STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265353	A. Building B. Wing	03/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Quail Run Health Care Center	1405 West Grand Ave Cameron, MO 64429

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on observation, interview and record review, the facility failed to treat residents with dignity and respect with dining when the facility allowed one resident (Resident #24) to eat a meal in his/her room while setting next to his/her soiled bed and when staff stood to assist four residents (Resident #1, #8, #22, #42) with eating while in the dining room. This affected five of 15 sampled residents. The facility census was 55.Review of the undated facility policy titled, Resident Rights, showed:-Residents have the right to a dignified existence;-Residents have the right to personal privacy, including accommodations;-Residents have the right to be free from involuntary seclusion;-The facility shall care for its residents in a manner that promotes enhancement of each resident's quality of life. 1. Review of Resident #24's Quarterly Minimum Data Sheet (MDS), a federally mandated resident assessment tool completed by facility staff, dated 02/12/2026, showed:-Mild cognitive impairment;-Moderate assistance required for toileting, hygiene, and lower body dressing;-Frequently incontinent of bowel and bladder;-Diagnoses included Schizophrenia, Alzheimer's Dementia, overactive bladder, and urinary incontinence. Review of the resident's care plan dated 03/17/2026, showed:-Resident had an Activities of Daily Living (ADL) self-care performance deficit and activity intolerance;-Resident was dependent on nursing staff for assist with all ADL's.-Resident wished to be satisfied with current living situation;-Staff were supposed to allow the resident to make some decisions about treatment and care; Observation of the resident on 03/24/2026 at 08:35A.M. showed:- He/She was in his/her room in a wheelchair;-The resident did not have pants or underpants or an incontinent brief on;-The resident's bed and linens were saturated with urine. Observation on 03/24/2026 at 10:04A.M., showed:-He/She sat in a wheelchair in his/her room;-The resident was sitting next to his/her soiled bed; the bed linens were saturated with urine; -A strong odor of urine present;-The resident's eaten meal tray was on the bedside table next to bed;-The resident had consumed meal while sitting next to a saturated bed of urine. During an interview on 03/27/2026 at 09:20 A.M., Nursing Aid (NA) A said: -The resident's meal tray should not have been delivered to the resident since he/she had been incontinent and required assist with toileting; -Staff should have removed the meal tray, assisted resident with incontinence care and dressing;-The staff should have cleaned the resident's soiled bed, warmed the meal and then served the meal;-It is not reasonable for the resident to eat his/her meal next to his/her soiled bed. During an interview on 03/27/2026 at 09:50 A.M., Licensed Practical Nurse (LPN) A said:-The resident's meal tray should have not been delivered to the resident when he/she was next to his/her soiled bed; -The meal should have been removed and the resident assisted with getting soiled areas cleaned;-The resident should have been offered meal; -The resident eating a meal next to a soiled bed was un-dignified. During an interview on 03/27/2026 at 10:15A.M., the Assistant Director of Nursing (ADON) said:-Residents should not have to eat meals next to a soiled bed; -Staff should have assisted the resident with hygiene, grooming and dressing;-Staff should have cleaned up the resident's soiled bed, warmed the resident's food and served resident after clean-up was completed. 2. Observation on 03/24/2026 from 12:51P.M. through 1:15P.M., showed staff members standing to feed residents in the dining room:-RN C standing to feed Resident #8;-RN C standing to feed Resident #1;-NA B standing to (continued on next page)

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

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	feed Resident #8;-NA A standing to feed Resident #8;-RN C standing to feed Resident #22;-NA A standing to feed Resident #42. During an interview on 03/24/2026 at 2:35P.M., NA B said that staff should be seated when assisting residents with meals but there are not enough chairs in dining room for all staff to sit while feeding residents. During an interview on 03/27/2026 at 09:30A.M., the Activities Director/CNA said that staff should not stand to feed residents, they should be at resident's eye level so residents can see and interact with staff. During an interview on 03/27/2026 at 09:50A.M., LPN B said staff are supposed to sit at eye level when assisting residents to eat. During an interview on 03/27/2026 at 10:40A.M., the DON said staff should be seated when assisting residents with meals to maintain eye contact and interact with each other.

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F 0569 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Notify each resident of certain balances and convey resident funds upon discharge, eviction, or death. Based on interview and record review, the facility failed to provide personal funds and a final accounting within thirty days upon discharge for six residents (Resident #11, #63, #64, #65, #66 and #67). This affected six of 14 residents sampled. Facility census was 55. Resident policy on the management of discharged resident fund accounts not provided;1. Review of the facility's Accounts Receivable Aging Report, dated 3/24/26, showed:- Resident #11 discharged on 7/4/23 and had an outstanding credit of $176.38 to his/her private pay account. - Resident #63 discharged on 1/3/25 and had an outstanding credit of $2,697.40 to his/her patient liability account.- Resident #64 discharged on 1/19/25 and had an outstanding credit of $923.68 to his/her patient liability account.- Resident #65 discharged on 2/3/24 and had an outstanding credit of $885.24 to his/her private pay account.- Resident #66 discharged on 8/9/24 and had an outstanding credit of $26.05 to his/her patient liability account.- Resident #67 discharged on 5/27/23 and had an outstanding credit of $717.08 to his/her patient liability account. During an interview on 3/25/26 at 10:00 A.M., the Business Office Manager (BOM) said:- The facility switched accounting systems in July 2024 and this has caused some reconciliation delays with discharged resident accounts.- Resident #11 was reviewed and Medicare was informed of the outstanding credit balance through the submission of a TPL form dated 3/25/26.- Resident #63 did not have a TPL form submitted at the time of discharge. The corporate office was notified of the outstanding credit balance on 12/8/25 but no response has been received. This issue is ongoing and being following up by the BOM.- Resident #64 is due a refund of $923.68 and a request was sent to the corporate office for approval on 3/25/26.- Resident #65 is due a refund of $885.24 and a request was sent to the corporate office for approval on 12/6/25. - Resident #66 requires a TPL form to be submitted and a request for corporate approval was submitted 3/25/26.- Resident #67 is due a refund of $717.08 and a request was sent to the corporate office for approval on 12/12/25.During an interview on 3/26/26 at 9:30 A.M., the BOM and Corporate Accountant said that the expectation is that residents upon discharged have their accounts reconciled within 30 days.During an interview on 3/27/26 at 8:15 A.M., the Administrator said that when residents discharge or expire their accounts should be reconciled within 30 days.

