STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265374	A. Building B. Wing	01/14/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Grandview Healthcare Center	201 Grand Ave Washington, MO 63090

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview and record review, facility staff failed to store food in a manner to prevent potential contamination and outdated use and use food in a first-in first out manner. Facility staff failed to perform hand hygiene as often as necessary using approved techniques to prevent cross-contamination. Facility staff failed to maintain kitchen equipment and surfaces in a clean and sanitary manner and ensure staff personal items were stored away from food storage and preparation areas. Facility staff failed to properly wash, sanitize and air-dry mechanically washed dishes to prevent cross-contamination and the growth of foodborne pathogens. Facility staff also failed to maintain a chemical sanitizer test kit to ensure the chemical sanitizer used in the mechanical dishwasher maintained the appropriate concentration. These failures have the potential to affect all residents. The facility census was 52.1. Review of the facility's policy titled Receiving and Storage of Food, undated, showed the dietary manager (DM) is responsible for receiving and storing food and nonfood items. Review showed the policy directed staff to follow the rule of First In, First Out, keep all foods in clean, undamaged wrappers or packages, and to reseal open boxes effectively. Review of the facility's policy titled Storage of Dry Food and Supplies, dated May 2015, showed metal or plastic containers with tight fitting covers, labeled top or side, must be use for storing opened products. Open boxes are to be effectively resealed. Bulk crackers, cereal, cookies, pasta, et cetera are to be stored and properly labeled in sealed containers. Food-grade plastic bags are to be tightly closed after being opened. Observation on 01/13/26 at 8:29 A.M., showed the cook's station contained: -An undated plastic bulk storage container which contained an undated bag of quick oats removed from its original packaging; Observation showed the bag inside the container opened to the air and a golf ball sized hole in the back side of the container; -An undated plastic bulk storage container which contained an opened and undated 25 pound bag of fish breading. Observation showed a delivery sticker on the bag dated 02/14/23 and the bag prevented the lid to the container from being sealed;-An undated plastic bulk storage container which contained an opened and undated 25 pound bag of flour;-An undated plastic bulk storage container which contained an opened and undated 50 pound bag of sugar;-An opened 57 ounce (oz.) container of instant mashed potatoes with a stock date of 12/29 and no opened date. Observation on 01/13/26 at 9:46 A.M., showed the dry goods pantry contained: -Three undated plastic storage containers of raisin bran cereal removed from its original packaging; -Two undated plastic storage containers of fruit whirls cereal removed from its original packaging;-Two undated plastic storage containers which contained honey nut toasted oats cereal removed from its original packaging;-An undated plastic storage container of crip rice cereal removed from its original packaging;-An opened and undated 10 pound box of graham crumbs;-An opened and undated one gallon bottle of red wine vinegar with use by date of 5/18/22;-An opened 32 oz. bag of light brown sugar with stock date of 7/31 and no opened date. Observation showed the contents of the bag hardened into small rock sized pieces; -An opened five pound bag of devil's food cake mix with a stock date of 7/31 and not dated when opened;-A 24 oz. box of quick grits opened to the air with stock date of 10/28 and not dated when opened; -An opened five pound bag of buttermilk pancake mix with stock date of 10/30 and not dated when opened;-An opened five pound bag of cornbread mix with (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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	a stock date of 11/20 and not dated when opened;-An opened five pound bag of devil's food cake mix with stock date of 12/12 and not dated when opened; -An opened 28 oz. bag of creamy wheat farina cereal with stock date of 12/14 and not dated when opened;-An opened 57 oz. container of instant mashed potatoes with a stock date of 12/29 not dated when opened;-An opened 35 oz. bag of honey nut toasted oats cereal with stock date of 1/8 and not dated when opened. During an interview on 01/3/26 at 10:50 A.M., the DM said food is dated when it enters the facility and anything that is opened should also be dated when it is opened so each item should have two dates on the package, except items removed from their original packages would only have the opened date. The DM said staff are expected to date any items leftover or made before they are put away in storage and ensure they are stored in sealed containers. The DM said the dates on the items identified in the dry goods pantry would be their stock dates and not their opened dates and he/she did not have a good reason as to why the food in the bulk containers and dry goods pantry were not dated and stored as required. The DM said staff would also be expected to discard any food items past their best by or use by dates. Observation on 01/13/26 at 12:14 P.M., showed the walk-in refrigerator contained: -An opened and undated five pound box of grated parmesan cheese;-An opened and undated five pound bag of shredded mozzarella cheese;-An opened 8.44 pound bottle of salsa with stock date of 12/18;-An opened and undated one gallon container of sweet pickle relish. Observation showed the delivery sticker on the container dated 06/05/25. Observation on 01/13/26 at 3:02 P.M., showed the walk-in freezer contained: -An opened and undated 40 oz. bag of corn;-An opened and undated bag of tater tots;-Two opened and undated bags of french fries;-An undated case of breadsticks opened to the air;-Three opened and undated bags of hashbrowns;-An opened and undated box of southern style biscuits;-An opened and undated bag of chicken tenders;-An opened and undated box of pork egg rolls. During an interview on 01/13/26 at 3:08 P.M., the DM said he/she is responsible to monitor food storage, and he/she looks in the refrigerator about every three days, but he/she does not really look around the other food storage areas. The DM said if he/she picks out a food item and notices it is not good, such as the hardened brown sugar, he/she would just throw it away and get a new one. The DM said staff should use all of one item before they open another of the same item so that food is used in a first-in, first-out manner. The DM said he/she had noticed multiple packages of the same item opened in the freezer, but he/she just had not had an opportunity to address it yet, since he/she had to work as the cook several days. The DM said if staff see something not stored properly, it should be corrected upon discovery, and he/she did not have a good reason as to why the food items were not stored correctly or used in first-in, first-out manner. During an interview on 01/13/26 at 3:34 P.M., the administrator said the DM is responsible to ensure food is stored appropriately and he/she should check it daily to ensure it not expired, stored in the appropriate place and properly sealed, labeled and dated. The administrator said if anything is not stored appropriately, it should be corrected at the time of discovery. The administrator said staff are expected to discard food items that are past their best by or use by dates and staff should use all of one food item before they open another like item to ensure food is used in a first-in, first-out manner. The administrator said staff are trained on proper food storage procedures upon hire during their orientation in the kitchen. 