STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265170	A. Building B. Wing	08/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Delmar Gardens of Chesterfield	14855 North Outer 40 Road Chesterfield, MO 63017

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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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure a medication error rate of less than 5%. Out of 25 opportunities, two errors occurred, resulting in an 8% medication error rate (Residents #45, and #145). The census was 171 with 166 with certified bed.Review of the facility's Medication Administration-General Guidelines Policy, revised 1/2021, showed: Policy: Only a Registered Nurse (RN), License Practical Nurse (LPN), Certified Medication Aide, or Certified Medication Technician (CMT) are assigned responsibility for preparing, administering and/or record the administration of medications. Medications must be administered in accordance with a physician's order (i.e., the right resident, the right medication, the right dosage, the right route and the right time). Review of the facility's Administration Insulin policy, dated 5/2021, showed:-Remove the pen cap and cleanse the rubber stopper with an alcohol wipe. Attach pen to needle to device;-Prime the pen immediately before injections. Priming is dialing up 2 units (U) of insulin and pressing the button on the pen to shoot some insulin into the air. You should see a drop of insulin at the tip of the needle. More than one prime may be required for new pens;-[NAME] up the dose on the pen as indicated on the order. 1. Review of Residents #45 quarterly MDS, dated [DATE], showed:-Cognitively intact;-Diagnoses included diabetes, neuropathy (decrease in nerves sensation) and chronic kidney disease. Review of the resident's ePOS showed an order dated 7/17/25, for insulin aspart (fast acting insulin) sliding scale before meals and at night. Administer 2 units for a blood sugar of 131 through 180. During a Medication administration observation on 8/4/25 at 11:36 A.M., LPN G administered and verified the resident's electronic medical record (eMar) prior to administration. The resident's blood sugar measured at 217. LPN G administered 3U to the resident. He/She did not prime the insulin pen prior to administration. 2. Review of Resident #145's quarterly [NAME] Data Set (MDS, a federally mandated assessment instrument completed by facility staff), dated 07/23/25, showed:-Cognitively intact;-Diagnoses included diabetes with chronic kidney disease. Review of the resident's electronic physician order sheet (ePOS), showed an order dated 4/1/25 for: -Lispro (fast acting insulin) 3U three times a day (TID) standard order;-Sliding scale 2U for blood sugars between 200-250. During observation and interview on 8/4/25 at approximately 11:24 A.M., showed LPN G entered the resident's room and explained to the resident the need for an accucheck (blood sugar check). The resident's glucose (blood sugar) measured 200 which required the standing order of 3U plus the sliding of additional 2U making the total of 5U that Resident #145 required. LPN G dialed the insulin pen to 6U, one unit over the physician's order/recommendation. LPN G did not prime the insulin pen prior to administration. 3. During an interview on 8/4/25 at 11:26 A.M., LPN G said he/she adds an extra unit when administering insulin for priming the pen prior to each dose. 4. During an interview on 8/4/25 at 12:28 P.M., the DON said she would expect staff to follow protocol for insulin administration. He/She acknowledge that LPN G failed to follow policy by not placing a needle on the device then priming with 2U of insulin prior to physicians ordered dose. DON said, resident may not have received the ordered dose.

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 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 the facility failed to ensure proper storage and labels on medications. For three out of four certified medical technician (CMT) carts checked and one of four medication storage rooms checked. The census was 171 with 166 with certified bed. Review of the facility's Medication Storage Policy, dated December 2021, showed:-Drugs and medications are to be stored in the original container in which they were received;-Only the charge nurse or medication nurse has access to the narcotics keys;-No discontinued, outdated, or deteriorated drugs or medications are stored in the facility over the thirty (30) days;-Medications which require refrigeration are kept in the refrigerator in the locked medication room. Drugs stored under the refrigeration are stored separately from food;-Compartments and areas containing drugs are locked when not in use or when left unattended. Such area included drawers, cabinets, rooms, refrigerators, carts and boxes. 1. Observation of the 100-hall medication CMT cart on 8/4/25 at 7:15 A.M., showed a small white pill with markings of 11/x in the far back of the second draw and second column. 2. Observation on the 700-hall CMT cart on 8/4/25 at 10:08 A.M., showed a mini refrigerator that had personal items in a gallon Ziplock bag, to include a 12 ounce can of Mountain Dew and a 20 ounce disposable bottled water.During an interview on 8/4/25 at 6:35 A.M., License Practical Nurse (LPN) J said the Ziplock bag with Mountain Dew and disposable plastic water bottle was his/hers. Staff do not really have a place to put their things. 3. Observation of the 700-hall medication storage room on 8/4/25 at 10:08 A.M., showed:-Five pre-pulled tums in the top drawer without a resident identifier;-A blister pack of vancomycin hydrochloride (antibiotic) 125 milligram (mg) capsule without a resident identifier;-The third drawer on the far-right side had a 20-ounce disposable plastic water bottle.During an interview on 8/4/25 at 6:32 A.M., CMT D said the cart should not have any medications loose in it. He/She did not understand why the pills were there since the blister pack is antibiotics. CMT said, CMT carts should not have any antibiotics. Nurses are only allowed to pass those. He/She was off for the weekend and grabbed the pre-pulled medicine cup in the top drawer to discard the five tums. CMT D grabbed the plastic water bottle and said, that is mine, I will remove it. 4. Observation on the 600 hall CMT cart on 8/4/25 at 9:57 A.M., showed the second drawer contained 26 whole pills of varied sizes, colors and shapes, 14 partial pills of varies sizes, shapes and colors not in pharmacy labeled medication containers. During an interview on 8/4/25 at 9:57 A.M., LPN I nurse said medication carts should be cleaned, and they would not dispense any of the unlabeled pills. 5. During an interview on 8/6/25 at 9:45 A.M., the Director of Nursing said, it is up to the CMT, LPN, and Registered Nurse (RN) to clean the carts as needed. They should clean the carts at the beginning and end of every shift. If loose pills are found on the carts, staff should notify the charge nurse or DON to have the pills discarded immediately. There should be no personal items on medication carts or in the medication storage rooms and refrigerators. This could lead to cross contamination.

