STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265349	A. Building B. Wing	01/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Golden Years Center for Rehab and Healthcare	2001 Jefferson Parkway Harrisonville, MO 64701

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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 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, the facility failed to keep the walk-in freezer floors clean; failed to ensure food preparation equipment were kept in a sanitary condition; failed to maintain plastic cutting boards and plate covers in good condition to avoid food safety hazards (cross-contamination); and failed to separate damaged foodstuffs, in accordance with State of Missouri rules and regulations, established national guidelines, and professional standards for food service safety. These deficient practices had the potential to affect all residents, visitors, volunteers, and staff who ate food from the kitchen. The facility's census was 67 residents with a licensed capacity for 119 residents at the time of the survey. 1. Observation on 1/21/26 between 12:29 P.M. and 12:43 P.M. during the initial kitchen inspection with the Dietary Manager (DM) showed the following:-The white and green cutting boards were excessively scored to the point of shedding small plastic particles.-A microwave had spills, splatters, and food debris inside on its rotating plate, the bottom, and sides.-There was a 6-pound (lb.) can of Mandarin oranges on the large-can dispenser rack, second from the top row, that had its edge dented.-In the walk-in freezer there was paper, plastic, and food debris on the floor and under racks.Observation on 1/23/26 at 12:03 P.M. during a follow-up kitchen inspection with the DM showed the following:-The white and green cutting boards were excessively scored.-The manual can opener blade had a sticky substance built up on it.-The 6 lb. dented can was still on the dispenser rack.-Several maroon plastic plates covers on the bottom shelf of a Baker's rack in the northwest corner had chipped edges.Observation on 1/27/26 at 9:35 A.M during the final kitchen inspection with the DM showed the following:-The cutting boards were still excessively scored.-The maroon plate covers' edges remained chipped.During an interview on 1/27/26 at 12:45 P.M. the DM said:-If food stuffs had damaged packaging, they were separated out for return to the food vendor.-The staff was pretty good about noticing things like that as they put things away after delivery.-He/She would expect prepared food to be free of any foreign substances.-Electrical food preparation items were cleaned after every use.-The walk-in freezer's floor was cleaned at least twice a day.During an interview on 1/28/26 at 12:37 P.M. the Administrator said the kitchen staff should be following best industry sanitation practices.

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

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to establish and maintain a comprehensive, facility-specific infection prevention and control program designed to help prevent the development and transmission of Legionella (A [NAME] of pathogenic Gram-negative bacteria that includes the species L. pneumophila, causing legionellosis, all illnesses caused by Legionella, including a pneumonia-type illness called Legionnaires' disease and a mild flu-like illness called Pontiac fever) and/or other water-borne pathogens (a bacterium, virus, or other microorganism that can cause disease) that included specific assessments and contents, in accordance with State of Missouri rules and Centers for Disease Control (CDC) and Centers for Medicare and Medicaid Services (CMS) standards and guidelines. This deficient practice had the potential to affect all residents, visitors, volunteers, and staff who resided, visited, used, or worked in the facility. The facility census was 67 residents with a licensed capacity for 119 residents at the time of the survey. 1. Review of the facility's water-borne pathogen prevention program paperwork, last reviewed in October of 2022 and removed by the Administrator from a binder entitled Disaster Plan, showed the following:-There was no facility-specific risk assessment that considers the American Society of Heating, Refrigerating, and Air Conditioning Engineers (ASHRAE) industry standard #188.-Their CDC toolkit assessment including control measures such as physical controls, temperature management, disinfectant level control, visual inspections, and environmental testing for pathogens, was missing pages 6 through 36.-There was no completed CDC Legionella Environmental Assessment Form.-There was a flowchart of the facility's water system, but no written explanation of the water flow throughout the facility that identified and indicated specific potential risk areas of growth within the building with assessments of each individual area's potential risk level.-There was no facility-specific infection prevention program or plan to deal with outbreaks of Legionella and/or other waterborne pathogens.-No testing protocols and acceptable ranges for control measures with a method of monitoring them specifically at this facility was present.-There were no facility-specific interventions or action plans for when control limits are not met.-There was no documentation included of any site log book being maintained with any dated cleanings, sanitizings, descalings, and inspections mentioned.Observation on 1/22/26 from 8:39 A.M. to 1:49 P.M. during a Life Safety Code (LSC) walk-through inspection with the Director of Maintenance (DOM) showed the following:-The water main supply entered in the basement of an older attached building and first spread out through their laundry, a dry fire sprinkler system, and former administrative offices, then over to the newer building addition.-There were at least two commercial clothes washers being used in the older building's basement and numerous sinks and unused water pipes throughout the rest of the building.-The newer building was equipped with a complete wet fire sprinkler system with sprinkler heads located throughout the facility and its riser room (a fire sprinkler riser room is a dedicated space for fire protection equipment situated on an outside wall at grade with direct exterior access) located inside the Service Kitchen on 500 Hall.-Public restrooms were located by the Central Nurse's Station with additional one's northeast of the Therapy Hall entrance.-There were housekeeping closets with floor mop sinks or ceramic service sinks (mop/service sinks are used in janitorial and maintenance areas to fill and empty mop buckets, clean mops, and dispose of dirty water), eyewash stations, water boilers, hot water storage tanks, and hot/cold running water piping throughout the six resident room hallways.-There were at least 55 resident rooms with private and/or shared bathrooms and sinks throughout those hallways.-There was a Beauty Shop with a sink and at least three used and/or unused Bathing Rooms in the facility.Observation on 1/27/26 at 9:35 A.M during the initial facility LSC kitchen inspection with the Dietary Manager (DM) showed there was a sanitizing three-sink area, a chemical, low-heat dish-washing machine, a hand-washing sink, and a steam table (also referred to as a hot food table, is specifically designed to hold food at steady, safe serving temperatures, and not (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	designed to cook or warm foods from a raw state), with an ice machine in the adjacent service hallway.During an interview on 1/27/26 at 10:49 A.M. the Administrator said:-They had talked with others about having a water-borne pathogen prevention program last week.-There really was not anything for Legionella except for what he/she had taken out of their disaster manual.-That documentation was old and outdated; they thought it was from 2022.During an interview on 1/28/26 at 11:59 A.M. the Director of Maintenance said:-He/She had no responsibilities regarding any Legionella prevention practices.-They had no training on that.

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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 observation, interview and record review, the facility failed to ensure smoking assessments were completed in a timely manner to ensure resident safety for three sampled residents (Resident #20, #65, and #4) out of 17 sampled residents. The facility census was 67 residents. Review of the facility's policy titled Resident Smoking dated 6/10/25 showed:-All residents would be asked about tobacco use during the admission process, and during each quarterly or comprehensive Minimum Data Set (MDS- a federally mandated assessment instrument completed by facility staff for care planning) assessment process.-Residents who smoked would be further assessed to determine whether supervision was required for smoking, or if a resident was safe to smoke at all.-If a resident who smoked experienced any decline in condition or cognition. He/she would be reassessed for ability to smoke independently and/or to evaluate whether any additional safety measures were indicated. 1. Review of Resident #20's care plan dated 7/2/25 showed:-The resident smoked as of 8/9/23, and his/her son would bring in the cigarettes.-Staff were to assist to and from the designated smoking area as needed.-The resident smoked cigarettes, he/she was alert and able to hold his/her cigarette without difficulty. Review of the resident's Smoking Safety Screen dated 8/22/25 showed the resident was safe to smoke with supervision. Review of the resident's Smoking Safety Screen dated 9/20/25 showed the resident was safe to smoke with supervision. Review of the resident's Significant Change MDS dated [DATE] showed:-The resident was cognitively intact.-The resident currently used tobacco. Review of the resident's Electronic Medical Record (EMR) on 1/23/26 showed the resident had no other smoking assessments. During an interview on 1/28/26 at 11:36 A.M., Certified Medication Technician (CMT) A said:-Special interventions for resident's who smoked were documented in the care plan. -Right now, only two residents needed smoking aprons.-There was a list of residents who smoked and interventions at the nurse's desk for all to review. During an interview on 1/28/2026 11:38 A.M., Certified Nurse's Aide (CNA) E said:-He/She would go to the nurse to find out what interventions or protection would be needed for the residents.-Interventions for smoking would also be listed in the care plan. -If he/she saw anything that changed the interventions he/she would have informed the nurse. During an interview on 1/28/26 at 11:42 P A.M. Licensed Practical Nurse (LPN) B said:-Residents who smoked needed to be assessed for safe smoking on admission, quarterly, and as needed if changes occurred. -The nurses would have done the smoking assessments. -When the safe smoking assessment was done, the corresponding interventions would populate based on answers to the questions. -Smoking interventions were in the care plan. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 1/29/26 at 1:47 P.M. the Director of Nursing (DON) said:-Residents should have a smoking assessment completed upon admission, quarterly, and with significant changes.-Resident #20 should have had more than two safe smoking assessments in his/her EMR. 2. Review of Resident #65's admission Record showed he/she was admitted to the facility on [DATE] with diagnoses that included:-Parkinson's disease (a chronic neurological disease characterized by a fine slowly spreading tremor, muscle weakness, muscle stiffness and a peculiar gait).-Alzheimer's disease (a slowly progressive disease of the brain that is characterized by impairment of memory and eventually by disturbances in reasoning, planning, language, and perception).-Abnormal posture. Review of the resident's Nicotine Habit care plan, initiated 3/2/23 showed:-The resident smoked cigarettes.-A smoking assessment would be done upon admission, reviewed quarterly, and with any significant change in condition. -Staff were to assist the resident to and from the smoking destination.-Resident was to wear a smoking apron when smoking. Review of the resident's Smoking Safety Screen dated 8/22/25 showed the resident:-Had a cognitive loss.-Had visual deficits. -Had dexterity problems.-Smoked two to five cigarettes daily.-Could not light his/her own cigarette.-Required a smoking apron.-Was safe to smoke with supervision. Review of the resident's Significant Change MDS dated [DATE] showed the resident:-Had moderately impaired vision.-Was moderately cognitively impaired.-Used tobacco. Review of the resident's EMR on 1/23/26 showed the resident had no other smoking assessments for 2025 through 1/23/26. During an interview on 1/21/26 the resident said he/she went outside to smoke multiple times a day. Observation on 1/23/26 at 1:13 P.M. showed:-The resident was in his/her wheelchair on the smoking patio wearing a smoking apron holding a cigarette in his/her right hand. -His/Her left hand was under the smoking apron.