2. Review of the facility's policy titled Handwashing, dated May 2015, showed the policy directed staff to lather their hands with antiseptic soap, giving particular attention to the areas between fingers, around cuticles and under fingernails, and to turn the water off with a paper towel when they wash their hands. Review showed the policy did not contain direction to staff on when to perform hand hygiene or how long to lather their hands with soap when they wash their hands. Observation on 01/13/26 at 8:13 A.M., showed [NAME] M entered the kitchen and disposed of trash in the trash can by lifting the lid with his/her bare hand. Observation showed the cook then washed his/her hands at the handwashing sink and turned the faucet off with his/her bare hand before he/she dried his/her hands. Observation on 01/13/26 at 8:19 A.M., showed the DM entered the kitchen and, without performing hand hygiene, retrieved a metal food service pan to use for food service. Observation on 01/13/26 at 8:35 A.M., (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	showed when Dietary Aide (DA) N washed his/her hands at the handwashing sink, he/she scrubbed his/her hands with soap for two seconds and turned the faucet off with his/her bare hand. Observation showed the DA then removed food service trays from the clean side of the mechanical dishwashing station and placed them on the food delivery cart. Observation on 01/13/26 at 8:54 A.M., showed DA N entered the kitchen and when he/she washed his/her hands at the handwashing sink, he/she scrubbed his/her hands with soap for two seconds and turned the faucet off with his/her bare hand. Observation showed the DA then put away dishes from the clean side of the mechanical dishwashing station. Observation on 01/13/26 at 8:56 A.M., showed when [NAME] M washed his/her hands at the handwashing sink, he/she scrubbed his/her hands with soap for seven seconds and turned the faucet off with his/her bare hand. Observation showed the cook then adjusted the glasses on his/her face and prepared drinks for service at the lunch meal. Observation on 01/13/26 at 9:10 A.M., showed when the DM washed his/her hands at the handwashing sink, he/she scrubbed his/her hands with soap for five seconds. Observation showed the DM then rolled a package of raw hamburger wrapped in plastic into a piece of aluminum foil and, without performing hand hygiene, tore off a piece of masking tape from the roll to date the hamburger, put the hamburger in the walk-in freezer and prepared food items for service at the lunch meal. Observation on 01/13/26 at 9:19 A.M., showed when the DM washed his/her hands at the handwashing sink, he/she scrubbed his/her hands with soap for five seconds. Observation showed the DM then continued to prepare food items for service at the lunch meal. Observation on 01/13/26 at 9:38 A.M., showed when DA N washed his/her hands at the handwashing sink, he/she scrubbed his/her hands with soap for two seconds and turned the faucet off with his/her bare hand. Observation showed the DA then put clean insulated dome plate covers onto the food service trays located on the food delivery cart. Observation on 01/13/26 at 10:33 A.M., showed the DM entered the kitchen and, without performing hand hygiene, picked up dishes from the clean side of the mechanical dishwashing station. During an interview on 01/13/26 at 10:33 A.M., the DM said he/she just came from the administrator's office and staff should wash their hands when they enter the kitchen. The DM said he/she did not think about the need to wash his/her hands when he/she entered the kitchen. During an interview on 01/13/26 at 3:16, the DM said staff should perform hand hygiene when they enter the kitchen, touch a trash can or anything that is dirty, which would include their glasses and raw meat. The DM said when staff wash their hands, they should scrub their hands with soap for at least 20 seconds and turn the faucet off with a towel and not their bare hand since the faucet is dirty. The DM said all staff are trained on proper hand hygiene upon hire. During an interview on 01/13/26 at 3:40 P.M., the administrator said staff should perform hand hygiene when they enter the kitchen, after they handle food and after they touch anything dirty, would include their glasses. The administrator said when staff wash their hands, they should scrub their hands with soap for at least 20 seconds and turn the faucet off with a paper towel, so they do not recontaminate their hands. The administrator said staff are trained on proper hand hygiene during orientation by their trainer and during routine hand hygiene in-services. 3. Review of the facility's policy titled Workspaces and Storage, dated May 2015, showed the policy provided direction to staff for the cleaning of drawers, vents, doors, walls, ceilings, light fixtures and switches. Review showed the policy did not contain direction to staff for the cleaning of other kitchen surfaces and equipment. Review of the facility's policy titled Handwashing, dated May 2015, showed the policy directed staff to store personal items in a designated area away from food preparation, service, and storage areas. Observation on 01/11/26 at 10:24 A.M., showed an excess of dried on food debris and liquid stains inside the reach-in refrigerator by the chest freezer. Observation on 01/11/26 at 10:24 A.M., showed an excess of hardened grease on the exterior of the two tabletop deep fat fryers and on the side of the range by the fryers. Observation on 01/13/26 at 8:22 A.M., showed an excess of dried on food debris and liquid stains inside the reach-in refrigerator by the chest freezer. Observation also showed an excess of paper trash and dirt on the floor behind the refrigerator and between the refrigerator and chest freezer. Observation on 01/13/26 at 8:23 A.M., showed an abundance of personal items stored (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	on top of the chest freezer and an accumulation of pens, markers and paper trash on the floor behind the freezer. Observation on 01/13/26 at 8:29 A.M., showed an excess of hardened grease on the exterior of the two tabletop deep fat fryers and on the side of the range by the fryers. Observation also showed multiple french fries on the floor behind the fryers. During an interview on 01/13/26 at 9:18 A.M., the DM said the personal items on top of the chest freezer belonged to staff and he/she instructed the staff to store their personal items either in his/her office or on top of the freezer. The DM said he/she did not realize personal items should not be stored in food storage and preparation areas. The DM said the facility did not really have a routine cleaning schedule for staff to follow. The DM said he/she puts some things on his/her cleaning list to do, like cleaning the deep fat fryers, while he/she assigns other tasks to staff as needed. The DM said he/she knew there were things in the kitchen that needed to be cleaned, but he/she just had not been able to clean them yet due to having to work as the cook most of the time. During an interview on 01/13/26 at 3:47 P.M., the administrator said he/she did not have a policy related to the cleaning of all kitchen surfaces and equipment, all dietary staff are responsible to keep the kitchen clean and the DM should monitor that daily. The administrator said the cook should clean the deep fat fryers and range after each use and staff should clean equipment as well as sweep and mop the floors, which would include the areas behind and between equipment, daily and as needed. The administrator said he/she knew the DM often assigned cleaning tasks to the evening staff for completion, but the kitchen should have a cleaning schedule for the routine cleaning of the kitchen. The administrator also said staff should not store their personal items in the kitchen and he/she did not know the DM had told the staff they could store their personal items on the freezer. 4. Review of the facility's policy titled Dishwashing Temperatures, dated May 2015, showed the effective temperature range for chemical sanitizing machine listed as 75 dF to 120 dF. Review showed the policy directed staff to record the temperatures of the wash and rinse cycles daily, or as directed by the consultant dietician, for chemical sanitizing machines. Review showed the policy also directed staff to check the concentration of the chemical sanitizer with a test strip and log the concentration on the Dish Machine Temperature log. Review of the facility's policy titled Dishmachine, dated May 2015, showed the policy directed the staff to ensure the temperature of low temperature machines measured a minimum of 120 degrees Fahrenheit (dF) before washing the morning dishes and to document the temperature on the Dish Machine Temperature Log. Review showed the policy also directed staff to check the concentration of the chemical sanitizer with a test strip and log the concentration on the Dish Machine Temperature Log. Review of the facility's policy titled Dish Machine Temperature Log, dated May 2015, showed the policy directed staff to log the wash and rinse temperatures before washing dishes after each meal to ensure the wash and rinse temperatures are properly monitored and controlled. Review showed the policy also directed staff to record the sanitizer concentration for low temperature dish machines. Observation on 01/13/26 at 8:30 A.M., showed DA P washed soiled dishes in the chemical sanitizing mechanical dishwasher. Observation showed the water temperature for the wash and rinse cycles of the dishwasher measured 100 dF. Observation showed staff removed the dishes from the dishwasher from the clean side of the station upon completion of the dishwasher's cycle. Observation showed staff loaded another rack of soiled dishes into the dishwasher and the water temperature of the wash and rinse cycles measured 108 dF. Observation showed the kitchen did not contain a visible test kit to measure the concentration of the sanitizer used in the dishwasher and the Dish Machine Temperature Log which hung on the wall in area was dated August 2025. Review of the dishwasher manufacturer's instructions posted on the dishwasher, showed the water temperature of both the wash and rinse cycles to be a minimum of 120 dF. Review of the manufacturer's instruction for use on the label of the sodium hypochlorite sanitizer used in the dishwasher showed the minimum concentration for the sanitizer to be at 100 parts per million. Review showed the information did not