STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265171	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Osage Beach Rehabilitation and Health Care Center	844 Passover Road Osage Beach, MO 65065

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 0575 Level of Harm - Potential for minimal harm Residents Affected - Many	Post a list of names, addresses, and telephone numbers of all pertinent State agencies and advocacy groups and a statement that the resident may file a complaint with the State Survey Agency. 39644 Based on observation and interview, facility staff failed to post, in a form and manner accessible to residents, resident representative, visitors and staff the required telephone number to the Department of Health and Senior Services (DHSS) elder abuse and neglect hotline. The census was 75. 1. Review of the facility's Patient Protection and Response Policy for Allegations/Incidents of Abuse, Neglect, Misappropriation of Property and Exploitation, revised 02/01/2023, showed the names, addresses, and telephone numbers of all pertinent State client advocate groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network are available to all patients and their families and will be posted prominently in the center. 2. Observation of the facility on 02/24/25 at 1:00 P.M., showed the DHSS Abuse and Neglect Hotline number posted at the end of an unoccupied hall and not in a prominently located area within the facility for residents to see. Observation of the facility on 02/25/25 at 8:15 A.M., showed the DHSS Abuse and Neglect Hotline number posted at the end of an unoccupied hall and not in a prominently located area within the facility for resident to see. Observation of the facility on 02/26/25 at 10:15 A.M., showed the DHSS Abuse and Neglect Hotline number posted at the end of an unoccupied hall and not in a prominently located area within the facility for residents to see. Observation of the facility on 02/27/25 at 2:25 P.M., showed the DHSS Abuse and Neglect Hotline number posted at the end of an unoccupied hall and not in a prominently located area within the facility for residents to see. During an interview on 02/27/25 at 2:41 P.M., the Social Service Designee (SSD) said the hotline number was posted up front in the facility, however when he/she went to look he/she realized it was not there. He/She said they are unsure why its not posted any longer. Observation on 02/27/25 at 2:45 P.M., showed the front area of the facility did not contain the DHSS Abuse and Neglect Hotline number posted. (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265171	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/27/2025
NAME OF PROVIDER OR SUPPLIER Osage Beach Rehabilitation and Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 844 Passover Road Osage Beach, MO 65065	

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F 0575 Level of Harm - Potential for minimal harm Residents Affected - Many	During an interview on 02/27/25 at 4:45 P.M., the Director of Nursing (DON) said the hotline number is posted back by his/her office and thought it was posted in the front of the building. The DON said he/she was not aware the number wasn't posted up front. The DON said it is not in a good location, it should be posted visible for everyone to see it. Observation on 02/27/25 at 5:00 P.M., showed the front area of the facility did not contain the DHSS Abuse and Neglect Hotline number posted. During an interview on 02/27/25 at 5:05 P.M., Resident #42 said he/she has never heard anyone talk about the hotline number. He/She said she does not know where the number is located. During an interview on 02/27/25 at 5:07P.M., Resident #76 said he/she does not know where the hotline number is posted. The resident said he/she has not seen this posted around anywhere. During an interview on 02/27/25 at 5:50 P.M., the Administrator said the SSD is responsible making sure the information is posted. The administrator said the information use to be posted in the front, but it is back by the DON's office.

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F 0583

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Keep residents' personal and medical records private and confidential.

50422

Based on observation and interview, facility staff failed to ensure residents' personal information was protected when staff left the computer screen open in public areas for six residents (Resident #7, #26, #31, #61, #74 and #79) of nine sampled residents. The facility's census was 75.

1. Review of the facility's policy titled, National Healthcare Corporation (NHC) Health Insurance Portability and accountability Act (HIPAA) Privacy Program, dated 12/2024, showed:

-NHC is committed to complying with the HIPAA Privacy Rule and maintaining the confidentiality of patient's Protected Health Information (PHI) through appropriate, authorized access, uses, and disclosures;

-NHC creates, stores, maintains, uses, transmits, collects and disseminates PHI in an environment that promotes confidentiality and integrity without compromising PHI.

2. Observation on 02/24/25 at 7:45 A.M., showed Registered Nurse (RN) A left the computer screen open and unattended on with Resident #31 medication information visible in Hallway A. Observation showed residents and staff walked by the cart.

Observation on 02/24/25 at 8:00 A.M., showed RN A left the computer screen open and unattended with Resident #26 medication information visible in Hallway A. Observation showed residents and staff walked by the cart.

Observation on 02/24/25 at 8:05 A.M., showed RN A left the computer screen open and unattended Resident #7 medication information visible in Hallway A. Observation showed residents and staff walked by the cart.

During an interview on 02/24/25 at 12:57 P.M., RN A said he/she knows he/she should close the screen when he/she walks away. He/She said it is a risk for HIPAA and it exposes resident information. He/She said he/she just forgets to minimize it.