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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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure one discharged resident's (Resident #131) Oxycodone (narcotic used to treat pain) and one resident's (Resident #185) discontinued Ativan (used to treat anxiety) were appropriately destroyed in accordance with the facility's policy and free from medication misappropriation. The facility started the investigation when the Assistant Director of Nursing (ADON) questionably destroyed a resident's discontinued Hydrocodone (Resident #113). The ADON admitted to taking the discontinued medications of Resident #131 and Resident #185 for personal use. She provided the card of Oxycodone and the bottle of Ativan at the time of questioning. The census was 177 with 166 in certified beds. The Administrator was notified on 8/6/25, of the past non-compliance. Upon notification of the misappropriation allegation on 6/25/25, the facility immediately suspended staff, investigated and implemented abuse/neglect in-servicing to all facility staff. The training also included training on narcotic medication destruction. During the onsite investigation, interviewed staff verified in-servicing and verbalized education. The deficiency was corrected on 6/29/25.Review of the Abuse, Neglect and Misappropriation policy, revised 9/22, showed:-Policy: to maintain a work and living environment that is professional and residents are free from threat of abuse or misappropriation of property;-Residents must not be subjected to abuse;-Definitions: -Misappropriation of property: means the deliberate misplacement, exploitation or wrongful, temporary or permanent use of a resident's belongings or money without the resident's consent;-Procedure: -On going education: annually, in-service programs shall be presented which encompass: -Identifying, intervening and reporting situations in which occurrences of unexplained misappropriation of resident property may occur;-Procedure for investigation: -Any employee suspected of violation of safety policies may be suspended pending investigation; -Staff found to be in violation of the resident safety policies may be reported to local law enforcement as appropriate; -Summaries of the investigation will be reviewed during quality assurance and assessment committee meeting for re-evaluation of policies and procedures, if warranted, to prevent further occurrences. Review of the controlled substance medication policy, showed:-Purpose: to outline procedures to accurately maintain records of controlled substance medications;-Procedure: Destruction of controlled substance medications: -Only two licensed nurses or a licensed nurse and pharmacist may destroy controlled substances. 1. Review of Resident #113's medical record, showed: -Diagnoses included lower back fracture, hip arthritis, heart failure, diabetes, depression and anxiety. Review of the June Medication Administration Record (MAR), showed:-An order, Hydrocodone 10-325 mg, administer one tablet four times a day for pain. Thirty documented refusals. Review of the physician order sheet (POS), showed:-An order, dated 6/19/25 to discontinue Hydrocodone 10-325 milligrams (mg) four times a day. Review of the progress notes, dated 6/19/25 at 5:17 P.M., showed a nurse note: new orders to discontinue Hydrocodone 10-325 mg. 2. Review of Resident #185's progress notes, dated 5/30/25 at 1:10 P.M., showed a nurse note: the resident admitted to the facility following a left femur fracture and surgical repair. Alert and oriented, able to make needs and wants known. Weight bearing as tolerated and stand by assist with transfers. Review of the POS, showed an order, dated 5/30/25: Oxycodone 5 mg, take 2.5 mg tablet as needed (PRN) for pain. Review of the progress notes, dated 5/31/2025 at 4:42 A.M., showed a nurse note: the resident ambulates with one assist and the walker. He/She denied pain. Review of the May 2025 MAR, showed:-An order, dated 5/30/25, to monitor of pain during the day and medication passes. On 5/30/25 and 5/31/25, showed a 0 or no pain reported;-On 5/31/25 at 6:27 P.M., a documented administration of oxycodone and the administration was effective. Review of the admission Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 6/6/25, showed:-Received rehabilitation services;-Able to make needs and wants known;-Diagnoses included heart failure, renal failure, hip fracture and dementia;-Received routine and as needed pain medications;-Surgical repair (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	to the left hip. Review of the care plan, revised 6/12/25, showed:-Problem: Pain: the resident is at risk for discomfort related to surgical left hip pain;-Goal: the resident will remain pain free;-Approach: assess pain level, provide medication and document effectiveness and identify the source of the pain. Review of the June 2025 MAR, showed:-Monitor for pain during A.M and P.M. med passes twice a day. Pain ratings noted at 0;-On 6/7/25 at 3:25 P.M., an administration of oxycodone, documented as effective;-On 6/11/25 at 8:14 P.M., an administration of oxycodone, documented as effective. Review of the progress notes, dated 6/17/25 at 2:00 P.M., showed a nurse note: the resident discharged to assisted living. No complaints of pain. Review of the resident's June POS, showed an order, dated 6/18/25: discontinue oxycodone 5 mg, take 2.5 mg PRN for pain. 3. Review of Resident #131's quarterly MDS, dated [DATE], showed:-Moderate cognitive impairment:-Diagnoses included high blood pressure, Parkinson's disease (a disorder of the central nervous system that affects movement, often including tremors), and anxiety;-Received hospice services. Review of the current care plan, showed:-Problem: behaviors during care;-Goal: no behaviors and accept care from staff;-Approach: approach with acceptance, administer medications as ordered. Review of the May 2025 POS, showed:-An order: 5/30/25 for Ativan 0.5 mg every eight hours for anxiety.