-The lit end of the cigarette was approximately two to three inches from the resident's stomach (covered by the apron) and the resident's eyes were closed. -His/Her head hung downward with the resident's chin close to his/her chest. During an interview on 1/27/26 at 12:26 P.M. CNA C said:-Staff had to remind the resident to hold his/her cigarette up because he/she sometimes fell asleep.-He/She wore a smoking apron for safety. Observation on 1/28/26 at 10:06 A.M. showed:-Staff placed a smoking apron on the resident covering his/her left hand and gave him/her a cigarette and lit it.-Within a few minutes the resident's head hung downward, and the lit end of the cigarette was a couple of inches from his apron-covered stomach. During an interview on 1/28/26 at 2:25 P.M. CNA D said:-The resident had to wear a smoking apron for his/her safety.-Staff had to take his/her cigarette away when it got to be a stub, so he/she didn't burn his/her fingers. During an interview on 1/29/26 at 11:23 P.M. LPN C said:-The resident needed to wear a smoking apron for his/her safety.-He/She would smoke the cigarette all the way down and needed prompts that he/she was at the end of his/her cigarette, so he/she didn't get burned.-Staff should place the (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	non-smoking hand under the apron or make sure it didn't rest under the lit end of the resident's cigarette.-Smoking assessments should be completed upon admission, quarterly, with any change in a resident's condition, or any time staff noticed it needed to be done, such as when they thought a person could benefit from a smoking apron. 3. Review of Resident #4's admission Record showed he/she admitted to the facility on [DATE] with a diagnosis of Cerebral Infarction (ischemic stroke- occurs as a result of disrupted blood flow and restricted oxygen to the brain). Review of the resident's Smoking Safety Screen dated 8/22/25 showed the resident was safe to smoke with supervision. Review of the resident's Significant Change MDS dated [DATE] showed:-The resident had moderately impaired cognition.-The resident currently used tobacco. Review of the resident's care plan on 1/23/26 showed he/she didn't have a care plan focus or interventions in place related to the resident's smoking status. Review of the resident's EMR on 1/23/26 showed the resident had no other smoking assessments in place. During an interview on 1/29/26 at 11:51 A.M. CNA A and CNA B said:-They were unsure when smoking assessments were completed for the residents who smoked but assumed it should be completed before the residents smoked at the facility.-They were unsure of who completed the smoking assessments.-The smoking assessments should be completed per facility policy.-If the smoking assessment policy showed the assessment should be completed upon admission, then Resident #4's smoking assessment was completed too late. During an interview on 1/29/26 at 12:12 P.M. Agency LPN A said:-He/She was unsure when smoking assessments were completed at the facility.-He/She assumed the smoking assessments were completed upon admission to the facility once it was known that the resident smoked.-The smoking assessments should be completed per facility policy.-If the smoking assessment policy showed the assessment should be completed upon admission, then Resident #4's smoking assessment was completed too late. During an interview on 1/29/26 at 12:38 P.M. LPN B said:-Smoking assessments should be completed per facility policy.-He/She was newly hired to the facility and was unsure of what the smoking assessment policy showed.-He/She assumed it would get completed as soon as it was known the resident smoked.-If the smoking assessment policy showed the assessment should be completed upon admission, then Resident #4's smoking assessment was completed too late. During an interview on 1/29/26 at 1:47 P.M. the DON said:-Resident #4 should have had a smoking assessment completed upon admission.-Resident #4's smoking assessment was completed too late after admission to the facility.

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F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Post nurse staffing information every day. Based on observation, interview and record review, the facility failed to post the facility census and actual hours worked for Registered Nurses (RN's), Licensed Practical Nurses (LPNs), Certified Medication Technicians (CMTs) and Certified Nursing Assistants (CNAs) directly responsible for resident care per shift and to update the posting as necessary for view by residents, family members and visitors. The facility census was 67 residents. Review of the facility Nurse Staffing Posting Information policy dated 5/13/2025 showed:-The Nurse Staffing Sheet would be posted on as daily basis and would contain the facility census, the total number and the actual hours worked for licensed and unlicensed nursing staff responsible for resident care per shift.-The facility would post the Nurse Staffing Sheet at the beginning of each shift. -After the start of each shift, the information posted would reflect staff absences and actual hours worked would be updated.Observation on 1/21/26, 1/22/26, 1/27/26, 1/28/26 and 1/29/26 of the posting of staffing showed it did not include the resident census and did not show actual hours worked for licensed and unlicensed staff for each shift 12-hour shift.During an interview on 1/29/26 at 10:40 A.M. the facility Staffing Coordinator said:-He/she posted staffing sheets at the beginning of the day shift Monday through Friday.-He/she had not included the resident census on the staff posting since the first of January 2026.-Staffing sheets were not updated on weekends.-He/she posted weekend staffing sheets each Friday and he/she made changes to weekend staffing sheets on Mondays.During an interview on 1/29/2026 at 1:00 PM the Director of Nursing said:-The facility staffing sheets should have included two 12-hour shifts, the resident census and the actual hours worked for licensed and unlicensed nursing staff.-Licensed charge nurses were responsible for updating staffing sheets at the beginning of each shift.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure a drug regimen review (DRR) was completed monthly for four sampled residents (Resident #7, #10, #6, and #69) out of 17 sampled residents. The facility census was 67 residents. Review of facility policy entitle Quality Reporting: Drug Regimen Review revised 6/30/25 showed:-It was the policy of this facility document whether a drug regimen review was conducted upon a residents Skilled Nursing Facility (SNF) Prospective Payment System (PPS) admission and throughout the resident's stay, and to document whether any clinically significant medication issues identified were addressed in a timely manner. -Documentation of a drug regimen review may be located in various locations throughout the medical record. Examples included, but were not limited to:-- A nurse might have documented the review in nurses' notes or on a designated form.--A pharmacist might have documented the review in a designated location such as a medication regimen review form. --A physician might have documented the review in the resident's history and physical, physician progress notes, or discharge summary. -Documentation would have included whether any clinically significant medication issues were identified, and how the issues were addressed. -Documentation to support follow-up on identified issues would have included:--Two-way communication between the clinician(s) physician by midnight the next Calander day, and--All-physician-prescribed/recommended actions were completed by midnight of the next Calendar Day.-Frequency of drug regimen reviews, coincident with the resident's medical chart, would be in accordance with the facility's policy for such reviews. 1. Review of Resident # 69's admission Record showed the resident admitted to the facility on [DATE]. Review of the resident's quarterly Minimum Data Set (MDS - a federally mandated assessment instrument completed by facility staff for care planning) dated 1/10/26 showed:-Was cognitively intact. -Received injections every day of the look back period. -Received high risk medications during the look back period. Review of the requested copies of the monthly DRR showed: -There were no drug regimen reviews for January 2025, February 2025, March 2025, April 2025, May 2025, and June 2025. 2. Review of Resident # 10's admission Record showed the resident admitted to the facility on [DATE].Review of the resident's quarterly Minimum Data Set, dated [DATE] showed:-Was moderately cognitively impaired. -Received high risk medications during the look back period. Review of the requested copies of the monthly DRR showed there were no drug regimen reviews for January 2025, February 2025, March 2025, April 2025, May 2025, and June 2025. 3. Review of Resident #7's admission Record showed the resident initially admitted to the facility on [DATE] and was most recently readmitted on [DATE] with diagnoses that included:-Chronic Kidney Disease, Stage 4 (severe).-Type 2 Diabetes.-Retention of urine.-Hypertension (high blood pressure).-Major Depressive Disorder. Review of the resident's comprehensive care plan showed, since at least 7/2/24, he/she was on (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	several high-risk medications (medications that had a heightened risk of causing significant harm, especially when used in error) to treat his/her diagnoses. Review of the resident's requested monthly DRRs showed there were no drug regimen reviews available for January2025, February 2025, March 2025, April 2025, May 2025, June 2025 and December 2025. Review of the resident's quarterly MDS, dated [DATE], showed the resident:-Was moderately cognitively impaired. -Received injections daily. -Received several high-risk medications. 4. Review of Resident #6's admission Record showed the resident was admitted to the facility on [DATE] and most recently readmitted on [DATE] with diagnoses that included:-Anxiety disorder.-Schizoaffective disorder (a mental condition that causes loss of contact with reality and mood problems).-Bipolar disorder, mixed, severe, with psychotic features (a mental health disorder featuring extreme mood fluctuations, racing thoughts, irritability, perceptions that are not related to environmental reality, and false beliefs).-Major depressive disorder.-Hypertension (high blood pressure). Review of the resident's comprehensive care plan showed, in 2025 the resident had been on several high-risk medications for his/her diagnoses. Additionally, interventions were added on 6/26/25 related to a diagnosis of bladder cancer for which the resident received chemotherapy (powerful drugs intended to kill or stop the growth of rapidly dividing cancer cells). Review of the resident's requested monthly DRR showed there were no drug regimen reviews for January 2025, February 2025, March 2025, April 2025, May 2025, June 2025, September 2025, October 2025, and November 2025. Review of the resident's significant change MDS, dated [DATE] showed the resident:-Was cognitively intact. -Received several high-risk medications. 5. During an interview on 1/28/26 at 11:36 A.M., Certified Medication Technician (CMT) A said:-He/She did not participate in the monthly drug regimen review.-He/She thought the nurse handled the monthly drug regimen review. During an interview on 1/28/26 at 11:42 A.M., Licensed Practical Nurse (LPN) B said:-The Assistant Director of Nursing (ADON) was responsible for ensuring the monthly drug regimen review was done. -He/She did nothing with the pharmacist recommendations. -The ADON was responsible to ensure the recommendations were followed up in the time frame. During an interview on 1/28/26 at 11:53 A.M., ADON said:-He/She used to the monthly DRR and would give monthly medication regimen to the doctors if there were recommendations on them.-The former Director of Nursing (DON) took the responsibility of the monthly DRR from him/her.-The DRR was to be done monthly with recommendations followed up in a timely manner. -He/She was unaware of what the former DON did the DRR. -He/She had looked an could not find the requested DRRs for Resident #69, #10, #7, and #6.-It would have to be assumed that since he/she could not find them the reviews must not have been done and not documented as not done. During an interview on 1/29/26 at 1:01 P.M., the DON said:-The DRR would have been done monthly. -He/She had only been at the facility for two weeks.-He/She was only able to provide the drug (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	regimen reviews and follow ups since the new company took over the facility in July 2025.-He/She could not provide the drug regimen reviews or any follow ups prior to July 2025. -He/She knew the DRR should be retrievable. -He/She had no idea where the former DON put the previous DRRs, he/she had looked all over and the DRRs were not found. -Residents #69, #10, #7, and #6 should have had DRR available for review.

