STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265236	A. Building B. Wing	08/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avenir at Mark Twain	11988 Mark Twain Lane Bridgeton, MO 63044

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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 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 ensure residents were treated in a dignified manner affecting 5 of 18 sampled residents (Residents #1, #58, #64, #28 and #5). The census was 75. Review of the facility's resident's rights policy, undated, showed:-Employees shall treat all residents with kindness, respect, and dignity;-Residents are entitled to exercise their rights and privileges to the fullest extent possible. Our facility will make every effort to assist each resident in exercising his or her rights to assure that the resident is always treated with respect, kindness, and dignity;-Respect: Treat others as you want to be treated-every person matters. 1. Review of Resident #1's annual Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated, 5/31/25, showed:-Cognitively intact;-Diagnoses included Ogilvie syndrome (acute dilation of the colon), chronic obstructive pulmonary disease (COPD, a group of lung diseases that block airflow and make it difficult to breathe) and major depressive disorder. Observation on 8/15/25, in the resident's room, showed:-At 7:33 A.M., Restorative Aide W came into the resident's room and started to clean the room. He/She put on gloves, grabbed a paper towel and then wiped up a pile of bowel movement (BM) located near the resident's bed. He/She turned to the resident and said why did you put this on the ground? You have all these nasty wet clothes. You need to clean this up.;-At 7:39 A.M., he/she walked to the resident's door and grabbed the doorknob with one gloved hand while he/she grabbed the dirty linen cart with his/her other gloved hand. He/She said this resident is always making messes. Observation on 8/15/25 at 8:03 A.M., showed the resident sat in a chair next to the nurse's station. Housekeeping Aide M turned and said, you have to excuse me. This one (gesturing towards resident) and I [NAME] multiple times a day. He/She likes to make messes and throw BM all over. The resident looked up towards where Housekeeping Aide M was standing, visibly upset with a frown. During an interview on 8/15/25 at 8:07 A.M., Restorative Aide W said that is how he/she always talks to the resident. He/She said it hard to work with the resident and the resident should be cleaning up his/her own messes. During an interview on 8/20/25 at 1:48 P.M., the Director of Nurses (DON) and Administrator said staff should speak to residents in a respectful manner. It is not appropriate for staff to express displeasure with residents in front of them. 2. Review of Resident #58's quarterly MDS, dated [DATE], showed:-Cognitively intact;-Diagnoses included anxiety, depression, and mental disorder not otherwise specified. Review of the resident's care plan, in use at the time of survey, showed:-Focus: The resident has a potential psychosocial well-being problem;-Goal: The resident will demonstrate adjustment to nursing home placement by/through review date;-Tasks included allow the resident time to answer questions and to verbalize perceptions and fears. Observation on 8/18/25 at 1:00 P.M., showed the resident propelled into the dining room in his/her wheelchair. The Dietary Manager (DM) passed a lunch tray behind the resident, then bumped into the resident's wheelchair. The Dietary Manager said something in a stern, loud, and rude voice and said, You should have said hi, I'm behind you, and walked away from the resident. At 1:10 P.M., the resident asked dietary staff for silverware. As the DM prepared trays at the food prep line within earshot of the resident, the DM said, We're not doing this today. The resident asked the DM for a plate (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	of food and said he/she did not want a burger and wanted to eat whatever was on the menu. The DM said, It's too late, you already asked for a burger. The resident asked why it was too late and said he/she had the right to change his/her mind. The DM ignored the resident and continued plating food for other residents in the dining room. During an interview on 8/18/25 at 1:23 P.M., Certified Nursing Assistant (CNA) I said the DM speaks rudely to the residents all the time. He/She said he/she goes out of his/her way to not work in the dining room during meals so he/she does not have to hear the DM speak to residents. During an interview on 8/18/25 at 1:32 P.M., the resident said fettuccine was served at lunch. He/She wanted a burger with a side of fettuccine and one of the staff told him/her it was ok to ask for that. The DM said no, he/she could not have what was requested. The way the DM talked to him/her was not very nice. During an interview on 8/19/25 at 8:51 A.M., Licensed Practical Nurse (LPN) J said some of the dietary staff is rude and they get upset with residents asking for things, particularly the DM. Staff should speak to residents nicely and try to accommodate them.During an interview on 8/19/25 at 9:47 A.M., CNA S said the DM talks to people rudely. Residents should get what they request and should be able to ask for things without getting yelled at. During an interview on 8/19/25 at 1:56 P.M., the DM said residents should be treated with dignity and respect. She said she did not intentionally speak rude to the resident. The resident tries to order food too late all the time and it aggravates her. During an interview on 8/20/25 at 1:48 P.M., the DON and Administrator said staff should speak to residents in a respectful manner. It is unacceptable for staff to yell at residents. If these issues are observed by other staff, staff should report their observations to Administration. 3. Review of Resident #64's quarterly MDS, dated [DATE], showed:-Cognitively intact;-Diagnoses included type two diabetes, muscle weakness and major depressive disorder. Observation on 8/19/25 at 8:38 A.M., showed the resident having a conversation with a surveyor. He/She said that he/she was told he/she could only have three bowls of cereal. The DM came up to the table where the resident was having a conversation and said, that didn't come from us in the dietary department. The resident asked the DM to not butt into his/her conversation. The Dietary Manager walked into the kitchen and yelled through the kitchen window, how many bowls do you want, the resident responded with one bowl and a cup of coffee. The DM brought the bowl of cereal to the table and when the resident said thank you, the DM turned without responding and walked back into the kitchen, muttering under her breath. During an interview on 8/19/25 at 1:56 P.M., the DM said residents should be treated with dignity and respect. She said she did not intentionally speak rudely to the resident. She said her tone could have been nicer. During an interview on 8/20/25 at 1:48 P.M., the DON and Administrator said staff should speak to residents in a respectful manner. It is unacceptable for staff to yell at residents. If these issues are observed by other staff, staff should report their observations to Administration. 4. Review of Resident #28's admission MDS, dated [DATE], showed:-Moderately impaired cognition;-Diagnoses included hemiplegia and hemiparesis (muscle weakness or partial paralysis) affecting the dominant right side, type two diabetes and acute kidney failure. Observation on 8/18/25, of the resident in the dining room, showed:-At 8:40 A.M., the resident was seated in the dining room for breakfast. The resident struggled to open a carton of juice with one hand. He/She called out for someone to help him/her;-At 8:46 A.M., CNA I walked past the resident's table. The resident started to ask for help but CNA I walked past him/her;-At 8:49 A.M., the Restorative Aide W walked up to the resident's table. The resident asked him/her for help. Restorative Aide W walked away without assisting the resident;-The resident poked a hole in the seal with a finger in order to open his/her drink. During an interview on 8/18/25 at 9:52 A.M., the resident said no staff ever help him/her in the dining room. They walk away before he/she can even finish asking for help. During an interview with on 8/20/25 at 1:48 P.M., the DON and Administrator said any staff member can assist a resident with opening a food package or retrieving new silverware. They expected staff to assist residents with meals and not ignore the residents or walk away while the residents are talking. 5. Review of Resident #5's medical record, showed:-Diagnoses included hypertension (high blood pressure), end stage renal disease (ESRD, permanent kidney failure requiring (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	transplant or dialysis for survival), history of transient ischemic attack (TIA, a temporary interruption in blood flow to the brain causing stroke-like symptoms) and Type 2 diabetes. Review of the resident's care plan, in use at the time of the survey, showed:-Focus: the resident is at risk for falls as evidenced by a fall the resident suffered on 3/5/25; -Interventions: Ensure personal items were within the resident's reach. Ensure the resident's call light is within reach for the resident to use in order to ask for assistance. During an interview on 8/18/25 at 7:40 A.M., the resident said a few days ago a member of the night shift, CNA P, got into a power struggle with him/her over the call light. The resident said CNA P attempted to pull the call light away from him/her in order to prevent him/her from using it for the rest of the night. The resident said the staff member told him/her this would prevent the resident from pressing it all night and bothering staff on the hall. The resident said he/she felt disrespected by the staff member during that interaction, and these undignified interactions happen with other staff members as well. During an interview on 8/18/25 at 8:39 A.M., the Administrator said the resident came to his office on 8/17/25 to discuss the alleged incident with CNA P. The resident was assessed and found without injury. The resident did not allege abuse occurred and did not state he/she was in pain but felt the treatment given to him/her by CNA P was undignified. CNA P was removed from the future schedule at that time while the facility investigated the incident. The Administrator had not been able to successfully contact CNA P to discuss the alleged incident. 2588074 25793742572384161199516119822591662

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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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to provide a homelike environment to all residents in the facility by failing to keep resident rooms at a comfortable temperature and cleanliness (Residents #26, #1, #64), ensuring bed sheets are changed when soiled (Resident #47) and failing to keep resident shower rooms free of obstruction. Concerns were noted with the cleanliness of resident rooms for four out of 18 sampled residents in addition to resident shower rooms on the [NAME] hall. The census was 75.1. Review of Resident #26's medical record, showed diagnoses included bipolar disorder (mood disorder that can cause intense mood swings), depression, seizure disorder, generalized muscle weakness, difficulty walking, unsteadiness on feet, and other abnormalities of gait and mobility.Observation on 8/15/25 at 12:27 P.M., showed the resident seated on the side of his/her bed with a small fan on his/her bedside table. The air conditioning (AC) unit beneath the window set to cool, on and blowing warm air, with its external gauge showing 65 degrees Fahrenheit (F). A calibrated thermometer showed the resident's room at 80.2 degrees F. The outside temperature was 92 degrees F. During an interview, the resident said his/her room was hot. His/Her AC has been broken for months, all summer. He/She reported it to maintenance, but they have not fixed the unit. He/she preferred his/her room to be cool, around 65 degrees F, especially when he/she sleeps. During the interview, Housekeeper X entered the room. He/She said it was too hot in the resident's room. Observations on 8/18/25, showed:-At 1:29 P.M., the resident on his/her side in bed. The AC unit underneath the window set to cool, on and blowing warm air, with its external gauge showing 65 degrees F. A calibrated thermometer showed the resident's room at 83.4 degrees F. The outside temperature was 93 degrees F. During an interview, the resident said he/she was [NAME] hot;-At 4:07 P.M., the resident seated in bed. The AC unit underneath the window set to cool, on and blowing warm air, with its external gauge showing 65 degrees F. A calibrated thermometer showed the resident's room at 83.8 degrees F. The outside temperature was 95 degrees F. During an interview, the resident said it was too hot in his/her room.Review of the maintenance communication log at the nurse's station, reviewed on 8/18/25 at 4:14 P.M., showed no documentation over the past two months regarding the resident's AC unit. During an interview on 8/20/25 at 8:10 A.M., Certified Nurse Aide (CNA) T said when staff notice issues with a resident's AC unit, they should document it in the maintenance log at the nurse's station.During an interview on 8/20/25 at 11:07 A.M., the Maintenance Director and Administrator said the facility is trying to get new AC units for resident rooms. They received a couple new units, but they were the wrong type. When staff first notice a maintenance issue in a resident's room, such as a broken AC unit, they should document the issue in the maintenance communication binder at the nurse's station. This binder is checked daily by maintenance staff. Prior to 8/18/25, the Maintenance Director said the resident always told Maintenance Assistant Y about the AC unit. The unit is blowing cool air but does not cool the entire room and probably needs to be replaced. The temperature in a resident's room should not exceed 82 degrees F. 2. Review of Resident #1's annual MDS, dated [DATE], showed:-Cognitively intact;-Diagnoses included Ogilvie syndrome (acute dilation of the colon) COPD (chronic obstructive pulmonary disease), and major depressive disorder.Observation and interview on 8/14/25 at 11:07 A.M., showed dirty depends on the floor next to the resident's bed with brown matter on them. [NAME] liquid matter was on the floor next to the depends. [NAME] liquid splatters were in various areas of the floor in the room and bathroom. Multiple flies flew around the resident's room. The resident's mattress had a large brown matter stain with flies on the stain. The resident said staff come in to clean his/her room but he/she would like his/her room cleaned more frequently.Observation on 8/18/25 at 7:07 A.M., showed the resident's room had an odor of feces permeating from the room. Bowel movement (BM)smears were on the floor next to the resident's bed (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	alongside a used incontinence brief. [NAME] matter splatter was on the wall next to the bedroom door above the trash can. [NAME] matter was on the call light, which was on the ground next to the resident's bed. Two flies flew around the resident's bed. During an interview on 8/20/25 at 9:46 A.M., Registered Nurse (RN) C said when cleaning up bodily fluids, nursing staff are to clean the bodily fluids up and then the housekeeping staff come behind and do a deep cleaning of the area. He/She expected resident rooms, medical equipment and furniture to be free from bodily fluids and debris. 3. Review of Resident #64's quarterly MDS, dated [DATE], showed:-Cognitively intact;-Diagnoses included type two diabetes, muscle weakness and major depressive disorder. Observation on 8/14/25 at 11:17 A.M., showed the bathroom toilet to have brown and yellow matter on the seat and sides. The floor surrounding the toilet had brown matter. Trash and debris were surrounding the resident's nightstand. Observation on 8/15/25 at 7:54 A.M., showed the bathroom toilet to have brown and yellow matter on the seat and sides. The floor surrounding the toilet had brown matter. Trash and debris were surrounding the resident's nightstand. Observation on 8/19/25 at 10:49 A.M., showed trash and food debris surrounding the resident's bed and nightstand. Observation and interview on 8/20/25 at 9:25 A.M., showed trash and food debris on the floor surrounding the resident's bed. The resident said he/she does not feel that the housekeeping staff clean his/her room or bathroom enough. He/She has to use the shower room to use the bathroom when his/her bathroom is not clean. During an interview on 8/20/25 at 9:51 A.M., Housekeeping Aide M said both Resident #1 and Resident #64 are nightmare residents to clean after and always make messes in their rooms. He/She said he/she does not like to clean their rooms. 2. Review of Resident #47's quarterly MDS, dated [DATE], showed:-Cognitively intact;-Diagnoses included depression, seizure disorder, and history of stroke;-Partial/moderate assistance with walking 10 feet.Observation on 8/14/25 at 11:08 A.M., showed the resident seated in a chair next to his/her bed. The fitted sheet over the mattress had a yellow stain, approximately five inches long, and small dark brown chunks on top of the sheet. During an interview, the resident said he/she is unsteady on his/her feet and needs staff to assist with changing the sheets on his/her bed. The sheets are supposed to be changed daily.Observation on 8/15/25 at 8:15 A.M., showed the resident seated on the side of his/her bed. The same fitted sheet with a yellow stain on the mattress of his/her bed. During an interview, the resident said staff have not helped him/her change his/her sheets. Observation on 8/19/25 at 12:22 P.M., showed the resident on his/her back in bed with eyes closed. The same fitted sheet with a yellow stain was on his/her mattress of his/her bed. During an interview on 8/20/25 at 8:10 A.M., CNA T said the resident needs help changing his/her sheets and making his/her bed. CNAs are responsible for changing sheets on resident beds. Sheets should be changed on shower days and as needed.During an interview on 8/20/25 at 8:24 A.M., CNA B said CNAs are responsible for changing the sheets on resident beds. Sheets should be changed daily.During an interview on 8/20/25 at 1:48 P.M., the Director of Nurses (DON) and Administrator said CNAs are responsible for changing the sheets on resident beds. Sheets should be changed at least every three to five days, and as needed. Some nursing staff change sheets on shower days. 5. Observation on 8/14/25 at 11:51 A.M., 8/15/25 at 8:58 A.M. and 8/18/25 at 12:31 P.M., of the Hydrotherapy Room near the [NAME] nurse's station, showed the space filled with two Hoyer (full body lifts) lifts, one sit-to-stand lift, two wheelchairs and a bedside commode blocking the path to the walk-in hydrotherapy tub. A loose ceiling tile just above the doorway created an opening into the ceiling and electrical wiring above. 6. Observation on 8/14/25 at 5:32 P.M., 8/15/25 at 1:38 P.M. and 8/18/25 at 8:32 A.M. of the shower room near the [NAME] nurse's station, showed the space contained a Hoyer lift, a sit to stand lift, and a clean linen cart blocking the path into the shower stalls. During interview on 8/20/25 at 8:25 A.M., Housekeeping Aide M said lifts should not be stored in shower rooms or other resident areas as this is not homelike to residents and it makes using these areas harder for staff and residents. Storing lifts in the shower rooms also makes it harder for housekeeping staff to keep those areas clean. 7. During an interview on 8/20/25 at 10:18 A.M., the Environmental Services Director said he expected nursing staff to (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	inform housekeepers if there are any rooms that need more cleanings on top of the regular scheduled cleanings. He expected resident rooms to be free from trash, food and matter debris, and bodily fluids. He expected resident rooms to be free from flies and other pests. Shower rooms located on resident halls should be kept clean and free of obstructions such as carts and lifts. 8. During an interview on 8/20/25 at 1:48 P.M., the Administrator and DON said they expected all resident rooms in the facility to be kept in a clean, homelike manner, including changing sheets and cleaning up food or other biological debris from the room daily and as needed. Resident rooms should be equipped with air conditioning and heating elements that are in working condition to provide a comfortable, homelike environment to the residents. Shower rooms should be kept organized in a manner that allows residents to use the space without being blocked by equipment.

