STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265200	A. Building B. Wing	08/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Loch Haven	701 Sunset Hills Dr Macon, MO 63552

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility failed to store, prepare, and serve food in accordance with professional standards for food service safety. Staff did not securely seal, label, date, or store food items per manufacturer's instructions. Staff did not practice proper hand and glove hygiene, hair restraint usage, and consumption of personal food items. Staff did not maintain surfaces and equipment to be free from a buildup of grease and debris and did not ensure surfaces were sanitized properly. Staff did not ensure dishes and utensils were stored and handled in a sanitary manner. The facility census was 73. 1. Review of the facility policy, Food Storage (Dry, Refrigerator, and Frozen), dated 2020, showed the following:-Food shall be stored on shelves in a clean, dry area free from contaminants;-Food should be stored at appropriate temperatures and using appropriate methods to ensure the highest level of food safety;-All food items will be labeled. The label must include the name of the food and the date by which it should be sold, consumed, or discarded;-Discard food that has past expiration date, and discard food that has been prepared in the facility after seven days of storing under proper refrigeration;-Leftover contents of cans and prepared food will be stored and covered, labeled and dated containers and refrigerators and or freezers;-Store dry food 6 inches off the floor to allow for proper sanitation;-Dented cans are set aside in a separate labeled area of the storeroom to avoid using them and discarded according to vendor procedure. Review of the kitchen inspection, conducted by the facility's registered dietitian on 5/5/25, showed the following item needed correction: Recommend placing all opened items in a sealable bag or container with a label. Review of the kitchen inspection, conducted by the facility's registered dietitian on 6/9/25, showed the following item needed correction: Recommend placing all opened items in a sealable bag or container with a label. Review of the kitchen inspection, conducted by the facility's registered dietitian on 7/25/25, showed the following items needed correction:-Recommend keeping bins covered at all times. Flower bin and sugar bin are each missing part of their lid. This exposes them to cross contamination. Debris observed inside of sugar. Recommend discarding contents, clean bins, refill bins, and keep them covered;-Recommend to label all opened and prepped items;-Recommend checking labels on items daily and discard outdated products. Observation on 8/4/25 at 8:41 A.M., in the kitchen, showed the following:-In the reach-in cooler, approximately ten broken eggshells were intermixed in a carton of whole eggs;-In the reach-in freezer, open bags of French fries and buns loosely folded over and not securely sealed;-In the dry storage room, open bags of rotini, macaroni, baking chips, and brown sugar loosely folded over, not securely sealed, and did not have open dates indicated on the bags. Bulk bins of flour and sugar were uncovered, and the sugar was very clumpy and had a package of crackers in the sugar. A large bag of sugar had a metal scoop in the bag and the bag was not sealed. An onion was on the floor;-In the walk-in cooler, a head of cabbage, butter packets, kiwi, and applesauce cup were on the floor under the shelves;-In the walk-in freezer, a bag of tortillas and three frozen biscuits were on the floor. A bag of frozen beef patties was unsealed and open to the air. Observation on 8/4/25 at 9:48 A.M., in the special care unit kitchenette, showed the following:-In the cabinets, a box of pancake mix and a box of raisins were both unsealed. A jar of yeast, with the label that read ?Refrigerate or freeze after opening and use within four (continued on next page)

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

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	months. Best if used by February 2025,' sat unrefrigerated on the shelf;-In the refrigerator, sandwiches in zipper top bags were undated and unlabeled. Observation on 8/4/25 at 9:36 A.M., in the north activity room kitchenette, showed the following:-In the cabinets, an open bag of marshmallows was loosely folded over and not sealed;-On the countertop, scoops were stored in bulk containers of flour and sugar;-In the refrigerator, a plastic container containing a red sauce and a plastic container containing a light, gray-colored food item was both unlabeled and undated. Observation on 8/4/25 at 11:06 A.M., in the dry storage room, showed a can of black beans had heavy dent damage and was in service with the rest of the canned food items. Observation on 8/5/25 at 1:43 P.M., in the south utility room refrigerator, showed the following:-The sign on the refrigerator door said, ?The food and drinks in this refrigerator are for residents only, everything must be labeled and dated;'-In the freezer section, a cup of orange ice cream-like substance was uncovered, unlabeled, and undated;-In the refrigerator section, a bowl of a brown food item and a bowl of white and black food item were both unlabeled and undated. During an interview on 8/6/25 at 2:05 P.M., [NAME] V said food items should be labeled, dated, and sealed. During an interview on 8/6/25 at 2:33 P.M., the Dietary Manager said she expected food to be stored, prepared, and served under safe and sanitary conditions. She expected food items to be labeled, dated, and stored per label instructions and for there not to be dented cans, expired, or unsealed food items. Staff should discard eggshells in the trash. 2. Review of the facility policy, Proper Handwashing and Glove Use, dated 2020, showed the following:-All employees will use proper hand washing procedures and glove usage in accordance with state and federal sanitation guidelines;-The proper procedure for washing hands is as follows: -Turn on water as hot as comfortable; -Wet hands and apply soap; -Scrub 15 to 20 seconds or more getting under nails between fingers and all exposed areas such as back of hands and forearms; -Rinse hands thoroughly; -Dry hands with paper towel or air dryer; -Turn off faucet with paper towel;-All employees will wash hands upon entering the kitchen from any other location, after all breaks, and between all tasks;-Employees will wash hands before and after handling foods, after touching any part of the uniform, face, or hair;-Gloves are to be used whenever direct food contact is required;-Hands are washed before donning gloves and after removing gloves;-Gloves are changed anytime hand washing would be required. This includes when leaving the kitchen for a break or to go to another location in the building, after handling potentially hazardous raw food, or if the gloves become contaminated by touching the face, hair, uniform, or other non-food contact surfaces such as door handles and equipment;-When gloves must be changed, they are removed, hand washing procedure is followed, and a new pair of gloves is applied. Gloves are never placed on dirty hands, the procedure is always wash, glove, remove, rewash and re-glove. Observation on 8/4/25 at 8:41 A.M., in the kitchen near the handwashing sink, showed the step-pedal trash can was broken and would not open the lid with the step-pedal. Observation on 8/4/25 at 10:38 A.M., in the kitchen, showed [NAME] V used his/her gloved hands to open a package of raw meat and transferred the meat to a pan. After he/she discarded the raw meat wrapper, he/she changed his/her gloves and did not wash his/her hands. He/She opened a utensil drawer and obtained a spatula to assist Dietary Aide W frost a cake and then handed the spatula to Dietary Aide W to continue frosting the cake. Observation on 8/4/25 at 10:43 A.M., in the kitchen, showed Dietary Aide W dropped a measuring cup onto the floor, picked up the cup with his/her gloved hands, and did not wash his/her hands or change his/her gloves. With his/her gloved hands, he/she frosted a cake and sliced the cake into pieces. He/She then served the cake into individual bowls with a spatula, touching the sides of the cake as he/she slid the cake off the spatula into the bowls. Observation on 8/4/25 at 11:37 A.M., in the kitchen, showed the Dietary Manager used his/her gloved hands to obtain pieces of bread from a bag on a cart where she prepared sandwiches for the lunch meal service. She touched the handles of the cart, a serving utensil, and then wiped the side of her face with her gloved hands. She removed her gloves, washed her hands, and touched the lid of the broken handwashing sink trash can with her clean hands to open the lid and discard a paper towel. She put on gloves and continued preparing sandwiches at the cart. Observation (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	on 8/4/25 at 4:54 P.M., in the kitchen, showed Dietary Aide Y served residents' food items from the steam table onto plates during the dinner meal service. He/She left the steam table to obtain a resident's drink by grasping and opening the door of the walk-in cooler with his/her gloved hands. He/She returned to the steam table, did not wash his/her hands or change his/her gloves, and continued serving food items. He/She touched utensil handles and grasped pieces of bread (served onto residents' plates) with his/her gloved hands. Observation on 8/6/25 at 2:25 P.M., in the kitchen, showed Dietary Aide X entered the kitchen and was texting on his/her phone. He/She did not wash his/her hands and put on gloves. Using his/her gloved hands, he/she grasped silverware by the eating surfaces of the utensils and wrapped the silverware into napkins. He/She washed his/her hands and turned off the faucet handles with his/her clean hands. He/She put on gloves and prepared pureed fruit at the food processor. As he/she added fruit to the food processor, he/she touched the fruit with his/her gloved hands. During an interview on 8/6/25 at 2:33 P.M., the Dietary Manager said she expected staff to not touch ready to eat food items with bare hands or soiled gloves. Staff should wash their hands prior to conducting clean tasks, when changing gloves, after conducting dirty tasks, and after picking up items from the floor. The step-trash can by the handwashing sink had been broken for a couple months. 3. Review of the facility policy, Cleaning Rotation, dated 2020, showed the following:-Equipment and utensils will be cleaned and sanitized according to the following guidelines or manufacturer's instructions;-Items cleaned daily: stove top, grill, exterior of large appliances;-Items cleaned weekly: hoods, filters, storerooms, shell, cupboards;-Items clean monthly: refrigerators, freezers, ingredient bins comma ice machines, food containers, walls. Review of the facility policy, Dishwashing: Machine Operation, dated 2020, showed the following:-Check the dishwashing machine for cleanliness before the start of each meal. Wipe down the dishwashing machine and clean per equipment cleaning procedure at the end of each workday. Remove any built up debris, lime, or scale as necessary or generally complete a thorough deliming per cleaning schedule or one time weekly. Review of the kitchen inspection, conducted by the facility's registered dietitian on 5/5/25, showed the following items needed correction:-Recommend to clean grease and debris from area surrounding flat top grill;-Recommend to clean carbon buildup from the top oven; Review of the kitchen inspection, conducted by the facility's registered dietitian on 6/9/25, showed the following items needed correction:-Recommend to clean carbon buildup on stove top;-Recommend to clean exterior (include top) of dish machine to remove debris build up;-Recommend cleaning food debris from bottom of reach-in freezer. Review of the kitchen inspection, conducted by the facility's registered dietitian on 7/25/25, showed the following items needed correction:-Recommend clean grease debris from hood vents and to clean hood vents weekly;-Recommend to clean food debris from exterior of dish machine;-Recommend to clean grease buildup on wall behind fryer and oven. Review of the facility's maintenance and inspection documentation showed the kitchen range hood six-month cleaning last occurred on 4/16/25. Observation on 8/4/25 at 9:07 A.M., in the kitchen and adjacent dining room, showed the following:-The food preparation sink and wall above it were splattered with dried brown, white, and gray-colored debris;-The two burner stove top had a thick layer of black encrusted debris across its surface;-There was a heavy accumulation of yellow drips on the wall behind and on the sides of the cooking equipment;-The range hood baffle filter above the fryer and flat-top griddle had a moderate accumulation of yellow grease;-The tops and sides of the dishwashing machine had a heavy accumulation of dried brown crusty debris;-The ice dispenser in the dining room had a heavy accumulation of dried white and brown drips and debris around the spout and dispensing mechanism. Observation on 8/5/25 at 1:43 P.M., in the south utility room refrigerator, showed sticky clear and brown residue on the shelves and in the bottom of the refrigerator. During an interview on 8/6/25 at 4:08 P.M., [NAME] V said a company cleaned the range hood. Facility staff did not clean the range hood baffle filters in between professional cleanings. During an interview on 8/6/25 at 2:33 P.M., the Dietary Manager said the area by the range and cooking equipment needed a deep cleaning. She would like staff to clean cooking equipment daily as staff had free time to clean the items. 4. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of the facility policy, Hair Restraints, dated 2020, showed the following:-Staff shall wear hair restraints in all food production, dishwashing, and serving areas;-Hair restraints, hats, and or beard guards shall be used to prevent hair from contacting exposed food. Observation on 8/4/25 at 10:57 A.M., in the kitchen, showed the Dietary Manager wore a hair restraint but the hair restraint did not cover two-inch sections of hair on the sides and back of her head. She covered individual bowls of cake with plastic and placed the bowls on a cart. Observation on 8/4/25 at 11:35 A.M., in the kitchen, showed the Dietary Manager wore a hair restraint but the hair restraint did not cover two-inch sections of her hair on the front, sides and back of her head. She stood by open bowls of cake and instructed staff to pour milk into some of the bowls for pureed food items. During an interview on 8/6/25 at 2:33 P.M., the Dietary Manager said she expected staff to properly wear hair restraints when in the kitchen. 5. Review of the facility policy, Storing Utensils, Tableware, and Equipment, dated 2020, showed the following:-Employees will store utensils, tableware, and equipment according to the following guidelines;-Cleaned and sanitized utensils and equipment will be stored at least six inches off the floor in a clean, dry location in a way that keeps them from contamination by splash, dust, or other means;-Cleaned and sanitized equipment and utensils should be handled in a way that protects them from contamination. Spoons, knives and forks should be touched only by their handles. Cups, glasses, bowls, plates, and similar items should be handled so as not to touch any surface that may come into contact with food or a resident's mouth;-Store flatware and utensils with handles up so employees can pick them up without touching food contact surfaces. Observation on 8/4/25 at 12:10 P.M., in the kitchen at the steam table, showed Dietary Aide Y served residents' plates of food for the lunch meal service. He/She obtained a plate from the plate warmer. The plate had dried green food debris on the eating surface of the plate. He/She served a resident's food items onto the plate and placed it on the cart of food trays to go to the resident halls. Observation on 8/4/25 at 9:07 A.M., in the kitchen beverage area, three pitchers had brown staining across their interior surface and one pitcher had a large amount of moisture accumulation on the interior surface. During an interview on 8/6/25 at 2:33 P.M., the Dietary Manager said she expected dishes to be in good condition and properly cleaned and sanitized between uses. She expected dishes to be stored clean and free of moisture. 6. Review of the Sanitizing Bucket Chemical Logbook, located in the kitchen, showed the following:-A log sheet for June 2025 was blank;-No log sheets for July 2025 or August 2025. Observation on 8/4/25 at 11:25 A.M., in the kitchen, showed the Dietary Manager washed her hands at the handwashing sink and carried the paper towel (she used to dry her hands and turn off the faucet handle) in her hand as she picked up a clean pan. She held the paper towel in the same hand as the clean pan and took the pan to the dining room ice dispenser where she filled the pan with ice. She returned to the kitchen, sat the pan of ice on the preparation counter, and obtained additional paper towels (she was still holding the previous paper towel). She then used the old and new paper towels to wipe down a three-tier cart in the food serving and preparation area of the kitchen. She did not use sanitizing spray, nor did she use a sanitizing cloth obtained from a bucket of sanitizing solution. During an interview on 8/6/25 at 4:08 P.M., [NAME] V said staff should log the pH level of the sanitizing bucket solution every two hours on the sanitizing bucket log. During an interview on 8/6/25 at 2:33 P.M., the Dietary Manager said she expected staff to clean surfaces using cloths stored submerged in buckets of sanitizing solution. Staff should monitor and record the pH of the sanitizing solution on the log sheet during their shift. 7. Observation on 8/4/25 at 2:13 P.M., in the kitchen dishwashing room, showed Dishwasher Y ate food from a bowl next to the clean dish area where clean dishes were drying. During an interview on 8/6/25 at 2:33 P.M., the Dietary Manager said staff should not eat in the kitchen or dishwashing room and should instead eat in the office within the kitchen or in the staff break room.