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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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. Based on observation, interview, and record review, the facility failed to ensure the medication administration error rate was less than five percent (5%) when staff failed to prime the insulin pen needles prior to administering Insulin for three sampled residents (Residents #27, #61 and #56) out of three sampled residents observed for Insulin administration resulting in a medication error rate of 11.54%. The facility census was 67 residents. Review of the facility Insulin Pen policy dated 5/16/2025 showed:-The facility would use Insulin pens to improve accuracy of insulin dosing.-A new needle would be used for each injection.-Insulin pens would be primed prior to each use to avoid collection of air in the Insulin reservoir.-Attach the needle to the Insulin pen.-Remove the outer cover from the pen needle.-Dial two (2) units of Insulin by turning the dose selector to clockwise to 2 units.-With the needle pointing up, push the plunger and watch that at least one drop of Insulin appears on the tip of the needle, if not, repeat until at least one drop of Insulin appears.-Then set the Insulin dose by turning the dose selector to the ordered Insulin dose.1. Review of Resident #27's Medication Administration Record (MAR) dated January 2026 showed:-He/she had a diagnosis of Diabetes Mellitus (a complex disorder of carbohydrate, fat, and protein metabolism that is primarily a result of a deficiency or complete lack of Insulin secretion in the pancreas or resistance to Insulin resulting in elevated blood sugar levels).-A physician's order for Lispro Insulin (a fast acting form of Insulin) 100 units/milliliter (ml) one unit dial, inject 5 units subcutaneously (under the skin) three times a day.-A physician's order for Lispro Insulin 100 units/ml one unit dial, inject subcutaneously before meals per sliding scale, including to administer 3 units of for a blood sugar of 179.Observation on 1/21/2026 at 11:07 A.M. showed Licensed Practical Nurse (LPN) D:-Obtained the resident's blood glucose level result of 179.-Removed the resident's Lispro Insulin pen from the medication cart, applied the needle to the Insulin pen, and dialed 8 units of Insulin without priming the pen prior to administration.2. Review of Resident #61's MAR dated January 2026 showed:-He/she had a diagnosis of Diabetes Mellitus.-A physician's order for Lispro Insulin 100 units/ ml one unit dial, inject 16 units subcutaneously before meals.-A physician's order for Lispro Insulin 100 units/ml one unit dial, inject subcutaneously three times a day per sliding scale, including to administer 9 units of for a blood sugar of 280.Observation on 1/21/2026 at 11:23 A.M. showed LPN D:-Obtained the resident's blood glucose level result of 180.-Removed the resident's Lispro Insulin pen from the medication cart, applied the needle to the Insulin pen, and dialed 25 units of insulin without priming the pen with 2 units of insulin prior to administration.3. Review of Resident #56's MAR dated January 2026 showed:-He/she had a diagnosis of Diabetes Mellitus.-A physician's order for Lispro Insulin 100 units/ml one unit dial, inject 12 units subcutaneously before meals.Observation on 1/21/2026 at 11:49 A.M. showed LPN E:-Removed the resident's Lispro Insulin pen from the medication cart and prior to attaching the needle to the Insulin pen he/she dialed two units of insulin and depressed the pen's plunger.-Put the needle on the Insulin pen, dialed the pen to 12 units, uncapped the needle and without having properly primed the pen administered the resident's insulin.4. During an interview on 1/21/26 at 1:50 P.M. LPN D said:-He/she would not have done anything differently related to administering Insulin to resident #56.-When he/she administered Insulin to Resident #27 and Resident #61 he/she had not primed the Insulin pens.-He/she had never dialed any Insulin pen to two units with the needle on the pen and uncapped and expelled the Insulin to prime the Insulin pen.-He/she did not know that Insulin pens were to be primed with two units of Insulin prior to dialing the intended dose of Insulin and did not know what priming Insulin pens meant.During an interview on 1/21/2026 a 2:17 P.M. LPN E said:-He/she would not have done anything differently related to administering Insulin to residents #56.-Prior to putting the needle on Resident #56's Insulin pen he/she had dialed the resident's Insulin pen to two units and pushed the pens plunger to expel the Insulin.-He/she did not know that priming the Insulin pen meant to prime the needle of the pen.During an interview on 1/29/2026 at 1:00 P.M. the Director of Nursing (DON) said:-He/she expected licensed nurses to prime Insulin pens with two (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	units of Insulin prior to dialing the intended dose of Insulin.-The needle needed to be on the pen, the pen was to be dialed to two units, the needle cap needed to be removed and when depressing the pen plunger, the licensed nurse was to observe for at least one drop of Insulin on the tip of the needle.-Priming the Insulin pen meant priming the needle of the pen.-The facility did not monitor for competency of licensed nurses in the use of Insulin pens.

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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. Based on interview and record review, the facility failed to ensure one sampled resident's (Resident #44) rights remained intact when he/she had to move to a different room out of 17 sampled residents. The facility census was 67 residents. Review of the facility's policy titled Resident Rights dated 6/10/25 showed Information about resident rights and responsibilities would be given to the resident both orally and in writing.1. Review of Resident #44's admission Record showed he/she admitted to the facility with diagnoses that included:-Unspecified Dementia (a progressive organic mental disorder characterized by chronic personality disintegration, confusion, disorientation, stupor, deterioration of intellectual capacity and function, and impairment of control of memory, judgement, and impulses), Unspecified Severity, Without Behavioral Disturbance, Psychotic Disturbance, Mood Disturbance.-Anxiety (any group of mental conditions characterized by excessive fear of or apprehension about real or perceived threats).Review of the resident's care plan dated 1/7/26 showed:-The resident had dementia.-On 1/6/26 the room move was discussed with the resident and the resident agreed.-On 1/7/26 the staff were assisting the resident with the room move when the resident became upset and said that he/she wanted to leave the facility.Review of the resident's quarterly Minimum Data Set (MDS- a federally mandated assessment instrument completed by facility staff for care planning) dated 1/8/26 showed:-The resident had severely impaired cognition.-The resident did not have any wandering behavior.During an interview on 1/21/26 at 1:57 P.M. the resident said:-He/She did not agree to the room move.-He/She was very upset about the move and became tearful.-He/She did not understand why he/she had been moved to the locked unit.-He/She felt trapped when he/she was in the locked unit.-He/She was unable to answer whether he/she had received written notice of the room change.Review of the resident's Electronic Medical Record (EMR) on 1/27/26 showed:-The resident did not have a Guardian or Durable Power of Attorney (DPOA- a legal document giving someone authority to make financial, legal, or medical decisions for you that remains valid even when you become incapacitated).-The resident was his/her own responsible party.-No signed agreement had been uploaded related to the resident's room move.During an interview on 1/29/26 at 11:44 A.M. Certified Nursing Assistant (CNA) A and CNA B said:-The resident had moved rooms recently, but they did not realize that the resident had been moved to the memory care unit before moving into his/her current room.-All residents needed to be informed in writing when a room move occurred.-They were unsure if the resident had received a written notice.-If the resident did not receive a written notice, then he/she should have been provided with a written notice.-All parties needed to agree before a room change could be completed.During an interview on 1/29/26 at 11:55 A.M. Agency Licensed Practical Nurse (LPN) A said:-All residents needed to be informed in writing when a room move occurred.-He/She was unsure if the resident had received a written notice.-The resident should have been provided a written notice related to his/her room move.-He/She had been the nurse who assisted the resident the day of his/her original move.-The resident was upset about the room move.-The resident was refusing to move rooms once they started walking down the hall with the resident.During an interview on 1/29/26 at 12:24 P.M. LPN A said:-He/She was unfamiliar with the resident and was not aware that the resident had been originally moved to the memory care unit.-All residents were to be informed in writing when a room move occurred.-The resident should have received a written notice of the room move.-The facility needed to follow all policies and regulations related to resident's rights.During an interview on 1/29/26 at 1:34 P.M. the Director of Nursing said:-The resident had not been notified in writing about the room move.-He/She was not sure why the resident had not received a written notification.-He/She was unaware of the regulation.-The resident should have been notified in writing related to his/her room move.2713401

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure documentation of non-pharmacological behavioral interventions were attempted prior to administering pro re nata (PRN as needed) antianxiety medication (medication to address the symptoms of anxiety); to document events/triggers preceding behaviors; to ensure the PRN antianxiety medication had a stop date; and failed to include comprehensive symptoms and/or target behaviors and individualized interventions for one sampled resident (Resident #12) who was taking multiple psychotropic medications (drugs which affect psychic function, behavior, or experience) out of 17 sampled residents. The facility census was 67 residents. Review of the facility's Behavioral Health Services policy, revised 6/10/25 showed:-The facility utilizes the comprehensive assessment process for identifying and assessing a resident's mental and psychosocial status and providing person-centered care. -Staff will share concerns with the interdisciplinary team (IDT) to determine underlying causes of mood and behavior and document the frequency of occurrence and potential triggers in the resident's record.-The facility will provide for meaningful activities which promote engagement and positive relationships. -Behavioral health training will include competencies and skills necessary to provide meaningful activities and individualized non-pharmacological approaches to care.Review of the facility's Use of Psychotropic Medications policy, revised 5/7/25 showed:-Non-pharmacological approaches must be attempted, unless clinically contraindicated, to minimize the need for psychotropic medications, use the lowest possible dose, or discontinue the medications.-Psychotropic medications used on a PRN basis must have a diagnosis specific condition and indication for the PRN use documented in the resident's medical record and is subject to limitations.