STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265356	A. Building B. Wing	12/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Valley Manor and Rehabilitation Center	1410 Hospital Drive Excelsior Springs, MO 64024

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 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to maintain the highest practicable physical wellbeing of the residents when no annual training records were found for, Nurse Aide (NA) A, Certified Nurse Aide (CNA) A and CNA C, when staff failed to adhere to proper infection control practices and when the facility did not have an a infection surveillance program. The facility census was 67. The facility did not provide the requested policy on education or of staff competencies.Review of the facility's Personal Protective Equipment - Using Gloves policy, dated September 2010, showed:-Gloves are used to prevent the spread of infections;-Gloves are used to protect wounds from contamination;-Gloves are used to protect hands from infectious material;\-Wash hands after removing gloves;-Use gloves when touching excretions, secretions, blood, body fluids.Review of the facility's Handwashing/Hand Hygiene policy dated October 2023, showed:-All personnel are expected to adhere to hand hygiene policies;-Hand hygiene is indicated before:- Touching a resident;- After contact with contaminated surfaces;- After touching a resident's environment;- Before moving from work on a soiled body site to a clean body site.Review of the facility's Enhanced Barrier Precautions policy, dated 3/20/24, showed:-It is the policy of this facility to implement enhanced barrier precautions for the prevention of transmission of multidrug-resistant organisms;-Enhanced barrier precautions (EPB) refer to an infection control intervention designed to reduce transmission of multidrug-drug resistant organisms that employs targeted gown and gloves used during high contact resident care activities;-Enhanced barrier precautions will be initiated for residents with chronic wounds, surgical wounds, central lines, ports, urinary catheters and feeding tubes;-Make gowns and gloves available immediately near or outside of the resident's room;-PPE for enhanced barrier precautions are only necessary when performing high contact care activities;-High contact resident care activities include, dressing, bathing, transferring, providing hygiene, changing linens, changing briefs and assisting with toileting, device care (central lines, urinary catheter and feeding tubes) and wound care (any skin opening requiring a dressing).1.Review of the employee files showed:Certified Nurse Aide (CNA) A;- Date of hire was 11/20/24;- No documentation of required trainings was found;CNA B;- Date of hire was 6/14/24;- No documentation of required trainings was found;CNA C;- Date of hire 3/5/21;- No documentation of required trainings was found.During an interview on 12/18/25 at 1:21 P.M., the Director of Nursing said:-She did not know where the trainings were located;-She had just been hired a few weeks ago;-Staff should be observed performing cares quarterly;-She had not documented the observation of cares; -The former administrator is no long here, and she is unsure if the acting Administrator knew where the education files were;-The facility should have a training program for all new and existing staff.During an interview on 12/18/25 at 1:25 P.M. the Administrator said:-She did not know where the trainings were located;-She was hired as the administrator just recently;-The facility should have a training program for all new and existing staff. 2. Review of Resident #61's Medicare 5-day Minimum Data Set (MDS), A federally mandated assessment tool completed by facility staff, dated 11/27/25, showed:- No cognitive impairment;- (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 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Impairment of lower extremities;- Incontinent of bowel and bladder;- Dependent on staff for all Activities of Daily Living (ADL)s;- Diagnoses included seizure disorder, anxiety and high blood pressure.Review of the resident's care plan, dated 12/05/25, showed:-Dependent on staff for ADLs;-Incontinent of bowel and bladder.Review of the resident's Physician's Order Sheet (POS) dated December 2025, showed:-Order start date: 12/14/25, Peripherally Inserted Central Catheter (PICC, a thin tube inserted into a vein in the arm and guided to a large vein near the heart, used for IV medications and fluid), change dressing every weekly.Observation and interview on 12/17/25 at 10:34 A.M., showed:-A sign outside the resident's room that showed the resident was on enhanced barrier precautions;-An infection control cart sat outside the resident's room;-The resident had a PICC line with two uncapped lumens in place in his/her left arm;-The resident had a dressing on his/her right hip;-The resident said he/she had surgery on his/her right hip;-The resident said he/she had a PICC line because he/she got an infection after the hip surgery;-The resident said he/she received medication in the PICC line for the infection;-Nurse Aide (NA) A and Certified Nurse Aide (CNA) A entered the resident's room;-CNA A and NA A applied gloves and provided peri care to the resident;-NA A used gloved hands to open a drawer in the resident's room and grabbed a package of wipes;-NA A did not wash his/her hands or change gloves before he/she took the package of wipes out of the resident's dresser drawer;CNA A and NA A did not put on isolation gowns before they entered the resident's room and provided care.During an interview on 12/17/2025 at 10:41 A.M., NA A said:-He/She should have put on a gown before he/she entered the resident's room;-Anytime a resident is on EPB a gown should be worn when providing peri care;-He/She should have washed his/her hands and applied clean gloves before he/she removed the wipes from the resident's dresser drawer;-The resident was on EPB because the resident had a PICC line and surgical wound.During an interview on 12/17/2025 at 10:54 A.M., CNA A said:-He/She should have put on a gown before he/she entered the resident's room;-The resident was on EPB because the resident had a PICC line and surgical wound;-Anytime a resident is on EPB a gown should be worn when providing peri care;-Gloves should be changed and hands washed between clean and dirty tasks. During an interview on 12/18/25 at 1:21 P.M., the Director of Nursing said: -Resident #61 is on EBP for a surgical wound and the use of IV antibiotics;-She expected staff to have applied a gown, gloves and a face shield before they entered and performed cares on the resident;-She expected staff to change gloves and wash hands between clean and dirty tasks.During an interview on 12/18/25 at 1:25 P.M. the Administrator said:-She expected staff to use the PPE when performing cares on resident who is on EPB;-She expected staff to change gloves between clean and dirt task;-She expected staff to wash hands between glove changes.3. Observation in main dining room on 12/15/25, showed: - 12:21 P.M. NA (B) pushed a meal cart with four trays of food to the halls for delivery. The ice cream and drinks for the meals were not covered.- 12:23 P.M. Dietary Aide (A) dropped condiment packets on the ground and picked them up with gloved hands and placed them in his/her pocket. Dietary Aide (A) continued to serve residents their drinks and touched silverware without washing his/her hands. Dietary Aide (A) hugged and patted a resident on the back with his/her gloved hand and then grabbed a carafe of coffee and served a resident. - 12:28 P.M. Dietary Aide (B) put ice into cups and filled them with beverages and then carried them to the hall for room delivery without covers over the cups. Observation in resident hallway on 12/15/25, showed:- 12:38 P.M. Dietary Aide (B) pulled drink cart down the hall while wearing gloves and poured and delivered drinks to resident rooms. Dietary Aide (B) knocked on doors, set up trays and moved the cart between resident rooms and did not sanitize or change gloves between residents.During an interview on 12/15/25 at 1:07 P.M., Dietary Aide (B) said he/she was hired three months ago and initially was trained on infection control and hand washing. He/she had not been told to sanitize hands between serving resident rooms when passing drinks. Observation of 400 Hall on 12/16/25 at 9:17 A.M., showed NA (C) served a hall tray to room [ROOM NUMBER] and then pushed the tray cart to the next room and served the resident in that room without washing hands. Observation in the main dining room on 12/17/25 at 8:08 A.M. showed staff member (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	pushing a tray cart to the halls with a bowl of cereal uncovered. Observation of 400 Hall on 12/17/25 at 8:40 A.M. showed Dietary Aide (B) serving residents drinks in their rooms while putting fingers inside of the plastic drinking cups and not sanitizing hands between residents. 4. Review of Resident #46's Minimum Data Set (MDS) a federally mandated assessment tool completed by facility staff, dated 9/23/25, showed:-The resident was dependent on staff to perform activities of daily living;-Diagnosis of: Alzheimer's Disease (progressive mental deterioration due to generalized degeneration of the brain), hemiplegia (paralysis of one side of the body) affecting the left side, and depression.Review of the Resident's care plan, dated 11/1/25, showed:-The resident required enhanced barrier precautions (EBP) for wounds;-The resident had impairment of skin integrity to the left second toe.Review of the resident's Physician order Summary Report, dated 12/17/25, showed apply skin prep to second toe of left foot every day shift and leave open to air for skin integrity.Observation on 12/17/2025 at 2:32 P.M. showed:-Licensed Practical Nurse (LPN) A entered the resident's room apply skin prep to the resident's second toe of his/her left foot and applied gloves;-LPN A did not put on an isolation gown to apply skin prep to the resident's toe;-The resident had a sign on his/her door indicating the need to wear EBP (Enhanced Barrier Precautions-when direct care staff use additional personal protective equipment to minimize the spread of germs) when providing direct care to the resident. During a interview on 12/17/2025 at 3:55 P.M. LPN A said he/she should have worn a gown when doing the wound care treatment.During a interview on 12/18/2015 at 10:36 A.M. Certified Nursing Assistant (CNA) E said EBP was to be worn when caring for resident's with catheters, feeding tubes, and wounds.During a interview on 12/18/2025 at 1:08 P.M. CNA C said EBP was to be worn when providing care for resident's with wounds, catheters, and feeding tubes. During an interview on 12/18/2025 at 1:12 P.M. the Director of Nursing (DON) said EBP should be worn when providing direct care for resident's with catheters, wounds, and feeding tubes.During an interview on 12/18/2025 at 1:23 P.M. the Administrator said EBP should be when providing direct care for resident's with wounds. 5. Review of the facility's Infection Surveillance binder, dated 2025, showed:- No surveillance and no monitoring had been provided for the months January through August 2025;- No completed McGreer's Criteria checklists (checklists used in healthcare, especially long-term care, aiming to reduce unnecessary antibiotic use) had been added; - The September 2025 Infection Control Surveillance Log had no infectious organisms listed, no cultures listed, no x-ray results listed. and no infections resolved dates listed;- The October 2025 Infection Control Surveillance Log had listed only four infectious organisms identified for urinary tract infections (UTI's) at the beginning of the month and none for the remaining four UTI's, and no resolved dates listed for last nine resident's affected;- The November 2025 Infection Control Surveillance Log had no infectious organisms listed for any of the 13 residents listed;- The December 2025 Infection Control Surveillance Log showed one resident on antibiotics for a skin infection with infectious organism and antibiotic listed, one resident on antibiotics for an upper respiratory infection with antibiotic listed, one resident on antibiotics for an eye infection with no organism or antibiotic listed, and a fourth resident named with no further details listed. During an interview on 12/17/25 at 11:44 A.M., the Assistant Director of Nursing (ADON) and Infection Preventionist (IP) said:- Staff should use Enhanced barrier Precautions (EBP) anytime going into a room with a resident having an indwelling medical device like a catheter, PICC (Peripherally Inserted Central Catheter, which is a thin, flexible tube inserted into a small vein in the arm and guided to a large central vein near the heart) line, ostomy, incisions, or wounds;- The infection surveillance binder should document and monitor facility infection, listed by month, mapped out by the resident rooms, and contain copies of resident urinalysis results and x-ray results;During an interview on 12/18/25 at 8:30 A.M., the Director of Nursing (DON) said:- Staff should use EBP with residents requiring EBP anytime they go in the resident's room for care and should use the face shield anytime emptying a catheter;- Staff have yearly training in competencies including, handwashing, EBP, and peri care as well as in-services when needed;- The Infection Surveillance binder should have complete information for the whole year from January (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	through December.During an interview on 12/18/25 at 2:38 P.M., the Administrator said:- Staff should utilize EBP whenever performing cares touching the resident and everyone should be washing their hands before and after as well as utilizing hand sanitizer;- The infection surveillance plan should be followed and documented every month.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, the facility failed to prepare and serve food in accordance with professional standards for food service safety when facility staff failed to observe proper handwashing and hairnet procedures in the kitchen, routinely sanitize food surfaces, or maintain kitchen cleanliness standards, failed to properly monitor food storage temperatures, failed to present food that was attractive on the plate, and additionally failed to properly store and monitor food items for expiration dates. This had the potential to affect all residents in the facility. The facility census was 67.Review of facility policy, Preventing Foodborne Illness - Employee Hygiene and Sanitary Practices, revised November 2022, showed:- Employees must wash their hands before coming in contact with any food surfaces, after handling raw meat, when switching from raw meat to ready to eat food, after handling soiled equipment or utensils, during food preparation as often as necessary to remove soil and contamination;- Gloves are considered single-use items and must be discarded after completing the task for which they are used;- Gloves are removed, hands are washed and gloves are replaced after direct contact with residents, between handling soiled and clean dishes, between handling raw meats and ready to eat foods;- The use of disposable gloves does not substitute for proper handwashing;- Hair nets or caps and/or beard restraints are worn when cooking, preparing or assembling food to keep hair from contacting exposed food, clean equipment, utensils and linens;Review of facility policy, Food Receiving and Storage, revised November 2022, showed:- Dry foods that are stored in bins are removed from original packaging, labeled and dated (use by date);- Food in designated dry storage areas are kept at least six inches off the floor unless packaged for case lot handling such as pallets or skids;- All foods stored in the refrigerator or freezer are covered, labeled and dated (use by date);- Functioning of the refrigeration and food temperatures are monitored daily and at designated intervals throughout the day by the food and nutrition services manager or designee and documented according to state-specific requirements;- Refrigerated foods are labeled, dated and monitored so they are used by their use-by date, frozen, or discarded;- Refrigerators must have working thermometers and are monitored for temperature according to state-specific guidelines;Review of facility policy, Food Preparation and Service, revised November 2022, showed:Food Preparation Area- Appropriate measures are used to prevent cross contamination which includes using sanitizing towels and cloths for wiping surfaces in containers filled with approved sanitizing solution and cleaning and sanitizing work surfaces and food-contact equipment between uses;Review of facility policy, Handwashing/Hand Hygiene, revised October 2023, showed:- Hand hygiene products and supplies (sinks, soap, towels) are readily accessible and convenient for staff use to encourage compliance with hand hygiene policies;- Procedure for washing hands includes drying hands thoroughly with a disposable towel and using a disposable towel to turn off the faucet to limit contamination of the hands;Review of facility policy, Food and Nutrition Services, revised October 2017, showed food and nutrition services staff will inspect food trays to ensure that the food appears palatable and attractive. Observation in the kitchen on 12/15/25 at 9:02 A.M., showed:Main Kitchen Area:- Both handwashing stations were out of paper towels for drying hands;- Walk-in Freezer had no thermometer inside the unit:- Heavy oil build-up on baffles over the frill in the overhead;- Walk-in Freezer, Three Stand-up Freezers, Three Stand-up Refrigerators, and One Large 2-Door Refrigerator were missing multiple Temperature Log readings between 12/12/25 and the morning of 12/14/25;- #2 Stand-up Freezer had individual sized frozen ice cream servings in cardboard containers with no dates of receipt on the container or best used by date on the metal container where they were stored;- #3 Stand-up Freezer had frozen cupcakes two containers of 12 cupcakes each with a best used by date of 10/15/25 (expired), and one container of frozen cupcakes with a best used by date of 10/10/25 (expired);- 4-foot area on the floor in front of #3 Refrigerator had liquid (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	egg spilled as well as a 5-foot area of egg spill on the inside of the refrigerator.Large 2-Door Refrigerator:- Two, one-gallon bottles of generic salad dressing, one bottle of bar-b-que sauce and one bottle of 1000 island dressing had dried up liquid caked on the outside of the container;- Fancy ketchup 64oz can re-sealed with tin foil without an open date or best used by date annotated on container;- Leftover sliced tomato and onion wrapped in clear plastic without any used by dates annotated;- Glass of unknown liquid, sealed with plastic wrap on the top, labeled [NAME] Lunch had no date annotated;- Thickened water, 46oz, opened 7/15/25, re-sealed with expiration date of 12/4/25 (expired);- Thickened orange juice 11/4/25 opened, not resealed;- Three quarter sized dried food and liquid stains on the bottom right side of door lip;- Food crumbs covering two fresh vegetable bins on the bottom left shelf;Room Next to Dry Storage:- Container of white powder in clear tub unlabeled and not dated;- Bin of fresh onions with no dates stored in clear plastic bins;- Shortening oil, five-gallon jug, stored on the ground;- Oil stains on both walls around shortening oil jug;Dry Storage Room:- Four 28oz bags of insta mash potatoes no receipt date;- Bottled water, 40 cases, no receipt date;- Case of macaroni noodles stored on the ground;- Four 6-pound cans on the ground behind the can storage bin;Observation in main dining room on 12/15/25, showed at12:25 P.M. plates served to residents with stuffing and chicken on the plate. On the eating surface of the plate, a small bowl of green beans which is wedged between and in contact with the stuffing and chicken. During an interview on 12/15/25 at 12:45 P.M., Resident #65 said he/she doesn't like the bowl of green beans touching the other foods on her plate. He/she would prefer staff put the bowl on the tray instead of on the plate, it feels unsanitary when it touches his/her food.During an interview on 12/15/25 at 12:47 P.M., Resident #49 said he/she doesn't like the bowl touching his/her food either. It doesn't look good on the plate and it's unappetizing to see everything pushed together so they can hand you one plate that holds all the food. Observation in the Kitchen on 12/16/25 at 10:00 A.M. showed no Parts Per Million (PPM) tests were recorded in the log for the dishwasher solution from 12/9 - 12/13.During an interview on 12/16/25 at 10:05 A.M., Dietary Aide (B) said that PPM tests are done by the dishwashers every morning and afternoon and recorded on the log.During an interview on 12/16/25 at 10:08 A.M., the Dietary Manager (DM) said the kitchen assistant manager was responsible for the missing temperature log entries due to heavy workload and lack of staff due to call ins.Observation of the kitchen on 12/16/25 at 10:20 A.M., showed:- #3 Stand-up Freezer had five servings of half melted sherbet ice cream in bowls uncovered and undated;- Liquid egg spill observed on 12/15/25 still present on the inside of Refrigerator #3;- No sanitation buckets with clean rags observed for cleaning kitchen counter surfaces;- Dietary Aide (C) cleaning in the kitchen with gloves on, removes soiled gloves, puts them in his/her hand and used the same hand while holding onto soiled gloves to grab a clean spoon and stir a resident's drink that he/she was preparing;- [NAME] (A) wearing gloves while working with raw pork, changes gloves to perform a different kitchen preparation task and does not wash hands between glove change;- Dietary Aide (A) touches face with bare hands, puts on gloves without hand washing and works with mixer to prepare cake mix;- 10:35 A.M. DM puts out sanitation buckets for cleaning kitchen surfaces;- Dietary Aide (C) working at dishwashing station not wearing a hair net;- [NAME] (A) preparing main entree has a beard but is not wearing a beard net;- 12:10 Food was plated with rice and pork on the plate with a smaller container placed on the plate holding collard greens. The small container was wedged in between the entree and rice and was touching the food;- 12:15 P.M. Food preparation area had accumulated breading crumbs from pork chop preparation, spilled milk, raw pork pieces, an ink pen, and dirty gloves all on one counter surface with no staff wiping down area with rags from sanitation bucket over the previous 90 minutes;During an interview on 12/18/25 at 2:00 P.M., the Administrator said:- Hand washing stations should have disposable towels for staff to use;- Temperature checks should be done in the morning and in the evening for all refrigerators and freezers;- She would not expect staff to serve food that had a best used by date that was expired and out of date.- Food spills should be cleaned up immediately and upon discovery;- The DM with oversight from the Administrator is responsible for monitoring the cleanliness of the (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	kitchen spaces;- Food items that are opened should have the unused portion sealed and properly stored with the use by date annotated;- Leftover vegetables wrapped in plastic or any containers should have a use by date annotated;- Plates served with food containers on the plate touching other food items is not appetizing to all residents;- All containers should have a label as to the contents;- Cooking items and/or cooking oil containers should not be stored on the ground;- Food items should have a receipt date annotated on them;- There should be a thermometer in each refrigerator and freezer;- Sherbet should not be stored uncovered and undated in the freezer.