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F 0620 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Not require residents to give up Medicare or Medicaid benefits, or pay privately as a condition of admission; and must tell residents what care they do not provide. Based on observation, interview and record review, the facility failed to have a system in place to safeguard resident's personal belongings for two residents (Resident # 68 and Resident #9). The facility also failed to have an admissions policy that did not require residents to waive the facility of liability for loss of personal property. The sample was 18. The census was 75. Review of the facility's current admission packet showed:Personal Property of Resident: The resident is strongly urged to mark all his or her clothing and personal property for easy identification. The resident or authorized representative will be responsible to complete a personal items inventory sheet and update the inventory sheet as needed. The facility shall not be liable for any resident's items that are lost or stolen, with the exception of those items noted for replacement under state guidelines that the facility might reside. 1. Review of Resident #68's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated, 5/9/25, showed:-An admission date of 5/5/24;-The resident is cognitively intact;-The resident is dependent on staff for personal hygiene, toilet hygiene, upper and lower body dressing, and bed to chair transfer;-The resident uses a wheelchair. Review of the resident's inventory of personal effects sheet, dated, 5/5/24, showed:-Dresses: Several-Ladies sweaters: Several;-Gloves: Several;-One small refrigerator;-Cell phone;-Remarks: The family member will notify the staff after any new items are brought in;-Signed by family representative. 2. Review of Resident #9's, comprehensive MDS, dated , 6/9/25, showed:-An admission date 6/10/24;-The resident is cognitively intact;-The resident is dependent on staff for personal hygiene, toilet hygiene, upper and lower body dressing, and bed to chair transfer;-The resident uses a wheelchair. Review of the resident's inventory of personal effects sheet, dated, 6/10/24, showed:-House slippers: One pair;-Slacks: Several;-Men's hats: Several;-Socks: Several;-Pajamas: Yes;-Shaving kit: Yes;-Small refrigerator; -Remarks: The family member will notify the staff after any new items are brought in;-Signed by family representative. Observation and interview on 8/18/25 at approximately 9:00A.M., showed Resident #68 and Resident #9 share a room. The room had a large curio cabinet with multiple figurines, a land line cordless phone, multiple body lotions, colognes and perfumes, a large digital clock and multiple plastic chest of drawers filled with personal items and snacks. The closets on both sides of the room were filled with multiple clothing items. Resident #68 said about four months ago, he/she had an iPad (computer tablet) and now it is missing. Resident #9 said he/she had a pair of brown shoes that had a non-skid sole so that he/she could wear them to physical therapy. Resident #9 said his/her family member paid $45.00 for the shoes about two weeks ago, and now the shoes are missing. Resident #68 and Resident #9 said staff looked for the shoes, but they could not find them. Resident #68 and Resident #9 said they have not been compensated for their missing items or been offered a lock box to secure items. During an interview on 8/19/25 at 8:55 A.M., the Social Service Director (SSD) said she normally just adds the larger items and more expensive items to the inventory list on admission and the Certified Nursing Assistants (CNAs) are responsible for updating the inventory list when new items arrive to the resident's room. The inventory sheets are kept in her office in a book. CNAs can write new items that the resident receives on a piece of paper or inform the SSD verbally and the SSD will then add the items to the list. The SSD said the process of inventory sheets has not been completed lately. During an interview on 8/19/25 at approximately 9:00 A.M., CNA B said there is an inventory sheet for staff to fill out when a resident is admitted or when any new items come in for a resident. CNA B said he/she does not know where the inventory sheets are kept or who is responsible to keep them updated. During an interview on 8/19/25 at 9:25 A.M., Licensed Practical Nurse (LPN) J said he/she was not sure how the inventory sheets are being completed or who is responsible to fill them out. During interviews on 8/20/25 at 1:47 P.M. and on 8/26/25 at 1:38 P.M., the Administrator said he would expect the inventory list to be completed accurately on admission and when the (continued on next page)

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F 0620 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	resident receives new items. He was not aware of Resident #68's missing iPad and Resident #9's missing shoes. The admission Director is responsible for initiating the inventory sheets on admission and the CNAs are responsible to add items as needed to the list. This process is currently not in place, and he is aware the inventory sheets are not being filled out. The Administrator said he was not familiar with the verbiage in the admission packet and was not aware of that the admission packet stated the facility is not responsible for lost or stolen items. The admission packet needs to be updated to clearly reflect the regulations related to the residents' personal belongings.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure residents received an accurate assessment reflective of the residents' status at the time of assessment by coding side rails as restraints on the Minimum Data Set (MDS, a federally mandated assessment instrument completed by facility staff) for four residents who were determined to use side rails without restriction of freedom of movement (Residents #49, #10, #11, and #35). The sample was 18. The census was 75.Review of the facility's Resident Assessment Instrument (RAI) policy, created 4/14/25, showed facility will adhere to Centers for Medicare and Medicaid Services (CMS) regulations which are considered the definitive source in completion of the RAI process. This includes coding the MDS with accuracy, completion of Care Area Assessments (CAAs) and the development of the comprehensive care plan. Facility will use the CMS RAI manual for completion of the RAI process.Review of the CMS Long-Term Care (LTC) Facility RAI 3.0 User's Manual, revised October 2024, showed:-Section P: The intent of this section is to record the frequency that the resident was restrained by any of the listed devices, at any time during the day or night, during the 7-day look=back period. Assessors will evaluate whether or not a device meets the definition of a physical restraint and code only the devices that meet the definitions in the appropriate categories;-Physical restraints are any manual method or physical or mechanical device, material or equipment attached or adjacent to the resident's body that the individual cannot remove easily which restricts freedom of movement or normal access to one's body.1. Review of Resident #49's medical record, showed diagnoses included morbid obesity and generalized muscle weakness.Review of the resident's Device/Restraint evaluation, dated 11/21/24, showed:-Device: Side rails;-Medical symptoms necessitating device/restraint: Bed positioning or transferring;-Does this device meet the definition of a restraint per the RAI manual: No.Review of the resident's quarterly MDS, dated [DATE], showed:-Cognitively intact;-Dependent on assistance to roll left and right, to move sitting to lying, and to move lying to sitting;-Physical restraints: Bed rails used daily.Review of the resident's care plan, in use at the time of survey, showed:-Focus: Assist bars - resident has 1/4 rail to increase independence with bed mobility;-Tasks included: Complete initial assessment and consent per facility protocol. Repeat assessment quarterly or as indicated. Observation and interview on 8/14/25 at 11:51 A.M., showed the resident in bed with quarter-length rails raised on both sides of the bed at the head of the bed. The resident was positioned so his/her upper body was supported by the side rail to his/her left side. The resident said he/she uses the side rails for repositioning.2. Review of Resident #10's medical record, showed diagnoses included generalized muscle weakness and anxiety.Review of the resident's quarterly MDS, dated [DATE], showed:-Cognitively intact;-Dependent on assistance to roll left and right, to move sitting to lying, and to move lying to sitting;-Physical restraints: Bed rails used less than daily.Review of the resident's care plan, in use at the time of survey, showed:-Focus: Resident uses 1/4 rails to increase bed mobility due to diagnosis related to impaired mobility;-Tasks included to remove when no longer benefiting resident. Observation and interview on 8/15/25 at 8:45 A.M., showed the resident in bed with halo-shaped rails raised on both sides of the bed at the head of the bed. The resident said he/she uses the rails when he/she wants to sit up.3. Review of Resident #11's quarterly MDS, dated [DATE], showed:-Short and long-term memory problem; -Partial to moderate assistance required to roll left and right and to move from lying to sitting;-Diagnoses included dementia and history of stroke;-Physical restraints: Bed rails less than used daily.Review of the resident's care plan, in use at the time of survey, showed:-Focus: Assist bars - resident has 1/4 rails to increase independence in transferring and/or bed mobility;-Tasks included to remove when no longer benefiting resident.Observation and interview on 8/19/25 at 8:48 A.M., showed the resident in bed with U-shaped rails raised on both sides of the bed at the head of the bed. The resident said he/she did not know what the rails were or what to do with them. 4. Review of Resident #35's (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	quarterly MDS, dated [DATE], showed:-Cognitively intact;-Upper and lower extremity impairment on both sides;-Dependent for assistance to roll left and right, to move sitting to lying, and to move lying to sitting;-Diagnoses included neurofibromatosis (condition characterized by changes in skin coloring and the growth of tumors along nerves in the skin, brain, and other parts of the body);-Physical restraints: Bed rails used less than daily;Review of the resident's care plan, in use at the time of survey, showed:-Focus: The resident has an activities of daily living (ADL) self-care performance deficit;-Tasks included bed mobility - the resident is totally dependent on staff for repositioning and turning;-The care plan failed to identify the resident's use of side rails. Observation and interview on 8/19/25 at 8:35 A.M., showed the resident in bed with full-length side rails raised on both sides of the bed. The resident said he/she has minimal movement of his/arms due to tumors on his/her spine. He/She has not had any falls at the facility. He/She cannot turn him/herself. He/She is not sure why he/she has rails on his/her bed because he/she cannot use them. 5. During an interview on 8/19/25 at 2:48 P.M., the MDS Coordinator said restraints are not used by any resident in the facility. When a resident uses side rails, she marks them as in use in the restraint section of the MDS. She was not aware that if side rails are not used as a restraint, she should not mark them as in use in the restraint section.6. During an interview on 8/20/25 at 7:32 A.M., the Administrator said restraints are not used by any resident in the facility. Side rails used by residents are to assist with repositioning are not a restraint. Side rails used for repositioning should not be marked as restraints on the MDS. He expects the MDS Coordinator to code items in accordance with the guidelines outlined in the RAI Manual.

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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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure services provided met professional standards of practice when one resident (Resident #27) did not receive his/her routine anti-anxiety medication as prescribed for over two weeks. The facility also failed to document accurate weights on one resident (Resident #10) and failed to document when two residents (Resident #9 and Resident #68) left the facility for outside appointments and when the residents returned to the facility. The sample was 18. The census was 75. Review of the facility's Medical Provider Orders policy, revised 4/7/23, showed:-Policy: The facility shall use uniform guidelines for the ordering and following of medical provider orders;-Following of Medication and/or Treatment Orders;-Staff should follow all valid medical provider orders timely unless there is an emergency which would temporarily delay the implementation of the order;-The policy did not provide guidance for processes on reordering medications or pulling medications from the emergency kit (E-kit) if a prescribed medication was unavailable.Review of the facility's Weight Monitoring Program Guidelines policy, dated 10/11/10, showed:-The Director of Nursing (DON)and the Staff Development Coordinator will be responsible for monitoring the weights of each resident in the facility;-All new admissions will be added to the weekly schedule for the first four weeks after admission; After that time the assigned Nurse Manager will assess the stability of the resident's weight and decide when to continue to monitor the residents weight on a weekly basis or monthly basis. -The Nurse Manager will monitor on a weekly basis if the residents will be added to or removed from the weekly weight list;-The Nurse Manager will review significant weight gains and losses. 1. Review of Resident #27's medical record, showed:-Diagnoses included anxiety;-A physician order, dated 9/12/24, for clonazepam 1 milligram (mg), one tablet by mouth at bedtime for anxiety.Review of the resident's July and August 2025 Medication Administration Record (MAR) and progress notes related to clonazepam, showed:-A nurse's note, dated 7/31/25, showed the medication was ordered;-A nurse's note, dated 8/5/25, showed the medication is out of stock;-A nurse's note, dated 8/8/25, showed waiting on pharmacy to deliver medication;-A nurse's note, dated 8/9/25, showed waiting on medication to be sent by pharmacy, no access to E-kit;-A nurse's note, dated 8/11/25, showed waiting on medication from pharmacy;-A health status note, dated 8/11/25, showed nurse spoke to the resident's primary care physician, Physician EE, regarding resident's clonazepam. Per Physician EE, the facility's psychiatrist, Physician FF, was responsible for filling the script. Pharmacy contacted. Per pharmacy, will send additional request to Physician FF for medication. Resident made aware;-Staff documented 9 to indicate medication not received on 16 occasions from 7/26/25 through 8/13/25.Review of the resident's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 8/13/25, showed the resident cognitively intact.Review of the resident's care plan, in use at the time of survey, showed:-Focus: The resident has a potential psychosocial well-being problem related to anxiety;-Focus: The resident has a mood problem;-Tasks included the resident is taking anti-anxiety medications.During an interview on 8/18/25 at 12:04 P.M., the resident said there are issues with getting some medications consistently. He/She was recently out of clonazepam for two weeks. The clonazepam was back in stock within the past week. The facility needed a script from a psychiatrist. Two weeks was too long to be without his/her medication. He/She takes clonazepam for anxiety. He/She had an increase in anxiety during his time without the medication. During an interview on 8/19/25 at 8:51 A.M., Licensed Practical Nurse (LPN) J said the resident was out of clonazepam. The facility was waiting on a signed script from Physician EE. The resident even personally called Physician EE to request refills. Facility nurses have sent scripts and tried contacting Physician EE. When a resident is out of medication, they should notify the physician to get the order filled and pass the information along to the oncoming shift.During an interview on 8/20/25 at 9:31 A.M., Registered Nurse (RN) A said the resident's clonazepam was (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	received on 8/13/25 after being out of stock for two weeks. Physician EE is the resident's physician, but cannot prescribe narcotic medication, so the medication has to be prescribed by Physician FF. The facility has issues getting a hold of Physician FF. When the resident's clonazepam ran out, staff should have pulled it from the E-kit. When a nurse pulls narcotics from the E-kit, it has be removed in the presence of two witnesses. The facility uses some agency nurses and they do not have access to the E-kit, so this is another problem. The resident should not have been without his/her medication for two weeks. People cannot just stop taking medications like that right away. During an interview on 8/19/25 at 11:04 A.M., the DON said there have been ongoing issues getting a response from Physician EE. Clonazepam is a narcotic medication and Physician EE cannot prescribe narcotics, so he/she refers his/her residents to the psychiatrist, Physician FF, for narcotic anxiety medication, or to a pain management clinic for narcotic pain medication. This results in delays in residents getting some of their medications. If a resident is out of their prescribed narcotic medication and Physician EE is their primary physician, nurses should reach out to the facility's medical director, Physician GG, regarding the issue. Nurses could also check the E-kit for the medication.Review of the facility's E-kit Active Inventory list, reviewed 8/19/25, showed a quantity of 23 clonazepam 0.5 mg tablets on hand.During an interview with the DON and Administrator on 8/20/25 at 1:48 P.M., they said they expected residents to receive their medications as prescribed. If a narcotic medication is not on hand, staff should call the pharmacy and place a STAT (immediate) order for the medication, which would require a script from the physician. Since Physician EE cannot prescribe narcotic medication, staff could contact the medical director, Physician GG. Staff should pull the medication, if available, from the E-kit. If a medication is not administered, the physician should be notified. Two weeks was too long for the resident to be without his/her anxiety medication. 2. Review of Resident #10's quarterly, MDS, dated [DATE], showed:-Diagnoses included: Malnutrition (inadequate nutrition), dysphagia (difficulty swallowing), gastrostomy status (a tube surgically inserted into the abdomen that is used for medications, liquid nutrition), and adult failure to thrive. Review of the resident's care plan, in use at the time of the survey, showed the care plan did not note the resident's weekly weights. Review of the resident's physician order sheets, dated, August, 2025, showed:-An order, dated 4/7/25, weekly weights, every Monday, day shift. Review of the resident's weight summary located in the resident's medical records, showed:-On 6/16/25: 112.0 pounds (lbs.);-On 6/30/25: 108.0 lbs;-On 7/7/25: 107.0 lbs;-On 7/7/25: 113. 4 lbs;-On 7/14/25: 116.0 lbs;-On 7/21/25: no weight. Review of the resident's paper documentation of weekly weights showed:-On 6/16/25: 110 lbs;-On 6/30/25: 113.4 lbs;-On 7/7/25: 116.0 lbs;-On 7/14/25: 112.0 lbs;-On 7/21/25: 112.0 lbs. During an interview on 8/18/25 at 1:10 P.M., LPN J said the Restorative Aide (RA) obtains all the weights. The RA will then inform the nurse verbally of the weight and the nurse places the weight in the electronic medical record (EMR). During an interview on 8/19/25 at approximately 10:00 A.M., RA W said he/she was responsible to complete all the weights. Weekly weights were completed every Monday. Once the weights are obtained RA W writes them on the weekly weight sheet, and the sheet is kept in his/her office. RA W said he/she will either verbally communicate the resident's weights to the nurse or write the resident's weights on a separate piece of paper and hand it to the nurse. RA W said he/she was instructed by the former DON that he/she is not allowed to place the residents' weights directly into their EMR. RA W said it would be better if he/she could directly place the weights in the EMR so there would be no delays, confusion or inaccuracy of the weights. During an interview on 8/20/25 at 1:27 P.M., the DON said the Charge Nurse on the floor oversees the residents' weights. The RA was responsible to obtain the weights and place them in the EMR. All weights were expected to be added into the EMR timely and accurately to avoid any inaccuracy about the weights. She was not aware that the RA was not placing the weights directly into the EMR. 3. Review of Resident #9's medical record showed diagnoses that include atrial fibrillation (irregular heartbeat), stroke, slurred speech, pacemaker, heart failure, infection of cardiac devices, and muscle weakness. Review of the resident's request transportation form showed:-On 5/20/25 , eye doctor appointment;-On 5/27/25, cardiology (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	(heart) doctor appointment;-On 5/30/25, infectious disease doctor appointment-On 7/15/25 , foot and ankle surgery doctor appointment;-On 8/14/25, wellness visit appointment;-On 8/19/25, foot and ankle surgery doctor appointment. Review of the resident's progress notes showed:-On 5/20/25, no documentation related to the eye doctor's appointment;-On 5/27/24, no documentation related to the cardiology doctor's appointment;-On 5/30/25 at 9:38 A.M., the nurse received a call that the resident arrived late to the appointment, and the appointment was rescheduled for 8/4/25;-On 7/15/25, no documentation related to the foot and ankle surgery doctor's appointment;-On 8/4/25, no documentation related to the rescheduled infectious disease doctor's appointment;-On 8/14/25, no documentation related to the wellness visit appointment;-On 8/19/25, no documentation related to the foot and ankle surgery doctor's appointment. 4. Review of Resident #68's medical record showed diagnoses that included stroke, high blood pressure, edema (swelling), breast cancer, cardiomegaly (weakened and enlarged heart), atrial fibrillation, and lumbar (lower back) radiculopathy (nerve irritation or compression that causes pain). Review of the resident's request transportation forms showed:-On 5/15/25, primary care doctor appointment;-On 5/20/25, eye doctor appointment;-On 6/13/25, pain management doctor appointment;-On 6/17/25, neurology (brain and nervous system) doctor appointment;-On 7/10/25, pain management doctor appointment. Review of the resident's progress notes showed:-On 5/15/25, no documentation related to the primary care doctor's appointment;-On 5/20/25, no documentation related to the eye doctor's appointment;-On 6/13/25, no documentation related to the pain management doctor's appointment;-On 6/17/25, no documentation related to the neurology doctor's appointment;-On 7/10/25, no documentation related to the pain management doctor's appointment. During an interview on 8/19/25 at approximately at 10:15 A.M., the resident said he/she has many doctor appointments due to his/her many medical conditions. Some of his/her appointments are missed due to transportation delays. 5. During an interview on 8/19/25 at 9:25 A.M., LPN J said when the residents go out to any appointments, there should be a note that the resident left for the appointment and when the resident returned. The return note should contain the condition of the resident, any information the resident said about the appointment and any new orders related to the appointment and when the next appointment is scheduled; all that information should be documented in the progress notes. 6. During an interview on 8/20/25 at 1:27 P.M., the Administrator and DON said a progress note is expected to be added every time the resident leaves for an appointment and when they return. The notes are expected to include when the resident left and where they were going. When the resident returns, a note is expected to include what time the resident returned and if there are any new recommendations, orders or appointments that need to be added to the resident's medical record. If the resident does not go to the appointment a note is expected to be added related to the missed appointment. 1611982