3. Observation on 02/25/25 at 12:05 P.M., showed RN Bleft the computer screen open and unattended with Resident #61 medication information visible on the insulin cart. Observation showed residents and staff walked by the cart.

Observation on 02/25/25 at 12:08 P.M., showed RN B left the computer screen open and unattended with Resident #74 medication information visible on the insulin cart. Observation showed residents and staff walked by the cart.

During an interview on 02/25/25 at 2:13 P.M., RN B said he/she should not leave computer screen open exposing resident information when he/she walks away from cart. He/She said it is a risk of privacy and HIPAA.

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	4. Observation on 02/27/25 at 07:45 A.M., showed RN C left the computer screen open and unattended with Resident #26 medication information visible in the dining room. Observation showed residents and staff walked by the cart. Observation on 02/27/25 at 07:50 A.M., showed RN C left the computer screen open and unattended with Resident #7 medication information visible in the dining room. Observation showed residents and staff walked by the cart. Observation on 02/27/25 at 08:00 A.M., showed RN C left the computer screen open and unattended with Resident #79 medication information visible in the dining room. Observation showed residents and staff walked by the cart. During an interview on 02/27/25 at 8:24 A.M., RN C said he/she should have closed her screen when he/she walked away from the cart. He/She said it is a risk of HIPAA and exposing resident information. During an interview on 02/27/25 at 4:49 P.M., Director of Nursing (DON) said computer screens should not be up with resident information showing. He/She said the risk of leaving computer screen up is anyone going by computer can see the resident information on the screen. He/She said the staff with that computer is responsible for ensuring the residents information is not exposed when they walk away. During an interview on 02/27/25 at 5:46 P.M., the administrator said when staff walk away from their computer, the screen should be minimized because of privacy and HIPAA. He/She said when he/she seeing a screen open he/she will close them.

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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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39440 Based on interview and record review, facility staff failed to document an accurate Minimum Data Set (MDS), a federally mandated assessment, when staff did not accurately code section A of the MDS for two residents (Residents #9 and #41), and section B of the MDS for one resident (Resident #43) out of 18 sampled residents. The facility's census was 75. 1. Review of the facility's policies showed staff did not provide a MDS policy. 2. Review of the Centers for Medicare and Medicaid Services (CMS) Resident Assessment Instrument (RAI) Manual, a guideline for staff to complete each resident's MDS, dated [DATE], showed federal regulations require the assessment accurately reflects the resident's status, and the assessment process includes direct observation, as well as communication with the resident and direct care staff on all shifts. In addition, an accurate assessment requires collecting information from multiple sources, some of which are mandated by regulations. 3. Review of Resident #9's Annual MDS, dated [DATE], showed staff assessed the resident as follows: -readmitted to facility 06/05/23; -Moderate cognitive impairment; -Has not been evaluated by Level II Pre-Admission Screen and Resident Review (PASRR) and determined to have a serious mental illness and/or mental retardation or a related condition; -Diagnosis of Manic Depression. Review of the resident's PASARR Level II determination, dated 02/07/23, showed the resident evaluated with a PASRR related disability: specifically, Serious Mental Illness related to diagnosis of Bipolar I Disorder. During an interview on 02/27/25 at 1:05 P.M., the MDS Coordinator said based on the RAI instructions, section A1500 and A1510 on the resident's MDS were inaccurate and was just an oversight by him/her. He/She said he/she had never seen a copy of the resident's PASARR Level II determination report prior. During an interview on 02/27/25 at 4:45 P.M., the Director of Nursing (DON) said Section A1500 and A1510 on the resident's MDS were inaccurate. 4. Review of Resident #41's Annual MDS, dated [DATE], showed staff assessed the resident as follows: -admitted to facility 11/17/23; -Cognitively intact; (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Has not been evaluated by Level II PASRR and determined to have a serious mental illness and/or mental retardation or a related condition; -Diagnoses of Major Depression Disorder and Post Traumatic Stress Disorder (PTSD). Review of the resident's PASRR Level II determination, dated 02/27/24, showed the resident evaluated with a PASRR related disability: specifically, Serious Mental Illness. During an interview on 02/27/25 at 4:00 P.M., the MDS Coordinator said he/she was not aware resident was a level two. He/She said the resident's MDS should reflect the resident's level two. 5. Review of Resident #43's annual MDS, dated [DATE], showed staff assessed the resident as follows: -admitted to facility 03/29/22; -Cognitivley intact; -Adequate vision. During an interview on 02/24/25 at 7:46 A.M., the resident said he/she can't see and is blind. The resident said, I can see only outlines and some shapes. The resident said he/she can not watch TV, because he/she is not able to see it. During an interview on 02/27/25 at 4:45 P.M., the DON said the resident's vision assessment of adequate vision is inaccurate on his/her MDS, the resident is visually impaired. 6. During an interview on 02/27/25 at 9:55 A.M., the DON said the MDS Coordinator had been in his/her role for about seven months and is responsible to accurately complete residents' MDS assessments. He/She said no one double checks the accuracy of the MDS assessments, but as the DON he/she is responsible for the oversight. The facility does not have a Policy for MDS. He/She said facility staff uses the CMS guidelines and the RAI manual as guidance to complete each resident's MDS. During an interview on 02/27/25 at 1:05 P.M., the MDS Coordinator said he/she was responsible to accurately complete each resident's MDS, and uses the CMS guidelines and the RAI manual to complete the MDSs. He/She said all sections including Section A and B of the MDS should accurately reflect each resident at the time of the assessment. During an interview on 02/27/25 at 5:48 P.M., the administrator said he/she expects each resident's MDS to be accurately completed per CMS guidelines. He/She said the DON oversees the MDS Coordinator. 39644 50422