-PRN orders for psychotropic medications, excluding antipsychotics (a group of psychoactive drugs (pertaining to a drug or other agent that affects such normal mental functioning as mood, behavior, or thinking processes) commonly but not exclusively used to treat psychosis), shall be limited to no more than 14 days unless the prescribing practitioner believes it is appropriate to extend the order beyond the original 14 day order. The medical record should include documentation from the prescriber for the rationale for the extended time period and indicate a specific duration.-PRN orders for antipsychotic medications shall be limited to 14 days with no exceptions. If the prescribing practitioner believes it is appropriate to write a new order for the PRN antipsychotic they must first evaluate the resident to determine if the new order for the PRN antipsychotic is appropriate.1. Review of Resident #12's admission Record showed the resident was admitted with diagnoses that included dementia (a progressive organic mental disorder characterized by chronic personality disintegration, confusion, disorientation, stupor, deterioration of intellectual capacity and function, and impairment of control of memory, judgment, and impulses) with agitation.Review of the resident's Psychotropic Medications Related to Dementia care plan, dated 10/24/25, showed:-Administer psychotropic medications as ordered by physician and report any adverse reactions.-Psychiatry to follow resident.Review of the resident's admission Minimum Data Set (MDS - a federally mandated assessment instrument completed by facility staff for care planning), dated 10/28/25 showed the resident:-Was severely cognitively impaired.-Felt down and depressed two to six days out of 14.-Had difficulty concentrating daily or nearly daily.-Had delusions (firmly held beliefs contrary to reality).-Had behaviors not directed towards others one to three days a week which significantly interfered with the resident's social interactions.-Wandered daily, potentially placing the resident at risk.-Found it very important to be able to listen to his/her preferred type of music and to get fresh air, weather permitting.-Had a primary diagnosis of progressive neurological conditions (acquired conditions such as dementia or brain damage characterized by a decline in mental function).-Was diagnosed with dementia. Was not diagnosed with anxiety, depression, or a psychotic disorder (a mental disorder in which there is a severe loss of contact with reality).-Was (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	taking the following scheduled psychotropic medications: antianxiety, antidepressant, and antipsychotic. Review of the resident's progress notes, dated 11/4/25 showed:-At 5:49 A.M. the resident had been sexually inappropriate, trying to kiss other residents and staff members, and slapped a staff member on the butt. Easily redirected.-At 1:40 P.M. the resident had been sexually inappropriate with others on the unit. Spoke with the psychiatrist. Order for Paxil (generic name Paroxetine HCl, a potent Selective Serotonin Reuptake Inhibitor (SSRI) classified as an antidepressant (used for symptoms of depression which increases serotonin in the brain to help regulate mood and reduce anxiety).Review of the resident's Sexually Inappropriate Behavior Related to Dementia care plan, initiated 11/5/25, showed:-The resident would attempt to kiss other residents and staff and pat staff on the behind.-Administer medications per order and report any side effects to the physician.-Listen to the resident's concerns and be supportive as the resident missed his/her spouse.-Psychiatric evaluation as indicated.-Reduce stimulation and keep conversion short and simple.-When the resident had behaviors redirect as staff reported he/she was easily redirected.-NOTE: There were no specific interventions showing how staff could proactively engage the resident such as in his/her favorite music, going outside (weather permitting and if safe to do so), or another activity the resident had indicated was meaningful for him/her. It didn't show if the behavior was more pronounced if others were sitting or standing close to the resident.Review of the resident's progress notes dated 11/6/25 showed:-On 11/6/25 at 1:24 P.M. the resident had insomnia. Slept very little at night and paced continuously during day. Caled the physician. New order noted for Melatonin (a supplement to aid with insomnia) 9 milligram (mg) every night for insomnia.-On 11/6/25 at 3:54 P.M. the resident continuously paced up and down the hallways. Rest periods encouraged, but frequently non-compliant.Review of the resident's Secured Unit care plan, initiated 11/6/25 showed:-Encourage participation and provide assistance with dementia-based activities.-Offer frequent snacks and drinks.-Provide consistent staffing.-NOTE: There were no specific preferred activities indicated that engaged the resident. Review of the resident's History of Agitation care plan, initiated 11/10/25 showed-Administer medications as ordered.-Maintain structured daily routine.-Monitor behavioral changes and report patterns.-Provide redirection and reassurance.-NOTE: There were no proactive non-pharmacological interventions showing how best to direct the resident's attention or engage the resident in something he/she had demonstrated was of interest. There was no indication of what events/activities preceded the agitation. There was no indication of what the resident did when he/she was agitated. Review of the resident's Psychiatrist's note dated 11/23/25 showed:-Staff reported the resident was aggressive, and Lorazepam (an benzodiazepine used for short term relief of anxiety medication) wasn't working. Sundowning by 4:00 P.M. Turned the table over the other day. Still sexually inappropriate.-Discontinue 0.5 mg Lorazepam and make it 1 mg every eight hours as needed. -Add Depakote (generic name divalproex sodium, an anticonvulsant medication primarily used to treat seizure disorder, bipolar mania (characterized by persistent periods, lasting at least one week, of abnormally elevated or irritable moods), and to prevent migraines) for sundowning. -Increase Paxil from 10 mg to 20 mg for sexual inappropriateness. Decrease Zyprexa (an antipsychotic medication used to treat schizophrenia, bipolar disorder and treatment resistant depression) from 2.5 mg three times daily to two times daily due to the added Depakote.Review of the resident's orders dated 11/23/25 showed he/she was also on Mirtazapine (brand name Remeron, a tetracyclic antidepressant) 7.5 mg. Give one tablet at bedtime for depression.Review of the resident's progress notes, dated 11/25/25, showed:-At 5:29 P.M. the housekeeping supervisor was getting in his/her car and observed the resident climbing out a window of the Memory Care unit and into the employee parking lot. The resident was in line of sight while staff called for assistance. Another staff member came on the scene and the two staff walked the resident back into the building. The resident was agitated. Nurse administered PRN Ativan. Physician, Administrator, and family member updated.--NOTE: This entry did not indicate what non-pharmacologic interventions were used to calm the resident's agitation. It did not describe what the resident was doing to indicate he/she was (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	agitated. -At 6:12 P.M. Ativan (lorazepam) 1 mg every eight hours as needed for aggression was given and was effective. Review of the resident's Elopement Risk/Wandering care plan, revised 11/26/25 showed:-Distract the resident from wandering by offering pleasant diversions, structured activities, food, conversation, television, or a book.-Redirect the resident when he/she went to doors to try to leave.-Educate staff to ensure doors locked behind them.-Maintenance to check the windows on the unit weekly for four weeks and monthly thereafter.-NOTE: The care plan didn't show what type of music the resident liked. The MDS showed music was very important to him/her.Review of the resident's progress notes, dated 11/27/25 to 1/4/26 showed:-On 11/27/25 at 1:37 P.M. the resident was having intermittent episodes of agitation and resisting cares and followed a visitor out of the locked unit. He/She was difficult to redirect. The resident was pacing frequently and was asking to go home. PRN Ativan (lorazepam given after several attempts to redirect earlier this shift. Resident was currently calm and sitting at a table in the dining room.-On 11/29/25 at 12:28 P.M. the client had increased pacing and exit-seeking and was very difficult to redirect. The resident became aggressive towards staff. PRN Ativan (lorazepam) given after multiple attempts to redirect. A note on 11/29/25 at 1:13 P.M. showed the PRN was effective.-On 11/30/25 at 11:04 A.M. the resident was pacing and wanted to go home. Increased agitation and aggression with redirection. PRN Ativan (lorazepam) given at 8:00 A.M. with good results. The resident was currently sitting at a table in the dining room watching TV. Calm at present.-On 12/2/25 at 1:03 P.M. the resident was pacing the unit and exit seeking. Placed on 15-minute checks. The resident was becoming more agitated and aggressive with redirection. PRN Ativan given at 9:15 A.M. with good results. Resident was currently sitting at a table eating a cookie. Calm and denied discomfort.-On 12/4/25 at 8:06 A.M. Ativan (lorazepam) as needed for aggression/increased agitation. 12/4/25 at 9:07 P.M. showed the PRN was effective.-On 12/9/25 at 6:26 A.M. the resident was aggressive with staff, attempted to pick up the TV and throw it. PRN Lorazepam given. Medication effective and resident slept from 10:00 P.M. to the change of shift.-On 12/11/25 at 1:54 P.M. the resident had increased agitation this morning, arguing with staff and attempted to elope. PRN Ativan (lorazepam) was given at 8:00 A.M. with good results. The resident was sitting in the dining room having a snack and watching a movie.-On 12/14/25 at 10:08 A.M. the resident was very unsteady. He/She had not been sleeping much at night and received PRN medications for frequent aggression in addition to scheduled medications. The Physician was on rounds and assessed resident. Medications held, except prescribed antibiotic. -On 12/14/25 at 6:00 P.M. the resident was very aggressive, swinging at and pinching staff. Unable to follow commands. Very unsteady at times. Couldn't get the resident to calm down and PRN Ativan (lorazepam) was given. At 7:31 P.M. the PRN was effective.-On 12/16/25 at 9:04 A.M. the resident had increased aggression and was frequently resistive to cares. PRN Ativan (lorazepam was given at 8:45 A.M. Frequent pacing. Gait becoming more unsteady. Right lower extremity (RLE) had increased edema, redness and warmth to touch. Resident removed support hose and wraps when applied. Non-compliant with resting and elevating legs. The resident was sent to the emergency room (ER) for RLE evaluation and aggression. At 9:48 A.M. the PRN was ineffective.-On 12/16/25 at 5:00 P.M. the resident was combative upon return from the hospital and scheduled medications were given.-On 12/18/25 at 9:03 A.M. Ativan (lorazepam) 1 mg tablet was pulled from the emergency kit due to the resident grabbing random items. At 10:00 P.M. the resident was combative and refused Intravenous (IV) hydration. At 11:48 P.M. the PRN was effective.