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. Based on observation, interview, and record review the facility failed to provide respiratory services consistent with professional standards of practice when staff failed to ensure oxygen tubing and nebulizer (a medical device that administers breathing medication in an aerosol form) face masks were changed when contaminated and properly stored for two residents (Resident #1 and Resident #17). The staff failed follow the physician orders and ensure the resident was received the ordered amount of oxygen for three residents (Resident #17, Resident #10 and Resident #55). The sample was 18. The census was 75. Review of the facility's Oxygen and Therapy Policy and Procedure, undated, showed:-Purpose: To ensure residents who require oxygen therapy receive safe, person-centered, and clinically appropriate respiratory care consistent with professional standards of practice;-Policy Statement: Oxygen requires a licensed prescriber order except for emergency use under the facility's standing emergency protocol, with immediate provider notification; -Preparation and Verification: Verify prescriber order, identify allergies, and review care plan; Inspect equipment for integrity and cleanliness; Confirm concentrator (device that separates oxygen from ambient air to provide continuous oxygen) or cylinder function and oxygen availability; Set up humidification if ordered;-Infection Prevention: Replace components per schedule: Nasal cannula (tubing that administers oxygen) and oxygen tubing weekly and immediately if visibly soiled or contaminated., after respiratory infection: Replace masks at least weekly; Use single-use items: Store equipment covered and off the floor. Review of the facility's Medical Provider Orders, revised 4/7/23, showed:-Policy: -This facility shall use uniform guidelines for the ordering and following of medical provider orders;-Documentation of medication and treatment orders: -Each medication and or treatment order should be documented with the date, time, and signature of the person receiving the order; -If using electronic medical records, input the medication and/or treatment according to the electronic health record instructions and facility policy;-Following of medication and or treatment orders: -Medical provider orders should be reviewed prior to administration of medication and/or treatment to validate the orders contain all required elements; -Staff should follow all valid medical provider orders timely unless there is an emergency which would temporarily delay the implementation of the order; -If an order does not contain all the required elements, staff should contact the ordering provider for clarification of the order prior to implementation of the order. 1. Review of Resident #1's annual Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated, 5/31/25, showed:-Cognitively intact;-Diagnoses included Ogilvie syndrome (acute dilation of the colon) chronic obstructive pulmonary disease (COPD), and major depressive disorder. Review of the resident's care plan, in use at the time of the survey, showed:-Focus: The resident has COPD;-Goal: The resident will display optimal breathing pattern daily through review date;-Interventions: Give oxygen therapy as ordered by the physician. Oxygen at 2 (L) Liters per nasal cannula (NC) as needed via concentrator. Review of the resident's physician orders summary (POS), dated 8/2025, showed:-An order, dated 5/6/25, ipratropium-Albuterol Solution (a medication used to open airway passages) 0.5-2.5 (3) milligrams (mg)/3 milliliters (ml). Inhale three times a day via nebulizer. Observation on 8/18/25 at 11:23 A.M., showed the resident's nebulizer mask on the floor next to the resident's bed, with brown matter on the floor under the mask. The nebulizer mask was dated 9/28/24. The tubing was dated 10/28/24. There was a dusty film on the inside of the mask. Observation on 8/19/25 at 8:33 A.M., showed the resident's nebulizer mask hanging uncovered on a dusty, unused concentrator. The nebulizer mask was dated 9/28/24. The tubing was dated 10/28/24. The mask had a dusty film on the inside. During an interview on 8/19/25 at 7:16 A.M., the resident said staff give him/her the medication for his/her nebulizer treatment, and then he/she sets up and administers the breathing treatment to himself/herself. He/She said he/she does not feel like the nebulizer treatment is working. Observation and interview on 8/19/25 at 11:01 A.M. showed Registered Nurse (RN) H arrived at the resident's room to administer his/her nebulizer (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	treatment. Before administering the treatment, RN H realized the resident's nebulizer mask and tubing needed to be changed. RN H said he/she was not aware that the resident's tubing had not been changed since 2024. He/She said the night shift nurse was responsible for changing oxygen tubing and masks. RN H said he/she did not usually administer the resident's nebulizer treatments due to the resident snatching the medication from him/her. RN H did not stay in the resident's room to ensure the resident administered the treatment properly. During an interview on 8/20/25 at 8:05 A.M., RN C said the resident should be receiving his/her nebulizer treatments three times a day. He/She would expect the nurse to be administering the treatment and not the resident. The resident was not assessed to administer his/her own treatments. RN C would have expected the resident's oxygen tubing to be changed since 2024. During an interview on 8/20/25 at 2:44 P.M., the Director of Nursing (DON) said nurses should be administering the resident's nebulizer treatments. The resident should not be administering his/her own treatments. She would expect the resident's nebulizer mask and tubing to be changed once a week on night shift and cleaned as needed. She would expect the nebulizer mask to be stored properly when not in use. She would expect the resident's nebulizer mask to be off the floor. 2. Review of Resident #17's quarterly MDS, dated , 6/19/25, showed:-Cognitively intact;-Diagnoses included hemiplegia and hemiparesis (muscle weakness or partial paralysis) affecting the non-dominant left side, dementia and acute respiratory failure. Review of the resident's care plan, in use at the time of the survey, showed:-Focus: The resident has asthma;-Goal: The resident will remain free from complications of asthma through the review date;-Interventions: Advise resident to minimize contact with known offending allergens. Give medications as ordered. Monitor/document side effects and effectiveness. Give nebulizer treatments and oxygen therapy as ordered;-Focus: The resident has oxygen therapy, diagnosis of acute respiratory failure;-Goal: The resident will have no symptoms of poor oxygen absorption through the review date;-Interventions: The resident has oxygen via NC at 2L as needed. Review of the resident's POS, dated 8/2025, showed:-An order, revised on 6/16/24, may have oxygen at 2 L as needed;-An order, dated 4/23/25, Albuterol Sulfate Nebulization Solution (a medication used to open airway passages) (2.5 mg/3 ml) 0.083%, inhale orally via nebulizer. Observations on 8/18/25 at 9:51 A.M., 11:24 A.M., and 3:28 P.M., showed the resident in his/her bed asleep. The resident had his/her NC on. The concentrator was turned on and set to 4 L. The resident's nebulizer mask was on the bed uncovered. Observations on 8/19/25 at 7:15 A.M. and 10:31 A.M., showed the resident's uncovered NC on the ground next to the resident's bed. The resident's concentrator was turned on and set to 4 L. During an interview on 8/20/25 at 7:45 A.M., Certified Nursing Assistant (CNA) M said oxygen concentrators should be set to the rate ordered by the physician. Oxygen masks should be stored in a plastic bag when not in use. Nurses were in charge of ensuring resident's concentrators are set to the proper rate. Night shift nurses were responsible for changing oxygen tubing and masks once a week. During an interview on 8/20/25 at 8:05 A.M., RN C said oxygen concentrators are expected to be set at the rate prescribed by the resident's physician. When oxygen is not in use, masks are to be stored in a bag, not on the floor. Oxygen tubing and masks are to be changed once a week by the night shift nurse. During an interview on 8/20/25 at 2:44 P.M., the DON said the resident's oxygen concentrator should be set to 2 L not 4 L. She would expect the resident's NC and nebulizer mask to be stored properly when not in use. 3. Review of Resident #10's, quarterly MDS, dated , 6/27/25, showed:-Cognitively intact;-Diagnoses include malnutrition (inadequate nutrition), dysphagia (difficulty swallowing), adult failure to thrive, and dependence on oxygen;-Requires oxygen therapy. Review of the resident's care plan, in use at the time of survey, showed:-Focus: The resident receives oxygen therapy;-Interventions: The resident has oxygen per nasal cannula or mask at 1 L. Review of the resident's POS, dated August, 2025, showed:-An order dated, 6/16/23, oxygen 1 L continuously. Review of the resident's Medication Administration Record (MAR), dated, 8/1 through 8/14/25 showed:-An order, undated, oxygen 1 L continuously, monitor every shift related to shortness of breath;-On 8/1, 8/2, 8/3, 8/5, 8/6, 8/7, 8/8 8/9/ 8/10/ 8/11, 8/12, 8/13, and 8/14/25, 7:00 A.M. shift documented as completed;-On 8/1, 8/2, (continued on next page)

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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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	8/4, 8/6, 8/7, 8/8, 8/9, 8/10, 8/11, 8/12, 8/13, and 8/14/25, 7:00 P.M. shift documented as completed. Observation on 8/14/25 at 11:00 A.M. and 5:51 P.M., 8/15/25 at 8:09 A.M. and 9:15 A.M., 8/18/25 at 9:05 A.M., and 8/19/25 at 8:44 A.M., showed the resident wearing an oxygen nasal cannula. The nasal cannula was connected to his/her oxygen concentrator The oxygen concentrator was turned on and set on 2 L. During an interview on 8/19/25 at 9:25 A.M., Licensed Practical Nurse (LPN) J said the resident is to be on 1 L of oxygen and did not know why the resident's oxygen concentrator was set on 2 L. Checking the resident's oxygen concentrator for the correct setting should be verified every day by the nurse. 4. Review of Resident #55's medical record showed:-An admission date of 8/12/22;-Medical diagnoses included: Diabetes, chronic respiratory failure with hypoxia (a severe, ongoing condition where the lungs cannot supply enough oxygen to the blood), chronic systolic heart failure (a lifelong condition where the heart's left ventricle is too weak or enlarged to pump enough oxygen-rich blood to the body), and dependence on supplemental oxygen. Review of the resident's most recent quarterly MDS, conducted on 6/24/25 showed:-The resident received ongoing oxygen therapy while a resident at the facility. Review of the resident's active physician orders showed:-An active order for oxygen via nasal cannula to be administered at 2L continuously, order placed on 4/13/2022 at 7:08 P.M. Review of the resident's care plan, in use at the time of the survey, showed:-A focus indicating the resident has altered respiratory status and difficulty breathing. Interventions included elevating the head of the bed to 45 degrees, monitoring for symptoms of respiratory distress, and providing oxygen as ordered. Observation and interview on 8/14/25 at 10:55 A.M. showed the resident resting comfortably in bed with oxygen on via nasal cannula. Review of the oxygen concentrator output showed the resident was receiving 3.5 L of oxygen. The resident said he/she did not know the oxygen administration orders, but he/she received oxygen continuously, and this had not been changed since admission to the facility, to his/her knowledge. Observations on 8/15/25 at 1:38 P.M., 8/18/25 at 8:53 A.M., 8/19/25 at 8:30 A.M. and on 8/20/25 at 9:28 A.M., showed the resident resting in bed each day with nasal cannula on and receiving oxygen at 3.5 L per minute. 5. During an interview on 8/20/25 at 8:20 A.M., Certified Medication Technician (CMT) O said the nurses were responsible for ensuring oxygen orders were updated or revised as needed. Active orders should match the output of the resident's oxygen concentrator, and the charge nurse should be notified if the orders are incorrect. 6. During an interview on 8/20/25 at 8:29 A.M., RN C said nursing staff should check a resident's oxygen concentrator on each shift to ensure the resident receives oxygen per the physician's order. If it is noted a resident feels better on a higher dose of oxygen, nursing staff should verify the order with the physician to update it in the medical record. 7. During an interview on 8/20/25 at 1:47 P.M., the DON, said she would expect staff to follow physician orders and document the correct setting of the oxygen. If the resident required more oxygen, staff should notify the physician.

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to assess residents for safety for side rail use, to obtain informed consent for the use of side rails, and to have a policy that provided guidance for staff assessing residents for use of side rails that were not used as a restraint (Residents #35, #11, #48, #10, #49, and #2). The facility identified 14 residents with side rails. The sample was 18. The census was 75.Review of the facility's Use of Restraints policy, reviewed February 2021, showed: - Physical Restraints are defined as any manual method or physical or mechanical device, material or equipment attached or adjacent to the resident's body that the individual cannot remove easily, which restricts freedom of movement or restricts normal access to one's body;-The definition of a restraint is based on the functional status of the resident and not the device. If the resident cannot remove a device in the same manner in which the staff applied it given that resident's physical condition, and this restricts his/her typical ability to change position or place, that device is considered a restraint;-The policy failed to provide procedural guidance for staff to follow regarding the use of side/bed rails, grab bars, and enabling devices that are not used to restrict movement. 1. Review of Resident #35's medical record, showed:-Diagnoses included neurofibromatosis (condition characterized by changes in skin coloring and the growth of tumors along nerves in the skin, brain, and other parts of the body);-No physician order for the use of side rails;-No nursing assessment for the use of side rails;-No signed consent for the use of side rails.Review of the resident's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 7/9/25, showed:-Cognitively intact;-Upper and lower extremity impairment on both sides;-Dependent for assistance to roll left and right, to move sitting to lying, and to move lying to sitting;-Physical restraints: Bed rails used less than daily.Review of the resident's care plan, in use at the time of survey, showed:-Focus: The resident has an activities of daily living (ADL) self-care performance deficit;-Tasks included bed mobility - the resident is totally dependent on staff for repositioning and turning;-The care plan failed to identify the resident's use of side rails. Observation on 8/18/25 at 3:28 P.M., showed the resident in bed with full-length side rails raised on both sides of the bed. Observation and interview on 8/19/25 at 8:35 A.M., showed the resident in bed with full-length side rails raised on both sides of the bed. The resident said he/she has minimal movement of his/arms due to tumors on his/her spine. He/She has not had any falls at the facility. He/She cannot turn him/herself. He/She is not sure why he/she has rails on his/her bed because he/she cannot use them. During an interview on 8/20/25 at 9:31 A.M., Registered Nurse (RN) B said he/she did not think the resident had side rails because he/she cannot move his/her arms.2. Review of Resident #11's medical record showed:-Diagnoses included dementia and history of stroke;-No physician order for the use of side rails;-No nursing assessment for the use of side rails;-No signed consent for the use of side rails.Review of the resident's quarterly MDS, dated [DATE], showed:-Short and long-term memory problem;-Partial to moderate assistance required to roll left and right and to move from lying to sitting.Review of the resident's care plan, in use at the time of survey, showed:-Focus: Assist bars - resident has 1/4 rails to increase independence in transferring and/or bed mobility;-Tasks include remove when no longer benefiting resident.Observations on 8/15/25 at 9:29 A.M. and 8/18/25 at 9:14 A.M., showed the resident in bed with U-shaped rails raised on both sides of the bed at the head of the bed. Observation on 8/19/25 at 8:48 A.M., showed the resident in bed with U-shaped rails raised on both sides at the head of the bed. During an interview, the resident said he/she did not know what the rails were or what to do with them. 3. Review of Resident #48's medical record, showed:-Diagnoses included morbid obesity, generalized muscle weakness, lack of coordination, and abnormal posture;-No physician order for the (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	use of side rails;-No nursing assessment for the use of side rails;-No signed consent for the use of side rails.Review of the resident's quarterly MDS, dated [DATE], showed:-Cognitively intact;-Lower extremity impairment on both sides;-Dependent on assistance to roll left and right, to move from sitting to lying, and to move from lying to sitting.Review of the resident's care plan, in use at the time of survey, showed:-Focus: The resident has an ADL self-care performance deficit and requires maximum assistance;-Tasks included two half-length side rails up to assist with bed mobility. Observation on 8/15/25 at 8:10 A.M., showed the resident in bed with half-length rails raised on both sides of the bed at the head of the bed. Observation and interview on 8/18/25 at 8:46 A.M., showed the resident in bed with half-rails raised on both sides at the head of the bed. The resident said he/she uses the rails for positioning.Observation on 8/19/25 at 9:10 A.M, showed the resident in bed with half-rails raised on both sides at the head of the bed. During an interview on 8/20/25 at 9:31 A.M., RN A said the resident uses side rails for repositioning.4. Review of Resident #10's medical record, showed:-Diagnoses included generalized muscle weakness and anxiety;-No physician order for the use of side rails;-No nursing assessment for the use of side rails;-No signed consent for the use of side rails.Review of the resident's quarterly MDS, dated [DATE], showed:-Cognitively intact;-Dependent on assistance to roll left and right, to move sitting to lying, and to move lying to sitting.Review of the resident's care plan, in use at the time of survey, showed:-Focus: Resident uses 1/4 rails to increase bed mobility due to diagnosis related to impaired mobility;-Tasks included to remove when no longer benefiting resident. Observation and interview on 8/15/25 at 8:45 A.M., showed the resident in bed with halo-shaped rails raised on both sides of the bed at the head of the bed. The resident said he/she uses the rails when he/she wants to sit up.Observation on 8/19/25 at 9:08 A.M., showed the resident in bed with halo-shaped rails raised on both sides at the head of the bed.During an interview on 8/20/25 at 9:31 A.M., RN A said the resident uses side rails for repositioning.5. Review of Resident #49's medical record, showed:-Diagnoses included morbid obesity and generalized muscle weakness;-No physician order for the use of side rails;-No signed consent for the use of side rails.Review of the resident's Device/Restraint evaluation, dated 11/21/24, showed:-Assessment status: In progress;-Does the resident use or request to use bed rails: Blank;-Device: Side rails;-Medical symptoms necessitating device/restraint: Bed positioning or transferring.Review of the resident's quarterly MDS, dated [DATE], showed:-Cognitively intact;-Dependent on assistance to roll left and right, to move sitting to lying, and to move lying to sitting;-Physical restraints: Bed rails used daily.Review of the resident's care plan, in use at the time of survey, showed:-Focus: Assist bars - resident has 1/4 rail to increase independence with bed mobility;-Tasks included: Complete initial assessment and consent per facility protocol. Repeat assessment quarterly or as indicated. Observation and interview on 8/14/25 at 11:51 A.M., showed the resident in bed with quarter-length rails raised on both sides of the bed at the head of the bed. The resident was positioned so his/her upper body was supported by the side rail to his/her left side. The resident said he/she uses the side rails for repositioning.Observations on 8/15/25 at 7:42 A.M. and 8/18/25 at 11:47 A.M., showed the resident in bed with quarter-length rails raised on both sides at the head of the bed. During an interview on 8/20/25 at 9:31 A.M., RN A said the resident uses side rails for repositioning.6. Review of Resident #2's medical record showed:-An admission date of 8/1/13;-Medical diagnoses including hemiplegia and hemiparesis (paralysis, loss of strength, and weakness on one side of the body) of the right side, aphasia (inability to form spoken words), and Parkinson's Disease (a progressive neurodegenerative disorder affecting the brain, primarily causing motor symptoms like tremors, muscle stiffness, and slowness of movement).Observation on 8/14/25 at 11:18 A.M., showed the resident resting in a low bed with 1/2 rails up on both sides of the bed.Observation on 8/15/25 at 8:51 A.M., showed the resident resting in a low bed with 1/2 rails up on both sides of the bed.Observation on 8/18/25 at 2:18 P.M., showed the resident resting in a low bed with 1/2 rails up on both sides of the bed.Review of the resident's assessments showed no assessment conducted or documented indicating the resident was evaluated for safe use of bed rails (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	while residing at the facility.Review of the resident's active physician orders showed no order for bed rails while residing at the facility.Review of the resident's care plan, in use at the time of survey, showed no mention of the resident's use of side rails or the necessity to evaluate the resident for use of the device.During an interview on 8/20/25 at 9:31 A.M., RN A said the resident uses side rails for mobility.7. During interview on 8/20/25 at 8:29 A.M., RN C said any resident with side rails requires a safety assessment to ensure the device is safe for the resident to use. If a resident is deemed safe to use the device, a physician order is obtained by the nursing staff for its use. RN C was unsure how often safety evaluations are repeated, but would assume they are completed at least yearly.8. During an interview on 8/20/25 at 9:31 A.M., RN A said nurses should complete an assessment for the use of side rails upon a resident's admission. Therapy can assess a resident for side rails if the resident is admitted for a short-term stay. A physician order should be obtained for the use of a side rail. Documentation of a resident's consent for the use of side rails is not required.9. During an interview on 8/19/25 at 12:32 P.M., the Director of Rehabilitation said therapy can assess residents for the use of side rails. Once their assessment is documented, they obtain a physician order for the use of side rails, or they give their assessment to the Director of Nurses (DON) for her to obtain the physician order. During an interview on 8/19/25 at 1:55 P.M., the Director of Rehabilitation said she could not locate side rail assessments completed by therapy for Residents #35, #11, #48, #10, or #49. 10. During an interview with the DON and Administrator on 8/20/25 at 1:48 P.M., the DON said she prefers for side rails not to be used. When a resident has side rails, it is usually because their family requested them. If a resident or family member requests side rails, the nurse must obtain a signed consent and document it in the resident's medical record. Nurses should complete an assessment for the resident's ability to use side rails safely. This can also be done by the Director of Rehabilitation. After the initial assessment, neither the DON nor Administrator were sure if the assessment is done again. If a resident is determined to be able to use side rails, a physician order must be obtained.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure residents were served food at a palatable, safe, and appetizing temperature during meal service. This affected 10 of 18 sampled residents (Residents #5, #7, #17, #26, #27, #48, #54, #60, #64 and #68). The census was 75. Review of the facility's meal temperature policy, revised 1/2019, showed:-Purpose: To ensure appropriate food temperatures during meal service and to ensure appropriate food holding temperatures. To comply with federal and state regulations governing food meal service;-Policy: Meals temperatures shall be monitored by the Dietary Manager and the Cooks on a daily basis. Hot food shall be cooked or heated to a temperature above 165 degrees Fahrenheit (F) . Cold food shall be chilled to a temperature below 40 degrees F. Foods shall be provided at point of service to support resident/patient satisfaction. Temperatures of hot food shall be supported to promote service temperatures of hot foods to about 120 degrees F and cold foods to below 50 degrees F. 1. Review of Resident #5's medical record, showed:-Cognitively intact;-Diagnoses included hypertension (HTN, high blood pressure), end stage renal disease (ESRD, permanent kidney failure requiring transplant or dialysis for survival), history of transient ischemic attack (TIA, a temporary interruption in blood flow to the brain causing stroke-like symptoms) and tType 2 diabetes. During an interview on 8/18/25 at 7:40 A.M. the resident said meals at the facility are often served cold and taste bland. A hamburger was served for dinner over the weekend that the resident described as burned, dry, and covered in a nasty sauce. 2. Review of Resident #7's comprehensive Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 8/16/25, showed:-Cognitively intact;-Independent with eating;-Diagnoses included emphysema (lung disease), heart failure, breast cancer, iron deficiency anemia, hyperlipidemia and chronic kidney disease. During an interview on 8/14/25 at 12:18 P.M., the resident said the only issue he/she has with the facility is the food. The food is always cold when it is supposed to be hot. The food doesn't taste good. He/She doesn't bother asking for an alternative food because it won't be good or hot, either. Observation on 8/14/25 at 12:54 P.M., showed the resident eating lunch in his/her room. The food on his/her plate consisted of a pinkish meat, diced mixed vegetables, and mashed potatoes. During an interview, the resident said the food was meh and not very good. 3. Review of Resident #17's quarterly MDS, dated [DATE], showed:-Cognitively intact;-Diagnosis included hemiplegia and hemiparesis (muscle weakness or partial paralysis) affecting the non-dominant left side, dementia and acute respiratory failure. During an interview on 8/14/2025 at 11:19 A.M., the resident said the food is not good. The food is usually cold when delivered. 4. Review of Resident #26's quarterly MDS, dated [DATE], showed:-Cognitively intact;-Independent with eating;-Diagnoses included depression and bipolar disorder (mood disorder that can cause intense mood swings).During an interview on 8/14/25 at 5:36 P.M., the resident said food is often served cold. Residents can ask staff to microwave their food, but he/she doesn't like doing this because he/she feels like he/she is being inconvenient. 5. Review of Resident #27's quarterly MDS, dated [DATE], showed:-Cognitively intact;-Independent with eating;-Diagnoses included diabetes, acute kidney failure, high blood pressure, dehydration, depression, and anxiety. During an interview on 8/18/25 at 12:04 P.M., the resident said the food served by the facility is terrible. The food is served cold when it should be hot. The food tastes bad and can be undercooked. 6. Review of Resident #48's quarterly MDS, dated [DATE], showed:-Cognitively intact;-Setup or clean-up assistance required for eating;-Diagnoses included diabetes, hyperlipidemia, high blood pressure, and morbid obesity. Observation on 8/15/25 at 8:13 A.M., showed Certified Nurse Aide (CNA) HH delivered a breakfast tray to the resident's room. At 8:28 A.M., the resident's breakfast tray contained a scoop of scrambled eggs and a biscuit. During an interview, the resident said his/her food was served cold and it was not enough to eat. At 9:05 A.M., CNA HH removed the resident's breakfast tray. As he/she was leaving the room, the resident said his/her food was nasty. CNA HH laughed and (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	said he/she would remove the tray for the resident. CNA HH did not offer to get the resident an alternate. Observation on 8/18/25 at 8:46 A.M., showed the resident in bed with a tray of breakfast on his/her bedside table, consisting of a scoop of scrambled eggs and a donut. No dietary slip on the breakfast tray. During an interview, the resident said this is ridiculous. He/She is hungry and did not get served enough to eat. He/She is upset, tired and hungry. 7. Review of Resident #54's medical record, showed:-Cognitively intact;-Diagnoses included acute kidney failure, muscle weakness and depression. During an interview on 8/14/2025 at 12:03 P.M., the resident said the food is horrible. He/She said food temperatures are cold when food is delivered. He/She said two months ago, the kitchen served raw meat to the residents. 8. Review of Resident #60's comprehensive MDS, dated [DATE], showed:-Moderate cognitive impairment;-Setup or clean-up assistance required for eating;-Diagnoses included diabetes, adult failure to thrive, heart disease, chronic obstructive pulmonary disease (lung disease) and dementia. Observation on 8/18/25 at 8:47 A.M., showed the resident eating breakfast in his/her room. Breakfast consisted of one donut and one scoop of scrambled eggs. No dietary slip was on the tray. During an interview, the resident said his/her breakfast was not good. The donut was not sweet and it was dry. The food served at the facility does not taste good. It is always served cold when it should be hot. 9. Review of Resident #64's quarterly MDS, dated [DATE], showed:-Cognitively intact;-Diagnosis included type two diabetes, muscle weakness and major depressive disorder. During an interview on 8/14/2025 at 1:48 P.M., the resident said the food is awful. The coffee is not hot when served. Staff do not offer refills. 10. Review of Resident #68's quarterly MDS, dated [DATE], showed:-The resident is cognitively intact;-Diagnoses include stroke, high blood pressure and heart failure. During an interview on 8/14/25 at 5:58 P.M., the resident said he/she does not eat the food in the facility. The food does not look appetizing, and it is often cold. The food is not nutritious and does not provide the 5 food groups. The resident's family brings in meals for him/her every day. 11. Observation on 8/14/25 at 5:37 P.M., of dinner on the [NAME] hallway, showed:-Baked beans measured 103.2 degrees F;-Barbeque (BBQ) burger measured 92.3 degrees F. The meat was chewy. Observation on 8/14/25 at 5:53 P.M., of dinner on the East hallway, showed:-BBQ burger measured 95.6 degrees F. The meat was bland and chewy. 12. During a group interview on 8/18/25 at 11:03 A.M., six out of six residents, whom the facility identified as alert and oriented, said there are ongoing issues with dietary. Food that is supposed to be hot is served cold. Food is served that is not cooked all the way through. They have discussed this in resident council meetings and the dietary issues have continued. During an interview on 8/14/25 at 11:43 A.M., CNA B said the food served at the facility is terrible, not good. The residents don't like the food and won't eat it. The portions are small and residents do not get enough to eat. The food is always served cold when it should be hot. During an interview on 8/19/25 at 1:03 P.M., Dietary Aide F said food should be served at a safe and palatable temperature and should taste good. During an interview on 8/19/25 at 12:44 P.M., the Dietary Manager said food should be delivered to residents at a safe and palatable temperature to prevent illness. She said the food has not been served at the required temperature due to broken kitchen appliances not warming the food. During an interview on 8/20/2025 at 2:12 P.M., the Administrator and Director of Nursing (DON) said they expected food to be served to residents at a safe and palatable temperature. They expected food to be palatable. They expected staff to heat up food if it is not at the appropriate temperature. 161200116119951611992