contain instruction for the use of the product with a water temperature of less than 120 dF. During an interview on 01/13/26 at 8:35 A.M., DA P said he/she did (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	not know what the required water temperature of the dishwasher should be, he/she had never checked the concentration of the sanitizer used in the machine and he/she had never seen a test kit to measure the concentration of the sanitizer. During an interview on 01/13/26 at 8:40 A.M., the DM said they switched chemical companies a couple of months ago. The DM said he/she was not present when they came to switch the dishwasher chemicals, but the company representative turned the water temperature down on the dishwasher and stated that the water temperature needed to be lower so it would not affect the effectiveness of the sanitizer. The DM said he/she did not put any Dish Machine Temperature Logs up after the company switched the chemicals since the dishwasher would not be at 120 dF. The DM said he/she did not have a test kit to measure the concentration of the sanitizer used in the dishwasher. The DM said they should have a sanitizer test kit, and he/she should have put a new Dish Machine Temperature Log up, but he/she did not have a good answer as to why he/she did not ensure those things were present. Review of an email to the administration from the facility's corporate purchasing coordinator, dated 01/14/26, showed the facility switched chemical companies and the new chemicals for the dishwasher were installed on 09/05/25. During an interview on 01/13/26 at 4:00 P.M., the administrator said the water temperature and concentration of the chemical sanitizer used in the dishwasher should be in accordance with the policies and staff should check the water temperature and sanitizer concentration each time they wash dishes and record the information on the log put out by the DM. The administrator said the kitchen should contain a test kit to measure sanitizer concentrations, but he/she could not recall if he/she had seen a test kit in the kitchen. The administrator said if the dishwasher is not working correctly, staff should notify maintenance and not continue to use the machine. The administrator said they were already using their current chemical company when he/she became the administrator in November 2025, and he/she did not know the water temperature of the dishwasher did not reach 120 dF or that the kitchen did not have a test kit for the sanitizer. 5. Review of the facility's policy titled Dishmachine, dated May 2015, showed the policy directed staff to allow all dishes to air-dry after they are washed in the mechanical dishwasher. Observation on 01/13/26 at 8:30 A.M., showed DA P removed cleansed plastic food service trays while wet from the mechanical dishwasher and placed them on the food delivery cart. Observation also showed 10 plastic food service trays, 10 insulated plate covers, and six insulated plate holders stacked together wet on the storage shelf on the clean side of the mechanical dishwashing station. Observation on 01/13/26 at 8:35 A.M., showed DA N removed cleansed plastic food service trays while wet from the clean side of the mechanical dishwashing station and placed them on the food delivery cart. Observation showed the DA then dried the trays with a cloth towel. Observation showed the DM in-serviced the DA to allow dishes to air-dry after they are washed. Observation on 01/13/26 at 8:54 A.M., showed DA P put the wet stacked insulated plate holders from the shelf onto the towel dried trays on the food delivery cart. Observation on 01/13/26 at 9:00 A.M., showed DA N removed cleansed food service pans while wet from the clean side of the mechanical dishwashing station and stacked them on top of the other pans on the storage shelf. During an interview on 01/13/26 at 9:00 A.M., DA N said dishes should be dry before they are put away and he/she thought the pans were dry. Observation on 01/13/26 at 9:25 A.M., showed [NAME] M used a cloth towel to dry cleansed dishes in the mechanical dishwashing station. During an interview on 01/13/26 at 3:20 P.M., the DM said dishes should be air-dried before they are put away. The DM said he/she does not train staff on putting the dishes away, but the DA who they work with during their orientation should train them to allow the dishes to air-dry. During an interview on 01/13/26 at 4:00 P.M., the administrator said staff should allow dishes to air-dry and staff are trained on that requirement. The administrator said the DM is responsible to ensure staff are trained on the requirements and routinely monitor the storage of dishes.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Implement a program that monitors antibiotic use. Based on record review and interview, facility staff failed to maintain an Antibiotic Stewardship Program (the monitoring for appropriate antibiotic use and effectiveness to improve outcomes and prevent development of antibiotic resistance). The facility census was 52. 1. Review of the facility's policy titled, Antibiotic Stewardship Champion Program, undated, showed:-The community will select an Antibiotic Stewardship Champion (ASC) who will be responsible for implementing and maintaining the Antibiotic Stewardship Champion Program;-Antibiotic usage will be reviewed during morning meeting, the resident's name, antibiotic, start date and location/type of infection will be listed on the white board for follow up until antibiotic is complete or repeat culture results are received;-Seventy-two hours after the start of antibiotics, a Time Out will be conducted: the resident's clinical record will be reviewed for the correct antibiotic, the correct length of time for the antibiotic prescribed, if any lab/culture results have been received, and any adverse reaction;-The Antibiotic Stewardship Champion will review the resident's Medication Administration Record (MAR) throughout the use of antibiotic to ensure administration of the antibiotic;-The ASC will also keep track of the location of infections throughout the facility monthly by highlighting the location of infections on a map of the facility. 2. Review of the Antibiotic Stewardship program, dated May 2025 to January 2026, did not contain documentation staff tracked antibiotics and infections in the facility.During an interview on 01/14/26 at 12:07 P.M., the Assistant Director of Nursing (ADON) said he/she has been working the floor a lot recently and has not had time to keep up with the antibiotic stewardship program. He/She said there is not another staff that is trained that could help while he/she is working the floor. He/She said its important to track infections and antibiotics in the facility to ensure residents are getting the prescribed antibiotic and to see if there is a way to prevent infections from occurring in the facility. During an interview on 01/14/26 at 3:42 P.M., the Director of Nursing (DON) said he/she is honestly unsure if the antibiotic stewardship program has been getting done because he/she has only worked at the facility since December 2025. During an interview on 01/14/26 at 4:24 P.M., the administrator said he/she was not aware that the antibiotic stewardship program had not been getting done. He/She said he/she was not sure who is responsible for completing the antibiotic stewardship program but will ensure the ADON is responsible moving forward.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, facility staff failed to review and revise the plan of care with changes in the residents' needs for six residents (Resident #2, #6, #7, #17, #22, and #27) out of 21 sampled residents. The facility census was 52.Review of the facility's policy titled Care Plan Comprehensive, undated, showed an individualized comprehensive care plan that includes measurable goals and time frames will be developed to meet the resident's highest practicable physical, mental, and psychosocial well-being. The comprehensive care plan will be based on a thorough assessment that includes but is not limited to the Minimum Data Set (MDS), a federally mandated assessment tool. A well-developed care plan will be oriented to preventing avoidable declines in functioning or functional levels, managing risk factors to the extent possible or indicating the limits of such interventions, applying current standards of practice in the care planning process, assessing and planning for care to meet the resident's medical, nursing, mental and psychosocial need, and addressing additional care planning areas that are relevant to meeting the resident's needs in the long-term care setting. The interdisciplinary care plan team is responsible for the periodic review and updating of care plans when a significant change in the resident's condition has occurred, at least quarterly, and when changes occur that impact the resident's care (i.e. change in diet, discontinuation of therapy, changes in care areas that do not require a significant change assessment).1. Review of Resident #2's Quarterly MDS, dated [DATE], showed staff assessed the resident as:-Severely cognitively impaired;-Weight of 158 pounds (lbs.);-Did not have weight loss;-Diagnoses of stroke, dementia with