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39440 Based on interview, and record review, facility staff failed to meet professional standards of care when staff did not document an order for code status (the level of medical interventions a resident wishes to have if their heart or breathing stops) for one Resident #9, did not document a clear order for code status for one Resident #37, and did not document clinical condition or symptoms for use of medications for three Residents (#75, #79, and #80) out of 18 sampled residents. The facility's census was 75. 1. Review of the facility's policy titled, Code Status/Advance Directives Procedure, dated [DATE], showed: -Nursing will discuss with the patient, if unable-the legal/patient representative about code status Do not Resuscitate (DNR) versus cardiopulmonary resuscitation (CPR) as well as other life sustaining measures on the Physician's Orders for Life Sustaining Treatment (POLST) Form; -The POLST Form is completed by Nursing and forwarded to Health Information Department for physician signature; -Code status documentation by nurse: Enter order for DNR versus CPR; -Audit Process: Health Information Department will audit all new admissions by verifying the order, banner icon, and POLST Form (if in place all match). Health Information Department will continue to audit on a monthly basis by running the Advance Directives Report and comparing to ensure Resident Banner, order and POLST form (if used) all match. 2. Review of Resident #9's annual Minimum Date Set (MDS), a federally mandated assessment, dated [DATE], showed staff assessed the resident as moderately cognitively impaired, and readmitted to facility on [DATE]. Review of the resident's Physician's Order Sheet (POS), dated [DATE] through [DATE], showed the POS did not contain documentation of an order for code status. During an interview on [DATE] at 10:28 A.M., the Director of Nursing (DON) said each resident should have an order for code status to indicate either full code (CPR) or DNR. He/She said the admitting nurse is responsible to verify the code status and enter the order, and the health information staff audits after. During an interview on [DATE] at 1:43 P.M., the resident said he/she is a full code and would like staff to perform CPR if needed. During an interview on [DATE] at 1:32 P.M., the Clinical Coordinator said the resident did not have an order for code status and should have one on his/her POS. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on [DATE] at 4:28 P.M., the Health Information staff said he/she was not sure why the resident did not have an order for CPR or DNR since [DATE], when the order was apparently discontinued and did not get re-entered. He/She said he/she completes quarterly audits, but does not necessarily check for code status orders on residents who have been at the facility for a while. 3. Review of Resident #37's admission MDS, dated [DATE], showed staff assessed the resident as severely cognitively impaired and admitted on [DATE]. Review of the resident's POS, dated [DATE] showed an order for a DNR code status. Review of the resident's POS, dated [DATE] showed an order for a Full Code status. During an interview on [DATE] at 4:48 P.M., the DON said the resident should not have two different orders for his/her code status and did not know why he/she did. He/She said the admitting nurse is responsible to verify the code status and enter the order, and the health information staff audits after. 4. During an interview on [DATE] at 1:32 P.M., the Clinical Coordinator said each resident should have an order for either DNR or CPR, and the admitting nurse is responsible to verify the code status and enter the order. He/She said the health information staff is responsible to check orders a few days after admission and ensure each resident has an order for CPR or DNR and if not, notify the nurse for follow up. During an interview on [DATE] at 4:28 P.M., the health information staff said the nurse is responsible to document the order for code status on admission, he/she audits the medical records a few days after and notifies the nurse of any discrepancy or missing orders. During an interview on [DATE] at 5:48 P.M., the administrator said each resident should have a physician's order for code status to indicate either DNR or CPR. He/She said the nursing staff is responsible to ensure there is an order and the health informatiom department monitors. 5. Review of the facility's policy titled, Medication and Treatment Orders, dated [DATE], showed orders for medications and treatments will be consistent with principles of safe and effective order writing. Orders for medications must include a clinical condition or symptoms for which the medication is prescribed. 6. Review of Resident #75's Entry Tracking MDS, dated [DATE], showed the resident admitted to the facility on [DATE]. Review of the resident's POS, dated [DATE] to [DATE], showed an order for Cefdinir (antibiotic) capsule 300 milligrams (mg), one capsule by mouth twice daily for ten days. Review showed the POS did not contain documentation of a clinical condition or symptoms for the Cefdinir medication. During an interview on [DATE] at 10:53 A.M., the Infection Preventionist/Clinical Coordinator said the resident recently admitted with antibiotic treatment for a urinary tract infection. He/She said on weekends, the admitting nurse is responsible to ensure an antibiotic medication has an indication for use, and he/she is responsible on weekdays, but had not had a chance to review the resident's medications yet. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	7. Review of Resident #79's Admission MDS, dated [DATE], showed staff assessed the resident as follows: -admitted to facility [DATE]; -Diagnoses of seizure isorder or epilepsy, Schizophrenia (a chronic mental illness that affects how people think, feel and behave); -Received antipsychotic medication with indication noted. Review of the Resident's POS, dated [DATE] through [DATE], showed an order for Aripiprazole (an antipsychotic medication used to treat schizophrenia) 30 mg tablet, one tablet by mouth daily at 10:30 A.M. Review showed the POS did not contain documentation of a clinical condition or symptoms for the Aripiprazole medication. 8. Review of Resident #80's Admission MDS, dated [DATE], showed staff assessed the resident as follows: -admitted to facility [DATE]; -Diagnoses: Hypo-osmolality and hyponatremia (excess water in the body with low sodium levels in the blood), high blood pressure. Review of the Resident's POS, dated [DATE] through [DATE], showed the physician ordered Amlodipine (used to treat high blood pressure) 5 mg tablet, one tablet by mouth daily at 10:30 A.M. Review of the POS showed it did not contain documentation of a clinical condition or symptoms for the Amlodipine medication. 9. During an interview on [DATE] at 11:00 A.M., the Infection Preventionist/Clinical Coordinator said he/she said the facility recently started using an external company to enter admission orders for residents and the process has not being going smoothly, but he/she expects the admitting nurse to verify all residents' admission orders have an indication for use within the first four hours of admission and notify him/her or the DON for follow-up. During an interview on [DATE] at 1:26 P.M., the MDS Coordinator said residents' medications should have an indication for use and he/she had not seen that on all medication orders at the facility, so he/she was not sure if it was required by facility staff. During an interview on [DATE] at 1:32 P.M., the Infection Preventionist/Clinical Coordinator said all medications listed on the residents' POS should have an indication for use regardless of the type of medication. He/She said he/she is responsible to ensure as needed medications and antibiotics have an indication for use, and the DON oversees all other medications. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on [DATE] at 4:48 P.M., the DON said each prescribed medication listed on residents' POS should have an indication for use regardless of the type of medication. He/She said Resident #79 and #80 admitted to the facility almost two weeks prior and all their medications should have an indication for use. He/She said the pharmacist also reviews the medications for new admissions and give recommendations for medications without an indication for use. He/She said he/she is responsible to oversee but he/she is currently behind. During an interview on [DATE] at 5:17 P.M., Licensed Pharmacist G said he/she tries to review the medications for residents newly admitted within one week and can complete the medication reviews remotely. He/She said he/she had not reviewed the medications for residents admitted after his/her last visit to facility on or about [DATE] and planned to complete those reviews the next day when he/she is at the facility.