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide food that accommodates resident allergies and preferences, and to provide alternative meal options (Residents #26, #5, #49, #48, #60, #27, #35, and #55). The sample was 18. The census was 75.1. Review of the facility's resident council meeting minutes, showed:-On 6/25/25, 13 residents in attendance. Staff are not properly reading the tickets and sending meals to their rooms that their tickets state they do not want. Alternative menus - some meals they do not have in the kitchen, so they do not reach out to ask if they want another alternative meal; -On 7/16/25, 20 residents in attendance. Residents complained the kitchen staff is rude and fail to read the tickets accurately. They also noted that some meals are not available. One resident expressed frustration of being served daily eggs when he/she is allergic to eggs. During a group interview on 8/18/25 at 11:03 A.M., six out of six residents, whom the facility identified as alert and oriented, said there are ongoing issues with dietary. They have discussed their concerns with staff in resident council meetings and the dietary issues have continued. The facility does not post menus, so residents do not know what meal are going to be served. The facility has an alternate menu, but the kitchen is out of stock of the items on the alternate menu all the time. Three of the six residents in attendance said when dietary slips are provided with meals, staff do not follow the guidance on the dietary slips. 2. Observations on 8/14/25 at 10:14 A.M., 8/15/25 at 8:54 A.M., and 8/18/25 at 8:30 A.M., showed no menus posted in the facility. During an interview on 8/19/25 at 1:56 P.M., the Dietary Manager (DM) said the expectation is that the menus for each day and for the month are to be posted on the wall outside the main dining room. This has not been done. 3. Review of Resident #26's electronic medical record (EMR), showed:-Diagnoses included depression and bipolar disorder (mood disorder that can cause intense mood swings);-Allergies to eggs and poultry flagged at the top of the screen in the EMR;-A comprehensive nutritional assessment, dated 3/6/24, showed allergies to eggs and poultry. Resident has an allergy to chicken;-A physician order, dated 2/15/25, for regular diet. Allergies: Eggs, poultry. Review of the resident's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 5/31/25, showed:-Cognitively intact;-Independent with eating. Review of the resident's care plan, in use at the time of survey, showed a focus of the resident has nutritional problem or potential nutritional problem. No documentation related to the resident's allergies of food preferences. Review of the resident's dietary slips, undated, showed NO EGGS (ALLERGY) and NO POULTRY (ALLERGY) at the top of the slips for breakfast, lunch, and dinner. During an interview on 8/14/25 at 5:36 P.M., the resident said he/she is allergic to poultry and eggs. He/She is served eggs at breakfast all the time. If eggs are on the menu for breakfast, he/she is supposed to get an alternate meat. Observation on 8/18/25 at 9:07 A.M., showed the resident in his/her room eating breakfast. During an interview, the resident said he/she was served eggs for breakfast yesterday. The resident showed a picture he/she took on his/her phone of the eggs. The picture showed a plate of scrambled eggs, and the picture was timestamped 8/17/25 at 9:06 A.M. During an interview on 8/20/25 at 8:24 A.M., Certified Nurse Aide (CNA) B said the resident is allergic to eggs and gets served eggs all the time. 4. Review of Resident #5's quarterly MDS, dated [DATE], showed:-Cognitively intact;-Setup or clean-up assistance required for eating;-Diagnoses included high blood pressure, kidney failure, and diabetes. During an interview on 8/18/25 at 7:40 A.M., the resident said he/she was served a burger for dinner over the weekend that was burned, dry, and covered in nasty sauce. He/She asked for a hotdog as a substitute but was told by dietary staff the item was not available. Observation on 8/18/25 at 12:45 P.M., showed the resident in the hallway outside of the kitchen. He/She requested a hotdog for lunch. Dietary Aide (DA) OO said no, he/she does not get a hotdog today, DA OO will give him/her a burger. During an interview on 8/18/25 at 12:55 P.M., the resident said he/she wanted a hotdog for lunch. He/She has been (continued on next page)

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	265236	A. Building B. Wing	08/20/2025

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	wanting a hotdog for two weeks, and they never have any. It makes him/her upset. He/She eats a burger every day and he/she doesn't want another burger. 5. Review of the facility's alternate menu, undated, showed:-Please circle: Lunch or dinner;-Date, resident name, room;-Please circle your choice:-Grilled cheese;-Soup;-Hamburger and chips;-Cheeseburger and chips;-Deli sandwich and chips;-Chef salad;-Hot dog and chips;-Tuna salad and chips;-Please have completed and return to Dietary by 10:00 A.M. for lunch and 3:30 P.M. for dinner. Observation of the kitchen on 8/18/25 at 12:27 P.M., showed no hot dogs or tuna in the food storage areas. Cans of cream of chicken soup were located in the pantry. During an interview on 8/18/25 at 12:35 P.M., DA OO and the DM said food listed on the alternate menu is always available. Residents must fill out their request for an alternate and give it to dietary two hours in advance of each meal. The facility is out of hot dogs right now. They are also out of tuna. The only soup they have is cream of chicken, which is more of a base for other dishes rather than a soup someone would order to eat at a meal. 6. Review of Resident #49's medical record, showed:-Diagnoses included respiratory failure, morbid obesity, diabetes, heart failure, kidney failure, dysphagia (difficulty swallowing), disorientation, depression, anxiety, schizophrenia (serious mental illness that affects how a person thinks, feels, and behaves), and schizoaffective disorder (mental illness combining symptoms of a mood disorder and schizophrenia);-A quarterly nutritional assessment, dated 3/1/24 with blank fields for food likes and food dislikes;-No other nutritional assessments completed after 3/1/24. Review of the resident's quarterly MDS, dated [DATE], showed:-Cognitively intact;-Supervision or touching assistance required for eating. Review of the resident's care plan, in use at the time of survey, showed a focus of the resident has a nutritional problem. No documentation related to the resident's food preferences was noted in the care plan. Review of the resident's dietary slips, undated, showed no documentation of likes or dislikes for breakfast, lunch, or dinner. During an interview on 8/14/25 at 11:51 A.M., the resident said the food has gone downhill. He/She doesn't like eggs or cheese and he/she gets served that a lot. He/She hates that because he/she doesn't want to waste food. He/She keeps telling staff he/she does not like eggs. He/She loves breakfast, just not eggs. Observation and interview on 8/15/25 at 8:24 A.M., showed the resident in bed with a breakfast tray on his/her table containing scrambled eggs. The eggs were untouched. The dietary slip on the tray did not show the resident's dislike of eggs. The resident said he/she does not like eggs. He/She told the aide and asked for meat or something. The aide said they would be back and they did not return. At 9:22 A.M., the resident's eggs remained on his/her bedside table, untouched. During an interview, the resident said the aide never came back with meat. He/She just received a food delivery of chips and snacks. He/She guesses that is better than nothing. Observation and interview on 8/18/25 at 9:22 A.M., showed the resident in bed with a breakfast tray on his/her bedside table containing scrambled eggs and no dietary slip on the tray. The eggs were untouched. The resident said he/she does not like eggs. 7. Review of Resident #48's medical record, showed diagnoses included diabetes, hyperlipidemia (high cholesterol), high blood pressure and morbid obesity;-A quarterly nutritional assessment, dated 4/23/24, with blank fields for food likes and dislikes;-No other nutritional assessments completed after 4/23/24. Review of the resident's quarterly MDS, dated [DATE], showed:-Cognitively intact;-Setup or clean-up assistance required for eating. Review of the resident's care plan, in use at the time of survey, showed a focus of the resident has a nutritional problem related to morbid obesity and diabetes. No documentation related to the resident's food preferences was noted in the care plan. Review of the resident's dietary slips, undated, showed no documentation of likes or dislikes for breakfast, lunch, or dinner. Observation and interview on 8/18/25 at 8:46 A.M., showed the resident in bed with a tray of breakfast on his/her bedside table, consisting of a scoop of scrambled eggs and a donut, with no dietary slip on the breakfast tray. The resident said there should be a dietary slip on the tray at every meal. Dietary doesn't post a menu anymore, so he/she never knows what he/she is getting and if he/she should request to get something else. 8. Review of Resident #26's medical record, showed:-A comprehensive nutritional assessment, dated 3/6/24, with no likes or dislikes (continued on next page)

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	documented;-No nutritional assessments completed after 3/6/24. Review of the resident's quarterly MDS, dated [DATE], showed:-Cognitively intact;-Independent with eating. Review of the resident's care plan, in use at the time of survey, showed a focus of the resident has nutritional problem or potential nutritional problem. No documentation related to the resident's allergies or food preferences were noted in the care plan. Review of the resident's dietary slips, undated, showed no likes or dislikes documented. During an interview on 8/14/25 at 5:36 P.M., the resident said he/she is allergic to poultry and eggs, so he/she relies on the alternate menu. He/She requests alternates all the time and seldom gets what he/she requested. The kitchen is always out of stuff. 9. Review of Resident #60's comprehensive MDS, dated [DATE], showed:-Moderate cognitive impairment;-Setup or clean-up assistance required for eating;-Diagnoses included diabetes, adult failure to thrive, heart disease, chronic obstructive pulmonary disease (lung disease), and dementia. Review of the resident's care plan, in use at the time of survey, showed no documentation related to the resident's food preferences. Review of the resident's medical record, showed no documentation of nutritional assessments. Observation and interview on 8/18/25 at 8:47 A.M., showed the resident eating breakfast in his/her room, with no dietary slip on the tray. The resident said there are no menus posted in the facility, so residents never know what is going to be served. 10. Review of Resident #27's quarterly MDS, dated [DATE], showed:-Cognitively intact;-Independent with eating;-Diagnoses included diabetes, acute kidney failure, hypertension, dehydration, depression, and anxiety. Review of the resident's care plan, in use at the time of survey, showed a focus of the resident has a potential nutritional problem. No documentation related to the resident's food preferences. Review of the resident's medical record, showed no nutritional assessments documented. During an interview on 8/18/25 at 12:04 P.M., the resident said the facility used to have a menu posted for meals served each day, but they don't do that anymore. The kitchen doesn't actually have the alternates listed. 11. Review Resident #35's quarterly MDS, dated [DATE], showed:-Cognitively intact;-Dependent on assistance for eating;-Diagnoses included neurofibromatosis (condition characterized by changes in skin coloring and the grown of tumors along nerves in the skin, brain, and other parts of the body), hypotension (low blood pressure), and anemia. Review of the resident's care plan, in use at the time of survey, showed a focus of the resident has nutritional problem or potential nutritional problem. No documentation related to the resident's allergies of food preferences were noted in the care plan. Review of the resident's medical record, showed no nutritional assessments documented. During an interview on 3/18/25 at 3:28 P.M., the resident said the staff do not follow diet orders. If residents ask for something specific, they are told no. Last week, the resident asked for something, and the DM said they are not going to do that. If the resident requests toast for breakfast, staff tell him/her toast is not on the menu so he/she can't have that. The resident said, It's bread.how hard can it be to serve the residents toast? 12. Review of Resident #55's comprehensive MDS, dated [DATE], showed:-Cognitively intact;-Setup or clean-up assistance required for eating;-Diagnoses included heart failure, high blood pressure, respiratory failure, diabetes, hyperlipidemia, and depression. Review of the resident's dietary meal ticket slip (undated) showed:-The resident is to be served a regular, low sodium, controlled carbohydrate diet for all meals. During an interview on 8/14/25 at 1:58 P.M., the resident said substitutes are not always available from the kitchen. He/She requested two grilled cheese sandwiches from the kitchen after the lunch meal and was served two bologna sandwiches, both of which were marked as expired as of 8/12/25. 13. Observation and interview on 8/20/25 at 8:10 A.M., showed CNA T passed trays of food to resident rooms on the hallway. None of the trays had dietary slips. CNA T said dietary slips are not on the trays sent out to the hallway by dietary. He/She is just passing trays to residents without knowing what should be on their dietary slips. Dietary slips tell staff if the resident has allergies and what the resident likes/dislikes. Residents should receive the right foods. Menus are not posted in the facility. Residents need to know what is on the menu so they can know if they should request an alternate or not. Observation and interview on 8/20/25 at 8:24 A.M., showed CNA B passed trays to resident rooms from carts on the (continued on next page)