agitation, anxiety, depression, violent behavior, and stage three chronic kidney disease .Review of the resident's Physician Order Sheet (POS), dated January 2026, showed the physician directed staff as follows:-Diet: Level Six soft and bite sized (a diet for people with mild chewing difficulties, requiring foods that are soft, moist, and cut into small pieces), no fried foods, dated 03/22/25;-Boost Breeze Nutritional (food supplement, lactose-reduced) liquid, 120 milliliters (mL) three times a day, dated 05/01/25;-Super Cereal (a calorie-dense, fortified hot cereal enhanced with ingredients like cream, butter, milk, and sugar to combat unintended weight loss and malnutrition) at breakfast, dated 12/01/25;-Weight: Weekly until stable, on Monday, dated 12/01/25.Review of the resident's monthly weights showed the resident weight as follows:-On 08/01/25 weighed 155.4 lbs;-On 01/12/26, weighed 140.4 lbs a 9.65% loss.Review of the resident's care plan, dated 12/03/25, showed staff did not update the care plan to include the resident's recent weight loss, use of nutritional supplements, or change in frequency of weights.During an interview on 01/14/26 at 3:02 P.M., Certified Nurse Aide (CNA) A said the resident will spit his/her food out, like a behavior, but he/she will get the resident other things, like snacks throughout the day, and he/she did not know the resident had weight loss. The CNA said if he/she was aware the resident had weight loss, he/she would try to get him/her to eat more throughout the day.During an interview on 01/14/26 at 3:13 P.M., the MDS Coordinator said weight loss should be on the care plan, without interventions the resident could continue to lose weight, and the interventions are put in place to prevent and help regain some loss, and it should show supplements, food preferences, and assistance level needed with eating.3. Review of Resident #6's Quarterly MDS, dated [DATE], showed staff assessed the resident as: -Rarely/never understood;-Short and long-term memory problems;-Weight of 154 lbs.,-Did not have weight loss;-Received a mechanically altered diet (a diet that provides moist, soft-textured foods that are chopped, ground, or mashed for easier chewing and swallowing);-Dependent on staff for eating;-Diagnoses of anoxic brain damage (occurs when the brain receives no oxygen at all), diabetes, stroke, dementia, schizophrenia, gastroparesis (a chronic stomach condition in which the muscles in the stomach do not move food as they should for it to be digested), depression, and anxiety.Review of the resident's POS, dated January 2026, showed physician directed staff as follows:-Add yogurt (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	yummy (a protein rich yogurt) with breakfast and lunch, twice a day A.M. and P.M., dated 10/01/25;-Diet: Level Six soft and bite size, dated 10/23/25;-Check weight weekly, on Monday, dated 11/17/25;-2.0 Supplement (a high-calorie, high-protein liquid nutritional drink) once daily, 90 milliliters (mL) once a day in the A.M., dated 11/18/25.Review of the resident's monthly weights showed staff documented the resident weight as:-On 08/01/25 weighed 179.2 lbs:-On 01/12/26, weighed 151.6 lbs. a 15.4% loss in five month.Review of the resident's care plan, dated 12/15/25, showed staff did not document the resident's recent significant weight loss, use of nutritional supplements, or change in frequency of weights.During an interview on 01/14/26 at 3:02 P.M., CNA A said staff feed the resident because his/her hands do not work. The CNA said he/she did not know the resident had lost weight. The CNA said if he/she was aware the resident had weight loss, he/she would try to get him/her to eat more throughout the day.During an interview on 01/14/26 at 3:13 P.M., the MDS Coordinator said weight loss should be on the care plan, without interventions the resident could continue to lose weight, and the interventions are in place to prevent and help regain some loss, and it should show supplements, food preferences, and assistance level needed with eating.During an interview on 01/14/26 at 4:05 P.M., the Director of Nursing (DON) said he/she often sits with the resident to assist with breakfast and lunch, and the resident will say no, no, and he/she has to encourage the resident to get him/her to eat.4. Review of Resident #7's admission MDS, dated [DATE], showed staff assessed the resident as cognitively intact.Review of the resident's care plan, dated 10/03/25, showed the care plan did not contain direction for the use of bed rails.Observation on 01/11/26 at 12:45 P.M., showed the resident in bed with the right grab bar in the upright position on the bed.Observation on 01/12/26 at 9:56 A.M., showed the resident in bed with the right grab bar in the upright position on the bed.Observation on 01/14/26 at 8:10 A.M., showed the resident in bed with the right grab bar in the upright position on the bed.During an interview on 01/14/26 at 3:13 P.M., the MDS Coordinator said if a resident used bedrails, it should be listed on the care plan.6. Review of Resident #17's Significant Change in Status Assessment (SCSA), dated 12/31/25, showed staff assessed the resident as:-Severely cognitively impaired;-Had delusions and behavioral symptoms not directed towards others daily;-Had identified symptoms that put the resident at risk for physical illness or injury;-Had significant interferences with participation in activities or social interaction;-Weight of 118 lbs.;-Did not have weight loss;-Dependent on staff for eating-Diagnoses of dementia with agitation, anxiety, and depression.Review of the resident's POS, dated January 2026, showed the physician orders as followed:-House supplement, dated 12/28/25;-Diet:Regular, dated 12/28/25;-Weight: weekly times four weeks, on Monday, dated 12/28/25.Review of the resident's monthly weights showed staff documented:-On 08/01/25, weighed 129.8 lbs:-On 01/12/2026, weighed 103.6 lbs. a 20.18% loss in five month.Review of the resident's care plan, dated 12/22/25, showed staff did not document the resident's significant weight loss, use of nutritional supplements, and change in frequency of weights.During an interview on 01/14/26 at 3:02 P.M., CNA A said it depends on the day, if staff can get the resident out of the merry walker (a walker/chair combination decided to provide stability and promote independent mobility for people with walking difficulties), then he/she will sit there and eat, but if the resident is sat down too early, then staff will have to feed the resident. The CNA said he/she did not know the resident had weight loss. The CNA said if he/she was aware the resident had weight loss, he/she would try to get him/her to eat more throughout the day.During an interview on 01/14/26 at 3:13 P.M., the MDS Coordinator said weight loss should be on the care plan, without interventions the resident could continue to lose weight, and the interventions are in place to prevent and help regain some loss, and it should show supplements, food preferences, and assistance level needed with eating.During an interview on 01/14/26 at 4:05 P.M., the DON said that staff will get the resident into the dining room chair from his/her merry walker, and he/she can feed himself/herself, but when the resident is ready to get up, he/she is ready and will not stay.7. Review of Resident #22's admission MDS, dated [DATE], showed staff assessed the resident as severely cognitively impaired with a diagnosis of Alzheimer's disease.Review of the resident's care plan, dated 11/12/25, (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	showed staff did not document the resident's Alzheimer's diagnosis or include any interventions related to cognitive impairment. During an interview on 01/14/26 at 3:13 P.M., the MDS Coordinator said the resident should have his/her diagnosis of Alzheimer's/dementia on the care plan so that staff know what to do for the resident.8. Review of Resident #27's Quarterly MDS, dated [DATE], showed staff assessed the resident as cognitively impaired, required substantial/maximal assistance to roll left to right, sit to lying position, and lying to sitting on side of bed.Review of the resident's care plan, dated 10/23/25, showed staff did not document direction for use of an assist bar on the bed.Observation on 01/11/26 at 11:35 A.M., showed the resident in bed with a left assist bar in the upright position on the bed. Observation on 01/12/26 at 9:05 A.M., showed the resident's bed had an assist bar on the left side in the upright position.Observation on 01/14/26 at 8:51 A.M., showed the resident's bed had an assist bar on the left side in the upright position.9. During an interview on 01/14/26 at 3:02 P.M., CNA A said he/she can look at care plans in the point of care (POC) care plan tab, and the care plan will say if a resident needs nutritional supplements, but the nurses also tells him/her that, so he/she does not have to look. CNA A said bed rails should be listed on the care plans for residents who use them, and if a resident has a diagnosis of dementia or Alzheimer's that should be on the care plan, so staff know how to take care of them.During an interview on 01/14/2026 at 3:13 P.M., the MDS Coordinator said