STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265239	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/05/2026
NAME OF PROVIDER OR SUPPLIER Hermitage Nursing & Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE 18599 First Street Hermitage, MO 65668	

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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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. Based on observation, interview, and record review, the facility failed to protect the resident's right to be free from physical abuse when one staff member (Certified Nurse Assistant (CNA) A) yelled at and physically forced one resident (Resident #1), with a diagnosis of dementia, back into his/her room twice while the resident was resisting and trying to exit his/her room. The resident received multiple bruises on their hands and forearms and exited their room visibly upset after the altercation and stating he/she wanted the staff member arrested. The CNA was later arrested and charged with assault. The facility census was 65. The Administrator was notified on 02/26/26, at 12:30 P.M., of an Immediate Jeopardy (IJ) which began on 02/20/26. The IJ was removed on 02/27/26, as confirmed by surveyor on-site verification. Review of the facility's policy titled, Abuse Policy, undated, showed the following:-It is the policy of the facility that each resident will be free from abuse;-Abuse can include verbal, mental, sexual, or physical abuse, misappropriation of resident property and exploitation, corporal punishment or involuntary seclusion;-Additionally, residents will be protected from abuse, neglect, and harm while they are residing at the facility;-No abuse or harm of any type will be tolerated, and residents and staff will be monitored for protection;-An owner, licensee, Administrator, licensed nurse, employee or volunteer of a nursing home shall not physically, mentally or emotionally abuse, mistreat, or neglect a resident. Review of Resident #1's face sheet showed the following:-admission date of 04/01/24;-Diagnoses included vascular dementia (progressive decline in thinking, memory, and behavior, caused by impaired blood flow to the brain) with agitation. Review of the resident's care plan, dated 07/17/25, showed the following:-The resident will not sustain serious injuries due to memory/recall deficit;-Ensure resident's areas are free of hazards;-Redirect resident when entering unsafe areas.-Resided on the special care unit (SCU) for safety. Review of the resident's quarterly Minimum Data Set (MDS - a federally mandated assessment tool completed by facility staff), dated 12/12/25, showed the following:-Usually understood and usually understands communication;-Severely cognitively impaired;-Exhibited inattention, behavior present, fluctuates (comes and goes, changes in severity);-Exhibited disorganized thinking, behavior present, fluctuates;-No physical, verbal, or other behavioral symptoms directed toward others;-No rejection of care;-No wandering. Review of the resident's progress note dated 02/20/26, at 12:53 P.M., showed the Director of Nursing (DON) documented resident had been up and active in the SCU per usual routine. He/she was observed ambulating around the unit throughout the shift. Resident was seen in the dining room (continued on next page)

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

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)

F 0600

Level of Harm - Immediate jeopardy to resident health or safety

Residents Affected - Few

consuming meals without difficulty. Resident noted to spend most of his/her days in his/her room watching television. He/she did come out occasionally and would talk with other residents. Resident denied pain or any current concerns. No behavioral issues noted at this time. Will continue current plan of care.

Review of the resident's progress note dated 02/23/26, at 12:59 P.M., showed the DON documented a skin assessment. Resident noted to have scattered bruising on his/her bilateral upper extremities (hands/arms) in various stages of healing. When the nurse asked the resident about the cause of the bruising, the resident said he/she woke up that way. Resident denied pain or drainage associated with the bruised areas. No tenderness reported. Resident demonstrated full range of motion to fingers without difficulty. No functional impairment observed. Physician notified of bruising.

During an interview on 02/25/26, at 10:56 A.M., the Administrator said the following:-On Monday, 02/23/26, at approximately 9:00 A.M. to 9:30 A.M., the resident's responsible party (RP) came to the Administrator's office and said the resident had bruises on his/her hands and arms and an unnamed staff member in the SCU told him/her CNA A abused the resident;-The Administrator interviewed CNA C who said he/she worked the day shift at the facility on the morning of 02/20/26. He/she arrived at work on 02/20/26 at approximately 5:55 A.M. and entered the SCU, walked down the hallway, and saw CNA A in the resident's room holding the resident's arms;-CNA C asked why CNA A was in the resident's room and CNA A informed CNA C he/she was putting the resident back to bed;-The Administrator said the resident was typically very pleasant and cared for him/herself. If not for the resident wandering on occasion, he/she would not need to be in the SCU;-The Administrator said the facility had video surveillance cameras (without audio) in the common areas, including the hallway of the SCU. On 02/23/26, the Administrator viewed (02/20/26) video footage from the hallway of the SCU. The video showed CNA A grab the resident by the arms and push the resident back into his/her room on two separate occasions;-The Sherriff's department arrived and arrested CNA A on the evening of 02/23/26 and he/she was charged with assault of the resident.

Observation of the facility's surveillance video (with no sound), dated of 02/20/26 showed the following:-At display time 6:45 A.M., CNA A grabbed the resident's right forearm while the resident stood in the doorway of his/her room. The resident pulled his/her arm away from CNA A;-Between display time 6:45 A.M. and 6:50 A.M., the resident stood (fully dressed) in the open doorway to his/her room with his/her back to the door frame and CNA A stood facing the resident, just outside the resident's door frame. CNA A's arms were crossed over his/her chest and the staff member stood in a wide stance with feet apart. The resident appeared to be motioning/pointing toward the day area and the staff member pointed toward the resident's room. They each pointed several times;-At display time 6:50 A.M., the resident raised his/her own hands and arms up in front of CNA A. CNA A appeared to knock the resident's arms down using his/her hands. CNA A held the resident's forearms and pushed the resident back into his/her room. CNA A exited the resident's room, closed the door, and walked toward the day area. The resident opened his/her door and again and stood in the doorway, CNA A walked quickly toward the resident and grabbed the resident's forearms with his/her hands. CNA A again appeared to forcefully push the resident into his/her room while holding the resident's forearms;-At display time 6:51 A.M., CNA C (the day shift aide) entered the SCU and walked down the SCU resident hall. CNA C stopped at the doorway to the resident's room and turned and appeared to look inside the room. CNA A exited the resident room and walked toward the day area. The resident exited his/her room.(Note: The facility staff stated the time on the time stamp on the video was off.)

During an interview and observation of the resident on 02/26/26, at 8:50 A.M., Licensed Practical Nurse (LPN) B reported the bruising on the resident's hands and forearms looked like somebody had
(continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	hygiene, and dressing;-It took approximately two hours for the resident to calm back down on 02/20/26 after the incident. CNA K said he/she tried to reassure the resident. During an interview on 02/25/26, at 2:33 P.M., Certified Medication Technician (CMT) P said the following:-He/she passed medication on 02/20/26 and he/she noticed the bruising on the resident's hands and forearms, but was never told that it was from an employee;-The resident was not an aggressive resident and was mostly independent. The resident was not clumsy and did not fall. During an interview on 02/25/26, at 3:45 P.M., LPN B said the resident was low key, was physically independent with walking, and did not fall. There was no reason staff should make the resident stay in his/her room. During an interview on 02/26/26, at 10:00 A.M., the resident's physician said the following:-A staff member trying to keep residents from falling or hurting themselves, would be the only acceptable reason to grab a resident's arms;-A resident should not have multiple bruises to his/her arms/hands, unless the resident was on a lot of blood thinners;-The resident had a diagnosis of dementia but had exhibited no recent behaviors. During an interview on 02/25/26, at 11:00 A.M., the DON said the following:-The resident generally got him/herself up out of bed around the same time each day, dressed him/herself, and walked to the dining/day area in the unit;-The DON could not think of any reason why CNA A would try to prevent the resident from exiting his/her room;-After the Administrator informed the DON of the allegation on 02/23/26, the DON assessed the resident for injuries;-The DON observed multiple circular and oval shaped reddish-purple bruises to the resident's forearms and to the back of his/her hands. The bruises were reddish-purple in color. During an interview on 03/05/26, at 5:45 P.M., the Administrator said abuse should be reported immediately. The resident should be assessed, and notifications should be initiated after abuse allegation. NOTE: At the time of the abbreviated survey, the violation was determined to be at the immediate and serious jeopardy level J. Based on observation, interview, and record review completed during the onsite visit, it was determined the facility had implemented corrective action to address and lower the violation at the time. A final revisit will be conducted to determine if the facility is in substantial compliance with participation requirements. At the time of exit, the severity of the deficiency was lowered to the D level. Complaint 2785595 and 2785807

