gloves will vary according to the procedure involved. The use of disposable gloves is indicated when handling soiled linen or items that may be contaminated, during all cleaning of blood, body fluids, and decontaminating procedures;- Wash your hands after removing gloves. 1. Observation on 04/13/26 at 2:33 P.M., of Resident #13's wound care showed:- EBP signage on the door;- Registered Nurse (RN) G performed hand hygiene, put on gloves and gown, turned off the wound vac (vacuum-assisted closure used to conduct negative pressure wound therapy to promote healing), clamped the tubing, disconnected the tubing, removed the canister from the wound vac, discarded the canister and tubing, (continued on next page)

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	265164	A. Building B. Wing	04/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
West Vue Nursing and Rehabilitation Center	210 Davis Drive West Plains, MO 65775

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	did not perform hand hygiene, and did not change gloves;- RN G attached the new wound vac tubing to the wound vac dressing, attached the new canister to the wound vac, and turned on the wound vac;- RN G removed gown and gloves, performed hand hygiene, and exited the room. 2. Observation on 04/14/26 at 6:27 A.M., of Resident #5's incontinent care showed:- Certified Nurse Assistant (CNA) H and CNA I entered the resident's room, did not perform hand hygiene, and put on gloves;- CNA H and CNA I transferred the resident from the wheelchair to the toilet with a gait belt (device used to transfer residents from one position to another);- CNA H did not perform hand hygiene, changed gloves, did not perform hand hygiene, touched the linens to make the resident's bed, removed gloves, did not perform hand hygiene, exited the resident's room, retrieved washcloths, reentered the room, did not perform hand hygiene, entered the resident's bathroom, put on gloves;- CNA I removed the resident's shoes, urine-soiled underwear, did not perform hand hygiene, and did not change gloves;- CNA I pulled the resident's clean underwear and pants up to the resident's thighs, put the resident's shoes on, removed the gait belt, retrieved a clean shirt from the resident's closet, removed the resident's shirt, put deodorant on the resident, assisted CNA H to put the clean shirt on the resident, placed the gait belt on the resident, touched the wheelchair, and assisted the resident to stand;- CNA H did not perform hand hygiene, did not change gloves, applied lotion to the resident's back, did not perform hand hygiene, did not change gloves, assisted CNA I with placing the clean shirt on the resident, and assisted the resident to stand;- CNA H did not perform hand hygiene, did not change gloves, wiped fecal material from the resident's gluteal cleft (the crease between the right and left buttocks), did not change gloves, and did not perform hand hygiene;- CNA H and CNA I pulled the resident's clean underwear and pants into place and assisted the resident to his/her wheelchair;- CNA I did not perform hand hygiene and changed gloves;- CNA H did not perform hand hygiene and did not change gloves;- CNA H placed the resident's feet on the wheelchair foot pedals, removed the gait belt, removed gloves, and did not perform hand hygiene;- CNA H touched the resident's shirt, drink cup, and bedroom doorknob to exit the room, did not perform hand hygiene, reentered the room with clean linens, exited the room, and performed hand hygiene;- CNA I wet a washcloth and gave it to the resident to clean his/her face and hands, removed gloves, did not perform hand hygiene, propelled the resident in the wheelchair from the bathroom into the room, retrieved a brush from the sink counter and gave it to the resident, did not perform hand hygiene, put on gloves, gathered the soiled items and trash, removed gloves, did not perform hand hygiene, retrieved the brush from the resident and placed it on the bathroom sink counter, placed the resident's tray table on the arm of the wheelchair, did not perform hand hygiene, propelled the resident out of the room to the dining room with the trash bags of soiled items and trash in his/her bare hand, took the trash bags to the soiled utility room, placed the trash into the trash can, opened and dumped the bag of soiled clothing over the open washer, and performed hand hygiene. 