he/she has worked at the facility for a couple of months and has never done MDS or care plans before, and he/she is trying to learn. The MDS coordinator said care plans should be updated with every change of condition, quarterly and annually.During an interview on 01/14/26 at 3:40 P.M., the DON said the MDS nurse is responsible to update the care plans. The DON said he/she expects the care plan to be individualized to fit the resident's needs. The DON said the care plan directs the resident's care. The DON said he/she would expect the care plan to have bed rails, weight loss and weight loss interventions, and frequency of weight checks. During an interview on 01/14/26 at 4:00 P.M., Administrator A said the MDS Coordinator is responsible to update the care plans quarterly and as needed with changes. Administrator A said he/she would expect the care plan to be individualized and reflect the resident's needs to direct staff on their cares. Administrator A said he/she would expect the care plan to have if a resident has bed rails, and the amount of assistance a resident need from staff. Additionally, the care plan should include nutritional supplements, weight changes with interventions and cognitive status. Administrator A said the facility has a morning meeting to discuss incidents or changes at that time. Administrator A said he/she expects the care plan to be updated if needed for those incidents or changes discussed.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Number of residents sampled:Number of residents cited:71.Review of the facility policy titled Event Investigation, undated, showed complete a Report of Event form as soon as possible whenever there is an unusual, unexpected and/or unintended event that is not consistent with the routine operation of the facility, the routine care of the resident and/or adversely effects or has the potential to adversely affect a resident. Examples of when a form should be completed include fall or person found on the floor. The charge nurse is responsible for completing the Report of Event form and forwarding to the Director of Nursing (DON) as soon as possible. When completing the form be certain to complete the form in full, leaving no blanks. Review of the facility policy titled Charting and Documentation, dated March 2015, showed for accidents/incidents the narrative documentation does not take the place of the Event Report form. Documentation pertaining to accidents or incidents involving residents should include: circumstances surrounding the accident or incident, where the accident or incident took place, date and time the accident or incident occurred, time the physician was notified as well as the time the physician responded, the date and time family was notified and by whom, the condition of the resident to include vital signs, disposition of the resident (i.e., transferred to hospital, put to bed, etc.), and all pertinent observations. Review of the facility policy titled Fall Event Instructional Flowsheet, undated, showed when a fall occurs, the charge nurse opens Fall Event and completes the short description, the charge nurse completes the event form details and the charge nurse enters initial vitals, progress note, and any orders and completes neuro-checks on paper form then scan and upload into resident documents. Review of the facility's Neurological Checks flowsheet, undated, showed neurological checks required for 72 hours post unwitnessed fall or head injury, to be completed every 15 minutes times four for the first hour, every 30 minutes times two for the second hour, every one-hour times two for the next two hours, and every shift for the next 72 hours. Review of the facility policy titled Wound Care and Treatment, undated, showed it is the purpose of this facility to prevent and treat all wounds. Prevention strategies include on-going skin assessment with weekly documentation of status. Review of the facility policy titled Weight and Height Measurement, undated, showed residents are weighed on admission and monthly unless otherwise ordered by the attending physician to monitor the resident's condition. 1. Review of Resident #2's Quarterly Minimum Data Set Assessment (MDS), a federally mandated assessment tool, dated 10/22/25, showed staff assessed the resident as:-Severely cognitively impaired; -Weight of 158 pounds (lbs.), -Did not have weight loss;-Diagnoses of stroke, dementia with agitation, anxiety, depression, and stage three chronic kidney disease (kidneys have moderate damage and are not filtering waste as effectively). Review of the resident's Physician Order Sheet (POS), dated January 2026, showed the physician directed staff on 12/01/25 to weigh the resident weekly until stable, on Monday.Review of the resident's weight documentation showed staff did not document the resident's weights for 12/01/25, 12/15/25, 12/22/25, and 01/05/26. During an interview on 01/14/2026 at 4:05 P.M., the Director of Nursing (DON) said he/she has started checking to make sure weights are being done for the resident. The DON did know why staff had obtained the weights. He/She had just started in mid-December as the DON. 2. Review of Resident #5's Quarterly MDS, dated [DATE], showed staff assessed the resident as:-Severely cognitively impaired;-Did not have behaviors or resist care,-At risk for skin breakdown;-Diagnoses of Schizophrenia, bipolar (mental health condition that causes extreme mood swings), malnutrition, venous insufficiency (occurs when veins don't allow the blood to flow back to the heart normally), and diabetes.Review of the resident's care plan, dated 05/21/25, showed staff documented the resident at risk for skin complications related to diabetes, and monitor skin per orders. Review of the resident's POS, dated 01/11/26, showed the physician directed staff to obtain weekly skin assessments on Friday during the day shift.Review of the resident's weekly skin assessments, dated 11/24/25 through 01/13/26, showed staff did not document a skin assessment (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	on 11/24/25, 11/28/25, 12/5/25, 12/12/25, and 01/09/26. 3. Review of Resident #6's Quarterly MDS assessment, dated 12/16/25, showed staff assessed the resident as:-Rarely/never understood;-Weight of 154 lbs.;-Did not have weight loss-Received a mechanically altered diet (a diet that provides moist, soft-textured foods that are chopped, ground, or mashed for easier chewing and swallowing);-Diagnoses of anoxic brain damage (occurs when the brain receives no oxygen at all), diabetes, stroke, dementia, schizophrenia, gastroparesis (a chronic stomach condition in which the muscles in the stomach do not move food as they should for it to be digested), depression, and anxiety. Review of the resident's POS, dated January 2026, showed the physician directed staff to weigh the resident weekly, on Monday.Review of the resident's weight documentation showed staff failed to document weights for 11/17/25, 11/24/25, 12/1/25, 12/15/25, 12/22/25, 12/29/25, and 01/05/26. During an interview on 01/14/2026 at 4:05 P.M., the DON said he/she did not know the resident's weights were not being done weekly as ordered. 4. Review of Resident #15's Quarterly MDS, dated [DATE], showed staff assessed the resident as severely cognitively impaired, did not have behaviors or resist care, and had two or more falls since prior assessment.Review of the resident's progress note, dated 12/31/25, showed staff documented the resident had an unwitnessed fall without injury. The record did not contain a completed Event Report. Review of the resident's progress note, dated 01/08/26, showed staff documented the resident had an unwitnessed fall without injury. The medical record did not contain a completed event report or 11 of the 14 required neurological checks. 5. Review of Resident #16's admission MDS, dated [DATE], showed staff assessed the resident as:-Severely cognitively impaired;-Did not have behaviors or resist care;-Required assistance with Activities of Daily Living (ADLs);-At risk for falls. Review of the resident's care plan, dated 11/07/25, showed staff documented the resident at risk for falls and fell on [DATE]. Review of the resident's neurological checks showed staff did not document neurological checks after the resident had an unwitnessed fall on 11/19/26.During an interview on 01/13/26 at 1:00 P.M., the Assistant Director of Nursing (ADON) said he/she was the nurse on duty when the resident fell on [DATE]. The ADON said it was an unwitnessed fall, and he/she should have completed neurological checks on the resident. The ADON said he/she does not remember why he/she did not complete the neurological checks. The ADON said he/she should have completed the neurological checks per the facility policy. 