Department of Health & Human Services
Centers for Medicare & Medicaid Services

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265245	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Colonial Springs Healthcare Center	750 West Cooper Buffalo, MO 65622

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on interview and record review, the facility failed to ensure all residents were treated with dignity and respect when one staff (Certified Nurse Aide (CNA F)) spoke in disrespectful tone and cursed when interacting with one resident (Resident #3). The facility census was 106.Review of the facility's policy titled Resident Rights, Rules and Regulations, revised 10/01/21, showed residents have the right to be treated with dignity and respect.1. Review of Resident #3's face sheet (admission data) showed the following:-admission date of0 5/01/19;-Diagnoses included dislocation of right ankle joint. Review of the resident's quarterly Minimum Data Set (MDS-a federally mandated assessment tool completed by facility staff), dated 02/20/26, showed the following:-Cognitive skills intact;-The resident had no behaviors;-The resident was dependent with toileting and personal hygiene;-The resident required substantial/maximal assistance with showering.Review of the resident's care plan, reviewed 02/26/26, showed the following:-The resident was admitted to the facility with a dislocation of his/her right ankle. The resident required extensive to total assistance with one to two staff assistance with all activities of daily living (ADL - dressing, grooming, etc.);-Use a calm reassuring approach.Review of the facility investigation, dated 02/17/26, showed the following:-The resident reported that he/she did not feel like CNA F's language in his/her room on 02/14/26, at approximately 9:30 P.M. were appropriate;-The resident reported CNA F got frustrated with the sit to stand lift that he/she utilized and cursed utilizing the f word at it;-The resident felt CNA F used inappropriate language. During an interview on 03/10/26, at 1:39 P.M., the resident said the following: -On 02/14/26, the sit stand was hard to turn;-CNA F took him/her to the bathroom and had trouble turning the lift;-The resident said he/she told Licensed Practical Nurse (LPN) G and the Social Service Director (SSD) of the incident with the lift and about CNA F cursing;-LPN G and SSD informed the resident to tell the Administrator;-The resident went to the Administrator's office and informed him of the incident with the lift and how mad CNA F was with the sit to stand lift and the CNA cursed.During an interview on 03/10/26, at 3:11 P.M., the Administrator said he received a delayed report something happening. The resident thought CNA F was unprofessional. CNA F cursed in the room with the resident, upset with some equipment. The resident said he/she did not appreciate the language. During an interview on 03/10/26, at 4:25 P.M., CNA F said he/she considered staff cursing around a resident not respectful and that is a form of abuse. During an interview on 03/11/26, at 9:28 A.M., CNA J said staff should not curse around a resident. CNA J considered it disrespectful if staff cursed around a resident. During an interview on 03/11/26, at 3:47 P.M., the Director of Nursing (DON) said staff should not curse around a resident. During an interview on 03/11/26, at 5:36 P.M., the Administrator he expected staff to be respectful with residents.Complaint 2718595

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

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

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F 0559 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to share a room with spouse or roommate of choice and receive written notice before a change is made. Based on interview and record review, the facility failed to ensure residents received written notice before resident room changes when staff failed to provide and document room change notifications for one resident (Resident #1). The facility census was 106.Review of the facility's policy titled Changes in Patient/Resident Condition: Notification Guidelines, revised January 2025, showed the facility will promptly notify the resident and new roommate assignment in writing and the resident's legal representative or interested family member by phone if applicable when there is a change in room or roommate assignment. Review of the facility's policy titled Room and Roommate Transfers, revised 08/15/18, showed the following: -The facility reserved the right of room and roommate transfer at its discretion, so long as the transfer is not solely for the purpose of staff convenience;-The facility shall provide advance notice of a room or roommate transfer;-The facility agreed to allow resident to designate a roommate of his or her choice at any time, so long as accommodation of the resident's designation was practicable, both residents live at the facility, both residents consented to the arrangement, and the request did not infringe upon the rights of another resident;-In the event a room is not available at the time of resident's designation, accommodation of resident's roommate requests may be delayed until a room becomes available. 