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. Based on interview and record review, the facility failed to provide a Skilled Nursing Facility Advance Beneficiary Notice (SNFABN-form CMS-10055) or a denial letter at the initiation, reduction or termination of Medicare Part A services and Notice of Medicare Non-Coverage (NOMNC-form CMS-10123, a notice that indicates when care is set to end from a skilled nursing facility) for two sampled residents (Resident #39 and Resident #62) This affected two of the 14 sampled residents. The facility census was 55.The facility was unable to provide a SNF/ABN policy when requested. 1.Review of Resident #62's Electronic Medical Record (EMR) showed:-Medicare Part A last day of coverage 01/04/2026;-SNF/ABN form provided to resident;-Resident signed form 01/05/2026;-The resident was unable to appeal Medicare A discharge. 2.Review of Resident #39's EMR showed:-Medicare Part A last day of coverage 02/16/2026;-SNFABN provided to resident/representative;-SNFABN form signed by resident/representative on 02/26/2026;-The resident or representative was unable to appeal Medicare A discharge. During an interview on 04/02/2026 at 4:00P.M., the Social Services Designee (SSD) said:-A weekly Inter Disciplinary Team meeting happens weekly to determine which residents will lose covered days soon;Residents should be notified prior to loss of coverage;-Some Insurance companies do not notify facility until day of stoppage of coverage, even if on a weekend. During an interview on 03/27/2026 at 11:00A.M., the Administrator said that SNFABNs are completed by SSD and is not sure why it was not completed prior to end of services/coverage.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure a safe, clean, comfortable, and homelike environment, ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk when the facility failed to ensure that flooring, baseboards, and windows were in good repair for two residents (Resident #11 and #18). Failed to allow one resident (Resident #29) to sit where he/she would like during meals in the dining room with a broken window in view of all residents, and when the facility staff served Resident #28 a peanut butter and jelly sandwich in a plastic bag rather than on a plate, and when the facility failed to ensure the small shower room on the North hall was repaired in a timely manor for all resident's on the North hall. The facility census was 55. Review of the facilities Homelike Environment policy, dated February 2021, showed: - Residents were provided with a safe, clean, comfortable and homelike environment. - The facility staff and management maximize, to the extent possible, the characteristics of the facility that reflect a personalized, homelike setting. 1. Review of Resident #18's Quarterly Minimum Data Set (MDS) a federally required assessment tool completed by facility staff, dated 3/19/26, showed: - The resident was cognitively intact; - The resident used a walker to assist with walking; - The resident had diagnoses of repeated falls, presence of right artificial hip, and hypertension (high blood pressure). Review of the resident's care plan, dated 2/27/26, showed: - The resident required minimal assistance with completing activities of daily living; - The resident was grieving due to having to sell the home he/she resided in for 20 years to finically support his/her admission to the facility. It was important to help facilitate the resident's adjustment to new home at the facility. Observation on 03/24/2026 at 10:30 A.M. showed: - The flooring in the resident's room had chips in the tile flooring near the resident's bed and bathroom; - There were no baseboards in the resident's room. During an interview on 03/24/2026 at 9:20 A.M. the Maintenance Supervisor said: - A Rehab project started on the north hall resident rooms in November of 2025 where all of the baseboards were removed from the resident rooms and resident bathrooms; (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- He had been asking for several months when the work would be completed but had not received an answer from administration. During an interview on 03/24/2026 at 10:33 A.M. the resident said: - The floor needed fixed, he/she stubbed his/her toe on the chipped flooring in his/her room; - The baseboards in his/her room had been missing since he/she moved into the facility in September of 2025. Observation on 03/24/2026 at 1:06 P.M. showed a large crack in the middle of the glass on the door in the dining room that goes outside to the patio. During an interview on 03/25/2026 at 2:00 P.M. the resident said: - The window in the dining room had been cracked since he/she moved into the facility in September of 2025; - He/she would not touch the window because he/she was afraid it might break. During an Interview on 03/27/2026 at 11:01 A.M. the Administrator in Training said: - Flooring in resident rooms had been chipped for approximately a year; - Baseboards in resident rooms had been removed for approximately a year; - An outside contractor was putting in the new flooring in the resident rooms. Observation on 03/27/2026 at 10:22 A.M. showed the small shower room on the north hall was unable to be used due to a broken shower handle. During an interview on 03/27/2026 at 10:29 A.M. Resident #18 said, it was inconvenient to wait and made the process for showers very slow. It would have been nice to have two working showers on the north hall so more than one resident could take a shower at a time. During an interview on 03/27/2026 at 10:32 A.M. LPN C said: - The small shower on the north hall had been broken for over a year; - Only having one functioning shower room on the north hall made it difficult to get all of the resident's showers done in a timely manor. During an interview on 03/27/2026 at 11:01 A.M. the Administrator in Training said: - The handle in the small shower room had been broken for approximately a year and a half; - There were other maintenance projects that were placed ahead of getting the small shower on the north hall fixed. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-He said he hadn't heard any complaints about their only being one shower on that hall but was aware that there was only one working for an extended amount of time. 2. Review of Resident #52's Comprehensive MDS dated [DATE], showed: -No cognitive impairment; -Dependent on staff for assist with mobility and transfers; -Diagnoses included arthritis, diabetes and depression. Review of Resident's care plan dated 03/06/2026, showed: -Resident at risk for depression due adjusting to her new living arrangements at the facility; -Resident will be continuously monitored to ensure he/she has the resources in place to address depression and mental health concerns; -Resident to take anti-depressant medication as prescribed; -No specific interventions, goals, activities or psychosocial interventions for depression. During an interview on 03/25/2026 at 08:30A.M., resident said: -He/she would like curtains open during the day, but there are other residents that sit in the courtyard, and he/she does not want to be looked at; -A sheer curtain or opaque window cling would be acceptable coverage to keep outsiders from looking in; -A window cling would likely not stick to the shattered window; -The window has been shattered since he/she was admitted over a year ago; -Facility staff told him/her the windows were to be replaced soon; -He/she feels forgotten. An observation on 03/25/2026 at 08:30A.M., showed windows with heavy curtains drawn shut, when curtains pulled back, window had greater than five cracks with clear tape. During an interview on 03/27/2026 at 11:00A.M., the Administrator said: -There are ways to have curtains open to allow sunlight and an exterior view while keeping others from looking in; -A broken window in a resident room for over a year is unreasonable; -The facility should replace all broken windows as soon as possible. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. Review of Resident #11's Quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 1/28/26 showed: Cognitive skills intact. Independent with transfers and toilet use. Occasionally incontinent of urine. Always continent of bowel. Diagnoses included depression, psychotic disorder (a mental health disorder where a person loses touch with reality) and schizophrenia (a long-term mental illness where a person has trouble telling what is real and what is not). Observation and interview on 3/24/26 at 3:36 P.M., showed: There were no baseboards around the entire room including the bathroom. The white toilet seat in the bathroom showed it was significantly worn with the original white finish no longer visible and underlying material exposed. The resident said the staff removed the baseboard about a year ago when they painted the room. It did not bother him/her, and the toilet seat did not bother him/her. During an interview on 3/27/26 at 10:40 A.M., the Administrator in Training (AIT) said: If the white has worn away and underlying material is exposed, it should be replaced. The baseboards have been missing from some of the rooms for about a year. 4. Review of Resident #29's Quarterly Minimum Data Set, dated [DATE], showed:- Resident was cognitively intact;- Diagnoses: coronary artery disease, dementia, and seizure disorder; During an interview on 3/24/26 at 12:35 P.M., the Resident said:- He/she has no choice where he/she can sit in the dining room. All the seats are assigned, and they won't let her choose where he/she can sit. He/she would like to sit with a friend so he/she could talk more at lunch. It makes him/her very frustrated and mad he/she can't sit where he/she wants to each day. Observation in the dining room on 3/24/26 at 12:37 P.M., showed drink cart service for the dining room residents starting. 5. Review of Resident #28's Quarterly MDS, dated [DATE], showed:- No cognitive screening done for resident;- Diagnoses: aphasia (impaired ability to understand or produce speech), stroke, dementia, anxiety disorder, depression and seizure disorder; Observation in the dining room on 3/24/26 at 12:46 P.M., showed:- First meals for lunch coming out of the kitchen for the main dining room.- 12:52 P.M. Resident did not eat his/her lunch, and he/she was offered a peanut butter and jelly sandwich. The resident agreed to having the substitute and it was (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	delivered to the resident in a plastic bag without a plate. Observation in the dining room on 3/24/26 at 12:37 P.M., showed:- Drink cart service for the dining room residents started.- NA (B) delivered a food tray to a resident without saying a word to the resident or asking if he/she needed anything to go with his/her meal. NA (B) just placed the dishes on the table and immediately turned his/her back to the table and went back to get another resident's food order.- 1:10 P.M. Three eight-foot-high food carts with dirty dishes are taken to the main dining room and stored at the front center of the room less than 15 feet from residents eating. Observation in the kitchen on 3/26/25 at 7:10 A.M., showed pre-made peanut butter and jelly sandwiches made on 3/25/26 in plastic bags in a plastic container sitting on the counter. The use by date was 3/28/26, 4 days after being made. Observation of the main dining room on 3/24/26 at 12:30 P.M., showed the exit door window in the dining room has two large cracks in the window, three feet by one foot in diameter. - A sign posted showing lunch is to be served a noon; -21 residents assembled at various tables throughout the dining room. -No drinks had been served, no condiments were on any of the tables, there were no place settings on the tables, there were no napkins or silverware available and there were no decorations or centerpieces on any of the tables. During an interview on 3/27/26 at 10:45 A.M., the Administrator said:- Breakfast starts at 8:00 A.M. in the main dining room and she would not expect residents to have to wait until 8:40 A.M. to be served.- She would expect alternate food items for meals to be made to order and not prepared the day before.- She would not expect sandwiches to be served in plastic bags to residents during the meal;

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure they developed and implemented a comprehensive person-centered plan of care which included measurable objectives and timeframes to address and meet each resident's specific medical, nursing, mental, and psychosocial needs when the facility staff failed to ensure call light within reach and ensure anti-slip material in place to ensure safety (Resident #8); when the facility had conflicting information regarding discharge planning in resident's current care plan (Resident #10); when the facility failed to develop a plan of care regarding resident wandering or exit seeking behavior and when the facility failed to initiate a care plan for a resident that required meal intake in a specific location that was not the public dining room or personal room (Resident #37) and additionally when the facility failed to initiate or implement life-enriching activities for a resident diagnosed with depression (Resident #52). This affected four of 15 sampled residents the facility census was 56. 1.Review of Resident #8's Quarterly Minimum Data Set (MDS, a federally mandated assessment tool completed by facility staff) dated 02/12/2026, showed:-Moderate cognitive impairment;-Incontinent of bowel and bladder;-Maximum assist with transfers related to hemiplegia (inability to use one side of the body);-Diagnoses included: heart failure, stroke and diabetes mellitus (metabolic disease). Review of the resident's care plan dated 02/06/2026, showed:-Dependent on staff for meeting emotional, intellectual, physical, and social needs;-Staff to ensure resident's call light is within reach;-Resident required (Dysem), an anti-slip material to be placed in his/her wheelchair to help prevent falls);-No goals or staff interventions to help prevent skin breakdown/skin injury related to resident's incontinence or immobility. Observation on 03/24/2026 at 09:52A.M., showed:-Resident seated in his/her Broda chair (a wheelchair used to assist with positioning and pressure reduction);-Call light attached to shirt at shoulder level to resident's non paralyzed side;-Resident unable to move opposite limb to reach call light to alert staff of needs. Observation on 03/25/2026 at 1:12P.M., showed resident in room, seated in Broda chair, call light laying across bed behind resident out of his/her reach. Observation on 03/26/2026 at 02:22P.M., showed:-Resident lying in bed, watching television;-Call light attached to calendar, hung from wall, on resident's paralyzed side, out of reach;-No Dysem in resident's wheelchair. During an interview on 03/27/2026 at 09:50A.M., Licensed Practical Nurse B said that residents that have Dysem care planned, as a safety intervention should have product in place, as well as the nurses check for placement each day and chart if in place or missing. 