STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265333	A. Building B. Wing	08/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aspire Senior Living Jonesburg	308 Cedar Avenue Jonesburg, MO 63351

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 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. Based on observation, interview and record review, facility staff failed to use standardized recipes to prepare foods for service to all residents and serve food in accordance with the nutritionally calculated menus. Facility staff failed to provide menus with the food items and portion sizes to be served for all diet types utilized by the facility and failed to record substitutions made to the menus. These failures have the potential to affect all residents. The facility census was 59. 1. Review of the facility's policy titled Food Service to Residents, dated 01/30/24, showed food will be prepared and served in a manner that meets the individual needs of the resident. Review of the facility's policy titled Menus, dated 01/30/24, showed the policy directed staff that the menus must: -Meet the nutritional needs of the residents in accordance with established national guidelines;-Be prepared in advance;-Be followed;-Reflect, based on a facility's reasonable efforts, the religious, cultural, and ethnic needs of the resident population, as well as input received from residents and resident groups. Review of the facility's policy titled Food Substitutions, dated 01/30/24, showed the dietary manager will make food substitutions as appropriate or necessary, he/she will consult the dietitian as necessary prior to making a substitution, and all substitutions are to be noted on the menu and filed in accordance with established dietary policies. Review of the residents' diet cards showed the residents' diet types included regular, minced and moist (a diet in which the foods consist of very soft, small moist lumps that does not require more than minimal chewing ability) and pureed. Review of the menus posted on the dietary manager's door, showed a four-week cycle of contracted vendor prepared menus for a regular diet type. Observation on 08/27/25 at 7:45 A.M., showed the kitchen did not contain visible menus for the minced and moist and pureed diet types, standardized recipes for staff to use in food preparation, or a menu substitution log. Review of the breakfast menu dated 08/27/25 (Week 1, Day 4), showed the menus directed staff to provide the residents on a regular diet with: -Four ounces (oz.) of hot cereal or six oz. of cold cereal;-Breakfast sandwich which consisted of two slices of bread and two oz. of protein; and-A four oz. fresh fruit cup. Review showed the menu did not contain documentation of any substitutions made to the menu. Observation of the breakfast meal service on 08/28/25 at 7:45 A.M., showed [NAME] M served the residents who received regular diets four oz. of hot cereal or six oz. of cold cereal, one oz. of scrambled eggs, and two oz. of diced potatoes. Observation showed the cook did not prepare, serve or offer the residents the breakfast sandwich or the fresh fruit cup as indicated by the menus. Observation showed the cook did not prepare, serve or offer the residents an additional protein and fruit source. Observation of the breakfast meal service on 08/28/25 at 7:45 A.M., showed [NAME] M served the residents who received minced and moist diets four oz. of hot cereal, one oz. of scrambled eggs, and two oz. of diced potatoes. Observation showed the cook did not prepare, serve or offer the residents the breakfast sandwich or the fresh fruit cup as indicated by the menus. Observation showed the cook did not prepare, serve or offer the residents an additional protein and fruit source. Observation of the breakfast meal service on 08/28/25 at 7:45 A.M., showed [NAME] M served the residents who received pureed diets four oz. of hot cereal, three oz. of pureed scrambled eggs and two oz. of pureed sausage. Observation showed the cook did not prepare, serve or offer the residents a pureed (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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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	breakfast sandwich, pureed fruit or an additional pureed starch. During an interview on 08/27/25 at 8:28 A.M., [NAME] M said the breakfast served is different from the menus, because the dietary manger had been mixing and matching food items to make menus due to something with the food orders and possibly being over budget. The cook said the dietary manager told him/her to substitute the breakfast menu with the food items he/she served the residents, but he/she did not tell him/her how much to serve of each item. The cook said the only menus they had were the menus posted on the dietary manager's door and he/she did not have documentation of the substitutions made to the menu. The cook also said they did not have any recipes to use to prepare the resident meals, so they just made things how they think they should be made. During an interview on 08/27/25 at 1:15 P.M., the dietary manager said staff are expected to serve the menus as planned unless otherwise directed and staff should call him/her for direction if they do not have something they need to make the meal. The dietary manager said he/she did not direct the staff to not serve the breakfast as directed by the menu and staff did not contact him/her about needed substitutions to the breakfast meal. The dietary manger said substitutions to the menu should be approved and documented, but he/she did not know staff substituted the breakfast menu so he/she did not have documentation of the substitutions. The dietary manager said if substitutions are made, there should be food items to cover all food types indicated on the menu to meet the residents' nutritional needs. The dietary manager said, based on the original breakfast menu and what staff served the residents, staff should have served the residents on regular and minced and moist diets an additional protein source and a fruit source and the residents on a pureed diet should have received a pureed starch and fruit source. The dietary manager said he/she did not have menus for minced and moist and pureed diets, nor did he/she have standardized recipes available for staff to use to prepare meals. The dietary manager said he/she had repeatedly asked the dietician and facility management about the menus and recipes because he/she knew they should have them. The dietary manager said the registered dietician told him/her the menus and recipes were in the contracted menu computerized program, but he/she had not been trained how to use the program and did not know how to access the menus and recipes. During an interview on 08/28/25 at 10:38 A.M., the administrator said staff are expected to prepare food in accordance with the standardized recipes and serve it in accordance with the planned menus, which included the food items and portion sizes for modified textured diets. The administrator said if staff do not have what they need to prepare a meal, they should notify the dietary manager or him/her to get what they need or contact the registered dietician to figure out a substitution. The administrator said staff did not contact him/her about a need to substitute the breakfast menu on 08/27/25. The administrator said, if staff make substitutions to the menu, the substitutions should be of equal nutritional value and documented. The administrator said the dietary manager is responsible to ensure the dietary staff have the menus and recipes to prepare the meals and that staff serve the meals accordingly. The administrator said when they got the new spring/summer menus in, he/she asked the dietary manager if he/she had all the menus and recipes needed and the dietary manager said that they did, so he/she had no idea that the dietary staff did not have recipes or menus for minced and moist and pureed diets because the dietary manager did not know how to retrieve them from the computerized program. The administrator said if the department heads do not know how to do something, they should come to him/her for help. The administrator said he/she does a kitchen sanitation inspection on to two times a month, but he/she does not look for the menus and recipes when he/she does his/her inspections.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview and record review, facility staff failed to store food in a manner to prevent potential contamination and outdated use and ensure the use of food in a first-in, first-out manner. Facility staff failed to ensure dishes were clean and air dried prior to stacking in storage to prevent the growth of foodborne pathogens. Facility staff failed to perform hand hygiene as often as necessary using approved techniques to prevent cross-contamination. Facility staff also failed to maintain kitchen surfaces and equipment clean and in good repair to prevent potential contamination. These failures have the potential to affect all residents. The facility census was 59. 1.Review of the facility's policy titled Storage of Food in Refrigeration, dated 01/30/24, showed: -Store raw meats on the bottom shelves to prevent contamination of other perishable items; -Food being returned to storage after cooking or preparation must be covered; -All containers must be labeled with the contents and date the food item was placed in storage; -Food items that remain sealed from the supplier may be held until the expiration date if unopened. Review of the facility's policy titled Food Safety, dated 01/30/24, showed: -A purpose of the policy is to ensure the facility follows proper sanitation and food handling practices to prevent the outbreak of foodborne illness; -The facility must store, prepare, distribute, and serve food in accordance with professional standards for food service safety; -For food brought into the facility that has been prepared by others, the facility is responsible to: a. Store visitor food in such a way to clearly distinguish it from food used by or prepared by the facility; b. Ensure safe food handling once the food is brought to the facility, including safe temperatures of food and handling of leftovers; c. Clearly identify what food has been brought in by visitors for residents and guests when served; d. Food brought in must be dated, stored in the resident's room, and discarded after three days; e. Store bought items in original wrapping or container unopened; f. Food may not be stored in the facility kitchen/refrigerator. Observations on 08/25/25 at 10:10 A.M., showed the reach-in refrigerator labeled as #1 contained: -An opened and undated bag of uncooked hot dogs stored inside an undated plastic resealable bag stored on the top shelf over containers of ready-to-eat and leftover prepared food items; (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-An unopened package of uncooked ham and an opened and undated package of sliced turkey breast stored inside an undated plastic resealable bag on the top shelf over containers of ready-to-eat and leftover prepared food items. Observation showed liquid from the turkey package dripped on a container of tossed salad stored below the turkey; -An opened and undated bag of precooked bacon pieces stored in an undated plastic resealable bag opened to the air on the second shelf. Observations on 08/25/2025 at 10:26 A.M., showed the reach-in freezer labeled as #3 contained: -An undated case of beef patties opened to the air; -An undated and unlabeled plastic resealable bag which contained two uncovered burritos, a grocery store bag and an undated and unlabeled unidentifiable packaged food item. Observations on 08/25/2025 at 10:30 A.M., showed three dented six pound eight ounce (oz.) cans of diced pears and a dented six pound 10 oz. can of fancy tomato sauce stored on a shelf with the in-use food supply in the dry goods pantry. Observation showed the dent on the can of tomato sauce located on the top edge seal of the can. Observations on 08/27/25 at 9:08 A.M., showed the reach-in refrigerator labeled as #1 contained: -An opened and undated bag of uncooked hot dogs stored inside an undated plastic resealable bag and a case of uncooked ham stored on the top shelf above containers of shredded cheese, vanilla pudding and chocolate puddings; -Containers of leftover prepared brown gravy, peas and turkey with gravy stored above the containers of shredded cheese and puddings; -Opened and undated one gallon containers of mayonnaise, enchilada sauce, sweet and sour sauce, and fresh sauerkraut. Observation showed the container of sauerkraut with a delivery sticker dated 01/23/25 and the exterior of the container excessively soiled with mold-like debris. Observation on 08/27/25 at 9:17 A.M. showed two opened and undated five pound containers of peanut butter stored on the shelf above the microwave. Observation showed the top exterior excessively soiled with peanut butter residue. During an interview on 08/27/25 at 9:22 A.M., the dietary manager (DM) said raw foods should be stored below ready-to-eat and prepared foods and prepared foods should be stored above raw foods and below ready-to eat foods to avoid cross-contamination. The DM said opened and leftover prepared food items should be labeled with the date the item is opened or made to prevent staff from serving spoiled food. The DM said staff should use all of one food item before they open another to ensure food is used in a first in, first out manner. The DM said he/she is responsible to monitor food storage and he/she should look at it every day, but he/she had not done so and he/she had not been able to do a lot of his/her duties due to some staffing issues. Observation on 08/27/25 at 9:46A.M., showed an undated container of sugar, removed from its original packaging, stored below the cook's food preparation counter and scoop stored uncovered on top of the container. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Observation on 08/27/25 at 10:22 A.M., showed the reach-in refrigerator labeled as #2 contained: -Opened and undated 46 oz. bottles of nectar consistency thickened apple juice, orange juice and iced tea; -An opened and undated 46 oz. bottle of honey consistency thickened cranberry juice; -An opened and undated 32 oz. carton of honey consistency thickened dairy beverage; -An opened and undated 32 oz. carton of half and half with a use by date of 08/24/25; -An unopened 32 oz. carton of half and half with best by date of 08/17/25; -An opened and undated 12 oz. bottle of wing sauce with a best by date of 06/09. Observation showed the year of the best by date worn off of the bottle; -An uncovered pitcher of cranberry juice dated 08/26/25; -An undated plastic resealable bag of leftover pizza slices; -An unlabeled bottle of a factory prepared coffee drink. During an interview on 08/27/25 at 10:25 A.M., [NAME] M said the coffee drink bottle belonged to an employee and employee food items should not be stored in the refrigerator with resident food. During an interview on 08/27/25 at 10:30 A.M., the DM said opened and prepared food items should be labeled, dated and stored in sealed containers. The DM said staff are expected to discard food that is past its expiration date and if it does not have an expiration date then the best by or use by dates would be considered the expiration date and staff should dispose of those items if they are past the best by or use by dates. The DM said if an expiration date or best by date on a food item is not legible then it should also be discarded. The DM said the bottle of wing sauce, bag of pizza and coffee drink bottle belonged to staff and staff food should not be stored with the resident food. The DM said he/she told staff to store their food in his/her office refrigerator. Observation on 08/27/25 at 10:45 A.M., showed the reach-in freezer labeled as #3 contained: -An undated case of beef patties opened to the air; -An undated and unlabeled plastic resealable bag which contained two uncovered burritos, a grocery store bag under the burritos and an undated and unlabeled unidentifiable packaged food item. During an interview on 08/27/25 at 10:45 A.M., the DM said the food plastic resealable bag belonged to a resident. The DM said the bag should have been labeled with the resident's name and the date it was received. The DM said he/she did not know what the unlabeled packaged food item was or how old it was, staff should not have stored the grocery bag with the items because it is contaminated, the burritos should be wrapped to prevent contamination from the other items in the bag and he/she did not know how old the burritos were. Observation on 08/27/25 at 11:15 A.M., showed the dry goods storage pantry contained: (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-An opened and undated 25 pound bag of sugar; -An opened and undated 50 pound bag of flour; -An undated bag of egg noodles opened to the air; -A dented six pound eight oz. can of diced peaches and two dented six pound 10 oz. cans of fancy tomato sauce stored on a shelf with the in-use food supply. Observation showed a dent on one of the two cans of tomato sauce located on the top edge seal of the can. During an interview on 08/27/25 at 4:15 P.M. the DM said dented cans should be disposed of and not stored with the in-use food supply. The DM said staff are trained on food storage requirements upon hire and as needed. During an interview on 08/28/25 at 10:55 A.M., the administrator said opened and prepared food items should be stored sealed in appropriate containers, labeled with what it is and dated with the opened or made date. The administrator said uncooked foods should be stored below prepared and ready-to-eat foods and prepared foods should be stored above uncooked foods and below ready-to-eat foods to prevent cross-contamination. The administrator said staff should use all of one food item before they open another to ensure food is used in a first-in,first-out manner and dented cans should be discarded and not be stored with the in-use food items. The administrator said staff food should not be stored with the resident food supply and outside food items brought in for residents should be stored in sealed containers dated with the date received, labeled with the resident's name, and not stored with anything that could be contaminated, like a grocery store bag, to prevent cross-contamination. The administrator said staff are expected to dispose of items past their best by or use by dates or if they cannot read what the best by or use by date is. The administrator said scoops used to dispense food should be stored in clean covered containers. The administrator said staff are trained on food storage requirements upon hire and as needed and the DM is responsible to monitor food storage daily. The administrator said he/she did not know the DM had not monitored the food storage daily. 2. Review of the facility's policy titled Dish Washing, dated 01/30/24, showed the policy did not contain direction for staff related to the drying and storage of dishes. Observations on 08/25/25 at 10:10 A.M., showed five metal sheet pans and 14 metal food preparation pans of various sizes stacked together wet on the shelf below the cook's station food preparation table. Observation also showed five of the 14 wet stacked food service pans contained food debris on the inside and another two of the pans had soap residue on the inside. Observation on 08/27/25 at 2:50 P.M., showed Dietary Aide (DA) O washed dishes in the mechanical dishwashing station. Observation showed the DA stacked sanitized plates and plate covers from the clean side of the station while wet and then put them in storage. Observations on 08/27/25 at 3:00 P.M., showed 18 metal food service pans of various sizes stacked together wet on the shelf below the cook's station food preparation table. Observation also showed eight insulated plate covers stacked together wet and stored upside down on the shelf by the ice machine. During an interview on 08/27/25 at 3:15 P.M., the DM said staff should ensure dishes are clean and allow the dishes to air dry before they put them away and staff are trained on this requirement. The (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	DM said he/she is responsible to monitor dish washing and storage daily, but he/she had not done so daily due to staffing issues. During an interview on 08/28/25 on 11:18 A.M., the administrator said staff should ensure the dishes are clean, without food residue, and allow the dishes to air dry before they put them away. The administrator said staff are trained on dish washing and storage procedures and the DM is responsible to monitor dish storage after each meal's wash. 3. Review of the facility's policy titled Hand Hygiene, dated 01/30/24, showed: -Handwashing will be regarded by this facility as the single most important means of preventing the spread of infection; -Staff will follow the facility's established hand hygiene procedures to prevent the spread of inspection and disease to other staff, residents and visitors; -Hands should be washed for at least 20 seconds using soap and water when staff come on duty, whenever hands are visibly soiled, after handling items potentially contaminated with blood, body fluids, excretions, or secretions, before and after glove use, and upon completion of duty; -The policy did not provide direction to staff on the proper procedure for washing their hands with soap and water. Review of the facility's policy titled Food Safety, dated 01/30/24, showed: -A purpose of the policy is to ensure the facility follows proper sanitation and food handling practices to prevent the outbreak of foodborne illness; -Staff should have access to proper hand washing facilities with available soap, hot water and disposable towels and/or heat/air drying methods. The use of disposable gloves is not a substitute for proper hand washing; -Hands must be washed before putting on and after removing gloves as well as between tasks and between handling soiled and clean dishes; -The policy did not provide direction to staff on the proper procedure for washing their hands with soap and water. Observations on 08/27/25 at 8:56 A.M. and 9:08 A.M., showed DA N washed soiled dishes in the mechanical dishwashing station and then washed his/her hands at the handwashing sink. Observation showed when the DA washed his/her hands, he/she scrubbed his/her hands with soap for three seconds, rinsed his/her hands and turned the faucet off with his/her bare hands. Observation showed the DA then put away sanitized dishes from the clean side of the station. Observations on 08/27/25 at 3:06 P.M. and 3:08 P.M., showed DA O washed soiled dishes in the mechanical dishwashing station. Observation showed, without performing hand hygiene, he/she put away sanitized dishes from the clean side of the station. Observation on 08/27/25 at 3:10 P.M., showed DA N entered the kitchen from outside and washed (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	his/her hands in the handwashing sink. Observation showed when the DA washed his/her hands, he/she scrubbed his/her hands with soap for three seconds and turned the faucet off with his/her bare hands. During an interview on 08/27/25 at 3:10 P.M., DA N said staff should scrub their hands with soap for at least 20 seconds when they wash their hands, and he/she thought he/she had just scrubbed his/her hands with soap for 30 seconds but guessed he/she got in too much of a hurry. The DA said he/she did not know he/she should not turn the faucet off with his/her bare hands, but it would make sense not to do so since the faucet is turned on with dirty hands. During an interview on 08/27/25 at 3:11 P.M., DA O said staff should wash their hands between tasks and anytime they get dirty. The DA said he/she should have washed his/her hands between handling the dirty and clean dishes, but he/she forgot to do so because he/she was stressed out and overwhelmed. During an interview on 08/27/25 at 4:15 P.M., the DM said staff should wash their hands with soap and water when they enter the kitchen, between tasks and after they touch anything dirty. The DM said, when staff wash their hands, they should scrub their hands with soap for at least 30 seconds before they rinse and turn the faucet off with a paper towel to prevent recontamination of their hands. The DM said all staff are trained on hand hygiene upon hire and as needed so they should know better. During an interview on 08/28/25 at 11:39 A.M., the administrator said staff should perform hand hygiene anytime they enter the kitchen, between tasks and after they touch something dirty. The administrator said, when staff wash their hands, they should scrub their hands with soap for 30 seconds before they rinse and turn the faucet off with a paper towel because the faucet is dirty. The administrator said staff are trained on hand hygiene upon hire, annually and as needed. 4. Review of the facility's policy titled Cleaning, dated 01/30/24, showed: -The purpose of this policy is to ensure a clean and sanitary dietary environment; -All equipment, food contact surfaces and utensils shall be cleaned whenever contamination may have occurred; -All food surfaces will be cleaned at the end of each food preparation session; -Refrigerator units must be cleaned; -Wall surfaces that become splattered during the food preparation process must be cleaned daily; -The policy did not contain information specifically related to the cleaning and maintenance of freezers, gasket seals, vents, fans, the steam table, and the ice machine. Observations on 08/25/25 at 10:08 A.M. and 08/27/25 at 9:00 A.M., showed the kitchen did not contain a visible cleaning or maintenance schedule. 5. Observations on 08/25/25 at 10:08 A.M. and 08/27/25 at 9:30 A.M., showed a piece of foil, which contained an accumulation of dirt and food debris, on the windowsill below the air conditioner unit in the food preparation area. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 08/27/25 at 3:45 P.M., the DM said staff put the foil on the windowsill to protect it from the air conditioner condensation. The DM said staff should check the windowsill daily and ensure it is cleaned as needed. The DM said he/she did not notice the accumulation of dirt and food debris on the foil. During an interview on 08/28/25 at 11:23 A.M., the administrator said the dietary staff are responsible to ensure the kitchen surfaces are routinely cleaned and the DM should monitor the cleanliness of the kitchen daily. The administrator said he/she recently directed the dietary staff to replace the foil on the windowsill since it was dirty and he/she did not know staff did not replace it as directed. 6. Observation on 08/25/25 at 10:08 A.M., showed the steam table wells contained a white sediment buildup and food debris floating in the water and the top of the water with an oily film layer. Observation on 08/27/25 at 9:30 A.M., showed the steam table wells contained a white sediment buildup and food debris floating in the water and the top of the water with an oily film layer. Observation also showed dark mold-like specks along the sides of two of the wells. During an interview on 08/27/25 at 9:30 A.M., [NAME] M said staff take the steamtable outside weekly to drain and clean it and they had last cleaned the steamtable wells on 08/18/25. During an interview on 08/27/25 at 9:35 A.M., the DM said the white sediment buildup is calcium deposits that accumulates quickly due to the facility's hard water. The DM said the steamtable should be drained and cleaned daily, but it is currently cleaned once a week because staff must take it outside and tip it over to dump out the water. The DM said staff must take the steamtable outside to drain and clean it because the wells will no longer drain through the drainpipe due to calcium buildup. The DM said he/she had not tried to remove the calcium deposits from the drain manually or chemically, but he/she had notified maintenance staff on multiple occasions about the drain issue and they had not fixed it to date. During an interview on 08/27/25 at 3:45 P.M., the maintenance assistant said every time the DM reports that the steam table will not drain, he/she goes to the kitchen and manually unclogs the drain. The maintenance assistant said the facility does have hard water that creates a buildup of calcium deposits, but he/she felt the steam table drain issues were related to the staff not cleaning it often enough. The maintenance assistant said dietary staff had not reported any current issues with the steam table drain and he/she did not know it would not drain as designed. During an interview on 08/28/25 at 11:23 A.M., the administrator said the steam table wells should be drained and cleaned after each meal, but at least once a day. The administrator said if something is in need of repair, staff should notify the maintenance staff and if they have notified maintenance staff and the issue is not taken care of, they should notify me. The administrator said no one reported any issues with the draining of the steam table to him/her and he/she did not know staff were only cleaning the steam table once a week. 7. Observation on 08/25/25 at 10:18 A.M., showed the gasket seal on the kitchen chest freezer torn in multiple areas and an excessive accumulation of ice built up on the lid, interior walls and food items stored inside the freezer. Observation on 08/27/25 at 10:53 A.M., showed the gasket seal on the kitchen chest freezer torn in multiple areas and an excessive accumulation of ice built up on the lid, interior walls and food items (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	stored inside the freezer. Observation also showed the exterior of the chest freezer with multiple scratches, dents and areas of rust. During an interview on 08/27/25 at 10:53 A.M. the DM said the gasket seal and ice buildup had been an on-going issue for months. The DM said maintenance staff have repaired it several times, but the repairs do not last long. The DM said he/she also reported the disrepair of the freezer to the administrator and corporate staff. During an interview on 08/27/25 at 3:45 A.M., the maintenance assistant said maintenance staff make repairs to the chest freezer the best they can when dietary staff let them know there is an issue. The maintenance assistant said no one had reported any recent issues with the chest freezer to maintenance staff. The maintenance assistant said they have worked on the freezer multiple times in the past and make the repairs the best they can, but the freezer is old. During an interview on 08/28/25 at 11:23 A.M., the administrator said if something is in need of repair, staff should notify the maintenance staff and if they have notified maintenance staff and the issue is not taken care of, they should notify me. The administrator said he/she knew about the poor condition of the chest freezer and intended to replace it, but he/she forgot. 8. Observation on 08/25/25 at 10:40 A.M. and 08/27/25 at 11:11 A.M., showed six ceiling vents and a small tabletop fan, which were located over food preparation and dishwashing stations in the kitchen, with a buildup dirt and debris. During an interview on 08/27/25 at 3:45 P.M., the DM said the maintenance staff are responsible to clean the kitchen vents and fans and he/she did not know how often they were expected to clean them. During an interview on 08/28/25 at 11:23 A.M., the administrator said the dietary staff are responsible to clean the kitchen vents and fans and they should clean them at least monthly. The administrator said he/she did not know dietary staff thought maintenance staff were responsible to clean them and were not cleaning them. 9. Observation on 08/27/25 at 9:08 A.M., showed the gasket seals torn on the doors to the reach-in refrigerators labeled as #1 and #2. During an interview on 08/27/25 at 9:22 A.M., the DM said he/she did not know about the torn seals on the refrigerators. The DM said he/she is responsible to monitor food storage, which would include the condition of the refrigeration units, and he/she should look at it every day, but he/she had not done so and he/she had not been able to do a lot of his/her duties due to some staffing issues. During an interview on 08/28/25 at 11:23 A.M., the administrator said if there are issue with the refrigerators, staff should document the issue in the maintenance binder to notify maintenance staff. The administrator said the DM is responsible to monitor food storage, which would include the condition of the storage areas daily. The administrator said he/she did not know about the torn gasket seals on the refrigerators or that the DM had not monitored the food storage daily. 10. Observation on 08/27/25 at 4:00 P.M., showed a utility cart with an ice chest stored in the dining room. Observation showed the scoop to dispense the ice from the chest stored uncovered in a container previously used for manufacturer packaged ice cream. Observation showed the container (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	did not contain a description or emblem to indicate the container was not a single-service container. Observation also showed the ice scoop for the ice machine stored in an uncovered container with an accumulation of white sediment, debris and water. During an interview on 08/27/25 at 4:15 P.M. the DM said scoops used to dispense ice should be stored in clean covered containers and staff should clean ice machine scoops and bins daily. The DM said upon review of the ice machine's scoop bin, he/she did not believe staff cleaned the scoop and the bin daily as directed. The DM also said he/she did not know they could not reuse the ice cream containers for other food things. During an interview on 08/28/25 at 10:55 A.M., the administrator said scoops used to dispense ice should be stored in clean covered containers and staff should not reuse ice cream containers to store food or food-contact items. The administrator said dietary staff are responsible to clean the ice scoops and bins daily and the DM should monitor their cleanliness daily. The administrator said he/she did not know the issues with the ice scoops and bins or that the DM had not monitored them daily.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, facility staff failed to provide a comfortable and homelike environment for residents, when staff failed to maintain resident rooms. Staff failed to clean and maintain wheelchairs for four residents (Resident #5, #6, #16, and #58) of 24 sampled residents. The facility census was 59. 1. Review of the facility policy titled Maintenance, dated 01/30/24, showed it is the job of all staff to identify areas of concern regarding the maintenance of the building. Preventive maintenance will occur throughout the year. Review of the facility policy titled Maintenance Work Request, dated 01/30/24, showed when a resident, staff member, or family member recognizes the need for maintenance services, a Maintenance Work Request form will be completed by a staff member. Maintenance personnel will review all Maintenance Work Requests daily, Monday through Friday, and prioritize work to be done. All Maintenance Work Requests will be completed within five days of receipt, unless the work needed is of an urgent nature, in which case it will be done as soon as possible. If parts or supplies must be purchased to complete a job, permission to do so must be secured from the administrator in a timely manner. 2. Observation on 08/25/25 at 11:02 A.M., showed resident occupied room [ROOM NUMBER] drywall damaged between bed A and the electrical outlet at the height of the recliner chair and headboard of bed. 3. Observation on 08/25/25 at 3:15 P.M., showed resident occupied room [ROOM NUMBER] doorframe, wall and door with black marks and missing paint. Observation showed the bathroom door to the room had chipped and missing paint. 4. Observation on 08/26/25 at 11:26 A.M., showed resident occupied room [ROOM NUMBER]-bathroom wall and door with missing drywall and paint. Two large missing areas of plaster above bed B with missing paint on the walls by the beds. Plaster sprayed on ceiling in bathroom over sprayed down the wall. Door and doorframe to room has missing and chipped paint. 5. Observation on 08/26/25 at 11:54 A.M., showed resident occupied room [ROOM NUMBER] closet door base trim missing, the bathroom door with a patched hole unpainted and areas of unpainted wall between the beds. Observation showed the bathroom wall with unpainted drywall patch and a cracked window. 6. Observation on 08/26/25 at 2:44 P.M., showed resident occupied room [ROOM NUMBER]-bathroom ceiling with two large water and cracks. 7. Observation on 08/26/25 at 3:08 P.M., showed resident occupied room [ROOM NUMBER] had a broken plastic skid plate on the door, base trim by the bathroom door is peeled away from the wall and missing paint above the base trim. 8. During an interview on 08/28/25 at 1:35 P.M., Certified Nurse Aide (CNA) J said if something needs fixed, staff write it down in the maintenance book at the nurse's station, and then maintenance will sign off on it when it is fixed. The CNA said he/she has noticed missing plaster on the ceilings, and damaged doors and drywall, but can't remember the room. The CNA said the damage he/she has seen in the rooms is not homelike. The CNA said he/she had not filled out a maintenance request this month. The CNA said he/she doesn't really pay attention that much to the walls and doors and she doesn't look up at the ceilings. 9. Review of the facility Maintenance Book, dated August 2025, showed three maintenance tickets for the month of August, each signed as completed by the Maintenance Director. During an interview on 08/28/25 at 2:30 P.M., Licensed Practical Nurse (LPN) F said staff should write things that need fixed in the maintenance book at the nurse's station. The LPN said he/she has seen the damaged walls and doors in the rooms and has not reported it this month. The LPN said he/she has seen the rubber base trim coming off the walls and reported it a long time ago, it has been that way for a while. During an interview on 08/28/25 at 3:58 P.M., the Director of Nursing (DON) said staff should put things that need to be fixed in the maintenance log. The DON said he/she has noticed some of the damage in the rooms. The DON said the administrator is responsible to make sure maintenance request are followed up on. The DON said he/she has completed maintenance request, but does not remember what for and he/she does not remember the specific rooms she seen things in as she is in (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	and out of so many rooms every day. The DON also said she does not look at the ceilings when she goes in rooms. During an interview on 08/28/25 4:43 P.M., the maintenance director said staff should submit a work order in the book at nurse's station. The maintenance director said he/she looks at the book every day and completes the requests. The maintenance director said he/she signs and dates the work orders the day it is completed. The maintenance director said he/she thinks the administrator goes through and looks at work orders in the book. The maintenance director said he/she leaves all work orders in the book, even after completed. The maintenance director said the three work orders in the book for august is all he/she has had for august. The maintenance director said he/she had not been told about missing ceiling plaster, base trim off walls and he/she hasn't got back to painting the patches on the doors, and walls. During an interview on 08/28/2025 at 5:02 P.M., the administrator said he/she has a maintenance book at nurse's station that staff can write concerns in. The administrator said maintenance should check the book daily, and once done with work orders, maintenance need to sign off on it. The administrator said he/she is responsible to make sure maintenance is completing work orders. The administrator said staff has reported damage to the walls, doors, and ceilings in the resident's rooms. The administrator said he/she told corporate, he/she needed a new window, for the cracked window, and he/she has let it fall through the cracks. 