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to provide care in a manner that enhanced residents' dignity and ensured full recognition of individuality for one resident (Resident #72), in a review of 18 sampled residents, and three additional residents (Residents #26, #32 and #57). The facility census was 72. Review of the facility policy, Assistance with Meals, revised March 2022, showed the following:-Residents shall receive assistance with meals in a manner that meets the individual needs of each resident;-Facility staff will serve resident trays and will help residents who require assistance with eating;-Residents who cannot feed themselves will be fed with attention to safety, comfort, and dignity, - Do not stand over residents while assisting them with meals. 1. Review of Resident #26's Quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 05/22/25, showed the following:-Severely impaired cognitive skills for daily decision making;-Diagnoses of cerebral palsy (a condition marked by impaired muscle coordination (spastic paralysis) and/or other disabilities, typically caused by damage to the brain before or at birth) and quadriplegia (partial or total loss of function in all four limbs and torso); -Dependent on staff for eating. Review of the resident's Care Plan, dated 07/01/25 showed the following:-The resident will be assisted with ADLs and will have needs/wants met by staff;-Resident to be assisted with all meals/snacks/drinks-dependent with feeding/drinking. Observation on 08/04/25 at 12:10 P.M. in the dining room showed the following:-The resident sat in a reclining wheelchair;-Certified Nurse Assistant (CAN) H stood beside the resident while he/she fed the resident bites of pureed food. During an interview on 08/11/25 at 3:30 P.M., CNA H said he/she stood while feeding in the dining room to keep an eye on the other residents and to monitor for choking. 2. Review of Resident #32's Annual MDS, dated [DATE], showed the following:-Short and long-term memory problems;-Dependent on staff for eating;-Diagnosis of Alzheimer's disease (dementia). Review of the resident's Care Plan, revised 08/05/25, showed the following:-Provide set up, oversight, encouragement, cueing and assistance during eating and drinking;-Resident has a chewing problem related to cognition and was edentulous (no teeth);-Encourage resident to eat/drink during meals;-Resident requires assistance with eating. Observation on 08/04/25 at 12:05 P.M. in the dining room showed the following:-The resident sat in a reclining wheelchair at the table;-CNA B stood beside the table and fed the resident bites of pureed food. During an interview on 08/11/25 at 03:45 P.M., CNA B said the following: -Staff should probably sit next to a resident when they assisted residents; -Most of the staff, stood when they helped a resident to eat because several residents needed assistance, and staff did not want food to get cold. 3. Review of Resident #72's undated Continuity of Care Document (CCD), showed the following diagnoses included multiple sclerosis (MS, a progressive disease-causing damage to nerves), and dementia. Review of the resident's Care Plan, dated 03/06/23, showed the following: -Encourage the resident to eat/drink during meals;-The resident was still able to feed self at this time;-The resident had mild dysphagia (difficulty swallowing); -Regular diet with nectar thick liquids. Review of the resident's undated Physician Order Sheet (POS) showed finger foods to increase self-feeding/independence at meals, start date 03/31/25, open-ended (no stop date). Review of the resident's significant change MDS, completed by facility staff on 05/23/25, showed the following: -Severe cognitive impairment; -Partial to moderate assistance for eating; -Mechanically altered diet. Observation on 08/04/25 at 12:15 P.M. showed the following: -The resident sat in his/her wheelchair with his/her neck supported by a neck pillow at the dining room table; -The resident had a chicken salad sandwich and fried zucchini on his/her plate; a sealed container of apple sauce sate out of the resident's reach; -CNA B asked the resident if he/she wanted to be pulled up before CNA B started to feed the resident, the resident did not answer. -CNA B stood next to the seated resident, opened the container of applesauce, and fed the resident a few (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	bites of applesauce while standing;-CNA B did not speak to the resident further during the meal. During an interview on 08/11/25 at 06:00 P.M., the Director of Nurses (DON) said the following: -She would prefer staff to sit next to a resident when assisting a resident to eat; -Sitting next to a resident allowed for a better interaction with the resident. During an interview on 08/11/25 at 06:35 P.M., the Administrator said staff should sit next to a resident and not stand if a resident needed assistance to eat.