6. Review of Resident #17's Significant Change in Status Assessment (SCSA), dated 12/31/25, showed staff assessed the resident as:-Severely cognitively impaired;-Weight of 118 lbs., -Did not have weight loss; -Had a fall since prior assessment, had two or more falls with no injury, had one fall with major injury;-Diagnoses of dementia with agitation, anxiety, and depression.Review of the resident's POS, dated January 2026, showed the physician directed staff to obtain weekly weight for four weeks, on Monday. Review of the resident's weight documentation showed staff did not document the resident's weights for 12/29/25 and 01/05/26. Review of the resident's progress notes showed staff documented the resident had an unwitnessed fall with minor injury on 10/26/25. The medical record did not contain an event report or 13 of the 14 required neurological checks. Review of the resident's progress notes showed staff documented the resident had an unwitnessed fall without injury on 10/28/25, 10/29/25, 11/19/25, and 11/29/25. The medical record did not contain a completed Event Report for the falls. During an interview on 01/14/2026 at 4:05 P.M., the DON said he/she did not know that the resident's weights were not being done and just found out. 7. Review of Resident #22's admission MDS, dated [DATE], showed staff assessed the resident as severely cognitively impaired and had two or more falls since admission/entry or prior assessment.Review of the resident's progress notes showed staff documented the resident had a witnessed fall with minor injury on 11/05/25. The record did not contain a completed Event Report. Review of the resident's progress notes showed staff documented the resident had an unwitnessed fall without injury on 11/09/25. The record did not contain a completed Event Report. 8. Review of Resident #29's Quarterly MDS, dated [DATE], showed staff assessed the resident as:-Cognitively intact;-Did not have behaviors or resist cares; -At risk for skin (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	breakdown and has wounds;-Diagnoses of heart failure, cellulitis of lower limbs (bacterial infection of the skin), disorder of the subcutaneous tissue of the skin (disorder of the connective tissue and fat that connects the skin to muscle), lymphedema (localized swelling of a body part), chronic kidney disease and venous insufficiency. Review of the resident's POS, dated 01/11/26, showed an order to complete weekly skin assessments on Mondays.Review of the resident's weekly skin assessments, dated 11/24/25 through 01/13/26, showed staff did not document skin assessment on 11/24/25, 12/01/25, 12/08/25, 12/15/25, 12/29/25, and 01/05/26. 9. Review of Resident #31's Quarterly MDS, dated [DATE], showed staff assessed the resident as:-Severely cognitively impaired;-Weight of 113 lbs.;-Diagnosis of malnutrition or at risk for malnutrition, Review of the resident's POS, dated January 2026, showed an order for weekly weight, on Tuesdays.Review of the resident's weight documentation showed staff did not document weights for 10/28/25, 12/30/25, and 01/06/26. 10. Review of Resident #38's Quarterly MDS, dated [DATE], showed staff assessed the resident as:-Severely cognitively impaired;-Weight of 217 lbs.;-Did not have weight loss; -Diagnosis of malnutrition or at risk for malnutrition.Review of the resident's POS, dated January 2026, showed an order for monthly weights on the first of the month.Review of the resident's weight documentation showed staff did not document the resident weight for 10/01/25 and 01/01/26. 11. Review of Resident #51's Quarterly MDS, dated [DATE], showed staff assessed the resident as:-Cognitively intact;-Did not have behaviors or resist cares; -At risk for skin breakdown;-Diagnoses of spina bifida (a congenital condition in which part of the spinal cord and are exposed through a gap in the backbone, often causing paralysis of the lower limbs), incomplete paraplegia (inability to move the lower body parts), and end stage renal disease.Review of the resident's POS, dated 01/11/26, showed an order for weekly skin assessments every Thursday.Review of the resident's weekly skin assessments, dated 11/24/25 through 01/13/26, showed staff did not document a skin assessment on 11/27/25, 12/11/25, 12/25/25, and 01/01/26. 12. During an interview on 01/13/25 at 11:20 A.M., the DON said the facility fall policy is to be followed for all residents. The DON said the policy states if a resident has an unwitnessed fall or a fall with a head injury, neurological checks are to be completed every 15 minutes times four, every 30 minutes times two, every hour times two, and every shift for 72 hours. The DON said if a resident refuses to have the neurological checks completed, he/she expects the staff to document the refusal. The DON said an event report is to be completed by the charge nurse with each resident fall. The DON said he/she expects the event report and neurological checks to be filled out completely per facility policy. During an interview on 01/14/26 at 2:13 P.M., LPN C said the purpose of a physician's order is to direct staff how to care for a resident. LPN C said the charge nurse is responsible to enter and follow all physician's orders and the DON is responsible to oversee the charge nurse and ensure staff follow the orders. LPN C said if staff do not follow physician's orders it could be a detriment to the resident's wellbeing. LPN C said it is the charge nurse's responsibility to give the aides a list of weights needed to be completed each day. LPN C said the aides are responsible to obtain the weights and report those to the charge nurse. LPN C said it is the charge nurse's responsibility to enter the weights into the resident's chart. LPN C said if a resident refuses the charge nurse is expected to document the refusal. LPN C said the charge nurse is responsible to complete weekly skin assessments when they are due. LPN C said the skin assessment triggers on the treatment record and should be documented on a weekly skin assessment form. LPN C said he/she does not know why the skin assessments are not being completed weekly but said they should be. LPN C said if a resident has an unwitnessed fall or a fall with a head injury the charge nurse is responsible to document the fall correctly in the resident's medical record then complete neurological checks per the facility policy. LPN C said he/she does not know why the falls or neurological checks aren't documented correctly. LPN C said if something is not documented then it was not done.During an interview on 01/14/26 at 3:02 P.M., Certified Nurse Aide (CNA) A said CNA's or therapy staff obtain the weights for residents as directed by the nurses. The CNA said when he/she gets the resident's weights, he/she writes it on a form and then the nurse puts the weight in (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the computer. During an interview on 01/14/26 at 3:40 P.M., the DON said the purpose of a physician's order is to ensure staff provide appropriate care. The DON said he/she expects all staff to follow physician's orders. The DON said he/she expects staff to complete weekly skin assessments that are triggered in the system when due and the charge nurse is responsible to complete the assessment and document it in the resident's chart. The DON said weekly or daily weights should be completed per orders. The DON said the treatment record triggers the charge nurse to complete the weights as ordered. The DON said the charge nurse or aides are responsible to obtain the weights, and the charge nurse is responsible to document the weights in the resident chart. The DON said he/she is responsible to ensure the charge nurses and aides complete the weights per the orders. The DON said if something does not get documented there is not a way to know if it was completed. During an interview on 01/14/26 at 4:00 P.M., administrator A said the purpose of a physician's order is to direct resident care. Administrator A said the charge nurse is responsible to enter and to follow all physician's orders. Administrator A said the DON or ADON are responsible to ensure the charge nurses follow the physician's orders. Administrator A said weekly and daily weights should be completed per the orders. Administrator A said he/she expects staff to complete any weekly skin assessments as ordered by the physician. Administrator A said if something isn't documented it is not done.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record reviews, facility staff failed to ensure the residents' environment remained safe from hazards when staff failed to safely propel four residents (Resident #2, #15, #37, and #52) out of 21 sampled residents while in wheelchairs. Facility staff failed to store medication in a safe and effective manner when medication carts were left unlocked and unattended, and medication was left on top of the cart with residents close by. The facility census was 52. 1.Review of the facility's policy titled Wheelchair, Use of, undated, showed the policy did not address the use of foot pedals while propelling residents. 