STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265339	A. Building B. Wing	08/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Alpine Breeze Health and Wellness	6124 Raytown Road Raytown, MO 64133

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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 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide activities to meet all resident's needs. Based on observation, interview and record review the facility failed to provide individualized and customized activities based on the resident's previous lifestyle (occupation, family, hobbies), preferences and comforts, failed to ensure to individualized activities for resident who are bed-bound or unable to participate in group activities for one sampled resident (Resident #118) and failed to provide cognitively appropriate activities for residents residing in the memory care unit, out of 29 sampled residents and potential affect all 27 residents residing on the memory care unit. The facility census of 140 residents. Review of the facility's Activities Policy revised on 8/1/25 showed:-The facility will provide an ongoing activity program to support resident choices of activities based on their comprehensive assessment, care plan and preference for each resident. -Activates will be designed with the intent to enhance the resident sense of well-being, belonging and usefulness by: --Promote or enhance, physical activity, cognition, emotional health, self-esteem, dignity, pleasure, comfort, education, creativity, success and independence.--Reflect on the residents, choices, interest and age. -Activities may be conducted in different ways, one-one programs and person appropriate.-Activities can occur at any time and are not limited to formal activities, provided by activities staff. 1. Review of Resident #118's admission Record showed, the resident had diagnosis to include: -Vascular Dementia (is a general term describing problems with reasoning, planning, judgment, memory and other thought processes caused by brain damage.-Schizoaffective disorder, bipolar type, (is a condition characterized by psychotic symptoms (like hallucinations and delusions, as seen in schizophrenia) alongside mood episodes (mania and sometimes depression, as seen in bipolar disorder). -Cognitive Communication deficit (is an impairment in the ability to use and/or comprehend verbal or nonverbal language).Review of the resident's Minimum Data Set (MDS, a federally mandated assessment tool completed by facility staff for care planning) dated 7/30/25 showed: -He/She was moderately cognitive impaired. -Sometimes understand others, rarely able to make his/her needs known. Review of the resident's Activity Log dated July 2025 showed: -The resident resided on long term care units. -For Active participation for social and parties, he/she attended 10 out 18 opportunities. No documentation of the resident's preferred activities or of 1:1 activities offered for the resident.-Refused to attend movies, music, religious services, board games, arts & crafts, and beauty/barber. Observation on 8/13/25 at 12:05 P.M., the resident showed: -He/She was in bedroom lying in bed. -CNA B provided the resident with a lunch meal tray. Observation on 8/18/25 at 7:47 A.M., of the resident showed: -He/She in laid down in his/her bed covered up with blanket. -Would not verbally respond when asked question. Observation on 8/19/25 at 9:40 A.M., of the memory care unit showed:-Resident #118 was in room in bed with blanket covering head. -A few residents in chairs or recliner watching TV in a common area. -There were three resident's walking hallways and wandering around the memory care area. -The activities office was located on memory care unit. -The activities staff were in the room with door shut. -DON and Administrator in the area, along with a CNA and one CMT on unit, interacting with residents or redirecting residents as needed. They were not assisting with resident activities.Review resident's posted activities calendar dated 8/19/25 showed:-Had schedule for arts and craft at 10:30 A.M. for all residents. -Had popcorn social schedule at 1:30 P.M. and puzzles & pondering at 2:30 P.M.Observation the memory care unit on (continued on next page)

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

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	8/19/25 at 10:00 A.M., showed:-Care staff offering water to all the residents. -The DON and Administrator on the unit at that time, walking around the unit, checking on residents and staff.-The Administrator entered the activity room to obtain activities for the residents while the two activity staff were in the activity office away from residents. Observation the memory care unit on 8/19/25 at 10:05 A.M., showed: -The Administrator obtained large playing cards, sat in living area with memory care unit residents to offer activity. -He/She had turned on music and started to dance, as memory care residents got up started to dance also. -Activity Aides were in activity room with the door open and did not participate or interact with the memory care residents while the activity was going on. Observation of Resident #118 on 8/19/25 at 10:26 A.M., showed:-He/She laid in bed had the blanket over his/her head. -The resident did not leave his/her bedroom and activities staff did not attempt to interact or encouraged to participate in activities with the resident at that time. 2. During an interview on 8/18/25 at 2:21 P.M., Certified Nursing Assistant (CNA) B said: -The resident will get up go to bathroom then lay back down. He/She was not aware of any activities provided for Resident #118. -Not aware any activity provided expect for food/snack offered like popcorn.-During memory care unit activities only seen the activity staff member hand out snacks or drinks, normally on their phone in the activity office.-Had not seen ongoing interaction with the residents during schedule activities times.-No planned physical activity/movement or seen interacting with the resident like with remembering when young or daily events.-Had not seen activities utilizing the secure courtyard as did in past. During an interview on 8/19/25 at 9:52 A.M., Activities Aide (AA) A said:-He/She recently hired as Activities Aide, he/she had not attended any special activity training for his/her position as Activities Aide. -He/She had just started working on changing and offering more group activities, individual activities for those residents on memory care and all residents at the facility. -He/She was working on printing off coloring pages for the residents to color if they wish to. -The activities staff were spread thin (short staffed) and only had one person to provide activities at that time. -He/She would document in the facility's activities binder on each resident log sheet if the resident attended or refused to attend activities that day and time. -He/She not aware of any activities plan for those residents that were bed bound residents.-Not aware any special activities for those residents on memory care unit. -The facility had same activities calendar for all resident in the facility. During an interview 8/20/25 at 12:23 P.M., Anonymous staff member said:-He/She said mainly seen activities such as offering popcorn, drinks and other snacks as activities.-He/She has not seen activities staff interacting with the any resident on memory care unit during the snack activity times.-Whenever he/she is assigned to the memory care unit, he/she would ensure they had TV on, has music, game shows or movies. -He/She had not seen activities staff provided one-one activities for those residents who were bed bound or refuse to attend group activities. -He/She would try to plan some daily activities around remember old events or songs that happen in residents time frame and review current daily news.-He/She would expect staff to interact with residents about different topic such as summertime, would ask if they every plant garden, what type of plants etc . During an interview on 8/20/25 at 12:38 P.M., Activities Director said: -Activity staff provide one on one activities for those residents who were bed bound, to include activities such as nail spa day, talking with the resident. -Resident #118 have tried offer and setup activities does not like to attend group offer painting does not like.