STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265355	A. Building B. Wing	03/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Life Care Center of Grandview	6301 East 125th St Grandview, MO 64030

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	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 observation, interview, and record review, the facility failed to ensure appropriate medication and medical equipment storage in three medication carts out of four medication carts and in two out of two medication storage rooms. The facility census was 98 residents. Review of the facility's policy titled Medication Storage in Refrigerator/Freezer dated 9/9/25 showed:-The facility would ensure that medications and biologicals were stored at their appropriate temperatures according to manufacturer's specifications or per the United States Pharmacopeia guideline for temperature ranges.-A safe temperature for refrigeration was between the range of 36 degrees Fahrenheit and 46 degrees Fahrenheit.-The facility should monitor the temperature of medication storage areas at least two times a day.-The facility could use the Medication Refrigerator-Freezer Temperature Log to record and track temperatures.-If the nurse checked the temperature and it was out of range, the nurse should adjust the setting to increase or decrease the temperature accordingly.-The medication should also be removed and placed in an alternate storage area until the compartment returned to an acceptable temperature.-If there was excessive ice build-up in the freezer, the maintenance department should be notified to defrost the unit to ensure proper functioning.A policy related to medication or medical equipment storage was requested and not received prior to exit on 3/9/26.1. Observation on 3/5/26 at 11:10 A.M. of the Spring Bridge nurse cart showed:-One opened vial of Aplisol (tuberculin purified protein derivative, used as an aid in diagnosing Tuberculosis (a serious, contagious bacterial infection, primarily affecting the lungs), with the instructions to refrigerate after opening.-Five wound dressings that expired on 10/31/25.-One wound dressing that expired on 6/30/25.-One wound dressing that expired on 9/30/25.-One wound dressing that expired on 8/1/25.-Three Warfarin (a blood thinner), one milligram (mg) tablets that expired on 1/31/26.-One opened bottle of Acidophilus (a probiotic that aids in digestion and nutrient absorption) capsules, with the instructions to refrigerate after opening.-One wound dressing kit that expired on 1/1/26.2. Observation on 3/5/26 at 11:25 A.M. of the 300-hall medication cart showed:-Approximately thirty loose pills at the bottom of two different drawers of the medication cart.-A powdery substance underneath the loose pills of two different drawers of the medication cart.3. Observation on 3/5/26 at 11:35 A.M. of the East side medication room showed:-One 24-gauge needle that expired on 4/30/25.-Two 22-gauge needles that expired on 3/31/25.-One 22-gauge needle that expired on 4/1/22.-One refrigerator that had no temperature log within plain sight.-The refrigerator temperature was 50 degrees Fahrenheit.4. Observation on 3/5/26 at 11:45 A.M. of the Spring Bridge medication room showed:-One wound dressing that expired on 4/1/23.-One wound dressing that expired on 2/1/26.-Three wound dressings that expired in March 2020.-Four wound dressings that expired on 3/1/24.-Two wound dressings that expired on 2/28/25.-Two wound dressings that expired on 9/30/21.-Five wound dressings that expired on 7/31/25.-Eight wound dressings that expired on 3/31/25.-Two wound dressings that expired on 9/30/22.-Two wound dressings that expired on 1/6/26.-One wound dressing that expired on 2/28/26.-Four wound dressings that expired on 4/1/24.-Three wound dressings that expired on 7/1/25.-Six 24-inch (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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	extension tubing sets that expired on 10/2/25.-One wound dressing that expired on 10/2/25.-The medication refrigerator freezer area had a significant amount of ice buildup of an inch or greater.5. Observation on 3/5/26 at 12:05 P.M. of the Spring Terrace nurse/treatment cart showed:-One opened bottle of Acidophilus capsules, with the instructions to refrigerate after opening. -One nasal spray that expired in January 2026.-One 472 milliliter (ml) bottle of Potassium Chloride Oral Solution (used to prevent low potassium levels) in which the label was covered in the medication and the lid had crusted medication surrounding it.6. During an interview on 3/9/26 at 9:42 A.M. Certified Medication Technician (CMT) A said:-Expired medications should not be stored in medication carts.-Expired medical supplies should not be stored in medication carts or medication rooms.-The night shift nurses were responsible for checking the medication refrigerator temperatures.-He/She was unsure if there was an exact time frame of when a freezer needed to be de-frosted but thought that if it looked like ice was building up, then staff should go ahead and de-frost the freezer.-Staff should follow the manufacturer's recommendations for storage after medications were opened.-Certified staff were to check the medication carts daily.-He/She was unsure of the facility's protocol related to medication storage.-Loose pills should not be stored in medication carts and should be appropriately disposed of when found.-Medication residue should not be in the medication carts and should be cleaned out when found.-All liquid medication containers should be clean and free from any drips.During an interview on 3/9/26 at 10:00 A.M. Registered Nurse (RN) B said:-Expired medications should not be stored in medication carts.-Expired medical supplies should not be stored in medication carts or medication rooms.-The night shift nurses were responsible for checking the medication refrigerator temperatures.-If he/she noticed that the temperature had not been recorded on the log, then he/she would record the temperature on the log.-He/She was unsure what the typical temperature range was for storing medications in the refrigerator.-If he/she noticed too much accumulation of ice in the medication freezers, then he/she would call maintenance and unplug the unit.-Staff should follow the manufacturer's recommendations for storage after medications were opened.-Staff were responsible for checking medication carts every other day.-He/She was unsure of the facility's protocol related to medication storage but thought that nurse management checked the medication carts and medication rooms regularly.-Loose pills should not be stored in medication carts and should be appropriately disposed of when found.-Medication residue should not be in the medication carts and should be cleaned out when found.-All liquid medication containers should be clean and free from any drips.During an interview on 3/9/26 at 10:27 A.M. Licensed Practical Nurse (LPN) C said:-Expired medications should not be stored in medication carts.-Expired medical supplies should not be stored in medication carts or medication rooms.-The night shift nurses were responsible for checking the medication refrigerator temperatures.-If he/she was unable to find the refrigerator temperature log and felt that the temperature was too high, then he/she would remove the medications, put them in a different medication refrigerator, and call maintenance.-Medication refrigerators with freezers should not have any build-up of ice.-Staff should follow the manufacturer's recommendations for storage after medications were opened.-Medication carts were checked each shift.-Nurse management checked the medication carts and medication rooms monthly to ensure appropriate storage of medication and medical supplies.-Loose pills should not be stored in medication carts and should be appropriately disposed of when found.-Medication residue should not be in the medication carts and should be cleaned out when found.-All liquid medication containers should be clean and free from any drips.During an interview on 3/9/26 at 11:52 A.M. the Director of Nursing (DON) said:-Expired medications should not be stored in medication carts.-Expired medical supplies should not be stored in medication carts or medication rooms.-The night shift nurses were responsible for checking the medication refrigerator temperatures.-If staff were unable to find the refrigerator temperature log and felt that the temperature was too high, then he/she expected the staff to remove the medications, put them in a different medication refrigerator, and call maintenance.-A refrigerator temperature of 50 degrees Fahrenheit was too high.-He/She expected staff to de-frost the freezers when there was an (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	accumulation of ice.-Staff should follow the manufacturer's recommendations for storage after medications were opened.-He/She expected staff to check medication carts every shift.-He/She had only been at the facility for two weeks and was unsure of the facility's protocol/process related to medication storage.-In his/her prior facilities he/she checked the medication carts and medication rooms weekly.-Loose pills should not be stored in medication carts and should be appropriately disposed of when found.-Medication residue should not be in the medication carts and should be cleaned out when found.-All liquid medication containers should be clean and free from any drips.-If the liquid medication bottle could not be wiped clean, then he/she expected staff to dispose of the medication appropriately.