2. Review of Resident #10's comprehensive MDS dated [DATE], showed:-Resident cognitively intact;-Independent with mobility, ambulation and ADLs (Activities of Daily Living);-Diagnoses included Bipolar, cancer, heart disease and high blood pressure. Review of resident's care plan dated 02/26/2026, showed:-Resident at risk for urinary retention and is perform intermittent self-catheterization (a tube temporarily placed in the bladder to drain urine and then removed) twice daily with minimal assist from staff;-Resident is unable to make sound decisions or live independently;-Resident to be satisfied with current living arrangements at facility;-Wishes to be discharged to the community upon successful completion of treatment (dated 12/2024);-Resident will be able to verbalize/communicate required assistance post-discharge and the services required to meet needs before discharge. Review of the Physician's Order Set dated 03/24/2026 showed no orders for intermittent catheterization by staff or by resident. A catheterization requires a physician order and aseptic technique (a set of specific practices used in healthcare to prevent contamination and maintain sterility). 3.Review of Resident 37's Quarterly MDS dated [DATE], showed:-Severe cognitive impairment;-Wandering behavior not displayed;-Supervision and intermittent assist from staff required for meal intake;-Diagnoses included cancer, pneumonia, tremors and hearing loss. Review of resident's care plan dated 12/02/2025, showed:-Dependent on staff for meeting emotional, (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	intellectual, physical, and social needs;-Resident often wandered and had exit seeking behaviors; -Potential fluid deficit related to poor intake and dementia;-Swallowing problem related to pocketing food in cheek and delayed swallowing;-No interventions or indications that resident needs to be assisted with meals in hallway; Review of resident's physician order set dated 03/25/2026, showed no orders for wander guard (a specialized electronic system that prevents residents with dementia from wandering into danger.) Observation on 03/24/2026 at 09:11A.M., showed resident assisted by facility staff at south nurse's station, wander guard bracelet in place to right ankle. Observation on 03/25/2026 at 08:30A.M., showed resident being assisted with meal by facility staff at south nurse's station, wander guard bracelet in place to right ankle. Observation on 03/25/2026 at 12:53P.M., showed resident being assisted with meal by facility staff at south nurse's station, wander guard bracelet in place to right ankle. During an interview on 03/27/2026 at 09:50A.M., the Activity Director (AD) said:-The resident should not be made to eat alone in the hallway, that resident's family/representative wants him/her to have meals in the hallway;-Eating in hallway should be care planned as a preference;-He/She is able to input and edit care plans. 4. Review of Resident #52's Comprehensive MDS dated [DATE], showed:-No cognitive impairment;-Dependent on staff for assist with mobility and transfers;-Diagnoses included arthritis, diabetes and depression. Review of Resident's care plan dated 03/06/2026, showed:-Resident at risk for depression due adjusting to her new living arrangements at the facility (initially dated 03/21/2025);-Resident will be continuously monitored to ensure he/she has the resources in place to address depression and mental health concerns;-Resident was grieving the loss of his/her independence;-No specific interventions, goals, activities or psychosocial interventions for depression;-No mention of resident preferences such as food, activities, time of rising, books, television, etc. During an interview on 03/25/2026 at 08:30A.M., the resident said:-He/She preferred not to get out of bed as it caused increased pain;-He/She received a monthly activities calendar dropped off to him/her;-The staff provided activity and puzzle books intermittently, all the ones he/she currently had were all completed;-He/She would be willing to get out of bed and go to one previously agreed upon group activity per week;-He/She felt forgotten. During an interview on 03/27/2026 at 09:50A.M., the Activity Director (AD) said:-He/She can implement and make changes to resident care plans;-All residents have activities categories with personal preferences in their care plans;-To know the resident feels forgotten makes him/her feel heart broken. During an interview on 03/27/2026 at 10:40A.M., the Director of Nursing said:-Residents that require isolation with meals should have that intervention on his/her care plan;-Dysem is obtained from therapy staff and should be in place at all times;-Baseline care plans are formulated from staff assessments and comprehensive care plans are formulated after care conference meetings with the interdisciplinary team (IDT);-Residents that are incontinent of bowel or bladder are at risk for skin integrity impairment;-A physician order is required for wander guards and placement of wander guard should be in care plan;-Call lights should be within reach of each resident when in his/her own room. During an interview on 04/02/2026 at 4:00P.M., the Social Services Designee (SSD) said:-All residents should have an activities category, including personal preferences on their care plans;-The AD inputs most activities and preferences, but upon admission, SSD does a thorough assessment with resident and family members;-Wander guards are supposed to have a physician order and be in the resident's care plan as an intervention to maintain safety; -If an intervention such as Dysem is care planned, then that intervention should be in place;-It is not reasonable that a resident has a goal to be comfortable and adjusted in new environment for over 12 months without any additional interventions; -Residents that are incontinent of bowel or bladder are at risk for skin integrity impairment and that interventions such as checking resident for soiling every 2 hours and repositioning should be care planned;-Quarterly IDT meetings are held and care plans are amended within two weeks of meeting date;-SSD, MDS Coordinator, AD and dietary manager are the only staff that are able to make changes to care plans. During an interview on 04/02/2026 at 4:15P.M., the MDS Coordinator said:-All care planned interventions should be in place;-Care plans and MDS assessments (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	are completed per regulations;-The care plan and MDS assessments should accurately reflect each other;-After an MDS assessment or care conference, the care plan is required to be updated within 14 days.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure resident's who were unable to carry out activities of daily living received the necessary services to maintain good grooming and personal hygiene when the facility failed to ensure proper perineal care was provided to three (Resident's #1, #42, and 54) of 14 sampled resident's. The facility census was 55. Review of the facility policy titled, Perineal Care, dated February 2018, showed: - The purpose of this procedure was to provide cleanliness and comfort to the resident, to prevent infections and skin irritation, and to observe the resident's skin condition; - For the female resident: wet a washcloth and apply soap or skin cleansing agent, separate labia and wash area downward from front to back, continue to wash the perineum moving from inside to outward toward the thighs, rinse perineum thoroughly in the same direction using fresh water and a clean washcloth, have resident turn to side, rinse washcloth and apply soap or skin cleansing agent, wash and rinse the rectal area thoroughly wiping from the base of the labia towards and extending over the buttocks; - For the male resident: wet a washcloth and apply soap or skin cleansing agent, wash perineal area starting at the urethra and working outward, wash and rinse urethral area using a circular motion, continue to wash the perineal area including the penis, scrotum, and inner thighs, thoroughly rinse the perineal area in the same order using fresh water and a clean washcloth, have resident turn to side, rinse washcloth and apply soap or skin cleansing agent, wash and rinse the rectal area thoroughly including the area under the scrotum, the anus, and the buttocks; - The facilities policy did not address the use of disposable cleansing wipes. 