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to complete a comprehensive assessment, including a review of the clinical rationale and approved indication for use of psychotropic medications (prescription drugs that manage mental health conditions by affecting brain activity, mood, thoughts, and behavior), for one resident (Resident #3) with a diagnosis of dementia, prior to utilizing anti-psychotic medications (a class of medications primarily used to manage psychosis) to treat the resident's behaviors. The facility failed to consistently monitor, identify, and implement nonpharmacological interventions to address the resident's behaviors and failed to care plan use of antipsychotic medication. The facility census was 65. Review of the facility's policy titled, Abuse Policy, undated, showed the following:-It is the policy of the facility that each resident will be free from abuse;-The resident will be free from physical or chemical restraints imposed for purposes of discipline or convenience and are not required to treat the resident's medical symptoms. Review of the facility policy titled Care Plan Comprehensive, undated, showed the following:-An individualized comprehensive care plan that includes measurable goals and time frame will be developed to meet the resident's highest practicable physical, mental, and psychosocial well-being;-The interdisciplinary team with input from the resident, family, and legal representative will develop a comprehensive care plan for each resident;-Care plan will be revised as changes occur in the resident's condition;-The care plan will be based on a thorough assessment;-The comprehensive care plan should be developed within seven days of the comprehensive assessment;-A well-developed care plan will be oriented preventing avoidable declines in functioning; managing risk factors or indicating the limit of interventions; applying current standards of practice in care planning process; and evaluating treatment of measurable goals, timetables, and outcomes of care;-Use an interdisciplinary approach to care plan development to improve the resident's functional abilities;-Assess and plan for care to meet the resident medical, nursing, mental, and psychosocial needs. 1. Review of Resident #3's face sheet (a general information sheet) showed the following:-admission date of 02/06/26;-Diagnoses included dementia (loss of mental functions that are severe enough to affect your daily life and activities), anxiety, and cerebral infarction (a blockage in an artery that restricts blood flow to the brain, leading to tissue death). Review of the resident's quarterly Minimum Data Set (MDS - a federally mandated assessment instrument completed by facility staff), dated 01/12/26, showed the following:-Severe cognitive impairment; -Did not have a psychiatric diagnosis;-Did not have delusions or hallucinations;-Had physical behavioral symptoms directed towards others one to three days a week;-Had other behavioral symptoms not directed at others one to three days a week;-Behavioral symptoms put resident at risk for physical illness or injury;-Required moderate staff assistance for toileting, bed mobility, dressing, and transfers;-Dependent on staff for showering and hygiene;-Utilized a wheelchair for mobility;-Resident received antipsychotic medication;-One injection had been administered in last seven days;-Did not utilize any restraints. Review showed the facility did not provide a care plan for the resident. Review of the resident's hospital Discharge summary, dated [DATE], showed the resident did not receive antipsychotic, antianxiety, or antidepressant medications upon discharge. (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the resident's physician admission progress note, dated 02/06/26, showed the resident denied acute complaints today. The resident was alert and oriented with a pleasant demeanor. No acute delirium today. Resident alert and oriented but unable to state location. Resident was awake and conversant and followed commands appropriately with clear speech. Staff should monitor neurological status and report any changes in mental status or weakness. (The physician did not document regarding need for, orders for, or use of anti-psychotic medications.) Review of the resident's nursing progress note dated 02/06/26, at 9:17 P.M., showed the following: -Resident attempted to ambulate without assistance;-Resident was alert, oriented to self, and did not take redirection;-Resident brought to nurses' desk to be monitored closely;-Resident continued to attempt to ambulate without assistance;-Staff called the on-call Nurse Practitioner (NP) and received an order for melatonin (a hormone in the body that plays a role in sleep) 5 milligrams (mg) at bedtime. Staff attempted to give it to the resident, and he/she spit it at the nurse on two separate attempts;-Staff contacted the NP and received an order to give Haldol (antipsychotic medication) 2.5 mg IM (intermuscular – into the muscle) injection. Resident returned to his/her room and the Haldol IM injection was given;-Staff brought resident back to nurses' station to be observed until the medication took effect to provide for safety. Review of the resident's February 2026 Physician's Order Sheet (POS) showed an order, dated 02/06/26, for haloperidol lactate (Haldol) solution, 5 mg/milliliter (ml), give 2.5 mg IM injection one time for a diagnosis of dementia. Review of the resident's February 2026 Medication Administration Record (MAR) showed on 02/06/26, staff documented haloperidol lactate solution 5 mg/ml, 2.5 mg IM was given but documentation did not show a time or an indication for administration. Review of the resident's nursing progress note dated 02/07/26, at 3:13 P.M., showed the following: -The resident slid out of the wheelchair with no injuries were noted;-Staff moved the bed next to the wall and fall mats placed on the floor;-Staff notified all parties and the physician for as needed medication for anxiety and restlessness;-Resident will not stay in his/her wheelchair and tries to walk down hallways. Review of the resident's nursing progress note dated 02/07/26, at 3:13 P.M., showed a new order for risperidone (antipsychotic medication) 0.5 mg daily, as needed (prn) received. Staff updated the pharmacy, family, and the administrator were updated. Review of the resident's February 2026 POS showed an order, dated 02/07/26, for risperidone (antipsychotic medication) 0.5 mg tablet, give one tablet daily as needed for a diagnosis of dementia without behavioral, psychotic, mood disturbance, and anxiety. Review of the resident's February 2026 MAR showed staff documented on 02/07/26, at 4:22 P.M., risperidone 0.5 mg one tablet given prn to the resident for crawling on the floor. Review of the resident's February 2026 MAR showed the following:-On 02/08/26, at 11:40 A.M., staff documented risperidone 0.5 mg one tablet given prn for anxiety;-On 02/09/26, at 3:58 P.M., staff documented risperidone 0.5 mg one tablet was given prn for anxiety. Review of resident's nursing progress notes, dated 02/08/26 and 02/09/26, showed staff did not document regarding the behaviors at the time of administration or nonpharmacological interventions (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	tried. Review of the resident's nursing progress note dated 02/10/26, at 6:35 P.M., showed the resident was alert and oriented to person and place with confusion and occasional delusions. The resident's speech was clear, and he/she was usually able to make needs known. As needed risperidone given this morning following episode of yelling and agitation when staff attempted to redirect resident after continual attempts to walk unassisted. Staff noted medication effective and resident calm rest of shift. Review of the resident's February 2026 MAR showed on 02/10/26, at 11:08 A.M., staff documented risperidone 0.5 mg one tablet was given prn for anxiety and yelling out. Review of the resident's February 2026 MAR showed the following: -On 02/13/26, at 5:13 P.M., staff documented risperidone 0.5 mg one tablet was given for being restless and agitated;-On 02/14/26, at 8:10 P.M., staff documented risperidone 0.5 mg one tablet prn was given for roaming;-On 02/15/26, at 4:36 P.M., staff documented risperidone 0.5 mg one tablet prn was given for yelling. Review of the resident's nursing progress notes, dated 02/13/26 to 02/15/26, showed staff did not document regarding the behaviors at the time of administration or nonpharmacological interventions tried. Review of the resident's nursing progress note dated 02/16/26, at 3:25 P.M., showed the following: -Resident noted to have increased confusion, attempting to stand without assistance, observed walking down the hallway without supervision, throwing items, and exhibiting increased anxiety;-Resident had a prn risperidone available and the as needed dose was administered as ordered;-Staff notified physician on the resident's change in behavior and increased symptoms. New orders received to change risperidone 0.5 mg to daily administration and to initiate Zoloft (antidepressant) 25 mg daily. Review of the resident's February 2026 POS showed the following:-An order, dated 02/16/26, for risperidone 0.5 mg tablet, give one tablet daily for a diagnosis of dementia without behavioral, psychotic, mood disturbance, and anxiety; -An order, dated 02/16/26, for Zoloft (antidepressant) 25 mg tablet, give one tablet once daily for a diagnosis of dementia without behavioral, psychotic, mood disturbance, and anxiety. Review of the resident's February [DATE] showed on 02/16/26, at 2:16 P.M., staff documented risperidone 0.5 mg one tablet prn was given for throwing things and yelling. Review of the resident's nursing progress note dated 02/17/26, at 1:25 A.M., showed staff had kept the resident at the desk due to attempting to stand and/or walk by him/herself. The resident was alert to self only. Resident was cursing and uncooperative with directions and staff assistance. He/She attempted to bite and hit staff. Scheduled risperidone started. Review of the resident's February 2026 POS showed an order, dated 02/17/26, for lorazepam (antianxiety) 0.5 mg tablet, give one tablet four times daily for anxiety disorder. Review of the resident's medical record showed staff did not document regarding receipt of a new order for lorazepam on 02/17/26. (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of resident's nursing progress dated 02/18/26, at 4:09 A.M., showed the following: -Staff kept resident at the desk due to attempting to stand and/or walk by him/herself;-Resident alert to self only;-Resident cursing and uncooperative with directions and staff assistance;-Resident attempted to bite and hit staff;-Scheduled risperidone and lorazepam 0.5 mg four times daily started;-Resident had three falls on this shift regardless of keeping resident at nurses' station; -Resident currently resting in bed with call light in reach. Review of the resident's February 2026 POS showed the order for lorazepam, dated 02/17/26, was discontinued on 02/19/26. Review of the resident's medical record showed staff did not document regarding the lorazepam order being discontinued. Review of the resident's nursing progress note dated 02/20/26, no time noted, showed the following: -Resident demonstrated an increase in confusion this shift;-Resident observed walking to the exit doors and attempting to leave the unit;-Resident informed he/she was safe and redirected from the exit;-Resident continued to display confusion and required ongoing verbal assurance;-No physical behaviors noted. Review of the resident's February 2026 POS showed a new order, dated 02/20/26, for lorazepam 0.5 mg tablet, give one tablet every four hours, as needed, for anxiety disorder. Review of a nursing note dated 02/20/26, no time noted, showed the following:-Resident alert and oriented to self and time;-Resident did not get out of bed until noon;-Staff sat resident in wheelchair at nurses' station;-Resident spit out medications on the floor when administered;-Resident went to the fire alarm and attempted to break it by punching it;-Staff redirected the resident from the area. Resident continued to grab other residents' arms;-Resident was aggressive and continued one-to-one supervision. Review of the resident's February 2026 MAR showed on 02/22/26, at 2:20 P.M., lorazepam 0.5 mg one tablet was given because the resident was yelling for family, then at staff, when they attempted to redirect. Review of the resident's nursing progress note dated 02/22/26, at 4:20 P.M., showed the following: -Resident was aggressive with actions;-Resident threw a butter knife and a fork in the dining room;-Resident always looked for family members;-Resident wanted his/her purse and wanted to leave;-Resident had issues with following directions. Review of the resident's February 2026 POS showed the following:-A new order, dated 02/22/26, for risperidone 4 mg disintegrating tablet, 4 mg to be given every morning for a diagnosis of dementia, mild, with psychotic disturbance;-A new order, dated 02/22/26, for risperidone 4 mg disintegrating tablet, may give 4 mg once daily, as needed, for a diagnosis of dementia, mild, with psychotic disturbance;-A new order, dated 02/22/26, for haloperidol lactate solution 5 mg/mL, give 0.5 ml (2.5 mg); IM injection as needed for dementia, mild, with psychotic disturbance; -A new order, dated 02/22/26, for haloperidol decanoate 100 mg/mL solution, give 25 mg via IM injection every four hours as needed for dementia, mild, with psychotic disturbance. Review of the resident's medical record, dated 02/22/26, showed staff did not document regarding the new medication orders. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265239	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hermitage Nursing & Rehab	18599 First Street Hermitage, MO 65668