-Resident #118 was offered nail spa day for the resident today did not want to attend. -Document in the activity log sheet for each resident. During an interview on,08/20/25 2:45 P.M. Director of Nursing (DON) said: -He/She would expect have one-one activities for those residents that were bed bound and unable to attend groups activities.-Would expect to provide more cognitive appropriated activities for those residents on memory care unit such as reading, body movement activity and singing, -He/She would not consider offering snack and popcorn as a positive activity for the resident. -Drinks and snacks should be part of appropriate activity not the sole activity itself. -He/She would expect activity planning be focus on resident preference, likes, hobbies and person center.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation and interview, the facility failed to maintain that all foods were up to date and not expired in the walk in refrigerator; keeping the walk in refrigerator floor dry, ice buildup in the walk in freezer; black hose that connects to the cooling unit was falling apart and had insulation sticking out of it; ice and food on the floor of the walk in freezer. This practice potentially affected 140 residents who ate food from the kitchen. The facility census was 140 residents.Sanitation Inspection policy date implemented 9/1/21 showed:It was the policy of this facility, as part of the department's sanitation program, to conduct inspections to ensure food service area were clean, sanitary and in compliance with applicable state and federal regulations.Policy Explanation and Compliance Guidelines:-All food service areas shall be kept clean, sanitary, free from litter, rubbish and protected from rodents, roaches, flies and other insects.-Sanitation inspections would be conducted in the following manner:--Daily: Food service staff shall inspect refrigerators/coolers, freezers, storage area temperatures, and dishwasher temperatures daily.--Weekly: The dietary manager shall inspect all food service areas weekly to ensure the areas were clean and comply with sanitation and food service regulations.Inspections would be conducted but not limited to the following areas:--Dry storage.--Freezer.--Refrigerator. 1. Observations during the breakfast meal preparation on 8/15/25 from 5:26 A.M. through 8:00A.M., showed:-Expired salad mix with the date expiration date of 7/15/25.-Water on the floor of the walk-in refrigerator.-Ice buildup in the walk-in freezer on the ceiling and floor. -Corn and other food on the rubber rug on the floor of the walk-in freezer. -Black hose that connects to the cooling unit was falling apart and had insulation coming out of it. During interview on 8/15/25 at 5:26 A.M the Dietary Manager (DM) said:-They receive one truck a week and the truck driver would clean out the expired food and restock it with new food.-The kitchen was cleaned every day by staff.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview the facility failed to maintain a faucet in resident room [ROOM NUMBER] in good repair and failed to maintain the cleanout (a capped pipe that provides access to a sewer or drain line, allowing for inspection, cleaning, and maintenance of the system) cover on the 300 Hall secured tightly to the cleanout valve. This practice potentially affected 23 residents and any facility staff who worked on the 300 Hall. The facility census was 140 residents. Observation on 8/13/25 at 10:35 A.M. and 3:39 P.M., showed the cleanout cover moved when it was stepped on.During an interview on 8/13/25 at 3:39 P.M., the Facility Maintenance Director said he/he did not know the cleanout cover needed to be tightened.During a phone interview on 8/26/25 at 12:19 P.M., the Facility Maintenance Director said typically, the facility does not have issues with the cleanout covers so they do not really check them, however if a cleanout cover is reported as loose or slack, they would address it.2. Observation on 8/13/25 at 3:32 P.M. and on 8/15/25 at 9:31 A.M. showed the faucet in resident room [ROOM NUMBER] had a broken handle and a leak in the faucet drainpipe. During an interview on 8/13/25 at 3:33 P.M. the Facility Maintenance Person said he/she did not know about the broken handle or the leak in the pipe from the faucet in resident room [ROOM NUMBER].

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F 0923 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have enough outside ventilation via a window or mechanical ventilation, or both. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, the facility failed to ensure there was negative airflow in required areas such as restrooms and soiled utility rooms in the following rooms: resident room [ROOM NUMBER], 311, 309, 306/307, 306/304, 305, 303, 302/300, 301, 210, 208, 102, 607, 603, 512, 511, 510, 508, 507, 506, 503, 502, 406, 407, 404, This practice potentially affected 44 residents. The facility census was 140 residents. **Note: Air flow was tested by holding one piece of tissue paper to the ceiling vent. If the paper was drawn to the vent, then negative air flow was present; if the paper fell, then negative airflow was absent. 1. Observations on 8/13/25 with Maintenance Person A, showed the following:-At 3:35 P.M. there was the absence of negative air flow in the shared restroom of resident rooms 310/308.-At 3:40 P.M. there was the absence of negative airflow in the restroom of resident room [ROOM NUMBER].-At 3:42 P.M. there was the absence of negative airflow in in the restroom of resident room [ROOM NUMBER].-At 3:46 P.M. there was the absence of negative airflow in the shared restroom of 306/304.-At 3:49 P.M. there was the absence of negative airflow in the restroom of resident room [ROOM NUMBER].-At 3:52 P.M. there was the absence of negative airflow in the restroom of resident room [ROOM NUMBER].-At 3:55 P.M. there was the absence of negative airflow in the shared restroom of resident rooms 302/300.-At 3:56 P.M. there was the absence of negative airflow in the restroom of resident room [ROOM NUMBER]. 2. Observations on 8/14/25 with Maintenance Person B, showed the following:-At 9:26 A.M. there was the absence of negative airflow in the restroom of resident room [ROOM NUMBER].-At 9:29 A.M. there was the absence of negative airflow in the restroom of resident room [ROOM NUMBER].-At 11:30 A.M. there was the absence of negative airflow in the restroom of resident room [ROOM NUMBER].-At 1:33 P.M. there was the absence of negative airflow in the restroom of resident room [ROOM NUMBER].-At 1:37 P.M. there was the absence of negative airflow in the restroom of resident room [ROOM NUMBER].-At 1:49 P.M. there was the absence of negative airflow in the restroom of resident room [ROOM NUMBER].-At 1:57 P.M. there was the absence of negative airflow in the restroom of resident room [ROOM NUMBER].-At 2:02 P.M. there was the absence of negative airflow in the restroom of resident room [ROOM NUMBER].- At 2:05 P.M. there was the absence of negative airflow in the restroom of resident room [ROOM NUMBER].-At 2:08 P.M. there was the absence of negative airflow in the restroom of resident room [ROOM NUMBER].-At 2:12 P.M. there was the absence of negative airflow in the restroom of resident room [ROOM NUMBER].-At 2:39 P.M. there was the absence of negative airflow in the restroom of resident room [ROOM NUMBER].-At 2:50 P.M. there was the absence of negative airflow in the restroom of resident room [ROOM NUMBER]. During an interview on 8/14/25 at 3:10 P.M., Regional Maintenance Supervisor said he/she was not sure why the ventilation worked in some resident rooms and did not work in other rooms. During a phone interview on 8/26/25 at 12:21 P.M., the Facility Maintenance Director said he/she has not checked for negative airflow in the ceiling vents in the resident rooms and the last time he/she remembered negative airflow being checked for, was in 2024 by an assistant maintenance person who was no longer employed at the facility.