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F 0677 Level of Harm - Potential for minimal harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39440 Based on observation, interview, and record review, facility staff failed to provide care to meet basic hygiene needs for three (Resident #5, #24, and #80) out of five sampled residents. The facility census was 75. 1. Review of the facility's policies showed the staff did not provide a bath policy. 2. Review of Resident #5's Quarterly Minimum Data Set (MDS), a federally mandated assessment, dated 01/30/25, showed staff assessed the resident as follows: -Brief Interview for Mental Status ((BIMS) - a short cognitive screening tool) score not conducted as the resident is rarely/never understood; -Did not reject care; -Required substantial/max assist from staff with personal hygiene and to shower/bathe. Review of the resident's care plan, dated 02/12/25, showed staff are directed to assist the resident with dressing, personal hygiene, transfers, and showers. Review of the facility's shower schedule showed the resident will be assisted with a bed bath/shower on Tuesdays and Fridays by facility staff. Review of the resident's electronic record for bathing, dated 12/01/24 through 02/27/25, showed staff documented showers were provided on 12/04/24, 12/11/24, 12/17/24, 12/27/24, 01/07/25, 01/24/25, and 02/25/25. Staff did not document refusals. Observation on 02/24/25 at 8:35 A.M., showed the resident in the dining room with greasy hair. Observation on 02/25/25 at 9:23 A.M., showed the resident in bed with greasy hair. During an interview on 02/27/25 at 4:36 P.M., the Clinical Coordinator said the resident does not refuse his/her showers. 3. Review of Resident #24's Quarterly MDS, dated [DATE], showed staff assessed the resident as follows: -BIMS not assessed; -Did not reject care; -Required substantial/max assist from staff with personal hygiene and to shower/bathe. Review of the resident's care plan, dated 02/06/25, showed the resident needs substantial assist with showers, upper and lower body dressing and personal hygiene. (continued on next page)