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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 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 98 residents with a licensed capacity for 172 residents at the time of the survey. 1. Review of the facility's floorplan map, dated 9/7/2023 and provided by the Director of Maintenance (DOM), showed the building was basically laid out in three sections: an older long-term care unit, a rehabilitation unit, and a memory care unit, with administrative and nursing offices, a kitchen/kitchenette, and a laundry area. Review of the facility's 24-page water-borne pathogen infection prevention and control policy and procedure of loose pages kept in a plastic sheet protector entitled Water Management Program, Life Care Center of Grandview, updated 2/23/26 and provided by the DOM, showed:-There was no facility-specific risk assessment that considers the American Society of Heating, Refrigerating, and Air Conditioning Engineers (ASHRAE) industry standard #188.-A completed CDC toolkit assessment including control measures such as physical controls, temperature management, disinfectant level control, visual inspections, and environmental testing for pathogens was missing.-No CDC Legionella Environmental Assessment Form had been done.-There was a written explanation of the water flow that identified and indicated specific potential risk areas of growth within the building with assessments of each individual area's potential risk level, but no accompanying schematic, flowchart, or diagram of the facility's water system.-No documentation of any site log-book being maintained with dated cleanings, sanitizings, descalings, and inspections was included or mentioned.-Table 13: Activity Log for Flushing Vacant/Unoccupied Rooms (Add, edit, or delete as needed) was blank.-At Table 14: Multi-Unit Building Description (add edit or delete as needed) it listed: 100 Hall - 14 rooms, 20 sinks, 2 showers, 2 bathtubs; 200 Hall - 16 rooms, 19 sinks, 2 showers, 1 bathtub; 300 Hall - 15 rooms, 19 sinks, 6 showers; 400 Hall - 14 rooms, 24 sinks, 2 showers, 1 ice machine; 400 Hall - 14 rooms, 24 sinks, 2 showers, 1 ice machine; 500 Hall - 15 rooms, 19 sinks, 1 shower, 1 bathtub; and 600 Hall - 13 rooms, 20 sinks, 3 showers, 2 bathtubs, 1 ice machine.-The questions and answers for Table 20: Ice Machine Protocols were, Who is responsible for maintaining ice machines? Maintenance Department works with vendor, How often are ice machines cleaned? Quarterly cleaning, and How often are ice machines sanitized? Annually and when issues arise.- Table 21: Ice Machine Maintenance Checklist (Add, edit, or delete as needed) was blank.Observation on 3/2/26 between 11:43 A.M. and 1:19 P.M. during the initial Life Safety Code (LSC) kitchen inspection showed there was a steam table (also referred to as a hot food table, specifically, steam tables are designed to hold food at steady, safe serving temperatures, but not designed to cook or warm foods from a raw state), a 3-sink sanitizing area, a low-heat, chemical dishwashing machine, a hand-washing sink, and an ice machine.Observation on 3/4/26 between 10:09 A.M. and 12:39 P.M. during a LSC walk-through inspection with the DOM showed the following: -The city municipal water supply first entered the facility through a northern main pipe in the 200 Hall fire sprinkler Riser Room (a dedicated space for fire protection equipment).-The building was equipped with a complete fire sprinkler system with sidewall and ceiling mounted sprinkler heads located throughout the facility.-Two public restrooms were in the front administrative office hall with an additional restroom by the Rehab Gym nurse's (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	desk.-A medication room with sink was located behind each of the two separate main nurse's desks.-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) and hot/cold water piping throughout the facility.-There were at least two commercial clothes washers in the laundry area.-There were four bathhouses with showers and/or baths in the facility. -There was a Beauty Shop with a sink next to the 200 Hall. -There was a steam table and sink in the kitchenette off the Rehab Dining room. -In the 500 Hall Riser Room there was a hot water heater for the 500 and 600 halls and a hot water heater across from the Director of Nursing (DON) office was for the 100 and 300 halls.During an interview on 3/4/26 at 1:14 P.M. the DOM said:-He/She oversaw the Water Management Program.-The water heater across from the DON's office had gone out that morning so it was being replaced.-There were four total water heaters in the facility.During an interview on 3/9/26 at 10:34 A.M. the DOM said:-He/She assisted with creating the Legionella program by identifying risk areas.-Overseeing the program entailed doing routine flushing in empty resident rooms and running their sinks every month.-They also annually conducted tests for Legionella.During an interview on 3/9/26 at 10:49 A.M. the Administrator said:-He/She was educated on the Legionella prevention requirements during in-services and corporate zoom meetings.-He/She helped update the Legionella program. -When they started there about 15 months ago it was already in process.

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures to prevent abuse, neglect, and theft. Based on interview and record review, the facility failed to complete Employee Disqualification List (EDL-a Missouri State screening tool used to check if an individual was prohibited from working with residents due to past abuse, neglect, or misappropriation of property) background checks for ten out of ten sampled employees. The facility census was 98 residents. Review of the facility's Missouri Employee Disqualification List Policy, dated 12/5/25, showed:-The facility checked the EDL in accordance with state requirements.-The facility did not knowingly employ anyone who was listed on the EDL.-The Executive Director of the facility ensured that:--Prior to offer of employment being made, the applicant was screened and was not listed on the EDL.-Documentation of the pre-offer and quarterly screenings were maintained at least seven years.-The acting Regional [NAME] President awas responsible for ensuring the requirements of this policy were met in the absence of an Executive Director.1. Review of the facility's list of employees hired since the facility's last annual survey showed:-Employee A was hired 9/17/25.-Employee B was hired 4/21/25.-Employee C was hired 11/18/25-Employee D was hired 3/19/25-Employee E was hired 3/6/25-Employee F was hired 4/16/25.-Employee G was hired 9/2/25-Employee H was hired 10/8/25.-Employee J was hired 11/10/25-Employee K was hired 3/12/25.Review of the facility's EDL background checks showed:-Employee A's EDL was completed 10/1/25.-Employee B's EDL was completed 5/5/25.-Employee C's EDL was completed 12/1/25.-Employee D's EDL was completed 4/1/25.-Employee E's EDL was completed 4/1/25.-Employee F's EDL was completed 5/5/25.-Employee G's EDL was completed 10/1/25.-Employee H's EDL was completed 11/3/25.-Employee J's EDL was completed 12/1/25.-Employee K's EDL was completed 4/1/25.During an interview on 3/6/26 at 9:42 A.M., the Administrator said:-The EDL checks were done upon hire and then quarterly. -He/She was unaware the background checks were not completed prior to hire date.-Currently, Corporate Compliance was responsible for completing the EDL checks.During an interview on 3/9/26 at 11:52 A.M, the Administrator said: -The EDL background checks were completed by the Staff Development Coordinator and Human Resources.-They were supposed to be completed prior to hire.-It was documented in the employee's file.-If it was not in the facility records it was not completed.

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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 a medication error rate under five percent (%) with a medication error rate of 88%. This affected two sampled residents (Resident #12 and #89) and two supplemental residents (Resident #51 and #72) out of 20 sampled residents and two supplemental residents. The facility census was 98 residents. Review of the facility's policy titled Administration of Medications dated 9/9/25 showed:-The facility would ensure medications were administered safely and appropriately per physician order to address residents' diagnoses and signs and symptoms.-A medication error was defined as an observed or identified preparation or administration of medications or biologicals which were not in accordance with:--The prescriber's order.--Manufacturer's specifications regarding the preparation or administration of medication or biological.--Accepted professional standards and principles which applied to professionals providing services.--Accepted professional standards and principles included various practice regulations in each State, and current commonly accepted health standards established by national organizations, boards, and councils.-Staff who were responsible for medication administration would adhere to the ten Rights of Medication Administration which included:--Right drug.--Right resident.--Right dose.--Right route.--Right time and frequency.--Right documentation.--Right assessment.--Right to refuse.--Right evaluation/response.--Right education and information.Review of the facility's policy titled Insulin Pen Administration dated 5/27/25 showed:-The facility would ensure residents with orders for insulin (a hormone produced in the pancreas which regulates the amount of glucose (sugar) in the blood) administration using a pen delivery device was performed in accordance with current standards or practice and manufacturer's guidance.-The insulin pen should be primed prior to each use (in accordance with manufacturers guidelines) to prevent the collection of air in the insulin reservoir. -General guidance on priming an insulin pen in the absence of manufacturers guidance included:--Dial two units by turning the dose selector clockwise.--With the needle pointing up, push up on plunger, and watch to see that as least one drop of insulin appears at the tip of the needle.--If not, repeat this procedure until at least one drop of insulin appears.1. Review of Resident #51's admission Record showed he/she admitted to the facility with a diagnosis of Major Depressive Disorder (MDD- a mental health disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in daily life), Recurrent, Moderate.Review of the resident's Order Summary Report dated March 2026 showed the following orders:-Brimonidine Tartrate Ophthalmic Solution (used to help lower eye pressure) 0.15%, instill one drop in both eyes two times a day.-Dorzolamide HCl-Timolol Maleate Ophthalmic Solution (used to treat high eye pressure) 2-0.5%, instill one drop in both eyes two times a day.-Vitamin B12 (a supplement) Oral Tablet 500 micrograms (mcg), give one tablet by mouth one time a day.Review of the resident's Medication Administration Audit Report dated 3/4/26 showed:-The following medications were to be administered at 8:00 A.M.:--Brimonidine Tartrate Ophthalmic Solution 0.15%.--Dorzolamide HCl-Timolol Maleate Ophthalmic Solution 2-0.5%.--Vitamin B12 500 mcg.Observation on 3/4/26 at 9:00 A.M. of the resident's medication administration completed by Registered Nurse (RN) A showed:-The following medications were given at 9:04 A.M.:--Brimonidine Tartrate Ophthalmic Solution 0.15%.--Dorzolamide HCl-Timolol Maleate Ophthalmic Solution 2-0.5%.