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the physician responded to the pharmacist's recommendation for a gradual dose reduction of two psychotropic medications for one sampled resident (Resident #6) out of 29 sampled residents. The facility census was 140 residents.Review of the facility's Medication Regimen Review and Reporting policy and procedure revised 9/2018, showed the Medication Regimen Review is a thorough evaluation of the medication regimen of the resident with the goal of promoting the positive outcomes and minimizing adverse consequences and potential risks associated with medication. The medication review includes review of the medical record in order to prevent, identify, report and resolve medication-related problems, medication errors, or other irregularities. The Medication review also involves collaborating with other members of the Interdisciplinary Care Team, including the resident, family/responsible party. The policy showed:-The consultant pharmacist has access to residents and the resident's medical record and reviews the medication regimen and medical record at least monthly to appropriately monitor the medication regimen and ensure that the medications the resident receives are clinically indicated.-In performing the medication review the consulting pharmacist incorporates federally mandated standards of care in addition to other professional applicable standards.-Resident specific medication review recommendations and findings are documented and acted upon by the nursing facility and /or physician.-The nursing facility follows up on the recommendations to verify that appropriate action has been taken.-For those issues that require physician intervention, the attending physician either accepts and acts upon the report and recommendations or rejects all or some of the report and should document his/her rationale of why the recommendation is rejected in the resident's medical record. 1. Review of Resident #6's Face Sheet showed the resident was admitted on [DATE], with diagnoses including anxiety disorder, personality disorder (a class of mental health conditions characterized by enduring maladaptive patterns of behavior, cognition, and inner experience, exhibited across many contexts and deviating from those accepted by the culture, schizophrenia (a chronic mental illness characterized by a combination of symptoms that significantly impair a person's daily functioning and social relationships), and depression. Review of the resident's Medication Regimen Review on 6/30/25, showed the consultant pharmacist completed the resident's medication review and showed the following: -6/30/25 The resident has been taking Remeron (an antidepressant) 30 milligrams (mg) at bedtime, Cymbalta (Duloxetine-a medication used to treat anxiety and depression) 60 mg daily and Abilify (Aripiprazole-an antipsychotic) 15 mg daily for quite some time now. Please evaluate the current dose and consider a dose reduction. Record review of the resident's Medical Record showed there were no notes or other documentation showing the physician had tried a gradual dose reduction of Cymbalta or Abilify or documented why it was not clinically indicated or in the best interest of the resident to try a gradual dose reduction of these medications. Review of the resident's annual Minimum Data Set (MDS-a federally mandated assessment tool to be completed by facility staff for care planning) dated 7/8/25, showed the resident:-Was alert, oriented and cognitively intact with minimal confusion.-Received antipsychotic and antidepressant medications during the lookback period.-Antipsychotics were used on a routine basis.-A gradual dose reduction had not been attempted.-A gradual dose reduction had not been documented by a physician as clinically contraindicated. Review of the Pharmacy Drug Regimen Review Response dated 7/9/25, showed:-The physician's response, showed agreed and the physician changed the physician's order to Remeron 15 milligrams (mg).-The physician did not respond to the pharmacist's recommendation for a gradual dose reduction for Cymbalta or Abilify. Review of the resident's POS showed a physician's order dated 7/9/25 for Remeron 15 mg at bedtime Review of the resident's Physician's Order Sheet dated August 2025, showed physician's orders for:-Abilify 15 mg daily for anxiety (ordered 4/12/25) was (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	still an active order.-Cymbalta 60 mg daily for depression (ordered 5/15/25; revision date 7/31/25) was still an active order. During an interview on 8/19/25 at 4:17 P.M., Registered Nurse (RN) A said:-The Director of Nursing (DON) or Assistant Director of Nursing (ADON) ensured the recommendations were put in the resident's medical record because the pharmacist's recommendations do not come directly to the Charge Nurses.-If the nurse is made aware of the recommendation, the nurse will notify the physician and if a gradual dose reduction is recommended, they will document the new order.-If the physician does not agree with the gradual dose reduction, the physician will tell them why and they will document that in the resident's medical record.-He/She did not know what the expectation was for the physician to respond to the pharmacist's recommendation. During an interview on 8/20/25 at 1:39 P.M., Licensed Practical Nurse (LPN) A said:-If the nurse gets the recommendation from the pharmacist recommending a gradual dose reduction, they will contact the physician to inform him/her of it.-He/She will follow whatever order the physician gives, whether it's to increase or decrease the medication.-If the physician does not want to follow the pharmacist's recommendation, they usually will tell them they don't want to change the medication, and the nurse will document that in the resident's medical record. During an interview on 8/20/25 at 2:45 P.M., the Director of Nursing (DON) said:-He/She expected the physician to review the pharmacist's recommendations for a gradual dose reduction for each medication documented.-The physician should respond as soon as the recommendation was received, within 7 days of notification or during the month of the review (depending on the recommendation) and document the response in the resident's medical record.-If the physician does not agree with the pharmacist's recommendation, the physician should document the clinical rationale for why he/she does not agree with the recommendation. -After 5 days he/she should contact the physician if there was no response.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure the fall investigation was completely documented and the post fall documentation was correct to show the resident's change in condition after a fall with injury for one sampled resident (Resident #6) and failed to maintain a safe transfer for one sampled resident (Resident #143), out of 29 sampled residents. The facility census was 140 residents. Review of the facility Fall policy and procedure dated 9/1/21, showed each resident will be assessed for fall risk and will receive care and services in accordance with their individualized level of risk to minimize the likelihood of falls. The policy showed: -Each resident's risk factors and environmental hazards will be evaluated when developing the resident's comprehensive plan of care. -When a resident experiences a fall, the facility will assess the resident, complete a post-fall assessment, complete an incident report, notify the physician and family, review the resident's care plan and update as indicated, document all assessments and actions and obtain witness statements in the case of injury. -The document went into no further detail regarding how the staff should documentation on the investigation or post fall assessment or what should be documented. Review of the facility's Safe Resident Handling/Transfers policy dated 9/1/21 showed: -It was the policy of this facility to ensure that residents were handled and transferred safely to prevent or minimize risks for injury and provide and promote a safe, secure and comfortable experience for the resident while keeping the employees safe in accordance with current standards and guidelines. -All residents require safe handling when transferred to prevent or minimize the risk for injury to themselves and the employees that assist them. While manual lifting techniques may be utilized dependent upon the resident's condition and mobility, the use of mechanical lifts were a safer alternative and should be used. -The interdisciplinary team or designee would evaluate and assess each resident's individual mobility needs, taking into account other factors as well, such as weight and cognitive status. -Mechanical lifting equipment or other approved transferring aids would be used based on the residents needs to prevent manual lifting except in medical emergencies. -Mechanical lifts may include equipment such as full body lifts, sit to stand lifts, or ceiling track mounted lifts. -Handling aids may include gait belts, transfer boards, and other devices. -The staff would inspect the equipment prior to use to ensure functionality and would alert maintenance or other designee if the equipment were not functioning properly. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Damage, broken, or improperly functioning lift equipment would not be used and tagged out according to facility policy. -The facility would ensure that there were appropriate amounts of varying sizes of slings to accommodate residents and that residents would be measured correctly as per the manufacturer's instructions on proper sling sizing. -Two staff members must be utilized when transferring residents with a mechanical lift. -Staff would be educated on the use of safe handling/transfer practices to include use of mechanical lift devices upon hire, annually and as the need arises or changes in equipment occur. -Staff must demonstrate competency in the use of mechanical lifts prior to use and annually with documentation of that competency places in their education file. -Staff members were expected to maintain compliance with safe handing/transfer practices. Failure to maintain compliance may lead to disciplinary action up to and including termination of employment. -Resident lifting and transferring would be performed according to the resident's individual plan of care. -Staff would perform mechanical lifts/transfers according to the manufacturer's instructions for use of the device. -Slings would be laundered according to manufacturer's instructions and any damaged, broken or unsafe slings would be removed from service and replaced. -The lift(s) would be cleaned and disinfected according to manufacturer's instructions and after each resident use. 1.Review of Resident #6's Face Sheet showed the resident was admitted on [DATE], with diagnoses including stroke with paralysis on the right dominant side, diabetes, high blood pressure, Chronic Obstructive Pulmonary Disorder (COPD-a condition involving constriction of the airways and difficulty or discomfort in breathing) anxiety disorder, unsteadiness on feet, difficulty walking, high blood pressure, lack of coordination, blindness in one eye, contracture of the right hand and shoulder and abnormal posture. Review of the resident's Care Plan updated 3/14/25 showed the resident was at risk for falls due to unsteady gait/balance, psychotropic medications, and history of falls. It showed the resident had a non-injury unwitnessed fall, had poor balance, poor communication and comprehension, unsteady gait, poor impulse control, and poor decision-making abilities. It showed the resident had a non-injury fall on 3/14/25 while trying to self-transfer. Interventions showed nursing staff would: -Anticipate and meet the resident's needs. -Be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed. The resident needs prompt response to all requests for assistance. -Ensure bolsters are in place. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Alpine Breeze Health and Wellness	6124 Raytown Road Raytown, MO 64133

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Encourage the resident to participate in activities that promote exercise, physical activity for strengthening and improved mobility. -Encourage/remind the resident to use mobility aides (cane and wheelchair) when ambulating/transferring to aide with fall prevention. -Ensure that the resident is wearing appropriate footwear when ambulating or mobilizing in his/her wheelchair. Resident is weight bearing as tolerated when wearing orthopedic boot. -Encourage resident to use his/her call for assistance with transfers. -Post a sign in the resident's room to remind the resident to use his/her call light and/or request assistance with transferring (6/16/20). -Place anti roll-back on wheelchair to prevent the wheelchair from moving with transfers. -Check the resident's range of motion (specify number) times daily. -Continue interventions on the at-risk plan. -Continue current interventions for fall risk intervention include re-education on using call light for all transfers. -For no apparent acute injury, determine and address causative factors of the fall. -Monitor/document/report as needed for 72 hours to the physician for signs and symptoms of pain, bruises, change in mental status, ne onset of confusion, sleepiness, inability to maintain posture, and agitation. -Place the resident in a room with higher visibility for increased supervision. -Encouraged the resident to use his/her call light to ask for assistance (3/14/25). Review of the resident's quarterly Minimum Data Set (MDS-a federally mandated assessment tool to be completed by facility staff for care planning) dated 5/6/25, showed the resident: -Was alert, oriented and cognitively intact with minimal confusion. -Needed substantial to maximum assistance with bathing, dressing, toileting, and mobility. -Had upper and lower impairment on one side and used a wheelchair for mobility. -Needed substantial to maximal assistance to transfer. -Had a non-injury fall since admission. Review of the resident's Incident Report/Fall investigation dated 6/14/25, showed: -The resident had an unwitnessed fall on 6/14/25. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The nurse documented nursing staff observed the resident in his/her room, lying on the floor on his/her right side next to his/her bed. -The resident's mobility status showed the resident was wheelchair bound. -The resident said he/she was trying to transfer to his/her wheelchair and missed it. -The resident was alert, and denied hitting his/her head, and there were no injuries noted at this time. -The resident's range of motion was within normal limits. The resident was able to bear weight on his/her left side. -Nursing staff assisted the resident up and back to bed per his/her request. -Nursing staff encouraged the resident to call for help with transfers and the resident verbalized understanding. -The resident's call light was within reach. -The nurse documented that neurological checks (neurological checkpoints to monitor level of consciousness, ability to move extremities, eye responses and change in pupils and vital signs-temperature, blood pressure, pulse, respirations and oxygen level) were initiated, however the resident's vital signs were not documented on this document. -The nurse documented the notifications to the resident's physician and Director of Nursing (DON) and documented the resident's plan of care was ongoing. -There was a section of the report to document any predisposing factors that could have contributed to the resident's fall (environmental, physiological, situational factors) and there was also space to document any additional information that was related to the fall or notes. These sections were left blank. -The investigation/incident report was incomplete in showing a comprehensive account of the resident's fall. Review of the resident's undated Post Fall Huddle showed: -The resident had an unwitnessed fall on 6/14/25 at 11:55 P.M. -The resident was observed on the floor in his/her room. -He/she was alert and had good judgement. -The lighting in the room was okay, but the resident's vision contributed to his/her fall. -The resident was attempting to transfer prior to his/her fall. -The resident used a wheelchair and needed assistance per his/her care plan. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The document showed areas to be completed that were left blank such as behaviors exhibited, any factors observed at the time of the fall, what footwear the resident was wearing, the last time staff had checked on the resident and what the resident was doing at the time, if the resident was having pain at the time or had received any pain medication prior to the fall and factors observed at the time of the fall. Review of the resident's Care Plan showed updated fall interventions dated 6/14/25 that showed: -Therapy evaluation and treatment (6/14/25). -Educate on locking brakes on wheelchair (6/14/25). -Eye exam (6/14/25). Review of the resident's Fall Risk Score dated 6/15/25, showed a score of 30 (a score of 30 was determined to be at high risk for falling). Review of the resident's Nurse's Note showed on 6/15/25-the nurse documented the resident complained of pain to his/her right knee after his/her fall. The resident had no bruising; some swelling was noted. The physician was notified and new orders for an x-ray (were obtained). Review of the resident's Care Plan showed updated interventions dated 6/15/25, that showed the resident complained of knee pain and the nursing staff obtained an x-ray. Review of the resident's Post Fall Observation dated 6/15/25, showed: -The nurse documented the resident's vital signs. -The resident complained of pain to his/her right knee with movement. -The resident's current pain level was zero and he/she did not complain of new or worsened pain. -An x-ray was ordered, obtained and the conclusion showed the resident had osteoarthritis to his/her right knee. -There had been no reports of swelling, bruising or injury since the event; the resident had no change in mental status, activity of daily living (bathing, dressing, toileting, hygiene) ability or mobility. -There had been no change in physician's orders related to this event and the resident had no change in the resident's sleep pattern. -The nurse included no additional notes or comments. Review of the resident's Post Fall Huddle dated 6/16/25 showed: -This was the follow up to the undated Post Fall Huddle (second page). -The resident was assessed and the assessment showed the resident's vital signs were documented, the resident had no injury, his/her range of motion of upper and lower extremities were within normal (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	limits, and the resident had no pain. -The resident said he/she had a few drinks prior to his/her fall. -The root cause showed the resident would receive further evaluation, was educated on locking his/her wheelchair brakes and obtain an eye exam for the resident. -Immediate interventions was to educate the resident on the dry (substance-alcohol/drug) policy. Review of the resident's Nursing Notes showed: -On 6/16/25 the nurse documented the interdisciplinary team meeting regarding the resident's unwitnessed, non-injury fall was held and they discussed self-transferring. A new intervention to develop a sign posted in the resident's room to remind the resident to use his/her call light and/or request