1. Review of Resident #1's Quarterly Minimum Data Set (MDS) a federally required assessment tool completed by facility staff, dated 03/10/26, showed: - The resident was cognitively intact; - The resident required assistance with toileting and dressing; - The resident had diagnoses of depression, muscle weakness, and cognitive communication deficit. Review of the resident's care plan, dated 03/06/26, showed: - The resident was occasionally incontinent of bowel; - The resident was occasionally incontinent of urine; - The resident required assistance with activities of daily living due to a mobility deficit. Observation on 03/26/2026 at 1:52 P.M. showed: - Certified Nursing Assistant (CNA) C and Nursing Assistant (NA) D performed perineal care for the resident; (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- The resident's perineal appeared to be red from moisture sitting on the skin too long; - NA D used a disposable cleansing wipe to clean bowel movement off of the resident, folded the cleansing wipe and used it again to clean more bowel movement off of the resident; - NA D used a disposable cleansing wipe to clean bowel movement off of the resident, folded the cleansing wipe and used it again to clean more bowel movement off of the resident. During an Interview on 03/26/2026 at 2:09 P.M. NA D said disposable cleansing wipes could be folded up to four times while cleaning bowel movement off of a resident but he/she usually did not fold the cleansing wipes more than twice. During an Interview on 03/27/2026 at 9:25 A.M. Certified Medication Technician (CMT) A said disposable cleansing wipes should not be folded and used again when providing perineal care to residents. During an Interview on 03/27/2026 at 9:22 A.M. Licensed Practical Nurse (LPN) B said disposable cleansing wipe should only be used once while providing perineal care to residents. During an Interview on 03/27/2026 at 10:32 A.M. LPN C said disposable cleansing wipes should not be folded and reused while providing perineal care for residents. During an Interview on 03/27/2026 at 11:01 A.M. the Director of Nursing (DON) said while cleaning bowel movement off of a resident disposable cleansing wipes should not be folded and reused. 2. Review of Resident #42's Comprehensive MDS, dated [DATE] showed: - Cognitive skills severely impaired. - Physical behavior directed at others and verbal behaviors directed at others occurred one to three days; - Other behaviors not directed at others occurred one to three days. - Upper and lower extremities impaired on both sides; - Dependent on staff for toilet use, dressing, personal hygiene and transfers; - Always incontinent of bowel and bladder; - Diagnoses included stroke, psychotic disorder (a mental condition where a person loses touch with reality) and schizophrenia (a long-term mental illness where a person has trouble telling what is real and what is not). Review of the resident's care plan, revised on 02/11/26 showed: - The resident had bowel incontinence related to immobility. Interventions included checking the resident every two hours and assist with toileting as needed. Provide peri care after each incontinent episode. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- The resident had an activity of daily living (ADLs) self-care performance deficit related to stroke. The resident is not toileted. The resident is a check and change. Observation on 03/25/26 at 9:27 A.M., showed: - CNA A and the Activity Director used the mechanical lift and transferred the resident from the Broda chair (a type of reclining geri chair) to his/her bed; - CNA A wiped down each side of the resident's groin and used a different wipe each time; - CNA A did not separate and clean all of the skin folds; - The resident urinated during the peri care; - After the resident finished, the Activity Director wiped down each side of the groin with a different wipe each time; -The Activity Director did not separate and clean all the skin folds or all areas of the skin where urine had touched; - CNA A and the Activity Director turned the resident side to side and removed the wet incontinent brief and placed a clean one on the resident and fastened it; - CNA A and the Activity Director did not clean the buttocks. During an interview on 03/26/26 at 2:51 P.M., CNA A said: - He/She should have separated and cleaned all areas of the skin where urine had touched; - He/She should have cleaned the front skin folds and the buttocks. During an interview on 03/26/26 at 3:15 P.M., the Activity Director said: - He/She should have separated and cleaned all areas of the skin where urine had touched; - The front should be cleaned the front because that's where the urine was and should have cleaned the buttocks. 3. Review of Resident #54's Quarterly MDS, dated [DATE] showed; - Cognitive skills intact; - Upper and lower extremities impaired on both sides; - Dependent on staff for toilet use, personal hygiene, and transfers; - Frequently incontinent of urine; - Occasionally incontinent of bowel; (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Diagnoses included neurogenic bladder (a dysfunction that results from interference with the normal nerve pathways associ8ated with urination), anxiety, depression, bipolar disorder (a mental health condition that causes extreme mood changes), paraplegia (a person cannot feel or move the lower half of their body) and quadriplegia (a condition where a person cannot move or feel both arms and both legs). Review of the resident's care plan, revised on 03/23/26 showed: - The resident had an ADL self-care performance deficit related to disease process paraplegia; -The interventions included the resident is occasionally incontinent of urine; -Required the assistance of two staff for the use of the sit to stand (a mechanical lift that allows a resident who can bear weight to transfer from a sitting position to standing position); -The resident used a motorized wheelchair; - The resident had a neurogenic bladder with occasional bladder incontinence related to cervical myelopathy (a condition where the spinal cord in the neck is compressed). Observation on 03/25/26 at 3:25 P.M., showed: - CNA B and NA D used the sit to stand mechanical lift and transferred the resident from his/her motorized wheelchair to bed; - CNA B and NA D turned the resident onto his/her side; - CNA B used one wipe and with the same area of the wipe, cleaned both sides of the resident's buttocks and wiped from front to back; -CNA B and NA D turned the resident onto his/her back; - CNA B wiped down each side of the groin and used a different wipe each time; - CNA B used a new wipe and with the same area of the wipe and cleaned the front skin folds; -CNA B did not separate and clean all the skin folds. During an interview on 03/25/26 at 3:39 P.M., CNA B said: - He/She should not have used the same area of the wipe to clean different areas of the skin; - It should have been a single wipe per area; - He/She should have separated and cleaned all the skin folds where urine had touched. During an interview on 3/27/26 at 10:40 A.M., the DON said: - Staff should separate and clean all the skin folds, including the buttocks and after the resident had (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	urinated, should have made sure to clean all areas of the skin where urine had touched; - Staff should not fold the wipe and should not use the same area of the wipe to clean different areas of the skin.