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a plan that describes the process for conducting QAPI and QAA activities. Based on interview and record review the facility failed to make a good faith attempt at utilizing the best available evidence to define and measure indicators of quality and facility goals that reflect processes of care and facility operations that have been shown to be predictive of desired outcomes for residents, when the facility did not monitor and review performance improvement plans (PIPs) for 2025 regarding resident pressure ulcers, resident snacks, and medication administration. This had the potential to affect all residents. The facility census was 67. Review of the facilities Quality Assurance and Performance Improvement (QAPI) Program policy, dated February 2020, showed:-This facility shall develop, implement, and maintain an ongoing, facility-wide, data-driven QAPI program that is focused on indicators of the outcomes of care and quality of life for our residents;-The objectives of the QAPI program are to: provide a means to measure current and potential indicators for outcomes of care and quality of life, provide a means to establish and implement performance improvement projects to correct identified negative or problematic indicators, reinforce and build upon effective systems and processes related to the delivery of quality care and services, establish systems through which to monitor and evaluate corrective actions. Review of Performance Improvement Plans (PIPs) for 2025 regarding pressure ulcers, resident snacks, and medication administration showed:-There were no signatures indication who was responsible for following through with the PIPs;-There was no tracking of performance improvement regarding the facilities PIPs. During an Interview on 12/18/2025 at 12:07 PM The Administrator said she had only been at this facility for three weeks and had reviewed the PIPs for the facility from before she began and noticed that the PIPs were lacking.

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. Based on interview and record review the facility failed to prioritize its improvement activities; measure the success of actions, track performance; regularly review, analyze, and act on data collected regarding the facilities performance improvement plan. The facility census was 67. Review of the facilities Quality Assurance and Performance Improvement (QAPI) Program policy, dated February 2020, showed:-This facility shall develop, implement, and maintain an ongoing, facility-wide, data-driven QAPI program that is focused on indicators of the outcomes of care and quality of life for our residents;-The objectives of the QAPI program are to: provide a means to measure current and potential indicators for outcomes of care and quality of life, provide a means to establish and implement performance improvement projects to correct identified negative or problematic indicators, reinforce and build upon effective systems and processes related to the delivery of quality care and services, establish systems through which to monitor and evaluate corrective actions. Review of Performance Improvement Plans (PIPs) for 2025 regarding pressure ulcers, resident snacks, and medication administration showed:-There were no signatures indication who was responsible for following through with the PIPs;-There was no tracking of performance improvement regarding the facilities PIPs. During an Interview on 12/18/2025 at 12:07 PM The Administrator said she had only been at this facility for three weeks and had reviewed the PIPs for the facility from before she began and noticed that the PIPs were lacking.