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure two residents (Residents # 27 and #72), in a review of 18 sampled residents, and one additional resident (Resident #26), were provided the right to choose schedules (including waking times) and make choices about aspects of their lives in the facility that were significant to the residents. The facility census was 72. Review of the facility policy, Quality of Life-Dignity, revised February 2020, showed the following:-Each resident shall be cared for in a manner that promotes and enhances his/her sense of well-being, level of satisfaction with life, feeling of self-worth and self-esteem;-Residents are treated with dignity and respect at all times;-The facility culture is one that supports and encourages humanization and individuation of residents and honors resident choices, preferences, values and beliefs. This begins with the initial admission and continues throughout the resident's facility stay;-Some examples of ways in which respect for choices and values are exercised include schedules. Residents may choose when to sleep, eat, and conduct activities of daily living. 1. Review of Resident #27's care plan, last revised 06/03/25, showed the following: -Resident needed assistance with ambulation, transfers and activities of daily living (ADLs); -Resident transfers with staff assistance and sit-to-stand lift; -Offer resident toileting and position changes throughout the day, as well as assisting resident to and from the dining room area at mealtimes; -The resident's care plan did address preference for waking time. Review of the resident's annual Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 07/02/25, showed the following: -Severe cognitive impairment;-No behaviors or rejection of cares; -Substantial to maximal assistance for toileting; -Dependent for personal hygiene; -Substantial to maximal assistance for mobility;-Diagnosis of cerebral vascular accident (stroke) with hemiplegia (loss of ability to move one side of the body or the other). Observation on 08/06/25 at 04:10 A.M. showed the following: -The resident lay in bed with both eyes closed and appeared to be sleeping; -The resident wore a pajama top; -The resident's room was dark and the hallway lights were turned down low. Observation on 08/06/25 at 05:05 A.M. showed the following: -Certified Nurse Assistant (CNA) A came out of the resident's room; -The resident was dressed and sat in his/her wheelchair beside the bed; -The resident's head was down with both eyes closed and appeared to be sleeping. Observation on 08/06/25 at 06:10 A.M. showed the following: -CNA A pushed the resident in his/her wheelchair to the television room on the south wing of the facility; -The resident's head was down with both eyes closed, and appeared to be sleeping; -The overhead lights and television were on. Observation on 08/06/25 at 07:10 A.M. showed the following: -The resident sat in his/her wheelchair in the television room on the south wing of the facility; -The resident's head was down with both eyes closed and appeared to be sleeping. Observation on 08/06/25 at 07:30 A.M. showed the following: -An unidentified staff pushed the resident in his/her wheelchair from the television room to the dining room; -The resident opened his/her eyes initially, but then closed them again and appeared to be sleeping. Observation on 08/06/25 at 08:00 A.M. showed the resident sat at the dining room table in his/her wheelchair with his/her eyes closed, head down, and appeared to be sleeping. Observation on 08/06/25 at 08:30 A.M. showed the following: -The resident sat in his/her wheelchair at the dining room table with his/her eyes closed, and appeared to be asleep; -An unidentified staff told the resident it was time to wake up and began to set up the resident's breakfast tray. During an interview on 08/06/25 at 05:30 A.M., CNA A said the following: -The resident was a one-person assist, so night shift staff could get the resident up and dressed; -Getting the resident up and dressed early in the day helped day shift. During an interview on 08/06/25 at 12:50 P.M., the resident's power of attorney (POA) said the following: -The resident used to get up early, but not as early as the facility woke him/her up; -The resident would probably have liked to stay in bed until a time closer to breakfast. 2. Review of Resident #72's (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	undated Continuity of Care Document (CCD), showed the resident's diagnoses included multiple sclerosis (MS, a progressive disease-causing damage to nerves) and dementia. Review of the resident's care plan, last revised 07/27/23, showed the following: -The resident required assistance with ADLs due to a diagnosis of MS; -The resident required assistance of one staff for morning cares, to include oral care, brushing hair, peri care and catheter care and deodorant; -The resident's care plan did not specify the resident's preference related to early rising. Review of the resident's significant change MDS, completed by facility staff, dated 05/23/25, showed the following: -Severe cognitive impairment; -No behaviors or rejection of cares; -Dependent for mobility. Observation on 08/06/25 at 04:10 A.M. showed the following: -The resident lay in his/her bed with eyes closed and appeared to be sleeping;-The resident wore a hospital gown. Observation on 08/06/25 at 07:10 A.M. showed the following: -The resident was dressed and sat in his/her wheelchair in the television room on the south wing of the facility; -The resident's eyes were closed and he/she appeared to be sleeping. Observation on 08/06/25 at 07:30 A.M. showed the following: -The administrator pushed the resident in his/her wheelchair from the television room to the dining room for breakfast; -The resident sat at the dining room table with his/her eyes closed and appeared to sleep. Observation on 08/06/25 at 08:30 A.M. showed the following: -The resident sat in his/her wheelchair at the dining room table, with his/her eyes closed and appeared to be sleeping; -Staff woke the resident up, set up his/her breakfast tray, and told the resident it was time to eat. During an interview on 08/06/25 at 11:52 A.M., the resident's family member said the following: -The resident was not typically an early riser; -He/She would prefer staff allow the resident to sleep later, unless there was a reason or need for the resident to get up. 3. Review of Resident #26's quarterly MDS, dated [DATE], showed the following:-Severely impaired cognitive skills for daily decision making;-No speech;-Diagnoses of cerebral palsy (a condition marked by impaired muscle coordination (spastic paralysis) and/or other disabilities, typically caused by damage to the brain before or at birth) and quadriplegia (paralysis of all four limbs);-Dependent on staff for eating, dressing, personal hygiene and bed to chair transfer;-Hospice care. Review of the resident's Care Plan, dated 07/01/25 showed the following:-The resident declined in physical abilities and ability to perform/assist with activities of daily living (ADLs) related to cerebral palsy/increased weakness;-Staff will assist the resident with ADLs and will meet the resident's needs/wants;-The resident's care plan did not specify the resident's preference related to early rising. Observation on 08/06/25 at 5:14 A.M. showed the following:-The resident lay in bed awake;-The resident was fully dressed;-A cloth mechanical lift pad was positioned underneath the resident in the bed. Observation on 08/06/25 at 5:27 A.M. showed the following:-The resident lay in bed with his/her eyes open;-Certified Nurse Aide (CNA) M and Certified Medication Technician (CMT) N hooked the lift pad up to the mechanical lift;-CNA M and CMT N transferred the resident from bed to his/her wheelchair. Observation on 08/06/25 at 7:05 A.M. at the nurses' station showed the following:-The resident sat in his/her wheelchair;-The resident was awake. Observations on 08/06/2025 in the dining room showed the following:-At 8:07 A.M., the resident sat in his/her wheelchair. Staff fed the resident breakfast; -At 8:16 A.M., staff finished feeding the resident breakfast;-At 8:25 A.M., the resident sat in his/her wheelchair in the dining room. The resident's eyes were closed. During an interview on 08/07/2025 at 11:11 A.M., the resident's representative said he/she thought getting the resident up around 5:00 A.M. was too early. During an interview on 08/06/25 at 5:27 A.M., CNA M said the following:-Staff (unknown name) directed him/her to get the resident up before he/she left at 7:00 A.M.; -He/She did not know if the resident preferred to get up early;-The resident was unable to verbalize his/her wants or needs. 4. During an interview on 08/11/25 at 6:05 P.M., the Director of Nursing (DON) said the following:-Staff should not wake a resident and get them up in the early morning if the resident was sleeping;-If the resident was cognitively impaired, the resident's representative should be asked about the resident's preference on rising. During an interview on 08/11/25 at 06:35 P.M., the administrator said the following: -Staff should not wake residents in the early morning hours if the resident was sleeping soundly; -If a (continued on next page)

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Loch Haven	701 Sunset Hills Dr Macon, MO 63552

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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 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	resident was cognitively impaired, staff should ask the resident's representative about the resident's preference on rising.

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F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Encode each resident?s assessment data and transmit these data to the State within 7 days of assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to electronically transmit a Minimum Data Set (MDS - a federally mandated assessment instrument completed by the facility staff) in a timely manner and in accordance with guidelines for one resident (Resident #18) in a review of 18 sampled residents and five additional residents (Resident #15, #25, #30, #32 and #36). The facility's census was 72. The facility did not provide a policy for MDS assessment and transmission upon request. Review of the Minimum Data Set (MDS, a federally mandated assessment instrument completed by facility staff) version 3.0 Resident Assessment Instrument (RAI) User's Manual, dated October 2024, showed the following: -For all non-admission assessments, the MDS completion date must be no later than 14 days after the Assessment Reference Date (ARD); -For the admission assessment, the MDS Completion Date must be no later than 13 days after the entry date;-Encoding Data: Within 7 days after completing a resident's MDS assessment or tracking record, the provider must encode the MDS data (i.e., enter the information into the facility MDS software). 1. Review of Resident ##15 MDS record showed the following:- admitted on [DATE];-Significant Change MDS completed on 05/23/25;-Significant Change MDS accepted on 08/01/25;-The facility did not transmit the MDS within 14 days of the completion date. 2. Review of Resident #18's MDS record showed the following:-admitted on [DATE];-Quarterly MDS completed on 06/26/25;-Quarterly MDS accepted on 08/01/25; -The facility did not transmit the MDS within 14 days of the completion date.3. Review of Resident #25's MDS record showed the following: -admitted on [DATE]; -Quarterly MDS completed on 06/25/25;-Quarterly MDS accepted on 08/01/25; -The facility did not transmit the MDS within 14 days of the completion date. 4. Review of Resident #30's MDS record showed the following: -admitted on [DATE]; -Quarterly MDS completed on 06/02/25; -Quarterly MDS accepted on 08/11/25; -The facility did not transmit the MDS within 14 days of the completion date. 5. Review of Resident #32's MDS record showed the following: -admitted on [DATE]; -Annual MDS completed on 06/20/25;-Annual MDS accepted on 08/01/25;-The facility did not transmit the MDS within 14 days of the completion date. 6. Review of Resident #36's MDS record showed the following: -admitted on [DATE]; -Quarterly MDS completed on 06/21/25;-Quarterly MDS accepted on 08/01/25; --The facility did not transmit the MDS within 14 days of the completion date. During an interview on 08/11/2025 at 02:15 P.M. and 06:00 P.M., the MDS Coordinator said the following: -She was the Director of Nurses (DON) for the facility and the only staff person on-site who submitted MDS information;-She tried to submit MDS information weekly and could usually get that done; -The facility did have some consultants off-site who helped with entering MDS information; -She did not always review the MDS information submitted by the consultant for accuracy before signing; -The facility should follow the RAI manual regarding completion and submission of MDS assessments. During an interview on 08/11/2025 at 06:35 P.M., the administrator said the facility should follow the RAI manual regarding completion and submission of MDS assessments.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. Based on observation, interview and record review, the facility failed to review and revise the care plan for two residents (Resident #2 and Resident #72) in a review of 18 sampled residents, to reflect the resident's specific condition and/or needs. The facility census was 72. Review of the facility policy, Goals and Objectives, Care Plans, revised 2009, showed the following: -Care plans shall incorporate goals and objectives that lead to the resident's highest obtainable level of independence; -Care plan goals and objectives are derived from information contained in the resident's comprehensive assessment and: -Are resident oriented; -Goals and objectives are entered on the resident's care plan so that all disciplines have access to such information and can report whether the desired outcomes are being achieved; -Goals and objectives are reviewed and/or revised when there has been a significant change in the resident's condition and at least quarterly.;-The policy did not define expectations for review and revision of care plans. 1. Review of Resident #2's quarterly Minimum Data Set (MDS, a federally mandated assessment instrument completed by facility staff), dated 06/28/25, showed the following: -Cognitively impaired; -Hallucinations/delusions and verbal behaviors directed at others; -Rejection of cares; -Supervision/touching for personal hygiene and toileting;-Independent for mobility; -Diagnosis Alzheimer's dementia (a group of brain disorders that cause a decline in cognitive abilities like memory, thinking, and reasoning, and ultimately interfere with daily activities). Review of the resident's progress notes showed staff documented the following:-On 05/11/25 at 09:33 A.M., the resident refused a shower yesterday and today. The resident's family member was called to assist with getting the resident to the shower. At first, the resident was compliant, but then said he/she would not take a shower. The resident was physically and verbally aggressive to staff, and punched, scratched and hit them; -On 07/15/25 at 08:37 A.M., the resident walked up and down the hallway a lot this morning and carried a big pile of books in one arm and a baby doll in the other. The resident dropped the books on the floor, and when care staff attempted to pick them up, the resident tried to hit staff; -On 07/16/25 at 02:39 A.M., the resident was agitated and was physically and verbally aggressive; -On 07/19/25 at 10:35 A.M., the resident's family called the facility about the resident's care. Attempted to assist care staff with activity of daily living (ADLs), but the resident was noncompliant and combative with staff. The resident hit staff with a hanger and told him/her to get out, and that he/she did not want help. Observation on 08/04/25 at 09:50 A.M. showed the following: -A sign that read Security Camera in Use posted on the resident's door; -The resident sat on the edge of the bed and said in an agitated, high-pitched voice, What are you doing here! You were looking through my stuff! Review of the resident's care plan, revised 08/05/25, showed the following: -The resident was limited in ability to maintain grooming/personal hygiene related to dementia and not always cooperative with cares; -May have to use approach It's time to do our teeth as not always compliant with staff assistance. Review of the resident's care plan did not reflect the resident hallucinated and/or had delusions, verbal and/or physical behaviors, or that the resident had a security camera/device in use. During an interview on 08/07/25 at 08:47 A.M., Registered Nurse (RN) D said the following: -The resident had behaviors, called staff (derogatory) names, wandered into other resident's rooms, hit staff, and routinely refused cares; -The resident's family had a video device put in the resident's room to help monitor his/her care;-The family refused medications for behaviors so staff tried to learn the resident's patterns and do the best they could. ??????2. Review of Resident #72's undated Continuity of Care Document (CCD), showed the resident's diagnoses included multiple sclerosis (MS, a progressive disease-causing damage to nerves) and dementia. Review of the resident's Care Plan, dated 07/27/23, showed the following: -The resident had a diagnosis of MS and required assistance with cares; -The resident had a trapeze bar (a medical device attached to a frame above a bed, designed to assist residents who could use the upper body, with mobility and positioning in bed) to assist with (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	transfers; -The resident used an electric wheelchair and was independent with locomotion;-Stand-up lift (also known as a sit to stand, a device used to transfer residents who can bear weight with the transition) used for transfers. Review of the resident's significant change MDS, completed by facility staff, dated 05/23/25, showed the following: -Severe cognitive impairment; -Used a wheelchair; -Dependent for mobility;-No falls since admission/re-entry or prior assessment. Review of the resident's Care Plan, last revised 05/27/25, showed the following: -The resident was at risk for falls related to dementia and decreased functional status related to MS diagnosis; -Remind resident not to transfer without assistance and remind him/her to use call light to ask for assistance; -Staff to use stand up lift for transfers. Observation on 08/04/25 at 09:50 A.M. showed the following: -The resident was out of the room; -A mechanical lift sling lay across the resident's bed; -A mechanical lift was positioned next to the resident's bed; -The resident's bed did not have a trapeze bar or frame attached to it. During an interview on 08/07/25 at 10:10 A.M. and 08/11/25 at 03:45 P.M., Certified Nurse Assistant (CNA) B said the following: -The resident used to be a sit-to-stand transfer but required the use of a mechanical lift for some time now; -The resident was unable to use a trapeze bar to assist him/her in bed for about one year now due to his/her physical decline; -He/She just knew the resident required a mechanical lift for transfers because he/she knew the resident well. During an interview on 08/11/25 at 04:00 P.M., CNA U said the following: -He/She just started working at the facility; -To find the transfer status of a resident, he/she could ask the charge nurse or check the care plan in the electronic medical record (EMR). 3. During an interview on 08/11/25 at 02:15 P.M. and 06:05 P.M., the Director of Nurses (DON) said the following: -Resident #2 had behaviors (refusal of care, verbal and physical interactions with staff) pretty much since his/her admission;-Resident #2's family requested a video device for his/her room and called frequently to check on the resident based on what he/she was doing or when the resident was not seen on camera; -Resident # 72 required a mechanical device for transfers and had not used a sit-to-stand for some time; she was not aware the resident had had a trapeze in the past;-A residents' care plans should reflect the specific problems, goals and interventions for each resident, and be updated routinely and as needed. During an interview on 08/11/25 at 06:35 P.M., the Administrator said that a resident's care plan should be updated routinely and as needed, and should reflect the specific problems, goals and interventions for each resident.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 chemicals were secured in a locked storage area and not accessible to residents. The facility failed to ensure the electric range, located in the north activity room was disabled when not in use and staff were not present. The facility census was 72. 1. Review of Resident #62's admission Minimum Data Set (MDS, a federally mandated assessment instrument completed by facility staff), dated 06/17/25, showed the following: -Cognitively impaired; -Diagnosis of non-Alzheimer's dementia (a group of conditions causing cognitive decline, impacting memory, thinking and behavior, that are not due to Alzheimer's disease). Observation on 08/06/25 at 4:10 A.M. on the 400 hall showed the following:-The shower room door was unlocked and accessible to residents;-No staff was present in the area;-Resident #62 walked up and down the hallway; -Two bottles of Lysol disinfectant cleaner sat on the floor by the toilet. The label read, Warning: Causes substantial but temporary eye injury. Prolonged or frequently repeated skin contact may cause allergic reactions in some individuals. Do not get in eyes, on skin or on clothing. Storage and disposal: Store in areas inaccessible to children; -Two bottles of window cleaner sat on the floor by the shower stall. The label read, KEEP OUT OF REACH OF CHILDREN AND PETS;-A bottle of non-acetone nail polish remover sat on the shelf by the sink. The label read, Warning: Extremely flammable. Liquid and vapors may ignite. Keep out of eyes. Harmful if ingested. Keep out of reach of children;-A bottle of High Disinfecting Quotient (HDQ) disinfectant cleaner (hospital disinfectant cleaner and deodorant formulated to kill a broad spectrum of microorganisms) sat on the counter by the whirlpool tub. The label read, KEEP OUT OF REACH OF CHILDREN. DANGER. Observation on 08/07/25 at 05:35 P.M. on the 400 hall showed the following:-The shower room door was unlocked and accessible to staff and residents; -Two bottles of Lysol disinfectant cleaner sat on the floor by the toilet; -Two bottles of window cleaner sat on the floor by the shower stall;-A bottle of non-acetone nail polish remover sat on the shelf by the sink;-A bottle of High Disinfecting Quotient (HDQ) disinfectant sat on the counter by the whirlpool tub. 2. Observation on 8/4/25 at 9:48 A.M. showed a lower cabinet in the special care unit kitchenette was unlocked. Five residents were in the day room next to the kitchenette. The following items were located within the unlocked cabinet: -One bottle of bleach with a label that read, ?Danger: Corrosive. Causes irreversible eye and skin damage. May be fatal if swallowed. Hazards to humans and domestic animals. Physical and chemical hazards: strong oxidizing agent;' -One bottle of carpet and upholstery shampoo with a label that read, 'Caution: Keep out of reach of children. Harmful if swallowed. Causes eye irritation'; -One bottle of all-purpose cleaner with a label that read, 'Warning: Keep out of reach of children. Store in areas inaccessible to children. Hazards to humans and domestic animals. Warning: Causes substantial but temporary eye injury. Do not get in eyes, on skin or clothing'; -One bottle of peroxide disinfectant with a label that read, 'Caution: Keep out of reach of children. Causes eye irritation. Harmful if inhaled'. Observation on 08/04/25 at 11:57 A.M. on the Special Care Unit showed the lower cabinet, which contained cleaning chemicals, in the special care kitchenette remained unlocked. Four residents were at the kitchen table in this area. 3. Observation on 8/4/25 at 9:36 A.M., in the north activity room, showed the following: -A bag of fertilizer spikes, with a label that read, 'Keep out of reach of children and pets,' was in an unlocked drawer;-A sign above the electric range read, 'Stove must be turned off at the breaker box in closet after each use.' The range was able to be turned on. Three residents sat in the room, and no staff were present. During an interview on 8/6/25 at 3:49 P.M., the Activities Director said the breaker to the stove in the north activity room should be turned off after each use. She was unaware the breaker had not been turned off after the stove was used last. She was unaware the fertilizer spikes were unlocked. 4. Observation on 8/4/25 at 10:11 A.M., in room [ROOM NUMBER] (used for storage), located near the beauty shop and therapy department, (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	showed three bottles of toilet bowl cleaner with labels that read, 'Store in areas inaccessible to children. Hazardous to humans and domestic animals. Corrosive can cause severe burns. May be fatal if swallowed. Keep out of reach of children. Can cause severe eye damage.' The room was unlocked, and no staff were in or near the room. 5. During an interview on 8/7/25 at 8:43 A.M., the Maintenance Director said chemicals and hazardous materials should be secured or locked from resident access. He was unaware of the items found unsecured and unlocked. During an interview on 08/11/25 at 6:05 P.M., the Director of Nursing (DON) said chemicals should be locked and inaccessible to residents. During an interview on 08/11/25 at 6:35 P.M., the Administrator said chemicals should be locked and inaccessible to residents.