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the resident's February 2026 MAR showed on 02/22/26, at 8:36 P.M., staff documented haloperidol lactate 2.5 mg given IM due to resident being aggressive, continuous standing, cussing, and knocking on wall. Staff noted medication as effective as the resident appeared relaxed and asleep. Review of the resident's nursing note dated 02/23/26, at 12:41 A.M., showed the following:-Resident refused medication, spitting them at staff;-Resident was redirected;-Resident attempted to grab anyone that walked by;-Resident being very aggressive;-Resident placed on one-on-one with staff and Haloperidol prn given to resident for safety;-Staff will continue the current plan of care. Review of the resident's February 2026 POS showed a new order, dated 02/23/26, for Seroquel (an antipsychotic) 25 mg tablet, give one tablet at bedtime for a diagnosis of anxiety disorder. Review of the resident's nursing progress note dated 02/26/26, at 9:00 A.M., showed the following:-The medication regimen reviewed with the physician due to increased fall risk and history of stroke;-Verbal orders received for to discontinue IM Haldol and lorazepam;-Verbal orders received to decrease risperidone from 4 mg to 1 mg twice daily for agitation related to dementia;-Verbal orders to start Haldol 0.5 mg every six hours as needed;-Verbal orders to continue Seroquel 25 mg at bedtime. Review of the resident's February 2026 POS showed the following:-The orders for IM Haldol and lorazepam were discontinued;-A new order, dated 02/26/26, for haloperidol 0.5 mg tablet, give one tablet every six hours as needed for a diagnosis of dementia without behavioral, psychotic, mood disturbance, and anxiety; -A new order, dated 02/26/26, for risperidone 1 mg tablet, give one tablet twice daily for a diagnosis of dementia without behavioral, psychotic, mood disturbance, and anxiety. Review of the resident's February 2026 MAR showed on 02/27/26, at 3:26 A.M., staff documented haloperidol 0.5 mg one tablet prn given with no behaviors indicated. Review of the resident's nurse's note 02/27/26, at 3:26 A.M., showed staff noted the resident spit the medication out. Review of the resident's nursing progress note dated 02/27/26, at 6:57 A.M., showed the following:-The resident continued to argue, hit, spit, and grab at staff and other residents aggressively;-Since crawling in the hallway at 2:00 A.M., the resident had been on one-to-one supervision with staff;-On one-to-one supervision due to attempting to get up and walk;-Attempted to give as needed medication but the resident spit it at the nurse;-Redirection was unsuccessful. Review of the resident's physician note, dated 02/27/26, showed staff should monitor the resident for changes in mental status or behavioral disturbances. Recent medication adjustments were made for agitation and behavioral disturbances. Review of the resident's February MAR showed on 02/28/26, at 2:24 P.M., staff documented haloperidol 0.5 mg one tablet prn was given due to resident yelling out. Review of the resident's nursing progress notes, dated 02/28/26, showed staff did not document behaviors at time of administration. Review of the resident's record for February 2026 showed the facility did not provide documentation (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	of resident behavior monitoring, nonpharmacological interventions, or assessment for antipsychotic medication. During an interview on 03/05/26, at 3:00 P.M., Registered Nurse (RN) V said the following:-The resident tried to stand up from his/her wheelchair a lot, but RN V did not have many issues redirecting the resident;-Standing up was not a justification for administering an antipsychotic medication;-The only justification would be if the resident was causing harm to him/herself or another resident;-RN V had never seen the resident demonstrate behaviors that justified a nurse administering IM Haldol;-RN V would offer the resident's snacks, ask the resident to sit back down;-RN V said if a staff member took time with the resident to find out what he/she wanted and to re-direct his/her behaviors he/she did not have many issues;-The resident did slap at staff and call the staff names;-RN V said nurses should not request an antipsychotic medication for a resident from the provider, unless they had tried all other non-pharmacological approaches;-Some of the nurses were quick to call the physician and ask for a medication for a resident without trying other approaches, the nurse should assess the resident for incontinence, pain, or hunger. Some of the residents have difficulty communicating their needs;-Some of the nurses did take the time/effort with the resident;-A urinary tract or other infection can also lead to increased behaviors, especially in the elderly. During an interview on 02/27/26, at 2:08 P.M., the Director of Nursing (DON) said the increase of the resident's risperidone from 0.5 mg to 4 mg was a huge increase and concerns him/her. Antipsychotic medications should be initiated one and a time and increased in smaller dosages. During an interview on 03/05/26, at 11:45 A.M., NP O said the following:-It was not appropriate to give a resident haloperidol to prevent them from getting out of a wheelchair;-Antipsychotic medications can cause behaviors;-He/she was not comfortable ordering haloperidol very often due to side effects such as extrapyramidal symptoms (EPS -involuntary movement disorders caused primarily by antipsychotic medications);-He/she would be more comfortable ordering Seroquel or Zyprexa (antipsychotic medication). During an interview on 03/05/26, at 2:17 P.M., the resident's physician said the following:-An as needed antipsychotic order should be given for a resident who is a danger to others or self;-Antipsychotics should not be given for a resident standing up;-A diagnosis of vascular dementia is justification for administration of antipsychotics;-Short term antipsychotic medication is for serious harm, agitation, or psychosis when nonpharmacological measures fail;-A dose of 0.25 mg to 0.5 mg of haloperidol is appropriate for a first-time dose;-Risperidone 4 mg is too high of a dose for a resident;-He/she had never given 0.5 mg Haloperidol to a resident;-Possible issues with antipsychotic medications are increased falls, EPS, and cognitive impairment;-IM injection of haloperidol is for worst case scenario;-He/she did not think 2.5 mg haloperidol injection was appropriate when given to the resident on 02/06/26. He/she was not comfortable with this dosage;-He/she usually starts with Seroquel for resident behaviors. During an interview on 03/05/26, at 5:45 P.M., the Administrator said staff should have tried nonpharmacological interventions first for a confused resident trying to stand. Dementia without behaviors is not an appropriate diagnosis for antipsychotic medication. An as needed antipsychotic medication would be used for a dementia diagnosis or behaviors. Antipsychotics should not be administered for behaviors that do not affect the resident or other residents. Antipsychotic medications should be ordered based on past behaviors, interventions tried, and documented behaviors. Complaint 2784515

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	265239	A. Building B. Wing	03/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hermitage Nursing & Rehab	18599 First Street Hermitage, MO 65668

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure all allegations of abuse were reported immediately to facility management and within two hours of staff being aware of the allegation, when staff did not report two allegations of abuse involving two residents (Resident #1 and #2) to administration and the Department of Health and Senior Services (DHSS) in a timely fashion. The facility census was 65.Review of the facility's policy titled, Abuse Policy, undated, showed the following-It is the policy of the facility that each resident will be free from abuse;-Abuse can include verbal, mental, sexual, or physical abuse, misappropriation of resident property and exploitation, corporal punishment or involuntary seclusion;-Any nursing home employee or volunteer who becomes aware of abuse, mistreatment, neglect, exploitation, or misappropriation shall immediately report to the nursing home Administrator;-The nursing home Administrator or designee will report abuse to the state agency per state and federal requirements;-All allegations of abuse, neglect, exploitation, mistreatment, injuries of unknown sources, and misappropriation of resident property by facility employees, contract employees, volunteers, contract services, consultants, physicians, visitors, family members, or other individuals will be reported immediately, but no later than the following timeframes;-If abuse is alleged or the allegation results in serious bodily injury, the allegation must be reported within two hours after the allegation was made;-If the allegation does not allege abuse or result in serious bodily injury, the report must be made within 24 hours after the allegation was made;-The facility will ensure that all reports are made within two hours (abuse or serious bodily injury) or 24 hours (non-abuse);-The 2-hour timeframe must be met even during the night shift or during the weekend. 1.Review of Resident #1's face sheet showed the following:-admission date of 04/01/24;-Diagnoses included vascular dementia (a decline in thinking skills caused by conditions that block or reduce blood flow to the brain, depriving brain cells of oxygen) with agitation. Review of the resident's care plan, dated 07/17/25, showed the resident resided on the special care unit (SCU) for safety. Review of the resident's quarterly Minimum Data Set (MDS - a federally mandated assessment tool completed by facility staff), dated 12/12/25, showed the following:-Usually understood and usually understands communication;-Severely cognitively impaired;-Exhibited inattention, behavior present, fluctuates (comes and goes, changes in severity);-Exhibited disorganized thinking, behavior present, fluctuates;-No physical, verbal, or other behavioral symptoms directed toward others;-No rejection of care;-No wandering. Review of the resident's progress note dated 02/23/26, at 12:59 P.M., showed the Director of Nursing (DON) noted resident had scattered bruising on his/her bilateral (both sides) upper extremities (hands/arms) in various stages of healing. When the nurse asked the resident about the cause of the bruising, the resident said he/she woke up that way. Resident denied pain or drainage associated with the bruised areas. No tenderness reported. Resident demonstrated full range of motion to fingers without difficulty. No functional impairment observed. Staff notified physician of bruising. During an interview on 02/25/26, at 10:56 A.M., the Administrator said the following:-On Monday, 02/23/26, at approximately 9:00 A.M. to 9:30 A.M., the resident's responsible party (RP) came to the Administrator's office and said the resident had bruises on his hands and arms and an unnamed staff member in the SCU told him/her Certified Nurse Assistant (CNA) A abused the resident;-The Administrator interviewed CNA C who said he/she worked the day shift at the facility on the morning of 02/20/26. He/she arrived at work on 02/20/26, at approximately 5:55 A.M. and entered the SCU, walked down the hallway, and saw CNA A in the resident's room holding the resident's arms;-CNA C asked why CNA A was in the resident's room and CNA A informed CNA C he/she was putting the resident back to bed;-CNA C, said on 02/20/26 between 6:00 A.M. and 6:30 (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A.M., he/she informed Licensed Practical Nurse (LPN) L about CNA A holding onto the resident's arms;-On 02/23/26, the Administrator viewed 02/23/26 video footage from the hallway of the SCU. The video showed CNA A grab the resident by the arms and push the resident back into his/her room on two separate occasions. Review of Department of Health and Senior Services records showed the facility self-reported the allegation of abuse on 02/23/26, at 11:38 A.M. (Three days after the allegation of abuse was made.) During an interview on 02/25/26, at 12:56 P.M., CNA C said the following:-If he/she suspected resident abuse, he/she would notify the nurse immediately, and if they did not respond, he/she would go to the Administrator immediately;-He/she thought the facility had 12 hours to report an allegation of abuse to DHSS;-He/she arrived to work on Friday, 2/20/26, at a little before 6:00 A.M., clocked in and entered the SCU;-Upon entering the unit CNA C said he/she heard CNA A repetitively yell, You have to get back in bed;-The resident yelled back, I don't want to go back to bed.-CNA C walked down the hall, stopped at the resident's doorway and looked into the resident's room;-CNA A and the resident were standing near the resident's bed and CNA A had his/her hands on the resident's forearms;-The two were struggling. The resident was trying to get loose from CNA A's grasp, but CNA A held on to the resident's arms;-CNA C told CNA A to get out of the resident's room and leave the resident alone;-CNA A argued saying he/she was not doing anything wrong;-CNA C told CNA A he/she did not need to bother the resident because the resident was able to do his/her own care;-CNA A continued to try to force the resident back toward the bed by holding the resident's arms and pushing the resident;-CNA C then told CNA A to come out of the room and leave the SCU;-CNA A then came out of the resident's room and left the unit shortly after;-The resident was mad and wanted to call the police;-He/she had a hard time calming the resident down;-Approximately 15 minutes later, CNA C said he/she used the phone to call out to the nurses' station and told the nurse on duty, Licensed Practical Nurse (LPN) L, to come to the SCU and look at the resident's arms. CNA C told LPN L that CNA A was trying to hold the resident's arms down and the arms looked bruised;-LPN L came to the SCU and looked at the resident's arms;-He/she assumed LPN L would make out an incident report;-Later that same day on 02/20/26, at approximately 2:00 P.M., CNA C said he/she stood at the nurses' station at the end of his/her shift and told some of the aides and the DON thatCNA A had bruised the resident's arms while trying to force the resident back into bed;-He/she found out on Monday, 02/23/26, that LPN L did not report the incident to anyone. During an interview on 02/25/26, at 8:04 P.M., LPN L said the following:-He/she would report allegations of abuse immediately to the Administrator;-The facility had two hours to reports any allegation of abuse to DHSS;-He/she worked overnight on Thursday night 02/19/26 into Friday morning 02/20/26;-LPN L said he did not go to the SCU to make rounds because he/she did not have time;-No one informed LPN L of any incident involving the resident and CNA A. During an interview on 02/26/26, at 11:31 A.M., CNA I said the following:-CNA C told CNA I about the resident abuse on 02/20/26, but CNA I did not report the abuse, because CNA C said he/she had reported to the Administrator;-He/she would consider grabbing a resident's arms and causing bruises to be abuse;-All allegations of abuse should be immediately reported to the charge nurse or Administrator;-The facility should notify DHSS of allegations of abuse within two hours. During an interview on 02/25/26, at 7:42 P.M., Registered Nurse (RN) Q said the following:-No one reported an incident regarding the resident and CNA A to him/her;-If staff reported an allegation of abuse, he/she would immediately notify his/her DON. During an interview on 03/03/26, at 1:55 P.M., the DON said:-He/she would consider grabbing a (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Hermitage Nursing & Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE 18599 First Street Hermitage, MO 65668	