3. Observation on 04/14/26 at 7:13 A.M., of Resident #14's urinary catheter care showed:- EBP sign and PPE affixed to the outside of the resident's door;- CNA B, CNA C, Nurse Assistant (NA) D, and NA E entered the resident's room, performed hand hygiene, put on gloves, did not put on gowns, and performed the resident's urinary catheter care;- CNA B, CNA C, NA D, and NA E removed gloves, performed hand hygiene, and exited the room. 4. Observation on 04/14/26 at 7:30 A.M., of Resident #1's wound care showed:- EBP signage on the door;- RN S performed hand hygiene, put on gloves and a gown, and entered the room with supplies;- RN S cleaned the wound, did not perform hand hygiene, did not change gloves, measured the wound with a paper ruler, did not perform hand hygiene, and did not change gloves;- RN S picked up a pen from the resident's bedside table, wrote the date on the clean wound dressing, placed the dressing to the wound area, removed gown and gloves, and did not perform hand hygiene;- RN S placed the unused wound treatment supplies in the resident's bathroom, did not perform hand hygiene, exited the room, and walked back to the nurse's office. 5. Observation on 04/14/26 at 8:30 A.M., of Resident #24's incontinent care and gait belt transfer showed:- CNA Q and CNA R performed hand hygiene, entered the room, and put on gloves;- CNA Q cleaned fecal material from the gluteal cleft, removed the brief filled with fecal (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	clean tasks, and wash hands at the end of care. With catheter care, a person should not go over the same site more than once with the same area of a cloth. During an interview on 04/16/26 at 2:46 P.M., CNA P said a person should wash hands before care, with glove changes, and at the end. Gloves should be changed when going from dirty to clean tasks. During an interview on 04/16/26 at 2:47 P.M., the Infection Preventionist said anytime staff gloves become visibly soiled, they should remove the gloves, perform hand hygiene, and put on a pair of clean gloves. When staff were providing incontinent care with fecal material, staff should wipe until the resident was clean and the washcloth did not show fecal material or urine. When nurses were providing wound care, they should be wearing PPE, which included gloves and gowns. Staff should be putting on PPE for any resident with a catheter, wound, or g-tube. If a resident required catheter care be provided by a CNA, the CNA should put on a gown prior to providing the care. During an interview on 04/16/26 at 2:50 P.M., CNA J said hands should be washed before and after care. Gloves should be used from the start and changed when going from dirty to clean tasks. With catheter care, a person should not go over the same site more than once with the same area of the cloth. During an interview on 04/16/26 at 2:53 P.M., CNA K and NA L said hands should be washed at the start and end of care. Gloves should be used during care and changed when soiled or when going from dirty to clean tasks. During an interview on 04/16/26 at 2:58 P.M., RN M and LPN N said hands should be washed at the start of care, when going from dirty to clean tasks or changing sites, and at the end of care. That should go for incontinent care, catheter care, and even wound care. With catheter care, a person should not go over the same site more than once with the same area of the cloth. During an interview on 04/16/26 at 3:27 P.M., the Director of Nursing said residents with catheters, wounds, or g-tubes had EBP in place. Staff should put on gloves and gowns whenever providing direct care to residents on EBP. She would expect staff that were providing incontinent care with fecal material to wipe the resident until clean. Staff should change gloves and perform hand hygiene when going from dirty to clean tasks. During an interview on 04/16/26 at 3:30 P.M., the Greenhouse Manager said hand hygiene should be performed before, after care, and when hands were visibly soiled. Hand hygiene should be performed with glove changes and when moving from dirty to clean tasks. Staff should wipe the resident until the resident was clean, sometimes the resident would need a shower if they couldn't be cleaned with a wipe or washcloth. During an interview on 04/16/26 at 4:02 P.M., the Administrator said EBP was put in place for residents with chronic wounds, urinary catheters, and g-tubes. She would expect staff that were providing incontinent care to change their gloves when going from dirty to clean tasks and to wipe a resident until clean. During an interview on 04/24/26 at 1:11 P.M., RN S said hand hygiene should be performed when entering a resident's room and when exiting. Hand hygiene should be performed with glove changes when going from dirty to clean tasks, after a dressing removal during wound care, and before a clean dressing was applied. For incontinent care, he/she would expect a wipe or washcloth to be used to either wipe one time and discarded or to fold the wipe or washcloth to a new section/clean area and then discard it. The resident should be wiped until clean.