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. Based on interview and record review, the facility failed to ensure that a Registered Nurse (RN) was on duty for at least eight consecutive hours a day, seven days a week and failed to ensure the Director of Nursing (DON) worked as a charge nurse only when the facility had a census of 60 or less. The facility census was 72. 1. Review of the Facility Assessment, dated 07/09/25 showed the following:-Average daily census: 70;Staff included one Registered Nurse, Director of Nurses full time on days, an Assistant Director of Nursing (ADON) full time on days, and an RN or Licensed Practical Nurse (LPN), two for the day shift and one for night shift. 2.Review of the Licensed Nurse Schedule, dated January 2025, showed no hours of RN coverage for 01/01/25. Review of the Licensed Nurse Schedule, dated 01/07/25, showed no hours of RN coverage scheduled. Review of RN R's timecard, dated 01/07/25, showed he/she worked six hours and 45 minutes (did not fulfill the eight-hour requirement). 3.Review of the Census Activity Report, dated 01/11/25, showed the facility census was 68. Review of the Licensed Nurse Schedule, dated 01/11/25, showed the DON was scheduled to work 7:00 P.M. to 7:00 A.M. (12 hours). Review of the Daily Schedule, dated 01/11/25, showed the following:-Two LPNs worked 7:00 A.M. to 7:00 P.M.;-The DON worked 6:49 P.M. to 7:31 A.M. as charge nurse. 4. Review of the Census Activity Report, dated 01/12/25, showed the facility census was 68. Review of the Licensed Nurse Schedule, dated 01/12/25, showed the DON was scheduled to work 11:00 P.M. to 7:00 A.M. (8 hours). Review of the Daily Schedule, dated 01/12/25, showed the following:-Two LPNs worked 7:00 A.M. to 7:00 P.M.;-The DON worked 10:54 P.M. to 9:09 A.M. as charge nurse. 5. Review of the Licensed Nurse Schedule, dated January 2025, showed no hours of RN coverage for 01/17/25. 6. Review of the Licensed Nurse Schedule, dated 01/25/25, showed no hours of RN coverage scheduled. Review of the DON's timecard, dated 01/25/25, showed she worked six hours and 30 minutes (did not fulfill the eight-hour requirement). 7. Review of the Licensed Nurse Schedule, dated January 2025, showed no hours of RN coverage for 01/26/25. 8. Review of the Licensed Nurse Schedule, dated 01/29/25, showed no hours of RN coverage scheduled. Review of RN R's timecard, dated 01/29/25, showed he/she worked seven hours and 35 minutes (did not fulfill the eight-hour requirement). 9. Review of the Licensed Nurse Schedule, dated 02/08/25, showed no hours of RN coverage scheduled. Review of the DON's timecard, for 02/08/25, showed she worked six hours and 15 minutes (did not fulfill the eight-hour requirement). 10. Review of the Licensed Nurse Schedule, dated 02/09/25, showed no hours of RN coverage scheduled. Review of the DON's timecard, for 02/09/25, showed she worked six hours and 15 minutes (did not fulfill the eight-hour requirement). 11. Review of the Licensed Nurse Schedule, dated February 2025, showed no hours of RN coverage for 02/28/25. 12. Review of the Licensed Nurse Schedule, dated 03/04/25, showed no hours of RN coverage scheduled. Review of RN R's timecard, dated 03/04/25, showed he/she worked six hours and 45 minutes (did not fulfill the eight-hour requirement). 13. Review of the Licensed Nurse Schedule, dated March 2025, showed no hours of RN coverage for 03/14/25 and 03/28/25. 14. Review of the Licensed Nurse Schedule, dated May 2025, showed no hours of RN coverage for 05/23/25. 15. Review of the Licensed Nurse Schedule, dated 05/26/25, showed no hours of RN coverage scheduled. Review of RN R's timecard, dated 05/26/25, showed he/she worked seven hours and 15 minutes (did not fulfill the eight-hour requirement). 16. Review of the Licensed Nurse Schedule, dated June 2025, showed no hours of RN coverage on 6/28/25 and 06/29/25. 17. Review of the Licensed Nurse Schedule, dated 07/08/25, showed no hours of RN coverage scheduled. Review of the RN Consultant's timecard, dated 07/08/25, showed he/she worked six hours and 15 minutes (did not fulfill the eight-hour requirement). 18. Review of the Licensed Nurse Schedule, dated 07/12/25, showed no hours of RN coverage scheduled. Review of the DON's timecard, for 07/12/25, showed she worked five hours (did not fulfill the eight-hour requirement). 19. Review of the Licensed Nurse Schedule, dated 07/13/25, showed no hours of RN coverage scheduled. Review of the DON's (continued on next page)

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	timecard, for 07/13/25, showed she worked six hours (did not fulfill the eight-hour requirement). 20. Review of the Licensed Nurse Schedule, dated 07/18/25, showed no hours of RN coverage. 21. Review of the Licensed Nurse Schedule, dated 07/25/25, showed no hours of RN coverage scheduled. Review of the DON's timecard, for 07/25/25, showed she worked seven hours (did not fulfill the eight-hour requirement). 22. Review of the Licensed Nurse Schedule, dated 07/26/25, showed no hours of RN coverage scheduled. Review of the DON's timecard, for 07/26/25, showed she worked two hours and 45 minutes (did not fulfill the eight-hour requirement). 23. Review of the Licensed Nurse Schedule, dated July 2025, showed no hours of RN coverage on 07/31/25. 24. During an interview 08/11/25 at 6:04 P.M., the DON said the following:-Human Resources (HR) was responsible for the licensed nurse schedule;-The facility only had four RNs;-She was never scheduled to work as a charge nurse. She covered when there were call-ins. During an interview on 08/11/25 at 6:30 P.M., the Administrator said the following:-HR was responsible for ensuring RN coverage eight hours a day;-The facility tried to have an RN on duty eight hours a day;-Recently they had one RN out on medical leave and there were no agency RNs available;-The DON covered as charge nurse in emergency situations only.