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	resident's arms and causing bruising to be physical abuse;-Staff should have immediately reported the abuse to the DON or Administrator. 2. Review of Resident #2's face sheet showed the following:-Admisison date of 8/12/21;-Diagnoses included dementia, depression, anxiety disorder, delusional disorder, and paranoid personality disorder. Review of the resident's quarterly MDS, dated [DATE], showed the following:-Severe cognitive impairment;-Experienced inattention and disorganized thoughts, behavior present, fluctuates (comes and goes, changes in severity);-Dependent on staff for toileting hygiene, personal hygiene, showering, lower body dressing, and transfers. Review of the resident's care plan, revised 01/16/26, showed the following:-On occasion the resident has signs and symptoms of mood distress, weepy, crying, and doesn't think anyone likes him/her;-Resident has cognitive deficit, anxiety, and depression;-Resident will verbalize feelings of acceptance from others and involve self in activities of his/her choice;-Take resident to quiet, calm area; -Acknowledge to the resident that the current situation must be difficult; -Encourage resident to verbalize feelings, concerns, fears, etc.;-Clarify misconceptions; -Explore with resident past effective and ineffective coping mechanisms. Review of the resident's progress note dated 02/17/26, at 1:15 P.M., showed the DON documented the resident experienced episodes of increased confusion and hallucinations during the shift. Resident repeatedly asked for someone by name, stating that person was present at the facility. Resident also reported that a gentleman was present. Staff redirected the resident and informed the resident that the men present were staff members. Resident became mildly defensive with redirection but was able to be redirected. RN U (hospice nurse) was present and witnessed the hallucination. Staff will continue current plan of care. During an interview on 02/27/26, at 12:15 P.M., RN U said the following:-RN U visited the resident every week;-The resident was confused but during the previous two weeks, the resident would say, Don't let that man in here. He's raped me;-RN U said, I just kind of blew it off;-He/she did tell the family about the resident's comments, to see if the resident had a history of abuse in the past;-He/she believed he/she told LPN B or the DON about the resident's comments;-The nurse said the resident was hallucinating and would say, the man was coming to get us. We need to leave. The resident then said there he was and would point to no one;-RN U was unsure if he/she documented the resident's comments or not;-The nurse was unsure exactly when the resident made the rape allegation, but thought it occurred around the last part of January 2026;-On a couple of occasions, the resident was tearful and said this man comes in and rapes me;-He/she thought he/she told CNA H of the resident's comments about being raped on 02/17/26;-The nurse said he/she did not know he/she had to report the resident's allegation of rape since the resident had a diagnosis of dementia. During an interview on 02/27/26, at 1:15 P.M., CNA H said the following:-He/she recalled a time when the resident was at the nurses' station and stated he/she had been raped;-The resident was unable to provide any information about the person that had raped him/her when asked;-The charge nurse and him/her heard the resident say he/she had been raped;-The resident made the same comment about rape a couple days later while he/she and another aide were getting the resident out of bed;-He/she told LPN B or possibly another nurse about the allegation;-The nurse stated the resident had been confused;-He/she would report an allegation to the charge nurse, DON, or the Administrator immediately;-Abuse should be reported to the state in two hours. Review of the DHSS records showed the facility did not self-report the allegation of rape made by the resident. During an interview on 02/27/26, at 1:39 P.M., LPN B said the following:-If a resident reported they were raped, the nurse would speak with the resident and then immediately contact the DON and Administrator to notify;-LPN B would consider a resident claiming rape, to be an allegation of abuse and assault. Review of the resident's progress notes dated 2/27/26, at 2:21 P.M., showed an allegation of sexual assault reported to DHSS. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 02/27/26, at 2:04 P.M., the DON said the resident had never mentioned rape and no staff/visitor had informed the him/her of an allegation or rape. During an interview on 02/27/26, at 2:12 P.M., CNA I said the following:-He/she would report abuse right away to charge nurse, even if the resident was confused;-The resident would yell rape when he/she had a brief change;-He/she reported the resident allegation of rape to an unknown charge nurse over two months ago. During an interview on 02/27/26, at 2:20 P.M., CNA J said the following:-He/she would report any abuse to the charge nurse right away;-Abuse should be reported to the state within two hours;-He/she would report if a confused resident told him/ they had been raped. During an interview on 02/27/26, at 2:30 P.M., CNA F said the following:-He/she had heard the resident reported he/she had been raped;-He/she thinks this occurred sometime at the end of last year;-The resident had reported rape multiple times;-The rape allegation should have been reported to the Administrator or DON immediately;-The state should be notified of abuse within two hours. During an interview on 03/03/2,6 at 3:25 P.M., LPN G if a resident made an allegation of rape, he/she would notify the DON, Administrator, family, the physician, and DHSS within two hours. During an interview on 03/05/26, at approximately 3:00 P.M., RN V said the following:-If a resident alleged rape, he/she would immediately report the allegation to the Administrator and let the Administrator report to DHSS the allegation;-Staff should treat all allegations or rape as legitimate;-All allegations of rape should be called to DHSS within 2 hours. During an interview on 03/03/26, at 1:55 P.M., the DON said the following:-The hospice nurse should have immediately notified the charge nurse and the DON of the resident's allegation of rape;-Any staff with knowledge of the resident's comments should have also notified the DON;-The DON considered the comment to be an allegation of abuse. 3. During an interview on 02/26/26, at 9:07 A.M., CNA R said the following:-Staff should report all alleged abuse to the charge nurse immediately;-The facility should report all allegations of abuse to DHSS within two hours. During an interview on 03/03/26, at 3:25 P.M., LPN G said the following:-Any staff aware of an allegation of resident abuse should immediately report to their supervisor;-The facility DON or Administrator should report all allegations of abuse to DHSS within two hours. During an interview on 03/05/26, at 5:45 P.M., the Administrator said the following:-Allegations of abuse should be reported immediately to the Administrator;-He/she would notify the state within two hours. Complaint 2785595