-On 12/23/25 at 2:23 A.M. the Certified Nursing Assistant (CNA) asked if there was a PRN that could be given to the resident who was complaining of pain. The nurse couldn't find any orders for pain medication, so Ativan (lorazepam) was taken to the resident. The resident was sitting on the edge of his/her bed without a shirt and said he/she didn't want to wear it. After the CNA told the resident it was cold in the dining room the resident put on the shirt. The resident was very shaky when he/she took the Ativan (lorazepam) and drank his/her water. The CNAs told him/her to stand up so they could pull up his/her pants, and the resident was shaky then as well. One CNA felt the resident should be in a wheelchair due to his/her shakiness. The (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	prior to administering the PRN Ativan (lorazepam). Review of the resident's Pharmacy recommendation, signed by the physician 1/14/26, showed:-PRN psychotropic drug orders were limited to 14 days and could not be renewed unless the prescribing practitioner evaluated the resident for appropriateness of renewal. If the physician or prescribing practitioner believed it was appropriate for the PRN order to be extended beyond 14 days, he/she should document their rationale in the resident's medical record and indicate the duration of the PRN order.-The physician indicated he/she discontinued the PRN and reevaluated the resident for continued PRN Ativan (lorazepam) use.Review of the resident's progress notes dated 1/15/26 to 1/22/26 showed:-On 1/15/26 at 9:00 A.M. PRN Ativan (lorazepam) given for increased anxiety with agitation. At 10:20 A.M. the PRN was effective. -At 2:29 P.M. the behavior earlier in the day was described as very restless this morning, pacing continuously, turning over tables and trying to climb on furniture. He/She also attempted to remove his/her pants several times and was resistive with redirection and cares. -On /16/26 at 10:17 P.M. the resident had extreme agitation this shift. He/She was wandering, going through things, grabbing things that weren't his/hers. Upon redirection resident got worse. -On 1/22/26 at 12:10 P.M. the resident appeared anxious. He/She walked in and out of rooms and turned knobs. He/She was taken to the toilet and continued to walk up and down the hall after having been offered a snack. Eventually he/she sat in a chair, but was fidgety, rubbing his/her hands together, lifting his/her pant leg up and down and finally took the snack and drink. Observation on 1/21/26 at 9:32 A.M. showed:-The resident was calmly eating breakfast and appeared alert.-He/She was aware of others in the environment, looked around, and was talking in a pleasant tone, but the content could not be followed.Observation on 1/23/26 at 9:40 A.M. showed:-The resident was calmly sitting by himself/herself at a table in the dining room. -He/She looked around the room and initiated interaction, although the content was nonsensical. The tone of voice was calm and pleasant.-He/She was not fidgeting or showing other signs of restlessness. During an interview on 1/27/26 at 12:03 P.M. CNA F said:-He/She had been working with the resident on walking and walked him/her on the unit.-He/She had no behavioral issues with the resident on the day shift.-He/She didn't know the resident's behaviors.-If the resident seemed anxious or restless staff would give him/her an activity, a book or talk about photos he/she had in his/her room.-The facility provided education on working with residents with behaviors and dementia and what worked for most residents.-Target behaviors should be in each resident's care plan with interventions to address the behaviors. It should show the resident's triggers. Interventions should be unique for each resident. There is a behavioral book on each unit that showed what helped to soothe each resident. It should have the behavioral information found on the care plan.-Symptoms or behaviors related to depression or anxiety should be on the care plan to show staff when the problem was getting worse.-Any resident taking a psychotropic medication needed to have a care plan that showed target behaviors and symptoms and non-pharmacological interventions.During an interview on 1/27/26 at 1:54 P.M. CNA F said:-The resident was acting different than normal earlier in the day. He/She was physically combative and hitting staff. On the day shift he/she usually had few behaviors.-He/She started having loose stools during the night and was sent out to the hospital.-CNAs were able to look at the behavior book which showed what was on the care plan.-The care plan and behavior book should both show a resident's triggers, their specific behaviors, and what interventions worked best for the resident.During an interview on 1/27/26 at 2:11 P.M. CMT B said:-CNAs and CMTs used the behavior book that showed the resident's target behaviors individualized interventions the same as the care plan.-Any resident on psychotropic medications needed to have an individualized care plan that identified the resident's symptoms related to anxiety, depression, or psychosis and any target behaviors they had and what worked best for that individual resident.-Some of the resident's behaviors were triggered by someone who got in his/her space or forced him/her to do something he/she didn't want to do. He/She stayed calm if he/she was given space.-He/She would make inappropriate comments to staff and tried to touch their bottoms or tried to look down their shirt and would remove his/her pants. The psychiatrist put him/her on a (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	medication to address his/her sexually inappropriate behaviors.-The resident thought he/she was at work if given a binder and a pen. He/She used to be an engineer and liked to map things out and write things down.-He/She did better the calmer the unit was and the busier he/she was.-The resident would push furniture and asked to go home. He/She sometimes flipped tables over. Once he/she flipped an oxygen concentrator over and started fiddling with the wheels. There were wheels under the tables as well and he/she liked to fiddle with them. He/She believed he/she was fixing the wheels and got agitated if asked to stop.-The resident won't sit for long or stay focused, he/she went from one thing to another. If staff gave him/her something to do with his/her hands or gave him/her a fidget object or food and drink the resident would focus on it for a while. -He/She might like to have some wheels to spin or locks to manipulate, but nothing like that was on the unit.-The resident's spouse said he/she liked to fix things. Giving him/her something to fix would give the resident something he/she enjoyed doing.-It would be good to specify on the care plan what was usually effective and not just say staff should redirect the resident.-Psychotropic mediations were supposed to be limited to 14 days. Then the resident had to be evaluated by the doctor or psychiatrist before the PRN could be continued. PRN antianxiety medications should have a stop date when they were continued beyond the original 14 days.During an interview on 1/28/26 at 10:32 A.M. the MDS Coordinator said:-He/She tried to describe target behaviors and used individualized interventions on the resident care plans.-The care plan should be specific and unique for the resident.During an interview on 1/28/26 at 10:53 A.M. the MDS-in-Training said:-Symptoms of anxiety, depression and psychosis should be identified in the care plan for each resident who was on psychotropic medications. -Target behaviors should be specific, and interventions should be individualized for each resident.-The care plan should identify any known triggers for behaviors.During an interview on 1/29/26 at 1:50 P.M. the Director of Nursing (DON) said:-Residents on psychotropic medications should have care plans that show symptoms and target behaviors which were specific for the resident.-Progress notes should show specific behaviors the resident was having and there should be documentation of what non-pharmacological interventions were attempted before using a psychotropic PRN.-After the initial 14-day order for PRN psychotropic medications the resident needed to be re-evaluated before continuing the medication. -Any resident on a PRN antianxiety medication needed to have a stop date on their orders for that medication.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure two sampled residents (Resident #44 and #75) physician's orders were followed out of 17 sampled residents. The facility census was 67 residents. A policy related to following physician orders was requested and not received prior to exit on 1/20/26.1. Review of Resident #44's admission Record showed he/she was admitted to the facility with the following diagnoses:-Retention of Urine (the inability to completely empty your bladder), Unspecified.-Neuromuscular Dysfunction of Bladder (occurs when nerve damage disrupts the brain-bladder communication, causing problems with storage or emptying), Unspecified.Review of the resident's Order Summary Report dated December 2025 showed:-The resident had an order for a Urinary Analysis (UA- a test of your urine that checks and screens for diagnoses such as a UTI), ordered on 12/16/25.--The status of the order showed it had been completed.-The resident had an order for a UA to be completed between 12/21/25 through 12/28/25.--The status of the order showed it had been completed.Review of the resident's quarterly Minimum Data Set (MDS- a federally mandated assessment instrument completed by facility for care planning) dated 1/8/26 showed:-The resident had severely impaired cognition.-The resident did not have a Urinary Tract Infection (UTI-an infection caused by bacteria that enters and multiplies within any part of the urinary system).Review of the resident's care plan dated 1/19/26 showed:-The resident required an Indwelling Catheter (a thin, flexible tube left inside the body, most commonly in the bladder, to continuously drain urine into an external bag when a person cannot urinate on their own) due to his/her diagnosis of Neuromuscular Dysfunction of Bladder with an intervention for staff to monitor/record/report to the resident's physician signs and symptoms of a UTI.-On 12/22/25 the resident had a fixation with his/her private area causing complications with his/her catheter.-The resident would refuse catheter care at times. Review of the resident's Electronic Medical Record (EMR) on 1/23/26 showed:-No notes in place related to collecting the UA that was ordered on 12/16/25 and 12/21/25.-No results were found related to the results of any UA completed in December 2025.2. Review of Resident #75's admission Record showed he/she admitted to the facility on [DATE] with the following diagnoses:-Enterocolitis (inflammation of both the small intestine and the colon) due to Clostridium Difficile (C. diff- a bacteria that causes severe, contagious diarrhea and colon inflammation).-Morbid Obesity due to Excessive Calories.Review of the resident's Un-witnessed Fall report dated 1/20/26 showed:-The resident had been using the commode and tried to stand.-He/She lost his/her balance and fell to the floor.-An X-ray (a photographic or digital image of the internal composition of the body) had been ordered.-The X-ray was unable to be obtained due to the resident's abdomen size.-The resident's physician had been notified and had ordered a Computed Tomography (CT) scan (a noninvasive, diagnostic imaging that combines a series of X-rays with computer technology to create detailed, cross-sectional, 3D images of bones, soft tissues, and blood vessels).-The order had been faxed to the local hospital.Review of the resident's Order Summary Report dated January 2026 showed an order for the resident to have a CT scan of Back and Right Side due to a fall, which was ordered on 1/23/26.During an interview on 1/28/26 at 11:22 A.M. the resident said:-He/She was unaware that a CT scan had been ordered after his/her fall.-He/She had not been given a date in which the CT scan had been scheduled.During an interview on 1/29/26 at 10:25 A.M. a hospital scheduler from the local hospital said:-He/She was the manager of scheduling procedures at the hospital.-He/She did not see a CT order for the resident until 1/27/26.