2. Review of Resident #2's Quarterly Minimum Data Set (MDS), a federally mandated assessment tool, dated 10/22/25, showed staff assessed the resident with severe cognitive impairment, and required supervision or touch assist for wheelchair locomotion of 50 feet with two turns and wheeling 150 feet in wheelchair.Observation on 01/13/26 at 8:38 A.M., showed the Activity Director (AD) propelled the resident in his/her wheelchair without foot pedals. Observation showed the resident's feet drug the ground. Observation on 01/13/26 at 2:07 P.M., showed the Social Service Designee (SSD) propelled the resident in his/her wheelchair without foot pedals. Observation showed the resident's feet drug the ground. Observation on 01/14/26 at 7:28 A.M., showed Licensed Practical Nurse (LPN) C propelled the resident in his/her wheelchair without foot pedals. Observation showed the resident's feet drug the ground. Observation on 01/14/26 at 8:56 A.M., showed Certified Nurse Aide (CNA) K propelled the resident in his/her wheelchair without foot pedals. Observation showed the resident's feet drug the ground. During an interview on 01/14/26 at 1:37 P.M., CNA K said staff should not propel residents in their wheelchairs without foot pedals. He/She said residents could drag their feet, which could cause sores or for the resident to fall forward out of the chair. He/She said he/she is unsure why he/she did not check to make sure the resident's feet were on the pedals. Observation on 01/14/26 at 1:45 P.M., showed Licensed Practical Nurse (LPN) C propelled the resident around the nurse's station in his/her wheelchair. The wheelchair had foot pedals, but the resident's feet drug the floor. 2. Review of Resident #15's Quarterly MDS, dated [DATE], showed staff assessed the resident with severe cognitive impairment, and dependent on staff for wheelchair locomotion of 50 feet with two turns and wheeling 150 feet in wheelchair.Observation on 01/11/26 at 12:14 P.M., showed CNA A propelled the resident from the nurses' station to the dining room in his/her wheelchair. The wheelchair did not have foot pedals and the resident's feet drug the floor. 3. Review of Resident #37's admission MDS, dated [DATE], showed staff assessed the resident as cognitively intact, required substantial/maximal assistance for wheelchair locomotion of 50 feet with two turns, and dependent on staff for wheeling 150 feet in wheelchair.Observation on 01/11/26 at 11:50 A.M., showed Nurse Aide (NA) J propelled the resident from the hallway to the dining room in his/her wheelchair. The wheelchair did not have foot pedals and the residents right heel drug the floor. 4. Review of Resident #52's admission MDS, dated [DATE], showed staff assessed the resident as cognitively impaired, required partial/moderate assistance for wheelchair locomotion of 50 feet with two turns, and substantial/maximal assistance for wheeling 150 feet in wheelchair.Observation on 01/12/26 at 11:51 A.M., showed LPN C propelled the resident in his/her wheelchair with his/her feet in the foot pedals. Observation showed the resident foot would drop to the floor and stop the wheelchair. During an interview on 01/14/26 at 2:13 P.M., LPN C said he/she propelled the resident without foot pedals, but he/she thought it would be fine as he/she propelled the resident slowly. LPN C said he/she should have gotten the resident's foot pedals and put them on the wheelchair first. 5. During an interview on 01/14/26 at 1:34 P.M., NA J said residents should not be propelled in their wheelchairs without foot pedals. He/She said the resident could put their feet down and could fall forward out of the wheelchair. During an interview on 01/14/26 at 1:40 P.M., CNA A said staff should not propel residents in their wheelchairs without foot (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Grandview Healthcare Center	201 Grand Ave Washington, MO 63090

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	pedals. He/She said the resident could put their feet down which could cause them to flip out of wheelchair. During an interview on 01/14/26 at 1:43 P.M., the AD said if staff are propelling residents in their wheelchairs they should be using foot pedals. He/She said the resident could fall forward from the chair if foot pedals are not used. During an interview on 01/14/26 at 2:48 P.M., the MDS coordinator said staff are not supposed to propel residents in wheelchairs without foot pedals, because they could be injured. He/She said he/she does not remember pushing a resident without foot pedals, but if he/she did it may have been a short distance. During an interview on 01/14/26 at 3:10 P.M., CNA I said residents must have foot pedals on their wheelchairs when staff propel them. He/She said it's an accident risk and the resident could fall out of their wheelchair. During an interview on 01/14/26 at 2:13 P.M., LPN C said he/she has worked for the facility about two months, and he/she is not sure what the foot pedal policy is, but he/she said staff should ensure residents have foot pedals on their wheelchairs when propelling them. LPN C said if a resident doesn't have foot pedals it could lead to the resident getting an injury by rolling over their foot, or their foot getting trapped and falling out of his/her wheelchair. During an interview on 01/14/26 at 3:40 P.M., the Director of Nursing (DON) said he/she expects staff to ensure a resident has foot pedals on his/her wheelchair before propelling them. The DON said he/she educated staff on this recently. The DON said it is important to have the foot pedals on the resident's wheelchair to prevent injury. During an interview on 01/14/26 at 4:00 P.M., administrator A said he/she expects staff to ensure a resident has foot pedals on his/her wheelchair before propelling them. Administrator A said if a resident does not have foot pedals on his/her wheelchair they could drag feet and risk flipping forward out of their wheelchair and being injured. 6. Review of the facility's Medication Storage policy, undated, showed all medications for residents must be stored at or near the nurses' station in a locked cabinet, a locked medicine room, or one or more locked mobile medication carts. All mobile medication carts must be under visual control of the staff at all times when not stored safely and securely. An unattended medication cart must remain locked at all times, in the event the nurse is distracted from the task of passing medications by some unforeseen occurrence, the cart must be locked before leaving it or secured in a locked medication room. 7. Review of Resident #2's Quarterly MDS, dated [DATE], showed staff assessed the resident as severe cognitive impairment, required supervision or touch assist for wheelchair locomotion.Observation on 01/13/26 at 1:50 P.M., showed the 100/200/300 hallway medication cart sat unlocked and unattended at the nurses' station with residents nearby. Observation showed the resident pulled on the medication cart drawer handle to move his/her wheelchair around it. 8. Review of Resident #17's Significant Change in Status Assessment (SCSA), dated 12/31/25, showed staff assessed the resident as:-Severely cognitively impaired;-Had delusions and behavioral symptoms not directed towards others daily;-Had identified symptoms that put the resident at risk for physical illness or injury, and had significant interferences with participation in activities or social interactions;-Used a wheelchair for mobility;-Diagnoses of dementia with agitation, anxiety, and depression. Observation on 01/11/26 at 11:34 A.M., showed the resident wandered in his/her merry walker (a wheeled walker with a seat) through the hallways and around the nurses' station. Observation on 01/11/26 at 12:00 P.M., showed the resident wandered in his/her merry walker around the assisted dining room and into the lobby. Observation on 01/11/26 at 1:24 P.M., showed the 100/200/300 hall treatment cart sat unlocked and unattended by the nurses' station. Observation showed the resident by the cart. Observation on 01/11/26 at 3:17 P.M., showed the resident wandered throughout the 100/200/300 hallways and around the nurses' station. Observation at 01/12/26 at 8:27 A.M., showed the 100/200/300 treatment cart sat unattended and a cup of pink ointment sat on top of the cart. Observation showed the resident wandered nearby in his/her merry walker. Observation at 01/12/26 at 9:32 A.M., showed the 100/200/300 treatment cart sat unlocked and unattended with the resident nearby. Observation on 01/13/26 at 1:50 P.M., showed the 100/200/300 hall medication cart sat unlocked and unattended at the nurses' station with residents nearby. Observation showed the resident wandered nearby in his/her merry walker. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 01/14/26 at 8:15 A.M., showed the 100/200/300 hall medication cart sat unlocked and unattended at the nurse's station. Observation showed the resident wandered nearby in his/her merry walker. During an interview on 01/11/26 at 11:34 A.M., Certified Medication Technician (CMT) D said the resident wanders frequently throughout the facility in his/her merry walker. 9. Observation on 01/12/26 at 8:05 A.M., showed the 100/200/300 hall medication cart and the 100/200/300 hall treatment cart sat unlocked and unattended at the nurses' station.Observation at 01/12/26 at 2:10 P.M., showed the 100/200/300 treatment cart sat unattended with a tube of Triamcinolone acetonide cream 0.5% (medication used to reduce inflammation, redness, itching, and swelling from skin) on top of the cart. Observation showed multiple residents nearby. 