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure after an allegation of abuse, an immediate investigation was completed with steps implemented to protect all residents during the investigation, when staff failed to complete timely investigations of two allegations of abuse involving two residents (Resident #1 and #2). The facility census was 65.Review of the facility's policy titled, Abuse Policy, undated, showed the following-It is the policy of the facility that each resident will be free from abuse;-Abuse can include verbal, mental, sexual, or physical abuse, misappropriation of resident property and exploitation, corporal punishment or involuntary seclusion;-All employees who have been alleged to commit abuse will be suspended immediately pending investigation. Accused visitors will be removed from the building and not allowed to visit until the investigation is completed. Accused residents will be isolated and monitored;-Report the results of all investigations to the Administrator or his/her designated representative and to other officials in accordance with State law, including immediate or 24-hour reporting to the State Survey Agency (SSA – Department of Health and Senior Services (DHSS)) and law enforcement. Send follow-up report to the SSA within five working days of the incident.-If the alleged violation is verified appropriate corrective action must be taken. 1.Review of Resident #1's face sheet showed the following:-admission date of 04/01/24;-Diagnoses included vascular dementia (a decline in thinking skills caused by conditions that block or reduce blood flow to the brain, depriving brain cells of oxygen) with agitation. Review of the resident's care plan, dated 07/17/25, showed resident resided on the special care unit (SCU) for safety. Review of the resident's quarterly Minimum Data Set (MDS - a federally mandated assessment tool completed by facility staff), dated 12/12/25, showed the following:-Usually understood and usually understands communication;-Severely cognitively impaired;-Exhibited inattention, behavior present, fluctuates (comes and goes, changes in severity);-Exhibited disorganized thinking, behavior present, fluctuates;-No physical, verbal, or other behavioral symptoms directed toward others;-No rejection of care;-No wandering. Review of the resident's progress note dated 02/23/26, at 12:59 P.M., showed the Director of Nursing (DON) noted resident had scattered bruising on his/her bilateral (both sides) upper extremities (hands/arms) in various stages of healing. When the nurse asked the resident about the cause of the bruising, the resident said he/she woke up that way. Resident denied pain or drainage associated with the bruised areas. No tenderness reported. Resident demonstrated full range of motion to fingers without difficulty. No functional impairment observed. Staff notified physician of bruising. During an interview on 02/25/26, at 10:56 A.M., the Administrator said the following:-On Monday, 02/23/26, at approximately 9:00 A.M. to 9:30 A.M., the resident's responsible party (RP) came to the Administrator's office and said the resident had bruises on his/her hands and arms. An unnamed staff member in the SCU told him/her Certified Nurse Assistant (CNA) A abused the resident;-The Administrator informed the RP he/she was not aware of this allegation of abuse, but would investigate the allegation;-The Administrator interviewed CNA C who said he/she worked the day shift at the facility on the morning of 02/20/26. He/she arrived at work on 02/20/26, at approximately 5:55 A.M., entered the SCU, walked down the hallway, and saw CNA A in the resident's room holding the resident's arms;-CNA C asked why CNA A was in the resident's room and CNA A informed CNA C he/she was putting the resident back to bed;-CNA C said on 02/20/26, between 6:00 A.M. and 6:30 A.M., he/she informed Licensed Practical Nurse (LPN) L about CNA A holding onto the resident's arms;-After reviewing timeclock information, the Administrator said CNA A worked overnight at the facility on Thursday night, 02/19/26. CNA A clocked out on Friday, 02/20/26 at 6:54 A.M. CNA A also worked overnight at the facility on Friday night, 02/20/26, from 5:57 P.M. until Saturday morning, 02/21/26, at 7:01 A.M.; -CNA A worked after the alleged abuse, because the Administrator was not aware of the allegation until 02/23/26;-Both nights, CNA A worked in the dementia unit (SCU) alone;-On 02/23/26, the Administrator viewed 02/20/26 video footage from the (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	hallway of the SCU. The video showed CNA A grab the resident by the arms and push the resident back into his/her room on two separate occasions. During an interview on 02/25/26, at 12:56 P.M., CNA C said the following:-He/she arrived to work on Friday, 02/20/26, at a little before 6:00 A.M., clocked in and entered the SCU;-Upon entering the unit CNA C said he/she heard CNA A repetitively yell, You have to get back in bed;-The resident yelled back, I don't want to go back to bed;-CNA C walked down the hall, stopped at the resident's doorway and looked into the resident's room;-CNA A and the resident were standing near the resident's bed and CNA A had his/her hands on the resident's forearms;-The two were struggling. The resident was trying to get loose from CNA A's grasp, but CNA A held onto the resident's arms;-CNA C told CNA A to get out of the resident's room and leave the resident alone;-CNA A argued saying he/she was not doing anything wrong;-CNA C told CNA A he/she did not need to bother the resident because the resident was able to do his/her own care;-CNA A continued to try to force the resident back toward the bed by holding the resident's arms and pushing the resident;-CNA C then told CNA A to come out of the room and leave the SCU;-Resident #1 was mad and wanted to call the police;-He/she had a hard time calming the resident down;-Approximately 15 minutes later, CNA C said he/she used the phone to call out to the nurses' station and told the nurse on duty, Licensed Practical Nurse (LPN) L, to come to the SCU and look at the resident's arms. CNA C told LPN L that CNA A was trying to hold the resident's arms down and the arms looked bruised;-LPN L came to the SCU and looked at the resident's arms. He/she assumed LPN L would make out an incident report. During an interview on 02/25/26, at 8:04 P.M., LPN L said the following:-If a staff member reported an allegation of resident abuse, he/she would ensure the residents immediate safety. If the abuse involved a staff member, LPN L would walk the alleged staff member out of the building;-He/she worked overnight on Thursday night 02/19/26 into Friday morning 02/20/26;-LPN L said he did not go to the SCU to make rounds because he/she did not have time;-No one informed LPN L of any incident involving the resident and CNA A. During an interview on 02/26/26 at 11:31 A.M., CNA I said the following:-CNA C told CNA I about the resident abuse on 02/20/26, but CNA I did not report the abuse, because CNA C said he/she had reported to the Administrator;-He/she would consider grabbing a resident's arms and causing bruises to be abuse;-If he/she observed CNA A grabbing the resident's arms, he/she would have taken CNA A to the nurse and reported the incident immediately;-If the nurse did not respond appropriately, he/she would have notified the Administrator. During an interview on 02/25/26, at 7:42 P.M., Registered Nurse (RN) Q said the following:-If staff reported an allegation of abuse, he/she would remove the alleged perpetrator from resident care areas and immediately notify his/her DON;-CNA A worked another shift after he/she allegedly abused a resident, but RN Q was unaware of the alleged abuse until 02/23/26. During an interview on 03/03/26, at 1:55 P.M., the DON said:-He/she would consider grabbing a resident's arms and causing bruising to be physical abuse;-Staff alleged to have abused residents should be suspended immediately pending the outcome of the abuse investigation;-The Administrator was responsible for abuse investigations. 2. Review of Resident #2's face sheet showed the following:-Admisison date of 8/12/21;-Diagnoses included dementia, depression, anxiety disorder, delusional disorder, and paranoid personality disorder. Review of the resident's quarterly MDS, dated [DATE], showed the following:-Severe cognitive impairment;-Experienced inattention and disorganized thoughts, behavior present, fluctuates (comes and goes, changes in severity);-Dependent on staff for toileting hygiene, personal hygiene, showering, lower body dressing, and transfers. Review of the resident's care plan, revised 01/16/26, showed the following:-On occasion the resident has signs and symptoms of mood distress, weepy, crying, and doesn't think anyone likes (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	him/her;-Resident has cognitive deficit, anxiety, and depression;-Resident will verbalize feelings of acceptance from others and involve self in activities of his/her choice;-Take resident to quiet, calm area; -Acknowledge to the resident that the current situation must be difficult; -Encourage resident to verbalize feelings, concerns, fears, etc.;-Clarify misconceptions; -Explore with resident past effective and ineffective coping mechanisms. Review of the resident's progress note dated 02/17/26, at 1:15 P.M., showed the DON documented the resident experienced episodes of increased confusion and hallucinations during the shift. Resident repeatedly asked for someone by name, stating that person was present at the facility. Resident also reported that a gentleman was present. Staff redirected the resident and informed the resident that the men present were staff members. Resident became mildly defensive with redirection but was able to be redirected. RN U (hospice nurse) were present and witnessed the hallucination. Staff will continue current plan of care. During an interview on 02/27/26, at 12:15 P.M., RN U (hospice nurse), said the following:-RN U visited the resident every week;-The resident was confused but during the previous two weeks, the resident would say, Don't let that man in here. He's raped me.-RN U said, I just kind of blew it off.-RN U said he/she believed he/she told Licensed Practical Nurse (LPN) B or the DON about the resident's comments;-The nurse was unsure exactly when the resident made the rape allegation, but thought it occurred around the last part of January 2026;-After the nurse reviewed his/her notes, said he/she did not document the allegation of rape;-The nurse said he/she did not know he/she had to report the resident's allegation of rape since the resident had a diagnosis of dementia. During an interview on 03/03/26, at 1:55 P.M., the DON said the following:-The hospice nurse should have immediately notified the charge nurse and the DON of the resident's allegation of rape;-Any staff with knowledge of the resident's comments should have also notified the DON;-The DON considered the comment to be an allegation of abuse. 3. During an interview on 02/26/26, at 9:07 A.M., CNA R said staff should ensure the resident's immediate safety by removing the alleged perpetrator and then report all alleged abuse to the charge nurse immediately. During an interview on 02/26/26, at 9:41 A.M., CNA X said staff should ensure the resident's immediate safety by removing the alleged perpetrator and report all alleged abuse to the charge nurse immediately. During an interview on 03/03/26, at 3:25 P.M., LPN G said if a staff allegedly abused a resident, the facility should suspend the staff member pending the outcome of the investigation. During an interview on 03/05/26, at 5:45 P.M., the Administrator said the following:-Allegations of abuse should be reported immediately to the Administrator;-The nurse should assess the resident(s) involved and notify the resident's family and physician;-He/she would notify the state within two hours and investigate after the allegation;-The investigation should be completed in 5 days. Complaint 278559