1.Review of Resident #1's face sheet (admission data) showed the following:-admission date of 02/10/25;-Diagnoses included fracture of unspecified part of neck of left femur (hip injury). Review of the resident's s Minimum Data Set (MDS-a federally mandated comprehensive assessment instrument completed by facility staff), dated 11/26/25, showed the resident's cognitive skills intact. Review of the facility's document titled Registration Events showed the following:-On 02/10/25, at 3:49 P.M., the resident admitted to a room on 100 hall; -On 02/19/25, at 3:13 P.M., the resident had change of room/bed to a room on the 200 hall.Review of the room/roommate change notice form, dated 04/18/25, showed for quality-of-care purposes, the resident will move to a room on 100 hall. Review of the facility's document titled Registration Events showed the following:-On 04/19/25, at 1:05 A.M. the resident changed rooms to one on 100 hall;-On 05/23/25, at 12:26 P.M, the resident changed rooms to one on 200 hall. Review of the resident's record showed staff did not document a room/roommate change notice provided to the resident or resident's representative. During interviews on 03/11/26, at 11:19 A.M. and 4:55 P.M., the Social Service Director (SSD) said the following:-Staff call the family or speak with the resident if they are their own person regarding a room change;-Reasons for room changes include a resident not getting along with a roommate or exit seeking behaviors;-Staff give the room/roommate change request card to the resident or representative of the room change;-Staff do not move a resident if they do not want to move;-On 04/18/25, she notified the resident's family member of the move to the more independent hall;-She did not find documentation of when the resident was moved back to the 200 hall; -She did not find documentation of the notifications for the resident's room change.During an interview on 03/11/26, at 12:18 P.M., Certified Nurse Aide (CNA) J said staff should tell the nurse if a resident wants a room change. The social service staff inform a resident of a room change. During an interview on 03/11/26, at 12:41 P.M., Licensed Practical Nurse (LPN) M said the following:-Staff should contact the social service department for any room changes;-Staff should document in the progress notes of any room changes consent from the family and discussion with the resident of the room change. During an interview on 03/11/26, at 3:47 P.M., the Director of Nursing (DON) said the following:-Social service staff talk to family and/or resident to get permission for a room change;-Weekend staff usually did not move residents unless there were safety issues. The nurse may call family to move into the locked unit;-Staff should document in the progress notes of a room change. During an interview on 03/11/26, at 5:36 P.M., the Administrator said he expected staff to document in the progress notes of a resident's room change and resident and/or family notification. Complaint 2718595

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. Based on interview and record review, the facility failed to ensure timely notification of each resident's family/responsible party of changes in condition when staff failed to notify one resident's (Resident #1)'s x-ray results following a fall. A sample of four residents was reviewed in a facility with a census of 106.Review of the facility policy titled Changes in Patient/Resident Condition: Notification Guidelines, revised January 2025, showed the following:-Physicians, patients, residents, hospice when applicable, and families will be notified in a timely manner of changes in clinical conditions and environmental changes affecting the patient or resident;-Purpose to provide timely communication of condition and environmental changes to care providers, patients, residents, and families;-When patient/resident changes are noted nursing staff will notify the following: patient's or resident's attending provider, resident's legal representative (if patient/resident is incompetent), and/or interested family member;-Notification will occur as soon as possible when there is an accident or injury involving the patient/resident. 1. Review of Resident #1's face sheet (admission data) showed the following:-admission date of 02/10/25;-Diagnoses included fracture of unspecified part of neck of left femur (hip injury). Review of the resident's nursing progress note dated 11/19/25, at 1:10 P.M., documented as a late entry for 11/18/25, at 12:30 P.M. showed a nurse documented a fall communication form. A certified nurse aide (CNA) was in shared bathroom with another resident and heard a crash in the resident's room. Staff responded and noted the resident sat on the floor in front of his/her wheelchair. Staff notified the nurse. Staff assessed the resident for injury with none noted. The resident reported he/she attempted to transfer himself/herself to bed. Review of the resident's progress note dated 11/19/25, at 1:22 P.M. showed a late entry of 11/18/25 at 1:30 P.M., showed a nurse documented a verbal order received from the nurse practitioner for a STAT (as soon as possible) X-ray of the resident's right shoulder, humerus (upper arm bone), elbow, forearm and wrist. Staff notified the X-ray company and the X-ray completed as ordered. (Staff did not document family notification of the x-ray orders.)Review of the resident's X-ray report, dated 11/18/25 and reported on 11/18/25 at 4:08 P.M., showed the following:-Two views of the right elbow;-There was soft tissue swelling appreciated and suggestion of a fracture of the radial neck; -Impression of marked degenerative changes. Changes along the radial neck, which suggest a