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	265200	A. Building B. Wing	08/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Loch Haven	701 Sunset Hills Dr Macon, MO 63552

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observe each nurse aide's job performance and give regular training. Based on interview and record review, the facility failed to complete a performance review of each nurse aide at least once every 12 months and provide regular in-service education based upon the outcome of the reviews. The facility census was 72. The facility did not provide a policy for annual performance reviews. 1.Review of a list of current staff, dated 08/05/25 showed the following:-Certified Nurse Aide (CNA) I: Date of hire 04/15/09;-CNA J: Date of hire 07/03/23;-CNA H: Date of hire 07/04/07;-CNA B: Date of hire 10/20/22;-CNA L: Date of hire 02/10/11. Record review showed no documentation of nurse aide evaluations or annual performance reviews for CNA B, CNA H, CNA I, CNA J or CNA L. During an interview on 08/11/25 at 6:04 P.M., the Director of Nursing (DON) said the following:-Nurse aide evaluations/annual performance reviews had not been completed for a while;-If there were complaints regarding staff performance or skills, the Registered Nurse (RN) Consultant proved additional training to that staff member. During an interview on 08/11/25 at 6:30 P.M. the Administrator said the facility did not have nurse aide evaluations or annual performance reviews.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. Based on observation, interview, and record review, the facility failed to provide food at an appetizing temperature. The facility census was 73. Record review of the facility policy, Serving Temperatures for Hot and Cold Foods, revised 2020, showed the following: -Food will be served at the following temperatures to ensure a safe and appetizing dining experience: -Vegetables - 135 degrees Fahrenheit (F) to 170 degrees F; -Fruits, desserts, and dairy products - 41 degrees F or below; -The cook will take temperatures of hot and cold food items using approved food thermometers prior to each meal service. Food temperatures will be recorded. 1. Review of food temperature logs, located in the kitchen, for all meals (breakfast, lunch, dinner) for 8/1/25, 8/2/25, and 8/3/25 were blank. 2. Review of the Diet Orders, printed 8/4/25, showed the following: -57 residents with a physician-ordered regular diet; -Nine residents with a physician-ordered mechanical soft diet; -Five residents with a physician-ordered pureed diet; -Two residents with a physician-ordered finger foods diet. 3. Observation on 8/4/25 from 4:30 P.M. to 5:16 P.M., in the kitchen at the steam table at the dinner meal service, showed Dietary Aide Y served food items onto residents' plates, added a plate cover to each plate, and placed the food items onto trays on a cart to be transported to each resident hall. He/She included a test tray of food items on the south hall cart. Observation on 8/4/25 from 5:17 P.M. to 5:32 P.M., staff served trays of food from the kitchen food cart to residents on the south hall (300-400 halls). Once all residents were served, the test tray was taken from the cart to be tested. Observation on 8/4/25 at 5:33 P.M., of the food items and food temperatures tested on the south hall test tray, showed the regular green beans were 116.6 and tasted cool. Review of food temperature logs, located in the kitchen, for the 8/4/25 dinner meal, showed the following: -Meal Service Holding Temperature (placed into steam table): Regular green beans were 190 degrees F; -Meal Service Holding Temperature (prior to serving from steam table): Regular green beans were 187 degrees F; 3. Review of food temperature logs, located in the kitchen, for 8/4/25 lunch meal, showed the following: -Final Internal Preparation Temperature: -Chicken salad cold plate: 39 degrees; -Regular and pureed cottage cheese and fruit plate: no temperatures were recorded. Observation on 8/4/25 from 11:40 A.M. to 12:17 A.M., in the kitchen at the steam table at the lunch meal service, showed Dietary Aide Y served food items onto residents' plates, added a plate cover to each plate, and placed the food items onto trays on a cart to be transported to each resident hall. Dietary Aide W and the Dietary Manager served food items onto plates that were served to residents in the adjacent dining room. Observation on 8/4/25 at 12:18 P.M., after all residents were served food on the resident halls and in the dining room, Dietary Aide Y prepared a test tray of food items. Observation on 8/4/25 at 12:19 P.M., of the food items and food temperatures on the test tray, showed the following: -The regular cottage cheese and fruit plate was 56.1 degrees F and tasted warm;-The chicken salad cold plate was 46.4 degrees F and tasted lukewarm;-The pureed cottage cheese and fruit plate was 45.7 degrees F and tasted lukewarm. Review of the recipes, for food items served on 8/4/25 at the lunch meal, showed the following:-Chicken salad cold plate: maintain less than 40 degrees F;-Pureed cottage cheese and fruit plate: maintain at 41 degrees F or below. During an interview on 08/05/25 at 11:06 A.M., Resident #50 said the following: -He/She usually ate in his/her room, when meal trays were served, the coffee was never hot; -Staff were often stopped when delivering meal trays and asked to do another task, so his/her food was often cold when served; -Last week his/her milk was clabbered, staff served another one and it was sour; -He/She had seen milk cartons sitting out for over 45 minutes; -Staff did not pay attention to keeping liquids and food at the right temperatures. 4. Review of food temperature logs, located in the kitchen, for the 8/6/25 lunch meal, showed no temperatures recorded in the Final Internal Preparation Temperature, Meal Service Holding Temperature (placed into steam table) or Meal Service Holding Temperature (prior to serving from steam table) columns. Observation on 8/6/25 at 12:19 P.M., after all residents were served the lunch meal, of food items and temperatures on the test tray, showed the following:-Ranch dressing 73 degrees F;-Tiramisu pudding cup: 51.4 (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	degrees F;-Milk: 47.8 degrees F. Review of the recipe for Tiramisu pudding cup, served on 8/6/25 at the lunch meal, showed the food item should be maintained at 41 degrees F or below. 5. During interviews on 8/6/25 at 2:05 P.M. and at 4:08 P.M., [NAME] V said the following: -Staff should serve residents hot food items at a temperature between 145-160 degrees F; -Staff should serve residents cold food items at a temperature under 39 degrees F; -Staff should fill out the temperature log in the kitchen after food items are put into the steam table and prior to serving food items from the steam table. During an interview on 8/6/25 at 2:33 P.M., the Dietary Manager said she expected the temperature of hot food items to be 145-150 degrees F and cold food items 40 degrees F or below when served to residents.