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	265356	A. Building B. Wing	12/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Valley Manor and Rehabilitation Center	1410 Hospital Drive Excelsior Springs, MO 64024

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F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. Based on interview and record review, the facility failed to ensure that an effective training program for all new and existing staff was in place, when the facility failed to complete a facility assessment to include: Staff competencies and skill sets that are necessary to provide the level and types of care needed for the resident population. Furthermore, the facility failed to track attendance and hours of training for staff members who required at least 12 hours of education yearly. The facility census was 67. The facility did not provide a policy on education or of staff competencies. Review of the employee files showed:Certified Nurse Aide (CNA) A;-Date of hire was 11/20/24;-No documentation of required trainings was found;CNA B;-Date of hire was 6/14/24;- No documentation of required trainings was found;CNA C;- Date of hire 3/5/21;- No documentation of required trainings was found.During an interview on 12/18/25 at 1:21 P.M., the Director of Nursing said:-She did not know where the trainings were located;-She had just been hired a few weeks ago;-Staff should be observed performing cares quarterly;-She had not documented the observation of cares; -The former administrator is no long at the facility, and she is unsure if the acting Administrator is aware of where the education files were;-The facility should have a training program for all new and existing staff.During an interview on 12/18/25 at 1:25 P.M. the Administrator said:-She was just recently hired as the Administrator; -She/did not know where the trainings were located; - A training program should be in place for all new and existing staff.

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to inform residents and/or their responsible parties, in advance of the risks and benefits of proposed care, when the facility failed to obtain written consent before beginning psychotropic medications (medications that affect the mind, emotions, and behavior) for three (Resident #5, Resident #9, and Resident #30) of the 17 sampled residents. The facility census was 67. No policies were provided by the facility related to obtaining consent for psychotropic medications. 1.Review of Resident #9's Minimum Data Set (MDS) a federally mandated assessment tool completed by facility staff, dated 12/2/25, showed: - Cognition was not intact; - The resident took anti-anxiety and anti-depressant medication; - Diagnosis of depression, unspecified mood disorder, and cerebral vascular accident (a medical emergency where blood flow to the brain is suddenly blocked, commonly known as stroke). Review of the resident's care plan, revised on 10/21/25, showed: - Cognition was impaired and relied on nursing staff to anticipate and meet needs. - The resident used anti-anxiety and antidepressant medications. Review of the resident's Physician's order Sheet, dated 12/16/25, showed: - The resident began taking the anti-depressant medication Cymbalta 30milligrams (mg) daily on 12/3/25; - The resident began taking the anti-depressant medication escitalopram 10mg one time a day on 5/31/25. Review of the resident's consent for psychotropic medication therapy, dated 12/11/25, showed the resident signed the consent form for Cymbalta 30mg daily on 12/11/25, after he/she had already started the medication on 12/3/25. Review of the resident's Informed Consent for Psychotropic Medication, undated, showed: - Anti-depressant escitalopram 10mg one time a day for depression; - The form did not indicate whether or not the resident consented to taking the medication; - The form had not been signed by a facility representative; - The form had been signed by the resident and had not been dated. During an Interview on 12/18/2025 at 8:37 A.M. Licensed Practical Nurse (LPN) B said consents for (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	psychotropic medications should be signed by the resident or their family before the first dose is given. During an Interview on 12/18/25 at 10:40 A.M. Registered Nurse (RN) A said the Assistant Director of Nursing (ADON) or the Director of Nursing (DON) are to obtain consent from resident's or their responsible parties before starting psychotropic medications. 2. Review of Resident #5's, Quarterly MDS, dated [DATE], showed:- Resident had severe cognitive impairment; - Diagnosis of diabetes, dementia, Alzheimer's disease, and high blood pressure;- Medications: antipsychotic medication used on a routine basis. Review of the Resident's Care Plan, dated 11/14/25, showed the Resident used psychotropic medications related to dementia with psychotic disorder; Record review of the Resident's Informed Consent for Use of Psychoactive Medications, undated, showed:- Anti-Psychotic medication Olanzapine 15 milligrams daily had been diagnosed for dementia with behavior disturbance;- The form was incomplete for potential side effects for taking an Anti-Psychotic;- The form had not been signed by any facility representative;- The form had been signed by the resident's representative in the resident's signature block and had not been dated. Record review of the Resident's Informed Consent For Use of Psychoactive Medications, undated, showed:- Anti-Anxiety medication Buspirone 5 milligrams twice daily was diagnosed for anxiety; - The form was incomplete for potential side effects for taking an Anti-Anxiety;- The form had not been signed by any facility representative;- The form had been signed by the resident's representative in the resident's signature block and had not been dated. 3. Review of Resident #30's, Quarterly MDS, dated [DATE], showed:- Resident had severe cognitive impairment; - Diagnosis of coronary artery disease, kidney disease, diabetes, dementia, depression, psychotic disorder and anxiety disorder;- Medications: antipsychotic medication on a routine basis; Record review of Resident's medical records, showed Letters of Guardianship of an Incapacitated Person and Conservatorship of a Disabled Person, dated 5/13/25 for the resident with the country public administrator appointed as the residents Guardian. Record review of Resident's Informed Consent for Psychotropic Medication, dated 7/1/25, showed:- Form did not have any check boxes annotated for consent approval;- Form was incomplete for list of benefits and the box was not checked for the side effects for taking an Anti-Psychotic;- The form had been signed by the resident and not by the legal guardian. Record review of Resident's Informed Consent for Psychotropic Medication, undated, showed:- Anti-Depressant Escitalopram 20 milligrams daily was diagnosed for depression; - The form did not have any check boxes annotated for consent approval;- There was no expected benefits for taking this drug annotated for the resident;- The form had been signed by the resident without any date indicated. Review of Resident's Care Plan, dated 11/26/25, showed the resident was taking psychotropic medications for delusional disorder. Review of the Resident's Order Summary Report, dated 12/18/25, showed:- Quetiapine Fumarate Oral (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	tablet 100 milligram by mouth at bedtime for treatment of delusional disorder;- Sertraline HCL Oral Tablet 25 milligram by mouth one time a day for anxiety and depression. Review of Consent for Psychotropic Medication Therapy, dated 6/10/25, showed:- Consent permission for antipsychotic medication was not signed by the resident;- Consent permission for antidepressant medication was not signed by the resident;- Consent permission for antianxiety medication was not signed by the resident; Review of Resident's Care Plan, revised 12/11/25, showed:- Resident was taking antidepressant medications for depression;- Resident was taking anti-anxiety medications for anxiety disorder;- Resident was taking psychotropic medications for hallucinations; During an Interview on 12/18/2025 at 1:12 P.M. the DON said: - Consent from the resident or the resident's representative should be obtained before the resident is started on a psychotropic medication;-Consent could be obtained from the nursing staff on duty before the resident took the first does of the psychotropic medication. During an Interview on 12/18/2025 at 1:23 P.M. the Administrator said: -Consent from the resident or their representative should be obtained before the resident began taking the medication;-Any licensed nursing staff could obtain consent in regard to psychotropic medications.

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to create an environment respectful of the rights of a resident to make choices about significant aspects of his/her life, when the facility did not provide a means for one resident (Resident #19) to attend Saturday church services in accordance with their religious preferences and additionally failed to post a list of food substitutes for each meal for three residents (Residents #30, #40, and #60). This affected four of 17 residents sampled. The facility census was 67.Review of facility policy, Activity Programs, revised June 2018, showed:- Activities offered are based on the comprehensive resident-centered assessment and the preferences of each resident; - The activities program is ongoing and includes facility-organized group activities, independent individual activities and assisted individual activities;- Activities are considered any endeavor that enhances cognitive or emotional health;- Individualized and group activities are provided that reflect the schedules, choices and rights of the residents;- Activities reflect the cultural and religious interests and personal preferences of the residents;Review of facility policy, Food and Nutrition Services, revised October 2017, included, reasonable efforts will be made to accommodate resident choices and preferences.1. Review of Resident #19's Quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 11/21/25, showed:- Resident was cognitively intact;- Diagnosis: liver cell carcinoma (malignant tumor in the liver); Review of the Resident's care plan, dated 11/18/25, showed the care plan did not address the resident's religious preferences for Saturday services for Seventh Day Adventist.During an interview on 12/18/25 at 9:15 A.M., the Resident said he/she is a Seventh Day Adventist and the facility had no church services he/she could attend on Saturdays.During an interview on 12/18/25 at 9:30 A.M., the Social Services Director (SSD) said she was aware that the resident's religious denomination was Seventh Day Adventist and the church and food requirements that went with that religion. She said the Activities department would handle support for residents' religious preferences. The SSD had not researched to see if there were any Seventh Day Adventist churches in the area that would come to the facility or pick up the resident to attend services in the community on Saturday. The SSD said she is aware the resident was a member of the Seventh Day Adventist and would only attend services on Saturday.During an interview on 12/18/25 at 12:20 P.M., the Activities Director said the facility offers non-denominational services on Saturday which the resident could attend even though they are not Seventh Day Adventist.Review of the Activities calendar for the months of October, November and December 2025, showed no Saturday church services had been scheduled or provided at the facility.During an interview on 12/18/25 at 1:45 P.M., LPN (A) said there aren't church services held on Saturday at the facility, the only church services are held on Sundays for residents.2. Review of Resident #60's Annual MDS, dated [DATE], showed:- Moderate cognitive impairment;- Diagnosis: GERD (acid reflux), diabetes, dementia, depression, and Parkinson's Disease;Observation on 12/15/25 at 2:52 P.M., showed there was no substitute food item list provided to the resident to select options for his/her meal.During an interview on 12/18/25 at 9:56 A.M., the Resident said:- He/she had been at the facility for two years and has not been offered a substitute list of food choices to choose from. -He/she would enjoy knowing what he/she could have from a list of alternate choices to pick from.3. Review of Resident #40's Quarterly MDS, dated [DATE], showed:- Resident was cognitively intact;- Diagnosis: dementia, anxiety disorder, depression, and seizure disorder;During an interview on 12/16/25 at 10:45 A.M., the resident said:- He/she has been here for about 8 months and does not recall being provided with a list of substitute items for the menu. From past experience he/she could remember about five items that he/she could select as substitutes for her meal. He/she feels frustrated with the menu selection and feels that too many items are repeated from week to week and there's no variety of ability to choose items he/she would like to eat. 4. Review of Resident (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	#30's, Quarterly MDS, dated [DATE], showed:- No cognitive score was recorded;- Diagnosis: Coronary Artery Disease, Hypertension, Diabetes, Dementia, Anxiety Disorder, and Depression;During an interview on 12/18/25 at 11:40 A.M., the Resident said he/she doesn't recall receiving or seeing a substitute menu list posted for the meals but would use if it was provided. It would make it easier for him/her to make choices when there are things on the menu, he/she doesn't like to eat.During an interview on 12/18/25 at 1:10 P.M., the ADON said the substitute menu for resident meals is not posted.Review of the A-LA-cart menu provided by the ADON on 12/18/25 at 1:40 P.M., showed:- 17 different items that could be selected by residents as meal substitutes;- The document was undated and unsigned;During an interview on 12/18/25 at 1:55 P.M., CNA (A) said:- He/she delivers meal trays to the residents in their rooms;- There was no alternate food list that he/she was aware of that the residents could choose from for their meal;- Residents could ask for a sandwich, cheeseburger, or some sort of soup from the kitchen as a substitute food item.Continuous observation from 12/15/25 through 12/18/25, showed the A-LA-cart menu was not posted in the kitchen, dining room, or any rooms or halls in the facility.Record review of combined Meal Menu Selection Card for residents, dated 12/17/25, showed, for lunch and dinner meal items were listed with no substitute options and only the word Beverage/Milk listed for drink options.During an interview on 12/18/25 at 8:45 A.M., the Dietary Manager (DM) said:- There is a daily selection sheet for each meal that residents can choose what they want to eat that day and annotate if they want a substitution;- The Nurses' station should have a list of the substitutes that residents can choose from and the list is given to each resident upon admission;- The substitution list should also be posted at the kitchen door. She did not know why it was not posted on the door.During an interview on 12/18/25 at 3:15 P.M., the Administrator said:- Staff should provide a list of substitute items the residents can choose from for each meal and it should be posted in a prominent area in the dining room or in the facility for all residents and visitors to see;- Resident's preferences should be honored as much as possible by the facility.