-The CT scan had not been scheduled yet because the facility sent in an invalid order.-Once the order was corrected, then the CT scan could get scheduled.3. During an interview on 1/28/26 at 1:03 P.M. the Administrator said:-To his/her knowledge, Resident #44 would not let staff collect the urine for the UA to be completed.-He/She expected staff to document a progress note if the UA had been attempted/refused and that staff were unable to collect a sample.During an interview on 1/29/26 at 11:49 A.M. Certified (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Nursing Assistant (CNA) A and CNA B said:-All physician orders should be followed.-All physician orders should be followed as written.-CNAs and nurses could collect UAs depending on the order.-If they were unable to collect a sample for a UA to be completed, then they would let the nurse know.During an interview on 1/29/26 at 12:07 P.M. Agency Licensed Practical Nurse (LPN) A said:-All physician orders should be followed.-All physician orders should be followed as written.-If a licensed staff member could not collect a UA, then a note needed to be documented somewhere in the resident's EMR.-Sometimes the UA orders could be seen on the Treatment Administration Record (TAR) and nurses could document on the TAR whether the sample had been collected.-When he/she received an order for a CT scan, he/she would call the location that the CT scan was to be completed and document who he/she spoke to.-He/She would also inform the resident about when the procedure was scheduled for.-If the CT order needed to be faxed, then he/she would wait for a fax confirmation number and put a note in the resident's EMR.-He/She was unsure of when the CT scan had been ordered and when the order was sent to the local hospital.-If the order was placed on 1/23/26, then the facility should have the CT scan scheduled by that point in time.During an interview on 1/29/26 at 12:30 P.M. LPN A said:-All physician orders should be followed.-All physician orders should be followed as written.-Staff should follow all facility policies related to following physician orders and sample collection.-If staff were unable to collect a UA, then a note should have been documented in Resident #44's EMR.-If he/she needed to send an order for a CT scan, then he/she would confirm the location that the order needed to be sent to.-He/She would then send the order and wait for confirmation that the order had been received.-He/She would then document a progress note with the order confirmation number.-Resident #75's CT scan order should have been sent on the day it was ordered.During an interview on 1/29/26 at 1:41 P.M. the Director of Nursing (DON) said:-All physician orders should be followed.-All physician orders should be followed as written.-When a UA was ordered, the order would show on the nurse Medication Administration Record (MAR).-He/She expected the nurses to document in the MAR or in a progress note if a UA could not be collected.-He/She was unsure why staff did not document a note that indicated that a UA could not be completed as ordered.-There should have been a note documented in Resident #44's EMR to indicate that a UA could not be collected.-He/She was unsure when Resident #75's CT scan order was sent.-He/She did not have any documentation to confirm that Resident #75's order had been sent prior to 1/27/26.-He/She would have expected staff to get confirmation that the order was received and document a progress note.2713401

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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 one sampled resident's (Resident #13) gastrostomy tube (also known as G-tube, percutaneous endoscopic gastrostomy/PEG tube/feeding tube - a flexible tube inserted through the wall of the abdomen directly into the stomach that is used to give medications, fluids and liquid food) placement was confirmed prior to administration of medication in accordance with facility policy and current professional standards of practice. The facility census was 67 residents. Review of https://www.ncbi.nlm.nih.gov/books/NBK593216/ the National Institutes of Health, National Library of Medicine, Enteral (also known as tube feeding) Tube Management, dated 2021 showed:-The placement of an enteral tube is immediately verified after insertion by an X-ray; after X-ray verification, the tube should be marked to indicate the point on the tube where the feeding tube penetrates the abdominal wall; the mark or number on the tube at the entry point should be documented in the resident's medical record.-At the start of every shift, nurses evaluate if the incremental marking or external tube length has changed. If a change is observed, bedside tests such as visualization or pH testing of tube aspirate can help determine if the tube has become dislocated. If in doubt, a radiograph should be obtained to determine tube location.-Older methods of checking tube placement included observing aspirated (using a syringe, a tube with a nozzle and piston or bulb for sucking in and ejecting liquid) contents or the administration of air with a syringe while auscultating listening with a stethoscope (a medical instrument for listening to sounds in the body) - however, research has determined these methods are unreliable and should no longer be used to verify placement.Review of the facility Care and Treatment of Feeding Tubes policy dated 5/2/2025 showed:-The facility would utilize feeding tubes in accordance with current clinical standards of practice with interventions to prevent complications.-Feeding tubes would be utilized according to physician orders.-Licensed nurses would monitor and check that the feeding tube is in the right location (the stomach or small intestine depending on the type of tube), including before beginning feeding and before administration of medications.Review of the facility Medication Administration via Enteral Tube (a tube that delivers nutrients or medication directly into the stomach or small intestine) policy dated 5/8/25 showed:-Verify physician's orders.-Enteral tube placement must be verified prior to administering any fluids or medication.Review of the facility Flushing a Feeding Tube policy dated 5/16/2025 showed:-Prior to flushing a feeding tube, administration of medication or providing tube feedings, the licensed nurse would verify the proper placement by noting the length of the tubing or performing a measure of the pH (a measure of how acidic or alkaline/base a substance is) of gastric secretions, if performed at the facility.Review of the facility Verifying Placement of Feeding Tube policy dated 5/30/25 showed:-For gastrostomy tubes, check that the tube is properly approximated to the abdominal wall by taking note of the marking on the tube or by measuring the length of the tube from insertion site to the tip of the tube and comparing the measured length to the recorded measurement of the tube on admission to the facility or with a new/replacement tube.1. Review of Resident #13's admission Record showed:-He/she was admitted to the facility on [DATE].-He/she had a diagnosis of gastrostomy status.Review of the resident's care plan, updated 5/30/25 showed:-He/she had a G-tube for nutrition.-Instruction to check the placement of his/her G-tube prior to flushes (introduction of water into the tube to clear feeding contents), medications and feedings, via integrity of tube, tube length from ostomy to end of tube 33 to 35 centimeters (cm) and residual, if more residual than 70 milliliters (ml) notify the resident's physician.Review of the resident's care plan, updated 5/30/25 showed:-He/she had a G-tube for nutrition.-Instruction to check the placement of his/her G-tube prior to flushes (introduction of water into the tube to clear feeding contents), medications and feedings, via integrity of tube, tube length from ostomy to end of tube 33 to 35 cm (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and residual, if more residual than 70 ml notify the resident's physician.Observation on 1/21/2026 11:06 PM showed:-Licensed Practical Nurse (LPN) D prepared the resident's Gabapentin 300 milligram (mg) for administration, obtained water for flushing the resident's G-tube, turned the feeding pump off and uncovered the resident's abdomen.-Without first measuring or observing the length of the residents G-tube he/she disconnected the resident's extension tubing (the tubing that extends from the outside end of the feeding tube to the feeding tube pump) from the residents G-tube.-He/she then attached a syringe to the resident's G-tube, attached the plunger to the syringe and pulled back on the plunger (aspirated) resulting in a small amount of tan liquid to appearing at the medication port of the G-tube.-He/she did not measure the pH of the contents that had been aspirated with the syringe.-He/she then removed the syringe plunger and flushed the resident's G-tube by pouring about 30 ml of water into the syringe.-He/she then poured the residents medication which had been mixed with a small amount of water into the syringe and allowed the medication to flow into the resident's G-tube.-He/she then flushed the resident's G-tube with about 30 ml of water and reconnected the resident's extension tubing to the resident's G-tube and turned on the residents feeding pump to resume his/her tube feeding.During an interview on 1/21/2026 at 1:12 P.M. LPN D said:-He/she had not looked at or measured the length of the resident's G- tube to confirm correct placement prior to flushing the resident's G-tube and administering the resident's medication.-He/she knew that licensed nurses were no longer to check placement of G-tubes by auscultation (listening over the stomach with a stethoscope for the sound of air being introduced into a G-tube) and since learning that a few years ago, the only method he/she had been using to assess for correct placement of G-tubes was to aspirate contents from the G-tube.-He/she knew that if aspirating was used as a method used for confirming correct placement of a G-tube, the pH of the fluid aspirated would have to be checked.-He/she had never tested the pH of the fluid aspirated from G-tubes and did not think that was done at the facility.Review of the resident's Physician's Order Summary Report dated January 2026 showed:-Check PEG tube placement before flushes, medications and feedings via integrity of tube, tube length from ostomy to the end of his/her feeding tube, length was 33 to 35 cm and residual, if residual was more than 70 ml, notify the resident's physician.-Nutren (tube feeding formula) 1.5 at 55 ml per hour continuous via feeding pump; stop continuous feedings for four (4) hours from 1:00 P.M. until 5:00 P.M.-The PEG tube was to be flushed with 30 ml of water before any medication administration, then flush with 15 ml of water after each medication, then after all medications flush with 30 ml of water for patency (keep open); stop continuous feedings for four hours from 1:00 P.M. to 5:00 P.M. for showers and activities then restart.-Gabapentin 300 milligrams (mg), one capsule via PEG tube three times a day for neuropathy (nerve damage).During an interview on 1/29/2026 at 1:00 P.M. the Director of Nursing said:-He/she expected licensed nurses to check placement of G-tubes, including prior to medication administration by aspiration.-He/she would have to check what the current standard of practice was regarding checking placement of G-tubes.-At this time, facility licensed nurses were to check placement of G-tubes by aspiration and the facility did not check pH when checking placement by aspiration.-Currently there was no monitoring in place to ensure licensed nurses correctly checked placement of G-tubes including prior to medication administration.