assistance with transferring. The physician and Assistant Director of Nursing (ADON) were notified. -6/17/25 the nurse notified the resident's physician of the results of an x-ray to the resident's right ankle. A new order was obtained for the resident to be on non-weight bearing status and a referral to the orthopedic clinic for follow up evaluation and treatment. An additional note showed the resident's family was notified (at the resident's request) and an appointment was set with the orthopedic clinic. Review of the resident's Care Plan updated showed on 6/17/2025 resident complained of ankle pain-an x-ray was ordered and obtained, and the resident was referred to the orthopedic clinic for follow up. The result of the x-ray noted the resident had a fracture. The resident said he/she attempted to walk to the bathroom and did not request assistance. Review of the resident's Social Service Notes showed on 6/18/25 the Social Services Designee visited with the resident regarding his/her fall with fracture on 6/14/25. The Social Service Designee asked the resident how the fall happened, and the resident said, it just happened. The Social Service Designee asked the resident if he/she was under the influence of alcohol or drugs when he/she fell and the resident denied this. The Social Service Designee educated the resident on the facility policy on illicit substance that alcohol/drugs were not allowed on facility premises. Review of the resident's Post Fall Observation dated 6/18/25, showed: -The nurse documented the resident's vital signs. -The resident's current pain level was zero and he/she did not complain of new or worsened pain, but the resident had physician's orders for Tylenol and Hydrocodone (narcotic) for pain as needed. -There had been no reports of swelling, bruising or injury since the event; the resident had no change in mental status, activity of daily living (bathing, dressing, toileting, hygiene) ability or mobility. -There had been no change in physician's orders related to this event and the resident had no change in the resident's sleep pattern. -The nurse included no additional notes or comments. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Documentation on the report did not show the resident had an x-ray of his/her ankle and results showed the resident sustained a right foot/ankle fracture since the incident, did not show the treatments provided (orthopedic treatment and rehabilitation), change in mobility status or current physician's orders. Review of the resident's Physician's Notes dated 6/19/25, showed the Nurse Practitioner completed a physical examination of the resident and reviewed his/her medical record, labs, medications and current health status. The Nurse Practitioner documented: -The resident's chief complaint at this visit was regarding activity of daily living deficits, mobility, debility, poor endurance, fall risk and right sided paralysis due to stroke. -The resident's plan and progress was discussed with nursing staff and therapy. The resident said: I had a fall a few days ago where I hurt my foot. It has been a 10/10 pain ever since it happened. There was an x-ray and I guess maybe it's broken and I am supposed to go out to an appointment to see a doctor about my foot. I know I am not supposed to put any weight on it, but I do sometimes anyway. The pain is the same no matter if I have taken pain medicine or not. -The resident's current functional status as of 6/18/25 showed the resident had a new onset of a right tibula-fibula fracture (a serious break in the lower leg's two bones. Symptoms include severe pain, swelling, bruising, and the inability to bear weight) with non-weightbearing for right lower extremity. -Due to the resident's inability to maintain non-weightbearing status of right lower extremity, therapy boot was recommended and provided. -The resident's right lower extremity continued to have increased swelling and 10/10 (on a scale from zero to 10, 10 is severe pain) pain. manual resistance. The resident was awake, alert and in no apparent distress. He/she was well-developed, well-groomed and dressed for the day, sitting in his/her wheelchair in the physical therapy gym, receiving therapy. Awaiting transfer to orthopedic appointment this morning. -There was some mild tenderness to palpation of right hand, tenderness to right lower extremity, ankle and foot. -Range of Motion: Functional range of motion in left upper and lower extremities. Limited range of motion in right-sided extremities. The resident used a manual wheelchair to self-propel throughout the facility. -The assessment and plan showed the resident had an unwitnessed fall on 6/14/25, with subsequent right lower extremity pain. The resident got an x-ray to the right ankle on 06/17/25 and a referral to orthopedics was completed. The resident is now non-weightbearing to that right lower extremity. The Nurse Practitioner will continue to provide education about the importance of non-weightbearing status and use of the therapy boot until he/she has been assessed by the orthopedic surgeon. -The resident will continue with skilled therapy services as necessary. Currently, the resident is receiving physical therapy twice a week and has also been receiving some occupational therapy as well. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the resident's undated Fracture Checklist and Timeframe showed: -The resident's fracture was discovered on 6/17/25 at 4:15 P.M. -Swelling was noted to the resident's right ankle and foot. The physician, Administrator, DON and corporate staff were notified and the physician ordered pain medication as needed, to elevate the resident's foot with ice as needed and make an appointment for follow up evaluation with the orthopedic clinic. -The resident had an unwitnessed fall on 6/14/25 while transferring himself/herself in his/her room. This could have contributed to the fracture. After determining the root cause of the fall, risk of alcohol consumption should be reviewed. -The resident received rehabilitation (physical and occupational therapy) three times weekly and had no complaints of pain. Pain is currently being addressed. -There was no device that could have contributed to the fracture. -The resident was interviewed on 6/17/25 and said he/she fell because he/she was drinking and his/her ankle did not hurt. -The summary of the investigation of fracture showed the resident sustained a fracture to his/her right ankle due to an unwitnessed fall on 6/14/25. The resident was going to visit the orthopedic clinic on 6/19/25. Observation on 8/14/25 at 8:10 A.M., showed the resident was sitting in his/her wheelchair in the dining area. On the resident's right foot was a brace from his/her foot to just under his/her knee that was wrapped with a brown bandage. The resident denied pain but did not talk about his/her fall. During an interview on 8/20/25 at 1:25 P.M., Licensed Practical Nurse (LPN) B said: -When a resident has a fall, the nurse will assess the resident for injury and notify the physician and family. -If the fall was witnessed, they will ask the witness for a statement and document what occurred, take the resident's vital signs and assess for injury and follow up as the physician ordered. -If the fall was unwitnessed they will try to get the resident's statement and start neurological checks then assess and follow up with the physician and follow any orders given. -The nurse documents the initial nursing note about the fall and it should be as detailed as possible. -The nurse also completes the incident report and fall risk assessment. -The DON/ADON completed the actual fall investigation. -The nurses complete the post fall assessments. -The post fall assessment required them to document the update of the resident after the resident's (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	fall like positioning in bed, mobility status, pain, change in the resident's condition/health status and any current information related to the resident's fall. -Documentation on the incident report and post fall observation should all be detailed, completed in full and show the status/condition of the resident. It should be comprehensive. During an interview on,08/20/25 2:45 P.M. DON said: -The resident had been drinking alcohol and tried to transfer himself/herself and fell. -They initially did not know that the resident had a fracture, initially the resident complained of knee pain and then later complained of foot/ankle pain and when they obtained the x-ray they discovered a fracture. -The initial Incident Report should be comprehensive and should be completed in full and include any and all information related to the fall. -The investigation should include the root cause of the resident's fall. The interdisciplinary team discussed the resident's fall in the post fall huddle and the root cause was discussed and determined the root cause of his/her fall, but this information was not included on the resident's incident report/fall investigation. -The Post Fall Observation should reflect the updated health status of the resident at the time and should show any changes that have occurred with the resident's care and mobility. 2. Review of Resident #143 admission Sheet dated 3/22/24 showed the following diagnoses: -Morbid (severe) obesity due to excess calories. -Muscle weakness. -Difficulty in walking. -Need for assistance with personal care. Review of the resident's quarterly MDS dated [DATE] showed: -He/She was cognitively intact. -Substantial/maximal assistance for toileting hygiene. -Substantial/maximal assistance for shower/bathe self. -Substantial/maximal assistance for lower body dressing. -Partial/moderate assistance for upper body dressing. -Wheelchair mobility. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation and interview of Certified Nursing Assistant (CNA) D on 8/14/25 at 10:51 A.M. showed: -CNA D was in the process of moving resident in a Hoyer lift by his/herself. -CNA D was moving resident from the bed to a motorized wheelchair. -Resident was in the air over the floor between the bed and the wheelchair when observed. -CNA D continued to attempt to aim the resident over the motorized wheelchair. -CNA D said there were supposed to be two people but did not know when the other staff member was coming. -While in the air the resident asked to be put back into the bed. -CNA D said he/she put the call light on and additional staff would be coming (to assist). -CNA D kept trying to put the resident in the motorized wheelchair. -CNA D had the resident recline the motorized wheelchair by having the resident reach back for the control knob while the resident was still in the air in the Hoyer lift. -The resident leg got caught on the lift and he/she cried out ow. -CNA D fixed the resident's leg and tried to re-adjust the resident. -The resident kept saying ow. -Surveyor asked staff to put the resident back into the bed. -The resident also asked to be put back into bed. -CNA D put resident back into bed. During an interview and observation on 8/14/25 at 11:02 A.M., CNA D said: -This was his/her first day working at this facility. -This was the first resident he/she had to transfer this morning. -He/She said everyone knows you were supposed to have two people when transferring a resident by a Hoyer, but the staff take too long and the resident wanted to get up. During an observation on 8/14/25 at 11:08 A.M. showed: -The resident's call light was still on. -No other staff member showed up to help. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure the catheter bag and tubing (a catheter is a flexible tube inserted through a narrow opening into the bladder for removing fluid. The fluid goes into a collection bag) was kept below the bladder to prevent cross contamination and infection for one sampled resident (Resident #149) out of 29 sampled residents. The facility census was 140 residents. Review of the facility Catheter Care policy and procedure revised 8/1/25, showed it was the facility's policy to ensure that residents with indwelling catheters receive appropriate catheter care and maintain their dignity and privacy when indwelling catheters are in use. The policy showed staff was to ensure the drainage bag was located below the level of the bladder to discourage backflow of urine. 1.Review of Resident #149's Face Sheet showed the resident was admitted on [DATE], with diagnoses including kidney disease, uropathy (any condition that impairs the normal flow of urine through the urinary tract, which includes the kidneys, ureters, bladder, and urethra), and need for personal assistance. Review of the resident's admission Minimum Data Set (MDS), a federally mandated assessment tool to be completed by facility staff for care planning dated 4/28/25, showed the resident:-Was alert, oriented and cognitively intact with minimal confusion.-Used an indwelling catheter for urination. Review of the resident's Care Plan dated 7/31/25, showed the resident had an indwelling catheter. Interventions showed nursing staff should:-Provide catheter care each shift.-Monitor for signs and symptoms of discomfort of urination and frequency, pain, signs and symptoms of urinary infection (and report to physician).-Position the resident's catheter and tubing below the level of the bladder and away from the entrance room door. Review of the resident's Physician's Order Sheet dated August 2025, showed physician's orders for catheter change as needed for leakage, obstruction, accidental removal or when ordered. (8/12/25) Observation on 8/15/25 at 5:43 A.M., showed the resident was laying in his/her bed on his/her back with his/her eyes closed resting comfortably. His/her catheter bag and tubing were laying in the resident's bed at the same level of his/her bladder, between the resident's legs, and was not below the bladder. Observation on 8/15/25 at 8:00 A.M., showed the resident was laying in his/her bed on his back with the cover over his/her head. The resident's catheter bag and tubing were still laying on the bed between the resident's legs at the same level of his/her bladder and not below the bladder. There was yellow fluid in the tubing. During an interview on 8/18/25 at 11:20 A.M. Certified Nursing Assistant (CNA) A said:-When he/she came in to work and went to check on the resident, the resident's catheter bag was always in a different place.-He/She has come into the resident's room and found the resident's catheter bag on the bed and today it was on the floor.-He/She hung the catheter bag on the side of the resident's bed.-Normally the resident's catheter bag was supposed to be hung on the side of the resident's bed, below the resident's bladder at all times.-He/She did not know whether the resident or other staff was placing the catheter bag in different places. -When they go in to check on the resident, they are supposed to check to see if the resident's catheter bag was placed correctly at the side of the resident's bed and below the resident's bladder. During an interview on 8/20/25 at 1:32 P.M., Licensed Practical Nurse (LPN) A said:-The resident's catheter bag should always be below the bladder.-The only reason the catheter bag would be on the bed was the nurse was in process of changing the catheter bag out and there should be a sterile field that the catheter bag is laying on in that scenario, otherwise it should never be on the bed.-The CNA rounds should be every two hours and they should be making sure it is in the right position, is not leaking and is below the bladder.-If the catheter bag is on the floor they should notify the nurse so the bag can be changed. She said it should never be found on the floor. During an interview on 8/20/25 at 2:45 P.M., the Director of Nursing (DON) said:-The resident's catheter bag placement should be below the waist and bladder at all times.-The catheter bag should never be laid on the bed or on the floor.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Alpine Breeze Health and Wellness	6124 Raytown Road Raytown, MO 64133

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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 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure infection control practice with the enteral tube feeding (A medical devices use to provide nutrition to residents who require to resident who cannot obtain nutrition by mouth requiring supplemental nutrition) process of changing the pump tubing every 24 hours for one sample resident (Resident #45), failed to ensure infection control practice wearing Personal Protective Equipment (PPE - is equipment worn to minimize exposure to a variety of hazards. Examples of PPE include such items as gloves, face masks or face shields, respirators, foot and eye protection, and gowns) for residents on Enhanced Barrier Precaution (EBP, for residents with chronic wounds or indwelling medical devices during high-contact resident care activities regardless of their multidrug-resistant organism status.) maintained during direct contract of a resident's with a Percutaneous endoscopic gastrostomy tube (Peg-tube/Feeding Tube (TF), is a flexible tube inserted through the abdominal wall into the stomach) during administration of medications through PEG tube for one sampled resident (Resident #91) and failed to ensure EBP maintained during dressing change and cleaning of Peg tube insertion site for the resident out of 29 sampled residents. The facility Census of 140 residents. Review of the facility's Enhanced Barrier Precaution (EBP) dated 4/23/25 showed: Refer to infection control intervention designed to reduce transmission of Multidrug-resistant organisms (MDROs is a germ that is resistant to many antibiotics) that employs targeted gown, and gloves use during high contact resident care activities that provided opportunities for transfer of germs to staff hands and clothing. -EBP will be obtained for resident with any of the following to include indwelling medical devices, wounds, catheters-High contact resident care activities include not limited to device care or use of feeding tubes wear gown, gloves and face mask as needed for potential of splatter1. Review of Resident #45 admission Record showed the resident admitted with the following diagnoses:-Adult failure to thrive (has a loss of appetite, eats and drinks less than usual, loses weight, and is less active than normal). -Protein-calorie malnutrition (is the state of inadequate intake of food).Review of the resident's Tube Feeding Care Plan dated revised 5/3/25 showed:-The resident dependent on tubing feeding and water flushes. -Provide site Peg-tube site care as ordered and monitor for infections. See physician orders for current feeding orders. Review of the resident's Physician Order Sheet (POS) dated 7/1/25, showed physician order for: -Enteral Feedings formula of Jevity 1.2 calories, via pump run at 55 milliliter (ml) per hour. Turn feeding off at 8:00 A.M. and back on at 12:00 P.M., total of 20 hour of running eternal feedings. -Every shift nursing staff to check PEG tube placement before initiation of formula, medication administration, and flushing of the feeding tube.-EBP for peg tube included gown and gloves required for high contact resident care activities. Review of the residents Registered Dietitian (RD) Dietary Note dated 7/21/25, showed the resident continuing to use tube feeding for all his/her nutritional/hydrational needs. Review of the resident's Minimum Data Set (MDS-a federally mandated assessment tool completed by facility staff for care planning) dated 7/30/25 showed: -He/she was severely cognitive impaired. -Required tube feeding for main source of nutrition.Observation on 8/13/25 at 11:34 A.M., of the resident's tube feeding (TF) showed:-TF pump was not running and not connected to the resident.