-An order: 6/6/25 to discontinue oral Ativan, and begin liquid Ativan 0.25 ml every two hours PRN for anxiety. Review of the June 2025 MAR, showed an order for Lorazepam (Ativan, used for anxiety) , administer 0.25 ml every two hours, PRN for anxiety. Documented as administered and effective on 6/6/25 at 4:10 A.M., and 6/26/25 at 11:13 A.M. 4. Review of the facility's investigation, dated 7/1/25, showed:-The facility DON reported to management concerns of medication misappropriation by the ADON. The ADON did not follow the policy regarding medication destruction. The ADON admitted to taking controlled substances. Upon further investigation, the ADON produced Resident #185's discontinued Oxycodone and a bottle which contained Resident #131's discontinued Lorazepam; -The police department was notified and responded to the facility. The ADON was suspended;-The facility implemented immediate in-servicing regarding the facility policy and procedures regarding controlled medication handling and destruction. 5. During an interview on 8/5/25 at 12:13 P.M., Licensed Practical Nurse (LPN) A said he/she was in-serviced regarding the facility policy to account and destroy discontinued narcotics. Narcotics should be destroyed with two nurses present. 6. During an interview on 8/5/25 at 12:51 P.M., LPN B said when he/she reported to work on 6/19/25, the ADON asked him/her for the nurse cart keys. The ADON asked where the narcotics were located in the medication cart. The ADON said he/she was going to remove Resident #113's discontinued card of Hydrocodone (Norco, used to treat moderate pain) and destroy the narcotics. There was one card of 60 and one card of 6. The ADON removed the card of 60 and left the card of 6 in the medication cart. LPN B entered the ADON's office later in the afternoon to destroy the card of 6 pills and the card of 60 Hydrocodone was not noted. He/She did not know where the card of 60 was located. The ADON said she threw away the card that contained the 60 pills. LPN B reported the concern to the facility Director of Nursing (DON). He/She had been in-serviced on policies and procedures to destroy narcotic medications with two nurses. 7. During an interview on 8/5/25 at 1:22 P.M., LPN C said he/she had been in-serviced on the appropriate way to destroy narcotic medications. The in-servicing included the requirement to have two nurses present to destroy all medications. 8. During an interview on 8/5/25 at 2:41 P.M., the DON said she was made aware by LPN B the ADON had asked for the nurse cart keys to remove discontinued narcotics from the cart for destruction. The DON notified upper management and started the investigation. Upon further investigation, LPN B informed him/her regarding the discontinued Hydrocodone pills. Mediprocity (a secure, patient confidential compliant communication and medication management system) showed 6 of the 60 Hydrocodone pills were destroyed by LPN B and the ADON, however, the system did not reflect destruction of 60 of the pills. When the ADON was interviewed, she stated she threw the card of 60 away. The ADON was suspended, and management requested drug testing. The drug test was negative. The ADON was questioned several times in person. During the questioning, she produced an unlabeled and unidentified medication card of 24 (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	tablets and a bottle of 20 discontinued Ativan tablets for personal use. The police were called. The facility did not press charges on taking the discontinued medications and is supporting the ADON in therapy options. All Certified Medication Technicians (CMT) and nurses have been in-serviced on the facility policy regarding medication destruction. 9. During an interview on 8/11/25 at 11:45 A.M., the DON said when LPN B reported to her the ADON had asked for the medication cart keys and then removed Resident #113's 60 tablets of Hydrocodone for destruction, it set of red flags. LPN B told the DON said that he/she and the ADON later destroyed the remaining card of 6 Hydrocodone but LPN B did not see the card of 60 in the ADON's office. The Hydrocodone had been discontinued due to not being used by Resident #113. The order to discontinue Resident #113's Hydrocodone medication was obtained by the ADON from the resident's physician. Management interviewed the ADON several times and during the questioning, she produced a card of 24 tablets of unidentified medications. She identified the medication as Resident #185's discontinued oxycodone. The ADON said she had torn the label off the medication card so it could not be identified. In addition, she produced a bottle of Ativan, which contained 20 tablets. She identified the Ativan as Resident #131's. The order had changed, and the ADON had the discontinued bottle on her person. The Ativan bottle had the ADON's name on it. The ADON said she poured the resident's discontinued Ativan into her own old Ativan bottle, so that it appeared the Ativan was her own. The concerns regarding the ADON started with LPN B's concern of Resident #113's Hydrocodone. It was during her interview she produced the discontinued medications that belonged to Residents #131 and #185. 1632884