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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. Based on observation, interview, and record review, the facility failed to ensure one sampled resident's (Resident #13) tracheostomy (a surgical procedure that creates an opening (stoma) through the neck into the trachea (windpipe), to provide a direct airway) suctioning supplies were stored appropriately and that staff were trained and competent in the correct method of suctioning out of 17 sampled residents. The facility census was 67 residents. Review of the facility's policy titled Tracheostomy (trach) Care dated 6/10/25 showed:-The facility would provide necessary respiratory care and services, such as oxygen therapy, treatments, tracheostomy care and/or suction.-Tracheostomy care would be provided according to physician's orders, comprehensive assessment, and individualized care plan such as monitoring for resident specific risks for possible complications, psychosocial needs, as well as suctioning as appropriate.-General considerations included maintaining a suction machine, a supply of suction catheters (a thin, flexible tube used to remove bodily fluids from a resident's airway), correctly sized cannulas (a curved, hollow tube inserted into the stoma to maintain an open airway), and an Ambu bag (a handheld, manual resuscitation device to provide ventilation to people who are not breathing adequately) easily accessible for immediate emergency care.Review of Chapter 22 Tracheostomy Care & Suctioning - Nursing Skills - NCBI Bookshelf dated 2021 showed tracheostomy suctioning uses a sterile catheter that is inserted through a tracheostomy tube into a patient's trachea. 1. Review of Resident #13's admission Record showed he/she admitted to the facility with the following diagnoses:-Diffuse Traumatic Brain Injury (TBI- widespread brain damage caused by rapid acceleration, deceleration, or rotational forces that stretch and tear white-matter nerve fibers (axons).-Other Tracheostomy Complication.Review of the resident's care plan dated 11/7/25 showed:-The resident had a tracheostomy related to a motor vehicle accident with the following interventions:--Change suction cannister as needed when it was three quarters full or as needed.--Suction as needed to remove excessive secretions.--Staff were to perform tracheostomy care every day and night shift.Review of the resident's Order Summary Report dated January 2026 showed:-An order to change the suction cannister pro re nata (PRN- as needed) when it was three quarters full.-An order for staff to suction secretions from the trach PRN to help clear the airway and maintain oxygen levels above 90 percent (%).-An order for staff to suction via trach PRN related to congestion every shift.Review of the resident's significant change Minimum Data Set (MDS- a federally mandated assessment instrument completed by facility staff for care planning) dated 1/21/26 showed:-The resident was severely impaired-never/rarely made decisions regarding tasks of daily life.-It did not indicate that the resident had a tracheostomy.Observation on 1/21/26 at 3:02 P.M. showed:-The suction cannister was not labeled with a date.-The suction catheter was hanging off the suction machine uncovered.Observation on 1/22/26 at 10:22 A.M. showed:-The suction cannister was not labeled with a date.-The suction catheter had been used and placed back into the original packaging.Observation on 1/23/26 at 9:01 A.M. showed the suction machine was covered with a pillowcase.Observation on 1/23/26 at 12:13 P.M. showed:-The suction cannister was not labeled with a date.-The suction catheter had been used and placed back into the original packaging.During an interview on 1/29/26 at 12:14 P.M. Agency Licensed Practical Nurse (LPN) A said:-The suction catheter could continue to be used once it was cleansed with sterile water.-It was okay for staff to store the suction catheter in its original packaging.-When staff suctioned the resident's tracheostomy it was not a sterile procedure.-The suction cannister needed to be labeled with a date.-He/She had not been educated on tracheostomy care while working at the facility.During an interview on 1/29/26 at 12:44 P.M. LPN A said:-The suctioning equipment used in tracheostomy care needed to be clean and covered.-When staff suctioned the resident's tracheostomy it was not a sterile procedure.-He/She would follow facility policy related to all tracheostomy care.-Suction catheters were one time use only.-If he/she were to go into the resident's room and see the suction catheter back into its original packaging, he/she (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	would go get a new suction catheter and throw away the one that had been used.During an interview on 1/29/26 at 1:48 P.M. the Director of Nursing (DON) said:-The procedure of suctioning a tracheostomy was considered a sterile procedure, so the suction catheters were to be thrown away after each use.-The suction cannister needed to be labeled with the date.-The resident's order for the suction cannister was incorrect and staff should have clarified the order with the resident's physician. -He/She was unaware that staff were storing the suction catheter back in the original container after use.-If a nurse walked into the resident's room and observed the resident's suction cannister not labeled, then he/she would expect the nurse to dispose the cannister and get a new one.-If a nurse walked into the resident's room and observed the resident's suction catheter opened and stored in its original packaging, he/she would expect the nurse to dispose of the used catheter and get a new one.-He/She was unaware that staff were covering the suction equipment with a pillowcase.-The suction equipment did need to be covered per facility policy.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265349	A. Building B. Wing	01/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Golden Years Center for Rehab and Healthcare	2001 Jefferson Parkway Harrisonville, MO 64701

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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 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. Based on observation, interview and record review, the facility failed to ensure orders were clarified for one sampled resident (Resident #7), who was receiving hemodialysis (a process of cleansing the blood of wastes, toxins and excess fluid by passing it through a special machine - necessary when the kidneys were not able to filter the blood), out of 17 sampled residents. The facility census was 67 residents. Review of the facility's Hemodialysis policy, dated 5/2/25, showed:-The facility will assure each resident receives care and services for the provision of hemodialysis consistent with professional standards of practice. This will include ongoing communication and collaboration with the dialysis facility regarding dialysis care and services.-The facility will ensure the physician's orders for dialysis include the location and type of access for dialysis (e.g. graft (uses a surgically implanted tube to connect an artery to a vein for hemodialysis access), arteriovenous shunt (directly connects the patient's artery and vein for hemodialysis access), external catheter (soft tubing inserted into a large vein for dialysis, with a portion remaining outside the body to connect to dialysis machines).-Residents with external dialysis catheters will be assessed every shift to ensure the catheter dressing is intact and not soiled. 1. Review of Resident #7's admission Record showed the resident was admitted to the facility with diagnoses that included:-Chronic Kidney Disease (CKD a condition in which the kidneys are damaged and can't filter blood as well as they should) Stage 4 (severe).-Dependence on renal (pertaining to the kidney) dialysis.Review of the resident's Stage 4 Kidney Disease, Requiring Dialysis care plan, dated 7/2/24, showed:-The resident had a port for dialysis on his/her right chest. Monitor dialysis shunt site for signs and symptoms of bleeding and/or infection every shift.-Nursing to monitor shunt site for warmth, color, edema, and bleeding. -Monitor shunt site right upper chest for bruits (in a dialysis fistula or graft, a continuous low-pitched whooshing sound, indicating proper functioning) and thrills (in a dialysis fistula or graft, a buzzing or vibrating sensation felt by placing fingers over the length of the site) twice daily. -If no bruits or thrills were heard, call the doctor and chart.Review of the resident's Physician Orders dated September 2025 showed:-Monitor dialysis shunt site for signs and symptoms of bleeding and/or infection every shift starting 9/10/25.-Monitor shunt site, right upper chest, for bruits and thrills every day and night shift for shunt care. If no bruits/thrills were heard, notify the doctor and chart starting 9/10/25.Review of the resident's progress notes dated November 2025 showed no documentation the orders were discussed with the physician for further clarification.Review of the resident's Quarterly Minimum Data Set (MDS - a federally mandated assessment instrument completed by facility staff for care planning), dated 12/9/25 showed the resident:-Was moderately cognitively impaired.-Was diagnosed with renal (kidney) failure/end stage renal disease (ESRD).-Received dialysis treatments.Review of the resident's progress notes dated December 2025, and January 2026 showed no documentation the orders were discussed with the physician for further clarification.Review of the resident's Medication Review Report, dated 1/23/26 showed:-Monitor dialysis shunt site for signs and symptoms of bleeding and/or infection every shift starting 9/10/25.-Monitor shunt site, right upper chest, for bruits or thrills every day and night shift for shunt care. If no bruits or thrills were heard, notify the doctor and chart starting 9/10/25.Review of the resident's Medication Administration Record (MAR), dated January 2026 showed:-Monitor the dialysis shunt site for signs and symptoms of bleeding and/or infection every day and night shift. --The day and night shifts both documented daily monitoring was being completed.-Monitor shunt site, right upper chest, for bruits or thrills every day and night shift for shunt care. If no bruits or thrills were heard, notify doctor and chart. --Staff documented daily on both shifts they were following the order.During an interview on 1/28/26 at 10:25 P.M. the MDS Coordinator said:-The resident's Dialysis Care Plan should be specific and accurate.-He/She used the physician orders to put the resident's interventions into the resident's care plan.-The resident's physician orders should be accurate, so the care plan was accurate.During an interview on 1/28/26 at 11:13 A.M. the Assistant Director of Nursing (ADON) said:-The resident's (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	bruit and thrill was checked twice a day, once by the day shift and once by the night shift. -The resident had a port on his/her chest related to his/her bradycardia (too slow heartrate).-Staff looked for discoloration or bruising on the resident's chest.-The resident's dialysis access site was on his/her arm. -He/She listened for the swish noise and felt for the throb.-The resident's orders said to check the bruit and thrill.Observation on 1/28/26 at 11:23 A.M. showed:-The ADON got a stethoscope and headed towards the resident's room.-While the resident was lying in bed, the ADON looked at both the resident's arms for the dialysis access site and then said he/she was incorrect about the location of the resident's access site. It was another dialysis resident who had the access site in their arm and the resident's access site was in his/her chest.-He/She put the end of the stethoscope and his/her fingers at the resident's upper right chest.During an interview on 1/28/26 at 11:30 A.M. the ADON said:-He/She checked the resident's access site for signs and symptoms of infection and drainage and made sure the dressing was clean, dry, and intact. -He/She also listened with the stethoscope for a whooshing sound and felt for good blood flow with his/her fingers.-The nurse needed to listen with the stethoscope and feel with his/her fingers no matter if the resident's access site was the arm or upper chest.During an interview on 1/29/26 at 10:50 A.M. Licensed Practical Nurse (LPN) B said:-A fistula and a port were not the same thing.-With a graft or fistula in the arm the nurse would check the bruit and thrill. -With a port in the chest the nurse did not check the bruit and thrill.-The nurse use to document on the Treatment Administration Record (TAR) when they checked the dialysis access site and now, they documented on the MAR. -If they had a port in the upper chest there would be no orders to check the bruit and thrill so that wouldn't be checked on the MAR.-The resident had a fistula in the past, but it failed and now he/she had a port in his/her upper chest.-He/She didn't work the resident's hall and didn't check his/her port site. Whoever was the nurse for the resident's hall would do that.-If the orders for checking the dialysis access site didn't make sense the charge nurse should contact the physician to clarify the orders.-He/She wasn't sure if the facility provided education within the past year on caring for the dialysis residents.During an interview on 1/29/26 at 11:06 A.M. LPN C said:-A dialysis fistula was under the skin, and a port was external tubing.-The nurse should check the bruit and thrill no matter if it was a fistula in the arm or a port in the chest.-If a nurse thinks an order needed to be clarified they should immediately check with the doctor and let the Director of Nursing (DON) know why they were contacting the physician. -After clarifying an order, the nurse should rewrite it as appropriate.-He/She never noticed anything unusual about the resident's orders related to checking his/her dialysis access site. -The resident had a port in his/her chest with external tubing.-He/She checked the bruit and thrill in the resident's chest. -He/She used his/her fingers to feel there was good blood flow and listened for the bruit which should be a beeping sound.-He/She checked to make sure the site was not red, irritated or infected and that the tubing was in place.-The facility provided training on caring for dialysis residents three or four years ago. At the time nurses were told to monitor the dialysis access site for infection every shift.During an interview on 1/29/26 at 1:50 P.M. the DON and Administrator said:-Orders should show the resident's type of access site.-If the resident had a graft or fistula in the arm the orders should show they needed to check the bruit and thrill. If the access site was in the chest, they would not check the bruit and thrill.-There had been no education provided to nurses since the new corporation took over a number of months back.-The resident's orders needed to be clarified and the nurses should have contacted the physician immediately.