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	hallway. There were no dietary slips on the trays. CNA B said dietary staff are not sending dietary slips out with room trays. Dietary slips should include diet type and if the resident has allergies and what they like/dislike. Staff won't know what is supposed to be on a resident's tray without the dietary slips, unless they get to know the resident over time and learn it themselves. 14. During an interview on 8/20/25 at 10:24 A.M., [NAME] V said when the previous DM left the facility, he/she took his/her computer, and the dietary slips were on the computer. The kitchen has a copy of all dietary slips that were available when the DM left. When plating food at meals, dietary staff go off the recipes for what they put on the plate. If a resident is allergic to eggs, dietary should give the resident meat instead, and/or cold cereal. Hot dogs and soup are on the alternative menu. The kitchen is out of hot dogs. All they have is cream of chicken soup, not real soup that someone would eat as a meal. The DM places orders for food. 15. During an interview on 8/19/25 at 1:56 P.M., the DM she would expect for all items on the alternate menu to be available for the residents. She would expect all alternate menu requests made by residents to be respected. During an interview on 8/20/25 at 10:08 A.M., the DM said dietary staff should refer to dietary slips when plating food for residents. Dietary slips show if the resident has allergies. Ideally, the slips should include the resident's likes/dislikes. Currently, the slips to not include this information. She does not have access to print the dietary slips at this time. The kitchen is out of hot dogs and tuna. They have cream of chicken soup, but no other soups. The kitchen should be stocked with all items that are available on the alternate menu. At this time, the DM is unable to place food orders. Food orders are currently placed by an outside company that is contracted to provide dietician services. The outside company sticks to a budget and only orders the items listed on each recipe for meals on the planned menu. The outside company is not ordering extra items for alternate meals. 16. During an interview with the Director of Nurses (DON) and Administrator on 8/20/25 at 1:48 P.M., they said they expected menus to be posted daily. Dietary staff should be sending dietary slips out with trays during meals. The DM has access to the dietary slips, and she should print them out at meals. Dietary slips should show the resident's name, room number, diet type, and other information, such as allergies and likes/dislikes. Dietary staff should follow the dietary slips when plating food. Nursing should check the dietary slips and make sure the correct items are there before delivering to the resident. The DM should complete assessments with each resident to determine their likes/dislikes. Dietary should have all items available that are listed on the alternate menu. Traditionally, the DM places food orders but since she is new, food orders are placed by an outside company contracted by the facility for dietician services. Residents have the right to ask for and receive alternative meal options. 16119952588074

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 ensure kitchen cooking appliances were in working order, failed to ensure the kitchen and appliances were clean and failed to ensure the dishwasher was in working order. The sample was 18. The census was 75. Review of the facility's kitchen daily cleaning schedule, undated, showed:-The cook is responsible for cleaning the oven, deep fryer, steam table, preparation station table, and microwave;-Dietary Aides are responsible for cleaning stainless steel, walk-in freezer, dish machine area, reach in refrigerator, and walk-in refrigerator. Review of the kitchen maintenance logs, showed no maintenance requests were made from 1/1/25 to 8/20/25 for the broken oven, range oven or walk-in freezer door. 1.Observation on 8/14/25, of the kitchen, showed:-At 10:17 A.M., the walk-in freezer door did not close all the way. Ice was built up on the floor near the door. There was no temperature log for the walk in freezer;-At 10:19 A.M., the dry storage room had food and trash debris on the floor under the racks. Two ceiling tiles above the food storage had a black, mold-like substance;-At 10:23 A.M., the walk-in refrigerator had trash and food debris on the floor. There was no temperature log for the walk in refrigerator;-At 10:26 A.M., the floor surrounding the oven had food debris and a liquid spill/build up;-At 10:27 A.M., the large oven had food debris and build up;-At 10 28 A.M 4 ceiling tiles above the steam cart serving station had dust accumulation and build up;-At 10:29 A.M., the reach-in refrigerator by the oven had a liquid spill and food debris on the bottom. There was no temperature log for the reach-in refrigerator;-At 10:30 A.M., the floor in the dish wash station had food and trash debris. Observation on 8/15/25, of the kitchen, showed:-At 6:38 A.M., the walk-in freezer door was cracked open, unable to shut. The temperature on the door read 15 degrees Fahrenheit (F). There was no temperature log posted for the walk in freezer. Trash and food debris were on the floor; -At 6:40 A.M., the floor in and around the dishwasher had food debris and trash. No temperature logs for the dishwasher were posted;-At 6:42 A.M., the walk-in refrigerator had ice and sludge build up on the floor by the door. The temperature on the door read 43 degrees F;-At 6:44 A.M., the reach -n refrigerator by the oven, had liquid spill and food debris on the bottom. No temperature log was posted for the reach-in refrigerator;-At 6:45 A.M., four ceiling tiles above the steam cart station had dust accumulation and build up. Observation on 8/18/25, of the kitchen, showed:-At 12:58 P.M., the walk-in freezer door was ajar and unable to fully close and latch. The external temperature gauge showed 36 degrees F Slush was on the floor upon entering the walk-in freezer. There was frostbite inside packages of stir-fry vegetables, ham, premade pizzas, hashbrowns, and veggie patties;-At 1:08 P.M., the walk-in freezer door remained ajar and was unable to fully close and latch. The external temperature gauge showed, Fre, and no temperature. A calibrated thermometer sat in the freezer for two minutes showed a temperature of 31.1 degrees F. The thermometer placed inside an open box of packaged ham showed a temperature of 20.9 degrees F, an open box of prepackaged pizza showed a temperature of 20.1 degrees F, and an open box of veggie burgers showed a temperature of 20.2 degrees F. 2. Observation on 8/15/25 at 11:51 A.M., showed the meat in the oven measured at 125 degrees F after being in the over for an hour and a half. The oven dial was set at 375 degrees F.During an interview 8/15/25 at 9:38 A.M., the Dietary Manager said the temperature dial does not work on the oven. She said if you turn the dial to 375 degrees F, the oven will only reach 120 degrees F. She confirmed that the oven was broken by taking the temperature with a hand held thermometer and observing that the food was not being cooked. 3. Observation on 8/15/25 at 10:30 A.M., showed:-Instructions on the outside of the dishwasher showed the machine needed to reach 120 degrees F during the rinse cycle;-The dishwasher only reached 95 degrees F during the rinse cycle. Observation on 8/15/25 at 10:37 A.M., showed the dishwasher reached a temperature of 90 degrees F during the rinse cycle. 4. During an interview on 8/19/25 at 1:03 P.M., Dietary Aide F said kitchen appliances should be in working order. The oven and range oven have not been working for at least two months. Temperatures should be (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	obtained and logged for all food storage. Temperatures had not been recorded for the walk-in refrigerator, freezer, or reach in refrigerator. He/She would expect the dishwasher to get up to the correct temperature when in use. Staff had not been doing the routine temperature tests for the dishwasher. He/She would expect the kitchen to be clean and free from trash and food debris. 5. During an interview on 8/19/25 at 1:56 P.M., the Dietary Manager said kitchen appliances should be in working order. The oven and range oven have not been working correctly since she started working at the facility a week prior. Temperatures should be obtained and logged for all food storage to ensure food does not spoil. Temperatures had not been recorded for the walk-in refrigerator, freezer, or reach in refrigerator in a while. He/She would expect the dishwasher to get up to the correct temperature of 120 degrees F, when in use, in order for dishes to be properly sanitized. Routine temperature tests for the dish washer had not been done. She would expect the kitchen to be clean and free from trash and food debris. She would expect the ceiling tiles to be free from dust accumulation and mold. 6. During an interview on 8/20/25 at 2:12 P.M., the Administrator said he would expect the kitchen to be clean and free from trash and food debris. He would expect all kitchen appliances to be in working order. He would expect the oven and range oven to be in working order. He would expect the dish washer to be working properly and reach 120 degrees F. He would expect dietary staff to obtain routine temperatures of the appliances to ensure food is stored safely. He would expect the Dietary Manager to put in a maintenance request when cooking appliances/ food storage appliances stop working.

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have a plan that describes the process for conducting QAPI and QAA activities. Based on interview and record review, the facility failed to maintain documentation and provide evidence of an ongoing Quality Assurance and Performance Improvement (QAPI) program that demonstrated systemic identification, reporting, investigation, analysis, and prevention of adverse events, and development, implementation, and evaluation of corrective actions or performance improvement activities. The census was 75.During an interview on 8/14/25 at 10:21 A.M., the Director of Nurses (DON) and Administrator said they began working at the facility approximately two months ago. Quality Assessment and Assurance (QAA) meetings should take place monthly and should be attended by the facility's department heads and Medical Director. The DON and Administrator were asked to provide documentation of the facility's QAPI plan. During an interview on 8/20/25 at 12:13 P.M., the Minimum Data Set (MDS) Coordinator said she has been a department head at the facility for two years. When the facility has QAA meetings, they are attended by department heads. When she attends the meetings, she brings a form that lists quality measures and areas of improvement or concern. Each department head discusses concerns within their department and the team comes up with a plan to address the concerns. There has been one QAA meeting this year and the last meeting was several months ago. They have not had any Performance Improvement Plans (PIPs) in months. The facility does not have any focus areas as far as QAPI goes right now. During an interview on 8/20/25 at 1:05 P.M., the Rehabilitation Manager said during QAA meetings, department heads write down their caseload, goals, what they need to work on, and a plan of correction. Their last QAA meeting was in April. The department heads meet for risk meetings every day, in which they discuss new business and things like who fell yesterday. There is no discussion of trends in the risk meetings. During an interview on 8/20/25 at 1:09 P.M., the Social Services Director said during QAA meetings, department heads meet to discuss identified problems and solutions. She held a QAA meeting in April 2025 when she was interim Administrator. There has not been a QAA meeting since April 2025. Dietary is the facility's biggest focus right now. She is also focused on trying to do more activities and hiring staff. The facility is not working on facility-wide PIPs at this time. During an interview on 8/18/25 at 10:12 A.M., the Administrator said the facility's last QAA meeting was in April 2025. He started working with the facility in June 2025 and has not had any QAA meetings, yet. QAA meetings are held to review key points he has identified and other trends in the facility. Items reviewed include falls, medication errors, grievances, and dietary issues. Once facility trends are identified, they are reviewed in QAA meetings to ensure all department heads are aware of the issues and they develop plans as a team to address the identified issues.During an interview on 8/20/25 at 10:52 A.M., the Administrator said the facility does not have a QAPI policy. The Director of Operations said the facility should follow the regulations in terms of timeliness, parties in attendance, and topics of discussion. During an interview on 8/20/25 at 4:49 P.M., the Administrator was asked to provide documentation of the facility's QAPI program. During an interview on 8/21/25 at 8:46 A.M., the Administrator was asked to provide documentation of the facility's QAPI program.Review of a QAPI Program, undated, submitted by the Administrator on 9/1/25 at 3:19 P.M., after the survey exit on 8/20/25, showed:-The facility will maintain a comprehensive, facility-wide QAPI Program. The program is designed to ensure continuous monitoring, evaluation, and improvement of resident care, staff performance and facility operations;-This program follows Centers for Medicare and Medicaid Services (CMS) QAPI requirement and will focus on resident-centered care, timeliness and accuracy of documentation, operational efficiency, and staff accountability and training.During an interview on 9/2/25 at 2:53 P.M., the Administrator said the QAPI Program he submitted on 9/1/25 is what he drafted after survey. He will discuss QAPI Program in the facility's upcoming QAPI meeting, scheduled for 9/5/25.

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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 maintain an infection prevention and control program to help prevent the development and transmission of communicable disease and infections. The facility failed to ensure employee two-step tuberculin skin tests were completed in accordance with State guidelines for three out of 10 employees reviewed. The facility failed to implement Enhanced Barrier Precautions (EBP, an infection control intervention designed to reduce the transmission of multidrug-resistant organisms (MDROs) that employs targeted gown and glove use during high contact resident care activities) as recommended by the Centers for Disease Control and Prevention (CDC) and required by the Centers for Medicare and Medicaid Services (CMS) for residents with gastrostomy tubes (g-tube, a tube surgically inserted into the abdomen that is used for medications and liquid nutrition) and chronic wounds requiring treatments (Residents #10, #4 and #3). In addition, staff failed to exhibit appropriate hand hygiene practices for infection control when cleaning up fecal material in one resident's room (Resident #1). The sample was 18. The census was 75.Review of the facility's Tuberculosis (TB) Screening - Employees policy, dated 2019, showed:-Residents in long-term care facilities have been identified as a high-risk group for re-activation of latent TB infection, acquisition of TB infection and potential spread of TB within the facility. This facility has a comprehensive TB screening program that is administered by Infection Preventionist (IP) at the direction of the Quality Assurance (QA) committee;-It is the policy of this facility to assess risks for tuberculosis based on regional/community data and screen staff according to State law. For example, all healthcare workers be tested for tuberculosis upon hire and yearly thereafter unless contraindicated or in accordance with State requirements. Initial testing will be a two-step procedure with the first dose given before beginning work and the second booster dose given 7-21 days after the first if the first dose is negative along with an employee risk screening tool;-Tuberculin skin test (TST) results will be documented in the employee's medical record; -a. Skin test results will be documented in millimeters (mm) of induration (raised, hardened area of swelling at injection site) rather than stating result is positive or negative;-b. The tuberculin manufacturer and lot number will be recorded; -TST Administration and Reading:-One-tenth mm of TST is administered intracutaneously (within the skin);-The test is read between 48 and 72 hours after administration by someone trained in Mantoux reading and interpretation. Review of the Department of Health and Senior Services (DHSS) TB Screening for Long Term Care Employees flowchart, updated 3/11/14, showed:-Employee accepts position (the hire date);-If no documentation of prior two-step TST, administer TST first step prior to employment. Can coincide reading the results with the employee start date by administering TST two to three days prior to the employee start date;-Read results of first step TST within 48 to 72 hours of administration. Results must be read and documented in millimeters prior to or on the employee start date;-If negative, administer second step within one to three weeks;-Read results within 48 to 72 hours of administration. Review of the facility's EBP policy, revised 12/12/23, showed:-Policy: It is the policy of this facility to implement EBP for the prevention of transmission of MDROs;-Definitions: EBP refer to the use of gown and gloves for use during high-contact resident care activities for residents known to be colonized or infected with a MDRO as well as those at increased risk of MDRO acquisition (e.g., residents with wounds or indwelling medical devices);-Policy Explanation and Compliance Guidelines:-All staff receive training on enhanced barrier precautions upon hire and at least annually and are expected to comply with all designated precautions -High-contact resident care activities include: -a. Dressing; -b. Bathing;-c. Transferring;-d. Providing hygiene;-e. Changing linens; -f. Changing briefs or assisting with toileting; -g. Device care or use: central lines, urinary catheters, feeding tubes, tracheostomy/ventilator tubes; -h. Wound care: any skin opening requiring a dressing;-EBP should be followed outside the resident's room when performing transfers and assisting during bathing in a shared/common shower room and (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	when working with residents in the therapy gym, specifically when anticipating close physical contact while assisting with transfers and mobility, or any high-contact activity;-EBP should be used for the duration of the affected resident's stay in the facility or until the wound heals or indwelling medical device is removed. 1. Review of Employee II's personnel file, showed:-Hire date 6/10/24;-No documentation of TB tests completed. Review of Employee MM's personnel file:-Hire date 7/4/24;-No documentation of TB tests completed. Review of Employee NN's personnel file, showed:-Hire date 4/11/25;-No documentation of TB tests completed. During an interview on 8/20/25 at 7:32 A.M., the Administrator said when a new employee is hired, the employee gets their first TB test done before they start working. The second step is done after the first TB test is read. Employee TB tests were overseen by the previous Assistant Director of Nurses (ADON), who has been gone since July. A new ADON started this week and will oversee the TB tests going forward. During an interview on 8/20/25 at 1:48 P.M., the Director of Nurses (DON) and Administrator said all new employees are expected to undergo the two-step TB test process. These should be documented in the employee's personnel file. Employees must undergo the TB testing process because TB is a highly contagious and very serious disease. 2. Review of the sign for EBP, undated, showed:-Everyone must clean their hands, including before entering and when leaving the room;-Providers and staff must also wear gloves and a gown for the following high-contact resident care activities:-Dressing;-Bathing/showering;-Transferring;-Changing linens;-Providing hygiene;-Changing briefs or assisting with toileting;-Device care or use (central line, urinary catheter, feeding tube, tracheostomy);-Wound care: any skin opening requiring a dressing. 3. Review of Resident #10's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 6/27/25, showed:-Cognitively intact;-Diagnoses included malnutrition (inadequate nutrition), dysphagia (difficulty swallowing), g-tube status and adult failure to thrive. Review of the resident's care plan, in use at the time of survey showed:-Focus: The resident requires EBP related to g-tube. The use of gown and gloves for use during high-contact resident care activities for residents to be colonized or infected with MDRO as well as those at increased risk of MDRO acquisition due to wound or indwelling devices;-Interventions: The resident's room will be posted with clear signage, indication EBP and required EBP use; Appropriate PPE (gowns, gloves, masks, face shields, and foot coverings); EBP will be used for the duration of stay or until the wound heals or the indwelling device is discontinued; Staff have received training on EBP and will comply with all designated precautions. Review of the resident's physician order sheets (POS), dated, August 2025, showed:-An order, dated, 6/9/25, EBP due to gastrostomy tube site, gown and gloves required for high contact resident care activities. Observation on 8/15/25 at 9:15 A.M., showed Registered Nurse (RN) A prepared the resident's medications at the medication cart in the East Wing hallway. The resident's door showed an EBP sign posted. RN A entered the resident's room and applied gloves. The resident raised his/her shirt and exposed a gastrostomy tube located in the resident's abdomen. RN A administered the resident's medications through his/her gastrostomy tube. RN A then prepared a water flush and a bolus (a single dose) tube feeding and administered them to the resident through his/her gastrotomy tube. RN A did not wear an isolation gown while administering medications, water and tube feeding through the resident's gastrostomy tube. 4. Review of Resident #4's medical record, showed:-Diagnoses included sepsis (blood infection) due to pseudomonas (bacteria), pneumonia due to pseudomonas, and gastrostomy (opening into the stomach from the abdominal wall) status;-An order, dated 6/9/25 for EBP related to g-tube site (gown and gloves required or high-contact resident care activities), every day and night shift. Review of the resident's care plan, in use at the time of survey, showed:-Focus: Resident requires EBP. EBP refers to the use of gown and gloves for use during high-contact care activities for residents known to be colonized or infected with a MDRO as well as those at increased risk of MDRO acquisition due to wounds or indwelling device, gastrostomy tube;-Tasks included: Appropriate personal protective equipment (PPE) shall be available either immediately outside or inside room. High contact activities include, but are not limited to personal (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	care (hygiene, toileting, peri-care). Resident's room will be posted with clear signate indicating EBP precautions, require EBP use. Observation and interview on 8/14/25 at 11:05 A.M., showed a sign posted on the resident's door for EBP. A PPE caddy in the hallway outside of the resident's room contained gloves and gowns. The resident said he/she receives tube feedings. At 11:16 A.M., Certified Nurse Assistant (CNA) S entered the resident's room. At 11:19 A.M., CNA S rolled the resident in bed, from side to side while changing the resident. CNA S wore gloves during the care activity but did not wear a gown. During an interview on 8/19/25 at 9:47 A.M., CNA S said EBP means staff should wear a gown and gloves while providing direct care. He/She acknowledged he/she should have worn a gown when providing incontinence care to the resident on 8/14/25. Sometimes he/she is just moving so quickly to help everyone, he/she forgets. During an interview on 8/20/25 at 8:10 A.M., CNA T said the resident requires EBP because he/she has a g-tube. During an interview on 8/20/25 at 9:31 A.M., RN A said the resident requires EBP because he/she has a g-tube. 5. Review of Resident #3's quarterly MDS, dated , 4/29/25, showed:-The resident is unable to complete a cognitive assessment;-Diagnoses included cancer and Alzheimer's disease. Review of the resident's care plan, in use at the time of survey, showed:-Focus: The resident requires EBP related to chronic wounds; The use of gown and gloves for use during high-contact resident care activities for residents to be colonized or infected with MDRO as well as those at increased risk of MDRO acquisition due to wound or indwelling devices;-Interventions: The resident's room will be posted with clear signage, indicating EBP and required EBP use; Appropriate PPE (gowns, gloves, masks, face shields, and foot coverings); EBP will be used for the duration of stay or until the wound heals or the indwelling device is discontinued; Staff have received training on EBP and will comply with all designated precautions. Review of the resident's POS, dated August 2025, showed:-An order, dated, 6/8/25, EBP due to chronic sacral (tailbone area) wound, gown and gloves required for high contact resident care activities. Observation on 8/18/25 at 1:56 P.M., showed the resident's door showed an EBP sign posted. The resident lay in bed and CNA L provided care and gave the resident a bath with gloved hands. CNA L turned the resident from side to side, changing the resident's bed sheets. The resident had a dressing to his/her sacrum dated 8/18/25. CNA L did not wear an isolation gown while providing care to the resident. 6. During an interview on 8/20/25 at 8:10 A.M., CNA T said EBP means staff should wear gloves and a gown when providing assistance with any contact activity. This includes when providing incontinence care and feeding assistance. EBP are used to protect the residents. 7. During an interview on 8/20/25 at 9:31 A.M., RN A said EBP means to take extra precautions for some residents, like those who have g-tubes and wounds. For residents on EBP, staff must wear a gown and gloves while providing high-contact activities, such as peri-care. Feeding assistance might be included in high-contact activities, but this is a debated area among staff. 8. During an interview on 8/20/25 at 1:48 P.M., the DON and Administrator said residents with a history of MDROs, chronic wounds, and indwelling devices, such as g-tubes, require EBP. When a resident is on EBP, staff should wear gloves, gown, and a mask when providing direct care where they may be exposed to bodily fluid. These activities include incontinence care, dressing changes, skin assessments, administration of g-tube medications, and while providing feeding assistance. 9. Review of Resident #1's annual MDS, dated [DATE], showed:-Cognitively intact;-Diagnoses included Ogilvie syndrome (acute dilation of the colon) chronic obstructive pulmonary disease (lung disease, COPD) and major depressive disorder. Observation on 8/15/25, in the resident's room, showed:-At 7:33 A.M., Restorative Aide (RA) W came into the resident's room and started to clean the room. He/She put on gloves, grabbed a paper towel and then wiped up a pile of fecal material located near the resident's bed;-At 7:38 A.M., he/she went to the resident's bathroom and wiped a pile of fecal material on the floor with a paper towel and then threw the paper towel away in the resident's trash can;-At 7:39 A.M., he/she walked to the resident's door and grabbed onto the doorknob with one gloved hand while he/she grabbed the dirty linen cart with his/her other gloved hand;-At 7:40 A.M., the resident asked RA W to hand him/her a remote off the floor. RA W grabbed the remote with his/her gloved hand and (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	then handed it to the resident;-At 7:42 A.M., RA W took off his/her gloves and washed his/her hands and then touched the resident's doorknob to open the door. During an interview on 8/20/25 at 9:51 A.M., RA W said proper hand hygiene should be used when cleaning bodily fluids. Staff should wash their hands before touching clean surfaces. During an interview on 8/20/2025 at 2:58 P.M., the DON said she expected proper hand hygiene to be performed by staff when cleaning bodily fluids in a resident's room. She expected Restorative Aide W to remove his/her dirty gloves, wash his/her hands, and then apply new gloves before touching clean surfaces and objects.