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F 0677 Level of Harm - Potential for minimal harm Residents Affected - Some	Review of the facility's shower schedule showed the resident will be assisted with a bed bath/shower on Mondays and Thursdays by facility staff. Review of the resident's electronic record for bathing, dated 12/01/24 through 02/24/25, showed staff documented bed/showers provided on 12/05/24, 12/12/24, 12/26/24, 01/09/25, 01/15/25, 01/27/25, 02/03/25, 02/12/25, and 02/13/25. Observation on 02/24/25 at 2:00 P.M., showed the resident in bed with long nails with a dark substance underneath and greasy hair. Observation on 02/26/25 at 10:30 A.M., showed the resident in bed with long nails with a dark substance underneath and greasy hair. During an interview on 02/24/25 at 2:01 P.M., the resident said he/she does not get showers very often. During an interview on 02/27/25 at 1:47 P.M., the resident said it makes him/her mad when he/she does not get a shower, because he/she was told they are to get a shower twice a week when he/she came to the facility. During an interview on 02/27/25 at 4:36 P.M., the Clinical Coordinator said the resident occasionally refuses his/her showers, but he/she was not sure if there was a pattern. 4. Review of Resident #80's admission MDS, dated [DATE], showed staff assessed the resident as follows: -admitted to facility 02/14/25; -Severely cognitively impaired; -Did not reject care; -Required supervision with oral hygiene, personal hygiene; -Ability to shower/bathe self: not attempted due to medical or safety concerns. Review of the resident's care plan, dated 02/20/25, showed staff are directed to assist the resident with some or all ADLs, and help him/her keep dentures clean after meals and at bedtime. Review of the facility's shower schedule showed the resident will be assisted with a bed bath/shower on Tuesdays and Fridays by facility staff. Review of the resident's electronic records for bathing, dated 02/14/25 through 02/27/25, showed staff documented one shower was provided on 02/25/25 and one refusal on 02/18/25. Observation on 02/24/25 at 10:07 A.M., showed the resident ambulated with a walker and staff assist down the hallway to his/her room. His/Her hair appeared uncombed and disheveled. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER: Osage Beach Rehabilitation and Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 844 Passover Road, Osage Beach, MO 65065	

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F 0677 Level of Harm - Potential for minimal harm Residents Affected - Some	Observation on 02/25/25 at 12:17 P.M., showed the resident sat at the dining table in his/her robe, and his/her hair appeared uncombed and disheveled. During an interview on 02/24/25 at 10:19 A.M., the resident said he/she admitted to facility over a week prior and had some oral concerns regarding his/her lower gum and dentures he/she needed staff to help resolve, as well as not being offered a shower yet. During an interview on 02/25/25 at 12:18 P.M., the resident said he/she was still waiting for staff to assist him/her with a shower so he/she could feel refreshed. During an interview on 02/27/25 at 4:36 P.M., the Clinical Coordinator said the resident could refuse his/her showers, but he/she was not aware/notified the resident refused any showers since his/her admission. 5. During an interview on 02/27/25 at 4:22 P.M., Certified Nursing Assistant/Certified Medication Technician (CNA/CMT) F said the shower aide was already gone for the day. He/She said Resident #5 and #80 is scheduled to receive a shower on Tuesdays and Fridays, and Resident #24 is scheduled on Mondays and Thursdays. He/She said the shower aide documents when he/she assists a resident with a shower in the electronic record. During an interview on 02/27/25 at 4:29 P.M., Registered Nurse (RN) C said Resident #5 and #80 is scheduled to receive a shower on Tuesdays and Fridays, and Resident #24 is scheduled on Mondays and Thursdays. The RN said the shower aide documents when he/she assists a resident with a bath/shower in the electronic record, and if the resident refuses. He/She said the shower aide does not always notify the nurse of a refusal, and does not normally document resident refusals on paper. During an interview on 02/27/25 at 4:36 P.M., the Clinical Coordinator said the shower aide is expected to document when he/she assists a resident with a bath/shower in the electronic record, and if the resident refuses once or twice. He/She said if a resident develops a pattern of refusing, then the shower aide is expected to notify the charge nurse and complete a paper shower sheet and have the resident sign his/her refusal, then the nurse or the clinical coordinator would follow-up with the resident. During an interview on 02/27/25 at 4:38 P.M., the Director of Nursing (DON) said the facility has two shower aides who are expected to offer the residents a bath or shower twice per week, and if the resident refuses, the shower aide should document the refusal in the electronic record and notify the charge nurse of the refusal. During an interview on 02/27/25 at 5:48 P.M., the administrator said he/she expects staff to offer residents a bath or shower at least once per week and if a resident refuses, then staff should re-approach the resident and offer alternate options such as a different day or time. The administrator said he/she is not sure why showers are not being completed, because there are two shower aides on staff. MO00249498 39644