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to monitor, obtain and document treatment orders, and care plan wounds for three residents. Resident #4 had a head laceration and right wrist splint, Resident #8 had open leg ulcers, and Resident #5 a skin tear and multiple scabbed areas to left arm. The facility census was 65. Review of an undated facility policy titled 'Wound Care and Treatment' showed the following:-It is purpose of the facility to prevent and treat all wounds;-Prevention strategies include ongoing skin assessments with weekly documentation of status;-Dietician consultation to obtain suggestions on dietary modifications and protein supplementation and to assess the need for a house vitamin supplement if a wound is present;-Obtain a consultation with the quality assurance nurse when resident has no improvement in existing wounds following a two-to-three-week plan of care;-Reevaluate dressing and skin integrity every shift;-Reevaluate the wounds response to the prescribed treatment on a regular basis;-Make recommendations for treatment changes and inform the physician of changes in wound status when needed;-Date, time, and initial all dressings at time of application;-Thoroughly document all wound information such as type, location, stage (if applicable), length, width, depth, drainage, notation of tunneling or undermining, description of tissue, state of peri wound area, and treatment of wound. Facility was unable to provide a policy regarding orthotics upon request. 1. Review of Resident #4's face sheet (a general information sheet) showed the following:-admitted to the facility on [DATE];-Diagnoses included vascular dementia (progressive decline in thinking, memory, and behaviors caused by impaired blood flow to the brain), diabetes mellitus (chronic disease that causes high blood sugar), and high blood pressure. Review of the resident's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 1/12/2026, showed the following:-Had severe cognitive impairment; -Had delusions and hallucinations;-Had a skin tear;-Dependent on staff for toileting, showering, and dressing;-Utilized a walker for mobility. Review of the resident's care plan, revised 01/29/26, showed the following:-Potential for injury or harm due to visual issues;-At risk for skin issues due to impaired sensory perception, cognitive deficit, impaired communication, and medication regimen;-At risk for falls related to cognitive deficit, delusions, anxiety, and frequent walking.(The care plan was not updated to include recent fall with laceration and right wrist sprain) Review of a nursing progress note dated 02/12/2026 at 4:37 P.M., showed staff were called to the special care unit (SCU) dining area after the resident experienced an unwitnessed fall. The resident was found face down in front of the wall in the dining area. Assessment revealed a laceration to the forehead extending into the eyebrow. Bleeding was controlled. The resident was noted to have slurred speech. Nurse practitioner was notified, and the resident was sent to the emergency room for further evaluation. Emergency medical services were called, and first responders were in the facility with the resident. Review of a hospital Discharge summary, dated [DATE], showed the resident was seen for a right wrist sprain, forehead laceration, closed head injury, and a cervical sprain. Resident should follow up with primary physician in one week and is to wear a splint until cleared by his/her physician. The resident is to return to the hospital immediately if he/she develops increased pain, weakness, (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	tingling, confusion, or other troubling symptoms. Follow-up and re-examination by his/her doctor is essential to complete medical care because it is often impossible recognize and treat all elements of injury. Review of a nursing progress note, dated 02/12/2026 at 10:27 P.M., showed, at 9:05 P.M., the resident returned via an ambulance. Report was received from the hospital registered nurse (RN). A computed tomography (CT- medical imaging procedure that uses x-rays and computers to create detailed images of bones, blood vessels, and soft tissues) scan and cervical spine assessment showed no injury. The right wrist was sprained and a removeable splint was on. The left forehead laceration was closed with Dermabond (liquid tissue adhesive that acts as a liquid bandage to lacerations and surgical incision). The laceration was without redness and with well approximated edges. The right hand splint was in place. Skin warm and pink. Review of a physician progress note dated 02/13/2026, at 1:54 P.M., showed the patient recently had a fall. No acute complaints were otherwise reported by the nursing staff. No acute complaints or obvious injuries noted. Reevaluate patient for physical and occupational therapy services for fall prevention and continue fall precautions and safety measures. Review of a nursing progress note dated 02/16/2026, at 6:16 P.M., showed the resident up per usual in the SCU. Laceration to forehead slightly draining. Resident denies pain. (No interventions implemented for draining laceration.) Review of a wound assessment dated [DATE] showed resident had a laceration on the middle of the forehead that measured 3 centimeters (cm) by 1 cm with no drainage and skin red in color. (Assessment completed six days after laceration occurred.) Observation on 02/23/26, at 9:07 A.M., showed the resident walking in the hallway with a splint to his/her left arm and a laceration to the forehead. Observation on 02/26/26, at 9:10 A.M., showed the resident walking in the hallway with a splint to his/her left arm and a laceration to the forehead. Review of a skin assessment, dated 02/26/26, showed the resident had a laceration to the forehead. The wound was closed with Dermabond. There were no further discharge orders from the hospital. During an interview on 02/27/26, at 1:50 P.M., Licensed Practical Nurse (LPN) A said Resident #4 had a fall and sustained a laceration. The laceration is closed, and they are just watching it. Observation on 02/27/26, at 4:09 P.M., showed the resident wearing the splint on the left arm walking in the SCU. During an interview on 02/27/29 at 4:10 P.M., Certified Nurse Assistant (CNA) E said a couple weeks ago the resident was leaning in his/her wheelchair and fell out. He/she had a super glued forehead and a splint. CNA E remembers the splint on the right arm upon return from the hospital. He/she is unsure as it is currently on the right arm. During an interview on 02/27/29, at 11:15 A.M., CNA F said the resident had a laceration to the forehead. The resident had a fall resulting in a fractured left hand. He/she thinks the resident always had it on the left hand and never saw it on the right. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 02/27/26, at 11:25 A.M., LPN G said the resident had a laceration to the forehead and it should be monitored and included in the treatment administration record. The splint to the left arm is due to a fracture, but he/she was unsure how the resident obtained the fracture. The laceration and the splint should be included in the care plan. Review of a physician progress note dated 02/27/26, at 7:45 P.M. showed a follow up evaluation after recent fall with head laceration and right wrist sprain. Patient sent to hospital for evaluation and returned same day. Right wrist sprain requiring splinting, patient non-compliant with splint use. Continue fall precautions and enhanced safety measures. Encourage splint compliance with frequent redirection and education. Monitor for signs of wrist reinjury or complications. Encourage right wrist splint compliance with frequent redirection. Follow-up as needed for acute changes or splint non-compliance. (follow up visit completed fifteen days after hospital visit) Review of the resident's February 2026 physician's order sheet (POS) showed the following:-An order dated 02/27/26, to monitor head laceration every shift until healed;-An order dated 02/27/26, to monitor skin under wrist split daily until wrist is healed, discontinued on 03/03/26. Review of a nursing progress note dated 02/28/26, at 10:14 A.M. showed the resident's laceration to forehead is healing well. During an interview on 03/03/26, at 3:10 P.M., Nurse Assistant (NA) M said the resident should have the splint on the left arm. The aide that gets him/her up in the morning is responsible for putting it on. The resident does take the brace off at times. During an observation on 03/03/26, at 3:15 P.M., showed the resident resting in bed with the splint on the counter near sink. Review of a wound assessment dated [DATE], showed the resident had a laceration that measured 3 cm by 0.25 cm with no drainage and skin pink in color.(No progress notes showing the resident refused to wear splint to right wrist or additional notes regarding monitoring of forehead laceration.) During an interview on 03/05/26, at 11:45 A.M., Nurse Practitioner (NP) O said the following:-Resident #4 should have an order to check his splint, including circulation and skin condition;-Nurse should check the laceration site every shift for infection or bleeding;-The resident should be monitored for any latent injuries following a fall. During an interview on 03/05/26, at 5:45 P.M., the Administrator said a resident with a brace or laceration should have an order for monitoring. The nurses should be monitoring the resident every shift and documenting it in a progress note. 2. Review of Resident #8's face sheet showed the following:-admitted to the facility on [DATE];-Diagnoses included intracerebral hemorrhage (ruptured blood vessel which caused bleeding into the brain), high blood pressure, open wound of the left lower leg, non-pressure chronic ulcer, open wound to right leg. Review of the resident's quarterly MDS, dated [DATE], showed the following:-Had severe cognitive impairment; -At risk for pressure injuries;-Dependent on staff for all activities of daily living (ADLs -essential, routine self-care tasks such as bathing, dressing, touting, and transfers) except eating;-Had one unhealed stage one pressure injury (Intact skin with non-blanchable redness of a (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	localized area usually over a bony prominence) and three stage two pressure injuries (Partial thickness loss of dermis presenting as a shallow open ulcer with a red or pink wound bed, without slough. May also present as an intact or open/ruptured blister). Review of resident's care plan, revised 12/23/25, showed the following:-At risk for skin issues related to edema (swelling caused by excess fluid trapped in body tissues), -Incontinence, impaired functioning and mobility;-Staff should report any signs of skin breakdown to the charge nurse and physician;-Required staff assistance with ADLs related to impaired mobility. Review of the resident's current POS showed an order, dated 12/18/25, to cleanse the right calf with wound cleanser, apply skin prep (skin barrier) to peri wound. Apply calcium alginate to wound bed, cover with border gauze. Change daily and as needed. Review of the resident's January MAR showed the order dated 12/18/25, to cleanse the right calf with wound cleanser, apply skin prep (skin barrier) to peri wound. Apply calcium alginate to wound bed, cover with border gauze. Change daily and as needed except on 01/04/26 due to leaving it open to air. Review of the resident's January progress notes showed no documentation related to right calf wound. Facility unable to provide any wound assessments for January 2026. Review of a skin assessment dated [DATE], showed the skin intact and no treatment in place. No skin assessment noted for 01/12/26 or 01/19/26. Review of a skin assessment, dated 01/26/26, showed skin intact and no treatment in place. Review of the resident's February POS showed an order dated 12/18/25, to cleanse the right calf with wound cleanser, apply skin prep to peri wound. Apply calcium alginate to wound bed, cover with border gauze. Change daily and as needed was documented as completed as ordered except on the following:-On 02/11/26, no documentation as completed;-On 02/14/26, documented as not completed. Review of a skin assessment, dated 02/02/26, showed skin intact with no treatment in place. Review of a nursing progress notes dated 02/06/26, showed treatment to bilateral lower extremities completed as ordered with two nurses. Review of a skin assessment dated [DATE], showed skin intact with no treatment in place. Review of a wound management report dated 02/18/26, showed the resident had an unspecified ulcer on the right ankle lower calf/top of ankle identified on 02/18/26. Wound measured 3 cm by 3 cm with moderate serosanguineous (thin, watery, pink or light red) drainage. Wound bed indicated as covered in slough (pale, yellow, white, or gray, moist, and stingy tissue that covers the wound bed of chronic or stalled wounds, acts as a barrier to healing). Review of a skin assessment dated [DATE], showed skin intact with no treatment in place. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of a skin assessment dated [DATE], showed skin intact with no treatment in place. No additional progress notes related to wounds in February. During an observation and interview of wound care with Resident #8 on 02/26/26 at 2:00 P.M., showed LPN B entered the resident room and reported the resident had a wound to the right calf. No dressing was in place upon arrival to the resident's room. The resident was sitting in the recliner with a blanket under his/her legs. The blanket had yellow colored, dried drainage under the right leg where the wound was located. The resident was noted to have two wounds on the right outer calf. Both circular shaped wounds appeared moist with a yellow-colored wound bed. LPN B said the resident had one treatment listed for wounds. LPN B cleansed both wounds with wound cleanser, applied skin prep, and then ripped the calcium alginate in half with his/her hands and applied it to both wound beds. LPN B then applied a dressing, covering both wounds. LPN B said the resident had more wounds, but they had healed and this was the only treatment ordered. During an interview on 02/27/26, at 11:25 A.M., LPN G said Resident #8 had wounds on the right calf area. He/she had not seen the resident in a while but remembers three small open areas on the right calf. Skin assessments should include all wounds or bruises. The Director of Nursing (DON) is responsible for completing the wound assessments weekly. A wound assessment should include size, drainage, depth, description of the wound, and if any odor is present. Review of a wound management report dated 03/04/26, showed the resident had an unspecified ulcer on the right ankle lower calf/top of ankle, identified on 02/18/26. The wound measured 2 cm by 3 cm with light serous (clear, amber thin, and watery) drainage. The wound bed indicated as covered in epithelial (pink or pearly white) tissue. Observation on 03/05/26 at 10:57 A.M, showed the following:-Resident #8 sat in his/her room in a wheelchair;-LPN B unwrapped a dressing from around the resident's right lower leg;-The resident had a total of 5 open areas, resembling shallow open blisters to his/her right lower leg with pink and yellow tissue present to the wound beds of each area;-Three open areas to the posterior (back side) lower leg, one approximately the size of a quarter and two pea sized areas;-Two open areas to the lateral (outside) lower leg, one approximately the size of a nickel and one approximately the size of a dime;-The nurse cleansed the areas with wound cleanser, patted dry, applied skin prep to the intact skin around the open areas, applied a Maxorb Extra dressing (highly absorbent dressing with antimicrobial silver) and attempted to cover all 5 open areas with one bordered gauze dressing (with an adhesive border);-The nurse placed the bordered gauze dressing, but did not sufficiently cover the nickel sized open area to the lateral lower right leg and the nurse attached the adhesive border to the open area. During an interview on 3/05/26 at 3:00 P.M., Registered Nurse (RN) V said the following:-The treatment order should list all the open areas on his/her legs instead of one area;-The bandage should cover the open areas and the adhesive border should not touch the open areas. During an interview on 03/05/26 at 10:45 A.M., NP O said nurses should be assessing any type of wound and documenting that observation. Resident # 8 should have all open areas monitored and have individualized orders for each. An adhesive bandage should not be put directly on the wound bed as it would impede the healing of the wound. During an interview on 03/05/26, at 5:45 P.M., the Administrator said staffing issues have affected (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Hermitage Nursing & Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE 18599 First Street Hermitage, MO 65668	