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. Based on interview and record review, the facility failed to collaborate with one sampled resident (Resident #6) who experienced past trauma, to identify triggers which may re-traumatize the resident and develop care plan interventions to decrease the resident's exposure to triggers and to minimize the effect of the trigger on the resident out of 17 sampled residents. The facility census was 67 residents. Review of the facility's Trauma Informed Care (TIC) policy, dated 6/10/25, showed:-The facility will use a multi-pronged approach to identifying a resident's history of trauma, as well as their cultural preferences. This will include asking the resident about triggers that may be stressors or may prompt recall of a previous traumatic event as well as using screening and assessment tools.-The facility will collaborate with residents, and as appropriate, their family, friends, physician, and other health care and mental health professionals to develop individualized care plan interventions.-In some cases, if the facility has more than one trauma survivor, as appropriate, social services will make a good faith effort at establishing a support group that is run by a qualified professional or will assist the resident in locating a support group in the community as appropriate and feasible.-The facility will identify triggers which may retraumatize residents with a history of trauma. Trigger-specific interventions will identify ways to decrease the resident's exposure to triggers which retraumatize the resident, as well as identify ways to mitigate or decrease the effects of the trigger on the resident. These will be added to the resident's care plan.-Trauma-specific care plan interventions will recognize the interrelation between trauma and symptoms of trauma such as substance abuse, eating disorders, depression, and anxiety.-The facility will evaluate whether the interventions have been able to mitigate (or reduce) the impact of identified triggers on the resident. The resident. and/or his/her family/representative will be included in this evaluation to ensure clear open discussion and to better understand if interventions must be modified.-In situations where a trauma survivor is reluctant to share their history, the facility will still try to identify triggers which may re-traumatize the resident and develop care plan interventions which minimize or eliminate the effect of the trigger on the resident.1. Review of Resident #6's admission Record showed he/she was admitted with diagnoses that included:-Post Traumatic Stress Disorder (PTSD - a mental health condition caused by an extremely stressful event. Symptoms may include flashbacks, nightmares, avoidance behaviors, negative thinking and/or mood, severe anxiety, and uncontrollable thoughts about the event. The symptoms may vary over time.)-Anxiety Disorder (a psychiatric disorder causing feelings of persistent anxiety).-Major depressive disorder (MDD - a mental disorder characterized by a feeling of profound and persistent sadness or despair and is frequently accompanied by a loss of interest in things that were once pleasurable).-Mood disorder (a variety of conditions characterized by a disturbance in mood as the main feature).-Borderline personality disorder (BPD-a mental illness marked by an ongoing pattern of varying moods, self-image, and behavior).-Bipolar disorder (a chronic mental health condition characterized by extreme mood swings ranging from extreme highs to deep lows impacting energy, sleep, and daily functioning).-Schizoaffective disorder (a mental condition that causes loss of contact with reality and mood problems), depressive type.Review of the resident's Pre-admission Screening and Resident Review, Level II (PASRR Level II - an in-depth person-centered assessment triggered by a positive Level I screen, designed to confirm if nursing facility applicants have a serious mental illness (SMI), intellectual disability (ID), or related condition; and determines if the individual needs specialized services and ensures appropriate placement), dated 11/10/21, showed:-Recommendations for psychiatric rehabilitative services of a lesser intensity which could be provided by the nursing facility.-The resident's psychiatric history included MDD, recurrent; PTSD; bipolar disorder; alcohol abuse with alcohol induced psychotic disturbance with hallucinations (occurs within two weeks after long-term abuse of heavy alcohol consumption, characterized by difficulties perceiving one's environment and interactions with others, persisting after the effects of alcohol have worn off and lasting from 48 hours to up to six months).-The resident had a history of sexual and (continued on next page)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	emotional abuse by his/her ex-spouse and reported nightmares and flashbacks in the past. He/She was also attacked by another resident at his/her current nursing home before moving to another unit.-He/She had a long history of receiving both in-patient and out-patient psychiatric services.-The resident had thoughts of self-harm in the past and overdosed on prescriptions medications.-He/She reported a history of feeling sad, hopeless, anxious, and of polysubstance abuse.Review of the resident's Trauma Informed Care (TIC) Assessment, dated 1/4/25 showed the resident:-Felt guilty for past events.-Experienced a frightening or traumatic event.-Was triggered by violence or acting out that caused him/her to re-experience the traumatic event or flashback.Review of the resident's Significant Change Minimum Data Set (MDS - a federally mandated assessment instrument completed by facility staff for care planning), dated 11/21/25, showed the resident:-Was cognitively intact.-Felt down and depressed.-Was diagnosed with anxiety disorder, depression, and PTSD.-Took medications for anxiety and depression.Review of the resident's Mental Health care plan, initiated 11/30/25 showed:-The resident had multiple mental health diagnoses including a history of suicidal ideation, mood disorder, anxiety, depression, bipolar disorder, schizoaffective disorder, and PTSD that affected his/her mood, behavior, and daily functioning.-Interventions included:--Encourage compliance with prescribed medications and psychiatric follow-up--Maintain safety if concerning behaviors arise.--Monitor behavioral changes, mood instability, or suicidal statements and report immediately.--Offer emotional support and engage resident in calming activities.--Provide re-assurance and structured daily routine to reduce anxiety.Review of the resident's comprehensive care plan showed no plan related specifically to PTSD that included:-Triggers that might re-traumatize the resident.-Interventions/instructions on how best to avoid triggering the resident.-Interventions/instructions on how staff should respond when the resident was triggered.-There were no interventions related to who the resident should receive personal cares from related to toileting hygiene, showers, and dressing.-There were no interventions showing if the resident might benefit from counseling services or a support group.Review of the resident's medical record showed there was no TIC assessments completed in 2025 after 1/4/25.Review of the resident's medical record showed in 2025:-The resident was seen by geriatric psychiatric services for review of psychotropic medications (medications that affect brain function and/or alter mood, perception, or behavior). -The resident did not receive counseling services.Review of the resident's TIC assessment, dated 1/7/26 showed the resident experienced a frightening or traumatic event with no known symptoms (e.g. nightmares, being constantly on-guard, feelings of guilt) within the past month. Review of the facility Behavior Book showed:-Residents with behaviors were divided by name in a three-ring binder.-There was a tabbed section for Resident #6 in the binder. -There was no information on the resident's behaviors or PTSD.During an interview on 1/21/26 at 3:09 P.M. the resident said:-He/She was diagnosed with PTSD many years ago. -The facility was aware of his/her PTSD diagnosis.-He/She saw a psychiatrist who oversaw his/her medications, but the psychiatrist didn't ask about his/her PTSD and didn't provide counseling.-He/She had seen a counselor in the past.-He/She would like to see a female counselor, but nobody at the facility had ever asked him/her if he/she wanted to see a counselor and he/she never mentioned it to anyone.-He/She experienced physical, sexual, and emotional abuse as an adult by his/her ex-spouse, but he/she was no longer in his/her life and the childhood physical, sexual, and emotional abuse still bothered him/her the most.-Triggers which could make him/her think of past trauma and upset him/her were having a male care-giver, especially for getting dressed, showering, and toileting assistance; bowel movement smells; and people yelling or criticizing him/her. --It reminded him/her of when he/she was a child and how his/her abusers treated him/her.-He/She didn't like being spoken to in a harsh or critical manner by staff or being jerked around quickly when assisted out of bed.-He/She asked facility staff for only female caregivers but couldn't remember who he/she asked. So far only female staff had ever provided cares to him/her. -Nobody at the facility had ever talked to him/her about any PTSD needs or care planning.During an interview on 1/27/26 at 12:16 P.M. Certified Nurse Assistant (CNA) (continued on next page)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	C said:-He/She was not aware the resident had a diagnosis of PTSD.-The Behavior Book was accessible to all nursing staff, including the CNAs. -If someone was diagnosed with PTSD the Behavior Book should show the diagnosis and what staff could do to help avoid triggering the PTSD symptoms.-The care plan should be comprehensive and have everything in it to show what the resident's triggers were and how staff could help the resident with a PTSD diagnosis.During an interview on 1/27/26 at 12:16 P.M. CNA D said:-He/She wasn't sure what Trauma Informed Care was.-If a person was diagnosed with PTSD their triggers should be in the Behavior Book accessible to all nursing staff. It should also be in the resident's PTSD Care Plan.-The PTSD Care Plan should show how to tell if a resident had been triggered and what to do if they were triggered as well as how to try to prevent triggering the resident.-He/She wasn't sure if the Behavior Book showed the resident's triggers or how staff could help him/her.During an interview on 1/28/26 at 10:42 A.M. the MDS Coordinator said:-He/She hadn't received TIC education at the facility.-The Social Worker provided information for the PTSD care plan.-A PTSD care plan should show the resident's past trauma and include the resident's triggers. During an interview on 1/28/26 at 10:50 A.M. the MDS-in-Training said:-A PTSD care plan should include the resident's triggers and show what staff could do to try to avoid triggering the resident. -It should also have interventions that show how staff could reduce the effects of the trigger on the resident.During an interview on 1/28/26 at 11:42 A.M. the Assistant Director of Nursing (ADON) said:-He/She had received TIC education at the facility. -Staff were taught that a resident may be triggered by different things. They may not want a male aide to provide cares or might be triggered by smells or loud noises such as the fire alarm. -Something they saw on television could also trigger the resident.-PTSD should be care planned and the care plan should show the resident's triggers and how staff could reduce the chance of the resident being triggered and what to do if they were triggered.-The information from the PTSD Care Plan should be reflected in the Behavior Book which all nursing staff have access to. -The CNAs have been told where to find the Behavior Books on both units.-He/She didn't know what the resident's triggers were.-He/She knew the resident didn't like his/her door shut or people in his/her space but didn't know if it was related to PTSD.-He/She didn't know the resident requested to not have male caregivers, but there were currently no male caregivers at the facility. -The resident was seen by a psychiatrist related to his/her psychotropic medications and was not currently seeing a counselor. -He/She thought counseling had been offered once to the resident and at the time the resident didn't want to go.During an interview on 1/28/26 at 12:02 P.M. the Social Services Director said:-The PTSD care plan should show a resident's triggers, how staff could avoid triggering the resident, and what to do if the resident was triggered.-The resident told him/her PTSD didn't bother him/her anymore and never said he/she wanted counseling services. -He/She never asked the resident what services or interventions the resident could benefit from related to his/her PTSD diagnosis.-There were a couple of mental health service providers in the area that could be set up for the resident if he/she wanted that.-The resident had a TIC assessment on 1/4/25 and another one on 1/7/26. The TIC assessment should have been done quarterly for any resident with a PTSD diagnosis.During an interview on 1/29/26 at 1:50 P.M. the Director of Nursing (DON) said:-Resident interventions should be individualized.-A PTSD care plan should include the resident's triggers and show what staff could do to minimize the chances of triggering the resident and how they could help if the resident was triggered.