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F 0689 Level of Harm - Minimal harm or potential for actual harm 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, the facility failed to ensure staff maintained safe resident transfer techniques during a Hoyer (used for persons who are non-weight bearing) lift (Resident #12) and during a gait belt transfer (Resident #157). The sample was 33. The census was 177 with 166 in certified beds.Review of the transfer and lift policy, reviewed 5/2021, showed:-Purpose: to provide communication to staff regarding the resident's transfer abilities and to assure all precautions are taken to maintain safety of the resident. -Policy: -Upon admission each resident will be assessed by the inter-disciplinary team on the capabilities of how the resident transfers. This will be re-assessed with changes in condition; -A butterfly magnet will be placed inside the resident room on the overhead light or the door frame of the room indicating how the resident transfers. The butterfly will be coded to inform the staff of the resident's transfer ability; -The resident's transfer ability will be indicated in the resident's orders and included on the profile and care plan; -All staff involved in the transfer of residents will be trained on each lift including return demonstration; -When using a mechanical lift to transfer residents, two employees are required to assist in the transfer; -All assisted transfers and ambulation of a resident require the use of a gait belt. Proper placement of the gait belt should be ensured before assisting the resident. 1.Review of Resident #12's quarterly Minimum Data Set (MDS) a federally mandated assessment instrument completed by facility staff, dated 6/11/25, showed:-Cognitively intact;-Used a wheelchair for mobility;-Dependent on staff for transfers;-Diagnoses included Alzheimer's disease, bipolar disorder (a disorder associated with episodes of mood swings ranging from depressive lows to manic highs), heart disease, vascular disease and kidney failure. Review of the resident's care plan, updated 7/18/25, showed:-Problem: the resident had a deficit with mobility;-Goal: the resident will participate in care activities;-Approach: the resident requires a two person Hoyer lift. Review of the physician order sheet (ePOS), showed:-An order, dated 7/28/25: Hoyer lift. During observation and interview on 8/1/25 8:32 A.M., Certified Nurse Aide (CNA) O and CNA P greeted the resident and explained the transfer to the resident. CNA O placed the Hoyer pad under the resident and applied a sling to the lift. CNA O held the back of the chair as CNA P operated the lift. The resident swung freely over bed. CNA P pulled on the lift and maneuvered the resident over the reclining Geri chair (a reclining wheeled chair). No support was given to the resident's legs. As the resident neared the chair, the staff switched places, and for approximately 10 seconds, no staff held onto the Hoyer lift. CNA P pulled on the back of the sling and CNA O operated the lift. As the resident was lowered into the chair, his/her right leg struck the main support post of the lift. The staff did not provide physical support to the resident during the Hoyer transfer and the resident was left with no staff touching the resident as another aide held onto the reclining Geri chair. CNA O and P said they did not preform the transfer correctly. They wanted to conduct the transfer timely. The staff who did not operate the lift, should always have a hand on the resident. The aides switched places for resident positioning. The resident swung unattended as the staff switched places. During an interview on 8/6/25 at 9:45 A.M., the Director of Nursing (DON) said when staff conduct a Hoyer lift, the staff not operating the lift should keep hands on the resident to ensure resident legs or arms do not hit the lift. Staff should not switch places during the transfer. 2. Review of Resident #157's quarterly MDS, dated [DATE], showed: -Severe cognitive impairment;-Required partial to moderate staff assistance;-Diagnoses included neurocognitive disorder with Lewy bodies (progressive brain disorder that affects thinking, movement, behavior, and sleep), muscle weakness (generalized), seizures, and Parkinson's disease without dyskinesia (uncontrolled, involuntary muscle movement). Observation on 7/31/2025 at 12:18 P.M., showed CNA Q and CNA R placed a gait belt around the resident's abdomen. CNA Q and CNA R grabbed the resident under his/her arm and lifted the resident to his/her feet. The resident did not appear to be fully alert (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	as the CNAs walked the resident to his/her seat in the dining room. Review of the resident's care plan, showed: -An updated entry on 8/1/2025: updated to transferring x1 assist. During an interview on 8/5/2025 at 9:54 A.M., CNA Q said, staff are made aware of how a resident is transferred by the butterfly system. Each resident has a butterfly outside their door, or staff can find the information in the binder located at the nurse's desk. CNA Q said a gait-belt is positioned above the naval and placed snugly around the waist. CNA Q said staff should not grab a resident underneath the arms or wing lifting. Lifting a resident under the arms could cause bruising, soreness or injury. During an interview on 8/5/2025 at 10:06 A.M., CNA R said he/she is made aware of how someone ambulates and transfers by the