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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 documentation of ongoing educational training provided to active Certified Nursing Aides (CNAs), totaling no less than 12 hours per year, for four of six sampled active CNAs. Insufficient training documentation was provided for four of six sampled CNAs. The sample was 18. The census was 75.1. Review of CNA E's CNA Annual In-Service Training Log, showed:-Inservices completed each month from January 2025 to June 2025, with each inservice totaling one hour;-No record of inservices completed prior to January 2025. 2. Review of CNA Z's CNA Annual In-Service Training Log, showed:-Inservices completed each month from January 2025 to June 2025, with each inservice totaling one hour;-No record of inservices completed prior to January 2025. 3. Review of CNA AA's CNA Annual In-Service Training Log, showed:-No record of inservices completed for the past year, from hire date to hire date, while employed at the facility. 4. Review of CNA BB's CNA Annual In-Service Training Log, showed:-No record of inservices completed for the past year, from hire date to hire date, while employed at the facility. 5. Review of CNA CC's CNA Annual In-Service Training Log, showed:-No record of inservices completed for the past year, from hire date to hire date, while employed at the facility. 6. Review of CNA DD's CNA Annual In-Service Training Log, showed:-No record of inservices completed for the past year, from hire date to hire date, while employed at the facility. 7. During an interview on 8/19/25 at 8:52 A.M., the Director of Nursing (DON) said she was unable to find annual education logs for four of the six sampled CNAs and does not have access to any annual trainings completed by employees prior to January, 2025. The DON said the previous administration walked out of the building with numerous documents and believes CNA trainings may have been among them. Ensuring annual education is completed by CNAs is the responsibility of the DON, and all CNAs at the facility should receive 12 hours of education annually per regulation guidelines.8. During an interview on 8/20/25 at 1:48 P.M the Administrator and DON said they expected all CNAs at the facility to receive 12 hours of ongoing education annually per regulation guidelines. It is believed the previous DON took inservice records and education documentation with them when resigning from the position.

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 residents' self-determined preferences and requests were implemented. The facility failed to assist two dependent residents to get out of bed after breakfast, in accordance with their preferences (Resident # 48 and Resident #49). In addition, staff failed to provide one resident a shower when requested (Resident #68). The sample was 18. The census was 75. Review of the facility's Resident Rights policy, undated, showed:-Residents are entitled to exercise their rights and privileges to the fullest extent possible: The facility will make every effort to assist each resident in exercising his/her rights to assure the resident is treated with dignity, kindness, and respect; -Self-determination: Personal freedom means allowing residents to make decisions about themselves. Some examples the facility protects are residents' self-determination including when to choose bath time and type of bath, choose waking and sleeping times, and choose activities and healthcare consistent with his/her interests and plan of care. 1. Review of Resident #48's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 8/5/25, showed:-Cognitively intact;-Lower extremity impairment on both sides;-Dependent on assistance for chair/bed-to-chair transfers;-Diagnoses included morbid obesity, generalized muscle weakness, lack of coordination, and abnormal posture. Review of the resident's care plan, in use at the time of survey, showed:-Focus: The resident has an activities of daily living (ADL) self-care performance deficit and requires maximum assistance;-Tasks included requires Hoyer (mechanical lift) and two staff for transfers. During an interview on 8/24/25 at 12:40 P.M., the resident said he/she required a Hoyer lift for transfers. It took a long time for staff to get him/her up and get him/her back to bed. He/She waited hours for staff to transfer him/her. Observation on 8/18/25 at 11:45 A.M., showed staff got the resident up into his/her wheelchair. During an interview at 12:00 P.M., the resident said he/she waited for hours for staff to get him/her up this morning. This was typical. He/She wanted to get out of bed daily, right after breakfast. 2. Review of Resident #49's medical record, showed:-Diagnoses included morbid obesity, generalized muscle weakness, abnormalities of gait and mobility, lack of coordination, depression, and generalized anxiety disorder;-A physician order, revised 11/5/24, for the resident to be out of bed in a chair two hours a day. Review of the resident's quarterly MDS, dated [DATE], showed:-Cognitively intact;-Lower extremity impairment on both sides;-Dependent on assistance for chair/bed-to-chair transfers. Review of the resident's care plan, in use at the time of survey, showed:-Focus: The resident has an ADL self-care performance deficit;-Tasks included the resident requires two-staff participation and Hoyer lift with transfers;-The care plan did not identify the resident's preference to be out of bed earlier in the day. Observations on 8/15/25 at 9:22 A.M, showed the resident was in bed. During an interview, the resident said he/she required a Hoyer lift for transfers. He/She preferred for staff to get him/her out of bed earlier in the day. He/She liked to get out of bed and to be a part of the facility. At approximately 12:00 P.M., the resident was out of bed and was propelled down the hall by staff. Observations on 8/18/25 at 11:47 A.M showed, the resident in bed. During an interview, the resident said he/she would have liked to have been up and out of bed by now. He/She hoped staff got him/her out of bed for lunch. At 12:26 P.M., staff got the resident out of bed. 3. During an interview on 8/14/25 at 12:06 P.M., Certified Nurse Aide (CNA) B said most of the residents require Hoyer lifts on the hall shared by Resident #48 and #49. There was not enough staff assigned to the hall to provide care and assist with Hoyer transfers for all residents at the same time. The residents had to wait for care and assistance. During an interview on 8/18/25 at 11:51 A.M., CNA U said almost all of the hall shared by Residents #48 and #49 consisted of residents requiring Hoyer transfers. Hoyer transfers required two staff. There was one aide assigned to this hall and it was not enough to get everything done. All the residents should be up and out of bed before lunch. He/She (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	could not get all the residents up before lunch. It was ridiculous. During an interview on 8/19/25 at 9:47 A.M., CNA S said the hall shared by Residents #48 and #49 had numerous residents who required Hoyer transfers. There was one aide assigned to that hall. One aide was not enough to perform all the Hoyer transfers and care needed for these residents. These residents were heavy care and totally dependent on staff for assistance. When one aide was pulled to another hall to provide care that could take an hour. It left all the other residents without an aide. Residents #48 and #49 liked to get up after breakfast. Residents should be able to get out of bed when they wanted. Sometimes, staff could not get residents up until nearly lunchtime or even later. During an interview on 8/20/25 at 8:10 A.M., CNA T said residents had the right to get up whenever they wanted. Residents #48 and #49 required Hoyer transfers and total care. Many of the other residents on their hall required the same thing. All of the residents on that hall liked to get out of bed between 10:00 A.M. and 11:30 A.M. It was impossible to get this done because there was only one employee assigned to the hall and it required two staff to complete Hoyer transfers and the care needed. During an interview on 8/20/25 at 9:31 A.M., Registered Nurse (RN) A said Residents #48 and #49 liked to be out of bed after breakfast but that did not happen every day. They both required total care and Hoyer transfers. Most of the residents on their hall required the same thing. All residents on their assignment liked to get up between 10:30 A.M. and 11:00 A.M. There was not enough staff on the assignment to get that done. 4. During an interview on 8/20/25 at 1:48 P.M with the Director of Nurses (DON) and Administrator, they said the previous Administrator moved all residents requiring Hoyer transfers to the same hall, and promised staffing would be adequate on the hall. Since the DON and Administrator began working with the facility within the past two to three months, they have observed residents unable to get up at their preferred times on that hall. Residents should be assisted out of bed in accordance with their preferences. 5. Review of Resident #68's MDS, dated [DATE], showed:-The resident is cognitively intact;-The resident is dependent on staff for personal hygiene, toilet hygiene, upper and lower body dressing, and bed to chair transfer;-The resident uses a wheelchair. Review of the resident's care plan, in use at the time of survey, showed;-Focus: The resident has ADL self-care performance deficit;-Interventions: The resident is totally dependent on staff to provide a bath three times a week and as needed. Review of the East Wing shower list, showed there were no scheduled showers on Sunday for residents who lived on that hall. During an interview on 8/18/25 at 8:44 A.M., the resident said he/she requested a shower on 8/17/25 because he/she was getting his/her hair braided this morning. His/Her hair needed to be clean and completely dry. His/Her regular shower days were Mondays, Wednesdays, and Fridays on the day shift. The beautician had already been paid and was arriving at the facility on 8/18/25 at 11:00 A.M. The resident said staff told him/her that he/she could not get a shower on a Sunday because there were no showers completed on Sundays. At 10:25 A.M., the resident said his/her shower was completed and the beautician was running late. The resident was hoping his/her hair would be dry by the time the beautician arrived. 6. During an interview on 8/18/25 at 12:09 P.M., CNA I said no resident showers were scheduled on Sundays. If a resident requested a shower on a Sunday, staff should honor the resident's request and provide the resident a shower. During an interview on 8/19/25 at 9:25 A.M., Licensed Practical Nurse (LPN) J said currently there were no showers scheduled for Sundays, but that didn't mean staff couldn't provide a shower if the resident requested it. Staff should honor the residents' requests. 6. During an interview on 8/20/25 at 1:47 P.M., the DON said she would expect the staff to give the resident a shower when requested. She was aware that showers were not scheduled on Sundays but that didn't mean staff could not provide showers on Sundays.

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F 0569 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify each resident of certain balances and convey resident funds upon discharge, eviction, or death. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure third party liability (TPL) forms were completed within 30 days for the final accounting for residents who expired. This affected three out of five sampled residents who expired and had money in their accounts (Residents #77, #78, and #79). The census was 75.Review of the facility's Resident Trust Fund policy, revised [DATE], showed:-Purpose: To establish policy and procedures for the Facility Resident Trust Fund;-Policy: It will be the policy of the management company that the Resident Trust Fund is managed and accounted for in accordance with State and Federal regulations. Each facility should follow the State guidelines of the payment programs using the greatest level of specificity if requirements vary in State and Federal programs;-Procedures:-If a resident receives any TPL payments, notification must be sent to the Medicaid caseworker within five business days or per State guidelines;-Facility shall refund the balance of the resident's personal funds when a resident is discharged . The amount shall be refunded by the end of the month following the month of discharge or by State/Federal specific guidelines if such policies are more stringent;-If facility does not receive notification of appropriate claim for deceased /discharged resident's funds, the unclaimed funds will be sent to the Unclaimed Property Section, Secretary of Revenue for the State with detailed information about the resident, next of kin if known, and amount of funds and such disbursement will be handled per the guidelines.-The policy failed to identify the federal requirement for notice and conveyance of funds to be completed within 30 days upon the death of a resident with funds remaining in their account.1. Review of Resident #77's resident fund account, showed:-Expired [DATE];-Ending account balance: $378.26;-No TPL form submitted to Medicaid.2. Review of Resident #78's resident fund account, showed:-discharged to hospital [DATE]. Confirmed as expired [DATE];-Ending account balance: $183.00;-No TPL form submitted to Medicaid.3. Review of Resident #79's resident fund account, showed:-Expired [DATE];-Ending account balance: $12.69;-No TPL form submitted to Medicaid.4. During an interview on [DATE] at 1:26 P.M., the Business Office Manager (BOM) said she started working with the facility in [DATE]. When a resident expired with funds left in their account, the funds should be released if there was somebody to release the funds to. If the resident had a prior account balance, she was unsure of what to do with that. She was unsure how payor source factored in. She was unsure what the notification or release timeframe was. She was not aware that a TPL form should be submitted to Medicaid for residents who expired with funds left in their account. 5. During an interview on [DATE] at 7:32 A.M., the Administrator said he expected the facility to notify Medicaid of funds left in the resident trust account following a resident's expiration. The BOM should submit the TPL as soon as possible, within 30 days of the resident's expiration.