-The formula bottle of Jevity 1.2 calorie was dated 8/12/25 at 3:50 P.M.-The tubing was dated 8/11/25 at 8:30 P.M.-The TF tubing had not been changed on 8/12/25 when nursing staff would have hung new bottle of formula. Observation on 8/14/25 at 9:51 A.M., of the resident's TF showed: -The resident TF pole and pump was in room with no eternal formula connected or running at that time. -The old formula bottle was dated 8/13/25 and tubing had been thrown away. Observation on 8/14/2025 at 11:58 A.M., of the resident tube feeding setup showed:-On the resident door had signage for EBP, required gown and gloves for whomever was providing direct contact care. -Registered Nurse (RN) D enter the resident's room washed his/her hands and then (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	applied gloves to his/her hands. -He/She apply a gown.-RN D had already setup TF supplies needed for reconnection of TF formula and had primed the tubing prior surveyor arrival. -He/She had new tubing connected and dated the tubing for 8/14/25 with the nurse initials. Observation on 8/18/25 at 2:06 P.M., of the resident's TF showed: -Was connected and running at 60 ml an hour. -Formula bottle dated 8/17/25 at 5:00 P.M. -Feeding tube tubing was dated 8/16/25.-The TF tubing had not been changed on 8/17/25 when staff would have hung a new bottle of formula. 2. Review of Resident #91's admission Record showed the resident admitted with the following diagnoses:-Huntington Disease (loss of nerve and brain cells, results in progressive movement, thinking, cognitive, and psychiatric symptoms).-Adult Failure to Thrive.Review of the resident's Tube Feeding Care Plan dated revised 4/22/25, showed:-The resident dependent on tubing feeding and water flushes. -Provide site Peg-tube site care as ordered and monitor for infections. See physician orders for current feeding orders. Review of the resident's Quarterly MDS dated [DATE], showed:-He/She was severely cognitive impaired. -Had diagnosis of Huntington Disease.-Required tube feeding for main source of nutrition. Review of the resident's POS dated August 2025, showed: -Clean tube feeding insertion site every day with normal saline and apply a split gauze pad. - Enteral Feedings formula of Jevity 1.5 calories, via pump run at 55 ml per hour. Turn feeding off at 6:00 A.M. and back on at 10:00 A.M., total of 20 hour of running eternal feedings. -Every shift nursing staff to check PEG tube placement before initiation of formula, medication administration, and flushing of the feeding tube.-Enhanced Barrier Precautions (EBP) for peg tube gown and gloves required for high contact resident care activities. Observation on 8/15/25 at 5:30 A.M. to 7:00 A.M., of the resident's medication administered via feeding tube showed:-On the resident door had signage for EBP, required who ever will be providing direct contact care for the resident, would be required to wear PPE of gown and gloves during cares. -RN A washed hand and checked vital signs prior to medication administration via PEG tube. -RN A had prep the resident's medications crushed four of the five pills to be given and dissolved capsula potassium in medication cup of water. He/she had difficulty get it to dissolve. -Entered the resident's room to started medication pass via PEG tube at 5:55 A.M. -He/She placed TF supplies on barrier on table in the room and then went washed his/her hands with soap and water. Placed clean gloves on hands. -He/She checked PEG tube placement and check for residual prior to medication administered. -Disconnected feeding tubing and flushed PEG tube with water prior to medication administered. -RN A completed medication pass one medication at a time. -He/She did not wear additional PPE of a gown during the TF medication administration process. -RN A proceeded change PEG tube dressing, with same gloves hands. -He/She removed the old split dressing from PEG tube site, slight amount reddish drainage noted on the old dressing.-RN A then cleanse the area with wet gauze pad and dried. -He/She removed soiled gloves and sanitize his/her hand, then placed a new pair of gloves on his/her hands.-He/She applied a clean split gauze pad around PEG tub insertion site and secured with tape. -Removed gloves and washed hands soap and water prior to exiting the resident room. -He/She did not wear additional PPE of a gown during the process of changing the resident's PEG tube site dressing. During an interview on 8/15/25 at 7:00 A.M., RN A said:-Residents on EBP care staff should wear a gown, gloves and mask if needed, when preform direct resident care during like wound care or peri care. -He/She was not required to wear gown during the care of the resident PEG tube feeding process and PEG tube site care. 3. During an interview on 8/20/25 at 11:30 A.M., Certified Nursing Assistant (CNA) A said PPE should be worn during peri care, catheter care, direct contact with residents that placed on EBP. During an interview on 8/20/25 at 11:38 A.M., Certified Medication Technician (CMT) A said: -PPE of gown and gloves should be worn during any direct contact care provided for a resident who had been placed on EBP. -Licensed nursing staff would be responsible for the resident care with PEG tubes related to feeding, medication, cleaning of PEG tube site and tube feedings process. During an interview on 8/20/25 at 11:55 A.M., CMT B said:-Resident with tube feeding would be placed on EBP, gown and gloves worn during direct contract resident care. -Licensed nursing staff would be responsible for the resident care with PEG tubes. During an (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	interview on 8/20/25 at 12:04 P.M., RN C said: -Resident on EBP due to PEG tube, the licensed nursing would be responsible for providing setup and monitoring of PEG tube and site, administration of TF formula. -He/She would expect staff to wear PPE of gown and gloves to during the TF process.-TF tubing should be changed every 24 hours and to ensure to label and date the tubing when replaced. -The facility provides monthly trainings, and he/she had completed annual skill check off. During an interview 8/20/25 at 12:23 P.M., RN B said: -He/She would wear PPE of a gown and gloves during the resident's TF process.-Licensed nursing staff would be responsible for changing tube feeding tubing at least every 24 hours.-TF formula and tubing should be dated when first opened and should be checked the dated before administration of tube feeding formula. During an interview on 8/20/25 at 1:42 P.M., Assistant Director of Nursing (ADON) said:-He/She would expect residents with tube feeding would be placed on EBP. -During resident TF care licensed nursing staff should wear PPE of gown and gloves. -He/She would expect TF tubing to be changed every 24 hours. During an interview on,08/20/25 2:45 P.M. Director of Nursing (DON) said: -Resident would be placed on EBP if indwelling medical devices such as PEG tube.-For resident requiring EBP, he/she would expect all care staff to wear gown and gloves during direct resident care. -He/She would have expected licensed nursing staff should have worn gown and gloves during care PEG tube site, Tube feedings process and during medication administration via PEG tube. -He/She would expect licensed nursing staff be responsible for ensuring the resident tube feeding tubing be changed every 24 hours and as needed.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, showed the facility failed to complete the correct procedure during tracheostomy care to include cleaning the inner canula, failed to use Enhanced Barrier Precautions (EBP-a set of infection control practices designed to reduce the spread of multidrug-resistant organisms (MDROs) in nursing homes. They focus on using personal protective equipment (PPE) like gowns and gloves during specific high-contact resident care activities for residents at increased risk of acquiring or known to be colonized or infected with an MDRO) upon entering the resident's room and failed to use infection control practices to prevent cross contamination during tracheostomy care for one sampled resident (Resident #15) out of 29 sampled residents. The facility census was 140 residents.Review of the resident's Tracheostomy Care policy and procedure dated 9/1/21, showed the facility will ensure that residents who need respiratory care, including tracheostomy (a surgical airway management procedure which consists of making an incision on the front of the neck to open a direct airway to the trachea) care, is provided such care consisting with professional standards of practice, the comprehensive person-centered care plan and resident goals and preferences.-Tracheostomy care will be provided according to the physician's orders, comprehensive assessment and individualized care plan. General considerations include providing tracheostomy care twice daily, and correctly sized cannulas (a hollow tube). -The facility will ensure staff responsible for providing tracheostomy care, are trained and competent according to professional standards.-Procedure with the use of a reusable cannula: perform hand hygiene; put exam gloves on both hands, remove the old dressing discard both and perform hand hygiene.