--Vitamin B12 500 mcg.2. Review Resident #72's admission Record showed he/she admitted to the facility with a diagnosis of Chronic Obstructive Pulmonary Disease (COPD- a disease process that decreases the ability of the lungs to perform ventilation).Review of the resident's Order Summary Report dated March 2026 showed the following orders:-Rivaroxaban (a blood thinner) 20 milligrams (mg), give one tablet one time a day.-Amlodipine (used to treat high blood pressure) 10 mg, give one tablet by mouth one time a day.-Atorvastatin (used to treat high cholesterol) 40 mg, give one tablet by mouth one time a day.-Bumetanide (used to treat fluid retention) 1 mg, give one tablet by mouth one time a day.-Carvedilol (used to treat high blood pressure) 12.5 mg, give one tablet by moth two times (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	a day.-Duloxetine (used to treat depression) 40 mg, give one capsule one time a day.-Losartan Potassium (used to treat high blood pressure) 100 mg, give one tablet by mouth one time a day.-Sennosides-Docusate Sodium (used to treat constipation) 8.6-50 mg, give one tablet by mouth two times a day.-Spironolactone (typically used to treat high blood pressure or fluid retention) 25 mg, give one tablet by mouth one time a day.-Umeclidinium-Vilanterol (used for long-term maintenance of COPD) 62.5-25 mcg/actuation (act), one inhalation one time a day.Observation on 3/4/26 at 9:05 A.M. of the resident's medication administration completed by RN A showed he/she:-Prepared the resident's medications and placed them in a 30 milliliter (ml) cup.-Could not find the resident.-Wrote the resident's name on the cup and placed the medication back into the medication cart.Observation on 3/4/26 at 9:54 A.M. showed RN A gave the resident his/her medication at that time.Review of the resident's Medication Administration Audit Report dated 3/4/26 showed:-The following medications were due at 8:00 A.M.:--Rivaroxaban 20 mg.--Amlodipine 10 mg.--Atorvastatin 40 mg.--Bumetanide one mg.--Carvedilol 12.5 mg.--Duloxetine 40 mg.--Losartan Potassium 100 mg.--Sennosides-Docusate Sodium 8.6-50 mg.--Spironolactone 25 mg.--Umeclidinium-Vilanterol 62.5-25 mcg/act.-RN A documented the Rivaroxaban 20 mg as administered at 9:05 A.M.-RN A documented the Amlodipine 10 mg as administered at 10:07 A.M.-RN A documented the Atorvastatin 40 mg as administered at 9:06 A.M.-RN A documented the Bumetanide one mg as administered at 9:07 A.M.-RN A documented the Carvedilol 12.5 mg as administered at 10:08 A.M.-RN A documented the Duloxetine 40 mg as administered at 10:08 A.M.-RN A documented the Losartan Potassium 100 mg as administered at 10:08 A.M.-RN A documented the Sennosides-Docusate Sodium 8.6-50 mg as administered at 9:08 A.M.-RN A documented the Spironolactone 25 mg as administered at 10:08 A.M.-RN A documented the Umeclidinium-Vilanterol 62.5-25 mcg/act as administered at 9:08 A.M.3. Review of Resident #12's admission Record showed he/she admitted to the facility with a diagnosis of Traumatic Subarachnoid (layer of the membranes surrounding the brain) Hemorrhage (a life-threatening type of stroke caused by sudden bleeding into the space surrounding the brain) with Loss of Consciousness Status Unknown, Subsequent Encounter.Review of the resident's Order Summary Report dated March 2026 showed the following orders:-Amantadine HCl (primarily used to treat Parkinson's Disease (a progressive, neurodegenerative brain disorder, affecting movement and central nervous system function) 100 mg, give one tablet by mouth one time a day.-Armodafinil (typically used to treat narcolepsy (a chronic neurological disorder that disrupts the brain's ability to regulate sleep-wake cycles, leading to extreme, uncontrollable daytime sleepiness) 50 mg, give two tablets by mouth one time a day.-Atorvastatin 10 mg, give one tablet one time a day.-Carvedilol 12.5 mg, give one tablet by mouth two times a day.-Doxazosin (used to treat high blood pressure) two mg, give one tablet by mouth one time a day.-Metformin HCl (used to treat Diabetes Mellitus (DM II- 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) 1000 mg, give one tablet by mouth one time a day.-Losartan Potassium 25 mg, give one tablet by mouth one time a day.Observation on 3/4/26 at 9:18 A.M. of the resident's medication administration completed by RN A showed he/she:-Prepared the resident's medication.-Was unable to locate the resident's Armodafinil 50 mg.-Documented that he/she would reorder the resident's Armodafinil 50 mg from pharmacy.-Gave the resident all his/her ordered medication except for the Armodafinil 50mg.Review of the resident's Medication Administration Audit Report dated 3/4/26 showed:-The following medications were to be administered at 8:00 A.M.:--Amantadine HCl 100 mg.--Armodafinil 50 mg.--Atorvastatin 10 mg.--Carvedilol 12.5 mg.--Doxazosin two mg.--Metformin HCl 1000 mg.--Losartan Potassium 25 mg.-RN A documented the Carvedilol 12.5 mg as administered at 10:19 A.M.-RN A documented the Doxazosin two mg as administered at 10:19 A.M.-RN A documented the Losartan Potassium as administered at 10:19 A.M.Review of the resident's Electronic Medical Record (EMR) on 3/5/26 showed no documentation related to notifying the resident's physician related to the resident's missed dose of Armodafinil 50 mg.4. Review of Resident #89's admission Record showed he/she (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	admitted to the facility with a diagnosis of Diabetes Mellitus Type II (DM II) with Unspecified Diabetic Retinopathy (an eye complication of diabetes caused by high blood sugar damaging retinal blood vessels) with Macular Edema (the swelling or thickening of the central part of the retina).Review of the resident's Order Summary Report dated March 2026 showed the following orders:-Insulin Glargine (a long-acting insulin) 100 unit/ml, inject 30 unit subcutaneously (under the skin) two times a day.-Novolog (a fast-acting insulin) FlexPen Subcutaneous Solution Pen Injector 100 unit/ml, inject as per sliding scale (when the dosage of fast-acting insulin is adjusted based on blood glucose (sugar) levels, if between 201-250 give four units.Observation on 3/4/26 at 9:50 A.M. of the resident's medication administration completed by RN A showed he/she:-Removed the insulin pens from the medication cart.-Said the resident's blood sugar had been 220 mg/deciliter (dL).-Put a needle on both of the insulin pens.-Dialed the Insulin Glargine pen to 30 units without priming the insulin pen.-Dialed the Novolog pen to four units without priming the insulin pen.-Administered the insulins.Review of the resident's Medication Administration Audit Report dated 3/4/26 showed:-The Insulin Glargine 30 units was to be given at 8:00 A.M.-The Novolog FlexPen 4 units was to be given at 7:00 A.M.-RN A documented the Novolog FlexPen four units as administered at 8:15 A.M.-RN A documented the Insulin Glargine 30 units as administered at 10:59 A.M.5. During an interview on 3/4/26 at 9:57 A.M. RN A said:-He/She would not have done anything differently during Resident #12's, Resident #51's, Resident #72's, and Resident #89's medication administration.-He/She could not remember if he/she had primed Resident #89's insulin pens.During an interview on 3/9/26 at 9:37 A.M. Certified Medication Technician (CMT) A said:-If a medication was ordered to be given at 8:00 A.M., then the medication could be given one hour before or one hour after the scheduled time and would be considered as given on time.-If a medication was given late then the medication would be less effective.-If he/she were unable to give a resident's medication, then he/she would notify the charge nurse.-A doctor would not need to be notified if a medication was not able to be given to a resident.-He/She would not consider Resident #12's, Resident #51's, Resident #72's medication as given late.During an interview on 3/9/26 at 9:53 A.M. RN B said:-If a medication was ordered to be given at 8:00 A.M., then the medication could be given one hour before or one hour after the scheduled time and would be considered as given on time.-If a medication was given late then the medication would be less effective.-Insulin pens needed to be primed before use.-Insulin pens needed to be primed before use because it ensured that the resident received the full dose of insulin.-RN A should have primed Resident #89's insulin pens before use.-If he/she was unable to give a resident their medication, then he/she would notify the resident's physician and document a progress note.-RN A's action related to Resident #12's Armodafinil 50 mg was inappropriate.-RN A should have called Resident #12's physician related to not being able to give the Armodafinil 50 mg.-Resident #12's, Resident #51's Resident #72's, and Resident #89's medications were all administered late.-When medications were administered to a resident, the time in which they were actually administered should be reflected in the resident's EMR.-RN A should have documented Resident #12's, Resident #51's, Resident #72's, and Resident #89's medication administration accurately.During an interview on 3/9/26 at 10:15 A.M. Licensed Practical Nurse (LPN) C said:-If a medication was ordered to be given at 8:00 A.M., then the medication could be given one hour before or one hour after the scheduled time and would be considered as given on time.-Insulin pens needed to be primed before use.-Insulin pens needed to be primed before use because it ensured that the resident received the full dose of insulin.-RN A should have primed Resident #89's insulin pens before use.-If he/she was unable to give a resident their medication, then he/she would notify the resident's physician and document a progress note.-RN A's action related to Resident #12's Armodafinil 50 mg was inappropriate.-RN A should have called Resident #12's physician and received an order to hold the medication.-Resident #12's, Resident #51's Resident #72's, and Resident #89's medications were all administered late.-When medications were administered to a resident, the time in which they were actually administered should be reflected in the resident's EMR.-RN A should have documented Resident (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	#12's, Resident #51's, Resident #72's, and Resident #89's medication administration accurately.During an interview on 3/9/26 at 11:52 A.M. the Director of Nursing (DON) said:-If a medication was ordered to be given at 8:00 A.M., then the medication could be given one hour before or one hour after the scheduled time.-When medications were given late it could cause unwanted medication interactions.-Insulin pens needed to be primed before use.-Insulin pens needed to be primed before use because it ensured that the resident received the full dose of insulin.-RN A should have primed Resident #89's insulin pens before use.-He/She would expect staff to notify a resident's physician and document a progress note if they were unable to give a medication to the resident.-RN A's action related to Resident #12's Armodafinil 50 mg was inappropriate.-RN A should have called Resident #12's physician and notified everyone.-Resident #12's, Resident #51's Resident #72's, and Resident #89's medications were all administered late.-When medications were administered to a resident, the time in which they were actually administered should be reflected in the resident's EMR.-RN A should have documented Resident #12's, Resident #51's, Resident #72's, and Resident #89's medication administration accurately.