butterfly system. The butterfly is placed on the outside of the doorframe. CNA R said residents should not be transferred under the arms. The gait belt should be used in the transfer. During an interview on 8/5/2025 at 12:00 P.M., Physical Therapy Manager (PTM) said the resident experienced some decline. PTM said staff should not pull on or underneath arms to lift a resident. Incorrect transfer techniques could cause physical damage to the shoulder or nerves. If a resident became more difficult to transfer, the staff are expected to communicate the change to therapy. During an interview on 8/6/25 at 9:45 A.M., the DON said gait belts should be applied snugly around the resident's waist. There should be enough room for one finger to slip between the belt and the resident. Residents who require a gait belt transfer, should not be lifted under the arms. Staff should use the gait belt to support the resident's weight.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. Based on observation, interview and record review, the facility failed to ensure one resident (Resident #6) received gastrostomy tube (g-tube, a tube surgically inserted into the abdomen used for liquid nutrition, fluids and medications) feedings at the specified times as ordered by the physician and to ensure the resident's head of bed (HOB) was elevated to prevent aspiration (choking). The sample was 33. The census was 171 with 166 in certified beds.Review of the facility's Tube Feeding policy, revised June, 2021, showed:-Purpose: to deliver a continuous, regulated drip feeding to gastrostomy tube-fed residents using an enteral (delivering nutrition and medications through the gastrointestinal system) pump;-Procedure: -Equipment: Enteral pump, enteral feeding bag and administration set, prescribed feeding, and a pole; -Review the physician's orders; The order should specify the amount and type of formula, and the flow rate. Review of the facility's Following Physician Orders policy, dated 6/29/21, showed:-Purpose: It is the policy of the community to ensure that all licensed professional nurses and other healthcare professionals, follow physician orders in accordance with state and federal regulations and their respective practice acts;-Procedure: All physician orders will be followed as prescribed and if not followed, the reason shall be recorded on the resident's medical record; If an order is questionable according to the seven rights of medication administration (right resident, right medication, right dose, right time, right route, right documentation and right reason), a clarification order will be obtained. Review of the facility's Aspiration Precautions policy, reviewed June, 2021, showed:-Purpose: To ensure that precautions are taken in order to prevent aspiration of a resident;-Definition: Aspiration is defined as the inhalation of food, saliva, medication or other foreign material int the trachea (windpipe) and lungs; Any material can be aspirated on the way to the stomach or as stomach contents are refluxed (return) back into the throat;-Guidelines on how to minimize the risk of aspiration: Keep the resident's HOB elevated 30-45 degrees. Review of Resident #6's admission Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 7/11/25, showed:-Cognitively intact;-Coughs or chokes during meals and taking medications;-Complaints of difficulty or pain with swallowing;-The resident has a feeding tube;-Proportion of total calories the resident receives through tube feeding: 51%;-Diagnoses included malnutrition (poor nutritional status), muscle weakness and dysphagia (difficulty swallowing). Review of the resident's care plan, in use during survey, showed:-Problem: The resident requires a feeding tube related to his/her dysphagia and recurrent aspiration;-Approach: The resident receives Jevity 1.5 calorie (cal), a type of liquid nutrition, at 80 milliliters (mls) an hour for 18 hours, 4:00 P.M. through 10:00 A.M.; Administer medications through the feeding tube; Elevate HOB to thirty degrees while tube feeding, medications, and water flushes are being administered. Review of the resident's physician order sheets (POS), dated July, 2025, showed:-An order, dated 7/18/25, Jevity 1.5 cal at 80 mls per hour for 18 hours; On at 4:00 P.M. and off at 10:00 A.M.;-An order dated, 7/8/25, elevate HOB 30 degrees; For your information (FYI) only. Review of the resident's Medication Administration Record (MAR), dated July, 2025, showed:-An order, dated, 7/18/25, Jevity 1.5 cal. at 80 mls per hour for 18 hours; On at 4:00 P.M. and off at 10:00 A.M.;-Time: Days 7:00 A.M. through 3:00 P.M.; -On 7/19 through 7/31/25, day shift documented tube feeding: Off;-Time: Evenings 3:00 P.M. through 11:00 P.M.;-On 7/18 through 7/31/25, evening shift documented tube feeding: On;-Time: Nights: 11:00 P.M. through 7:00 A.M., -On 7/18 through 7/31/25 night shift documented tube feeding: On;-No specific time was listed on the MAR for staff to start the tube feeding or to stop the tube feeding. -No order for the resident's HOB to be 30 degrees was noted. Review of the resident's POS, dated August, 2025, showed:-An order, dated 7/18/25, Jevity 1.5 cal at 80 mls and hour for 18 hours; On at 4:00 P.M. and off at 10:00 A.M.; Discontinue date, 8/4/25;-An order, dated 7/8/25, elevated HOB 30 degrees; For your information (FYI) only. Review of the resident's MAR, dated August, 2025, showed:-An order, dated, 7/18/25, Jevity 1.5 cal at 80 mls per hour for 18 hours; On at 4:00 P.M. and off at 10:00 A.M.; (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Discontinued