10. Review of the facility policy titled Wheelchair Maintenance and Cleaning, dated 05/01/25, showed daily, nursing staff will wipe down high-touch areas (armrests, seat belts, brakes, and push handles) using facility-approved disinfectant wipes. Spills, body fluids, or visible soil must be cleaned immediately. Weekly housekeeping staff will perform a more thorough cleaning of all wheelchair surfaces, including seat cushions, frames, footrests, and wheels. 11. Observation on 08/25/25 at 8:14 A.M., showed Resident #5 sat in his/her wheelchair in the dining room. Observation showed the lower part of the wheelchair had built up dirt and food debris. The front of the wheelchair had an orange pool noodle taped to the front and the tape dirty and peeled away. During an interview on 08/26/25 at 10:03 A.M., the resident said he/she has never seen anyone clean his/her wheelchair. He/She said it bothers him/her the wheelchair has dirt and food debris all over.12. Observation on 08/25/2025 at 3:37 P.M., showed Resident #6 sat in his/her wheelchair in the day room. Observation showed the foot pedals and wheels covered in dried food. The frame had a buildup of an unknown dark substance.Observation on 08/26/2025 at 10:43 A.M., showed the resident's wheelchair foot pedals and wheels covered in dried food. The wheelchair frame had a buildup of an unknown dark substance, the brake had a clump of hair and dried food on the wheelchair cushion. 13. Observation on 08/28/25 at 8:32 A.M., showed Resident #16 in his/her wheelchair in the dining room. Observation showed the wheelchair frame with built up dirt and debris.14. Observation on 08/26/25 at 12:47 P.M., showed Resident #58 in his/her wheelchair in the dining room. Observation showed the lower part of the wheelchair with built up dirt and debris.15. During an interview on 08/28/25 at 2:02 P.M., CNA J said the night shift CNAs are supposed to clean the wheelchairs. He/She said he/she is not sure how often, but he/she thinks there is a wheelchair cleaning schedule in the shower book at the nurse's station. He/She said he/she is unsure why they are not cleaned.During an interview on 08/28/25 at 2:46 P.M., LPN F said the CNAs on the night shift are supposed to clean the wheelchairs. He/She said he/she thought so many wheelchairs are supposed to get cleaned every night, but he/she is unsure of the actual schedule. He/She said he/she expects staff to wipe off food splatter and debris if they see it on the wheelchairs. He/She said he/she has noticed dirty wheelchairs and have passed the information along to night shift nurse in report.During an interview on 08/28/25 at 2:30 P.M., the Housekeeping Manager said he/she tries to clean wheelchairs when he/she has some spare time. He/She said he/she will take the wheelchairs to the shower room and wipe them down with a spray and bleach cleaner. He/She said he/she is unaware of any wheelchair cleaning schedule; he/she just tries to help clean them when he/she can. He/She was not aware that in the policy it said housekeeping is to do a deep cleaning of the wheelchairs weekly.During an interview on 08/28/25 at 4:04 P.M., the DON said the night shift CNAs are responsible for cleaning the wheelchairs weekly. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	He/She said he/she was not aware that per policy housekeeping is to clean them weekly. He/She said he/she is not sure why wheelchairs are not getting cleaned. He/She said it is the charge nurse's responsibility to ensure the night shift aides are cleaning them.During an interview on 08/28/25 at 5:15 P.M., the administrator said night shift aides are to wipe the wheelchairs down while the residents sleep every night. He/She said housekeeping does deep clean the wheelchairs. He/She said it is the DON's responsibility to ensure wheelchairs are getting clean.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, facility staff failed to review and revise the care plan for three residents (Resident #6, #38 & #55) with diagnoses and/or activity preferences out of 24 sampled residents. The facility census was 59. 1. Review of the facility policy titled Comprehensive Care Plan, dated 01/30/24, showed each resident will have a person-centered comprehensive care plan developed and implemented to meet his/her preferences and goals and address the resident's nursing, medical, physical, mental, and psychosocial needs identified in the comprehensive assessment. The comprehensive care plan will be developed by the interdisciplinary team using the Minimum Data Set (MDS), a federally mandated assessment tool, to assess the resident's clinical condition as well as cognitive and functional status and the use of services. The comprehensive care plan will be reviewed and revised, based on changing goals, preferences and needs of the resident and in response to current interventions, by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. 2. Review of Resident #6's Significant Change MDS, dated [DATE], showed staff documented activities of interest as follows: -Snacks between meals;-Staying up past 8 P.M.;-Listening to music;-Being around animals such as pets;-Participating in favorite activities;-Spending time outdoors. Review of the resident's care plan, revised 08/19/25, showed the care plan did not contain guidance for activities of interest.During an interview on 08/28/25 at 1:35 P.M., Certified Nursing Aide (CNA) J said the residents' activities of interest should be on the care plan. The CNA said the MDS Coordinator is responsible for updating resident care plans. During an interview on 08/28/25 at 2:30 P.M., Licensed Practical Nurse (LPN) F said the resident's activities of interest should be care planned. The LPN said the MDS Coordinator is responsible to put information in care plan, he/she takes information from morning meetings.During an interview on 08/28/25 at 3:23 P.M., the MDS Coordinator said he/she has not done activities of interest for resident care plans before. The MDS Coordinator said the resident's activities of interest is important to their care. During an interview on 08/28/25 at 3:58 P.M., the Director of Nursing (DON) saidCare plan is for resident care. Anything that pertains to that resident should go on care plan. MDS coordinator is responsible to create and update care plans. During an interview on 08/28/25 at 5:02 P.M., the administrator said the resident's activity preferences should be on the care plan. 3. Review of Resident #38's Annual MDS, dated [DATE], showed staff assessed the resident as severe cognitive impairment, diagnosis of diabetes mellitus, and received insulin.Review of the resident's Physician Order Sheet (POS), dated August 2025, showed an order for Insulin Aspart injection pen, inject 36 units once a day. Review of the resident's care plan, dated 08/13/25, showed the care plan did not contain direction for diabetes.During an interview on 08/28/25 at 1:42 P.M., Restorative Aide/CNA J said diabetes should be on the care plan so staff know if a resident is a diabetic in case the resident is acting different, their sugar may be low, and staff can alert the nurse. During an interview on 08/28/25 at 2:51 P.M., LPN F said diabetes should be recorded on the care plan, so staff know what to watch for, or if they get insulin, in case their blood sugars drop. During an interview on 08/28/25 at 3:23 P.M., the MDS Coordinator said care plans should include diagnoses such as diabetes and whether a resident requires insulin. He/she did not know the diagnosis was not on the care plan, he/she said it used to be. During an interview on 08/28/25 at 3:58 P.M., the DON said care plans are used for resident care and anything that pertains to the resident like diagnoses, diabetes, or if they use insulin. The DON said the MDS Coordinator is responsible for creating and updating care plans, and he/she is responsible for making sure he/she does it. During an interview on 08/28/25 at 5:09 P.M., The Administrator said diabetes should be listed on the care plan, because they have special diets and may use insulin. He/she said the DON would be responsible for ensuring care plans are updated since he/she oversees the MDS coordinator. 4. Review of Resident #55's MDS, dated (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	[DATE], showed staff assed the resident as: -Received as needed pain medication;-Had pain occasionally over the last five days;-Pain affected sleep over the last five days;-Pain occasionally affected the resident's day to day activities over the last five days;-Pain score of 5 (What does this mean?);-Received Opioid medication seven out of seven days in the seven day look back period. Review of the resident's POS, dated August 2025, showed an order for pain monitoring, assess for pain every shift, Acetaminophen 325 milligrams, give two tablets every four hours as needed for general discomfort, Tramadol (pain medication) 50 mg, give one tablet every six hours as needed for pain. Review of the resident's care plan, dated 04/17/25, showed the care plan did not contain direction for pain management, to include pharmacological and non-pharmacological interventions.During an interview on 08/28/25 at 1:35 P.M., CNA J said a resident's individualized care for pain, should be on a care plan. During an interview on 08/28/25 at 2:30 P.M., LPN F said pain management should be care planned, with alternative ways to manage pain.During an interview on 08/28/25 at 3:23 P.M., the MDS Coordinator said pain should be addressed on the care plan with interventions. The MDS Coordinator said medication as an intervention, and non-medication interventions should be on care plan. During an interview on 08/28/25 at 3:58 P.M., the DON said pain should be on resident's care plan, with medication and non-medication interventions.During an interview on 08/28/25 at 5:02 P.M., the administrator said pain should be on the care plan with interventions for pain relief.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, facility staff failed to document the required neurological checks (an assessment completed to determine if the nervous system is impaired) and update the plan of care with interventions after falls for four residents (Resident #6, #21, #25 and #34) out of 24 sampled residents. Staff failed to update the fall risk assessment for three residents (Resident #21, #25, and #34) out of 24 sampled residents. The facility census was 59. 1. Review of the facility policy titled Fall Incident Reporting and Neurological Checks Policy, undated, showed the purpose is to ensure timely, accurate reporting and monitoring following any resident fall in order to promote safety, identify causes, prevent recurrence, and promptly detect and manage potential injuries, especially head trauma. All resident falls, whether witnessed or unwitnessed, must be immediately reported, documented, and followed by a comprehensive assessment, including neurological checks when head trauma is suspected, or the fall was unwitnessed. The procedure is as follows: -Notify the licensed nurse immediately if unlicensed staff discover the fall; -Complete an incident report immediately including date, time, and location of fall, circumstances leading up to the fall (witnessed/unwitnessed), description of event and findings on assessment, interventions provided and resident response, notifications made (physician, family, Director of Nursing (DON)); -Enter progress note in resident's medical record. Neurological checks (assessments) are required for any fall with head strike (witnessed or suspected), any unwitnessed fall, and residents on anticoagulant therapy regardless of apparent injury. The frequency for neurological checks are every 15 minutes for one hour; every 30 minutes for two hours; every one hour for four hours; every four hours for 24 hours; and every eight hours for an additional 72 hours as indicated (per physician order or facility protocol). Assess and document level of consciousness/alertness, orientation and speech, pupils (size and reaction), limb strength and movement, vital signs (blood pressure, pulse, respirations), pain, nausea/vomiting, headache, dizziness, or changes in behavior; any abnormal findings must be immediately reported to the physician. Post-fall follow up includes update the resident's care plan with new interventions; and all staff will receive training on fall response, incident reporting, and completion of neurological assessments annually and upon hire. 2. Review of Resident #6's Quarterly Minimum Data Set (MDS), a federally mandated assessment tool, dated 06/25/25, showed: -Severe cognitive impairment;-Used a wheelchair;-Had not fallen. Review of the resident's medical record showed staff documented: -Fall Note, dated 06/4/25, resident fell out of wheelchair. Staff went to push wheelchair forward and resident fell forward. Head impacted on front of nurses' station. Abrasion to scalp in hairline. Review showed staff did not complete any neurological checks after the fall;-Fall Note, dated 08/12/25, staff documented while making rounds found resident on the floor next to the bed laying on his/her right side. Small abrasion to right upper forehead and right upper eyebrow. Review of the resident's 72-hour neurological checks documentation showed staff did not document 4 out of the 15 required neurological checks. Review of the resident's Care Plan, revised 08/19/25, showed staff did not document fall interventions for the falls on 06/04/25 or 08/12/25. 