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. Based on interview and record review, the facility failed to notify one closed record sampled resident's (Resident #108) responsible party after the resident fell on 2/14/26 out of two closed record sampled residents. The facility census was 98 residents. On 3/9/26 the Administrator was notified of the past noncompliance which occurred on 2/14/26. On 2/15/26 the facility administration was notified a resident's responsible party was not notified of a change in condition and the investigation was started. The resident's family was notified on 2/15/26. No employees were allowed to work prior to reeducation. The deficiency was corrected on 2/15/26. Review of the facility's policy titled Change in Resident's Condition or Status dated 8/29/25 showed the facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her own authority, the resident's representative(s) where there was an accident involving the resident which resulted in injury and had the potential for requiring physician intervention.1. Review of Resident #108's admission Record showed he/she was admitted to the facility for a respite stay on 2/13/26 with the following diagnoses:-History of Falling.-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).Review of the facility's Event Note dated 2/14/26 at 5:07 P.M. showed:-The resident was standing behind a door on the locked memory care unit.-A staff member had opened the door and startled the resident.-The resident then fell to the floor.-The resident fell on his/her right side.-The resident was non-verbal but moaned in pain when his/her right leg was touched.-The resident still had some range-of-motion (ROM) to the right leg.-The resident's hospice (end of life care) company was notified.-The hospice company reported that a nurse was going to see and assess the resident at the facility.Review of the facility's Event Note dated 2/14/26 at 9:30 P.M. showed:-A hospice nurse had come to assess the resident.-The resident had made no complaints of pain at that time.-The resident was able to move his/her leg without complaint.-No new orders were received at that time.-The hospice nurse would follow-up and inform the resident's family.Review of the resident's fall investigation dated 2/16/26 showed:-The hospice nurse stated that he/she would notify the family related to the fall.-There was no noted follow-up completed by the facility to ensure that the resident's family had been notified.Review of the resident's Electronic Medical Record (EMR) on 3/6/26 showed no documentation on 2/14/26 that indicated that the resident's responsible party was notified of the resident's fall.During an interview on 3/6/26 at 2:50 P.M. the Administrator said he/she was aware that the resident's family had not been notified by the facility related to the resident's fall on 2/14/26 until 2/15/26.During an interview on 3/9/26 at 9:34 A.M. Certified Medication Technician (CMT) A said:-Nurses were responsible for notifying a resident's responsible party after a change in condition.-A resident's responsible party should be notified immediately after a change in condition was noticed.-The facility would still be responsible for ensuring that a resident's responsible party was notified after a change in condition even when a hospice nurse said they would notify the family.-The resident's family should have been notified immediately after the resident fell. During an interview on 3/9/26 at 9:49 A.M. Registered Nurse (RN) B said:-Nurses were responsible for notifying a resident's responsible party after a change in condition.-A resident's responsible party should be notified immediately after a change in condition was noticed.-Usually, he/she would call the doctor first and then notify the family.-The facility would still be responsible for ensuring that a resident's responsible party was notified after a change in condition even when a hospice nurse said they would notify the family.-The facility did not need to ensure the hospice company notified the resident's family because the facility would be responsible for their own notification. -The resident's family should have been notified immediately after the resident fell.During an interview on 3/9/26 at 10:12 A.M. Licensed Practical Nurse (LPN) B said:-Nurses were responsible for notifying a resident's (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	responsible party after a change in condition.-A resident's responsible party should be notified immediately after a change in condition was noticed.-The facility would still be responsible for ensuring that a resident's responsible party was notified after a change in condition even when a hospice nurse said they would notify the family.-The resident's family should have been notified sooner related to the resident's fall.During an interview on 3/9/26 at 11:52 A.M. the Director of Nursing (DON) said:-Nurses were responsible for notifying a resident's responsible party after a change in condition.-A resident's responsible party should be notified immediately after a change in condition was noticed.-He/She expected the staff to follow the facility's policy on notification of change in condition regardless of a hospice nurse stating he/she would notify the family.-The resident's family was notified too late and should have been notified immediately after the resident fell on 2/14/26. 2748480

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. Based on interview and record review, the facility failed to ensure consistent documentation of daily activity participation and quarterly activity progress for one sampled resident (Resident #70) out of 20 sampled residents. There was insufficient documentation to show that an activity program was consistently provided for the resident or that the resident had been informed when activities were taking place. The facility census was 98 residents. Review of the facility's Therapeutic Activities Program policy, revised 9/26/25, showed the facility must provide, based on the comprehensive assessment, care plan, and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community.1. Review of Resident #70's admission Record showed the resident was admitted with the following diagnoses:-Stroke affecting right, dominant side.-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).-Anxiety disorder (a psychiatric disorder causing feelings of persistent anxiety).-Major depressive disorder (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).Review of the resident's Activities care plan, revised 7/2/24, showed:-Encourage ongoing family involvement.-Invite resident to scheduled activities such as music, movies, dancing, Bingo, going outside, religious activities, exercise, and food-related socials.Review of the resident's annual Minimum Data Set (MDS - a federally mandated assessment instrument completed by facility staff for care planning), dated 12/15/25, showed the resident:-Was moderately cognitively impaired.-It was somewhat important for the resident to participate with groups of people and read and very important to be outside, have family involvement, and attend religious services. Review of the resident's daily participation documentation dated December 2025 to March 5, 2026, showed:-There was no documentation available for December 2025.-There was no documentation available for January 2026. Review of the resident's past two quarterly Activity Participation notes showed:-On 2/13/26 the resident had not had a change in activity choice or level in the past 90 days. -Activities would proceed with current plan of care.--The 2/13/26 note did not show the types and frequency of activities offered during the quarter or explain the resident's level of participation.-NOTE: There was no quarterly Activity Participation note for November 2025. During an interview on 3/2/26 at 12:11 P.M. the resident's family member said:-When he/she visited, the resident would be in his/her room with the door shut and an activity would be taking place on the unit.-He/She was concerned that the resident might not be informed of the activity because the resident normally participated if aware the activity was going on.-He/She was concerned the resident might be bored at times because he/she had started re-arranging things in his/her room.-He/She had not yet said anything to staff about his/her concerns but was concerned enough that he/she planned to say something.During an interview on 3/4/26 at 8:16 P.M. Certified Nurse Assistant (CNA) F said:-The resident enjoyed music and would participate in activities if staff let him/her know activities were taking place.-If staff didn't let him/her know an activity was going on, the resident would stay in his/her room with his/her door shut.During an interview on 3/5/26 at 11:58 A.M. the Activities Director said:-He/She was responsible for completing admission, annual, and change of condition Activity assessments.-There used to be another Activity Director who worked on the resident's unit. He/She left the facility around the end of January 2026 and was responsible for activity assessments and preparing and presenting activities on the resident's unit as well as completing daily activity participation documentation and quarterly activity progress notes for that unit.-Since the other Activity Director left, the activity assistants were expected to help on the resident's unit and provide activities. -He/She expected the activity (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	assistants to complete activity participation documentation following each activity. -He/She had completed quarterly progress notes for the resident's unit after the other Activity Director left.-He/She did not know where the other Activity Director filed the activity participation documentation for the resident's unit. -Quarterly activity progress notes should be in the resident's electronic record.During an interview on 3/9/26 at 10:07 A.M. CNA G said:-The resident stayed in his/her room unless someone came and got him/her and asked him/her to join in the activity.-The resident wouldn't be aware an activity was going on unless staff told him/her and encouraged him/her to join.-The activities staff as well as nursing staff were responsible for ensuring the residents knew an activity was going on.-Activities staff were responsible for completing daily activities participation documentation.During an interview on 3/9/26 at 11:15 A.M. Licensed Practical Nurse (LPN) D said:-The resident tended to nap with his/her door closed in his/her room and wouldn't know an activity was going on unless activity or nursing staff let him/her know.-Activity participation documentation was completed by activities staff.During an interview on 3/9/26 at 11:45 A.M. the Director of Nursing (DON) said:-Whoever did an activity was responsible for documenting activity participation for residents. The activity participation should be completed after each activity provided or at least daily for each resident.-Activity progress notes should be completed by the Activity Director on a quarterly basis and show the resident's participation.-He/She had only been at the facility a couple of weeks, but either he/she, the Administrator, or a designee should be auditing resident records to ensure activities were offered and activity participation progress was being documented.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to prevent one sampled resident (Resident #15) with a history of intrusive and unsafe wandering out of 20 sampled residents from wandering into other resident rooms; and failed to document the frequency of the resident's intrusive and potentially unsafe wandering. The facility census was 98 residents. Review of the facility's Behavior Management policy, dated 1/3/22 and reviewed 12/1/25, showed:-The facility would initiate behavior monitoring, behavior management care planning, and utilize Kardex (provides a snapshot of a resident's daily care needs, covering medications, treatments, care plans, and communications) as indicated by assessment findings, resident/responsible party conversations, and observations.