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. Based on interview and record review, the facility failed to have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to maintain the highest practicable physical well-being of the residents when no annual training records were found for licensed nurses. The facility census was 55. The facility did not provide a policy for competencies for the licensed nurses. During an interview on 03/25/26 at 12:56 P.M., Licensed Practical Nurse (LPN) A said:- He/She has worked at the facility for about three weeks;- He/She remembered an in-service on gait belt (a special belt placed around the resident's waist to provide a handle to hold onto during a transfer) training;- He/She had completed online training for dementia care, abuse/neglect, infection control, communication, catheter care, peri care, and transfers;- He/She had not completed any competencies. During an interview on 03/25/26 at 3:14 P.M., LPN D said:- He/She has worked at the facility for about four or five months;- He/She had completed in-services on the computer for abuse/neglect, infection control, communication, dementia care, behaviors, transfers, catheter (sterile tube inserted into the bladder to drain urine) and per care;- He/She had not completed any competencies. During an interview on 03/26/26 at 03:08 P.M. the Regional Nurse Consultant (RNC) said the facility has not had any of the licensed nurses do any competencies. During an interview on 03/27/26 at 10:40 A.M., the Director of Nursing (DON) said the licensed nurses should have been doing competency skills during their orientation.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observations, interviews, and record review, the facility failed to label and date medications and biologicals stored within the North medication room. The staff failed to date an opened bottle of Lorazepam (used to treat anxiety) for one of the 14 sampled residents, (Resident #16), and failed to label four house stock insulin pens, and failed to date an opened bottle of house stock melatonin (a medication used for insomnia). The facility census was 55. The facility did not provide a policy for labeling and dating of medications. 1. Observation and interview on 03/25/26 at 12:37 P.M., of the North medication room showed: - Resident #16 had an opened bottle of Lorazepam 2 milligram per milliliter (2 mg/ml). It was filled on 2/13/26. The box said to discard 90 days after opening; - Licensed Practical Nurse (LPN) A said it should have been dated when it was opened; - Four Levemir (long acting) insulin pens were in a clear plastic cup and did not have pharmacy label to indicate if they were house stock or if they belonged to a resident; - LPN A said they were house stock and should have a pharmacy label on them. During an interview on 3/27/26 at 10:40 A.M., the Director of Nursing (DON) said: - The insulin pens should have a label on them to indicate who they belonged to, even if they were used for house stock; - The Lorazepam should have been dated when it was opened. 2. Observation on 03/26/2026 at 2:46 P.M. showed the south medication cart had an opened bottle of over the counter (OTC) 3milligram (mg) melatonin that did not have a date indicating when the bottle was opened. During an Interview on 03/26/2026 at 2:46 P.M. Certified Medication Technician (CMT) B said house stock of OTC medications should have the date written on the bottle indicating the day the bottle was opened. During an interview on 03/27/2026 at 9:25 A.M. CMT A said house stock of OTC medications should have the date written on the bottle indicating the day the bottle was opened. During an interview on 03/27/2026 at 9:22 A.M. LPN B said house stock of OTC medications should have the date written on the bottle indicating the day the bottle was opened. During an interview on 03/27/2026 at 10:32 A.M. LPN C said house stock of OTC medications should have the date written on the bottle indicating the day the bottle was opened. During an interview on 03/27/2026 at 11:01 A.M. the DON said house stock of OTC medications should have the date written on the bottle indicating the day the bottle was opened.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, facility staff failed to ensure prepared food items were served at a safe and appetizing temperature to residents, failed to monitor the internal temperature of hot food items held on the steam table, failed to offer a variety of meal substitutions to residents, and failed to utilize preparation and hot storage methods that preserved and enhanced the palatability of food items. The facility census was 55.Review of facility policy titled, Food Preparation and Service, revised November 2022, showed:- Internal cooking temperature for raw eggs was 145 degrees ( ) Fahrenheit;- Proper hot and cold temperatures are maintained during food distribution and service;- The temperatures of foods held in steam tables are monitored throughout the meal service by food and nutrition services staff;- The danger zone for food temperatures is above 41 and below 135 . This temperature range promotes the rapid growth of pathogenic microorganisms that cause foodborne illness;- Policy provided did not cover required serving temperatures to residents;1. Review of Resident #57's Quarterly Minimum Date Set (MDS, a federally mandated assessment tool completed by facility staff), dated 03/05/26, showed:- Resident was cognitively intact;- Diagnoses: dementia, depression, and psychotic disorder;During an interview on 03/26/25 at 9:15 A.M., the resident said:-The coffee was cold this morning;-Staff brought him/her three half-filled coffee mugs of lukewarm coffee instead of just filling his/her large insulated cup;-The amount of milk he/she got for breakfast was not enough for a bowl of cereal;-The French Toast and sausage was lukewarm and it feels like the kitchen staff don't care how they serve the hall trays;- It was not an enjoyable meal for him/her. 2. Review of Resident #11's Quarterly MDS, dated [DATE], showed:- Resident was cognitively intact;- Diagnoses included: Depression, psychotic disorder, and schizophrenia. During an interview on 03/24/26 at 3:38 P.M., the resident said:- He/She eats in the dining room;- The meat especially the pork is tough;- If he/she does not like the main course the staff always offers a peanut butter and jelly sandwich, there are very few alternatives to choose from that are fresh;- The food is not seasoned well and sometimes the food temperature is too hot and it makes it hard to eat;- He/She would prefer his/her food at the proper temperature so he/she can eat it.3. Review of Resident #18's Quarterly MDS, dated [DATE], showed: - Resident has moderately cognitive impairment;- Diagnoses included: Obstructive uropathy (blockage of the urinary tract), diabetes, and depression; During an interview on 03/24/26 at 10:34 A.M., the Resident said:- He/She normally eats in his/her room and the food is cold half the time it is served. There's not much variety with very few alternative options unless you want peanut butter and jelly. Eating cold food is not very appetizing and disappointing. 