fracture of indeterminate age. Review of the resident's X-ray report dated, 11/18/25 date of service and reported on 11/18/25 at 4:11 P.M, showed the following:-Views of the right forearm;-Possible fracture involving the radial neck;-Impression of abnormal radial neck region.Review of the resident's progress note dated 11/22/25, at 10:29 P.M, the following: -Fall team meeting on 11/19/25;-The resident was found sitting on the floor and no injuries noted at the time of the assessment but afterwards had complaints of pain to his/her right arm;-Staff obtained an X-ray and noted a fracture to the radial neck with indeterminate age, may not be acute;-The medical director is aware, and the orthopedic physician is aware and ordered the resident to wear a sling;-Addendum entered by Licensed Practical Nurse (LPN) M on 11/22/25, at 10:44 P.M., noted at fall meeting therapy stated they would pick up the resident up for rehab.(Staff did not document family notification of the fall and x-ray results.)During an interview on 03/11/26, at approximately 1:30 P.M., LPN M said the resident had a fall on 11/18/25. The next day, on 11/19/25 the resident complained of pain. On 11/18/25, an X-ray was completed with results of a radial neck fracture. He/she did not see documentation of staff notifying the resident's responsible party of the X-ray results. Staff should document in the progress notes of notification of a resident's responsible party of an injury. During an interview on 03/11/26, at 2:25 P.M., Registered Nurse (RN C) said staff should document in the progress notes of X-ray results and notification of the resident and/or responsible party. During an interview on 03/11/26, at 3:47 P.M., the Director of Nursing (DON) said the following:-Nurses assess a resident following a fall;-The X-ray company comes to the facility to perform an X-ray on a resident or staff can send a resident to (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the hospital for the procedure;-Staff should document in the progress notes of notification of the resident and and/or responsible party of a fall;-Nurses call the physician for an X-ray order. Staff should notify the resident if own person or the resident's responsible party and document in the nurse's notes. During an interview on 03/11/26, at 5:36 P.M., the Administrator said he expected staff to notify a resident's family of X-ray results and injury and document in the progress notes. Complaint #2718595

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. Based on interview and record review, the facility failed to have a complete grievance process in place when staff failed to consistently document in a timely manner grievances, steps taken to follow-up on the grievance, and resolution for one resident one resident (Resident #1). The facility census was 106.Review of the facility's policy titled Grievance Procedure, reviewed June 2024, showed the following:-Patients, residents, or their representatives may register a complaint or grievance regarding an aspect of the operation of a department or the care or treatment, abuse or neglect of a patient or resident without fear of reprisal;-Grievance is a formal or informal written or verbal complaint that is made to the facility by a patient, or the patient's representative, regarding the patient's care (when the complaint is not resolved at the time of the complaint by staff present), abuse or neglect, issues related to the facility's compliance with the Centers for Medicare and Medicaid Services (CMS) conditions of participation, or a Medicare beneficiary billing compliant related to rights and limitations;-A staff member who receives a complaint should promptly take steps to resolve the concerns. A complaint is considered resolved when the patient is satisfied with the actions taken on their behalf. If the concerns have not been resolved to the patient's /resident's satisfaction, the staff should notify their immediate supervisor. The supervisor should seek prompt action to resolve the complaint. If the supervisor cannot resolve the complaint, the Patient Advocate should be contacted to resolve the issue. In long term care facilities, the facility administrator should attempt to resolve the issue prior to contacting the Patient Advocate. If the concerns cannot be resolved by the Patient Advocate, the complaint will be elevated to a grievance;-Responses to relatively minor verbal requests shall be handled promptly and are not generally considered a grievance and do not require a written response. If a patient care complaint cannot be resolved at the time of the complaint by staff present, is postponed for later resolution, is referred to other staff for later resolution, requires investigation, and/or requires further actions for resolution, then the complaint is a grievance for purposes of this policy. The Patient Advocate shall maintain a log of complaints and grievances through computerized Quality/risk Management module;-Whenever a patient or their representative requests that his or her complaint be handled as a grievance, or when the patient requests a response from facility staff, the complaint is considered a grievance. Upon request, provider must give a copy of the grievance policy to the patient, resident or representative;-The Patient Advocate shall contact the individual lodging the grievance, in writing, at the completion of the investigation. Written notice shall include the name of the contact person (Patient Advocate, administrator, or designee), the steps taken to investigate the grievance, the results of the grievance process, and the date of completion. 