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. Based on interview and record review, the facility failed to complete criminal background checks on newly hired employees prior to the employee's start date, and/or failed to ensure newly hired employees were screened to rule out the presence of a Federal Indicator through the Nurse Aide (NA) Registry, for five of 10 employees hired since the last survey. In addition, the facility's policy for screening new hires failed to include completion of checking the NA Registry. The census was 75.Review of the facility's Abuse, Neglect, and Exploitation policy, revised June 2024, showed:-Policy: It is the policy of this facility to provide protections for the health, welfare, and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation and misappropriation of resident property;-Screening:-A. Potential employees will be screened for a history of abuse, neglect, exploitation, or misappropriation of resident property;-1. Background, reference, and credentials' checks shall be conducted on potential employees, contracted temporary staff, students affiliated with academic institutions, volunteers, and consultants;-2. Screenings may be conducted by the facility itself, third-party agency or academic institution;-3. The facility will maintain documentation of proof that the screening occurred.-The facility's policy failed to include completion of checking the NA Registry. 1. Review of the facility's active employee list, showed Certified Nurse Aide (CNA) KK hired 6/17/25. During an interview on 8/18/25 at 3:44 P.M., the Administrator was asked to provide the personnel file for CNA KK. During an interview on 8/20/25 at 7:32 A.M., the Administrator and Staffing Coordinator said they could not locate the employee file for CNA KK. The employee is working today. He/She will be removed from the schedule until his/her background checks are completed. 2. Review of Dietary Aide JJ's personnel file, showed:-Hire date: 8/15/25;-Family Care Safety Registry (FCSR) check requested 8/15/25, results not received;-No criminal background check completed. 3. Review of Housekeeper II's personnel file, showed:-Hire date: 6/10/24;-FCSR check requested 6/23/24, results not received;-No criminal background check completed. 4. Review of [NAME] V's personnel file, showed:-Hire date: 2/15/24;-FCSR check requested 6/23/24, results not received;-No criminal background check completed. 5. Review of Occupational Therapy Assistant (OTA) LL's personnel file, showed:-Hire date: 9/3/24;-No NA Registry check documented as completed. 6. During an interview on 8/20/25 at 7:32 A.M., the Administrator and Staffing Coordinator said the facility does not currently have a Human Resource manager. Pre-employment background checks for new hires are being run by a sister facility owned by the same management company. Pre-employment background checks must include checking the FCSR and Employee Disqualification List (EDL). If an employee has never registered with the FCSR, a criminal background check must be run on them through the Missouri State Highway Patrol. New hires must also be checked on the Nurse Aide (NA) register to make sure there are no adverse findings and to make sure the employee doesn't have something on their license. It is important for the facility to complete pre-employment background checks because the facility has an obligation to not employ anyone with a disqualifying crime as part of abuse prevention.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. Based on observation, interview, and record review, the facility failed to ensure Activities of Daily Living (ADL) needs were met for three of 18 sampled residents. The facility failed to ensure general hygiene needs were met for two residents (Residents #1 and #64) and feeding assistance was provided to one resident (Resident #28). The sample was 18. The census was 75. Review of the facility's ADL policy, undated, showed:-Purpose: To ensure residents receive assistance with ADLs to maintain or enhance their dignity, independence, and quality of life, while preventing avoidable decline in function;-Procedure: Care plans will reflect each resident's functional status, strengths, limitations, and preferences. Staff will provide individualized assistance with bathing, grooming, dressing, eating, mobility, toileting, and hygiene as needed. Residents will be encouraged to participate in their ADLs to the fullest extent possible. Care will be delivered in a private and respectful manner. All ADL care provided, resident participation, refusals, and changes in condition will be documented in the electronic health record. 1. Review of Resident #1's annual Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated, 5/31/25, showed:-Cognitively intact;-Diagnoses included Ogilvie syndrome (acute dilation of the colon), chronic obstructive pulmonary disease (COPD, lung disease), and major depressive disorder. Review of the resident's care plan, in use at the time of the survey, showed:-Focus: The resident has an ADL Self Care Performance Deficit;-Goal: The resident will maintain current level of function through the next review date;-Interventions: The resident requires some cueing and supervision of one staff for dressing. The resident requires one staff participation with personal hygiene and oral care. Observation on 8/18/25 at 11:58 A.M., showed the resident walking down the hallway back to his/her room. The resident's pants were falling down exposing his/her underwear. The resident's hair was oily. The resident's fingernails were dirty, stained with dark matter. Observation on 8/19/25 at 7:45 A.M., showed the resident seated in the dining room for breakfast. The resident's shirt was unbuttoned with his/her stomach exposed. His/Her hair was oily. His/Her fingernails were dirty, with dark matter underneath the nails. The resident's pants were falling down exposing his/her underwear. Observation on 8/19/25 at 8:34 A.M., showed the resident seated in a chair near the nurse's station. The resident's shirt was unbuttoned with his/her stomach exposed. His/Her hair was oily. His/Her nails were dirty, with dark matter underneath the nails. During an interview on 8/20/25 at 7:48 A.M., Certified Nursing Assistant (CNA) M said he/she would expect the resident to have clean nails and hair. He/She would expect staff to assist the resident with his/her clothing to ensure they are on correctly. During an interview on 8/20/25 at 8:01 A.M., Registered Nurse (RN) C said he/she would expect the resident's hair and nails to be cleaned during the resident's showers or as needed. He/She would expect staff to ensure the resident's clothing is on properly. During an interview on 8/20/2025 at 3:00 P.M., the Director of Nursing (DON) and Administrator said they would expect the resident's hair and nails to be clean. They would expect staff to ensure the resident's clothing is on properly and comfortable to the resident. 2. Review of Resident #64's quarterly MDS, dated , 7/3/25, showed:-Cognitively intact;-Diagnoses included diabetes, muscle weakness, and major depressive disorder. Review of the resident's care plan, in use at the time of the survey, showed:-Focus: Resident has an ADL self-care performance deficit;-Goal: Resident will maintain current level of function through the next review date;-Interventions: Resident requires one staff participation with bathing. The resident requires one staff participation with personal hygiene and oral care. Observation and interview on 8/14/2025 at 11:54 A.M., showed the resident in the dining room in an activity. He/She had oily hair and dirty fingernails with matter underneath the nails. The resident said he/she is not always given the chance to shower twice a week. Observation on 8/19/2025 at 8:38 A.M., showed the resident had oily hair and dirty nails with matter underneath the nails. During an interview on 8/20/25 at 7:48 A.M., CNA M said he/she would expect the resident to have clean nails and hair. He/She would expect the resident to receive at least two showers a week. During an interview on (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	8/20/25 at 8:01 A.M., RN C said nursing staff should ensure the resident receives at least two showers or bed baths a week. He/She would expect the resident's hair and nails to be washed. During an interview on 8/20/2025 at 3:00 P.M., the DON and Administrator said they would expect the resident to recieve at least two showers or bed baths a week. They would expect the resident's hair and nails to be cleaned during their showers or as needed. 3. Review of Resident #28's admission MDS, dated , 7/3/25, showed:-Moderately impaired cognition;-Diagnoses included hemiplegia and hemiparesis (muscle weakness or partial paralysis) affecting the dominant right side, diabetes, and acute kidney failure. Review of the resident's care plan, in use at the time of the survey, showed:-Focus: Resident has an ADL self-care performance deficit;-Goal: The resident will maintain current level of function through the next review date;-No interventions for eating assistance listed. Observation on 8/18/25 at 8:40 A.M., showed the resident in the dining room for breakfast. The resident struggled to open a carton of juice with one hand. He/She poked a hole in the seal with a finger in order to open his/her drink. During an interview on 8/18/25 at 9:52 A.M., the resident said no staff ever help him/her in the dining room. Observations on 8/19/25 during lunch, showed:-At 12:30 P.M., while in the dining room for lunch, the resident picked up his/her napkin and his/her fork fell on the ground;-At 1:10 P.M., the resident started to eat his/her pasta with his/her hands. During an interview on 8/20/25 at 7:48 A.M., CNA M said he/she would expect staff to assist the resident with any needs he/she might have during meals. The resident is someone who needs help due to low mobility in his/her right arm. During an interview on 8/20/25 at 8:01 A.M., RN C said he/she would expect staff to assist the resident during meals with opening drinks and positioning the resident's wheelchair up to the table. He/She would expect the resident's care plan to reflect his/her ADL needs. During an interview on 8/19/25 at 12:46 P.M., the DON said she would expect all staff in the dining room for meals to assist residents with opening drinks and bringing residents new silverware. She would expect nursing staff to inform her if residents are having a hard time feeding themselves so the residents can be evaluated for ADL care needs. 25880741612001

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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate foot care. Based on observation, interview and record review, the facility failed to ensure one resident received proper treatment and care to maintain mobility and good foot health (Resident #3). The sample was 18. The census was 75.Review of the facility's Nail and Foot Care policy, undated, showed:-Purpose: To ensure residents receive safe, hygienic, and person-centered nail and foot care that promotes dignity, prevents infection, and maintains independence in accordance with facility standards;-Procedures: On admission and quarterly, nursing staff will assess nail and foot status; Residents' care plan will reflect frequency and level of nail and foot care required;-Restrictions: Staff may not perform toenail trimming for residents with diabetes, peripheral vascular disease (a narrowing of the arteries in the legs that reduces blood flow), neuropathy (numbness and tingling in the feet), or on anticoagulation therapy (blood thinners); These residents require podiatry (foot doctor) or licensed nursing intervention; Any abnormal findings (redness, swelling, pain, drainage, or fungal infection) must be reported to the nurse immediately and documented;-Foot Care: Wash feet daily and keep dry, especially between the toes; apply lotion to heels and soles, but avoid between the toes; Inspect for pressure injuries, ulcers, or fungal growth; Ensure proper footwear and socks;-Podiatry Services: The facility will arrange podiatry visits for at-risk residents at least every 60 days or as ordered; Nursing staff will assist with referral and ensue findings are documented and integrated into the care plan. Review of Resident #3's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 4/29/25, showed:-The resident is unable to complete cognitive assessment;-The resident is dependent on staff upper and lower body dressing and putting on and taking off foot wear;-Diagnoses include cancer and Alzheimer's disease. Review of the resident's care plan, in use at the time of survey, showed:-Focus: The resident has an activities of daily living (ADL) self-care performance deficits;-Interventions: The resident requires total assistance from staff with personal hygiene. Review of the facility's list of residents currently seeing the podiatrist, dated 8/13/25, did not show the resident on the list. Review of the resident's comprehensive Certified Nursing Assistant (CNA) shower review sheets, showed:-On 7/1/25, Does the resident need his/her toenails cut?: Blank;-On 7/5/25, Does the resident need his/her toenails cut?: No;-On 7/14/25, Does the resident need his/her toenails cut?: Blank;-On 7/25/25, Does the resident need his/her toenails cut?: No;-On 7/28/25, Does the resident need his/her toenails cut?: Blank;-On 7/30/25, Does the resident need his/her toenails cut?: Blank;-On 8/2/25, Does the resident need his/her toenails cut?: Blank;-On 8/5/25, Does the resident need his/her toenails cut?: Blank;-On 8/16/25, Does the resident need his/her toenails cut?: Yes. Observation on 8/18/25 at 1:56 P.M., showed the resident lay in bed and CNA L provided care. The resident's socks were removed and the resident's feet had large flakes of dry skin. On both of the resident's feet, his/her toenails were curled under approximately one half an inch and extremely thick. CNA L said the resident needed his/her toenails cut and lotion applied to his/her feet. During an interview on 8/19/25 at 9:24 A.M., CNA B said if the resident nails require trimming, he/she will let the nurse know. CNAs should answer the questions on the shower sheets related to the resident's toenails. Staff can trim toenails if they are not diabetic. CNA B will not trim nails if the nails are too thick. Most of the residents in the facility require the podiatrist to trim their nails. Lotion can be applied to the residents' feet anytime. During an interview on 8/20/25 at 8:56 A.M., Registered Nurse (RN) A said the resident's toenails should be assessed when the CNA completes the resident's bath and the nurse should also assess toenails on the weekly skin assessments. The resident's nails should not be so long they are curled under. The nurse can trim nails if the resident is not diabetic but usually the podiatrist will trim the resident's nails if they are too thick. During an interview on 8/20/25 at 1:47 P.M., the Director of Nursing said an RN can trim the residents' nails if they are not diabetic. She expected staff to identify when the residents require toenail trimming and place the resident on the podiatrist list as needed. She expected staff to apply lotion when the resident's feet are dry.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure fall interventions were in place for two residents who were identified as high fall risks (Resident #3 and Resident #17). The facility also failed to ensure one resident with a diagnosis of dysphagia (difficulty swallowing) was in an upright position during meals to prevent choking or aspiration (food or liquids that is inhaled into the lungs) (Resident #10). The sample was 18. The census was 75. Review of the facility's Fall Prevention Policy (S.A.F.E.), revised February, 2001, showed;Policy: The S.A.F.E. program promotes Safety, Assessment, Fall prevention and Education of both staff and residents; At the time of admission and re-admission the Fall Risk Data Collection and Fall Risk Questionnaire will be completed; Residents found to be at high risk for falls are place on the S.A.F.E. program, and specific interventions is implementing, related to the resident's high risk for falls. 1. Review of Resident #3's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 4/29/25, showed:-The resident unable to complete cognitive assessment;-Dependent on staff for chair to bed transfers and bed to chair transfers, toileting, personal hygiene, and upper and lower body dressing;-Always incontinent of bowel and bladder;-Diagnoses include cancer and Alzheimer's disease. Review of the resident's care plan, in use at the time of survey, showed:-The resident has an actual or potential risk for falls; On 4/17/25, the resident fell out of bed; On 5/4/25, the resident rolled out of bed; -Interventions: Matts placed at side of bed; bolster mattress (a special mattress to prevent the resident from falling out of bed), and staff educated on limiting time the resident is up in the Broda chair (a specialized chair) to two hours, low bed, and night light. Review of the resident's Fall Risk Data collection, dated 7/12/25, showed the resident is high risk for falls. Review of the resident's progress note,s showed:-On 7/12/25 at 12:55 P.M., the resident was observed on the floor next to the Broda chair on the East wing TV area and bleeding was observed from the resident's head, laceration to left forehead above the resident's eyebrow was noted, a pressure dressing was applied;-On 7/12/25 at 2:52 P.M., the resident was transferred to the emergency room (ER) for post fall evaluation. Observation on 8/14/25 at 10:15 A.M., showed the resident lay in bed, with a bolster mattress in place. The resident's bed height was positioned approximately 30 inches from the floor. Two fall mats were positioned to the resident's left side of the bed. There were no fall matts to the resident's right side of his/her bed.Observation on 8/15/25 at 9:00 A.M., showed the resident lay in bed with a bolster mattress in place. Two fall matts were positioned to the resident's left side of his/her bed. There were no fall matts located to the resident's right side of his/her bed. Observation on 8/18/25 at 8:27 A.M, showed the resident lay in bed with a bolster mattress in place. Two fall matts were positioned to the resident's left side of his/her bed. There were no fall matts located to the resident's right side of his/her bed. The resident's call light was positioned under his/her bed and the resident yelled, Hey! when staff walked past the resident's room. The resident's room had a strong odor of bowel movement. Observation on 8/18/25 at 10:30 A.M. and 12:00 P.M., and on 8/19/25 at 8:39 A.M., showed the resident lay in bed with a bolster mattress in place. Two fall matts were positioned to the resident's left side of his/her bed. There were no fall matts located to the resident's right side of the bed. The resident's call light was positioned under his/her bed. The resident yelled, Hey! when staff walked past the resident's room. Observation on 8/20/25 at 7:56 A.M, showed the resident lay in bed with a bolster mattress in place. Two matts were positioned to the resident's left side of his/her bed. There were no fall matts located to the resident's right side of the bed. The resident's call light was positioned under his/her pillow. The resident's bed was positioned approximately 30 inches from the floor.During an interview on 8/18/25 at 1:01 P.M., Registered Nurse (RN) H and Certified Nursing Assistant (CNA) E said if the resident has a history of falls and is a high fall risk, the resident's bed should be in the lowest (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	position, fall matts to both sides of the bed and not just on one side, identify the resident's needs such as if they need to be toileted or are they in pain. Call lights are to always be within reach no matter what the resident's cognitive status is. 2. Review of Resident #17's quarterly MDS, dated [DATE], showed:-Cognitively intact;-Diagnoses included hemiplegia and hemiparesis (muscle weakness or partial paralysis) affecting the non-dominant left side, dementia and acute respiratory failure. Review of the resident's care plan, in use at the time of the survey, showed:-Focus: The resident is at risk for falls and has a history of falls;-Goal: The resident will be free of falls through the review date;-Interventions: Encourage the resident to participate in activities that promote exercise, physical activity for strengthening and improved mobility. Ensure personal items are within reach. Resident reminded to use call light for needs. Review of the resident's fall risk assessment, dated 6/19/25, showed:-Resident is at a high risk for falls. Observations on 8/18/25, of the resident in his/her room, showed:-At 9:51 A.M., the resident was in bed awake. He/She was positioned with his/her legs hanging off the bed. The resident said he/she was uncomfortable but could not reach the call light to call for help. The resident's call light was out of reach of the resident on the floor next to the bed. The resident's room door was open;-At 9:57 A.M., Certified Medication Technician (CMT) N walked into the resident's room and walked back out without assisting the resident;-At 10:16 A.M., the resident was still positioned with his/her legs hanging off the bed. Call light out of reach;-At 10:50 A.M., staff went into the resident's room and assisted him/her. During an interview on 8/20/25 at 7:47 A.M., CNA M said he/she expected the resident's call light to be in reach of the resident. He/She said the resident should be checked on every hour since he/she is a fall risk. During an interview on 8/20/25 at 8:00 A.M., Registered Nurse (RN) C said he/she expected the resident's call light to be in reach of the resident in order to allow the resident to call for help. He/She expected staff to round on the resident every 30 minutes to an hour to ensure resident is in a safe position in bed. 3. During an interview on 8/20/25 at 1:47 P.M., the Director of Nursing (DON) said she expected fall interventions to be in place for all residents who are a high fall risk and have had a history of falling. The interventions include making sure the residents needs are met, the bed is in a low position, rounding on residents frequently, proper positioning of the resident in the bed, bolster mattress, fall matts to be positioned on both sides of the bed, and the call light within reach of the resident. 4. Review of Resident #10's quarterly MDS, dated [DATE], showed:-Cognitively intact;-Required assistance from staff to set up and clean up with eating;-Diagnoses include malnutrition (inadequate nutrition), dysphagia (difficulty swallowing), gastrostomy status (a tube surgically inserted into the abdomen that is used for medications and liquid nutrition) and adult failure to thrive. Review of the resident's care plan, in use at the time of survey, showed:-Focus: The resident requires tube feeding related to dysphagia; -Interventions: The resident is dependent with tube feedings and water flushes; see physician orders for current feeding orders;-The care plan did not reflect the resident's diet order and swallow precautions. Review of the resident's Physician Order Sheets (POS), dated August, 2025, showed:-An order, dated 10/24/24, mechanical soft diet, regular consistency, upright 90 degrees during oral intake, alternate small bites and sips, upright 90 degrees for at least 30 minutes after meals. Observation on 8/14/25 at 12:17 P.M., showed a sign posted above the head of the resident's head of bed and at the resident's foot of the bed on the wall. The sign showed: Swallowing strategies to reduce the risk of choking and aspiration, upright no less than 90 degrees during oral intake and drinks; Small bites; Use liquid was or tongue sweep to clear food from mouth and cheeks; Swallow hard with each bite or sip. Observation on 8/14/25 at 5:49 P.M., showed the resident lay in bed. The resident's head was elevated approximately 30 degrees and the resident was slumped with his/her chin was downward into his/her chest. The resident was eating small bites of chopped meat. Observation on 8/15/25 at 8:45 A.M., showed the resident lay in bed and was slumped down. The head of the bed was raised 15 degrees. The resident was picking at the food and took a small bite of scrambled eggs. Observation and interview on 8/18/25 at 1:20 P.M., showed the resident lay in bed and the head of the bed was approximately 30 degrees. The resident was slumped in the bed with (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	his/her chin to his/her chest and was eating shredded pork with his/her hands. The Staffing Coordinator came into the room and offered the resident ice cream. The ice cream was given to the resident by the Staffing Coordinator and then he/she left the room. The resident said he/she was aware of the swallowing precautions posted on the wall and he/she will feel something stuck in his/her throat at times but has never choked. During an interview on 8/19/25 at 9:25 A.M., Licensed Practical Nurse (LPN) J said the resident is to be upright 90 degrees during meals and the swallowing guidelines should be encouraging the resident to follow to prevent the resident from choking or aspirating. During an interview on 8/19/25 at 9:45 A.M., CNA K said he/she was aware of the swallowing precautions and encourages the resident to follow them so the resident does not choke. The resident is to sit straight up in the bed or chair when eating. If the resident is not in the proper position for eating, CNA K would get another staff member to help pull the resident up in the bed. During an interview on 8/20/25 at 1:47 P.M., the DON said she expected staff to follow the resident's swallowing precautions and ensure the resident was in the proper position while eating to prevent choking or aspiration.