date, 8/4/25;-Time: Days 7:00 A.M. through 3:00 P.M.; -On 8/1 through 8/3/25, day shift documented tube feeding: Off;-Time: Evenings 3:00 P.M. through 11:00 P.M.;-On 8/1 through 8/3/25, evening shift documented tube feeding: On;-Time: Nights: 11:00 P.M. through 7:00 A.M., -On 8/1 through 8/3/25 night shift documented tube feeding: On;-No specific time was listed on the MAR for staff to start the tube feeding or to stop the tube feeding. -No order for the resident's HOB to be 30 degrees was noted. During observation and interview on 7/31/25 at 5:40 P.M., the resident lay in bed on his/her back and his/her HOB was approximately 10 degrees. The resident had a gastrostomy tube located in his/her abdomen. The resident had a tube feeding pump positioned on a pole, turned off and no tube feeding attached to the resident. The resident said his/her tube feeding is frequently hung late. It concerns him/her because the tube feeding is the only nutrition he/she received At 5:45 P.M., the resident placed his/her call light on and Licensed Practical Nurse (LPN) M entered the resident's room. The resident informed LPN M his/her tube feeding should have been started at 4:00 P.M. LPN M said he/she would check. LPN M returned to the resident room at approximately 6:00 P.M. and prepared the resident's tube feeding for administration.During observation and interview on 8/1/25 at 9:20 A.M., the resident lay in bed. The resident's HOB was elevated approximately 10 degrees. The resident said he/she has a pocket in his/her throat, and it makes it difficult for him/her to swallow. The resident said while at home, he/she had a choking episode and aspirated, and the stomach contents went into his/her lungs causing pneumonia. Observation showed the tube feeding bag was connected to the resident. The tube feeding pump alarmed and the resident's tube feeding bag was empty. The resident said it had been alarming for about 10 minutes. Certified Nursing Assistant (CNA) L entered the resident's room and said he/she would tell the nurse. At 9:30 A.M., the resident's tube feeding pump was turned off and remained attached to the resident. The resident's HOB remained at approximately 10 degrees. The tube feeding was stopped before 10:00 A.M. During an interview on 8/5/25 at 1:55 P.M., LPN K said the resident's orders on the MAR did not address the specific time the resident's tube feeding was to be started or stopped. Having the orders days, evenings and nights was too broad. The orders on the MAR should reflect the tube feeding is to be placed on at 4:00 P.M. and off at 10:00 A.M. The resident is not confused, and he/she will tell the staff if something is not done. It is important for the resident to receive all his/her tube feeding as ordered because that is his/her only nutrition he/she received. LPN K said the resident's HOB should always be at 30 degrees because he/she has a history of aspiration. During an interview on 8/6/25 at 8:51 A.M., Certified Medication Technician (CMT) D said residents who require tube feeding should have their HOB elevated 30 degrees so the stomach contents do not come back up. If the resident can use the bed controller by themselves, then more education needs to be given to the resident related to the HOB. During an interview on 8/6/25 at 10:25 A.M., CNA N said the resident's HOB should be at 30 degrees or higher since he/she is on tube feeding and has a history of aspiration. During an interview on 8/4/25 at 11:15 A.M. and on 8/6/25 at 9:50 A.M., the Director of Nursing (DON) said the resident's tube feeding orders needed to be clarified to reflect an actual time the tube feeding needed to be started and when it needed to be stopped to ensure there is no delay in the resident receiving his/her nutrition. The DON could not produce a report showing the actual times of the resident's tube feeding being started or stopped when requested. She expected staff to follow the physician orders and not delay in starting the tube feedings. She also expected staff to have enough tube feeding in the bag to complete the entire cycle of tube feeding. She expected staff to ensure the resident's HOB was at 30 degrees to prevent aspiration.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. Based on interview and record review, the facility failed to ensure the attending physician documented actions taken to address irregularities noted by the pharmacist for one of three residents sampled for medication regimen reviews (Resident #7). The sample was 33. The census was 171 with 166 in certified beds.Review of the facility's Pharmacist Consultant Duties and Responsibilities policy, reviewed May 2021, showed:-Purpose: To ensure that drug regimen reviews, medication pass observations, and medication audits are performed in accordance with state and federal regulations;-Drug regimen review (DRR):-Policy: The consultant pharmacist reviews the medications for each resident for any irregularities and to: verify appropriateness of the medications involved; evaluate disease state management; ensure appropriate medication monitoring to maximize safety and efficacy; and prioritize patient goals, safety, and quality of life;-Procedures: --The consultant pharmacist reviews each resident chart to identify and address any irregularities;--The consultant pharmacist will review the chart of every resident at every facility each month;--All recommendations (including no recommendations) will be printed each month (within 72 hours of completing the all of the DRR's in the facility) and sent to the corresponding