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 39440 Based on observation, interview, and record review, facility staff failed to obtain consents for side rails and failed to complete side rail assessments for five residents (Resident #18, #43, #64, #76 and #77), out of seven sampled residents. The facility census was 75. 1. Review of the facility's Proper use of Side Rails Policy, 12/2016, showed: -An assessment will be made to determine the resident's symptoms, risk of entrapment and reason for using side rails; -When used for mobility or transfer, an assessment will include a review of the resident's: -Bed mobility; -Ability to change positions, transfer to and from bed or chair, and stand and toilet; -Risk of entrapment from the use of side rails; -That the beds dimensions are appropriate for the resident's size and weight. -Consent for using restrictive deices will be obtained from the resident or legal representative per facility protocol; -Consent for side rail use will be obtained from the resident or legal representative, after presenting potential benefits and risks. 2. Review of Resident #18's quarterly Minimum Data Set (MDS), a federally mandated assessment, dated 01/08/25, showed staff assessed the resident as follows: -Severe cognitive impairment; -Impairment to one side of lower extremity (hip, knee ankle, foot); -Required substantial/max assist from staff to roll left and right, sitting to lying in bed, lying to sitting on side of bed. Review of the resident's electronic medical record (EMR), showed the record did not contain a signed consent from the resident or resident representative for the use of bed rails, or a side rail assessment. Observation on 02/24/25 at 12:16 P.M., showed the resident in bed with bed rails to both sides in the upright position. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 02/25/25 at 9:36 A.M., showed the resident in bed with bed rails to both sides in the upright position. Observation on 02/26/25 at 8:42 A.M., showed the resident in bed with bed rails to both sides in the upright position. During an interview on 02/27/25 at 1:26 P.M., the MDS/Care Plan Coordinator said the resident uses bed bed rails and he/she recently did an audit for residents with bed rails but must have missed the resident. 3. Review of Resident #43's annual MDS, dated [DATE], showed: -Cognitively intact; -No impairment; -Not assessed for assist from staff to roll left and right, sitting to lying in bed, lying to sitting on side of bed. Review of the resident's EMR showed the record did not contain an signed consent from the resident or resident representative for the use of bed rails, or a side rail assessment. Observation on 02/24/25 at 8:45 A.M., showed the resident in bed with bed rail on left side in the upright position. Observation on 02/25/25 at 11:30 A.M., showed the resident in bed with bed rail on left side in the upright position. Observation on 02/26/25 at 3:00 P.M., showed the resident in bed with bed rail on left side in the upright position. Observation on 02/27/25 at 5:15 P.M., showed the resident in bed with bed rail on left side in the upright position. 4. Review of Resident #64's Admission MDS, dated [DATE], showed staff assessed the resident as follows: -Severe cognitive impairment; -Impairment both sides upper and lower extremities; -Dependent with chair/bed-to-chair transfers; -Substantial/maximal assist with rolling left and right. Review of the resident's EMR showed the record did not contain an signed consent from the resident or resident representative for the use of bed rails or a side rail assessment. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 2/24/25 at 10:21 A.M., showed the resident in bed with both side rails in the upright position. Observation on 2/25/25 at 11:02 A.M., showed the resident in bed with both side rails in the upright position. Observation on 2/27/25 at 10:15 A.M., showed the resident in bed with both side rails in the upright position. 5. Review of Resident #76's Admission MDS, dated [DATE], showed staff assessed the resident as follows: -Cognitively intact; -Impairment both sides lower extremity; -Substantial/maximal assist with rolling left and right and chair/bed-to-chair transfers; -Partial/moderate assist with lying to sitting on side of bed. Review of the resident's EMR showed the record did not contain an signed consent from the resident or resident representative for the use of bed rails or a side rail assessment. Observation on 2/24/25 at 9:34 A.M., showed the resident in bed with both side rails in the upright position. During an interview on 02/27/25 at 10:20 A.M., the resident said he/she uses the side rails to help him/her sit up in bed and to help turn over while in bed. 6. Review of Resident #77's admission MDS, dated [DATE], showed: -Cognitively intact; -Impairment both sides lower extremity; -Dependent on staff for assistance to roll left and right, sitting to lying in bed, lying to sitting on side of bed. Review of the resident's EMR, showed the record did not contain an signed consent from the resident or resident representative for the use of bed rails, or a side rail assessment. Observation on 02/24/25 at 10:49 A.M., showed the resident in bed with both side rails in the upright position. Observation on 02/26/25 at 9:30 A.M., showed the resident in bed with both side rails in the upright position. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 02/27/25 at 1:50 P.M., showed the resident in bed with both side rails in the upright position. 7. During an interview on 02/27/25 at 1:26 P.M., the MDS/Care Plan Coordinator said he/she was not sure who was responsible to complete the residents' initial side rail assessments and obtain informed consents, he/she is only responsible to complete the quarterly side rail assessments with informed consent. During an interview on 02/27/25 at 2:05 P.M., Registered Nurse (RN) D said upon admission the resident or resident's family can request side rails. He/She said an evaluation would be completed to ensure resident can use the side rails. He/She said the admitting nurse would do the bed rail assessment in the observations tab and at that time go over the risks of entrapment with the resident or family and ensure they consent to use of side rails. He/She said from there he/she informs the Director of Nursing (DON) that side rails are wanted. He/She said he/she is unsure who does the bed rail assessments after the admission assessment is completed or how often they are done. During an interview on 02/27/25 at 9:44 A.M., the DON said the MDS Coordinator should be doing the bed rail assessment quarterly. He/She said the consents are at the bottom of the bed rail utilization assessment. He/She said upon admission the charge nurse should complete the bed rail assessment, but sometimes it may be the next day after therapy has evaluated the resident and determined bed rails are needed. He/She said all residents should have a consent for bed rails upon determination of need. He/She said it is the charge nurse responsibility for obtaining consent and the MDS Coordinator should be double checking when he/she is doing the quarterly assessments and updating the MDS. He/She said no one is currently overseeing if the MDS Coordinator is checking for the bed rail assessments. He/She said it should be the DONs responsibility to check and ensure consents and bed rail assessments are being done. During an interview on 02/27/25 at 5:43 P.M., the administrator he/she is unsure who does the bed rail assessments or how often they should be done. He/She said there should be consents for all residents who use bed rails. He/She said charge nurses ensure consents are done and the DON should oversee that they are being obtained. 39644 50422