3. Review of Resident #21's Quarterly MDS, dated [DATE], showed staff assessed the resident as: -Short and long-term memory problems;-Used a wheelchair;-Had falls since admission or prior assessment and had one fall with no injury. Review of the resident's medical record showed staff documented the resident had an unwitnessed fall on 07/14/25 with no injuries. Review showed the medical record did not contain documentation staff completed neurological checks. Review of the resident's Physician Order Sheet (POS), dated August 2025, showed an order to complete quarterly fall risk assessments with a start date of 07/29/25. Review of the residents medical record did not contain documentation staff completed the quarterly fall risk assessment. Review of the resident's care plan, dated 8/27/25, showed staff did not document additional fall interventions after the (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	07/14/25 fall. 4. Review of Resident #25's Significant Change MDS, dated [DATE], showed staff assessed the resident as: -Severely cognitively impaired;-Used a wheelchair;-Had not fallen since admission or prior assessment. Review of the resident's POS, dated August 2025, showed an order to complete quarterly fall risk assessment with state date of 01/9/2025. Review of the resident's medical record showed staff documented the resident had an unwitnessed fall with no injury on 07/14/25. The medical record did not contain documentation of neurological checks or an updated fall risk assessment. Review of the resident's medical record showed staff documented the resident had an unwitnessed fall with no injury on 08/04/25. The medical record did not contain seven of 15 neurological checks or an updated fall assessment. Review of the resident's medical record showed staff documented the resident had an unwitnessed fall with no injury and complained of pain on 08/07/25. The medical record did not contain documentation of neurological checks or an updated fall risk assessment. Review of the resident's medical record showed staff documented the resident had an unwitnessed fall with no injury on 08/17/25. The medical record did not contain documentation of neurological checks or an updated fall risk assessment. Review of the resident's care plan, dated 07/31/25, showed staff did not document the resident's falls and did not provide interventions. 5. Review of Resident #34's admission MDS, dated [DATE], showed staff assessed the resident as: -Severely cognitively impaired;-Used a wheelchair;-Had a fall prior to admission and since admission. Review of the resident's medical record showed an admission Fall Assessment, dated 07/13/25, showed a score of 17. Review of the resident's medical record showed staff documented the resident had an unwitnessed fall with no injury and complaints of shoulder pain on 08/17/25. The medical record did not contain documentation of neurological checks or an updated fall risk assessment. Review of the resident's medical record showed staff documented the resident had an unwitnessed fall with a scalp abrasion and bruise to right middle finger on 08/8/25. The medical record did not contain documentation of a neurological checks. Review of the resident's medical record showed staff documented the resident had an unwitnessed fall with 08/22/25. The medical record did not contain documentation of a neurological checks. Review of the resident's care plan, dated 07/01/25, showed resident is high risk for fall related to confusion, unaware of safety needs; with a goal of resident will not sustain serious injury through the review dates. Staff did not document any interventions and did not list any new interventions after the falls. 6. During an interview on 08/27/25 at 4:46 P.M., the Director of Nursing (DON) said if the neurological checks are not in the system under evaluations, then they were not done. During an interview on 08/28/2025 at 2:02 P.M., Licensed Practical Nurse (LPN) E said if a resident falls, he/she initiates neurological checks if the resident cannot say whether they hit their head. LPN E said the neurological checks should be completed every 15 minutes times four, then 30 minutes times four, then hourly times four, then every four hours times four, then every eight hours for 72 hours. The LPN said all fall follow up charting for 72 hours should be in the progress notes. LPN E said staff keep a report sheet at the nurses' desk that lets him/her know if there has been any falls and the date, so he/she knows if the neurological checks need to be continued. LPN E said if neurological checks are not completed the resident could have a brain bleed or something because the residents on the memory care unit cannot really communicate all that well, so he/she cannot really tell by talking to the residents. LPN E said he/she has noticed that the neurological checks are not always done, but sometimes there is only a Certified Medication Technician (CMT) on the unit that does not have access to the charting. LPN E said the care plans should be updated with interventions after every fall, and it is the MDS Coordinator who updates the care plan, the nurses do not. LPN E said the MDS Coordinator is told about falls during the morning meetings, but he/she has been pulled to another facility recently to work as well, and he/she has missed some morning meetings. LPN E said he/she should let the DON know if there are missing neurological checks so he/she can follow up and he/she does not know if he/she did that. During an interview on 08/28/25 at 3:23 P.M., the MDS Coordinator said as far as he/she knows the nurses can update the care plans, and the care plans should be updated after every fall. He/she said the nurses (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	should document an intervention within an hour of the fall. The MDS Coordinator said he/she takes his/her computer to the morning meetings to update the care plans at that time, and he/she puts the orders in for nursing to do the quarterly fall assessments. The MDS Coordinator believes the DON has in-serviced nursing staff about updating the care plans after falls. He/she did not know the resident's care plans were not updated, and he/she has been covering at a sister facility as well. During an interview at 08/28/25 at 3:58 P.M., the DON said the nurses should document an intervention in the care plan after a fall, and they have been told that. The DON said the nursing staff does not update the care plans because they think they do not know how. The MDS Coordinator is responsible for care plans, and he/she is responsible for overseeing the MDS Coordinator. The DON did not know the residents' care plans were not updated after the falls and they should be. The DON said for unwitnessed falls neurological checks should be completed every 15 minutes times four, every 30 minutes times four, every hour times four, then every four hours times four, then every eight hours for 72 hours. The DON said only nurses are allowed to chart the neurological checks, so if there is a CMT working he/she should notify the nurse out on the floor to complete the neurological checks. He/she said there is a list of residents at the nurses' desk that have had falls and need neurological checks, and it is important to complete them because the resident could have a brain bleed or a fracture, especially on the memory care unit where the residents cannot communicate as well. The DON said staff talk about falls in the morning meetings, and that he/she is responsible for checking to make sure the neurological checks are completed, and he/she did not know they were not being done. During an interview on 08/28/25 4:58 P.M., the Administrator said for unwitnessed falls nursing staff are expected to do neurological checks and treat the resident as if they hit their head; and they should do them for a total of 72 hours. He/she said staff should be completing them to ensure there are not any neurological issues. The Administrator said if there is only a CMT working on the memory care unit, they should contact the nurse on the floor to complete the neurological checks. The Administrator said care plans should be updated after falls, and the charge nurses can do that, he/she does not know why staff are not doing it, it is not only on the MDS Coordinator, and the nurses have been told repeatedly. He/she said the DON would be responsible for ensuring charting and care plans are updated, and he/she did not know neurological checks were not being completed and care plans were not being updated.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, facility staff failed to use proper hand hygiene and provide perineal care in a manner to reduce the risk of infection for four residents (Residents #1, #5, #41 and #55) out of five sampled residents. The facility staff failed to implement appropriate infection control procedures to prevent the spread of communicable diseases when staff failed to screen four staff (Nurse Aide (NA) S, Registered Nurse (RN) P, Certified Medication Technician (CMT) Q and NA R) out of 8 staff sampled for tuberculosis (TB), a contagious, air-borne bacterial infection primarily affecting the lungs, in accordance with facility policy. The Facility census was 59.1. Review of the facility's Hand Hygiene Policy, dated 01/30/24, showed hands should be washed for at least twenty seconds using soap and water under the following conditions:-Before having direct contact with a resident;-After having direct contact with a resident;-After contact with blood, body fluids, excretions, secretions, mucous membranes, or non-intact skin;-After handling items potentially contaminated with blood, body fluids, excretions, or secretions;-Before putting on gloves;-After removing gloves.Review of the facility's Standard Precautions Policy, dated 01/30/24, showed hands must be washed between any task that has the possibility of transferring bacteria from resident to resident. 2. Review of Resident #1's Quarterly Minimum Data Set (MDS), a federally mandated assessment tool, dated 06/26/25, showed staff assessed the resident as cognitively intact, required substantial/maximal assist with toileting, dressing, and bed mobility, and always incontinent of bowel and bladder. Observation on 08/28/25 at 10:10 A.M., showed Certified Nurse Aide (CNA) L entered the resident's room to perform perineal care and assist the resident out of bed. The CNA washed hands and applied gloves, performed perineal care and with the same soiled gloves and applied a clean brief to resident. CNA L removed his/her gloves, did not wash his/her hands and applied new gloves. The CNA dressed the resident, removed his/her gloves and walked out of the room. The CNA did not wash hands before he/she left the resident's room. Observation showed the CNA re-entered the residents room, transferred the resident to a wheelchair, combed the resident's hair and cleaned his/her glasses. During an interview on 08/28/25 at 10:28 A.M., CNA L said he/she should have washed his/her hands between gloves changes and before leaving the room. He/She said he/she usually washes his/her hands in the dirty utility room. The CNA said he/she is unsure why he/she did not wash hands between gloves changes and before leaving resident's room. He/She said that not washing hands is a risk for contamination. 