4. Review of Resident #4's Quarterly MDS, dated [DATE], showed:- Resident was cognitively intact;- Diagnoses included: Obstructive uropathy and diabetes;During an interview on 03/24/26 at 10:39 A.M., the Resident said:- He/She eats in his/her room and when the food is delivered it's barely warm. He/She has had to ask staff to warm up his/her meal at various occasions and would much prefer for the food to arrive hot so he/she could eat when it arrives instead of having to wait an additional five to 10 minutes before the tray comes back to the room. Record review of alternate food items for each meal on 03/24/26 showed residents could request a deli meat sandwich, grilled cheese, peanut butter and jelly sandwich, chips, or cottage cheese.Record review of recipe card on 03/26/26 at 7:00 A.M., showed: French Toast (non-applicable steps omitted):- 1 2/3 Tablespoons of cinnamon.- Optional: Powdered sugar sprinkled on each serving of completed French Toast.Observation in the dining room on 03/24/26, showed:- 12:46 P.M. Resident offered a peanut butter and jelly sandwich as the only option for a meal substitute. Resident received a sandwich in a bag for their substitute menu item.- 12:53 P.M. Resident offered a peanut butter and jelly sandwich as the only option for a meal substitute. Resident received a sandwich in a bag for their substitute menu item.- 1:06 P.M. Resident offered a peanut butter and jelly sandwich as the only option for a meal substitute. Resident received a sandwich in a bag for their substitute menu item.Observation in the kitchen on 03/26/26 at 7:30 (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A.M., showed:- Peanut butter and jelly sandwiches made on 03/25/26 with a use by date of 03/28/26 which is four days after initially made. These items were stored in a plastic open container sitting on a kitchen counter;- At 7:38 A.M. First batch of French Toast (17 slices) was completed, temperature checked showed 190 and placed in a metal container on the steam line;- At 7:49 A.M. Second batch of French Toast (17 slices) was completed by Dietary [NAME] (A) and temperature checked over 165 df and placed on a piece of parchment paper on top of the first batch of French Toast on the steam line;- At 7:59 A.M. Dietary [NAME] (A) preparing a third batch of French Toast grabbed the cinnamon spice bottle and tipped it over the liquid mixture he/she had prepared for dipping the bread. No measurement was taken and less than one teaspoon came out of the container and into the mixture; - At 8:02 A.M. Third batch of French Toast (17 slices) was completed by Dietary [NAME] (A) and not temperature checked. It was placed on a piece of parchment paper on top of the other two batches on the steam line in a metal container which is shut and keeps the heat and condensation from escaping the container;- At 8:10 A.M. Dietary [NAME] (A) finished fourth batch of French Toast (17 slices) and did not take a temperature of finished food product. This batch was placed on a piece of parchment paper on top of the other three batches on the steam line. The steam line now has 72 pieces of French Toast in one metal contained on the steam line. Dietary [NAME] (A) did not utilize the oven which was empty for a holding area for the breakfast food items; - At 8:52 A.M. Last hall tray goes out of kitchen with test tray loaded on the bottom shelf. No temperature checks of the food items on the steam line were observed.- At 9:00 A.M. Last hall tray delivered, test tray consisted of oatmeal, French toast, and a sausage patty. Temperatures taken showed: French Toast 113.5 , expected temperature 120.0 , Sausage patty 105.2 , expected temperature 120.0 ; - French toast was soggy, lukewarm and had very little flavor, with no taste of cinnamon when eaten plain without any condiments; - The sausage was cold to the taste.During an interview on 03/26/26 at 3:15 P.M., the Dietary Manager (DM) said:- Currently staffing in the kitchen was one cook missing but there is enough staffing to provide service to the residents daily. She fills in for the missing cook until a new one is hired;- The French Toast was soggy for breakfast on 03/26/26 because Dietary [NAME] (A) did not utilize the oven to keep the multiple batches of French toast hot and free from steam line condensation;- Powdered Sugar is stocked in the kitchen for meal preparation. She is not sure why Dietary [NAME] (A) did not follow the guidance on the recipe card which allowed for optional use of powdered sugar sprinkled on the French Toast. When she makes French toast for the residents, she makes half the batch with powdered sugar and half the batch with extra cinnamon for higher quality and taste;- She has tried to guide and teach Dietary [NAME] (A) how to improve service, but he/she does not take direction well and is resistant to change in the kitchen;- Whenever spices are used in a recipe they should be measured out and added exactly as stated for the recipe; - Food temperatures should be taken right before serving to residents from the steam line and when foods are completely cooked. If multiple batches of a product are being made such as French toast, the cook should take the temperature of each batch when it's completed cooking. The reason French Toast needs temperature checked is because of the eggs used to make the product;- The serving temperature to halls should be 165 for hot foods and 41 to 43 for cold foods.During an interview on 3/27/26 at 10:45 A.M., the Administrator said: - Food items should be served per state and federal regulations for temperatures and sausage patties served at 105 are too cold to be served as a hot food item;- Temperature of food items should be taken prior to service to residents and before the last tray is served;- The DM is responsible for monitoring the kitchen staff during food preparation and should train, guide, and re-direct kitchen staff as needed;- Residents should not expect to receive soggy French Toast for breakfast; - Alternate food items should be made to order for residents and not pre-made or served in a plastic bag.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265353	A. Building B. Wing	03/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Quail Run Health Care Center	1405 West Grand Ave Cameron, MO 64429