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F 0570 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Assure the security of all personal funds of residents deposited with the facility. During an interview and record review, the facility failed to maintain a surety bond that was equal or greater than one and one-half times the average monthly balance for the residents' personal funds for the last 12 consecutive months from December 2024 through November 2025. The facility census was 67. A policy regarding the Surety Bond Policy was requested and not provided;Record review on 12/17/2025 of the residents' personal funds account for the last 12 consecutive months from December 2024 to November 2025 showed:- The facility's current approved bond amount equaled $18,000- The average monthly balance for the residents' personal funds equaled $13,537.65 (which was determined using the total of each ending balance for the last 12 months bank statements plus the petty cash and divided by 12 months)- An average monthly balance of $13,537.65 ($14,000, when rounded to the nearest $1,000) required a bond of at least $21,000During an interview on 12/17/25 at 10:15 A.M., the Business Office Manager (BOM) said:- She monitors the bond amount and sends it up to corporate to ensure it is accurate.- The corporate office changed the methodology recently on how the bond requirement is calculated. The corporate office utilized the aging report to back out some of the funds from the calculation which resulted in a lower bond amount required which is a method she has never used before. This resulted in the corporate office reducing the bond amount from $25,000 to $18,000 on 12/15/25. During an interview on 12/17/25 at 2:45 P.M. with Administrator said:- The current bond amount does not cover our current liability, but we will get that adjusted as soon as possible. - The reason for the error is due to corporate direction to change the formula on how much bond coverage was required. - She had never calculated the bond amount using the aging report previously.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to follow facility policy and investigate a bruise of unknown origin for one resident (Resident #44) and failed to investigate an allegation of physical abuse, when one resident, (Resident #30) reported to the nurse a facility staff member had struck him/her on the leg with a wheelchair intentionally. This affected two of the 12 residents sampled. The facility census was 67. Review of the facility policy, Abuse, Neglect, Exploitation and Misappropriation Prevention Program, revised April 2021, showed:- The purpose of the program is to protect residents from abuse from facility staff;- Develop and implement policies and protocols to prevent and identify abuse or mistreatment of residents;- Identify and investigate all possible incidents of abuse, neglect, mistreatment, or misappropriation of resident property;- Protect residents from any further harm during investigations;Review of facility policy, Abuse Investigation and Reporting, revised July 2017, showed:- All reports of resident abuse and/or injuries of unknown source shall be promptly reported to local, state and federal agencies and thoroughly investigated by facility management;- If an incident or suspected incident of resident abuse, mistreatment, or injury of unknown source is reported, the Administrator will assign the investigation to an appropriate individual;- The Administrator will suspend immediately any employee who has been accused of resident abuse, pending the outcome of the investigation;- The Administrator will ensure that any further potential abuse is prevented;- The resident and/or representative will be notified of the outcome immediately upon conclusion of the investigation.1. Review of Resident #44's Quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 12/9/25, showed: - Cognition was severely impaired;- Resident had upper and lower body impairment to extremities;- Resident required a wheelchair for mobility and dependent of staff assistance for all activities of daily living;- Diagnosis: atrial fibrillation, anemia (iron deficiency), hypertension and dementia.Review of nursing progress notes dated 10/17/25 showed:-Licensed nursing staff documented that a Certified Nurses Aide (CNA), reported a bruise on resident's right hand;-The resident's hand was assessed by the nurse, and he/she observed dark purple bruising to the right hand;-The resident told the nurse he/she did not know how he/she got the bruise, then said that somebody grabbed me but did not know who;-Resident complained that his/her hand hurt; -The nurse documented the Assistant Director of Nursing (ADON) and the Administrator were notified.During an interview on 12/18/25 at 8:45 A.M., the Director of Nursing (DON) said there was no formal investigation on file for the resident with an injury of unknown origin only a post bruise investigation report. Review of the Post Bruise Investigation Report, dated 10/17/25, showed:- No interviews by staff conducted;- No root cause or identification of where the bruise came from;- One statement from the resident showing the resident did not know where the bruise came from;- Document reviewed and signed off by the ADON and Administrator.2. Review of Resident #30's, Quarterly MDS, dated [DATE], showed: - Cognition was not evaluated by facility staff;- Diagnosis: Coronary Artery Disease, high blood pressure, diabetes, dementia, anxiety disorder, and depression;Record review of nursing progress notes, dated 12/3/25, showed:- Registered Nurse (RN) A documented in the notes that he/she observed CNA D entering the dining room visibly upset and scared;- Resident was observed by CNA D standing in the doorway of his/her room and appeared agitated with a stiff posture; I don't understand this sentence. - Resident stated that the CNA D entered his/her room and demanded that he/she get up and that he/she hit him/her with the wheelchair striking his/her legs;- The resident told CNA D to leave his/her room;- RN A ensured the safety of both resident and staff member and assisted resident back to his/her recliner and assessed for injuries;- No visible injuries noted;- RN A spoke to both resident and staff member regarding the specifics of the incident;- Resident denies pain, DON, physician, and family member notified;- No documentation of notification of the incident to the Administrator. During an interview on 12/18/25 at (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	8:45 A.M., the DON said:-She did not do a formal investigation of Resident #30's incident based on reading the statement from CNA D; WHAT was in the statement that led her to believe the event didn't happen? -She did not interview the resident after finding out about the incident;-She did not recall notifying the Administrator of the incident. During an interview on 12/17/25 at 2:58 P.M., the Administrator said she was not notified about the incident with Resident #30 and the incident with Resident #44 happened prior to her starting as the Administrator. Both incidents should have been fully investigated with interviews with all witnesses and residents documented. A root cause of the incidents should have been identified. She started investigations as soon as she heard about these incidents on 12/16/25.

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure resident care plans were created accurately for two of 17 sampled residents (Resident #10 and Resident #59) when the facility failed to address the use of a seatbelt on Resident #10's wheelchair and failed to address specific care needs, goals, and interventions for Resident #59. The facility census was 67. Review of the facilities Care Plans, Comprehensive Person Centered policy, dated March 2022, showed: - A comprehensive, person-centered care plan includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed for each resident; - The comprehensive, person-centered care plan is developed within seven days of the completion of the required Minimum Data Set (MDS) (a federally mandated assessment tool completed by facility staff), and no more than 21 days after admission; - The comprehensive, person-centered care plan describes services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being and reflects currently recognized standards of practice for problem areas and conditions. 1. Review of Resident #10's MDS, a federally mandated assessment instrument completed by facility staff, dated 11/21/25, showed: -The resident was cognitively intact; -The resident used a wheelchair; -Diagnosis of stroke (a condition where blood flow to part of the brain is suddenly blocked depriving brain cells of oxygen) and hemiplegia (paralysis of one side of the body) affecting the left side. Review of the Resident's care plan, revised 11/28/25, showed: -The resident had an activity of daily living performance deficit due to hemiplegia; -The resident had limited physical mobility related to weakness; -The resident was at risk for falls due to gait/balance problems; -The care plan did not address the use of a seat belt on the resident's wheelchair. Observation on 12/18/2025 at 7:48 A.M. showed the resident sat in his/her wheelchair by the nurse's station, with a seatbelt fastened around his/her waist and the seatbelt was attached to the back of the wheelchair. During an Interview on 12/18/2025 at 11:10 A.M. the MDS Coordinator said: -Nurses can update care plans, especially when there is a fall; (continued on next page)

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	265356	A. Building B. Wing	12/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Valley Manor and Rehabilitation Center	1410 Hospital Drive Excelsior Springs, MO 64024

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-The seatbelt for the resident should have been addressed in the care plan. During an Interview on 12/18/2025 at 12:55 P.M. the Administrator said if a resident has a seatbelt on their wheelchair, it should be addressed in the resident's care plan. 2. Review of Resident #59's, Quarterly MDS, dated [DATE], showed:- Cognition was intact; - Dependent on facility staff for showering, toileting, and hygiene;- Diagnosis of diabetes, paraplegia (paralysis affecting the lower half of the body, including the legs), urine retention, restless legs, and high blood pressure. Review of the resident's care plan, dated 11/18/25, showed:- Code status was do not resuscitate and with corresponding goal and interventions;- The resident had been on Enhanced Barrier Precautions for urinary catheter (a tube that removes urine from the bladder) with corresponding goal and interventions;- No other focus, goal, or intervention had been listed for the resident regarding activities of daily living or resident's needs. Review of the Resident's Order Summary Report, dated 12/16/25, showed:- The resident required a mechanical soft texture diet;- The resident's urinary catheter should be changed on the 15th monthly and as needed for retention of urine;- The resident should have a barrier cream applied to bilateral buttocks every shift and staff are to encourage off loading of his/her buttocks every day and night shift to maintain skin integrity;- The resident required blood glucose monitoring, pain monitoring, monitoring of his/her heels for skin integrity, physical therapy, and urinary catheter care every shift. None of which had been listed on the Resident's care plan. Review of the Resident's Progress Notes, showed:- On 9/30/25 at 12:30 A.M., the nurse had charted that during the evening, the resident had continued to complain about his/her legs jerking and when his/her legs do that, it causes pain to both hips and his/her back. The provider had increased his/her Parkinson medication; not indicated in the care plan.- On 10/7/25 at 1:22 P.M., the Resident had been noted to have increased confusion, low grade temperature, increased urine sediment, and amber colored urine. The provider ordered a urinalysis, which had been drawn and sent out for processing; not indicated in the care plan.- On 10/13/25, at 8:17 P.M., the provider had ordered an antibiotic for the Resident for seven days; not indicated in the care plan.- On 11/21/25 at 8:40 P.M., the Resident had been sent to a nearby hospital emergency room (ER) for altered mental status, refusal of cares, and lower blood pressure. The Resident had been diagnosed with a urinary tract infection, prescribed antibiotics, and returned to the facility on [DATE] at 5:48 P.M. not indicated in the care plan. During an interview on 12/15/25 at 10:02 A.M., the resident said:- He/She was paralyzed from the waist down and legs would jump which had caused him/her to get stuck in the window frame by the bed once and he/she had been stuck in that position all night due to staff not checking on him/her every two hours like he/she believed they should;- Some staff would turn him/her and some would not;- Some staff would check his/her disposable underwear, and some would not;- He/She had to rely on nursing staff to do everything for him/her;- The staff were watching his/her heel and would apply protective boots some of the time;- He/She wanted two showers a week but would maybe get one a week or every eight days;- He/She transferred with two staff and the mechanical lift all the time. During an interview on 12/17/25 at 9:28 A.M., Registered Nurse (RN) A said:- Nursing staff know what cares to provide residents from the resident's care plan;- If a resident wanted two showers a week, that is the standard and should be given two unless it is care planned otherwise;- Cares for residents should be in the care plan, including interventions, fall risk, eating, toileting, and all cares needed. (continued on next page)