3. Review of Resident #5's Quarterly MDS, dated [DATE], showed staff assessed the resident as cognitively intact, impairment to upper and lower extremities, dependent on staff for bed mobility and toileting, and always incontinent of bowel and bladder. Observation on 08/27/25 at 2:47 P.M., showed NA I entered the resident's room washed his/her hands and applied gloves. He/She transferred the resident to bed with a mechanical lift. NA I performed perineal care and with the same soiled gloves put a clean brief under the resident and applied cream to the resident's buttock. NA I wiped the cream off of his/her soiled gloves onto the resident's clean brief, rolled the resident to his/her back, latched the brief, adjusted the resident's dress, and reattached the mechanical lift sling to the Hoyer with the same soiled gloves on. NA I removed his/her gloves and did not wash hands before he/she left the resident's room with a trash bag in hand went to another resident's room. 4. Review of Resident #41's Quarterly MDS, dated [DATE] showed staff assessed the resident as severe cognitive impairment, impairment to upper and lower extremities, dependent for bed mobility and toileting, and always incontinent of bowel and bladder. Observation on 08/27/25 at 2:27 P.M., showed NA I entered the resident's room, washed his/her hands and applied gloves. NA I cleansed stool from a round pillow with wipes, removed his/her gloves and did not wash his/her hands before he/she left the room to get new sheets. NA I returned to the room washed hands, applied gloves, and cleansed stool from the resident's buttocks. The NA wiped stool off his/her gloves and continued to wipe the resident. The NA put cream on his/her soiled gloves, applied it to (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the resident's buttocks, put a clean sheet under the resident, performed perineal care and applied cream to the resident. During an interview on 08/27/25 at 3:07 P.M., NA I said he/she should have changed gloves and washed hands between dirty to clean cares, before applying cream to buttock, and before leaving the resident's room. He/She said he/she felt that he/she could wipe his/her soiled gloves off with a wipe and it would be okay. He/She said he/she did that. He/She said the risk of not changing gloves or performing hand hygiene is cross contamination. 5. Review of Resident #55's Quarterly MDS, dated [DATE], showed staff assed the resident as cognitively intact, always incontinent of bowel of bladder, required maximal assistance from staff for bed mobility, and dependent on staff for personal hygiene, dressing and bathing. Observation on 08/27/2025 at 10:19 A.M. showed CNA H entered the resident's room to provide perineal care. The CNA washed his/her hands, applied gloves, wiped loose stool from the resident's buttocks and removed the resident's soiled brief. CNA H removed his/her right glove and put a new glove on without performing hand hygiene. Observation showed the resident had another loose stool. The CNA wiped the resident buttocks and placed a clean brief under the resident. The CNA removed his/her gloves, grabbed bags of soiled linens, opened the resident's door, exited the room and did not wash his/her hands. The CNA walked down the hall to the dirty utility room, opened the door, discarded the soiled linens, grabbed a clean incontinence pad and sheets for the resident's bed and returned to the resident's room, where he/she washed his/her hands. 6. During an interview on 08/28/25 at 3:06 P.M., Licensed Practical Nurse (LPN) F said staff should wash their hands upon entering a resident's room, apply gloves, perform care, change gloves from dirty to clean, and wash their hands before they leave the room. The LPN said it is not okay to wipe soiled gloves off with a wipe, apply cream to a glove and then put it on the resident. The LPN said it is an infection control concern. During an interview on 08/28/25 at 4:31 P.M., the Director of Nursing (DON) [NAME] if staff get stool on their gloves, staff should remove their gloves, wash their hands and put on clean gloves. Staff should change their gloves from dirty to clean tasks and is not acceptable to wipe stool off of gloves and then use the same gloves to apply cream to a resident. Staff are expected to wash their hands before they leave a resident's room, and they are not washing their hands and changing their gloves that is an infection control concern. During an interview on 08/28/25 at 5:37 P.M., the administrator said he/she expects staff to wash their hands upon entering the room and when they apply clean gloves. He/She said once gloves are soiled, he/she expects staff to remove the gloves and wash their hands before applying new gloves. He/She said it is not acceptable to use soiled gloves to apply cream to a resident or touch other things in the residents' rooms. 7. Review of the facility's Employee Tuberculosis Screening Policy, dated 01/30/24, show upon employment, the employee will receive 0.1 milliliter of Tuberculin Units intradermally (under the skin) on the forearm; this is step one. The employee is then instructed to return for the TB reaction reading in forty-eight to seventy-two hours. The Employee is not to have resident contact until after the results of the first skin test have been obtained. If the first skin test is negative, a second skin test is given within fourteen days after the original test; this is step two. If the second test is negative, a screen will be performed annually thereafter. 8. Review of NA S's personnel records showed a hire date of 01/28/25. Review of the NA's personnel record did not contain documentation staff administered the second TB test. During an interview on 08/28/2025 at 10:24 A.M., the DON said he/she can't saywhy the NA did not receive a two-step TST, it just got overlooked. 9. Review of RN P's personnel records showed a hire date of 02/10/25. Review of the RN's personnel record did not contain documentation staff administered the second step TB test. 10. Review of CMT Q's personnel records showed a hire date of 08/16/25, and the first day he/she worked on the floor as 08/16/25. Review showed the records contained documentation of a negative two-step TST with the first step administered on 08/15/25 and results not read until 08/18/25. Review of the CMT's personnel record did not contain documentation staff administered the CMT's second step TB test. During an interview on 08/28/2025 at 10:24 A.M., the DON said he/she had no answer for why the CMT worked the floor before his/her first step had been read. 11. Review of NA (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R's personnel records showed a hire date of 02/20/25, and the first day he/she worked on the floor as 02/25/25. Review showed the records contained documentation of a negative two-step TST with the first step administered on 02/20/25 and read on 08/22/25. Review of the NA's personnel record did not contain documentation staff administered the second step TB test. During an interview on 08/28/25 at 10:07 A.M., the BOM said payroll showed NA R's first date he/she worked on the floor as 02/25/25. During an interview on 08/28/2025 at 10:24 A.M., the DON said the NA's second step test was just overlooked.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, facility staff failed to provide care and services in a dignified manner, when staff propelled one resident (Resident #55) of a sample of 24 residents, down the hall backwards in a mechanical chair and left one resident (Resident #6) of a sample of 24 residents, in the dayroom with clothes soiled with food debris. The facility census was 59.1. Review of the facility's policy titled, Protecting, Promoting and Ensuring Resident Rights-Facility Responsibility, undated, showed each resident has the right to a dignified existence. All staff will be advocates for resident rights. Review of the facility's policy titled, Resident Rights, undated, showed staff should ensure that resident rights are respected, protected, and promoted. Staff should inform residents of their rights and provide an environment in which they can be exercised. Residents do not leave their individual personalities or basic human rights behind when they move to a long-term care facility. This facility will treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his/her quality of life and recognizes each resident's individuality. 2. Review of Resident #55's Quarterly Minimum Data Set (MDS), a federally mandated assessment tool, dated 07/19/25, showed staff assed the resident as: -Cognitively intact; -Used a wheelchair; -Dependent on staff members to propel him/her in a wheelchair. Observation on 08/25/25 at 12:18 P.M., showed Nurse Aide (NA) I pulled the resident out of his/her room backwards in a mechanical chair, and then pulled the resident down the full length of the hallway, to the administrator's office. The resident yelled and cussed while staff pulled him/her down the hall backwards. During an interview on 08/28/2025 at 11:33 A.M., the resident said staff dragging him/her down the hall backwards, bothered him/her. The resident said it embarrassed him/her and made him/her feel unsafe because he/she doesn't know if the staff is going turn the chair over. During an interview on 08/28/25 at 1:35 P.M., Certified Nurse Aide (CNA) J said staff should not pull a resident down the hall in a mechanical chair backwards, it's not safe and it's degrading. During an interview 08/28/25 at 2:30 P.M., Licensed Practical Nurse (LPN) F said staff should not pull a resident down a hall backwards in a mechanical chair, it is unsafe, and residents can't see where they are going. It's not dignified. During an interview on 08/28/25 at 3:58 P.M., the Director of Nursing (DON) said staff should never pull a resident down the hallway backwards, it is a dignity issue. The DON said staff should propel the resident forward so they can see where they are going. During an interview on 08/28/25 at 5:02 P.M., the administrator said he/she did see the NA pull the resident backward down the hallway to his/her office. The administrator said he/she told the NA his/her actions were not appropriate and undignified. 3. Review of Resident #6's Quarterly MDS, dated [DATE], showed: -Severe cognitive impairment;-Impairment to one side of upper extremities;-Impairment to both sides of lower extremities;-Used a wheelchair;-Dependent on staff members for eating, bathing, personal hygiene and to propel wheelchair 150 feet;-Diagnosis of Dementia. Observation on 08/26/25 at 10:43 A.M., showed the resident in a wheelchair in the dayroom by the nurse's station with dried food debris down the front of his/her shirt. Observation showed five other unidentified residents were in the dayroom with the resident. Observation on 08/26/25 at 2:24 P.M., showed the resident in his/her wheelchair, in the dayroom with pureed meat on both pant legs. Observation showed other residents in the dayroom. Observation on 08/27/25 at 9:34 A.M., showed LPN F propelled the resident out of the dining room and to the dayroom with other unidentified residents. The LPN left the dayroom. Observation showed food dribbled out of his/her mouth, down his/her chin, and down the front of his/her shirt. Observation showed Resident #8 wiped Resident #6's mouth and chin. Observation at 9:38 A.M., showed NA I wiped the resident's mouth and shirt. The NA then left the resident in the dayroom with food stains down the front of his/her shirt. Observation at 10:32 A.M., showed the resident is still in his/her wheelchair in the dayroom, with other (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	unidentified residents. Observation on 08/27/25 at 2:29 P.M., showed the resident in his/her wheelchair in the dayroom with other unidentified residents after lunch. Observation showed the resident has brown liquid down the front of his/her shirt and on pants. Observation on 08/28/25 at 9:45 A.M., showed the resident in a wheelchair, in the dayroom after breakfast, with other unknown residents. The resident has a brown liquid food substance on his/her face and his/her mouth and down the front of his/her shirt. During an interview on 08/28/2025 at 1:35 P.M., CNA J said the resident's cognition is severely impaired. The CNA said food on a resident's shirt and pants is not dignified and the resident should be changed. The CNA said it's not dignified for another resident to wipe food from this resident's face. During an interview on 08/28/25 at 2:30 P.M., LPN F said staff should change the resident clothes if they have food debris on them. The LPN said it is not dignified for the resident to sit in the dayroom with food on his/her clothes. The LPN said the resident is severely cognitively impaired. During an interview on 08/28/25 at 3:58 P.M., the DON said the resident has severe cognitive impairment. The DON said it is not dignified to leave the resident in the dayroom, with food on his/her clothes. The DON said staff should have changed him/her and not left him/her like that. During an interview on 08/28/25 at 5:02 P.M., the administrator said it is not dignified to leave the resident in the dayroom, with food on the front of his/her clothes. The administrator said staff should have taken the resident to his/her room and changed his/her clothes.