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely, quality laboratory services/tests to meet the needs of residents. Based on observation, interview and record review, the facility failed to provide or obtain laboratory services to meet the needs of one resident (Resident #9). The sample was 18. The census was 75. Review of the facility's Test Results policy, undated, showed:- Results of laboratory, radiological, and diagnostic tests shall be reported to the facility.-The medical practitioner shall be notified of the results.-The Director of Nursing (DON), or nurse receiving the test results, shall be responsible for notifying the medical practitioner of such test results. Review of the facility's Medical Provider Orders, revised 4/7/23, showed:-Policy: -This facility shall use uniform guidelines for the ordering and following of medical provider orders;-Documentation of medication and treatment orders: -Each medication and or treatment order should be documented with the date, time, and signature of the person receiving the order; -If using electronic medical records, input the medication and/or treatment according to the electronic health record instructions and facility policy;-Following of medication and or treatment orders: -Medical providers orders should be reviewed prior to administration of medication and/or treatment to validate the orders contains all required elements; -Staff should follow all valid medical provider orders timely unless there is an emergency which would temporarily delay the implementation of the order; -If an order does not contain all the required elements, staff should contact the ordering provider for clarification of the order prior to implementation of the order. Review of Resident #9's comprehensive Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated, 6/16/25, showed:-Cognitively intact;-Dependent on staff for toilet hygiene;-Always incontinent of bowel and bladder;-Diagnoses include stroke, muscle weakness, and diabetes. Review of the resident's care plan, in use at the time of survey, did not reflect any laboratory orders that were being implemented. Review of the resident's physician order sheets, dated, August, 2025, showed:-An order, dated 8/5/25, urinalysis (UA, a urine test to detect infection), and urine culture and sensitivity (a urine test that detects the exact bacteria growing and the type of antibiotic the bacteria is receptive to) related to the resident's confusion and urinary incontinence. Review of the resident's progress notes showed:-On 8/5/25 at 8:00 P.M., the resident's physician in to see the resident, new orders for UA and urine culture and sensitivity.-No further documentation noted related to urine test. Review of the resident's Treatment Administration Record (TAR) and Medication Administration Record (MAR) showed no order for the urine tests. Review of the resident's clinical results tab located in the resident's medical record did not show results for the resident's urine tests. During an interview on 8/20/25 at 8:56 A.M., Registered Nurse (RN) A said he/she was not aware of the physician's order for the resident's urine test. The order should be placed on the TAR or MAR for the nurse to complete. RN A said the resident's physician will sometimes place the order in the computer and the order is placed in the medical record incorrectly, and the nurse will usually have to go in and correct the order. During an interview on 8/19/25 at 10:05 A.M., the DON said she did not have any urine test results on the resident. She was told by staff that it was difficult to obtain a urine sample from the resident and that the resident would need to be sent out to a urologist (a bladder and kidney physician). The DON would have expected documentation in the resident's progress notes that the urine test was not obtained and a reason why it was not obtained. She would expect the order for obtaining a urine specimen to be placed on the resident's MAR or TAR clearly and accurately.

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F 0808 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure therapeutic diets are prescribed by the attending physician and may be delegated to a registered or licensed dietitian, to the extent allowed by State law. Based on observation, interview and record review, the facility failed to ensure one resident received double portions and nectar-thick liquids for aspiration precautions in accordance with physician orders (Resident #47). The sample was 18. The census was 75.Review of Resident #47's medical record, showed:-Diagnoses included pneumonitis (inflammation of the lungs) due to inhalation of food and vomit, dysphagia (swallowing disorder), history of stroke, epilepsy (seizure disorder), and hypertension (high blood pressure);-A physician order, revised 12/13/24, to admit to hospice with admitting diagnoses of aspiration pneumonia;-A physician order, dated 2/26/25, for regular diet, regular texture, nectar-thick liquids. Double portions. Review of the resident's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 7/12/25, showed:-Cognitively intact;-Supervision or touching assistance required for eating. Review of the resident's care plan, in use at the time of survey, showed:-Focus: Resident has an activities of daily living (ADL) self-care performance deficit;-Tasks included resident is able to feed self with tray set up;-Focus: The resident has potential nutritional problem. Regular diet with nectar-thick liquids;-Tasks included: Explain and reinforce to the resident the importance of maintaining the diet ordered. Monitor/document/report to physician as needed for signs/symptoms of dysphagia. Review of the resident's dietary slips, undated, showed a physician order for nectar thick liquids. No documentation regarding double portions. During an interview on 8/14/25 at 11:08 A.M., the resident said he/she does not get enough food to eat. Over the weekend, he/she received one egg for breakfast. Several days ago, he/she received one egg and one piece of bacon for breakfast. This morning, he/she was served one egg and a hashbrown. It was not enough to eat and he/she is still hungry. Observation on 8/14/25 at 5:32 P.M., showed a dinner tray delivered to the resident's room. The tray contained one meat patty on a bun with a piece of lettuce, a bowl of baked beans, a cup of fruit, a cup of thin consistency water, and a cup of thin consistency orange juice. The portions on the resident's tray were the same portion of food as other trays served on the hall. Observation on 8/15/25 at 8:15 A.M., showed a breakfast tray delivered to the resident's room. The tray consisted of one scoop of scrambled eggs, one biscuit, a bowl of hot cereal, a cup of thin consistency water, and a cup of thin consistency milk. The portions on the resident's tray were the same portion of food as other trays served on the hall. Observation on 8/18/25 at 8:41 A.M., showed the resident eating breakfast in his/her room. The tray consisted of a donut, a cup of thin consistency milk, and a cup of thin consistency orange juice. No dietary slip was on the resident's tray. During an interview, the resident said he/she just finished a scoop of scrambled eggs. He/She did not get enough to eat and wants more food. Observation on 8/20/25 at 8:10 A.M., showed Certified Nurse Aide (CNA) T passing trays to resident rooms from carts on the hallway. The cart containing beverages included a gallon of regular, thin consistency milk, and cups of thin-consistency apple juice. No nectar-thick liquids were on the cart. During an interview, CNA T said dietary slips are not on the trays sent out to the hallway by dietary. He/She is just passing trays to residents without knowing what should be on their dietary slips. Dietary slips tell staff if the resident is supposed to receive double portions or nectar-thick liquids. It is important for residents requiring nectar-thick liquids to receive drinks of that consistency because they might have a hard time swallowing thin liquids and thicker liquids go down slower. Resident #47 does not require nectar-thick liquids. CNA T did not know the resident is supposed to receive double portions. The resident always eats all of the food served to him/her. Observation on 8/20/25 at 8:24 A.M., showed CNA B passing trays to resident rooms from carts on the hallway. No nectar-thick liquids were on the carts. During an interview, CNA B said dietary staff are not sending dietary slips out with room trays. Dietary slips should include diet type and if the resident is supposed to receive things like double portions or nectar-thick liquids. Residents with orders for nectar-thick liquids should receive liquids as ordered because they could choke on thin liquids. Dietary does not (continued on next page)

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F 0808 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	send nectar-thick liquids out with the carts for room trays. Resident #47 is supposed to get nectar-thick liquids because he/she is an aspiration risk. He/She requires double portions. He/She eats a lot and is very hungry. During an interview on 8/19/25 at 9:47 A.M., CNA S said there are ongoing issues with dietary. Residents are not getting the food items they are supposed to get. Nursing staff go to the kitchen to ask for things for the residents and dietary staff get attitude with staff and the residents. During an interview on 8/20/25 at 9:31 A.M., Registered Nurse (RN) A said dietary slips should be on room trays. Dietary slips tell staff if a resident is supposed to receive double portions and nectar-thick liquids. It is important for residents with orders for nectar-thick liquids to receive the appropriate consistency as ordered because the resident is at risk for choking or aspiration. He/She has not seen nectar-thick liquids come out with room trays from dietary. Resident #47 does not require nectar-thick liquids. RN A did not think the resident required double portions but was not surprised he/she has orders for this. The resident eats well. RN A expects residents to receive diets as ordered by the physician. During an interview on 8/20/25 at 10:24 A.M., [NAME] V said when the previous Dietary Manager (DM) left the facility, he/she took his/her computer and the dietary slips were on the computer. The kitchen has a copy of all dietary slips that were available when the DM left. When plating food at meals, dietary staff go off the recipes for what they put on the plate. If a resident is supposed to get double portions, it should be on the dietary slip and dietary staff will make sure it is on there. Resident #47 is supposed to receive double portions. During an interview on 8/20/25 at 10:08 A.M., the DM said she began working with the facility a few days ago. She is not sure how to change dietary slips, yet. When plating trays for residents, dietary staff should follow recipes and the dietary slips to ensure residents receive nutrition in accordance with physician orders and resident needs. Dietary slips should include double portions and nectar-thick liquids. It is important for residents with orders for nectar-thick liquids to receive the appropriate consistency because those residents are at risk of choking. Dietary should send nectar-thick liquids with the carts that go out for hall trays. Nursing staff passing trays will not know what items a resident should receive if a dietary slip is not sent out with the tray. During the interview, the DM reviewed the dietary slip for Resident #47 and observed it did not indicate double portions. The DM said double portions should be included on the resident's dietary slip. During an interview on 8/20/25 at 1:48 P.M., the Director of Nurses and Administrator said dietary should send dietary slips out with trays during meals. The DM has access to the dietary slips and she should print them out at meals. Dietary slips should show the resident's name, room number, diet type, and other information, such as if the resident should receive double portions or nectar-thick liquids. Dietary staff should follow the dietary slips when plating food. Nursing should check the dietary slips and make sure the correct items are there before delivering to the resident. Dietary should provide all required items, such as nectar-thick liquids, on the carts that go out to the halls. Nectar-thick liquids should be received by residents with orders for this due to choking risk. Neither the DON nor Administrator were aware of Resident #47's specific dietary needs. They expected all residents to receive diets as ordered.

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F 0868 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have the Quality Assessment and Assurance group have the required members and meet at least quarterly Based on interview and record review, the facility failed to ensure Quality Assessment and Assurance (QAA) committee meetings were held at least quarterly to fulfill the committee's responsibilities to identify and correct quality deficiencies effectively. The census was 75.During an interview on 8/14/25 at 10:21 A.M., the Director of Nurses (DON) and Administrator said they began working at the facility approximately two months ago. QAA meetings should take place monthly. QAA meetings should be attended by the facility's department heads and Medical Director. Review of the facility's QAA sign in sheets for the last 12 months, from August 2024 to August 2025, showed:-Meeting held 9/6/24;-Meeting held in April 2025;-No documentation of other QAA meetings held within the 12-month timeframe.During an interview on 8/18/25 at 10:12 A.M., the Administrator said the QAA sign-in sheets provided were the only sheets he could locate. Before he started working with the facility, the Social Services Director (SSD) was the interim Administrator. She held one meeting in April 2025. The Administrator began working with the facility in June 2025. He has not held a QAA meeting, yet. Going forward, he would like to hold QAA meetings monthly. They should be held at least quarterly and attended by all department heads and the Medical Director. QAA meetings are held to review key points he has identified and other trends in the facility.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. Based on interview and record review, the facility failed to develop policies and procedures ensuring all residents in the facility had been offered the influenza vaccine. The facility failed to ensure documentation of received vaccines were noted in the medical records of three of five sampled residents (Residents #5, #11 and #4). The resident sample was 18. The facility census was 75.Review of the facility's Resident Immunizations and and Vaccinations policy, revised in 2019 showed:-It is facility policy that all residents are offered influenza vaccination annually;-All new admissions will be screened and given the influenza vaccine, unless specifically ordered by the Primary Physician;-A record of vaccination will be placed in the resident's medical record. 1. Review of Resident #5's medical record showed:-An admission date of 1/10/25;-Medical diagnoses including hypertension, End Stage Renal Disease (ESRD, permanent kidney failure requiring transplant or dialysis for survival), history of Transient Ischemic Attack (TIA, a temporary interruption in blood flow to the brain causing stroke-like symptoms), and diabetes.Review of the resident's documented immunizations showed:-No recorded documentation of administration or refusal/education of the influenza vaccine. 2. Review of Resident #11's medical record showed:-An admission date of 3/14/25;-Medical diagnoses including history of TIA, encephalopathy (a disorder that affects brain function characterized by symptoms such as confusion, memory loss, personality changes, and tremors), and pulmonary embolism (a blockage in an artery of the lungs, usually caused by a blood clot that forms in another part of the body and travels to the lungs).Review of the resident's documented immunizations showed:-No recorded documentation of administration or refusal/education of the influenza vaccine. 3. Review of Resident #4's medical record showed:-An admission date of 3/12/25;-Medical diagnoses including Chronic Obstructive Pulmonary Disease (COPD, a chronic narrowing of the airway, causing difficulty with breathing), gastrostomy status (a surgical line placed into the patient's stomach for the introduction of food or medication), dysphagia (difficulty swallowing), and paroxysmal atrial fibrillation (a-fib, a condition causing the atrium of the heart of beat faster than the ventricles, increasing the risk of blood clots and lowered cardiac output).Review of the resident's documented immunizations showed:-No recorded documentation of administration or refusal/education of the influenza vaccine. 4. During an interview on 8/19/25 at 9:14 A.M., Licensed Practical Nurse (LPN) Q, LPN R, and the facility Director of Nursing (DON) said there is no standardized process for obtaining consent for or documentation of vaccines for current and new residents at the facility. The acting Infection Preventionist (IP) is typically in charge of tracking and ensuring vaccinations are completed and documented, but LPN Q who is the acting facility IP, had only been working at the facility for a little over a week and had yet to begin this process. LPN R, who is finishing IP training and will become the facility's acting IP, will take on this responsibility once trainings are complete. LPNs Q, R, and the DON said all vaccinations should be documented in the medical record as completed or offered per federal regulation. 5. During an interview on 8/20/25 at 1:48 P.M., the facility Administrator and DON said vaccination records should be kept in the resident's medical record and documented as accepted or refused. There is no standard process for tracking immunizations of residents at this time other than the DON looking at records to see when it's time. The Administrator and DON said no staff member is currently responsible for the tracking of immunization status, as they have only been working at the facility for a little over a month. Residents should be offered required vaccinations on admission and when clinically appropriate throughout the year. The vaccination status for all residents should be reflected accurately in the medical record.

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 develop policies and procedures ensuring all residents in the facility had been offered COVID-19 vaccine education and/or had documentation of vaccination against COVID-19 in their facility medical record The facility failed to ensure documentation of received vaccines was noted in the medical records of three of five sampled residents. The resident sample was 18. The facility census was 75.Review of the facility's Resident Immunizations and and Vaccinations policy, revised in 2019 showed:-It is facility policy that all residents are offered influenza vaccination annually;-It is facility policy that all residents are offered pneumococcal vaccination;-No mention of vaccination against or education regarding COVID-19. 1. Review of Resident #5's medical record showed:-An admission date of 1/10/2025;-Medical diagnoses including hypertension, End Stage Renal Disease (ESRD, permanent kidney failure requiring transplant or dialysis for survival), history of Transient Ischemic Attack (TIA, a temporary interruption in blood flow to the brain causing stroke-like symptoms) and diabetes.Review of the resident's documented immunizations showed:-No recorded documentation of administration or refusal/education of the COVID-19 vaccine. 2. Review of Resident #11's medical record showed:-An admission date of 3/14/25;-Medical diagnoses including history of TIA, encephalopathy (a disorder that affects brain function characterized by symptoms such as confusion, memory loss, personality changes, and tremors), and pulmonary embolism (a blockage in an artery of the lungs, usually caused by a blood clot that forms in another part of the body and travels to the lungs).Review of the resident's documented immunizations showed:-No recorded documentation of administration or refusal/education of the COVID-19 vaccine; 3. Review of Resident #4's medical record showed:-An admission date of 3/12/25;-Medical diagnoses including Chronic Obstructive Pulmonary Disease (COPD, a chronic narrowing of the airway, causing difficulty with breathing), gastrostomy status (a surgical line placed into the patient's stomach for the introduction of food or medication), dysphagia (difficulty swallowing), and paroxysmal atrial fibrillation (a-fib, a condition causing the atrium of the heart of beat faster than the ventricles, increasing the risk of blood clots and lowered cardiac output).Review of the resident's documented immunizations showed:-No recorded documentation of administration or refusal/education of the COVID-19 vaccine; 4. During interview on 8/19/25 at 9:14 A.M., Licensed Practical Nurse (LPN) Q, LPN R, and the facility Director of Nursing (DON) said there is no standardized process for obtaining consent for or documentation of vaccines for current and new residents at the facility. The acting Infection Preventionist (IP) is typically in charge of tracking and ensuring vaccinations are completed and documented, but LPN Q who is the acting facility IP, had only been working at the facility for a little over a week, and had yet to begin this process. LPN R, who is finishing IP training and will become the facility's acting IP, will take on this responsibility once trainings are complete. LPNs Q, R, and the DON said all vaccinations, including vaccinations for COVID-19, should be documented in the medical record as completed or offered per federal regulation. 5. During interview on 8/20/25 at 1:48 P.M., the facility Administrator and DON said vaccination records should be kept in the resident's medical record and documented as accepted or refused. There is no standard process for tracking immunizations of residents at this time, other than the DON looking at records to see when it's time. The Administrator and DON said no staff member is currently responsible for the tracking of COVID-19 immunization status, as they have only been working at the facility for a little over a month. Residents should be offered required vaccinations on admission and when clinically appropriate throughout the year. The COVID-19 vaccination status for all residents should be reflected accurately in the medical record.

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. Based on observation, interview and record review, the facility failed to ensure the kitchen was free from flies during two of five days of survey. The sample was 18. The census was 75. 1.Review of the facility's pest control logs, showed:-On 6/20/25 the kitchen was treated for pests;-On 7/18/25 the kitchen was treated for pests;-On 8/15/25 the kitchen was treated for pests. 2. Observation on 8/15/25, of the kitchen, showed:-At 11:41 A.M. multiple flies flew around the food preparation station, landing on food and utensils;-At 11:50 A.M., the Dietary Manager stopped food preparations to kill a fly with a bottle of cleaning wipes;-At 12:07 P.M., multiple flies flew around the dish washing station landing on clean and dirty dishes. 3. Observation on 8/18/25, of the kitchen, showed:-At 10:04 A.M., multiple flies were in the dishwashing station landing on clean cups;-At 10:12 A.M., flies flew around the food preparation area landing on utensils. 4. During an interview on 8/15/25 at 9:39 A.M., the Maintenance Director said he was not aware of the amount of flies in the kitchen. He said a pest control company does come out and spray the facility. He would expect dietary staff to inform him if the pest control sprays are not working in order to find other options. 5. During an interview on 8/19/25 at 1:56 P.M., the Dietary Manager said the kitchen should be free from flies. She said the flies have been a problem since she started working at the facility a week prior. She did not report the flies to the maintenance team. 6. During an interview on 8/20/2025 at 2:12 P.M., the Administrator said he would expect the kitchen to be free from flies and pests. He said the facility has a pest control program. He would expect dietary staff to report any pest control concerns to the maintenance team.