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility failed to prepare and serve food in accordance with professional standards for food service safety when facility staff failed to observe proper handwashing procedures in the kitchen, failed to monitor food items for expiration dates, failed to properly label food items, and failed to properly monitor food cooking and serving temperatures. This affected all residents in the facility. The facility census was 55. Review of facility policy titled, Refrigerators and Freezers, revised November 2022, showed:- This facility will ensure safe refrigerator and freezer maintenance, temperatures, and sanitation, and will observe food expiration guidelines;- Monthly tracking sheets for all refrigerators and freezers are posted to record temperatures;- Monthly tracking sheets include time, refrigerator temperature and initials;- Food service supervisors or designated employees check and record refrigerator and freezer temperatures daily with first opening and at closing in the evening;- All food is appropriately dated to ensure proper rotation by expiration dates. Received dates are marked on cases and on individual items removed from cases for storage. Use by dates are completed with expiration dates on all prepared food in refrigerators. Expiration dates on unopened food are observed and use by dates are indicated once food is opened; - Supervisors are responsible for ensuring food items in pantry, refrigerators, and freezers are not past use by or expiration dates. Review of facility policy titled. Food Preparation and Service, revised November 2022, showed:- Danger Zone means temperatures above 41 degrees ( ) and below 135 that allow the rapid growth of pathogenic microorganisms that can cause foodborne illness;- Potentially Hazardous Food (PHF) means food that requires time/temperature control for safety to limit the growth of pathogens. Examples of PHF foods include ground beef, poultry, chicken, seafood, cut melon, unpasteurized eggs, milk, yogurt and cottage cheese; - Identification of potential hazards in the food preparation process and adhering to critical control points can reduce the risk of food contamination and thereby minimize the risk of foodborne illness;- Food preparation staff need to adhere to proper hygiene and sanitary practices to prevent the spread of foodborne illness;- Proper hot and cold temperatures are maintained during food distribution and service;- Jewelry is worn minimally for food and nutrition services staff.Review of facility policy titled, Handwashing/Hand Hygiene, revised October 2023, showed:- Hand hygiene is required immediately after glove removal;- The use of gloves does not replace hand washing/hand hygiene;- Perform hand hygiene before applying non-sterile gloves.Observation in the kitchen on 03/24/26 at 9:00 A.M., showed:Dry Storeroom:- Freezer log missing temperature checks on 3/22 and 3/23/26 evening shift. Unable to located refrigerator thermometer;Vestibule next to Dry Storeroom:- Two stand-up refrigerators missing temperature checks on 03/22 and 03/23/26 evening shift;- Two jugs of tea made 03/21/26 expired;- Chicken salad spread container, 5 pounds, opened 03/20/26 and not re-sealed;- Meat, unknown, in metal pan in refrigerator defrosting without any labeling;- 16-ounce original plastic container of fresh strawberries with no date contains three moldy strawberries;Main Kitchen Area:- Refrigerator missing 03/09, 03/10, 03/20, 03/23/26 temperature log entries for evening shift;- Refrigerator missing 03/05, 03/09, 03/10, 03/17, 03/20/26 temperature log entries for day shift;- Meat, unknown, in metal pan defrosting in refrigerator without any labeling;- Leftover cooked sausage in refrigerator expired 03/23/26;- Chicken pot pie in refrigerator dated 03/21/26 expired;- Leftover rice pilaf in refrigerator dated 03/19/26 expired;- Freezer temperature log missing entries for 03/05, 03/09, 03/10, 03/15, 03/17, 03/20/26 day shift:- Freezer temperature log missing entries for 03/09, 03/10/26 evening shift;- Freezer has Styrofoam cup of ice cream covered and not labeled or dated.Observation in the kitchen on 03/26/26 at 7:00 A.M., showed:- Meat defrosting in a pan in the refrigerator with no date other than the received date of 02/10/26;- Refrigerated Pimento Cheese Spread in a five-pound container with a use by date of 02/20/26 expired;- Peanut Butter and Jelly sandwiches made on 03/25/26 with a use by date of 03/28/26 which is four days after initially made. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265353	A. Building B. Wing	03/27/2026

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	These items were stored in a plastic open container sitting on a kitchen counter;- Breakfast menu for the day showed French Toast, Farina, Oatmeal, and Sausage patties;- At 7:27 A.M. Oatmeal completed cooking on the stove and transferred to the steam line by Dietary [NAME] (A). No temperature check taken on completed food item;- Dietary [NAME] (A) changed gloves after working with pork sausage and did not wash hands between glove change;- At 7:50 A.M. First batch of 17 pieces of French Toast completed, temperature check done with a reading of 190 and placed on steam line;- At 8:35 A.M. Dietary [NAME] (A) wearing gloves goes into the Dietary Manager (DM) office and picks up a book and returns to kitchen area and stacks food plate covers. Changes gloves without handwashing and then continues to work with food from the steam line and filling plates;- At 8:38 A.M. First food trays are loaded onto hall carts with no temperatures taken at the steam line;- At 8:45 A.M. Dietary [NAME] (A) changes gloves in kitchen and does not handwash between glove change. During an interview on 03/26/26 at 3:15 P.M., the DM said:- Food temperatures should be taken right before serving to residents from the steam line and when foods are completely cooked. If multiple batches of a product are being made such as French toast, the cook should take the temperature of each batch when it's completed cooking. The reason French Toast needs temperature checked is because of the eggs used to make the product;- The serving temperature to halls should be 165 for hot foods and 41 to 43 for cold foods;- Gloves should be changed whenever you leave the kitchen and return of whenever they are soiled or contaminated. Staff should always wash their hands between glove changes;- Expired food items should be discarded as soon as they are expired;- Leftovers are good for three days. If a food item is prepared on 03/23/26 then it would be discarded on 03/26/26; - Every refrigerator and freezer should have a thermometer for staff to record temperatures daily. Currently there are four missing thermometers, and they were likely taken recently by a disgruntled ex-dietary employee;- Missing temperatures in the refrigerator and freezer temperature logs are due to new employees and training that is ongoing.During an interview on 03/27/26 at 10:45 A.M., the Administrator said:- Temperatures should be taken on food items before meal service and at the last tray that is served. When dietary staff finished cooking a food item it should be temperature checked prior to going to the steam line;- Kitchen staff should wash their hands between gloves changes in the kitchen;- Items in the refrigerator and freezer should be properly labeled with expiration dates;- Temperature checks should be done in the morning and evening on all refrigerators and freezers and there should be a thermometer available in each location for staff to utilize;- Leftovers should be thrown away immediately after they have been there for three days;- Expired items should be thrown away immediately when they expire.