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Aspire Senior Living Jonesburg	308 Cedar Avenue Jonesburg, MO 63351

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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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, facility staff failed to consistently document the code status as Do Not Resuscitate (DNR) or Full Code - Cardiopulmonary resuscitation ((CPR) an emergency procedure that combines chest compressions and rescue breathing to restart a person's breathing and heartbeat) on the face sheet, and/or Physician Order Sheet (POS) for five residents (Resident #20, #25, #34, #42 and #53) out of 24 sampled residents. The facility census was 59.1. Review of the facility policy titled Basic Life Support/CPR, dated [DATE], showed the purpose is to ensure this facility is able to, and does provide, emergency basic life support when needed, including CPR, to any resident requiring such care prior to the arrival of emergency medical personnel in accordance with related physician orders, such as DNR and the resident's advance directives. Potential rescuers will initiate CPR, in addition to calling 911, unless a valid DNR order is in place; and the facility staff must provide basic life support, including CPR, prior to the arrival of emergency medical services in accordance with the resident's advance directives and any related physician order, such as code status. 2. Review of Resident #20's Quarterly Minimum Data Set (MDS), a federally mandated assessment tool, dated [DATE], showed staff assessed the resident as cognitively intact. Review of the resident's care plan, dated 08/25, showed staff documented the resident's code status as Full Code (provide CPR). Review of the resident's face sheet (a summary document that provides essential patient information), undated, showed staff did not document the resident's code status. Review of the resident's Physician Order Sheet (POS), dated [DATE], showed the resident did not have a physician order for code status. Review of the resident's medical record showed an advance directive dated [DATE]. Review showed the resident to be a full code. 3. Review of Resident #25's Significant Change MDS, dated [DATE], showed staff assessed the resident as severely cognitively impaired. Review of the resident's care plan, dated [DATE], showed staff documented the resident's code status as DNR. Review of the resident's face sheet, undated, showed staff did not document the resident's code status. Review of the resident's POS, dated [DATE], showed the resident did not have a physician order for code status. Review of the resident's medical record showed a signed DNR form dated [DATE]. 4. Review of Resident #34's admission MDS, dated [DATE], showed staff assessed the resident as severely cognitively impaired. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the resident's care plan, dated [DATE], showed staff documented the resident's code status as DNR. Review of the resident's face sheet, undated, showed staff documented the resident's code status as DNR. Review of the residents POS, dated [DATE], showed the resident did not have a physician order for code status. Review of the resident's medical record showed a signed DNR form dated [DATE]. 5. Review of Resident #42's MDS tracking record, dated [DATE], showed the resident was admitted to the facility on [DATE]. Review of the resident's face sheet, undated, showed staff did not document the resident's code status. Review of the resident's POS, dated [DATE], showed the resident did not have a physician order for code status. Review of the resident's medical record showed a signed DNR form dated [DATE]. 6. Review of Resident #57's Quarterly MDS, dated [DATE], showed staff assessed the resident as severely cognitively impaired. Review of the resident's care plan, dated [DATE], showed staff documented the resident's code status as DNR. Review of the resident's face sheet, undated, showed staff did not document the resident's code status. Review of the resident's POS, dated [DATE], showed the resident did not have a physician order for code status. Review of the resident's medical record showed a signed DNR form dated [DATE]. 7. During an interview on [DATE] at 1:57 P.M., Certified Nurse Aide (CNA) C said the code status would be in the chart, on the resident's face sheet, or he/she can ask the nurse; and it would also be on the care plan. CNA C said residents have color coded dots next to their name plates by their rooms and he/she would know from that as well. During an interview on [DATE] at 2:02 P.M., Licensed Practical Nurse (LPN) E said code status is found on the resident's Medication Administration Record (MAR), or there is a book at the nurse's desk that has code statuses. LPN E said the code status should be on the care plan, and there should be a physician order; and nursing is responsible on admission to enter the order. If the resident changes their code status, then the Social Services Director (SSD) lets him/her know, and he/she puts the order in the computer; and the face sheets updates when the order is put in. LPN E said he/she was not aware the residents did not have an order for their code status, and it would be important to have that so staff would know what to do if a resident were to code. He/she said staff (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	would have to start CPR because without an order it would be assumed they are a Full Code. LPN E said without an order CPR may be done on someone who did not want it, or not done on someone who did want CPR. During an interview on [DATE] at 3:58 P.M., the Director of Nursing (DON) said there are color coded dots outside the resident's door, and their code status should be in the charting and on the face sheet. The DON said there should be an order and the nurse who admits the resident is responsible for entering the order. The DON said without an order staff could end up doing CPR on someone who does not want it, or not do it on someone who does want it. The DON said the SSD goes through the book to make sure it is updated, he/she did not know the residents were missing physician orders and ultimately it is his/her responsibility to ensure there are orders for code status. During an interview on [DATE] at 4:58 P.M., the administrator said there are color coded dots on the name plate, the code status can be found on the face sheet, and there should be a physician order. The nurses put the orders in the computer; and the DON is responsible to ensure the nurses are putting the orders in. The Administrator said without an order for code status staff could do CPR on someone who does not want it, or not do CPR for someone who does want it; and he/she did not know residents were missing code status orders. He/she said the SSD and admission Coordinator go over it on admission with the advanced directive and give the information to the nurses to put in the computer.

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, facility staff failed to obtain signed consent for bed rail use and failed to assess three residents (Resident #2, #5 and #15) out of four sampled, for bed rail use. The facility census was 59. 1. Review of the facility's policy titled Bed Rail, dated 01/30/2024, showed bed rails are adjustable metal or rigid plastic bars that attached to the bed. Examples of bed rails include grab bars, assist bars, side rails, and safety rails. Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. The Facility should maintain evidence that is has provided sufficient information so that the resident or resident representative could make an informed decision. The Facility will assess the resident's need for bed rails, documentation in the resident's record will reflect this assessment and related information. 2. Review of Resident #2's Significant Change Minimum Data Set (MDS), a federally mandated assessment tool, dated 07/28/25, showed staff assessed the resident as follows: -Moderate cognitive impairment;-Lower extremity impairment on one side;-Dependent with toileting, and transfers;-Dependent with rolling left and right, sit to lying, and lying to sitting on bed side.Review of the resident's bed rail assessment, dated 07/14/25, showed the assessment did not contain recommendations for turn bars or assist bars.Review of the resident's medical record showed the record did not contain a signed informed consent from the resident or resident representative for the use of bed rails.Observation on 08/25/25 at 11:02 A.M., showed the resident in bed with both bed rails in the upright position. Observation on 08/26/25 at 8:25 A.M., showed the resident in bed with both bed rails in the upright position.Observation on 08/27/25 at 8:45 A.M., showed the resident in bed with both bed rails in the upright position.Observation on 08/28/25 at 8:34 A.M., showed the resident in bed with both bed rails in the upright position. 3. Review of Resident #5's Quarterly MDS, dated [DATE], showed staff assessed the resident as: -Cognitively intact;-Upper and Lower Extremity impairment on both sides;-Dependent with bed mobility, toileting, and transfers.Review of the resident's bed rail assessment dated [DATE], showed the assessment did not contain recommendations for turn bars or assist bars.Review of the resident's medical record showed the record did not contain a signed informed consent from the resident or resident representative for the use of bed rails.Observation on 08/25/25 at 11:13 A.M., showed the resident in bed with assist bars in the upright position on both sides. Observation on 08/26/25 at 8:29 A.M., showed the resident in bed with assist bars in the upright position on both sides. Observation on 08/27/25 at 8:50 A.M., showed the resident in bed with assist bars in the upright position on both sides. Observation on 08/28/25 at 8:36 A.M., showed the resident in bed with assist bars in the upright position on both sides. 4. Review of Resident #15's Quarterly MDS, dated [DATE], showed staff assessed the resident as: -Severe Cognitive impairment;-Upper extremity impairment on one side;-Lower extremity impairment on both sides;-Dependent with bed mobility, toileting, and transfers.Review of the resident's bed rail assessment, dated 07/30/25, showed the assessment did not contain recommendations for turn bars or assist bars. Review of the resident's medical record showed the record did not contain a signed informed consent from the resident or resident representative for the use of bed rails.Observation on 08/25/25 at 11:32 A.M., showed the resident in bed with assist bars in the upright position on both sides.Observation on 08/26/25 at 8:31 A.M., showed the resident in bed with assist bars in the upright position on both sides.Observation on 08/27/25 at 8:51 A.M., showed the resident in bed with assist bars in the upright position on both sides.Observation on 08/28/25 at 8:38 A.M., showed the resident in bed with assist bars in the upright position on both sides. 5. During an interview on 08/28/25 at 2:33 P.M., Licensed Practical Nurse (LPN) F said charge nurses sometimes complete the assessments, but usually the therapy department completes them. The LPN said he/she is unsure (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	who is responsible to obtain informed consent. During an interview on 08/28/25 at 11:25 A.M., the MDS Coordinator said the therapy department is responsible for completing bed rail assessments, and he/she did not know why the residents' assessments did not indicate assist bars. He/She said it is the MDS coordinators responsibility to ensure bed rail assessments are completed accurately by the therapy department. He/She said he/she has never completed a bed rail consent. The MDS coordinator said the older charting system prompted staff to complete the consent, but this one does not. During an interview on 08/28/25 at 11:38 A.M., the Director of Therapy said he/she started completing bed rail assessments in January 2025. He/She said the assessment states whether assist bars are indicated at this time or recommended, and he/she questioned this because if the resident already has the assist bars, then why would they need to be recommended or indicated. He/She said the MDS Coordinator is responsible for obtaining bed rails consents. During an interview on 08/28/25 at 4:12 P.M., the Director of Nursing (DON) said residents should have consents for bed rails use. He/She said the bed rail assessment did make it sound like the residents did not utilize assist bars. He/She said it is the DON's responsibility to oversee and ensure that everything is obtained and charted accurately. During an interview on 08/28/25 at 5:19 P.M., the administrator said he/she was not aware that bed rail consents needed to be obtained. He/She said he/she knows therapy discusses bed rails with the charge nurses, but he/she is unsure who completes the bed rail assessment. He/She said it is the DON's responsibility to oversee the bed rail assessments.