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 12/17/25 at 10:00 A.M., Certified Nurse Aide (CNA) C said:- He/She would know what care to provide for a resident by the resident telling him/her and by the care plans;- Everything about the care needed for a resident should be in the care plan, all he/she would need to know about the resident would be in there. During an interview on 12/17/25 at 11:44 A.M., the Assistant Director of Nursing (ADON) said:- Nursing staff would know what cares to provide to a resident from the Kardex tasks (an identifier of what care the resident needs) in the resident's electronic medical record;- Certain items from the resident's care plans carry over to create the Kardex tasks;- Resident cares that are required should be listed in their care plans, including any kind of fall intervention, if the resident had dentures or not, and more;- The facility was a teaching facility and would have a lot of new staff that need to know the information that should be listed in the care plans. During an interview on 12/18/25 at 8:30 A.M., the Director of Nursing (DON) said:- The aides would know what cares to provide a resident by using the Kardex to learn transfers, diets, and other cares;- The nurses would know what cares are needed from the resident care plans;- The resident care plans would be updated if there were a significant change in the resident's condition;- Resident's should have a comprehensive care plan. During an interview on 12/18/25 at 11:58 A.M., the MDS Coordinator said:- Staff should know what care to provide residents through the care plan, Kardex, and other staff;- He/She was new to the facility, but had been to facilities where resident shower preferences were care planned;- Cares that residents required should be in the care plans, including eating, transfers, locomotion or ambulation, showers, oral cares, and personal cares;- Resident shower preferences should be care planned;- Residents should absolutely have comprehensive care plans;- Care plans should be updated quarterly, after significant changes, and updated any time things happen, like if the resident now required a mechanical lift for transfers;- Anyone should be able to just look at the resident's care plan and take care of that person. During an interview on 12/18/25 at 2:38 P.M., the Administrator said:- Staff know what cares to provide residents by using the Kardex in the resident's electronic record and that Kardex is populated by the care plan;- Residents should have comprehensive care plans begun upon admission by the admitting nurse;- The care plan should be updated quarterly, when significant changes occur, and when needed;- Cares required by residents should be in the resident's care plan.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to develop and implement a comprehensive person-centered care plan for three of 17 sampled residents (Resident #13, #30 and #67) when the facility did not include activity preferences for Resident #13, did not include fall interventions for Resident #67 and when the facility did not address behaviors for Resident #30. The facility census was 67.Review of the facility's Comprehensive and Person-Centered Care Plan policy, revised March 2022, showed:-A person centered comprehensive care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident;-The comprehensive, person centered care plan describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental and psychosocial well being;-Services provided for or arranged by the facility and outlined in the comprehensive care plan are culturally competent and trauma informed;-Assessments of residents are ongoing and care plans are revised as information about the resident condition changes;-The facility updates the care plan when there as been a significant change in the resident's condition, when the desired outcome has not been met, when the resident has been readmitted from a hospital stay.1. Review of Resident #30's, Quarterly MDS, dated [DATE], showed:- Cognition was not evaluated by facility staff;- Diagnosis: coronary artery disease, hypertension, diabetes, dementia, anxiety disorder, and depression.Review of Resident's Care Plan, revised 11/26/25, showed:- Resident uses psychotropic medications;- Review behaviors/interventions and their effectiveness per facility policy;- Monitor/document/report as needed any adverse reactions of psychotropic medications such as behavior symptoms not usual to the person;- No documentation noted regarding aggressive behavior towards staff, hording of items not belonging to the resident, or the propensity to make up stories inconsistent with reality.Review of resident's progress notes, dated 12/3/25, showed the resident was very irate and chased a staff member out of his/her room when staff was attempting to provide bathing cares. The staff member was visibly shaken up and the shower was refused by the resident.Review of CNA (D) statement, dated 12/3/25, showed:- The resident pushed and grabbed CNA (D) and also struck CNA D with a wheelchair;- The resident was irate and verbally abusive to CNA (D) during a routine conversation about cares, CNA D was unable to manage the care the resident needed that day. Review of resident's progress notes, dated 12/6/25, showed the resident had other resident's clothing and belongings in his/her personal drawers. Facility staff also found medical supplies and dishes from the kitchen stored. All items which did not belong to the resident were removed from the resident's room. During an interview on 12/15/25 at 3:20 P.M., the resident said:- He/she had thousands of dollars in beard and razor equipment stolen from his/her room. He/she reported it to the facility but nothing was done about the issue. - He/she has a terrible skin rash on his/her leg that the facility will not do anything about.- He/she will lose his/her eyesight if a procedure is not done soon to fix an accident he/she had about two years ago before he/she got to the facility.Observation of the resident on 12/15/25 at 3:30 P.M., showed:- The resident's bare legs looked normal without any redness or rash associated with it;- The resident's eyes looked normal with a little red discoloration under one eye;- The resident did not appear to be in any distress, but was extremely confused to time, place and situation.During an interview on 12/17/25 at 10:20 A.M., the ADON said:- The resident makes up a lot of things that aren't based on reality. He/she had significantly impaired cognition and oftentimes speaks of stolen items which is easily re-directed. His/Her behaviors should be care planned with interventions to help staff care and manage the resident's needs, and this should be addressed on the MDS as well.During an interview on 12/18/25 at 10:05 A.M., the DON said if the resident has the potential to placed his/her hands on a staff member then that type of behavior should be care planned. The resident has had behavioral issues in (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the past with staff regarding personal items and making up stories because of impaired cognition.2. Review of Resident #67's Quarterly Minimum Data Set (MDS, a federally mandated assessment tool completed by facility staff), dated 12/15/25, showed:- Severe cognitive impairment;- No behaviors incidents or wandering noted;- Had impairment on both upper and lower body extremities;- Used a wheelchair for mobility;- Was completely dependent on nursing staff for all activities of daily living, cares, positioning and needs;- Resident had one fall since admission to the facility;- No restraints were listed for the resident;Review of Resident's Care Plan, revised 12/15/25, showed the resident was a fall risk and there is no direction for staff in regard to bolsters for positioning needs. Review of the resident's physician orders for the month of December showed there was no order for the facility to use bed bolsters for positioning.Observation on 12/15/25 at 3:01 P.M., showed the resident laid in bed sleeping, positioned on his/her back with a one-piece bolster on each side of the resident from the shoulder to just below the knees. During an interview on 12/18/25 at 10:25 A.M., the MDS Coordinator said all fall interventions should be care planned to include any bolsters or positioning devices installed or used on a resident's bed.During an interview on 12/18/25 at 10:40 A.M. the DON said:- Resident #30 has displayed aggressive behaviors to staff and residents at times. She is not sure what triggers these behaviors but interventions and this type of behavior should be care planned as needed. In the past he/she has taken things that don't belong to him/her and that should be in the care plan. - All fall risk interventions should be in the care plan including bolsters and positioning devices with a physician's order.During an interview on 12/18/25 at 2:00 P.M., the Administrator said all staff interventions for residents who are a fall risk should be care planned. Residents should not have bolsters used unless assessed, ordered by a physician, and care planned.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure dependent residents who were unable to carry out activities of daily living (ADLs) received the necessary services to maintain good personal hygiene when facility staff did not provide timely showers for three of 17 sampled residents (Resident #45, #56, and #59). The facility census was 67. Review of the facility policy, Shower/Tub bath, revised February 2018, showed:- The purpose of this procedure is to promote cleanliness, provide comfort to the resident and to observe the condition of the resident's skin;- Documentation included: the date and time other shower/tub bath was performed; then name and title of the individual who assisted the resident with the shower/tub bath; all assessment data (e.g. any reddened areas, sores, etc. on the resident's skin) obtained during the shower/tub bath; how the resident tolerated the shower/tub bath; if the resident refused the shower/tub bath, the reasons why and the intervention taken; the signature and title of the person recording the data.Review of the facility's policy for supporting activities of daily living (ADL's), revised March 2018, showed:- Residents will be provided with care, treatment and services as appropriate to maintain or improve their ability to carry out ADL's;- Residents who are unable to carry out ADL's independently will receive the services necessary to maintain good nutrition, grooming and personal and oral hygiene;- Residents will be provided with care, treatment and services to ensure that their ADL's do not diminish unless the circumstances of their clinical conditions demonstrate that diminishing ADL's are unavoidable;- Appropriate care and services will be provided for residents who are unable to carry out ADL's independently, with the consent of the resident and in accordance with the plan of care, including appropriate support and assistance with: hygiene (bathing, dressing, grooming, and oral care);- The resident's response to interventions will be monitored, evaluated, and revised as appropriate. 1. Review of Resident #45's Annual Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 10/20/25, showed:- Cognition intact;- Required moderate assistance from nursing staff for showers;- Diagnosis of diabetes, morbid obesity, and neuropathy (tingling and loss of sensation) of his/her legs.Review of the resident's care plan, dated 11/18/25/ showed:- The resident had an Activities of Daily Living (ADL) self-care performance deficit related to limited mobility and staff were to offer two showers weekly;- The resident preferred two showers per week with shampoo and nail care;- The resident was to be encouraged to practice good health care practices, including, good hygiene.Review of the Resident's shower sheets showed he/she had received showers on 10/20/25, 10/25/25, 10/30/25, 11/3/25, 11/12/25, 11/17/25, 11/25/25, 12/1/25, 12/9/25, and 12/15/25. Two showers a week were not documented as completed or offered.During an interview and observation on 12/15/25 at 10:54 A.M., the resident said:- He/She should have received a shower today, but was lucky to get one shower a week;- Sometimes a shower could stretch out eight to ten days in between since the last shower; - He/She appeared well kempt.- Going eight to ten days without a shower was not good, it makes him/her feel embarrassed that his/her hair is greasy and when he/she knows he/she stinks; 2. Review of Resident #56's Quarterly MDS, dated [DATE], showed:- Mild cognitive impairment;- Required substantial assistance from nursing staff for showers and activities of daily living (ADL)- Diagnosis of stroke, dementia, and diabetes.Review of the resident's care plan, dated 12/9/25, showed:- The resident was to have skin checks daily by the nursing staff;- The resident required substantial assistance by nursing staff with showering;- The resident had been at risk for pressure ulcer development related to immobility and dependent assistance of ADL care Review of the Resident's shower sheets showed he/she had received showers on 10/15/25, 10/22/25, 10/25/25, 10/31/25, 11/6/25, 11/16/25, 11/19/25, 11/26/25, 12/5/25, and 12/12/25 two showers a week were not completed or documented.During an interview on 12/15/2025 at 11:30 A.M., the resident said:- He/She only receives one shower a week and he/she wanted two;- Not getting two showers a week is upsetting to him/her.3. Review of (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #59's, Quarterly MDS, dated [DATE], showed:- Cognition was intact; - The resident was dependent on facility staff for showering, toileting, and hygiene;- Diagnosis of diabetes, paraplegia (paralysis affecting the lower half of the body, including the legs), urine retention, restless legs, and high blood pressure.Review of the Resident's Care Plan, dated 11/18/25, showed the care plan did not address ADL care, showers, bathing of resident's preferences.Review of the Resident's shower sheets showed he/she had received showers on 10/19/25, 10/26/25, 11/3/25, 11/12/25, 11/17/25, 11/26/25, 12/1/25, 12/9/25, and 12/15/25. The resident was not provided two showers a week and it was not documented.During an interview on 12/15/2025 at 10:02 A.M., the resident said:- He/She never received two showers a week;- He/She had received maybe one shower a week or every eight days;- He/She would like to have two showers a week;- He/She was paralyzed and had to rely on nurses to do everything for him/her and it was embarrassing not smelling clean.During an interview on 12/17/25 at 9:28 A.M., Registered Nurse (RN) A said all resident are to have two showers a week or be bathed. During an interview on 12/17/25 at 10:00 A.M., Certified Nurse Aide (CNA) C said:- Some residents only receive one shower a week if that had been care planned, but usually the resident's get two showers a week;- Residents should definitely get two showers a week if that was preferred by the resident.During an interview on 12/17/25 at 11:44 A.M., the Assistant Director of Nursing (ADON) said residents that want two showers a week should absolutely get them.During an interview on 12/18/25 at 8:30 A.M., the Director of Nursing (DON) said any residents wanting a shower twice a week should absolutely get two showers a week.During an interview on 12/18/25 at 11:58 A.M., the MDS Coordinator said resident shower preferences were to be care planned.The residents should get two showers a week if that is what they want.During an interview on 12/18/25 at 2:38 P.M., the Administrator said shower schedules had currently been scheduled with one to two showers per resident a week. The facility would be changing and scheduling showers three times a week so when a resident refused or missed a shower or two, they would at least get one shower a week.