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39440 Based on observation, interview, and record review, facility staff failed to provide a barrier for the glucometer (a device for monitoring blood sugars) supplies for seven residents (Resident #7, #26, #52, #55, #61, #74, and #79) out of seven sampled residents. Facility staff failed to wear gloves while administering insulin to three residents (Resident #52, #61, and #74) out of seven sampled residents. Facility staff failed to develop and implement complete policies and procedures for the inspection, testing and maintenance of the facility's water systems to inhibit the growth of waterborne pathogens and reduce the risk of an outbreak of Legionnaire's Disease (a serious type of pneumonia (lung infection) caused by Legionella bacteria, which places all residents of the facility at risk of exposure which could lead to illness).The facility census was 75. 1. Review of the facility's policy titled, Cleaning and Disinfecting Blood Glucose Meters, dated 2019, showed facility staff were directed to apply gloves before performing a blood glucose test, glucose monitoring, administration of insulin, and any other procedure that involved potential exposure to blood or body fluids. 2. Review of Resident #7's medical record showed the resident admitted to the facility on [DATE] with a diagnosis of diabetes. Observation on 02/27/25 at 7:50 A.M., showed Registered Nurse (RN) C obtained a blood sample and placed the glucometer directly on the dining room table without a barrier. 3. Review of Resident #26's medical record showed the resident admitted to the facility on [DATE] with a diagnosis of diabetes. Observation on 02/27/24 at 7:45 A.M., showed RN C obtained a blood sample and placed the glucometer directly on the dining room table without a barrier. 4. Review of Resident #52's medical record showed the resident admitted to the facility on [DATE] with a diagnosis of diabetes. Observation on 02/25/25 at 12:02 P.M., showed RN B obtained a blood sample and placed the glucometer directly on the dining room table without a barrier. Observation on 02/25/25 at 12:03 P.M., showed RN B did not wear gloves when he/she administered insulin to resident. 5. Review of Resident #55's medical record showed the resident admitted to the facility on [DATE] with a diagnosis of diabetes. Observation on 02/27/25 at 8:10 A.M., showed RN C obtained a blood sample and placed the glucometer directly on the dining room table without a barrier. 6. Review of Resident #61's medical record showed the resident admitted to the facility on [DATE] with a diagnosis of diabetes. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Observation on 02/25/25 at 12:05 P.M., showed RN B obtained a blood sample and placed the glucometer directly on the dining room table without a barrier. Observation on 02/25/25 at 12:06 P.M., showed RN B did not to wear gloves when he/she adminstered insulin to resident. 7. Review of Resident #74's medical record showed the resident admitted to the facility on [DATE] with a diagnosis of diabetes. Observation on 02/25/25 at 12:10 P.M., showed RN B obtained a blood sample and placed the glucometer directly on the dining room table without a barrier. Observation on 02/25/25 at 12:11 P.M., showed RN B did not to wear gloves when he/she administered insulin to resident. 8. Review of Resident #79's medical record showed the resident admitted to the facility on [DATE] with a diagnosis of diabetes. Observation on 02/27/25 at 8:00 A.M., showed RN C obtained a blood sample and placed the glucometer directly on the dining room table without a barrier. 9. During an interview on 02/25/25 at 2:13 P.M., RN B said he/she should have not put the glucose meter on the table due to contamination. He/She said he/she should wear gloves when having the potential for coming in contact with bodily fluids. He/She said when administering insulin, you could have the potential for coming in contact with bodily fluids. He/She said he/she does not have an explanation why he/she didn't wear gloves while administering insulin. During an interview on 02/27/25 at 08:24 A.M., RN C said he/she does not see a problem with putting the glucose meter on the table after obtaining a blood sample. He/She agreed it could be a risk for blood splitter where residents are eating and risk for contamination. During an interview on 02/27/25 at 4:30 P.M., the Director of Nursing (DON) said nurses should wear gloves when administering insulin. He/She said not wearing gloves is a risk of exposure to blood. He/She said staff should probably not lay the glucose meter on the dining room table because there could be a chance another resident could get ahold of the meter with blood still on the glucose strip. He/She said or if the nurse gets blood on glove and then touches the glucose meter and sets the meter on the table there is a chance of blood contamination. During an interview on 02/27/25 at 5:46 P.M., the administrator said it is probably not best practice to lay the glucose meter on the dining table due to potential of cross contamination. He/She said he/she is not sure if gloves should be worn while administering insulin. 