-The Social Services worker was primarily responsible for initiation of the Behavior Management Care Plan.-Behavioral health care and services will be person-centered and will maximize resident dignity, autonomy, privacy, socialization, independence, choice, and safety.1. Review of the Resident #15's admission Record showed the resident admitted to the facility with the following diagnoses:-Vascular dementia (a loss of mental function due to destruction of brain tissue related to reduced or blocked blood supply, often caused by large or several small strokes).-Cognitive communication deficit (communication difficulties such as trouble with word-finding and language organization stemming from underlying cognitive impairments common with strokes, brain injuries, and dementia).Review of the resident's elopement risk care plan, dated 10/18/23, showed:-Encourage the resident to participate in activities to divert from exit seeking behavior.-Provide safe wandering.-The resident was to reside on the secured unit.Review of the resident's wandering care plan, dated 10/18/23, showed:-The resident wandered into other resident rooms and could be agitated at times.-Staff were to redirect.-NOTE: The care plan had no intervention for any increased monitoring or supervision (such as line of sight, one on one supervision, 10 or 15 minute checks, or other increased monitoring). It did not show how staff were to proactively keep the resident from wandering into other resident rooms.Review of the resident's activity/social needs care plan dated 10/26/23 showed:-The resident enjoyed doing hair, going outside, crafts, drawing, family visits, movies, music, reading, religious services, and television.-Staff should invite the resident to activities.Review of the resident's Level I Pre-admission Screening and Resident Review (PASRR - a federally mandated screening for persons with serious mental illness or intellectual/developmental disability to assure appropriate placement in a Medicaid Certified bed facility) dated 10/27/23 showed:-The resident had a primary diagnosis of major neurocognitive disorder (a significant, progressive decline in cognitive abilities-such as memory, language, or executive function-that interferes with a person's independence in daily tasks).-The resident's most significant behavioral symptom was wandering.-The resident required a secured unit to allow for safe wandering.Review of the resident's Level II PASRR (a comprehensive evaluation required for nursing home applicants who trigger positive on the Level I screen for serious mental illness, intellectual disability, or related conditions which determines if the individual requires nursing care and specialized services), dated 11/2/23 showed:-The resident was unable to find his/her room despite his/her name being posted on the door.-The resident responded well to redirection. Staff provides redirection and reorientation with positive results.-The resident was unable to care for his/her basic needs unassisted and had extensive cognitive impairment with impaired concentration, consistent confusion, and severe memory impairment.Review of the resident's behavioral care plan, dated 6/4/24 showed:-The resident could potentially be verbally and physically aggressive.-He/She often undressed and walked around the unit and liked to go barefoot.-Staff were to observe and report resident posing a danger to himself/herself and others. Redirect when the resident undressed and encourage him/her to put on clothing. Provide music.Review of the resident's annual Minimum Data Set (MDS - a federally mandated assessment instrument completed by facility (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	staff for care planning), dated 8/26/25 showed the resident:-Was severely cognitively impaired and was inattentive.-Had no wandering behaviors.-Found it very important to listen to music, attend religious services, and spend time outdoors. -Found it somewhat important to look at magazines and be with groups of people.Review of the resident's progress notes dated October 2025 showed:-On 10/22/25 at 5:18 P.M. the resident was noted to be in a peer's room. Both were naked from the waist down with Resident #15 laying across the bed and the other resident standing in front of him/her. Staff were able to separate immediately. Skin assessment was performed with no apparent injury. Family and physician notified with new order received for continuous monitoring for behavior management.Review of the facility's internal investigation for the 10/22/25 incident, showed:-Three witnesses provided statements.-The investigation narrative showed on 10/22/25 at approximately 3:15 P.M. a Certified Nursing Assistant (CNA) was checking on residents. He/She opened a resident's door and found him/her standing at the side of the bed with his/her genitalia exposed and stating he/she was approached about having sex, but nothing happened. Resident #15 was reclined on the bed with legs in the air. The CNA called for his/her coworkers who called the Director of Nursing (DON). Immediate investigation initiated. Skin assessments completed and no injuries or evidence of intimate contact noted. Residents separated and diversional activities offered. Guardians, physicians, the DON, Executive Director, Regional contact notified.-Interventions were staff education regarding monitoring of residents. Diversional activities were provided with no further incidents. -Resident #15 was placed with a staff member to monitor.Review of the resident's progress notes dated November 2025 showed on 11/3/25 the Nurse Practitioner note showed the resident's caregiver reported the resident had been active and alert and having sexual inappropriateness with another resident. Both residents were under close observation.Review of the resident's progress notes dated November 2025 to 2/12/26 showed no documentation of the number of times during a shift the resident was known to wander into another resident's room or any documentation of potentially unsafe wandering. Review of the resident's Treatment Administration Record (TAR) dated February 2026 showed:-There was no documentation of how many times per shift the resident was wandering into other resident rooms.-There was no documentation of how many times per shift the resident had unsafe wandering. Review of the resident's quarterly MDS, dated [DATE], showed the resident had no wandering behaviors.Review of the resident's progress notes dated 2/13/26 to 3/4/26 showed no documentation of the resident's wandering into other resident rooms or other potentially unsafe wandering.Review of the resident's TAR dated March 3/1/26 to 3/3/26 showed:-There was no documentation of how many times per shift the resident was wandering into other resident rooms.-There was no documentation of how many times per shift the resident had unsafe wandering.Continuous observation on 3/2/26 between 9:33 A.M. and 11:25 A.M. showed:-At 9:33 A.M. residents were in the large activity/dining room watching a music video. -The resident wandered in the area and back out into the resident room hallway.-At 9:54 A.M. the resident was observed wandering up and down the hallway and going from resident room to resident room on both the left and right sides of the hall. Occasionally he/she went past the nurses' desk and into the hall behind the large activity/dining room.-At 10:10 A.M. a staff person took the resident by the hand and walked with him/her to the resident's own room.-At 10:11 A.M. the resident came out of his/her room and continued wandering the hallway.-At 10:15 A.M. the resident wandered into the open door of room [ROOM NUMBER] which was not occupied by another resident at that time.-At 10:37 A.M. the resident was again wandering the hall.-At 11:01 A.M. the resident was lying quietly on his/her left side facing away from the open door in the second bed in room [ROOM NUMBER]. The facility census showed the second bed in room [ROOM NUMBER] was assigned to a resident. The room did not have any residents in it at that time. Continuous observation on 3/3/26 between 2:39 P.M. and 2:55 P.M. showed:-At 2:39 P.M. the resident walked into the open door of room [ROOM NUMBER], which was occupied by another resident. The resident in room [ROOM NUMBER] placed a hand on each of Resident #15's arms and tried to guide him/her to the door towards the hallway. A staff person in the (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	hallway took Resident #15's hand and verbally encouraged him/her to come out of room [ROOM NUMBER].-At 2:49 P.M. Resident #15 walked into the open door of room [ROOM NUMBER] and walked to the second bed which the census showed was assigned to another resident. He/She laid down with his/her head at the foot of the bed and his/her feet facing the head of the bed. The room did not have any residents in it at that time. -At 2:53 P.M. a staff person going down the hall noticed the resident from the open door of room [ROOM NUMBER] and told the resident he/she would show him/her to his/her own room. The resident cooperatively left with the staff person.Review of the resident's physician orders dated 3/4/25 showed the resident had no current orders for any increased monitoring or supervision.Observation on 3/4/26 at 9:50 A.M., 10:03 A.M., 6:52 P.M., 8:00 P.M. and 8:24 P.M. showed the resident was in his/her own bed lying still as if asleep. During an interview on 3/4/26 at 8:01 P.M. CNA F said:-When he/she came onto the unit on 10/22/25 other staff were already with Resident #15 and the other resident who he/she heard was also undressed from the waist down. Both residents were placed on 1:1 staffing for five days. Since then, Resident #15 had not had any increased level of supervision or any other similar incident.-Resident #15 would undress a couple of times a week during the evening shift. The resident would wander and take his/her clothes off or often just his/her top off.-Staff tried to keep the resident in the common area, but as soon as staff were busy with another resident, Resident #15 would get up and wander off. He/She sometimes wandered non-stop.-Resident #15 would wander into someone's room and turn the water on and leave it running or get into someone's bed. Staff were supposed to redirect the resident, but he/she wandered so much it was hard to keep the resident out of other residents' rooms.Continuous observation on 3/5/26 between 10:48 A.M. and 11:20 A.M. showed:-At 10:48 A.M. the resident was standing near the large dining/activity room tables and headed down the resident room hallway. The Licensed Practical Nurse (LPN) was at the medication cart and two CNAs were in the large activity room/dining room trying to engage residents in table activities.-At 10:57 A.M. the resident returned to the large activity/dining room and one of the CNAs danced to music with the resident.-At 11:00 A.M. the resident wandered down the resident room hallway. -At 11:02 A.M. the resident was lying in the second bed in room [ROOM NUMBER] on his/her right side facing the hall. The room door was open. The room did not have any other residents in it at that time. -At 11:07 A.M. the LPN went down the hall checking resident rooms and towards the end of the hall found the resident in the second bed of room [ROOM NUMBER]. He/She took the resident's hand and led him/her to the large activity/dining room where the music video and table games were taking place.-At 11:10 A.M. the resident walked into room [ROOM NUMBER] and the LPN immediately encouraged him/her to come out.