1. Review of Resident #1's face sheet (admission data) showed the following:-admission date of 02/10/25;-Diagnoses included fracture of unspecified part of neck of left femur (hip injury). Review of the resident's significant change Minimum Data Set (MDS-a federally mandated comprehensive assessment instrument completed by facility staff), dated 11/26/25, showed the following:-Cognitive skills intact;-Resident required partial/moderate assistance with toileting, shower, bathing and personal hygiene. Review of the resident's progress note dated 12/16/25, at 2:17 P.M., showed a nurse documented the resident's family member present and complained to a certified nurse aide (CNA) that resident had not had breathing treatment this day and he/she was reporting to social services, stating the resident requested breathing treatment two times this day. The resident's family member did not come to speak with this nurse and the resident refused breathing treatment two times this day. CNA reported the resident's family member complained of the resident wearing a brief rather than a pullup stating the resident did not like diapers. CNA attempted to explain to the resident's family member of the pullups. Management not in the building, and this nurse was unable to locate social service staff. The nurse entered the resident's room with another nurse and asked the resident's family member if there (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	from the resident.During an interview on 03/11/26, at 5:36 P.M., the Administrator said he was informed of the resident's missing items, and he instructed staff to replace the items. SSD should document who she talked with about a grievance and if the grievance was resolved and the date, the grievance should be on the complaint form. Staff should document the response to the person who filed a grievance and if resolved. He was not aware of the resident giving $10.00 to a staff member. Complaint #2718595

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted Based on interview and record review, the facility failed to develop a baseline care plan for all residents when staff failed to complete a baseline care plan within 48 hours of admission for one resident (Resident #2). The facility census was 106.Review of the facility's policy titled Assessments in Long Term Care, revised February 2026, showed the following:-Licensed nursing staff will begin to initiate an admission assessment of the patient when the patient presents to the nursing unit. The nursing assessments and screening assessments will be completed within 24 hours of admission. Additional assessments may be completed when there is a significant change in the patient's condition or diagnosis;-Purpose to provide an initial assessment to use as a baseline. To provide reassessments as needed if a change is indicated for the patient's response to care, condition changes, and/or diagnosis;-Initial admission assessments will be completed by a licensed nurse and will be documented on the admission assessment. Assessment will include the patient's physical, psychological, and social status;-The nursing assessment and other screening assessments will be completed within 24 hours of admission. The scope and intensity of further assessments will be based on the diagnosis, the specific nursing unit, the patient's desire for care, the consent to treatment, and the patient's response to previous care provided;-The nursing care plan will be initiated according to identified needs from the admission assessment by a licensed nurse. Licensed nursing personnel will update care plans as needs are assessed. Review of the facility's initial care plan upon admission form showed the following:-admission status;-Name the responsible party/resident that was offered/received a copy of Initial care plan and whether they accepted or declined;-Resident medications: Provide a copy of the medication list to resident or family (Staff can view in the electronic medical record). 1. Review of Resident #2 face sheet (a document that gives a patient's information at a quick glance) showed the following:-admission date 01/26/26;-admission diagnoses included multiple fractures of the pelvis. Review of the resident's progress notes dated 01/26/26, at 3:59 P.M., showed a nurse documented the resident arrived at the facility at 2:45 P.M. from the hospital. Review of the resident's admission Minimum Data Set (MDS-a federally mandated comprehensive assessment instrument completed by facility staff), dated 01/26/26, showed the following:-Cognitive skills intact;-The resident required partial/moderate assistance with toileting and personal hygiene. The resident required substantial/maximal assistance with showering, bathing, and lower body dressing. Review of the resident's medical record showed staff did not document completion of a baseline care plan.During an interview on 03/11/26, at 2:00 P.M., the MDS Coordinator/Registered Nurse (RN) N said the following:-The admitting charge nurse completes the initial baseline care plan upon admission;-The baseline care plan populates on a template in the computer. The nurse fills in the answers;-The admitting charge nurse should complete the baseline care plan within 24 hours and should be completed with admission notes;-The baseline