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F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure meals and snacks are served at times in accordance with resident?s needs, preferences, and requests. Suitable and nourishing alternative meals and snacks must be provided for residents who want to eat at non-traditional times or outside of scheduled meal times. Based on observation, interview and record review, the facility failed to ensure staff offered a nourishing bedtime snack to two residents (Resident #6 and Resident #11) in a review of 18 sampled residents and two additional residents (Resident #25 and Resident #50) when meals were served greater than 14 hours apart. The facility census was 72. The facility did not provide a policy for frequency of meals or bedtime snacks upon request. 1. Review of the undated Meals and Memories Cafe Mealtimes, posted by the dining room, showed the following:-Breakfast: 7:30 A.M. to 8:30 A.M.;-Lunch: 11:30 A.M. to 12:30 P.M.;-Supper: 4:30 P.M. to 5:30 P.M. (14 hours between the supper and breakfast meals). 2. Observation and interview of the facility resident council meeting on 08/05/25 at 11:00 A.M. showed the following: -Ten residents attended the meeting; -Some of the residents said they didn't receive routine snacks at bedtime. 3. During an interview on 08/05/25 at 11:06 A.M., Resident #11 said the following:-He/She did not routinely receive a bedtime snack;-He/She would take a bedtime snack if it was offered. 4. During an interview on 08/05/25 at 11:06 A.M., Resident #25 said the staff did not offer a bedtime snack. 5. During an interview on 08/05/25 at 11:06 A.M., Resident #50 said the following: -He/She did not routinely receive a bedtime snack;-He/She would take a bedtime snack if staff offered one. 6. During an interview on 08/07/25 at 8:35 A.M., Resident #6 said the following: -Staff did not offer a bedtime snack; -He/She would like staff to offer a bedtime snack routinely; sometimes he/she got hungry. 7. Observation on 08/11/25 at 04:00 P.M. showed the following food items/snacks in the south clean utility refrigerator: five (leftover) beef brisket sandwiches from lunch, dated 08/11, two single packs of saltine crackers, four individual containers of thickened apple juice, four individual containers of peaches, six ice cream sandwiches, three fudge bars and 20 individual containers of sherbert. 8. During an interview on 08/07/25 at 02:30 P.M., the Dietary Manager said the following: -The kitchen staff routinely provided evening snacks; -Items available for residents included peanut butter and jelly sandwiches, ham and cheese sandwiches, ice cream, yogurt, fresh fruit, and left-over fruit cups (if any) from supper; -The snacks were prepared in the kitchen, and were kept in the clean utility room refrigerators on each hall (north and south) and on the special care unit (SCU); -Nursing staff had access to snacks for the residents from the clean utility room refrigerators, and they also had a key to the kitchen if needed; -Residents would have to go to the nurses' station to request a snack;-If a resident could not go to the nurses' station, nursing staff could take a snack to the resident's room if the resident asked for one; -Some residents had refrigerators in their rooms with their own snacks available. During an interview on 08/07/25 at 02:35 P.M., Certified Medication Technician (CMT) C said the following: -The facility used to have a snack cart that went out between 07:00 P.M. and 08:00 P.M., that had multiple types of snacks on it, including hard cooked eggs), cookies and fruit, but it had not been offered to residents routinely for some time; -Residents had to request a bedtime snack if they wanted one; -If a resident did not know to ask for a snack, or was unable to ask for a snack, they would go without; -Staff did not routinely go from room to room to see if a resident wanted a snack. During an interview on 08/07/25 at 05:25 P.M., CMT E said the following: -He/She usually worked from 05:00 P.M. to 05:00 A.M.; -He/She was not familiar with staff offering bedtime snacks to residents in the evening hours; -If a resident was hungry, he/she could ask for a snack, or some residents had refrigerators in their rooms and kept their own snacks. During an interview on 08/11/25 at 06:05 P.M., the Director of Nursing (DON) said the following: -Bedtime snacks should be offered to all residents and immediately available for staff; -Food was available for residents in the clean utility room and the kitchen. During an interview on 08/11/25 at 06:35 P.M., the administrator said staff should offer bedtime snacks to all residents and snacks should be immediately available for staff to obtain and pass.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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, the facility failed to ensure staff performed hand hygiene in accordance with acceptable standards of practice to prevent the spread of infection for three residents (Residents #3, #40 and #45). The facility failed to ensure staff utilized Enhanced Barrier Precautions (EBP), as required by facility policy, when repositioning to one resident (Resident #6), who had a pressure ulcer with infection. The facility failed to ensure catheter drainage bags and tubing were kept off the floor to prevent risk of contamination for two residents (Residents #3 and #72), and failed to ensure nebulizer and bilevel positive airway pressure (BiPAP; a non-invasive ventilation method that delivers pressurized air to help individuals with breathing difficulties) masks were stored in accordance with facility policy for three residents (Residents #6, #11, and #3), in a review of 18 sampled residents. The facility census was 72. Review of the facility's undated Infection Control Policy showed it is the policy of the facility to use the manual Infection Control for Long Term Care Facilities in Missouri, as well as Center for Disease Control Guidelines. Body fluid precautions must be followed in all resident services. Review of Infection Control for Long Term Care Facilities: Emphasis on Body Substance Precautions, dated January 2025, showed the following:-Implementing the body substance precautions system should be always followed by all personnel regardless of the resident's diagnosis;-Gloves must be changed between contact with different body sites of the same resident;-Dirty gloves are worse than dirty hands because microorganisms adhere to the surface of the gloves easier than to the skin on your hands. Handling medical equipment and devices with contaminated gloves is not acceptable;-Wash hands whenever they are soiled with body substances and when each resident's care is completed;-Clostridium difficile (C. diff; a bacteria that causes diarrhea and inflammation of the colon) can persist in the environment for months and is highly resistant to cleaning. Handwashing is the single most important means of preventing transmission of this disease. Body Substance Precautions should be used. Review of the facility policy, Handwashing/Hand Hygiene, dated 2001, showed the following: -The facility considers hand hygiene the primary means to prevent the spread of infections; -All personnel shall follow the handwashing/hand hygiene procedures to help prevent the spread of infections to other personnel, residents, and visitors; -Use of an alcohol-based hand rub containing at least 62% alcohol, or alternatively, soap (antimicrobial or non-antimicrobial) and water for the following situations: -Before and after direct contact with residents; -Before moving from a contaminated body site to a clean body site during resident care; -After contact with a resident's intact skin; -After contact with blood or bodily fluids; -After removing gloves; -The use of gloves does not replace hand washing/hand hygiene. Review of the facility's undated policy, Enhanced Barrier Precautions (EBP), showed the following: -Enhanced Barrier Precautions refers to an infection control intervention designed to reduce transmission of multidrug-resistant organisms (MDROs) that employs targeted gown and glove use during high contact resident care activities; -The facility will ensure staff are trained in EBP and will maintain sufficient supplies to support implementation of EBP. EBP is used in conjunction with standard precautions and expand the use of Personal Protective Equipment (PPE) to donning of gown and gloves during high-contact resident care activities that provide opportunities for transfer of MDROs to staff's hands and clothing; -EBP are indicated for residents with any of the following: -Wounds and/or indwelling medical devices, even if the resident is not known to be infected or colonized with a MDRO; -Wounds generally include chronic wounds, not shorter-lasting wounds, such as skin breaks or skin tears covered with an adhesive bandage (i.e.: Band-Aid) or similar dressing. Examples of chronic wounds include, but are not limited to, pressure ulcers, diabetic foot ulcers, unhealed surgical wounds, and venous stasis ulcers; -For residents for whom EBP are indicated, EBP is employed when performing the following high-contact resident care activities: Transferring and changing linens. Review of the facility policy, Respiratory Care Process, dated 03/03/22, showed the (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	following: -The following process is designed to provide consistent care of respiratory equipment and supplies used by residents receiving oxygen therapy and inhalation nebulizer therapy. It is everyone's responsibility to maintain the integrity of the respiratory supplies used by the residents of this facility;-Nasal cannula (a thin, flexible tube used to deliver oxygen or other gases directly into the nostrils) will be stored in clean zip lock bag that has been attached to equipment or near equipment when not in use by a resident; this includes portable oxygen tanks. This is done to protect the integrity and cleanliness of the cannulas; -Inhalation nebulizer equipment shall be rinsed of residue and stored in a zip lock bag near equipment between uses. This is done to protect the integrity and cleanliness of the nebulizer mask and chamber. 1. Review of Resident #3's Care Plan, dated 07/01/25, showed the following:-The resident had C. diff;-The resident had a urinary catheter (a flexible tube inserted into the bladder to drain urine) for urinary retention (inability to completely empty the bladder);-The resident needed assistance from two staff with most of his/her activities of daily living (ADLs) due to his/her history of strokes with right side paralysis (the loss of muscle function in part or all the body);-The resident needed two staff to assist with dressing, undressing and peri-care;-He/She was incontinent of bowel and needed to be changed when soiled. Review of the resident's admission Minimum Data Set (MDS, a federally mandated assessment instrument, required to be completed by facility staff), dated 07/02/25, showed the following:-Severe cognitive impairment;-Lower and upper extremity impairment on one side;-Dependent on staff for toileting hygiene and to roll left and right;-Indwelling urinary catheter;-Always incontinent of bowel;-Urinary tract infection (UTI; an infection in any part of the urinary system) last 30 days;-Diagnosis of stroke;-Isolation or quarantine for active infectious disease. Observation on 08/04/25 at 3:19 P.M. showed the following:-The resident lay away in bed;-The resident's BiPAP mask was uncovered and lay directly on the bedside table;-The resident's urinary drainage bag lay directly on the floor beside the resident's bed;-There was dark yellow urine with sediment (normal straw yellow without sediment) present in the urinary drainage bag and catheter tubing. Observation on 08/06/25 at 4:24 A.M. showed the following:-The resident lay awake in bed;-Certified Nurse Aide (CNA) A applied alcohol-based hand rub (ABHR), a gown and gloves;-CNA A entered the resident's room;-The resident was incontinent of loose feces;-CNA A provided front peri care with disposable wipes, assisted the resident to roll to his/her right side, and provided rectal peri care;-CNA A removed his/her gloves and gown and applied ABHR to his/her hands;-CNA A exited the resident's room;-CNA A returned to the resident's room and put on a clean gown and gloves;-CNA A placed a clean incontinence brief and cloth pad under the resident's buttocks and rolled the resident to his/her left side;-CNA A removed the soiled incontinence brief and cloth pads from under the resident and provided rectal peri care;-Feces was visible on the disposable wipes;-Without changing gloves and performing hand hygiene, CNA A pulled the clean incontinence brief and linens under the resident's buttocks, picked up and moved the resident's urinary catheter drainage bag and tubing, fastened the incontinence brief, and removed the resident's gown;-Wearing the same gloves he/she wore to clean feces from the resident's skin, CNA A placed a clean gown on the resident, picked up and bagged the soiled linens, and picked up and moved the urinary catheter drainage bag to the side of the bed. CNA A touched the bed control, changed the resident's bedsheet, touched, and moved the resident's wheelchair, opened the bathroom door, picked up the urinal, and opened up the spout on the resident's urinary drainage bag. CNA A emptied the urine into the urinal, cleaned the spout on the drainage bag with an alcohol pad, emptied the urine into the toilet, flushed the toilet and shut the bathroom door;-CNA A removed his/her gown and gloves, applied ABHR and exited the resident's room. 2. Review of Resident #6's undated Continuity of Care Document (CCD) showed the resident's diagnoses included chronic obstructive pulmonary disease (COPD, a group of lung diseases that block airflow and make it difficult to breath), hemiplegia (paralysis of one side of the body) and hemiparesis (weakness on one side of the body), and unspecified wound left buttock. Review of the resident's care plan, dated 05/19/25, showed the following: -The resident had a stage four pressure ulcer (full thickness tissue loss with (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	exposed bone, tendon, or muscle);-The resident had actual symptoms related to emphysema/COPD; -Respiratory therapy: nebulizer treatments as ordered. Review of the resident's quarterly MDS, dated [DATE], showed the following: -Cognitively intact; -Substantial to maximum assist for mobility;-Stage four pressure ulcer; -Oxygen use. Review of the resident's August 2025 physician order sheet (POS), showed the following: -Dakin's Solution (a topical antiseptic used to treat and prevent infections from wounds, burns, and surgery), small amount, 1/4 strength Dakin's wet-to-dry (dressing) two times a day, lightly pack wound making sure to get in the 2 o'clock tunnel (may use two-inch Kling for this). Clean wound with wound cleanser and secure with Medipore tape (a comfortable, breathable soft cloth medical tape). May use 1/2 strength as provided by pharmacy and dilute with one-part sterile water with one part Dakin's twice daily at 07:00 A.M. and 07:00 P.M. (order start date 07/17/25); -Ipratropium albuterol solution (a medication used to help control the symptoms of lung diseases such as COPD, used to treat air-flow blockage) for nebulization (the process of converting a liquid medication into a fine mist that can be inhaled) 0.5 milligram (mg)/3 milliliters (ml), inhalation, four times a day at 05:00 A.M., 11:00 A.M., 05:00 P.M., and 11:00 P.M., (order start date 08/01/22). Observation on 08/04/25 at 10:15 A.M. showed the following: -An enhanced barrier precaution (EBP)) was posted on the resident's door; -There was a three-drawer plastic container outside the resident's room that contained gloves, masks, and gowns;-A nebulizer face mask lay on the resident's nightstand and was not covered; -CNA B and Certified Medication Technician (CMT) C entered the resident's room, washed their hands, and donned gloves;-Neither CNA B nor CMT C put on a gown; -CMT C pulled down the resident's covers and assisted CNA B to pull the resident up and over to the right side in bed using the draw sheet beneath the resident; -CNA B leaned across the resident, rolled the resident onto his/her left side using the draw sheet under the resident; -CNA B's uniform touched the resident's clothing and bedding; -CMT C straightened the linens beneath the resident, then propped a pillow behind the resident's back; -CMT C's uniform touched the resident's linens and clothing. During an interview on 08/04/25 at 10:18 A.M., CNA B said the following:-The resident was on EBP due to a wound on his/her bottom; -Only gloves were needed when repositioning the resident, since the resident's wound was covered; -A gown would only be needed if staff messed with the wound. Observation on 08/11/25 at 04:00 P.M. showed the resident's nebulizer face mask lay uncovered on the resident's nightstand. During an interview on 08/11/25 at 04:00 P.M., the resident said the following: -He/She had a magnetic resonance imaging (MRI, a medical imaging technique that uses a strong magnetic field and radio waves to create detailed pictures of organs and tissues inside the body) the day before and he/she had osteomyelitis (an infection of the bone) of his/her wound;-He/She would need intravenous (through the bloodstream) antibiotics for six weeks. 3. Review of Resident #40's Care Plan, dated 05/20/22, showed the following: -The resident had urinary incontinence related to abnormality of gait and mobility, and may not get to the toilet on time; -Provide incontinence care after each incontinent episode. The resident often needed assistance with this, especially in the mornings. Review of the resident's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument, completed by facility staff, dated 07/16/25, showed the following: -Cognitively impaired; -Independent for toileting hygiene; -Occasionally incontinent of bowel and bladder. Observation on 08/06/25 at 05:25 A.M. showed the following: -CNA A entered the resident's room and donned gloves; -CNA A did not use hand sanitizer or wash his/her hands before putting on gloves; -CNA A assisted the resident out of bed to the bathroom, pulled down the resident's pajama pants and incontinence brief, and assisted the resident to sit on the toilet; -CNA A removed his/her gloves and did not use hand sanitizer or wash his/her hands and left the resident's room;-CNA A returned to the resident's bathroom, donned gloves, and assisted the resident to stand; -CNA A did not use hand sanitizer or wash his/her hands before putting on gloves; -CNA A used a wet wipe and cleaned the resident's buttocks; -CNA A did not remove his/her gloves; -CNA A pulled up the resident's incontinence brief and pajama pants, touched the resident's back and assisted the resident back to bed; -CNA A removed the resident's shoes, pulled up the resident's covers, placed the call (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	light within the resident's reach, and removed his/her gloves; -CNA A did not use a hand sanitizer or wash his/her hands after he/she removed his/her gloves. During an interview on 08/06/25 at 07:05 A.M., CNA A said the following: -Staff should wash their hands or use a hand sanitizer before and after providing personal care to a resident and before putting on gloves;-He/She did not carry a hand sanitizer and sometimes the sanitizer pumps were too far away to use quickly; -He/She did not think it was necessary to change his/her gloves if they appeared clean and did not look soiled. 4. Review of Resident #72's undated CCD, showed the resident's diagnoses included multiple sclerosis (a disease in which the immune system eats away at the protective covering of the nerves, resulting in nerve damage between the brain and the body), dementia, and history of urinary tract infections (UTI). Review of the resident's Care Plan, dated 03/06/23, showed the following: -The resident had a suprapubic (inserted through a small incision in the lower abdomen, into the bladder) catheter related to neurogenic bladder (a condition when nerve damage impairs the bladder's ability to store and release urine effectively); -Do not allow tubing or any part of the urinary drainage system to touch the floor. Review of the resident's significant change MDS, dated [DATE], showed the following: -Severe cognitive impairment; -Dependent for toileting; -Indwelling (urinary) catheter. Observation on 08/06/25 at 04:15 A.M. showed the following: -The resident lay in bed sleeping. The resident's bed was low to the floor; -The resident's urinary catheter drainage bag was covered with a privacy bag, but the top of the drainage bag and the catheter tubing lay on the floor; -There was a sign above the resident's bed that read, Please make sure the resident's catheter bag is not on the floor at NOC (NOC means night). During an interview on 08/06/25 at 07:05 A.M., CNA A said catheter drainage bags and tubing should not touch the floor because of the potential for infections. 5. Review of Resident #45's quarterly MDS, dated [DATE], showed the following:-Dependent on staff for toileting, dressing and personal hygiene;-Always incontinent of bladder. Review of the resident's Care Plan, with revision date of 02/24/25, showed staff were to provide incontinence care after each incontinent episode. Observation on 08/05/25 at 09:15 A.M., showed the following:-Without performing hand hygiene, Nurse Assistant (NA) G put on gloves and assisted the resident to walk to the bathroom; -While the resident sat on the toilet, NA G removed his/her gloves and put on new gloves without performing hand hygiene;-NA G removed the resident's pants and wet incontinence brief;-NA G did not change his/her gloves after removing the wet incontinence brief, and then put a clean incontinence brief and pants on the resident;-NA G removed his/her gloves, did not perform hand hygiene, and put on new gloves;-NA G cleaned the resident's skin that had been in contact with the urine soiled incontinence brief with a disposable wipe and pulled up the resident's incontinence brief and pants;-NA G removed his/her gloves and did not perform hand hygiene;-NA G assisted the resident to walk to his/her bed;-NA G touched the resident's hand, arms and legs while assisting the resident to bed;-NA G pulled the privacy curtain and left the room without performing hand hygiene. Observation on 08/06/25 at 06:57 A.M., showed the following:-CNA O put on gloves without performing hand hygiene and assisted the resident to the bathroom; -CNA O removed the resident's wet incontinence brief; -CNA O removed his/her gloves, did not perform hand hygiene, and put a clean shirt, incontinence brief and pants on the resident;-CNA O put on new gloves without performing hand hygiene;-CNA O cleaned the resident's skin that had been in contact with the urine soiled incontinence brief with disposable wipes; -CNA O did not change his/her gloves and pulled up the resident's incontinence brief and pants. During interview on 08/06/25 at 07:08 A.M., CNA O said the following: -He/She should change gloves when putting clean items on the resident;-He/She should perform hand hygiene as much as possible;-If the resident had a bowel movement, he/she would have removed his/her gloves and washed his/her hands;-He/She did not sanitize his/her hands between dirty and clean tasks during the resident's care but would have if the resident had a bowel movement. During interview on 08/11/25 at 02:44 P.M., NA G said the following:-He/She washed his/her hands before and after he/she was in a resident's room and after providing peri care;-He/She washed or sanitized his/her hands between glove changes. 6. Review of Resident #11's Care Plan, dated 03/27/25, showed the (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	resident was to have a BiPAP on at bedtime and off in morning. Review of the resident's quarterly MDS assessment, dated 06/01/25, showed the following:- Moderate cognitive impairment;-Diagnoses included obstructive sleep apnea and dementia;-Substantial/maximal assistance needed dressing. Review of resident's Physician Orders, dated 06/03/25, showed an order for BiPAP on at hours of sleep (HS) and off in the morning; Observation on 08/04/25 at 03:45 P.M., showed the following:-The resident's BiPAP was on the resident's nightstand. The BiPAP tubing and full face mask were attached to the machine;-The mask and tubing were wrapped around the cane rail on resident's bed and were uncovered. Observation on 08/05/25 at 08:38 A.M., showed the resident's BiPAP was on the nightstand. The BiPAP full face mask and tubing were wrapped around the cane rail on the resident's bed and were uncovered. Observation on 08/07/25 at 11:06 A.M., showed the resident's BiPAP was on the resident's nightstand. The BiPAP full face mask and tubing were wrapped around the cane rail on the resident's bed and were uncovered. During interview on 08/11/25 at 05:37 P.M., Licensed Practical Nurse (LPN) P said the following:-He/She was not sure how the BiPAP and accessories were to be stored;-Staff used to store the tubing and mask in a bag when not in use;-He/She thought the mask and tubing should be stored in a bag. 7. During an interview on 08/11/25 at 06:05 P.M., the Director of Nursing (DON) said the following: -Staff should wash their hands or use a hand sanitizer between glove changes; -Catheter bags and tubing should be kept off the floor; -Oxygen tubing and BiPAP equipment should be stored in a plastic bag and not left open at the resident's bedside. -Staff should follow EBP when repositioning a resident with a wound, even if the wound was covered. Staff should wear a gown if they had contact with the resident's clothing and/or bed linens. During an interview on 08/11/25 at 06:35 P.M., the Administrator said the following: -Staff should wash their hands or use a hand sanitizer between glove changes; -Catheter bags/tubing should be kept off the floor; -Oxygen tubing, BiPAP equipment should be stored in a plastic bag and not left open at the resident's bedside. -Staff should follow EBP when repositioning a resident with a wound, even if the wound was covered. Staff should wear a gown if they had contact with the resident's clothing and/or bed linens.