-At 11:11 A.M. the unit phone rang and the LPN went to the nurses' desk to answer it. Resident #15 wandered back into the open door of room [ROOM NUMBER]. -At 11:12 A.M. the resident exited the room while the LPN was still on the phone.-At 11:13 A.M. the resident wandered into the open door of room [ROOM NUMBER] and sat on the side of the second bed and then laid down on his/her right side, facing the door.-At 11:15 A.M. the resident walked out of room [ROOM NUMBER] and into the large activity/dining room where residents were engaged in table games and listening to music. The two CNAs were still in the activity area engaged with other residents.During an interview on 3/6/26 at 11:56 A.M. the Social Services Assistant said:-He/She had been informed of the 10/22/25 incident involving Resident #15 and another resident. There had been no other similar incidents.-It was common for the resident to wander in and out of resident rooms and lie in other residents' beds.-He/She was not aware of any verbal or physical conflicts with any other resident related to the resident's wandering.-Social Services was responsible for behavioral care plans. -Staff were supposed to redirect the resident from wandering into other residents' rooms.Continuous observation on 3/9/26 between 9:30 A.M. and 9:42 A.M. showed:-A housekeeper was cleaning resident rooms.-At 9:30 A.M. Resident #15 was in the second bed of room [ROOM NUMBER].-At 9:32 A.M. the resident got up and came out of the room into the hallway.-At 9:33 A.M. the resident went into the open door of room [ROOM NUMBER]. The facility census and names on the door showed two other residents (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	occupied room [ROOM NUMBER].-At 9:34 A.M. the resident came out of room [ROOM NUMBER] and entered the open door of room [ROOM NUMBER]. He/She sat on the second bed.-At 9:37 A.M. the resident got up and walked into the hallway.-At 9:38 the resident walked past a wet floor caution sign into the open door of room [ROOM NUMBER]. The facility census showed the room was occupied by two other residents.-At 9:39 A.M. the resident walked out of the room into the hallway.-At 9:40 A.M. the resident walked into the open door of room [ROOM NUMBER]. The census showed the first bed in room [ROOM NUMBER] was assigned to a resident and the second bed was not currently occupied by a resident. The resident laid down on the second bed in room [ROOM NUMBER] on his/her right side, facing the door.-At 9:42 A.M. the resident got up and walked over to the sink. He/She stood over the sink and stared at it for many seconds and then wandered back into the hallway.During an interview on 3/9/26 at 9:43 A.M. Housekeeper A said:-When he/she cleaned on the unit, Resident #15 normally wandered the hall and went in and out of other residents' rooms.-He/She didn't know what the resident's interventions were or been told if he/she was supposed to do anything or notify anyone when the resident was in another resident's' room.During an interview on 3/9/26 at 10:14 A.M. CNA G said:-The resident wandered in and out of other resident's rooms all day unless he/she was taking a nap.-Staff tried to keep Resident #15 out of other resident rooms by closing the other resident room doors. When room doors were closed the resident didn't wander into the rooms.-Staff kept Resident #15's door open so he/she would go in there. -Other residents on the unit were all able to open their own closed door.-The resident would try to turn on sinks in other resident rooms and would get in other residents' beds. Multiple times the sinks had overflowed from the resident leaving them on.-On 10/22/25 another CNA found Resident #15 undressed from the waist down in another resident's room. The other resident was also undressed from the waist down. The other CNA called him/her to the room. When he/she got to the room he/she found Resident #15 sitting at the foot of the bed undressed from the waist down and the other resident near the sink undressed from the waist down. -Sometimes the resident undresses himself/herself and probably had been found undressed in other resident rooms but had not had another incident where he/she was found partially undressed with another resident. The resident hadn't undressed himself/herself as much in the past year.-He/She was not aware of any altercations the resident had with any other resident when he/she wandered into their room. -The resident in room [ROOM NUMBER] would tell staff when Resident #15 wandered into his/her room. -The family member of the resident in room [ROOM NUMBER] had informed staff when Resident #15 was in room [ROOM NUMBER] when he/she visited. If the door was closed Resident #15 won't go in there. -The resident was not on any increased level of supervision or checks, although staff knew to redirect the resident when they noticed he/she was heading toward or was in another resident's room.During an interview on 3/9/2 at 11:04 A.M. LPN D said:-He/She tried to make room rounds every 30 minutes to make sure the resident was safe and not in another resident's room. He/She redirected the resident by gently taking his/her hand and walking with him/her to his/her own room.-There had been no resident-to-resident altercations, and the resident had not undressed in another resident's room in the past several weeks. He/She had not heard of any altercations or unsafe wandering having happened in several months. If there was any unsafe wandering the nurse should have documented that in the resident's progress notes. -He/She thought if other resident doors were shut except the resident's the resident would likely just open the other resident room doors and wander in.-To prevent the resident from entering other resident rooms, it would take a lot of observations and redirection. -When staff turn their backs, the resident just wandered to the next spot. -Staff couldn't keep the resident out of other resident rooms or redirect him/her from going into them without constant monitoring.During an interview on 3/9/26 at 11:45 A.M. the Director of Nursing (DON) said:-He/She would expect staff to try to redirect someone from going into another resident's room and to provide lots of activities as a diversion.-He/She had only been at the facility a couple of weeks and didn't know Resident #15 well enough to know what activities he/she could focus on or what interventions would work best to prevent wandering into other resident (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	rooms.-The resident's wandering should be care planned and include effective interventions. -Direct care staff should use the Kardex to see what interventions they should use.-The nurse was responsible for documenting resident behaviors in the progress notes.

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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 store a nebulizer (a device used to administer medication to people in the form of a mist inhaled into the lungs) mask in a plastic bag for one sampled resident (Resident #16) out of 20 sampled residents. The facility census was 98 residents. Review of facility policy entitled Oxygen Administration (Infection Control, Safety, and Storage) revised 9/30/25 showed:-The facility must have ensured that a resident who needed respiratory care was provided such care, consistent with professional standards of practice. -Stored respiratory supplies in a bag labeled (i.e., residents name) when not in use. 1. Review of Resident #16's admission Record showed he/she was admitted to the facility with the following diagnosis: -Asthma (a chronic respiratory condition that caused airway inflammation, swelling, and mucus production, that resulted in breathing difficulties, wheezing, chest tightness, and coughing).-Respiratory failure unspecified whether with hypoxia (low oxygen) or hypercapnia (elevated carbon dioxide).Review of the resident's Order Summary Report (OSR) dated 11/21/25 showed:- Monitor every shift related to asthma. Did the resident experience signs or symptoms of shortness of breath (SOB) when laid flat or avoided lying flat due to signs or symptoms of SOB (increased respiratory rate, pursed lip breathing, a prolonged expiratory phase, audible respirations, gasping for air, interrupted speech pattern, use of accessory muscles, anxiety, restlessness etc.)? -Ipratropium-Albuterol Solution 0.5-2.5 (3) milligram (mg)/3 milliliter (ml) 3 ml inhaled orally via nebulizer four times a day related to respiratory failure.Review of the resident's Quarterly Minimum Data Set (MDS-a federally mandated assessment instrument completed by facility staff for care planning) dated 1/5/26 showed:-The resident was cognitively intact. -Scheduled respiratory treatments were skipped. Review of the resident's care plan dated 2/26/26 showed:-The resident had altered respiratory status/difficulty breathing related to recent hospitalstay for respiratory failure.-Staff were to administer medication as ordered.-NOTE: Storage of the nebulizer mask was not addressed. -NOTE: Resident noncompliance was not addressed. Observation on 3/2/26 at 9:21 A.M. of the resident's room showed:-The nebulizer mask was set upright on the nebulizer machine not stored in plastic bag.-There was no plastic bag near the nebulizer for storage of the nebulizer mask. Observation on 3/2/26 at 2:32 P.M. of the resident's room showed:-The nebulizer mask was set upright on the nebulizer machine not stored in plastic bag.-There was no plastic bag near the nebulizer for storage of the nebulizer mask. Observation on 3/3/26 at 9:21 A.M. of the resident's room showed:-The nebulizer mask was set upright on the nebulizer machine not stored in plastic bag.-There was no plastic bag near the nebulizer for storage of the nebulizer mask. During an interview on 3/4/26 at 7:58 A.M., Licensed Practical Nurse (LPN) B said:-Nebulizers were to be stored in a dated plastic bag when not in use. -The plastic bag would be dated and changed out weekly. -When a nebulizer mask was found not in a plastic bag it would be replaced and placed in the plastic storage bag. -When a resident was not compliant with the storage of the respiratory item the resident would be educated about the importance of it, and the MDS Coordinator would be notified so the care plan could then be updated. During an interview on 3/6/26 at 8:48 A.M., Certified Nursing Assistant (CNA) E said:-A nebulizer mask should have been stored in a plastic bag. -If a nebulizer mask was not stored in a plastic bag, he/she would discard it and get a new one and put it in the plastic bag. -When a resident was non-compliant he/she would educate the resident on the importance of storing the nebulizer mask in a the plastic bag , and he/she would notify the nurse.During an interview on 3/6/26 at 8:51 A.M., Registered Nurse (RN) A said:-The nebulizer masks were to be stored in a dated plastic bag when not in use.-When the nebulizer mask was not stored in the plastic bag, he/she would get a new nebulizer mask and place it in the plastic bag. -The MDS Coordinator would be informed that resident was noncompliant on the storage of nebulizer mask, so the care plan could be updated for education and noncompliance. -When a resident was not compliant with the storage of the respiratory item the resident would be educated about the importance of (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	it.During an interview on 3/9/2026 11:52 A.M., the Director of Nursing (DON) said:-He/She expected nebulizer masks to be stored in dated plastic bags when not being used.-He/She expected when a nebulizer mask was found not stored in a plastic bag that it would be replaced and the new nebulizer mask was placed in the plastic bag. -He/She expected staff would have educated the resident on the importance of storing nebulizer masks in plastic bags when not in use.-When a resident was noncompliant with the storage of respiratory items he/she expected the MDS Coordinator to be notified and to update the care plan.