care plan has admitted status, medicines, initial goals, the responsible party and resident section of offered to receive initial care plan and whether accepted or decline;-He/she did not see a baseline care plan for the resident. During an interview on 03/11/26, at 2:00 P.M., MDS Coordinator/Licensed Practical Nurse (LPN) O said the following:-He/she completes an admission audit within 48 hours after an admission;-He/she circles what the nurses did not complete on the admission paperwork and takes it back to the nurses' desk for them to complete;-Staff did not complete the baseline care plan for the resident;-The next nurse coming onto shift should complete anything the previous nurse did not complete;-He/she was under the impression the resident's baseline care plan had been completed. During an interview on 03/11/26, at 2:25 P.M. RN C said nursing staff should compete the baseline care plan upon admission. During an interview on 03/11/26, at 3:47 P.M., the Director of Nursing (DON) said the following:-The admitting nurse completes the new admission paperwork which include a head-to-toe assessment, falls, and skin assessments;-The admitting nurse completes the baseline (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	care plan. The baseline care plan populates into the work list;-She expected the nurse to give a copy of the baseline care plan to the resident and/or family. During an interview on 03/11/26, at 5:36 P.M., the Administrator said the nurse on duty should complete the baseline care plan for a new admission. Staff should offer the resident and/or family to review the care plan.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265245	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/11/2026
NAME OF PROVIDER OR SUPPLIER Colonial Springs Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 750 West Cooper Buffalo, MO 65622	

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on interviews and record review, the facility failed to keep residents free from accident hazards when one staff (Certified Nurse Aide (CNA) F) assisted one resident (Resident #3) in a unsafe manner while using a sit to stand lift (mechanical lift) and when staff (CNA I) did not utilize a gait belt (a 2-to-4-inch wide, sturdy belt, typically made of canvas or nylon, placed around a patient's waist to help caregivers safely assist with walking, standing, or transferring) during a transfer out of bed with one resident (Resident #5). The facility census was 106.Review of the facility's policy titled, Patient/Resident Handling, revised April 2025, showed the following:-Because patient/resident handling activities have been identified as a significant risk of injury to employees and others in the delivery and receipt of health care services within the organization, establishing and maintaining safe procedures for providing patient/resident care is a high priority;-Patient/resident handling incidents are analyzed for trends or patterns and appropriate follow up, changes in policy, staff education, or equipment maintenance initiated as required;-Employees are encouraged to report hazards, assert complaints, and/or make suggestions for improving the safety of patient/resident handling through the established procedures. 1.Review of Resident #3's face sheet (admission data) showed the following:-admission date of 05/01/19;-Diagnoses included dislocation of right ankle joint. Review of the resident's quarterly Minimum Data Set (MDS-a federally mandated assessment tool completed by facility staff), dated 02/20/26, showed the following:-Cognitive skills intact;-The resident had no behaviors;-The resident was dependent with toileting and personal hygiene;-The resident required substantial/maximal assistance with showering. Review of the resident's care plan, reviewed 02/26/26, showed the following: -The resident was admitted to the facility with a dislocation of his/her right ankle;-The resident required extensive to total assistance with one to two staff assistance with all activities of daily living (ADL – grooming, toileting, dressing, etc.);-Lifting/transfers in accordance with decision flow chart. The resident required one to two staff assistance for transfers;-The resident was alert and oriented and able to make his/her needs known;-Use a calm reassuring approach;-The resident had pain related to his/her previous fracture;-The resident was at risk for falls related to previous ankle injury with generalized weakness, dependence on staff for transfers, and use of psychoactive medications. Review of the facility's investigation, dated 02/17/26, showed the following:-The resident reported that he/she did not feel like CNA F's behaviors in his/her room on 02/14/26, at approximately 9:30 P.M., were appropriate;-The resident reported CNA F got frustrated with the sit-to-stand lift that he/she utilized. CNA F rocked the lift back and forth trying to get the wheels unstuck and the resident had to tell CNA F to calm down;-The resident reported that his/her upper chest was sore due to this incident. The resident was elevated in the sit to stand, and CNA F tried to get the wheels unstuck which resulted in him/her rocked back and forth in the lift which caused some discomfort in his/her chest region. During an interview on 03/10/26, at 1:39 P.M. and 3:56 P.M., the resident said on 02/14/26 the sit to stand lift was hard to turn. CNA F took him/her to the bathroom and had trouble turning the lift. CNA F could not get the sit to stand out of the bathroom. CNA F started raising the lift up in the air and letting the lift down which hit the floor, with him/her hanging up with his/her arms in the air and he/she swayed. The resident said he/she screamed at CNA F to calm down. The resident said he/she felt it could have been prevented if the floor was better. Other staff had difficulty getting the sit to stand lift in his/her bathroom. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 03/10/26, at 4:25 P.M., CNA F said he/she was with the resident in the bathroom and when he/she rolled the resident out of the bathroom, two of the wheels on the lift had locked up. He/she could not move the lift. The resident started swinging on the lift. He/she was worried the resident was going to fall out of the lift. During an interview on 03/11/26, at 10:06 A.M., CNA K said the lift was hard to move and the floor was horrible in the resident's room. The lift gets stuck. Staff should report any equipment issues to maintenance staff using the Quick Response (QR) code or verbally inform him. During an interview on 03/10/26, at 1:31 P.M., Licensed Practical Nurse (LPN) G said the following:-The resident said CNA F got angry with a transfer and could not get the sit to stand to work;-The resident said he/she had to yell at CNA F to stop. The resident said the incident scared him/her. CNA F was angry trying to move the sit to stand lift. During an interview on 03/10/26, at 2:18 P.M., LPN H said about three weeks ago, the resident said the night aide had jostled him/her in the sit to stand lift. The resident said CNA F appeared to be frustrated with the sit to stand lift. The resident said the sit to stand lift got stuck on an area to the bathroom where the lift gets stuck. The resident said CNA F got frustrated and went over the area of the bathroom to get him/her out of the bathroom, and CNA F was frustrated the lift was stuck. The resident said he/she felt scared. During an interview on 03/11/26, at 1:04 P.M. the Maintenance Supervisor said staff should put a work order in the computer and he checked for work orders every day and prioritizes them. Staff also inform him in person of any work orders. The maintenance department put in a new floor a year ago in the resident's room and staff needed to stay off of it for 24 hours. Staff put the sit to stand on it less than eight hours which caused it to sink. He did not have a work order or complaint with the sit to stand. After the resident's floor was ruined, staff would have to evacuate the room so they could strip out the floors. He asked staff if they had any issues with lifts awhile back, staff said it was useable and were transporting across the floor in the resident's bathroom. During interviews on 03/10/26, at 2:58 P.M., and on 03/11/26, at 3:47 P.M., the Director of Nursing (DON) said the following: -CNA F got frustrated with a sit to stand lift and it got stuck. CNA F shook the lift trying to get it unstuck from the little notch in the floor;-Staff place a maintenance request in the QR code posted around the building or the computer;-The Maintenance Supervisor reviewed at the work orders in the morning and reported them to the Administrator;-The Administrator informed her of the incident with the lift with the resident and CNA F. CNA F was rough getting the lift over the notch in the floor, CNA F shook the resident in the sit to stand lift;-She expected staff to report issues with floors and wheels locking up on a lift;-Staff rocking a lift back and forth causes safety issues with that lift. During an interview on 03/11/26, at 5:36 P.M., the Administrator said he expected staff to report if a sit to stand lift wheels locked up. He wanted things fixed, Staff should complete a work order, with a QR code to make it simple for the staff. He was not aware of the lift wheels locking up, or issues with the resident's floor. He expected staff to report any equipment issues and if flooring needs replaced. CNA F said the lift got stuck and he/she was concerned for the resident, trying to make sure the resident was safe. He was not aware the if the maintenance supervisor was made aware of the lift getting stuck during the incident with the resident. 2. Review of Resident #5's face sheet showed the following:-admission date of 05/26/19;-Diagnoses (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	included dementia with behaviors. Review of the resident's quarterly MDS assessment, dated 02/12/26, showed the following:-Severely impaired cognitive skills;-Dependent on staff for toileting, personal hygiene and mobility. Review of the resident's care plan, revised 03/10/26, showed the following:-The resident required maximum staff assistance to total staff assistance with activities of daily living;-The resident required total assistance with all of his/her mobility needs;-The resident is at risk for falls related to advanced age, hearing and visual defects, opioid medication use, psychotropic medication use. Observation on 03/10/26, at 11:02 A.M. showed the following:-The resident lay in his/her bed;-CNA I rolled the resident to a sitting position and sat the resident up on the side of his/her bed;-Without using a gait belt, CNA I used both of his/her hands and placed them around the resident's back, stood the resident up, and pivoted to the right and sat the resident down in his/her wheelchair;-A gait belt hung on a hook on the wall beside the resident's bed. During an