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F 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Regularly inspect all bed frames, mattresses, and bed rails (if any) for safety; and all bed rails and mattresses must attach safely to the bed frame. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, facility staff failed to complete entrapment assessments and regular inspections of all bed frames, mattresses, and bed rails as part of a regular maintenance program to identify areas of possible entrapment for four residents (Residents #2, #3, #5, and #15) out of four sampled residents. The facility census was 59.1. Review of the facility's policy titled Bed Rail, dated 01/30/24, showed assess the resident for risk of entrapment from bed rails prior to installation. Ensure the bed's dimensions are appropriate for the resident's size and weight. Inspect and regularly check the mattress and bed rails for areas of possible entrapment. Check bed rails regularly to make sure they are still installed correctly as rails may shift or loosen over time. The facility must also conduct routine preventive maintenance of beds and bed rails to ensure they meet current safety standards and are not in need of repair. After installation of bed rails; it is expected that the facility will continue to provide necessary treatment and care, in accordance with professional standards of practice and the resident's choices. Review of the facility's policy titled Bed and Bed rail Maintenance to reduce/prevent entrapment, dated 1/30/24, showed this facility will assess the bed and bed rails for each resident and document such assessment prior to the use of bed rails for every resident. 2. Review of Resident #2's Significant Change Minimum Data Set (MDS), a federally mandated assessment tool, dated 07/28/25, showed staff assessed the resident as follows: -Moderate cognitive impairment; -Lower extremity impairment on one side; -Dependent with rolling left and right, sit to lying, and lying to sitting on bed side. Review of the resident's electronic medical record (EMR), showed the record did not contain an entrapment risk assessment for the use of bed rails, or a maintenance inspection to ensure the bed rails were properly secured to the resident's bed. Observation on 08/25/25 at 11:02 A.M., showed the resident in bed with both bed rails in the upright position. Observation on 08/26/25 at 8:25 A.M., showed the resident in bed with both bed rails in the upright position. Observation on 08/27/25 at 8:45 A.M., showed the resident in bed with both bed rails in the upright position. Observation on 08/28/25 at 8:34 A.M., showed the resident in bed with both bed rails in the upright position. 3. Review of Resident #3's Quarterly MDS, dated [DATE], showed staff assessed the resident as follows: (continued on next page)

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F 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Cognitively Intact; -Required substantial/maximal assistance with bed mobility and transfers; -Dependent with toileting. Review of the resident's EMR, showed the record did not contain an entrapment risk assessment for the use of bed rails, or a maintenance inspection to ensure the bed rails were properly secured to the resident's bed. Observations on 08/26/25 at 3:25 P.M., showed the resident in bed with a half bed rail up on the right side. Observation on 08/27/25 at 10:34 A.M., showed the resident in bed with a half bed rail up on the right side. Observation on 08/28/25 at 1:30 P.M., showed the resident in bed with a half bed rail up on the right side. 4. Review of Resident #5's Quarterly MDS, dated [DATE], showed staff assessed the resident as: -Cognitively intact; -Upper and Lower Extremity impairment on both sides; -Dependent with bed mobility, toileting, and transfers. Review of the resident's EMR, showed the record did not contain an entrapment risk assessment for the use of bed rails, or a maintenance inspection to ensure the bed rails were properly secured to the resident's bed. Observation on 08/25/25 at 11:13 A.M., showed the resident in bed with both assist bars in the upright position. Observation on 08/26/25 at 8:29 A.M., showed the resident in bed with both assist bars in the upright position. Observation on 08/27/25 at 8:50 A.M., showed the resident in bed with both assist bars in the upright position. Observation on 08/28/25 at 8:36 A.M., showed the resident in bed with both assist bars in the upright position. 5. Review of Resident #15's Quarterly MDS, dated [DATE], showed staff assessed the resident as: -Severe Cognitive impairment; -Upper extremity impairment on one side; (continued on next page)

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F 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Lower extremity impairment on both sides; -Dependent with bed mobility, toileting, and transfers. Review of the resident's EMR, showed the record did not contain an entrapment risk assessment for the use of bed rails, or a maintenance inspection to ensure the bed rails were properly secured to the resident's bed. Observation on 08/25/25 at 11:32 A.M., showed the resident in bed with both assist bars in the upright position. Observation on 08/26/25 at 8:31 A.M., showed the resident in bed with both assist bars in the upright position. Observation on 08/27/25 at 8:51 A.M., showed the resident in bed with both assist bars in the upright position. Observation on 08/28/25 at 8:38 A.M., showed the resident in bed with both assist bars in the upright position. 6. During an interview on 08/28/25 at 2:33 P.M., Licensed Practical Nurse (LPN) F said in the old charting system staff were asked for the entrapment measurements, but the new system does not prompt staff to add the measurements. The LPN said he/she did not know who was responsible to complete the assessments, and he/she did not know the assessments should be completed on a regular basis. During an interview on 08/28/25 at 11:25 A.M., the MDS Coordinator said staff does not complete entrapment assessments or measurements. He/She said maintenance puts the assist bars on the bed and nothing is done after that. He/She said the importance of entrapment assessments is to make sure the resident doesn't get entangled in the assist bar. He/She said he/she would expect entrapment measurements completed if assist bars are on the bed. During an interview on 08/28/25 at 11:38 A.M., the Therapy Director said therapy does not complete entrapment assessments. He/She said only bed rails larger than assist bars require measurements. During an interview on 08/28/25 at 12:31 P.M., the Maintenance Director said he/she puts the bed rail on the bed after the resident has been assessed. He/She said he/she doesn't complete any type of measurements with the bed rails. The maintenance director said he/she does not regularly inspect the beds to ensure the bed rails are working properly. He/She said he/she was not aware areas of entrapment should be measured. During an interview on 08/28/25 at 4:12 P.M., the Director of Nursing (DON) said the facility does not have entrapment assessments or measurements, just bed rail assessments. He/She said maintenance is responsible for putting the bed rails on the beds. He/She said not doing entrapment assessments and measurements could put the resident at risk for injury. During an interview on 08/28/25 at 5:19 P.M., the administrator said he/she is unsure who completes entrapments assessments. He/She said maintenance puts the bed rails on the bed. He/She said, I'll be honest I didn't even know there was an entrapment assessment. He/She said he/she does not see (continued on next page)

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F 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	an assist bar as a bed rail. He/She said the risk of not doing entrapment assessments is the resident getting trapped in the bed rail, breaking a bone, dying, or suffocation. He/She said he/she is not sure how often bed rails should be measured or checked but should probably be quarterly and as needed.

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. Based on observation, interview, and record review, facility staff failed to complete the required nurse staffing information to include the facility census. The facility census was 59.1.Review of the facility's policy titled Nurse Staffing Information, dated 01/30/24, showed the facility must post resident census daily at the beginning of each shift in a clear and readable format.2. Review of facility's August daily nurse staffing sheets showed the sheets did not contain a facility census on 08/07, 08/08, 08/12- 08/15, 08/18, 08/19, and 08/25- 08/28/25. 3. Observation on 08/25/25 at 11:49 A.M., showed the facility nurse staff posting located by the nurses' station did not contain a facility census.Observation on 08/26/25 at 10:13 A.M., showed the facility nurse staff posting located by the nurses' station did not contain a facility census.Observation on 08/27/25 at 8:49 A.M., showed the facility nurse staff posting located by the nurses' station did not contain a facility census.Observation on 08/28/25 at 08:35 A.M., showed the facility nurse staff posting located by the nurses' station did not contain a facility census. 4. During an interview on 08/28/25 at 3:00 P.M. Licensed Practical Nurse (LPN) F said the night shift charge nurse fills out the daily staffing sheet. He/She said the daily staffing sheet should include the census, number of staff, and how many hours worked. He/She was not aware the census was not being put on the sheet. He/She said the Director of nursing (DON) oversees that they are getting done daily.During an interview on 08/28/25 at 4:23 P.M., the DON said the night shift charge nurse fills out the daily staffing sheets. He/She said it should include the number of staff, hours worked, date, and census. He/She said he/she was not aware that the census line has been blank. He/She said it is his/her responsibility to ensure the forms are filled out correctly. During an interview on 08/28/25 at 5:25 P.M., the administrator said the night shift charge nurse fills out the daily nurse staffing sheet. He/She said it should include the census, date, total staff and hours worked. He/She said he/she was not aware that census was not being filled out daily. He/She said the DON oversees that the staffing sheet is being completed.