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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 a resident who required dialysis (process of cleansing the blood by passing it through a special machine - necessary when the kidneys are not able to filter the blood) received ongoing assessments of the dialysis site; and failed to have orders for dialysis for one sampled resident (Resident #38) out of 20 sampled resident. The facility census was 98. Review of the facility policy Area of Focus: Dialysis (a process by which dissolved substances are removed from a patient's body by diffusion from one fluid compartment to another across a semipermeable membrane) reviewed 12/01/25 showed:-The two types of dialysis that were currently in common use are hemodialysis (HD-process of cleansing the blood by passing it through a special machine - necessary when the kidneys are not able to filter the blood) and peritoneal dialysis (PD- kidney failure treatment that uses the lining of your abdomen (peritoneum) to filter waste and extra fluid from your blood using a surgically placed catheter).-The facility must have ensured that residents who required dialysis received such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and residents' goal and preferences. -Assessed for any signs/symptoms of infection, such as redness or edema at the vascular access site.-Assessed vascular access site for signs of clotting every eight hours.-Documented in the clinical nursing record: dialysis treatment completed, order changes, condition of shunt site, complaints from the resident (if applicable), and whether physician and responsible party notification. -Physicians shall have established an order for the amount of time required for the resident to be on dialysis.-Monitored vascular access site on a routine basis. 1. Review of Resident #38's admission Record showed the resident was admitted with the following diagnosis:-End Stage Renal (Kidney) disease (the final, irreversible stage of chronic kidney disease, and they can no longer support life). -Dependence on Renal (Kidney) dialysis.Review of resident's undated comprehensive care plan showed:-Hemodialysis (HD) related to end stage renal disease.-The resident would have no signs or symptoms of complications from dialysis through the review date.-Dialysis at dialysis facility Tuesday, Thursday, and Saturday chair time 11:00 A.M. to 3:00 P.M.-Dialysis treatments as ordered.-Dry weights obtained from dialysis center.-Had a tunneled dialysis catheter (a soft, flexible tube placed into a large vein (usually in the neck, chest, or groin) to provide immediate, temporary access to the bloodstream for hemodialysis, or for peritoneal dialysis) to right upper chest, until shunt was placed. -Observe for bleeding at dialysis access site.Review of resident's Progress Notes dated 2/16/2026 showed:-The resident returned to facility via stretcher accompanied by emergency medical services (EMS), at 5:10 P.M. temporary dialysis catheter on right upper chest, and arteriovenous (AV) fistula (the preferred long-term vascular access for hemodialysis, created by surgically joining an artery to a vein, usually in the forearm) on left upper arm.-The resident was compliant during assessment, with no issues. Review of the resident's Electronic Medical Record (EMR) showed that from readmission to 2/16/26 there was:-No dialysis orders in place.-No orders for when the resident was to attend dialysis.-No orders for site and type of access the resident had.-No orders for monitoring dialysis site nor how often. -No documentation that the resident's dialysis site was being monitored or assessed. Observation on 3/1/22 at 1:00 P.M. of resident showed:-He/She was sitting in his/her wheelchair. -He/She had a dialysis catheter on the right side of his/her chest with a clean, dry, intact dressing. During an interview on 3/4/26 at 7:58 A.M., Licensed Practical Nurse (LPN) B said:-He/She was unfamiliar with the resident.-There should be orders for when the resident went to dialysis and when to assess the dialysis site. -The dialysis site should be assessed every shift for bleeding and signs of infection. -The assessments should have been documented in the residents EMR.-If a resident received dialysis and there were no orders he/she would have called the doctor and obtained the orders. During an interview on 3/6/26 at 8:51 A.M., Registered Nurse (RN) A said:-The resident had a dialysis catheter in his/her chest. -Dialysis access should be assessed every shift and should be charted in the computer in the resident medical (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	chart. -He/She would expect the resident to have orders for what type of site and what would be monitored.-There should be orders to monitor for signs and symptoms and of infection and bleeding. -The site needed monitored for infection and bleeding, because if infected the site needed to be changed, and if bleeding the resident needed to be sent to the hospital. -If there were no orders, then the doctor would need to be contacted, and orders received for dialysis.-The resident had orders before last hospitalization.-He/She guessed that the old orders were not restarted upon admission and that was a mistake. During an interview on 3/9/2026 11:52 A.M., the Director of Nursing (DON) said:-It was his/her expectation that a nurse would know the type of dialysis access a resident had. -It was his/her expectation that the nurses knew how to assess the dialysis access. -It was his/her expectation that a resident that required dialysis would have orders for when and where to go for dialysis to include chair time, and when and how often to assess the dialysis site. -A dialysis site would be monitored every shift for infection, drainage and depending on the access a thrill (a fine, palpable vibration felt on the skin) and bruit (an abnormal, rushing or blowing sound heard through a stethoscope over a blood vessel) would be monitored and it would be charted in the EMR. -The nurse that readmitted the resident to the facility should have caught that there were no dialysis orders and called the doctor. -The team should have caught the missing dialysis orders in the morning meeting.-He/She had just started at the facility.

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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 ensure one sampled resident (Resident #70) with a history of physical and sexual trauma (an event or series of events experienced by a person as physically or psychologically harmful or threatening) out of 20 sampled residents had triggers (psychological stimulus that prompts recall of previous traumatic events) identified and interventions for staff to help mitigate triggers and avoid re-traumatization in the resident's Trauma Informed Care (TIC - an approach to care that recognizes and responds to the effects of trauma on a person) care plan. The facility census was 98 residents. Review of the facility's Person-Centered Care Planning policy, dated 8/16/22 and reviewed 8/29/25, showed:-Trauma-informed care was an approach to delivering care that involved understanding, recognizing, and responding to the effects of all types of trauma. A trauma-informed approach to care delivery recognizes the widespread impact, and signs and symptoms of trauma in residents, and incorporates knowledge about trauma in care plans, policies, procedures, and practices to avoid re-traumatization.-The facility will include the resident, and if applicable, the resident's representative participation in developing the person-centered plan. For residents with a history of trauma, the care plan will include the interventions for care and account for the resident's experiences and preferences to eliminate or mitigate triggers that may cause additional trauma for the resident.1. Review of Resident #70's admission Record showed the resident admitted with the following diagnoses:-Stroke affecting right, dominant side.-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).-Anxiety disorder (a psychiatric disorder causing feelings of persistent anxiety).-Major depressive disorder (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).Review of the resident's past two TIC assessments showed:-On 10/1/24 a family member provided information about the resident's past trauma related to sexual abuse as a child due to the resident's cognitive deficit. The family member was unaware of any known triggers related to the trauma.-On 7/25/25 a family member provided information related to the resident's history of sexual assault. The family member was unaware of any known triggers related to the trauma.Review of the resident's psychosocial well-being care plan, dated 5/14/25 showed:-The resident was easily distracted and found it difficult to concentrate.-The resident had ineffective coping surrounding his/her history of sexual assault from a family member.-Interventions included:--Consult pastoral care, social services, psychological services, and the physician.--Provide support to identify precipitating factors/stressors.--Provide support to identify problems that cannot be controlled. And identify solutions to present problems.--When conflict arises remove resident to a calm safe environment and allow resident to share feelings, allowing time to answer questions and to verbalize perceptions and fears.-NOTE: The psychosocial care plan did not identify possible triggers or specify what staff should do to lessen the likelihood of re-traumatization. Review of the resident's trauma care plan, dated 7/25/25 showed:-The resident experienced significant trauma related to sexual assault as a child.-The Interdisciplinary Team (IDT) shall meet proactively to discuss care strategies that consider safety, trustworthiness, peer support, collaboration, empowerment, choice, culture, history, and being sensitive and respectful concerning gender issues.-The IDT will reinforce that trauma refers to experiences that cause intense psychological stress reactions. The resident will be provided culturally competent, sensitive trauma-informed care in accordance with professional standards accounting for the resident experience and preferences to eliminate or mitigate triggers that may re-traumatize.-NOTE: The trauma care plan did not show strategies that staff could use to help the resident feel safe and build trust; what staff could do to help build peer support; how they would collaborate with the resident; and what they would do specifically to provide a sensitive and (continued on next page)

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	265355	A. Building B. Wing	03/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Life Care Center of Grandview	6301 East 125th St Grandview, MO 64030