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	nurses completing observations and follow up for wounds. The Assistant Director of Nursing (ADON) should complete the weekly wound assessments, however the current ADON resigned on 02/17/26. The nurse should document monitoring of skin areas in the progress notes. Skin treatment orders should address all open areas and not just one. 3. Review of Resident #5's face sheet showed:-admitted to the facility on [DATE];-Primary diagnosis of atrial-fibrillation (an irregular heart rhythm causing the heart to beat faster). Review of the resident's quarterly MDS, dated [DATE], showed the following:-Short-term and long-term memory problem;-Severely impaired cognitively skills for daily decision making;-Exhibited inattention and disorganized thinking, behaviors were continuously present;-Experienced hallucinations (sensory perceptions that seem real but are not) and delusions (false beliefs);-Functional limitation to range of motion to both lower extremities;-Dependent on staff for assistance with eating, oral hygiene, , personal hygiene, toilet hygiene, showers, upper and lower body dressing, turning and transfers;-Always incontinent of bowel and bladder;-Diagnoses of psychotic disorder, stroke, dementia, and anxiety;-No skin tears present. Review of the resident's care plan last reviewed/revised on 1/29/26, showed:-Resident at risk for skin impairment and/or breakdown;-Interventions will remain in place to reduce the resident's risk of skin impairment/breakdown to the extent possible;-A licensed nurse should look at the resident's skin at least weekly;-Avoid shearing during positioning, transferring, and turning;-Resident has skin tears, use a mechanical lift for transfers, if resident becomes combative stop care and come back later;-Report any signs of skin breakdown (sore, tender, red, or broken areas) to the charge nurse and the resident's physician. Review of the resident's most recent weekly skin assessment, dated 02/22/26, showed a nurse documented skin intact with no skin issues. Review of the resident's progress notes from 02/22/26 thru 02/26/26 showed no nurse notes. Observation of the resident on 02/26/26 at 8:50 A.M., showed the following:-The resident sat in a geriatric chair (reclining wheeled chair) in his/her room;-The resident scratched at his/her left forearm using his/her right fingers;-The resident's fingernails were long and extended approximately 0.5 cm beyond the end of his/her fingers;-The resident had four scabbed areas to his/her left forearm with redness to the surrounding skin, the largest scabbed area was approximately 3.0 centimeters (cm) long by 2.0 cm wide and the three smaller areas were approximately 1.0 cm long by 1.0 cm wide in size;-The areas were not covered and did not appear to have any ointment present. During an interview on 02/26/26 at 8:56 A.M., Certified Nurse Assistant (CNA) W said the resident's scabbed areas were most likely from skin tears cause by a previous fall or from combative behavior during cares. During an interview on 02/26/26 at 9:07 A.M., CNA R said the following:-The scabbed areas to the resident's left arm started as skin tears;-The areas were looking worse due to the presence of surrounding redness;-He/she thought the areas were present on Friday, 2/20/26. During an interview on 02/26/26 at 3:20 P.M., CNA X said the following:-The larger scabbed area to the resident's left forearm started out as a skin tear;-The CNA first saw the skin tear approximately one week ago and at that time, the resident had steri-strips (adhesive strips used for skin closure) to the open area;-The next time the CNA saw the area, the resident had a band aid covering the area;-Yesterday, 02/25/26, the resident had a bordered gauze (a wound dressing with an adhesive border) covering the open areas;-Today, 02/26/26, the scabbed areas were uncovered. During an interview on 02/27/26 at 11:00 A.M., CNA T said the following:-No one could explain how the resident sustained the left forearm skin tear;-He she came in to work approximately two weeks ago and the resident had an approximately 2-inch skin tear with steri-strips covering the wound to his/her left forearm;-Someone tried to cover the resident's open areas with a bandage, but the resident appeared to have a reaction to the adhesive;-The other open areas were caused by the adhesive and/or the resident scratching. Review of the resident's physician orders showed an order, dated 02/27/26, for staff to cleanse the (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	resident's left forearm scratches with wound cleanser, pat dry, apply A&D ointment (a skin protectant/moisture) daily. Review of the resident's progress notes from 02/28/26 thru 03/03/26 showed no nurse notes. During an interview on 03/03/26 at 1:50 P.M., the DON said the following:-If staff discovered a skin tear or open area on a resident, the nurse should document in the progress notes and notify the physician for treatment orders or for orders to monitor the areas until resolved;-The nurse should notify the DON and the resident's family about the skin tear;-He/she suspected the areas to the resident's left forearm started out as a skin tear;-He/she was not aware of the areas until 2/26/26;-On 2/26/26, he/she notified the physician and obtained a treatment order to apply A&D ointment to the areas. During an interview on 3/03/26 at 3:25 P.M., LPN G said the following:-If a resident's sustained a skin tear, the nurse should notify the resident's physician and the resident's family;-If the open area required a treatment, the nurse should obtain a treatment order from the physician;-The nurse should document in the resident's progress note daily until the areas were resolved. Review of the resident's progress note, dated 03/04/26, showed the DON documented the following:-Wound care note: Resident's left forearm continues to show improvement. Scabs remain present on the left forearm. Surrounding skin is intact but noted to be fragile and dry. Skin flaking observed to surrounding tissue. No drainage noted. Continue current skin treatment as ordered. During an interview on 3/05/26 at 3:00 P.M., RN V said the following:-The resident's had fragile skin and the resident picked at his/her skin;-If the resident sustained a skin tear, nurses should monitor the skin tear for signs and symptoms of infection, such as redness or drainage and obtain a physician's order for treatment, if needed. Complaint 2784515