Director of Nursing (DON) to distribute appropriately and get completed; -Individual recommendations (one page per recommendation) directed to physicians and nursing staff will be sent to the DON to distribute to individual charts and get completed; -Pharmacy consults should be signed, completed, and acted on within 30 days of being sent to the facility; -The facility should write a description of their attempts to get the consult completed on the actual consult (or in response to the observation in the electronic medical record (EMR). For example, faxed to physician on these dates: put in physician mailbox on this date, etc.; -Each month the consultant pharmacist will follow up on previous consults; -Physician consults will be repeated two months later if not completed. Review of Resident #7's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 6/4/25, showed:-Resident rarely/never understood;-Short and long-term memory problem;-Diagnoses included non-traumatic brain dysfunction, Alzheimer's disease, dementia, seizure disorder, traumatic brain injury (TBI), anxiety disorder;-Antipsychotic medication received on a routine basis;-Has a physician documented gradual dose reduction as clinically contraindicated: No. Review of the resident's medical record, showed:-Primary Care Physician listed as Physician U;-Psychiatrist listed as Physician V;-A physician order, dated 4/8/24, for quetiapine (antipsychotic medication) 50 milligrams (mg), three times a day. Diagnoses: dementia in other diseases classified elsewhere with behavioral disturbance. Note: TBI and Alzheimer's disease. Ordered by Physician U. Review of the resident's Pharmacist's Recommendations to Prescriber, dated 1/20/25, showed:-Resident is on hospice and has received the antipsychotic quetiapine 50 mg, take one tablet by mouth every morning, every evening, and at bedtime since 4/8/24 for the indication of dementia in other diseases classified elsewhere, severe, with other behavioral disturbance;-Based on information in the chart, resident does not appear to be a candidate for possible dose reduction. However, the required physician documentation of a clinical contraindication to a dose reduction is not present;-Please select a response below: Blank;-Prescriber's response: Box checked for Other, with a handwritten note, Refer to psychiatrist. Signed by Physician U. Review of the resident's Pharmacist's Recommendations to Prescriber, dated 2/28/25, showed:-Attention psych: please see the consult below (PCP referred consult to psych);-Resident is on hospice and has received the antipsychotic quetiapine 50 mg, take one tablet by mouth every morning, every evening, and at bedtime since 4/8/24 for the indication of dementia in other diseases classified elsewhere, severe, with other behavioral disturbance;-Based on information in the chart, resident does not appear to be a candidate for possible dose reduction. However, the required physician documentation of a clinical contraindication to a dose reduction is not present;-Please select a response below: Blank;-Prescriber's response: Box checked for Other, with a (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	handwritten note, Patient under hospice care, may refer to psych. Signed by Physician U. Review of the resident's Pharmacist's Recommendations to Prescriber, dated 4/15/25, showed:-Attention psych: please see the consult below (PCP referred consult to psych);-Resident is on hospice and has received the antipsychotic quetiapine 50 mg, take one tablet by mouth every morning, every evening, and at bedtime since 4/8/24 for the indication of dementia in other diseases classified elsewhere, severe, with other behavioral disturbance;-Based on information in the chart, resident does not appear to be a candidate for possible dose reduction. However, the required physician documentation of a clinical contraindication to a dose reduction is not present;-Please select a response below: Blank;-Prescriber's response: Blank. Review of the resident's Pharmacist's Recommendations to Prescriber, dated 6/7/25, showed:-Attention psych: please see the consult below (PCP referred consult to psych);-Resident is on hospice and has received the antipsychotic quetiapine 50 mg, take one tablet by mouth every morning, every evening, and at bedtime since 4/8/24 for the indication of dementia in other diseases classified elsewhere, severe, with other behavioral disturbance;-Based on information in the chart, resident does not appear to be a candidate for possible dose reduction. However, the required physician documentation of a clinical contraindication to a dose reduction is not present;-Please select a response below: Box checked for Other;-Prescriber's response: Box checked for Other, with a handwritten note, Refer to psych. Signed by Physician U. During an interview on 8/6/25 at 9:45 A.M., the DON said the pharmacist conducts medication regimen reviews monthly. The pharmacist enters their recommendations in the resident's EMR and a paper copy is given to the DON. The DON gives the pharmacist's recommendation to the appropriate physician. The physician reviews the recommendation, documents their response, and gives the form back to the DON. If the primary care physician (PCP) says to refer to psychiatry, the DON puts the resident on the list of residents to be seen during the psychiatrist's next visit to the facility. The PCP is the one who documents the response on the pharmacist's recommendation form. Resident #7's pharmacist recommendations go to his/her PCP, Physician U, and his/her psychiatrist, Physician V. The physician responding to the pharmacist recommendations should document a specific response to address the pharmacist's recommendation. During an interview with the Assistant Administrator and Administrator on 8/6/25 at 10:24 A.M., they said when the pharmacist notes irregularities during a medication regimen review, the prescribing physician should document their response to address irregularities, including documentation of a clinical contraindication to a dose reduction. if recommended. The physician's response should be completed within timeframes outlined in regulatory requirements and in accordance with facility policy.