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	respectful environment concerning gender issues. The care plan did not show what the resident's possible triggers were likely to be or what staff could do specifically to help mitigate possible triggers that might re-traumatize the resident.Review of the resident's annual Minimum Data Set (MDS - a federally mandated assessment instrument completed by facility staff for care planning), dated 12/15/25 showed the resident was moderately cognitively impaired.Review of the resident's nursing progress note dated 2/24/26 at 2:30 P.M. showed:-The resident was asleep and his/her roommate attempted to awaken the resident. -The resident screamed. -The nurse ran into the room and walked the roommate to the nurses' station. -The resident went back to sleep.During an interview on 3/5/26 at 9:40 A.M. the Social Services Assistant (SSA) said:-He/She did TIC assessments upon admission, annually, when there was a significant change in the resident's condition, or any time there was a newly known trauma.-The TIC assessment should reflect any past trauma or known triggers.-The MDS Coordinator was responsible for the TIC care plan and used the TIC assessment to do the care planning.-He/She was responsible for asking the resident or their responsible party about the resident's past trauma and any known triggers.-The resident's care plan should show any likely possible triggers and what staff can do to help the resident.During an interview on 3/5/26 at 1:10 P.M. the resident's family member (Family Member A) said:-The resident had an extensive history of sexual abuse as a child.-About a month ago the resident was awakened from sleep by his/her former roommate who was sitting on his/her bed. The staff let him/her know this had been highly disturbing to the resident. When the resident was highly upset, he/she would scream or yell out. He/She thought the experience could have triggered the resident's past trauma, but didn't know for sure. -The resident became upset if someone's tone of voice was loud and/or disrespectful, which could in part remind the resident of his/her childhood experiences.-The resident startled very easily. If touched or someone tried to assist the resident with cares without first explaining what they were about to do the resident would jump. Staff should always explain first so the resident wasn't fearful. The resident's familiar staff knew to do this. Staff on the unit should be as consistent, and familiar staff whom the resident trusts should work with the resident as much as possible.-He/She thought the resident would be significantly more comfortable and feel safer if a familiar, trusted, staff person of the same sex assisted the resident with showers, getting dressed and undressed, changed his/her disposable brief, and assisting with intimate cares. The resident wouldn't want a staff member of the opposite sex to bathe him/her, help him/her undress, or change his/her brief.-Approaches to care should reflect the resident's needs related to his/her past trauma and be clearly explained in his/her care plan.During an interview on 3/9/26 at 10:14 A.M. Certified Nurse Assistant (CNA) G said:-He/She had attended TIC training at the facility.-The education described different types of trauma and a resident's possible response and triggers to the response. For instance, a resident might clench up or refuse to be undressed. This could indicate fear if they were abused in the past. A person might become upset or scream if they heard a loud noise if they heard that during a traumatic experience.-He/She didn't know of the resident's past trauma and didn't know if the resident's care plan mentioned his/her triggers or interventions, but the care plan should show how staff were to help the resident with a trauma history.-He/She knew if anyone spoke loudly or sternly to the resident the resident would start screaming and yelling. The resident didn't like to be ordered around or spoken to like he/she was a child. Staff should tell the resident gently what they wanted him/her to do and why instead of ordering him/her to do it.-The resident startled easily in his/her sleep or if another resident walked into his/her room without knocking or he/she was touched unexpectantly. In any of these situations the resident would jump as if very startled. If another resident entered his/her room the resident would scream for someone to get the resident, or he/she would become upset and stern with the other resident and staff had to come and get them.-Staff should always explain what cares they were about to do and why and use a gentle, non-confrontational approach. Staff who provided cares should be familiar and trusted by the resident. Almost all the CNAs who provided care were the same sex as the resident, which he/she thought the resident would much prefer.During an interview on (continued on next page)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3/9/26 at 11:18 A.M. Licensed Practical Nurse (LPN) D said:-He/She received TIC education at the facility within the past six weeks. The training included examples of past trauma like someone having gone through a war, been assaulted in prison, and other traumatic experiences. They talked about possible triggers and how staff might help.-If someone had a history of trauma there should be a TIC care plan which showed the resident's triggers and ways staff could help the resident.-He/She did not know the resident's prior trauma, his/her possible triggers, or interventions related to trauma.-He/She knew the resident didn't like loud noises. Staff should use a soft, non-confrontational approach and give the resident time to respond.-Staff should knock and let the resident respond before entering his/her room and discretely ask him/her what he/she needed. They should let the resident know before checking his/her briefs for wetness and provide as much privacy as possible. They should say the resident's name and explain the care they were about to provide before starting.-Ideally care should be provided to the resident by a staff member of the same sex. In general, the unit used mainly staff members of the same sex to provide showers and change clothes and briefs for residents.-The resident's vision was compromised, especially on the right side, so anything that entered his/her space abruptly or any sudden movement made the resident jump. Loud noises or anything unexpected caused the resident to jump and look startled and should be avoided whenever possible.During an interview on 3/9/26 at 11:45 A.M. the Director of Nursing (DON) said:-The facility was responsible for providing TIC to all facility staff.-TIC care plans should include the resident's known or likely triggers. -Staff should know how to avoid triggering the resident and what approaches worked best with them.-The care plan should show this information as well as the Kardex (a quick reference tool providing a concise summary of the resident's care needs) which was used by staff providing the residents' direct cares.

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. Based on interview and record review, the facility failed to provide pre-treatment medication for one sampled resident (Resident #35) out of 20 sampled residents, prior to his/her dental appointment, causing a delay in his/her dental care leading to unnecessary pain between procedures. The facility census was 98 residents. Review of the facility's Physician Orders Policy, dated 2/11/26, showed:-All physician/practitioner orders, including verbal/telephone orders, were recorded in the medical record for each resident and must be signed and dated within 14 days by the ordering physician, physician assistant or nurse practitioner.-The receiving nurse, therapist, or approved dietician immediately enters the telephone or verbal orders into the clinical software.Review of the facility's Administration of Medications policy, dated 9/9/25, showed:-The facility ensured medications were administered safely and appropriately per physician order to address the resident's diagnoses and signs and symptoms.-Medication administration was the responsibility of those individuals who were authorized to administer medications.A policy specifically related to dental and oral care was requested and not received.1. Review of Resident #35's face sheet, undated, showed he/she admitted with the following diagnoses:-Type 2 Diabetes (a chronic condition where the body cannot properly use or make enough of a hormone called insulin, leading to high blood sugar levels).-Protein calorie malnutrition.-Anxiety disorder (excessive, persistent, and uncontrollable fear or worry that interferes with daily life).Review of the resident's dental care treatment summary dated 1/26/26 showed the resident was unable to be to be seen for treatment as the resident was not provided the necessary pre-treatment prior to procedure.Review of the resident's Progress Notes, dated 1/26/26, showed:-The dental instructions for pre-treatment were provided to nursing staff.-The pre-treatment was required prior to the procedure.Review of the resident's Progress Notes, dated 2/17/26, showed the resident was ordered to receive dental pre-treatment prior to next dental appointment.Review of the resident's Quarterly Minimum Data Set (MDS- a standardized, federally mandated assessment tool used in nursing homes to evaluate a resident's functional, medical, psychosocial, and cognitive status) dated 2/19/26, showed the resident was cognitively intact.Review of the resident's Physician Order Summary, dated March 2026, showed:-The resident was permitted to see the dentist as needed.-There were no orders for pre-treatment for dental visits.During an interview on 3/2/26 at 1:31 P.M., the resident said:-He/She had not seen the dentist the last time the dentist was at the facility.-He/She was supposed to take some type of medicine before the appointment, but it was not given to him/her.-He/She had to wait for the next time the dentist came to get the work done.-The resident reported being in pain, but received pain medication and it helped. During an interview on 3/4/26 at 7:43 A.M., Licensed Practical Nurse (LPN) B said:-The resident did complain to him/her about dental pain.-He/She did see it on reports that the resident had complained about dental pain to other staff. -There were a few times the resident did not get to the dentist due to pain. During an interview on 3/5/26 at 9:32 A.M., the Social Services Assistant (SSA) said:-There were some communication issues with the dental company regarding the resident's dental treatment.-The orders for the pre-treatment were not transmitted on time.-The orders were received on 2/17/26 and the resident was on the list to see the dentist this week.During an interview on 3/6/26 at 2:11 P.M., the Director of Nursing (DON) said:-The resident did not receive the premedication for his/her dental treatment scheduled for 1/26/26.-It was ordered.-The order was received on 2/17/26 and it was on hand for the next scheduled dental visit.During an interview on 3/9/26 at 11:52 A.M., the DON said:-If residents were ordered a pre-treatment needed for dental visits, it was the nurse on duty who was responsible for getting the orders on the Physician Order Summary. -The nurse transcribed the order to be sure it was on the order summary and the Medication Administration Record (MAR).-The order initially went to the dentist, which was then emailed to Social Services, who was responsible for getting the order to the nurse.-If the resident received the pre-treatment, it would have been documented on the MAR.-The order should have been entered, and the resident should have received the pre-treatment medication on 1/26/26.