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to complete skin assessments, document accurate wound assessments, obtain and update orders timely, provide treatment as ordered, and care plan for one resident (Resident # 2) with a pressure ulcer (localized damage to the skin and/or underlying soft tissue usually over a bony prominence or related to a medical or other device). The facility census was 65. Review of an undated facility policy titled ?Wound Care and Treatment' showed the following:-It is purpose of the facility to prevent and treat all wounds;-Prevention strategies include ongoing skin assessments with weekly documentation of status;-Dietician consultation to obtain suggestions on dietary modifications and protein supplementation and to assess the need for a house vitamin supplement if a wound is present;-Obtain a consultation with the quality assurance nurse when resident has no improvement in existing wounds following a two-to-three-week plan of care;-Reevaluate dressing and skin integrity every shift;-Reevaluate the wounds response to the prescribed treatment on a regular basis;-Make recommendations for treatment changes and inform the physician of changes in wound status when needed;-Date, time, and initial all dressings at time of application;-Thoroughly document all wound information such as type, location, stage (if applicable), length, width, depth, drainage, notation of tunneling or undermining, description of tissue, state of peri wound area, and treatment of wound.Review of Resident #2's face sheet (document that gives resident's information at a quick glance) showed the following:-admission date of 08/12/21;-Diagnoses included diabetes mellitus (chronic disease that causes high blood sugar), depression, and edema (fluid accumulation in the body's tissues).Review of the resident's quarterly Minimum Data Set (MDS - a federally mandated assessment instrument completed by facility staff), dated 12/31/25, showed the following:-Severe cognitive impairment;-Had delusions and hallucinations;-Resident had four unhealed stage 2 (partial thickness loss of skin presenting as a shallow open ulcer with a red or pink wound bed, without slough (pale, yellow, white, or gray, moist, and stingy tissue that covers the wound bed of chronic or stalled wounds, acts as a barrier to healing). May also present as an intact or open/ruptured blister) pressure injuries;-Resident is dependent on staff for all activities of daily living (ADLs -essential, routine self-care tasks such as bathing, dressing, touting, and transfers) except eating.Review of the resident's care plan, revised 01/16/26, showed the following:-Resident at risk for skin issues related to impaired function and mobility;-Right heel blister is 100% eschar (thick, dry, black or brown layer of dead tissue that forms over severe pressure ulcers). Area measures 3.5 centimeters (cm) by 7 cm with no drainage. Resident complains of pain to area. Continue treatment, dated 12/04/25;-Skin assessment and inspection every shift with close attention to heel, dated 08/14/24;-Right heel eschar is smaller. Stage 2 pressure area measures 3.5 cm by 4 cm. No depth, drainage or signs or symptoms of infection. Continuing skin prep treatment. Resident complains of pain with treatment, dated 12/26/25;-Observe me for changes in my skin condition during daily care and on bath days. Report any redness or open areas to my nurse, dated 08/14/24.Review of the resident's current 2026 physician's order sheet (POS) showed the following:-An order dated 11/07/25, to apply boot to right heel and float heels at all times;-An order dated 11/07/25, to apply skin prep to right heel blister daily, discontinued on 11/13/25;-An order dated 11/13/25, to skin prep to right heel blister twice daily.Review of a nursing progress note dated 11/07/25 at 4:22 P.M., showed hospice nurse here and noted the resident had a large blister on his/her right heel. Fluid filled, but not eschar. The foot was floating and the boot applied. This information was also added to plan of care.Review of a wound observation report dated 11/07/25 at 11:37 A.M., showed the resident had an unstageable (a full thickness wound where the true depth and stage cannot be determined due to slough or eschar) pressure ulcer measuring 4 cm by 8 cm on the right heel with no drainage.Review of a wound observation report dated 11/13/25 at 10:12 A.M., showed the resident had an unstageable pressure ulcer measuring 4 cm by 8 cm on the (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	right heel with no drainage.Review of a nursing note dated 11/13/25 at 10:17 A.M., showed right heel had an unstageable pressure ulcer which presented as a blister at this time. A 4 cm by 8 cm fluid filled blister appeared dark under the fluid. The resident had a soft boot on for protection, is to have skin prep applied twice daily, and foot is to be elevated for edema.Review of a wound observation report dated 11/20/26 at 11:20 A.M., showed the resident had a stage 2 pressure ulcer measuring 5 cm by 7.5 cm on the right heel, with no drainage. Wound edges noted as a blister.Review of a nursing note dated 11/20/25 at 1:43 P.M., showed the right heel blister remains intact. Measurements are 5 cm by 7.5 cm with darkened skin cover or fluid. Treatment continues. Surrounding skin is pink. Review of a wound observation report dated 11/27/25 at 10:20 A.M., showed the resident had a stage 2 pressure ulcer was measured to be 3.8 cm by 7 cm on the right heel with no drainage. The wound bed was noted to be 100% necrotic (dead, nonviable tissue that prevents healing) tissue.Review of a nursing note dated 11/27/25 at 10:24 A.M., showed right heel measurements are 3.8 cm by 7 cm. Eschar covering the blister remains intact. Fluid filled area palpated to be smaller than the entire area. Surrounding skin is pink/normal.Review of a physician progress note dated 11/30/25 at 10:43 A.M., showed the wound on the right heel is being treated and a protective boot is in place. Staff was to continue current wound care regimen and monitor for improvement or deterioration.Review of the resident's December 2025 Medication Administration Record (MAR) showed heel protectors and skin prep to the right heel were documented as completed as ordered.Review of a wound observation report dated 12/04/25 at 9:00 A.M., showed resident had a stage 2 pressure ulcer measuring 3.5 cm by 7 cm on the right heel with no drainage. Wound bed noted to be 100% eschar tissue.Review of nursing progress note dated 12/04/25 at 2:46 P.M., showed right heel blister is 100% eschar measuring 3.5 cm by 7 cm. No drainage noted. Resident complains of pain with area.Review of a wound observation report dated 12/11/25 at 4:40 P.M., showed the resident had a stage 2 pressure ulcer measuring 3.5 cm by 6.8 cm on the right heel with no drainage. Wound bed noted to be 100% eschar tissue.Review of nursing progress note dated 12/11/25 at 4:44 P.M., showed the stage 2 pressure ulcer to the right heel measured 3.5 cm by 6.8 cm with no depth noted. The area was covered with eschar but was starting to loosen. No drainage, odor, or signs or symptoms of infection noted.Review of a wound observation report dated 12/18/25 at 10:33 A.M., showed the resident had a stage 2 pressure ulcer measuring 3.4 cm by 5 cm on the right heel with no drainage. The wound bed was noted to be 100% eschar tissue.Review of nursing progress note dated 12/18/25 at 10:41 A.M., showed eschar covering the right heel measured 3.4 cm by 5 cm today. No drainage or infection noted. Review of a wound observation report dated 12/23/25 at 9:11 A.M., showed resident had a stage 2 pressure ulcer measuring 3.5 cm by 4 cm on the right heel with no drainage. Wound bed noted to be 100% eschar tissue.Review of nursing progress note dated 12/23/25 at 9:21 A.M., showed the right heel eschar is smaller. Stage 2 pressure area measures 3.5 cm by 4 cm. No depth, drainage, or infection. Continuing skin prep treatment. The resident complained of pain with treatment.Review of a skin assessment dated [DATE], showed no skin issues.Review of the resident's January 2026 MAR showed heel protectors and skin prep to the right heel documented as completed as ordered.Review of a skin assessment dated [DATE], showed no skin issues.Review of a skin assessment dated [DATE], showed no skin issues.Review of a skin assessment dated [DATE], showed no skin issues.Review of a physician progress note dated 01/20/26 at 11:00 A.M., showed the resident had no acute skin concerns noted by staff.No further progress notes for January 2026 related to heel wound.No wound assessments completed for January 2026 to the right heel wound.Review of the resident's February 2026 MAR showed heel protectors and skin prep to the right heel documented as completed as ordered.Review of a skin assessment dated [DATE], showed no skin issues.Review of a skin assessment dated [DATE], showed no skin issues.Review of a skin assessment dated [DATE], showed no skin issues.Review of a skin assessment dated [DATE], showed no skin issues.During an interview and observation of wound care for Resident #2 on 02/25/26 at 1:40 P.M., showed the resident resting in bed with heel protectors and socks on prior to wound care. Licensed (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Practical Nurse (LPN) B removed the resident's sock and there was a notable odor coming from resident's foot. LPN B said he/she thought the wound treatment should be re-evaluated due to the smell. He/she had noticed an odor since Monday. A black colored round scabbed area was noted to the right heel with no drainage noted. LPN B applied skin prep to the wound bed and then reapplied the sock and heel protector. The resident complained of discomfort upon touching his/her heel.Review of a nursing progress note dated 02/26/26 at 11:17 A.M., showed the resident has an unstageable right heel wound with necrotic tissue, measuring approximately 4 cm x 3.5 cm. Wound borders are no longer attached. The surrounding tissue is pink and warm. No drainage or odor noted. Resident denies pain unless the area is palpated. The hospice nurse and physician were notified and given an update. Continue the current treatment per hospice and physician.Review of a physician progress note dated 02/27/26 at 2:21 P.M., showed the resident had a functional decline and staff should monitor for pressure ulcer development with increased bed rest.Review of a nursing progress note dated 02/27/26 at 3:31 P.M., showed the resident had an unstageable ulcer to the right heel.No additional wound assessments or progress notes related to right heel wound were noted.During an interview on 02/27/26, at 11:25 A.M. and at 3:05 P.M., LPN G said the resident has eschar on his/her right heel that had been there for a while. The resident's order for skin prep to the right heel had not been changed. The wound did not have an odor one week ago when he/she saw it. Skin assessments should include any wounds or bruises. The DON is responsible for completing wound assessments weekly. A wound assessment should include size, drainage, depth, description of the wound, and if any odor is present. An odor from a wound would indicate an infection. During an interview on 02/27/26 at 12:15 P.M., the hospice registered nurse (RN) U said the following:-The resident noted to have a firm black eschar wound to the right heel that measured 3 cm by 3 cm;-The wound measured 8 cm by 4 cm on 11/07/25 and was a fluid filled blister with black soft eschar;-The wound care treatment order is for skin prep to the area and had not changed since initial order on 11/07/25;-He/she does not provide wound assessments to the facility, and he/she does not have access to the facility wound assessments;-He/she did not view the resident's wound during visit today.During an interview on 02/27/26 at 2:08 P.M., the Director of Nursing (DON) said the former Assistant Director of Nursing (ADON) was responsible for wound assessments. He/she did not know why there are no wound assessments since December 2025. He/she had been trying to get started on wound assessments for the last couple weeks.Review of a skin assesssent dated 03/01/26, showed no skin issues.Review of a nursing progress note dated 03/03/26 at 7:32 P.M., showed the right heel was assessed to have no change. Wound measurements were 3 cm by 3 cm with no drainage noted. The foot was elevated to keep the heel off the bed. Hospice nurse was present during treatment.During an interview on 03/05/26 at 22:45 A.M., NP O said nurses should be assessing any type of wound and documenting the observation. He/she had not seen the resident's wound recently. The hospice nurse should be documenting so other providers are able to view his/her notes. The providers would not know how the wound is progressing or, if it is getting worse, if documentation is not shared. During an interview on 03/05/26 at 5:45 P.M., the Administrator said staffing issues have affected nurses completing observations and follow up for wounds. The ADON should complete the weekly wound assessments. The current ADON resigned on 02/17/26. The nurse should document monitoring of skin areas in progress notes and stage all wounds correctly. The facility nurse and hospice nurse should both complete wound assessments if a resident is on hospice.Complaint 2784515

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F 0773 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain laboratory tests/services when ordered and promptly tell the ordering practitioner of the results. Based on interview and record review, the facility failed to provide laboratory services per standards of practice when the facility staff did not obtain an ordered urinalysis (UA) timely, did not follow-up to obtain timely results of a UA/culture and sensitivity result (a urine sample grown in a lab to identify bacteria or other pathogen and then tested against various bacteria to determine how effective different antibiotics are at killing the bacteria), and did not document follow-up or delays related to the UA for one resident (Resident #3) with an untreated urinary tract infection (UTI). The facility census was 65. Review of the nursing facility laboratory agreement, dated 11/02/20, showed the following:-Common tests will be reported the same day and most other tests will be reported within a 24-hour period;-For those tests that cannot be reasonably reported in those time frames listed, the lab will report results as soon as possible and in a time consistent with leading standards;-The lab provides routine lab days Monday through Friday, excluding holidays.Review of Resident #3's face sheet (a general information sheet) showed the following:-admission date of 02/06/26;-Diagnoses included dementia (loss of mental functions that are severe enough to affect your daily life and activities), anxiety, and cerebral infarction (a blockage in an artery that restricts blood flow to the brain, leading to tissue death).Review of the resident's comprehensive Minimum Data Set (MDS - a federally mandated assessment instrument completed by facility staff), dated 03/09/26, showed the following:-Resident had severe cognitive impairment; -Resident required moderate staff assistance for toileting, bed mobility, dressing, and transfers;-Resident dependent on staff for showering and hygiene;-Resident incontinent of bladder.Review showed the facility did not provide a care plan for the resident. Review of the resident's physician order, dated 02/14/26, showed an order for UA and urine culture for diagnosis of UTI.Review of the resident's progress notes, dated 02/14/26 to 02/17/26, showed staff did not document regarding obtaining the UA order, lab contact, if UA was obtained, if there was difficulty obtaining the UA, or results from a UA. Review of the resident's progress note, dated 02/18/26, showed a UA was obtained at 7:41 P.M. (four days after initial UA order).Review of the resident's progress notes, dated 02/19/26 to 02/26/26, showed staff did not document regarding the UA status, UA follow-up, or UA findings. Review of the resident's UA and culture final report dated 02/27/26, at 12:37 P.M., showed the following: -Specimen collected from facility on 02/18/26;-Greater than 100,000/milliliter (ml) Klebsiella Aerogenes (a gram-negative bacteria commonly found in the human gut and in the environment that can cause serious infections) and >100,000/ml Hafnia Alvei (a gram-negative bacteria commonly found in the human gut and in the environment that can cause serious infections);-Susceptibility results showed several antibiotics the bacteria were sensitive to, but the report showed both bacteria were resistant (indicating the bacteria will not be killed by the antibiotic) to nitrofurantoin (an antibiotic).Review of the resident's progress note, dated 02/27/26, showed the UA with culture and sensitivity results came in. The physician was in the facility and ordered nitrofurantoin (an antibiotic) 100 (milligrams) mg twice daily for seven days (13 days after initial urinalysis order). Staff did not document regarding a discussion of the infection being resistant to the antibiotic ordered. During an interview on 03/03/26, at 3:25 P.M., Licensed Practical Nurse (LPN) G said medical records used to check for lab results, but they do not have a medical records person now. Nurses should be looking for results by logging into the lab website and checking. He/she did not check the lab website for results regularly. The nurses do not have good communication at the facility.During an interview on 03/05/26, at 11:45 A.M., Nurse Practitioner (NP) O said an UA result with a culture should be complete in three to four days. The lab comes to the facility on Tuesdays and Thursdays. Nine days would be too long for results from a culture. During an interview on 03/03/26, at 2:08 P.M., the Director of Nursing (DON) said resident's initial UA came back and did not appear to be bad, but when the culture and sensitivity returned it was bad. He/she should be calling the laboratory to check on the status but is on the floor working. A culture and (continued on next page)

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For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0773 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	sensitivity result should be returned within 24 to 48 hours. He/she never received the results, and no staff had checked on the results. The results came back and said the sample was contaminated. A delay in receiving UA results could cause resident behaviors and a delay in treatment.During an interview on 03/05/26, at 5:45 P.M., the Administrator said he/she was unsure of the time element to receive lab results. A delay in results could have an adverse outcome and cause the resident to not be treated properly. He/she was not aware of any delays for the lab.