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, staff failed to following policies and procedures regarding hand hygiene and enhanced barrier precautions (EBP) prior to applying protective personal equipment (PPE) and touching the resident (Resident #12). The sample was 33. The census was 177 with 166 in certified beds.Review of the enhanced barrier precautions (EBP) policy, revised 8/2024, showed:-Purpose: to reduce the spread of multi-drug resistant organisms (MDRO, various bacteria that are resistant to various antibiotic therapies);-Definitions: -EBPs are indicated for residents with any of the following: -Infection or colonization with a MDRO when contact precautions do not apply; -Wounds even if the resident is not known to be infected or colonized with a MDRO;-Procedure: -Residents with colonization of MDRO and/or with indwelling medical devices (intravenous lines) will be placed on EBP; -Signage placed outside the room to alert staff that personal protective equipment (PPE) including gowns and gloves, will be available in an area accessible to use when high contact resident care activities are anticipated; -PPE should be worn with during high-contact resident care activities: dressing, transferring, and changing briefs. Review of the handwashing policy, revised 1/2021, showed:-Purpose: provide guidelines to employees for proper and appropriate hand washing techniques that will aid in the prevention of the transmission of infection;-When to wash hands: -Before and after each resident contact; -After contact with body fluids; -After handling any contaminated items (linens, soiled briefs, etc). Review of Resident #12's medical record, showed:-re-admitted from the hospital: 7/28/25;-Full staff assistance needed for daily care and hygiene needs. Review of the hospital Discharge summary, dated [DATE], showed:-Admitting diagnosis: Monoarthritis (inflammation and pain in a single joint) of the right knee;-Surgical irrigation and debridement to the right knee;-Hospital cultures grew: Escherichia coli (E.coli);-Orders: Ceftriaxone (Rocephin, antibiotic) 2,000 milligrams (mg) for infusion. Administer one dose by IV every 24 hours for 36 days. Review of the progress notes, showed:-On 7/28/25 at 5:07 P.M., a nurse note: the resident re-admitted with orders for IV antibiotics for 36 days. Noted a peripherally inserted central catheter (PICC, used for long term antibiotics) line to the left upper arm. Multiple small surgical incisions noted to the right knee;-On 7/29/25 at 8:11 P.M., a nurse note: received new orders for laboratory blood work to be completed and faxed to infectious disease physician;-On 7/29/25 at 9:51 P.M., a nurse antibiotic note: -Medication in use for infection: ceftriaxone; -Type of infection: right knee; -Adverse reactions from antibiotic: no; -Current signs and symptoms: IV antibiotic therapy; -Are vitals within normal limits: yes. Observation on 7/31/25 at 10:48 A.M., showed the resident's outer bedroom door frame had an EBP magnet noted on the door frame. Inside the room, over the bathroom door hung PPE supplies, which included yellow gowns, gloves and masks. Observation on 8/1/2025 at 8:32 A.M., showed Certified Nurse Aide (CNA) O and CNA P entered the resident's room, and explained care to the resident. Neither aide performed hand washing, and both applied gloves. The aides did not apply gowns before placing the sling pad under the resident. The aides completed the transfer and verified the resident's comfort. The aides removed their gloves and performed hand hygiene. CNA O and CNA P said they were unaware the resident's care required EBP. Neither aide observed the EBP PPE on the bathroom doorway. The aides did not observe the EBP magnet on the outside of the doorway. Observation on 8/4/2025 6:35 AM, showed CNA S and CNA T entered the resident's room. Neither aide performed hand hygiene and applied a gown and mask. CNA T applied gloves. CNA S did not. CNA T unfastened a wet brief and tucked the brief under the resident's hips and between the legs. CNA S placed his/her bare hands on the resident's hip, stopped, then applied gloves and assisted the resident to turn onto his/her side. The aides removed the gowns and gloves in the room, held used PPE in their bare hands, exited the resident's room walked across the hallway to the soiled utility room and disposed of the used PPE in the soiled utility room. During an interview on 8/5/2025 at 10:41 A.M., the Director of Nursing said staff should wash their hands when entering a (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	resident's room. Gloves should be applied before starting care tasks. Staff should don full PPE for residents identified as needing EBP. All used PPE should be disposed of in the resident's room and not carried outside of the room. Failure to perform hand hygiene and apply required PPE prior to care could spread infection.