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to provide an ongoing activities program for three of the 17 sampled residents (Resident #67, #8 and #13) when the facility staff failed to provide individualized and meaningful activities in accordance with the facility assessment and resident preferences. The facility census was 67. Review of the facility's Activity Programs policy, dated June 2018, showed:-The activities program is provided to support the wellbeing of residents and to encourage both independent and community interaction;-The activities program is ongoing and includes facility organized group activities, independent individual activities and assisted individual activities;-Individual and group activities are provided; -All activities are documented in the resident's record;-Adequate space and equipment are provided to ensure that the needed services identified in the resident's plan of care are met. Review of the activity Calendar dated October 2025 showed on Monday through Friday at 8:30 A.M., one on one individual activities.Review of the activity Calendar dated November 2025 showed on Monday through Friday at 8:30 A.M., one on one individual activities.Review of the activity Calendar dated December 2025 showed on Monday through Friday at 8:30 A.M., one on one individual activities.1.Review of Resident #67's Quarterly Minimum Data Set (MDS), A federally mandated assessment tool completed by facility staff, dated 12/15/25, showed:-Severe cognitive impairment;- Severe visual impairment;- Impairment of upper and lower extremities;-Dependent on staff for all Activities of Daily Living (ADL)s;- Diagnoses included diabetes, coronary artery disease and high blood pressure.Review of the resident's care plan, dated 12/12/25, showed:-The resident is dependent on staff for meeting emotional, intellectual, physical and social needs due to physical limitations;-The resident will attend activities of choice related to cognitive deficits and physical limitations;-The resident needed escorted to all activity functions;-Staff are to ensure that the activities the resident attends are compatible with physical and mental capabilities.Review of the resident's activity record dated October 2025 through December 2025 showed:-No documentation of activity offered to the resident;-No documentation of one to one activity or if offered to the resident. Observation on 12/16/25 8:30 A.M. to 9:30 A.M. showed:-The resident sat in a wheelchair in the TV area by the nurse's station;-No group activities or one to one activities were offered to the resident.Observation on 12/17/25 8:30 A.M. to 9:30 A.M. showed:-The resident sat in a wheelchair in the TV area by the nurse's station;-No group activities or one to one activities were offered to the resident.Observation on 12/18/25 8:30 A.M. to 9:30 A.M. showed:-The resident sat in a wheelchair in the TV area by the nurse's station;-No group activities or one to one activity was offered to the resident.2. Review of the resident #8's Quarterly MDS dated [DATE] showed:-No cognitive impairment;-Dependent on staff for toileting;-Diagnoses included high blood pressure, anxiety and depression.Review of the care plan dated 11/01/25 showed:-The resident had an ADL self-care performance deficit related to confusion and fatigue;-The resident will participate in activities of choice;-Invite the resident's family member to attend activities of choice with resident to support participationReview of the resident's activity record dated October 2025 through December 2025 showed:-No documentation of activity offered to the resident;-No documentation of one-to-one activity attended or offered to the resident. Observation on 12/16/25 8:30 A.M. to 9:30 A.M. showed:-The resident sat in a recliner in his/her room;-No group activities and/or one to one activities were offered to the resident.Observation and interview on 12/17/25 at 9:30 A.M. showed:-The resident sat in a recliner in his/her room;-No group activities and/or one to one activities were offered to the resident;-The resident said he/she watched TV in his/her room and took naps;-The resident said no staff had talked to him/her or his/her family about what activities he/she liked.Observation on 12/18/25 8:30 A.M. to 9:30 A.M. showed:-The resident sat in a recliner in his/her room;-No group activities and/or one to one activities were offered to the resident.3.Review of Resident #13's Quarterly MDS dated [DATE] showed:- Severe cognitive impairment;- Limited range (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	of motion in upper and lower extremities on both sides;- Diagnoses included Alzheimer's Disease, and high blood pressure. Review of the resident's care plan dated 11/18/25 showed:-The resident had an ADL self-care performance deficit related to Alzheimer's Disease and confusion;-The resident attended activities of choice.Review of the resident's activity record dated October 2025 through December 2025 showed:-No documentation of activity offered to the resident;-No documentation of one to one activity attended or offered to the resident.Observation on 12/16/25 8:30 A.M. to 9:30 A.M. showed:-The resident sat in a wheelchair in the TV area by the nurse's station;-No group activities or one to one activities were offered to the resident.Observation on 12/17/25 8:30 A.M. to 9:30 A.M. showed:-The resident sat in a recliner in his/her room;-No group activities or one to one activities were offered to the resident.Observation on 12/18/25 8:30 A.M. to 9:30 A.M. showed:-The resident sat in a recliner in his/her room;-No group activities or one to one activity was offered to the resident.During an interview on 12/18/25 at 3:34 P.M., the Activity Director said:-She checked the residents' MDS and care plans to determine what their goals and program activities should be;-Resident #13 was immobile and there was a lot that the resident could not do;-Resident #13 liked his/her nails to be painted;-She talked to resident #13's husband to determine what activities the resident would like;-She did not do any type of activity note except for when the quarterly assessment was completed;-She was just thrown into activities and did not receive any orientation or trainings;-She was the only person in activities and did not work evening or weekends;-She had activity packets that staff could do with the residents on the weekends, but staff did not record attendance or keep track of which residents did what activity;-She did not have a separate activity plan for cognitively impaired residents;-She did not keep a record of which resident did what activity during the week.During an interview on 12/18/25 at 4:18 P.M., the Administrator said:-She expected all residents to have ongoing activities program;-She expected the Activity Director to ensure that all residents had an ongoing activity program;-She expected group activities and one on one activities to be offered to all residents:-She expected cognitively impaired residents to have activities that met their needs;-She expected a record of individual activity attendance, name of activity and record of 1:1 activities to be kept up do date on all residents;-She expected weekend activities to include things that cognitively impaired residents could do as well.

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	265356	A. Building B. Wing	12/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Valley Manor and Rehabilitation Center	1410 Hospital Drive Excelsior Springs, MO 64024