10. Review of the Centers for Medicare and Medicaid Services (CMS) Quality, Safety and Oversight (QSO) 17-30, dated 06/02/17 and revised on 07/06/18, showed: (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The bacterium Legionella can cause a serious type of pneumonia called Legionnaire's Disease in persons at risk. Those at risk include persons who are at least [AGE] years old, smokers, or those with underlying medical conditions such as chronic lung disease or immunosuppression. Outbreaks have been linked to poorly maintained water systems in buildings with large or complex water systems including hospitals and long-term care facilities. Transmission can occur via aerosols from devices such as showerheads, cooling towers, hot tubs, and decorative fountains. Facilities must have water management plans and documentation that, at a minimum, ensure each facility: -Conducts a facility risk assessment to identify where Legionella and other opportunistic waterborne pathogens (e.g. Pseudomonas, Acinetobacter, Burkholderia, Stenotrophomonas, nontuberculous mycobacteria, and fungi) could grow and spread in the facility water system; -Develops and implements a water management program that considers the ASHRAE industry standard and the CDC toolkit; -Specifies testing protocols and acceptable ranges for control measures, and document the results of testing and corrective actions taken when control limits are not maintained. Review of the facility's Water Quality Management Program, dated November 2023 showed procedures included: -Implement a water management program that considers the ASHREA (American Society of Heating, Refrigerating and Air-Conditioning Engineers) standards and the CDC (Centers for Disease Control and Prevention) toolkit that includes control measures such as physical controls, temperature management, checking disinfectant levels, visual inspections and environmental testing for pathogens; -Document the results of the testing and corrective actions taken when water control limits are not met. Review of the facility's EPP policy showed control measures included: -Visual inspection and checking disinfectant levels at the water main entering the facility; -Visual inspection of ice machines; -Checking disinfectant levels at sinks/showers; -Checking temperatures at water heaters, all sinks and showers and the kitchen. Review of the facility's EPP showed the control measures did not indicate normal ranges or frequencies. Review of the program control measures and corrective actions process flow diagram indicated staff were to document all results of routine control measure monitoring and corrective actions where applicable. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of the Legionella Water Management Plan Review task from the facility's computerized preventative maintenance program (TELS), marked done on time May 1, 2024, showed instructions for staff to: -Identify how often routine monitoring and testing are completed; -Decide where control measures should be applied and how to monitor them. Staff will need to monitor and measure if preventative measures are working; -Establish ways to intervene when control limits are not met; -Document and communicate all activities. Review of the facility's Water Quality Management Program records, showed the records did not contain: -Acceptable ranges for control measures; -Corrective actions to take if control measures are outside acceptable range; -Documentation of routine monitoring of control measures. During an interview on 02/26/25 at 9:50 A.M., the maintenance director said he/she was not familiar with control measures in the water quality management program. The maintenance director said he/she had never looked at the facility specific risk assessment in the water plan. The maintenance director said he/she used a swimming pool test strip to test water quality. The maintenance director said he/she followed the normal ranges listed on the bottle but he/she did not document results and never took any action based on results. During an interview on 02/26/25 at 3:35 P.M., the administrator said he/she and maintenance staff were responsible for implementing the water quality management program. The administrator said he/she had reviewed the plan but was not very knowledgeable of the contents. The administrator said he/she was not aware of any specific inspections or action the maintenance director performed as part of the water management program. The administrator said specific control measure ranges and corrective actions should be included in the water management plan but he/she could not locate them. 45564 50422