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. Based on interview and record review, the facility failed to provide all staff with written documentation of education regarding the benefits, risks, and potential side effects associated with the COVID-19 vaccine and failed to maintain documentation related to staff COVID-19 vaccination status. The facility census was 72. Review of the facility's COVID-19 Staff Vaccination policy, dated October 2022, showed the following:-Before offering the COVID-19 vaccine, the staff member is provided with education regarding the benefits and risks, and potential side effects associated with the vaccine;-A vaccine administration record is provided to the individual and a copy if filed in the secure employee health file;-The infection preventionist (IP) maintains a tracking worksheet of staff members and their vaccination status;-The facility maintains documentation related to staff COVID-19 vaccination that includes, at a minimum, the following: -That staff were offered the COVID-19 vaccine or information on obtaining COVID-19 vaccine; -That staff were provided education regarding the benefits and potential risks associated with COVID-19 vaccine; -A copy of the informed consent; -Verification of vaccination or documentation of exemption/delay. 1. Review of the facility's list of new employees, dated 11/2/23 through 8/5/25, showed the facility hired 158 new employees during this time. Review of employee files showed the facility had no documentation to show staff were educated on the benefits, risks and potential side effects associated with the COVID-19 vaccine and/or had been offered or refused the vaccine. During an interview on 08/11/25 at 02:44 P.M., Nurse Assistant (NA) G said the following:-He/She had worked in the facility for two months;-The facility had not educated him/her about the COVID-19 vaccine;-The facility did not offer the COVID-19 vaccine. During an interview on 08/07/25 at 03:30 P.M., Human Resources Staff said the following:-There was no COVID-19 vaccine documentation in the new staff files;-She was not aware it was still required. During an interview on 08/11/25 at 6:05 P.M., the Director of Nursing (DON) said Human Resources Staff was responsible for educating new hires and offering the COVID-19 vaccinations. During an interview on 08/07/25 at 03:00 P.M., the Administrator said the following:-The facility verbally informed staff about the latest COVID-19 vaccines;-There was no documentation of staff education regarding the benefits, risks and potential side effects associated with the COVID-19 vaccine;-There was no documentation of staff's COVID-19 vaccination status in the employee files.