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to provide proper respiratory care when staff failed to document the date when oxygen tubing was cleaned for three residents (Residents #10, #18, and #56) and additionally failed to properly store oxygen accessories at the bedside for one resident (Resident #56) resulting in possible exposure to bacteria during oxygen usage. This affected three of 17 sampled residents. The facility census was 67.No policies were provided by the facility related to oxygen tubing care or storage. 1. Review of Resident #18's Quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 12/9/25, showed:- The Resident had moderate cognitive impairment;- The Resident had been dependent on nursing staff for all cares;- Diagnosis of dementia, Chronic Obstructive Pulmonary Disease (COPD - lung and airway diseases that restrict breathing), and heart disease. Review of the Resident's Care Plan, dated 12/16/25, showed:- The resident had COPD and the nursing staff were to monitor, document, and report as needed any signs or symptoms of respiratory infection;- The resident had oxygen therapy ordered related to COPD;- The resident's oxygen settings were to be: Oxygen per nasal cannula running at two liters continuously with humidification. Review of the Resident's Order Summary Report, dated 12/16/25, showed the nursing staff were ordered to change the resident's oxygen tubing and rinse the concentrator filter weekly on Thursdays. An observation on 12/15/2025 at 9:38 A.M., showed:- The resident laid in bed with a nasal cannula and oxygen on at 2 liters.- The oxygen humidifier bottle had been dated 11/17/25 and was outdated for more than 1 month.- No date had been written on the oxygen tubing;- No date had been written on the oxygen storage bag attached to the concentrator. An observation on 12/16/2025 at 1:15 P.M., showed:- The resident laid in bed with a nasal cannula and oxygen on at 2 liters.- The concentrator humidifier bottle had been dated 11/17/25, and was outdated for more than 1 month. - No date had been written on the oxygen tubing to determine when the tubing had last been changed.- No date had been written on the oxygen storage bag attached to the concentrator to determine when the storage bag had last been changed. 2. Review of Resident #56's Quarterly MDS, dated [DATE], showed:- The resident had mild cognitive impairment;- The resident had required substantial assistance from nursing staff for showers;- Diagnosis of stroke, dementia, and diabetes. Review of the resident's Care Plan, dated 12/9/25, showed:- The resident had required daily skin checks by the nursing aides;- The resident had an ADL self-care performance deficit related to activity intolerance and confusion and had required substantial assistance by nursing staff with showering;- No focus or interventions listed related to oxygen therapy. Review of the Resident's Order Summary Report, dated 12/16/25, showed:- The nursing staff were ordered to change the Resident's oxygen tubing and clean the concentrator filter weekly on Wednesday;- The nursing staff were ordered to change the Resident's oxygen tubing and rinse the concentrator filter weekly on Thursday. Observation on 12/15/2025 at 11:30 A.M., showed:- The resident sat upright in bed with a cannula (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	applied and oxygen concentrator on;- The oxygen tubing had been dated 11/12/25 and was over a month old.- There had been no storage bag attached to the oxygen concentrator;- The humidifier bottle was not dated and was empty. Observation on 12/16/2025 at 9:49 A.M., showed:- The resident laid in bed with a nasal cannula applied and oxygen concentrator on;- The oxygen tubing had been dated 11/12/25, over a month old;- No storage bag attached to the oxygen concentrator to keep tubing clean;- The humidifier bottle was not dated and was empty. During an interview on 12/17/2025 at 9:28 A.M., Registered Nurse (RN) A said:- Nursing staff should change the resident's oxygen tubing, humidifier bottles, and storage bags once a month;- The oxygen tubing, humidifier, and storage bags should be dated when changed. During an interview on 12/17/2025 at 10:00 A.M., Certified Nursing Assistant (CNA) C said:- The oxygen tubing, humidifier bottle, and tubing storage bag should usually be changed at night and once a week and did not know why it had not been done;- Nursing staff should date the tubing, humidifier bottle, and tubing storage bags when changed to know it was done. During an interview on 12/17/2025 at 11:44 A.M., the Assistant Director of Nursing (ADON) said the resident's oxygen tubing, humidifier bottle, and storage bag should be changed weekly and dated. During an interview on 12/18/2025 at 8:30 A.M., the Director of Nursing (DON) said oxygen tubing, humidifier bottles, and storage bags for residents should be changed weekly and dated when changed. During an interview on 12/18/25 at 2:38 P.M., the Administrator said:- Oxygen tubing, humidifier bottles, and storage bags for residents should be changed and dated weekly;- The task for changing the tubing, bottles, and bags would be added on the resident's orders for the medication technicians to complete. 3. Review of Resident #10's Quarterly Minimum Data Set (MDS) a federally mandated assessment tool completed by the facility, dated 11/21/25, showed: -The resident was cognitively intact; -The resident required maximal nursing assistance with most activities of daily living; -Diagnosis of hypercapnia (a condition where lungs cannot effectively remove carbon dioxide), respiratory failure, and heart failure. Review of the resident's care plan, revised on11/28/25, showed: -The resident had oxygen therapy due to history of respiratory illness; -Facility staff were to monitor the resident for signs of respiratory distress and notify the doctor as needed; -The resident's oxygen settings were oxygen via nasal cannula at two liters continuously. Review of the resident's Physician order summary report, dated 12/17/25, showed the oxygen tubing (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	was to be changed weekly on Thursdays by the nursing staff. Observation on 12/15/2025 at 4:05 P.M. showed: -The resident laid in his/her bed wearing a nasal cannula with oxygen being administered at two liters; -No date had been written on the oxygen tubing to determine when the tubing had last been changed; -The resident had an oxygen tank attached to the back of his/her wheelchair that had another nasal cannula attached to the oxygen tank. No date had been written on the oxygen tubing to determine when the tubing had last been changed. During an Interview on 12/15/2025 at 4:05 P.M. the resident said staff usually change his/her oxygen tubing once a month and they usually label it somewhere on the tube, he/she does not see a date on the tubing and could not remember when it was changed last. During an Interview on 12/18/2025 at 8:37 A.M. Licensed Practical Nurse (LPN) B said oxygen tubing was to be changed weekly and dated when it is changed. During an Interview on 12/18/2025 at 11:10 A.M. the MDS Coordinator said oxygen tubing was to be changed weekly and the tubing is to be dated when it is changed. During an Interview on 12/18/2025 at 12:55 P.M. the Administrator said oxygen tubing should be changed weekly and dated when it is changed.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to store drugs and biologicals in locked compartments under proper temperature controls when the facility failed to ensure refrigerator temperatures were accurately checked and recorded to ensure medications were being stored at a safe temperature. This had the potential to affect all residents who received refrigerated medication. The facility census was 67.Review of the facilities Medication Labeling and Storage policy, dated February 2023, showed: -The facility stores all medications and biologicals in locked compartments under proper temperature, humidity, and light control; -The nursing staff is responsible for maintaining medication storage and preparation areas in a clean, safe, and sanitary manor. 1.Observation of Medication room [ROOM NUMBER] on 12/16/25 at 10:11 A.M. showed: -The temperature log for the station 4 medication room fridge was kept in a binder outside of the medication room at the nurses station; -The month of November 2025 had no recorded check of the medication fridge temperature on the following days: 1st, 2nd, 5th, 6th, 10th, 11th, 14th, 15th,16th, 19th, 20th, 22nd, 23rd, 24th, 25th, 26th, 27th, 28th, 29th, and 30th; -The month of December 2025 had no recorded check of the medication fridge temperature on the following days: 3rd, 4th, 8th, 9th, 11th, 12th, 13th, and 14th. -The refrigerator housed liquid Ativan (anxiety medication) and Insulin medications. During an Interview on 12/17/2025 at 8:15 A.M. the Director of Nursing (DON) said: The refrigerator temp should be checked daily for the medication storage fridges. During an Interview on 12/18/2025 at 8:37 A.M. Licensed Practical Nurse (LPN) B said: The medication storage fridge temperature should be checked every 24 hours 2.Observation of medication room named TU on 12/17/2025 at 9:24 A.M., showed:- There had been no temperature check log sheets noted in medication room or on the refrigerator;- There was an old binder in the nearby nurses station containing previous temperature check logs;- There had been no initials added to the temperature check logs for the months of November or December.-The refrigerator housed liquid Ativan (anxiety medication) and Insulin medications. During an interview on 12/17/2025 at 9:28 A.M., Registered Nurse (RN) A said the temperature check logs should be checked daily per shift. During an interview on 12/17/2025 at 11:44 A.M., the Assistant Director of Nursing (ADON) said the refrigerator temperature check logs should absolutely be checked daily and monitored by the (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	department heads. During an interview on 12/18/2025 at 8:30 A.M., the Director of Nursing (DON) said the refrigerator temperature check logs should be checked daily and the logs initialed. During an interview on 12/18/25 at 2:38 P.M., the Administrator said the refrigerator temperature check logs should be checked and initialed daily and the task would be added on the treatment log for the nurses to complete.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on observation, interview and record review, the facility failed to establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections when, dietary staff did not change gloves between clean and dirty tasks and when facility staff did not apply Personal Protective Equipment (PPE) when they provided care and treatment for two residents (Resident #61 and Resident #46) and when the facility failed to have an infection surveillance program. The facility census was 67. Review of the facility's Personal Protective Equipment – Using Gloves policy, dated September 2010, showed:-Gloves are used to prevent the spread of infections;-Gloves are used to protect wounds from contamination;-Gloves are used to protect hands from infectious material;\-Wash hands after removing gloves;-Use gloves when touching excretions, secretions, blood, body fluids. Review of the facility's Handwashing/Hand Hygiene policy dated October 2023, showed:-All personnel are expected to adhere to hand hygiene policies;-Hand hygiene is indicated before: - Touching a resident; - After contact with contaminated surfaces; - After touching a resident's environment; - Before moving from work on a soiled body site to a clean body site. Review of the facility's Enhanced Barrier Precautions policy, dated 3/20/24, showed:-It is the policy of this facility to implement enhanced barrier precautions for the prevention of transmission of multidrug-resistant organisms;-Enhanced barrier precautions (EPB) refer to an infection control intervention designed to reduce transmission of multidrug-drug resistant organisms that employs targeted gown and gloves used during high contact resident care activities;-Enhanced barrier precautions will be initiated for residents with chronic wounds, surgical wounds, central lines, ports, urinary catheters and feeding tubes;-Make gowns and gloves available immediately near or outside of the resident's room;-PPE for enhanced barrier precautions are only necessary when performing high contact care activities;-High contact resident care activities include, dressing, bathing, transferring, providing hygiene, changing linens, changing briefs and assisting with toileting, device care (central lines, urinary catheter and feeding tubes) and wound care (any skin opening requiring a dressing). 1. Review of Resident #61's Medicare 5 day Minimum Data Set (MDS), A federally mandated assessment tool completed by facility staff, dated 11/27/25, showed:- No cognitive impairment;- Impairment of lower extremities;- Incontinent of bowel and bladder;- Dependent on staff for all Activities of Daily Living (ADL)s;- Diagnoses included seizure disorder, anxiety and high blood pressure. Review of the resident's care plan, dated 12/05/25, showed:-Dependent on staff for ADLs;-Incontinent of bowel and bladder. Review of the resident's Physician's Order Sheet (POS) dated December 2025, showed:-Order start date: 12/14/25, Peripherally Inserted Central Catheter (PICC, a thin tube inserted into a vein in the arm and guided to a large vein near the heart, used for IV medications and fluid), change dressing every weekly. Observation and interview on 12/17/25 at 10:34 A.M., showed:-A sign outside the resident's room that showed the resident was on enhanced barrier precautions;-An infection control cart sat outside the resident's room;-The resident had a PICC line with two uncapped lumens in place in his/her left arm;-The resident had a dressing on his/her right hip;-The resident said he/she had surgery on his/her right hip;-The resident said he/she had a PICC line because he/she got an infection after the hip surgery;-The resident said he/she received medication in the PICC line for the infection;-Nurse Aide (NA) A and Certified Nurse Aide (CNA) A entered the resident's room;-CNA A and NA A applied gloves and provided peri care to the resident;-NA A used gloved hands to open a drawer in the resident's room and grabbed a package of wipes;-NA A did not wash his/her hands or change gloves before he/she took the package of wipes out of the resident's dresser drawer;CNA A and NA A did not put on isolation gowns before they entered the resident's room and provided care. During an interview on 12/17/2025 at 10:41 A.M., NA A said:-He/She should have put on a gown before he/she entered the resident's room;-Anytime a resident is on EPB a gown should be worn when providing peri care;-He/She should have washed (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	his/her hands and applied clean gloves before he/she removed the wipes from the resident's dresser drawer;-The resident was on EPB because the resident had a PICC line and surgical wound. During an interview on 12/17/2025 at 10:54 A.M., CNA A said:-He/She should have put on a gown before he/she entered the resident's room;-The resident was on EPB because the resident had a PICC line and surgical wound;-Anytime a resident is on EPB a gown should be worn when providing peri care;-Gloves should be changed and hands washed between clean and dirty tasks. During an interview on 12/18/25 at 1:21 P.M., the Director of Nursing said: -Resident #61 is on EBP for a surgical wound and the use of IV antibiotics;-She expected staff to have applied a gown, gloves and a face shield before they entered and performed cares on the resident;-She expected staff to change gloves and wash hands between clean and dirty tasks. During an interview on 12/18/25 at 1:25 P.M. the Administrator said:-She expected staff to use the PPE when performing cares on resident who is on EPB;-She expected staff to change gloves between clean and dirt task;-She expected staff to wash hands between glove changes.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure that one of two sampled residents, Resident #28, identified with a pressure ulcer, received necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing when the facility failed to properly follow physician's orders when performing wound care. The facility census was 67.No policies were provided by the facility related to wound care or pressure injuries. 1. Review of Resident #28's Quarterly MDS dated [DATE], showed:-No cognitive impairment;-Assistance of two staff for bed mobility and transfers;-At risk for pressure ulcers;-Pressure ulcer present on admit;-Diagnoses included diabetes, high blood pressure and anemia. Review of the resident's care plan dated 12/08/25, showed:-The resident had a pressure ulcer;-Provide wound care per treatment order. Review of the resident's Physician's Order Sheet (POS) dated December 2025, showed an order dated 11/12/25 to clean coccyx (tail bone area) with hypohalous acid (used to disinfect and treat wounds), apply barrier cream to peri wound, apply collagen powder to wound bed and leave open to air daily. Review of the resident's Medication Administration Record (MAR) dated December 2025, showed clean coccyx area with hypohalous acid, apply barrier cream to peri wound, apply collagen powder to wound bed and leave open to air daily. Observation on 12/17/25 at 07:18 A.M., showed:-Registered Nurse (RN) A entered the resident's room;-RN A cleaned the resident's coccyx with hypohalous acid;-RN A removed his/her gloves, washed his/her hands and applied clean gloves;-RN A applied collagen powder to the wound bed and left the wound open to air;-RN A did not follow the physician's order when he/she failed to apply barrier cream to the resident's peri wound during the wound treatment. During an interview on 12/17/25 at 07:43 A.M., RN A said:-The treatment order for the resident should be followed;-He/She did not realize he/she did not apply the barrier cream to the resident's peri wound;-All medication and treatment orders should be followed as written by the physician. During an interview on 12/17/25 at 11:28 A.M., the DON said:-All medication and treatment orders should be followed as written by the physician;-The barrier cream should have been applied to Resident #28's peri wound. During an interview on 12/17/25 at 11:32 A.M., the Administrator said all medication and treatment orders should be followed as written by the physician. Intake 2597861