interview on 03/10/26, at 12:20 P.M., CNA I said the following:-He/she used a gait belt to transfer all residents;-The resident was care planned not to use a gait belt when getting resident up as he/she can fight getting up making it difficult to apply gait belt;-He/she did not use a gait belt to transfer resident this morning because he/she was worried resident might try and fight it;-The resident was not combative or resistant to care at that time. During an interview on 03/11/26, at 9:28 A.M., CNA J said staff should always use a gait belt with a one-person assistance transfer. During an interview on 03/11/26, at 10:06 A.M., CNA K said staff should always use a gait belt with the resident during transfers. During an interview on 03/11/26, at 12:21 P.M., Occupation Therapy Staff L said staff should use gait belts during transfers. Staff are trained on the use of the gait belt as the safest way to transfer. Staff should not lift on a resident's arms, which could cause injury. Staff should use a gait belt with getting a resident up and laying down a resident in bed if not using a lift. During an interview on 03/11/26, at 12:41 P.M., LPN M said staff should use a gait belt if the resident is not able to use the sit to stand. He/she had not heard of a gait belt not used getting up a resident. During an interview on 03/11/26, at 3:47 P.M., the DON said the following:-Staff should use a gait belt during transfers with a resident;-Gait belts use is for the resident and staff safety;-Gait belts make it easier for staff to control a resident and if they fall, it is a slow drop versus a hard hit;-The facility trains staff to use a gait belt with transfers;-Staff should use a gait belt during transfers with the resident. There is nothing in the resident's care plan or reason to not use a gait belt to get the resident up or lay the resident down with a gait. During an interview on 03/11/26, at 5:36 P.M., the Administrator said he expected staff to use a gait belt with the resident and there was no time the resident is care planned to not use a gait belt. Complaint #2718595

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide pharmaceutical services that meet the needs of all residents when staff failed to provide medications as ordered by the prescriber to meet the needs of each resident when the facility failed to administer medications within the time frame specified by the provider for two residents (Resident #2 and Resident #6) out of four residents sampled . The census was 106.Review of the facility's policy titled Medication Administration and Documentation, dated 11/01/26, showed the following:-Medications not eligible for scheduled dosing times will have a time specified by the provider:-Medications eligible for scheduled dosing times include daily (QD), twice a day (BID), three times a day (TID), and hourly intervals such as every 6 hours (Q6SCH);-Standard administration times used include daily (9:00 A.M.), BID (9:00 A.M., 9:00 P.M.), TID (9:00 A.M., 3:00 P.M., 9:00 P.M.), and Q12HSCH (9:00 A.M., 9:00 P.M.);-Standard administration times may be adjusted by pharmacy staff due to drug or food incompatibilities;-The medication administration window in LTC has been extended to three hours before and after scheduled administration times for oral medications;-This liberalized medication pass allows for a more home like environment for residents;-LTC providers may exclude certain patients or medications from liberalized medication pass;-Oral agents with narrow therapeutic index such as anticoagulants (slows or prevents blood clotting) and anticonvulsants (used to treat seizures) should not be liberalized if ordered at a specific time on the Medication Administration Record (MAR);-If a scheduled dose is missed for reasons such as patient availability or patient refused the provider will be consulted for directions concerning the missed dose;-In long-term care facilities (LTC) medications are considered late if they are given more than 3 hours after their scheduled administration time.1. Review of Resident #2 face sheet (a document that gives a patient's information at a quick glance) showed the following:-admission date of 01/26/26;-admission diagnoses included multiple fractures of the pelvis.Review of the resident's admission Minimum Data Set (MDS-a federally mandated assessment tool completed by facility staff), dated 1/30/26, showed the following:-Cognitive skills intact;-On anticoagulant medication.Review of the resident's care plan, reviewed 03/10/26, showed the resident at risk for bleeding due to taking anticoagulant medications.Review of resident's current physician orders showed the following:-An order, dated 01/26/26, for apixaban (an anticoagulant medication) 5 milligrams (mg) PO (by mouth) BID;-An order, dated 01/26/26, for flecainide (antiarrhythmic medication used to prevent and treat serious, often, or sustained, fast, and irregular heartbeats) 25 mg PO Q12hrs.Review of resident's MAR, dated 03/01/26 to 3/10/26, showed the following for apixaban:-On 03/01/26, staff administered a dose at 7:00 A.M. Staff did not document administration of the P.M. dose;-On 03/02/26, Staff did not document administration of the A.M. dose. Staff administered a dose at 8:01 P.M.;-On 03/03/26, staff administered the medication at 10:17 A.M. and 6:29 P.M.;-On 03/08/26, staff administered the medication at 12:14 P.M. and 7:10 P.M.;-On 03/09/26, staff administered the medication at 10:00 A.M. and 