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F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. Based on interview and record review, the facility failed to provide required in-service training for nurse aides that included dementia management training as part of the required minimum 12 hours of training per year. The facility census was 72. 1. Review of the Facility Assessment, dated 07/09/25, showed the following:-Staff training/education and competencies:-New hire training for nursing staff includes:-Dementia Care: Managing Challenging Behaviors;-Annual Education includes all the new hire training topics plus Corporate Compliance: The Basics for all staff, Overview of the Aging Process and Pressure Ulcer Prevention for all clinical staff. 2. Review of a list of current facility staff, dated 08/05/25, showed the following:-Certified Nurse Aide (CNA) I date of hire: 04/15/09;-CNA/Certified Medication Technician (CMT) C: date of hire 07/19/14;-CNA K date of hire: 12/7/19;-CNA J date of hire: 07/03/23. Review of a list of staff in-service education hours, dated 07/01/24 through 06/30/25, showed the following:-CNA I: 6.50 in-service hours. Dementia training hours blank;-CNA/CMT C: 8.00 in-service hours. Dementia training hours blank;-CNA K: 5.25 in-service hours. Dementia training hours blank;-CNA J: 2.75 in-service hours. Dementia training hours blank. During an interview on 08/11/25 at 6:04 P.M., the Director of Nursing said the following:-HR was responsible for ensuring CNAs have the required 12 in-service hours per year and she would expect this to be done;-There had been an issue getting the 12 in-service hours completed. During an interview on 08/11/25 at 6:30 P.M., the Administrator the following:-HR was responsible for tracking CNA in-service education;-The previous HR staff left at the end of 2024 and they could not find documentation of previous in-service hours;-The facility offered dementia training in January 2025, but they could not find documentation of the training;-She would expect the CNAs to receive 12 hours of in-service education annually including dementia training.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. Based on observation, interview, and record review, the facility failed to ensure staff served meals to meet the nutritional needs of the residents when staff failed to prepare and serve food according to the physician's orders and spreadsheet menu. The facility census was 72. 1. Review of Resident #45's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument, dated 07/27/25, showed the following:-Severe cognitive impairment;-Diagnoses included vitamin deficiency, -Dependent on staff for eating;-Mechanically altered diet such as pureed food. Review of the resident's Care Plan, revised 02/24/25, showed the following:-The resident receives regular pureed diet;-Staff will need to feed the resident; -Monitor and record percentage of food intake. Review of the resident's Physician Orders dated 03/27/25, showed diet pureed texture, double portions with meals every day. Review of the Diet Spreadsheet Menu, for 8/4/25 (Day 2, Monday) Lunch, showed staff were to serve residents on pureed diets the following items and portion sizes:-One 4-ounce portion of pureed chicken salad;-One 4-ounce portion of pureed cottage cheese;-One 3.25-ounce portion of pureed fruit plate;-One 2.875-ounce portion of pureed breaded zucchini. Observation on 8/4/25 at 11:40 A.M., in the kitchen during the lunch meal service, showed Dietary Aide S served the following items and portion sizes onto the resident's plate:-Two 4-ounce scoops (total of 8 ounces) of pureed chicken salad; -One 4-ounce scoop of pureed cottage cheese/fruit plate;-One 4-ounce scoop of pureed zucchini.(Dietary Aide S did not serve the resident double portions of all the menu items. The resident should have received an 8-ounce portion of cottage cheese, a 6.5-ounce portion of fruit plate, and a 5.75-ounce portion of pureed zucchini.) Review of the Diet Spreadsheet Menu, for 8/4/25 (Day 2, Monday) Dinner, showed staff were to serve residents on pureed diets the following items and portion sizes:-Two 4-ounce portions (total of 8 ounces) of pureed beef and noodles;-One 3.25-ounce portion of pureed green beans;-One 2-ounce portion of pureed dinner roll/margarine. Observation on 8/4/25 at 4:39 P.M., in the kitchen during the dinner meal service, showed Dietary Aide Y served the following items and portion sizes onto the resident's plate:-Two 4-ounce scoops (total of 8 ounces) of pureed beef and noodles;-One 4-ounce scoop of pureed green beans;-No pureed bread.(Dietary Aide S did not serve the resident double portions. The resident should have received 16 ounces of beef/noodles, 6.5 ounces of green beans, and 4 ounces of pureed bread.) Observation on 08/04/25 at 5:08 P.M., showed the following:-CNA L fed the resident at a table in the dining room;-The resident's plate contained pureed beef and noodles that filled up a section on the divided plate and pureed green beans that filled another section of the divided plate;-The resident did not receive double portions;-The resident ate 100% of his/her meal. During an interview on 8/6/25 at 2:05 P.M., [NAME] V said staff were to follow the diet spreadsheet menu and residents' diet orders for food items and portion sizes. During an interview on 8/6/25 at 2:33 P.M., the Dietary Manager said the following:-She expected staff to follow the spreadsheet menu when preparing and serving food items to residents;-She expected staff to follow residents' diet orders;-She was unaware staff didn't serve Resident #45 double portions during the 8/4/25 lunch and dinner meal services.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement a program that monitors antibiotic use. Based on interview and record review, the facility failed to follow their antibiotic stewardship policy and consistently track infections and antibiotic use for one resident (Resident #3) in a review of 18 sampled residents. The facility census was 72. Review of the facility's undated policy, Antibiotic Stewardship, showed the following:-The facility will record all antibiotics used in the facility on a resident-to-resident basis (dose, duration, indication);-The facility will alert the attending physician when antibiotics have reached 14 days and obtain new orders. Review of the facility's Surveillance for Infections policy, dated January 2022, showed the following:-The Infection Preventionist (IP) will conduct ongoing surveillance for Healthcare-Associated Infections (HAIs) and other epidemiologically significant infections that have substantial impact on potential resident outcome and that may require transmission-based precautions (TBP) and other preventative interventions;-The purpose of the surveillance of infections is to identify both individual cases and trends of epidemiologically significant organism and Healthcare-Associated Infections, to guide appropriate interventions, and to prevent future infections;-Infections that will be included in routine surveillance include those with;-a. Evidence of transmissibility in a healthcare environment;-b. Available processes and procedures that prevent or reduce the spread of infections;-c. Clinically significant morbidity or mortality associated with infection (e.g., pneumonia, urinary tract infections (UTI), Clostridioides difficile (C. Diff)) ((inflammation of the colon caused by the bacteria Clostridium difficile);-d. Pathogens associated with serious outbreaks (e.g., invasive Streptococcus Group A, acute viral hepatitis, norovirus, scabies, influenza);-If TBP or other preventative measures are implemented to slow or stop the spread of infection, the IP will collect data to help determine the effectiveness of such measures;-The IP or designated infection control personnel is responsible for gathering and interpreting surveillance data;-For targeted surveillance and reporting through the Centers for Disease Control and Prevention (CDC) National Health Safety Network (NHSN), follow the surveillance protocols for each module using the data collection tools provided at https://www.cdc.gov/nhsn/ltc/index.html;-For targeted surveillance using facility-created tools, follow these guidelines; -Daily: Record detailed information about the resident and infection on an individual infection report form; -Monthly: Collect information from individual resident infection reports and enter line listing of infections by resident for the entire month; -Monthly: Summarize monthly data for each nursing unit by site and by pathogen; -Monthly/Quarterly: Identify predominant pathogens or sites of infection among residents in the facility or in particular units by recording them month to month and observing trends; -Monthly/Quarterly: Compare incidence of current infections to previous data to identify trends and patterns;-Obtain the month's total resident days from the business office and use this data as the denominator to calculate the monthly infection rate. 1. Review of Resident #3's urinalysis (a physical and chemical test of the urine), dated 01/21/25, showed the following:-Blood 2+ (normal is negative);-Urine clarity: turbid (normal is clear);-Urine nitrites (a byproduct of bacteria converting nitrates (which are normal in urine) into nitrites): positive (normal is negative);-Bacteria: many (normal is none seen);-Urine protein confirmation SSA: 1+ (normal is negative);-White cells: greater than 100 (normal is 0-3);Test Comments: (Culture) Call lab within 48 hours to request culture of this specimen;-Noted by staff on 01/22/25. Review of the resident's medical record showed no documentation staff requested a culture of the 01/21/25 specimen. Review of the resident's physician's orders, dated 01/21/25, showed an order for ciprofloxacin (antibiotic) 250 milligrams (mg) by mouth twice daily for seven days for UTI. Review of the resident's Medication Administration Record (MAR) dated January 2025 showed the resident received ciprofloxacin 250 mg by mouth twice daily 01/22/25-01/29/25. Review of the resident's C-difficile Toxins Antigen Test (CDToxAG), dated 07/30/25, showed a positive result which indicated the presence of C. difficile toxin in a fecal sample (normal result is negative). Review of the resident's physician's orders, dated 07/31/25, showed an order for Vancomycin (antibiotic) 125 mg by mouth four times a day for C. diff. Review of the (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	resident's MAR dated 08/01/25 showed the resident received Vancomycin 125 mg by mouth four times daily 08/01/25-08/07/25. During an interview on 08/06/25 at 01:28 P.M., Registered Nurse (RN) Consultant said her only role as IP was to double check and make sure antibiotic orders were entered correctly into the computer. During interview on 08/06/25 at 10:40 A.M. and 08/11/25 at 6:05 P.M., the Director of Nursing (DON) said the following:-She printed out a list of residents who received antibiotics and reviewed the list with the Medical Director weekly;-She was responsible for gathering and interpreting surveillance data and looked at the Arsana (tool used for long term care facility infection surveillance and hand hygiene);-She kept up with cultures and sensitivities to make sure the residents were on the correct antibiotic. She reviewed the information with the Medical Director weekly;-Staff obtained cultures for infections when physician's orders were received; -She did not keep an infection treatment and tracking record;-She did not keep a line listing of infections by resident;-She did not keep a facility wide monthly infection report;-She did not keep a facility wide 12 month pathogen trends report;-She did not compare incidence of current infection to previous data to identify trends;-She did not calculate the monthly infection rate. During an interview on 08/11/25 at 6:30 P.M., the Administrator said the following:-She, the DON, and the RN Consultant serve as the IPs and were responsible for gathering and interpreting surveillance data;-Cultures were obtained when the physician prescribed them;-She did not keep an infection treatment and tracking record;-She looked at the progress notes and Arsana daily;-She did not keep a facility wide 12 month pathogen trends report;-She did not calculate the monthly infection rate.

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F 0628 Level of Harm - Potential for minimal harm Residents Affected - Many	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure staff notified the resident and/or the resident's representative in writing of a transfer to a hospital and failed to provide the bed hold policy at the time of transfer to four residents (Resident #3, #10, #74 and #78) or the resident representatives, in a sample of four residents reviewed related to discharge or transfer. The facility census was 72. Review of the undated document, Bed Hold Statement and Notice of Emergency Transfers, showed the following:-The facility established and maintains policies and procedures regarding transfer, discharge, and provision of services for all individuals. Upon admission to the facility and again if the resident is transferred to an acute care hospital, the resident (if able) or responsible party is information of the policy on bed holds;-The goal of the facility is to re-admit, after hospitalization, all residents who meet admission guidelines and whose needs can be met with our available services. To assure the assigned previous room is held for you, if the resident room type (example: private, suite, semi-private) has occupancy of 90% or higher it is necessary to pay 75% of the daily base rate to hold the specific room. Medicare and Medicaid do not pay for bed hold therefore it is necessary for this charge to be paid by the resident. If you choose not to reserve the bed, the resident and/or responsible party must notify the social services department or business office within 72 hours of the discharge. The facility will admit the resident to the first available bed if the bed has not been held;-Notice of Emergency Transfers: When a resident is temporarily transferred on an emergency basis to an acute care facility, notice of the transfer may be provided to the resident and resident representative as soon as practicable, according to 42 CRF 483.15 (4)(ii)(D). Documentation in the resident's progress notes stating resident or resident representative has been notified will meet the criteria for notification of emergency transfer. 1. Review of Resident #3's Face Sheet showed he/she had a responsible party. Review of the resident's electronic health record (EHR) census report showed the resident was transferred to the hospital and hospitalized from [DATE] through 06/20/25 and again on 06/21/25 through 06/22/25. Review of the resident's EHR showed no documentation the facility gave the resident a written transfer notice or a copy of the facility's bed hold policy for his/her hospitalizations on 05/05/25 and 6/21/25. 2. Review of Resident #10's Face Sheet showed he/she had a responsible party. Review of the resident's EHR census report showed the resident transferred to the hospital on [DATE]. Review of the resident's Progress Notes, dated 08/01/25, showed the following:-At 8:14 P.M., staff called the on-call physician. Orders were received to send the resident to the hospital;-At 11:26 P.M., the resident admitted to the hospital. Review of the resident's medical record showed no documentation the facility issued the resident or the resident's representative with a written notice of transfer when he/she was transferred to the hospital on [DATE]. 3. Review of Resident #74's Face Sheet showed he/she was his/her own responsible party. Review of the resident's Progress Notes, dated 06/19/25, showed the following:-At 10:15 A.M., the nurse received a call from the physician reporting abnormal labs and to send the resident to the emergency room if the resident continued to be confused;-At 11:20 A.M., the resident transferred to the hospital by ambulance. Review of the resident's EHR census report showed the resident was hospitalized from [DATE] through 06/27/25. Review of the resident's EHR showed no documentation the facility gave the resident or the resident's representative a written transfer discharge notice or bed hold notice when he/she was transferred to the hospital on [DATE]. 4. Review of Resident #78's Face Sheet showed he/she had a responsible party. Review of the resident's EHR census report showed the resident transferred to the hospital and was hospitalized from [DATE] to 12/11/24. Review of the resident's Progress Notes, dated 06/30/25, showed the following:-At 1:09 P.M., the nurse received a call from the primary care physician (PCP)/triage nurse with orders to send the resident to the emergency room to be evaluated based on behaviors that (continued on next page)

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F 0628 Level of Harm - Potential for minimal harm Residents Affected - Many	morning;-The nurse called and spoke with resident's responsible party. Review of the resident's EHR census report showed the resident transferred to the hospital and was hospitalized from [DATE] to 07/22/25. Review of the resident's EHR showed no documentation the facility gave the resident or the resident's representative a written transfer discharge notice or bed hold notice for his/her 12/10/24 or 06/30/25 hospitalization. 5. During an interview on 08/11/25 at 06:05 P.M., the Director of Nursing (DON) said the following:-The charge nurse should provide the resident with a written notice of transfer/discharge and bed hold policy if they are transferred to the hospital emergently;-Agency nurses may not always remember to provide the notice and the policy. During an interview on 08/11/25 at 06:35 P.M., the Administrator said the following:-The charge nurse should provide the resident with a written notice of transfer/discharge and bed hold policy when they were transferred to the hospital emergently;-The bed hold policy was sent with the resident on a transfer to the hospital.