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F 0728 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurse aides who have worked more than 4 months, are trained and competent; and nurse aides who have worked less than 4 months are enrolled in appropriate training. Based on interview and record review, the facility failed to ensure one nurse aide (NA) A completed a nurse aide training program within four months of his/her employment in the facility. The census was 67. The facility did not provide a policy regarding Nurse Aide training. Review of Nurse Aide (NA) A's employee file showed:-Date of hire 4/21/25; -No documentation that NA A had completed a nurse aide training program was found.During an interview on 12/15/24 at 10:11 A.M., NA A said:-He/She had not passed the knowledge part of the Certified Nurse Aide (CNA) test;-He/She worked as an NA only; -He/She was not sure when he/she would take the test again;-He/She was not aware he/she needed to be certified within 4 months of hire.During an interview on 12/18/25 at 1:15 P.M., the Director of Nursing said:-She was not aware that NA A had been working at the facility more than 4 months;-She was unsure why NA A was still working at the facility.During an interview on 12/18/25 at 1:25 P.M., the Administrator said:-She was not aware that NA A had been working at the facility more than 4 months;-She was unsure why NA A was still working at the facility;-NA A should have completed a nurse aide training program by now.

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. Based on observations, interviews and record review, the facility failed to honor one resident's religious preferences when the facility failed to offer a suitable substitute at the lunch meal service for Resident #19, who was assessed and documented as not being able to eat pork products. This affected one out of 12 sampled residents. The facility census was 67. Review of facility policy, Food and Nutrition Services, revised October 2017, showed:- The multidisciplinary staff will assess each resident's nutritional needs, food likes, dislikes and eating habits that affect eating and nutritional intake and utilization;- Reasonable efforts will be made to accommodate resident choices and food preferences;- Food and nutrition services staff will inspect food trays to ensure that the correct meal is provided to each resident;- If an incorrect meal is provided to a resident nursing staff will report it to the food service manager so that a new food tray can be issued;1. Review of Resident #19's Quarterly Minimum Data Set, a federally mandated assessment instrument completed by facility staff, dated 11/21/25, showed:- Resident was cognitively intact;- Diagnosis: liver cell carcinoma (malignant tumor in the liver);Observation of the kitchen on 12/16/25 at 12:37 P.M., showed:- Dietary Manager (DM) prepared a food tray for resident which had breaded pork on it;- Assistant Director of Nursing (ADON) inspected plate and informed DM that resident doesn't eat pork and could not be served that meal;- DM removed main course item which was breaded pork and gave the plate back to the ADON with only rice and green vegetables on the plate for the resident;- ADON refused the plate and asked that a new plate be prepared since the pork product had already touched the plate;- DM made up a new plate with only rice and green vegetable with no substitute for the entree prepared for the resident;- Staff asked the resident if he/she wanted something else and he/she asked for cold cereal as a substitute.During an interview on 12/17/25 at 9:10 A.M., the Resident said:- When the facility serves pork, he/she doesn't have a choice, it's normally placed on his/her plate even though he/she has told the staff he/she does not eat pork due to his/her religious convictions.- He/she prefers fish and doesn't know exactly what he/she can ask for a substitute. - He/she only choose cold cereal because he/she couldn't remember what else to ask for. Resident would have preferred a grilled cheese sandwich and tomato soup if that had been offered. - He/she feels frustrated that the facility doesn't care about his/her preferences or religious needs when it comes to menu choices. - He/she is served pork at least once a week. Record review of kitchen menu for the month of December showed:- Pork served for 19 out of 31 breakfast meals;- Pork served 8 out 31 lunch meals;- Pork served 2 out of 31 dinner meals.Review of Resident's Menu Card, dated 12/17/25, showed the resident is not to have pork.During an interview on 12/18/25 at 8:50 A.M., the DM said:- A preference list for each resident is developed through a one-on-one interview and that information is updated into the electronic medical record and updated on each resident's menu card.- Residents are not served items they do not like if it's listed on their dislikes on the menu card.- Residents who dislike items on that day's menu are expected to annotate on the menu card what they would like for a substitute.- If a resident does not annotate a substitute for an item, they do not like the DM will go out to the dining room and personally ask them what they want as a substitute.- Sometimes the kitchen staff do not catch that an item on the menu is also on the resident's dislike list.- Resident #19 will oftentimes fill out his/her ala carte sheet for grilled cheese and tomato soup as a substitute because he does not eat pork. For today's meal, the kitchen staff didn't have those items already prepared as a substitute for the resident since it wasn't requested beforehand.During an interview on 12/18/25 at 2:00 P.M., the Administrator said if a resident has it documented that they cannot eat pork and that item is on the menu then the kitchen staff should prepare a suitable substitute for the resident without being told by the resident what to prepare. The kitchen staff can choose an item from a known preference from the resident so that they have a full meal served to them that's nutritious.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265356	A. Building B. Wing	12/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Valley Manor and Rehabilitation Center	1410 Hospital Drive Excelsior Springs, MO 64024

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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 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement a program that monitors antibiotic use. Based on interview and record review, the facility failed to establish an infection prevention and control program that included an antibiotic stewardship program (a set of commitments and actions designed to optimize the treatment of infections while reducing the adverse events associated with antibiotic use) that included antibiotic use protocols and a system to monitor antibiotic use. The census was 67. Review of the facility Antibiotic Stewardship policy, dated December 2016 showed:- The purpose of antibiotic stewardship is to monitor the use of antibiotics in our residents and to include training, orientation, and education of staff with emphasize on the importance of antibiotics stewardship, and inappropriate use of antibiotics; - Antibiotics usage and outcome will be collected and documented using a facility-approved antibiotics surveillance tracking form; - The data will be used to guide decisions for improvement of individual resident antibiotic prescribing practices and facility wide antibiotic stewardship.The facility did not provide complete Antibiotic Stewardship Program documentation that should include ongoing monthly surveillance and monitoring of the following:- Protocols to optimize the treatment of infections by ensuring that residents who require an antibiotic are prescribed the appropriate antibiotic;- Procedures to reduce the risk of adverse events, including the development of antibiotic-resistant organisms, from unnecessary or inappropriate antibiotic use;- Procedures to promote and implement a facility-wide system to monitor the use of antibiotics including a system of reports related to monitoring antibiotic usage and resistance data;- Designated appropriate facility staff accountable for promoting and overseeing antibiotic stewardship;- Accessing pharmacists and others with experience or training in antibiotic stewardship; - Implementation of a policy or practice to improve antibiotic use;- Regular reporting on antibiotic use and resistance to relevant staff such as prescribing clinicians and nursing staff;- Educate staff and residents about antibiotic stewardship. Review of the facility's 802/Resident Matrix showed only one resident receiving antibiotics with that same resident being the only noted with an infection, there were four active infections in the building requiring antibiotics.Review of the facility's Infection Surveillance binder, dated 2025, showed:- No surveillance and no monitoring had been provided for the months January through August 2025;- No completed McGreer's Criteria checklists (checklists used in healthcare, especially long-term care, aiming to reduce unnecessary antibiotic use) had been added; - The September 2025 Infection Control Surveillance Log had no infectious organisms listed, no cultures listed, no x-ray results listed. and no infections resolved dates listed;- The October 2025 Infection Control Surveillance Log had listed only four infectious organisms identified for urinary tract infections (UTI's) at the beginning of the month and none for the remaining four UTI's, and no resolved dates listed for last nine resident's affected;- The November 2025 Infection Control Surveillance Log had no infectious organisms listed for any of the 13 residents listed;- The December 2025 Infection Control Surveillance Log showed one resident on antibiotics for a skin infection with infectious organism and antibiotic listed, one resident on antibiotics for an upper respiratory infection with antibiotic listed, one resident on antibiotics for an eye infection with no organism or antibiotic listed, and a fourth resident named with no further details listed.During an interview on 12/17/25 at 11:44 A.M., the Assistant Director of Nursing (ADON) and Infection Preventionist (IP) said:- The facility followed the provider preference regarding when to begin antibiotics which could be either before or after culture and sensitivity results or x-ray results;- The nurses monitored and charted daily on residents on antibiotics for adverse reactions until they are off the antibiotics;- The facility followed up after completion of antibiotics per the doctor's preference;- She was not able to provide any written protocols for antibiotic stewardship and added that the facility just goes by what the provider wants.During an interview on 12/18/25 at 8:30 A.M., the Director of Nursing (DON) said there should be written protocols for antibiotic stewardship on a shared computer drive, but she wasn't sure.During an interview on 12/18/25 at 2:38 P.M., the Administrator said yes, there should be written protocols for Antibiotic Stewardship and those protocols should be followed.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265356	A. Building B. Wing	12/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0882 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Designate a qualified infection preventionist to be responsible for the infection prevent and control program in the nursing home. Based on interview and record review, the facility failed to designate a qualified Infection Preventionist (IP), who had completed specialized training in infection prevention and control to be responsible for the facility's Infection Prevention and Control Program. The census was 67.Review of the facility Components of Infection Control policy, undated, showed:- The Infection Preventionist is a person designated to serve as a coordinator of the infection prevention and control program;- Generally, it is best to have a registered nurse in this position;- Infection Preventionist must complete the required Centers for Disease Control (CDC) course on Infection Preventionist training.Review of the facility's current Infection Preventionist's training showed:- Only modules one through 15 of the 23 module, CDC required course had been completed;- No course completion certificate was provided.During an interview on 12/17/25 at 11:44 A.M., the Assistant Director of Nursing (ADON) and Infection Preventionist (IP) said:- She was not sure how to get further documentation of her IP course besides the 15 module certificates provided;- She did not know her sign on for the CDC site.During an interview on 12/18/25 at 8:30 A.M., the Director of Nursing (DON) said the person responsible for Infection Prevention should have Infection Preventionist certification.During an interview on 12/18/25 at 2:38 P.M., the Administrator said:- The Infection Preventionist should be certified;- She had found out the new MDS coordinator was certified but the current Infection Preventionist was not.