6:58 P.M.;-On0 3/10/26, staff administered the medication at 10:55 A.M., and 7:15 P.M.Review of resident's MAR, dated 03/01/26 to 03/10/26, showed the following for flecainide:-On 03/01/26, staff administered a dose at 7:00 A.M. Staff did not document administration of the P.M. dose;-On 03/02/26, staff did not document the A.M. dose administered. Staff administered the medication at 8:01 P.M.;-On 03/03/26, staff administered the medication at 10:17 A.M. and 6:29 P.M.;-On 03/08/26, staff administered the medication at 12:14 P.M. and 7:10 P.M.;-On 03/09/26, staff administered the medication at 10:00 A.M., and 6:58 P.M.;-On 03/10/26, staff administered the medication at 10:55 A.M. and 7:15 P.M.Review of the resident's nurses' notes, dated 03/01/26 to 03/10/26, showed staff did not document related to medication missed or given outside of the ordered time frame. During an interview on 03/11/26, at 12:15 P.M., the Nurse Practitioner (NP) said apixaban should be given 8 hours between doses. If given earlier then (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	that, it would be a medication error.During an interview on 03/11/26, at 1:32 P.M., the Pharmacist said apixaban was typically scheduled at 9:00 A.M. and 9:00 P.M., due to the medication's half-life. Occasionally it would be okay to give six hours apart as not missing a dose was more important.2. Review of Resident #6 face sheet showed the following:-admission date of 05/28/25;-Admissions diagnoses included pressure ulcer of the sacral region (a wound near the end of the spine in-between the buttocks caused from pressure).Review of the resident's quarterly MDS, dated [DATE], showed the following:-Cognitive skills intact;-On anticoagulant medication.Review of resident's care plan, reviewed 03/11/26, showed the resident was at risk for bleeding due to taking anticoagulant medications.Review of resident's current physician orders showed an order, dated 05/28/25, for metoprolol succinate (a beta-blocker used to treat high blood pressure, angina, and heart failure) 12.5 mg give daily at 6:00 A.M. Review of residents' MAR, dated 03/01/26 to 03/10/26, showed the following for metoprolol succinate;-On 03/01/26, staff administered the medication at 9:20 A.M.;-On 03/02/26, staff administered the medication at 9:27 A.M.;-On 03/03/26, staff administered the medication at 10:27 A.M.;-On 03/04/26, staff administered the medication at 9:45 A.M.;-On 03/05/26, staff administered the medication at 9:36 A.M.;-On 03/06/26, staff administered the medication at 10:22 A.M.;-On 03/08/26, staff administered the medication at 11:10 A.M.;-On 03/09/26, staff administered the medication at 10:19 A.M.;-On 03/10/26. staff administered the medication at 11:01 A.M.Review of resident's nurses' notes, dated 03/01/26 to 03/10/26, showed staff did not document related to medication administration outside of accepted time frames. 3. During an interview on 03/10/26, at 10:36 A.M., Certified Medication Technician (CMT) A said the following:-Liberal medication pass gives staff a three-hour window to give daily medication;-Medication with a specific time should be given as close to that time as possible.During an interview on 03/10/26, at 12:20 P.M., Registered Nuse (RN) B said the following;-Liberal medication pass gives staff a three-hour window to give some medication;-Scheduled medications and BID medications were given at a specific time;-Medication given too early or too late can be an error.During an interview on 03/11/26, at 10:00 A.M., RN C said the following:-Liberal medication pass gives staff a 3-hour window to give certain medications;-If a medication was scheduled for 6:00 A.M., staff have one hour before and one hour after to give that medication;-Staff have one hour before and one hour after to give scheduled BID medications.During an interview on 03/11/26, at 10:20 A.M., CMT E said the following;-Liberalized medication pass gives a three-hour window to pass some medications;-One time a day at a certain time, BID, TID, QID medications need to be given as close to their scheduled times as possible.During an interview on 03/11/26, at 12:15 P.M., the NP said the following:-Liberal medication pass allowed staff to adjust the time a medication was given;-Medications that staff can adjust times are routine medication;-If a medication is scheduled at 6:00 A.M., it should be given at that time;-BID medication is given at 8:00 A.M., and 8:00 P.M., or 9:00 A.M., and 09:00 P.M.During an interview on 03/11/26, at 1:32 P.M., the Pharmacist said the following:-Liberal medication pass was to allow for a more home like environment and gives staff a three-hour window to administer certain medications;-Exceptions to the liberal medication pass would be scheduled medications, those would be time specific.During an interview on 03/11/26, at 4:18 P.M., the Director of Nursing (DON) said the following:-He/she expected staff to give medications to resident when they are due;-Liberal medication pass gives staff a three-hour window for daily medications;-He/she expects BID medications to be given 8 to 10 hours apart.During an interview on 03/11/26, at 5:41 P.M., the Administrator said the following:-He/she expected staff to administer all medication within the policy of the facility;-Liberal medication pass gives staff a three-hour window to give daily medications;-Scheduled medications, it depends on the medication and the order how long between doses.Complaint 2794617 and 2718595