-Open and set up sterile tracheostomy kit and apply sterile gloves. Pour saline of sterile water into basin of the kit with the non-dominant gloved hand. Remove the inner cannula using sterile technique and place in the cleaning container. Clean the inner cannula with the sterile brush or sterile pipe cleaner. Reinsert the inner cannula, Clean the stoma (the surgical opening created in the neck that leads to the trachea) with normal saline, moistened gauze or cotton tipped applicator. Dry the area with additional gauze, dispose of equipment and perform hand hygiene-Procedure with use of disposable cannula: Explain the procedure and screen for privacy; perform hand hygiene; put on clean gloves. Slowly remove the present inner cannula from the tracheostomy tube by squeezing the tabs on the connecter until both snaps clear the lock on the outer cannula. Dispose of the inner cannula. Pick up the new inner cannula, touching only the outer portion. Insert and lock the inner cannula into position. Discard gloves and perform hand hygiene. 1.Review of Resident #15's Face Sheet showed the resident was admitted on [DATE], with diagnoses including tracheostomy, dysphagia (difficulty swallowing), and muscle weakness. Review of the resident's quarterly Minimum Data Set (MDS-a federally mandated assessment tool to be completed by facility staff for care planning) dated 6/6/25, showed the resident:-Was alert, oriented and cognitively intact with minimal confusion.-Had a tracheostomy. Review of the resident's Physician's Order Sheet dated August 2025, showed physician's orders for:-EBP with gown and gloves required for high contact resident care activities every shift for precautions (5/5/25).-Change disposable inner cannula size 6 daily, every day shift for tracheostomy care and as needed (8/14/25).-Cleanse stoma area with normal saline, pat dry daily and as needed, every day shift for stoma care (5/12/25).-Tracheostomy care daily and as needed. Change inner cannula, gauze dressing and tracheostomy collar daily and as needed, every day shift (4/17/25).-Gown and gloves were required during high contact resident care activities.-EBP will be utilized during high-contact resident care activities including, but not limited to dressing, bathing, transfers, linen changes, incontinent care, wound and/or indwelling device care. -Nursing staff may assist with trach care daily and as needed. Observation and interview on 8/14/25 at 10:20 A.M., showed there was an EBP sign on the resident's door and there was PPE outside of his/her room in the hallway in a box. The resident was sitting in his/her wheelchair watching television while wearing (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	oxygen. The resident's tracheostomy looked clean and there was a split gauze around the tracheostomy (on the stoma) which was also clean. The resident was alert and oriented and said:-He/She had his/her tracheostomy replaced on Friday last week and it was a little tight, but he/she was not having much distress or discomfort currently.-The nursing staff was keeping it clean and maintaining it well.-He/She was to see the physician tomorrow and would inform him/her of what he/she was experiencing. Observation and interview on 8/14/25 at 2:24 P.M., showed there was an EBP sign on the resident's door and there was PPE outside of his/her room in the hallway. The resident was sitting in her wheelchair watching tv. The Assistant Director of Nursing (ADON) said he/she would be completing the resident's tracheostomy care. The resident's tracheostomy care supplies were in a closed sterile container on the resident's tray table. The following occurred:-The ADON re-entered the room at 2:32 P.M., holding a gown (packaged) and an unopened tracheostomy care container.-Without donning the gown, he/she placed the packaged gown on the small dresser the television was on.-He/She washed his/her hands and opened the tracheostomy care container, put on the sterile gloves, placed the sterile barrier cloth on the tray table and put the sterile supplies (that were inside of the container) on top of the sterile barrier cloth.-The ADON opened and poured the saline (salt water) solution into the tracheostomy care container then placed the sterile cloths inside the solution.-He/she took the sterile cotton swabs, with one hand, dipped them in the solution, and cleaned around and under the resident's tracheostomy. He/she discarded them then took the wet cloths from the solution and cleaned the resident's skin around and under the resident's tracheostomy. When he/she was done, he/she discarded them.-Without removing the sterile gloves, washing or sanitizing his/her hands, he/she placed a clean split gauze under the resident's tracheostomy.-The ADON degloved, sanitized his/her hands then discarded the gloves and tracheostomy care tray. He/she said he/she was going to check the orders for the right sized inner cannula and exited the resident's room.-The ADON re-entered the resident's room at 2:48 P.M. and put on the gown, pulled the residents privacy curtain (there were other people in the room), sanitized his/her hands, opened another tracheostomy care container, removed the sterile gloves from that container and donned the sterile gloves.-The ADON then opened the container with the inner cannula in it.-He/She removed the inner cannula from the resident's tracheostomy (that had a yellowish phlegm) with one hand and discarded it.-The ADON then took the new inner cannula and placed it into the resident's tracheostomy with the opposite hand. *NOTE: He/She did not cleanse the resident's stoma insertion site after removing the old inner cannula before placing the new inner cannula. During an interview on 8/14/25 at 2:56 P.M., the ADON said:-He/She thought he/she messed up when he/she opened the tracheostomy care supplies container and used his/her bare hands to put the sterile cloth down prior to donning the sterile gloves.-He/She did not remember if he/she had not donned a gown when he/she re-entered the resident's room and began to perform the resident's tracheostomy care.-He/She had checked the resident's tracheostomy orders prior to completing the resident's tracheostomy care, but he/she second guessed himself/herself which was why he/she left the room the second time.-He/She checked the cannula size and realized he/she had the correct inner cannula size.-He/She did not realize she had not washed or sanitize hands after she discarded the soiled cotton cloths and swabs.-He/She should have removed his/her gloves after cleaning around the resident's tracheostomy and washed or sanitized his/her hands.-He/She forgot to clean the outside and inside the resident's tracheostomy after removing the inner cannula, before inserting the new one. -He/She was frazzled and frustrated.-He/She should ensure he/she has all of the supplies he/she needed prior to starting tracheostomy care.-He/She should of don a gown upon entering the resident's room every time he/she is completing tracheostomy care and wash his/her hands and don gloves before beginning tracheostomy care.-He/She should ensure that he/she removes his/her gloves and washes his/her hands or sanitizes after every dirty to clean task during care.-He should remove his/her gown, gloves and wash his/her hands before leaving the resident's room.

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. Based on interview and record review the facility failed to ensure communication was established and completed between the facility and the hospice nursing staff for one sampled resident (Resident #130) out of 29 sampled residents. The facility census was 140 residents. Review of the Hospice Service Facility Agreement policy and procedure, dated 9/1/2021 showed a communication process, including how the communication will be documented between the facility and the hospice provider, to ensure that the needs of the residents were addressed and met 24 hours per day.Review of the Nursing Facility Services Agreement signed dated 5/24/24 showed the manner in which the facility and hospice were to communicate with each other and document such communications to ensure that the needs of the patients were addressed and met 24 hours a day. 1.Review of Resident #130's admission Sheet dated 5/8/25 showed the following diagnoses:-Anoxic brain damage (type of brain damage resulting from a complete lack of oxygen to the brain, leading to brain cell death).-Dysphagia (inability or difficulty swallowing). Review of the resident's Physician's Orders showed an order for the resident to begin hospice services on 7/25/25. Review of the resident's Minimum Data Set (MDS - a federally mandated assessment tool completed by the facility for care planning) dated 8/7/25 showed:-He/She was severely cognitively impaired-never/rarely made decisions.-Was on hospice services. Review of the facility's hospice communication book on 8/18/25 showed no documentation of any communication notes between hospice and the facility. During an interview on 8/18/25 at 10:58 A.M., the Certified Nursing Assistant (CNA) F said:-The CNAs do nothing with hospice. -He/She had seen the nurse communicate with hospice by the phone. During an interview on 8/18/25 at 11:20 A.M., the Registered Nurse (RN) C said:-He/She would communicate by phone.-If he/she needs more medication than he/she would call hospice, and they would give the orders then the RN would put the orders in the system.-Hospice was supposed to be filling out information in the book that they were there and what they had observed. During an interview on 8/20/25 at 2:37 P.M., the Director of Nursing (DON) said:-Hospice would communicate through the book.-Nurses would check in with the DON or the Assistant Director of Nursing (ADON).-If there were any changes the hospice staff would put the changes in the book.-Then if there was a change in condition hospice staff would talk to the DON.-The DON was responsible to make sure the information was put in the communication book.