10. During an interview on 01/14/26 at 2:13 P.M., LPN C said medication carts and treatment carts should never be left unlocked and unattended. LPN C said medications and/or treatments should never be left on top of the cart unattended. LPN C said if a cart is left unlocked and unattended, or a medication and/or treatment is left on top of the cart unattended anyone could get into it, and it could potentially cause resident harm. LPN C said the nurse with the keys to the cart is responsible to keep it locked. LPN C said he/she did not realize he/she left the cart unlocked. LPN C said he/she should have ensured the carts were locked when unattended for resident safety. During an interview on 01/14/26 at 3:40 P.M., the DON said medication carts and treatment carts should never be left unlocked and unattended. The DON said the staff member who has the keys to the cart is responsible to ensure the cart is locked. The DON said this is to ensure resident safety and to prevent anyone from getting into it. The DON said medications and/or treatments should not be left on top of the cart unattended for resident safety. During an interview on 01/14/26 at 4:00 P.M., administrator A said the staff member with the keys to the cart is responsible to ensure it is always locked. Administrator A said staff should never leave a medication cart or treatment cart unlocked and unattended for resident safety. Administrator A said a medication and/or treatment should never be left on top of a cart unattended for resident safety and to prevent potential resident harm.

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, facility staff failed to obtain consent for the use of bed rails and complete bed rails assessments for six residents (Resident #3, #7, #8, #27, #38, and #50) out of 21 sampled residents. The facility census was 52. 1. Review of the facility's policy titled Bed Rails, undated, showed:-Educate the resident/legal representative on the benefits and risks of bed rail use;-Once the bed rail observation is completed, the facility will print the observation and review associated risks and benefits with the resident and/or resident representative;-After the review is completed the resident and/or resident representative will sign the consent ling and the nurse will sign as well, once it is signed it will be uploaded into the resident's medical record.2. Review of Resident #3's Quarterly Minimum Data Set (MDS), a federally mandated assessment tool, dated 10/30/25, showed staff assessed the resident as Cognitively intact and restraints not used.Review of the resident's care plan, revised 10/20/25, showed bilateral grab bars on the bed to assist with repositioning and transfers. Review of the resident's medical record showed staff documented a bed rail assessment on 05/05/25 but it did not contain a signed consent. Review showed the record did not contain a bed rail assessment or signed consent after 05/05/25. Observation on 01/11/26 at 1:30 P.M., showed the resident's bed with bilateral grab bars.Observation on 01/11/26 at 3:14 P.M., showed the resident in bed with both grab bars in the upright position on the bed.Observation on 01/12/26 at 2:22 P.M., showed the resident in bed with both grab bars in the upright position on the bed.Observation on 01/13/26 at 2:05 P.M., showed the resident in bed with both grab bars in the upright position on the bed. 3. Review of Resident #7's admission MDS, dated [DATE], showed staff assessed the resident as cognitively intact and restraints not used.Review of the resident's care plan, dated 10/03/25, showed the care plan did not contain direction for the use of grab bars. Review of the resident's medical record showed the medical record did not contain an informed consent for bed rail use, or a bed rail assessment. Observation on 01/11/26 at 12; 45 P.M., showed the resident in bed with the right grab bar in the upright position on the bed.Observation on 01/12/26 at 9:56 A.M., showed the resident in bed with the right grab bar in the upright position on the bed.Observation on 01/14/26 at 8:11 A.M., showed the resident in bed with the right grab bar in the upright position on the bed. 4. Review of Resident #8's Quarterly MDS, dated [DATE], showed staff assessed the resident as cognitively intact and restraints not used.Review of the resident's care plan, revised 10/28/25, showed bilateral grab bars on the bed to assist with mobility.Review of the resident's medical record did not contain an informed consent for bed rail use, or a bed rail assessment. Observation on 01/11/26 at 11:26 A.M., showed the resident in bed with bilateral grab bars in the upright position on the bed.Observation on 01/12/26 at 8:09 A.M., showed the resident in bed with bilateral grab bars in the upright position on the bed.Observation on 01/13/26 at 2:00 P.M., showed the resident in bed with bilateral grab bars in the upright position on the bed.Observation on 01/14/26 at 8:05 A.M., and 11:12 A.M., showed the resident in bed with bilateral grab bars in the upright position on the bed. 5. Review of Resident #27's Quarterly MDS, dated [DATE], showed staff assessed the resident as cognitively impaired, required substantial/maximal assistance to roll left to right, sit to lying position, and lying to sitting on side of bed.Review of the resident's care plan, revised 10/23/25, showed staff did not document direction for use of U-Bar on bed.Review of the resident's medical record showed the record did not contain an informed consent for bed rail use, or a bed rail assessment.Observation on 01/11/26 at 11:35 A.M., showed the resident in bed with a left assist bar in the upright position on the bed. Observation on 01/12/26 at 9:05 A.M., showed the resident's bed had an assist bar on the left side in the upright position. Observation on 01/14/26 at 8:51 A.M., showed the resident's bed had an assist bar on the left side in the upright position. 6. Review of Resident #38's Quarterly MDS, dated (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	[DATE], showed staff assessed the resident as severely cognitively impaired, dependent on staff for rolling left to right, sit to lying position, and lying to sitting on side of bed.Review of the resident's care plan, revised 12/25/25, showed bilateral grab bars to assist staff with turning from side to side and repositions in bed.Review of resident's medical record showed staff documented a bed rail assessment on 06/30/25, the assessment did not contain a signed consent. Review showed staff did not document a further bed rail assessment or signed consent after 06/30/25.Observation on 1/11/26 at 2:40 P.M., showed the resident in bed with a grab bar in the upright position on the right side of the bed. Observation on 1/13/26 at 2:23 P.M., showed the resident in bed with a grab bar in the upright position on the right side of the bed.Observation on 1/14/26 at 2:53 P.M., showed the resident in bed with a grab bar in the upright position on the right side of the bed. 7. Review of Resident #50's Quarterly MDS, dated [DATE], showed staff assessed the resident as cognitively intact, required supervision or touch assistance for rolling left to right, sitting to lying position, and lying to sitting on side of bed.Review of the resident's care plan, revised 12/25/25, showed bilateral grab bars to assist with self-repositioning and transfers in/out of bed.Review of resident's medical record showed staff documented a bed rail assessment on 05/13/25 but it did not contain a signed consent. Review showed no further bed rail assessment or signed consent after 05/13/25.Observation on 01/11/26 at 12:57 P.M., showed the resident in bed with assist bars in the upright position on both side of the bed.Observation on 01/12/26 at 8:25 A.M., showed the resident in bed with assist bars in the upright position on both side of the bed.Observation on 01/14/26 at 8:58 A.M., showed the resident in bed with assist bars in the upright position on both side of the bed. 8. During an interview on 01/14/26 at 2:13 P.M., Licensed Practical Nurse (LPN) C said he/she does not know who is responsible to obtain bed rail assessments consents for use. LPN C said he/she knows they should be completed prior to putting any assist bars on the residents' bed, but he/she does not know how often they should be updated after that. During an interview on 01/14/26 at 3:00 P.M., the maintenance staff said he/she is new, this is his/her first long-term care maintenance job, and he/she has only been at the facility for three weeks. The maintenance staff said he/she does not know who is responsible to obtain the bed rail consents. During an interview on 01/14/26 at 3:40 P.M., the Director of Nursing (DON) said he/she does not know who is responsible to obtain bed rail consents. The DON said the consent should be updated quarterly with the care plan review. The DON said the bed rail consent should be completed to ensure the resident and/or their responsible party are aware of the risks of using the bed rails, such as a resident getting stuck in one and possibly injured.During an interview on 01/14/26 at 4:00 P.M., the administrator said the charge nurse is responsible to obtain bed rail consents. The administrator said the bed rail consent should be completed quarterly. The administrator said if a consent has not been completed since October 2025, then the facility would be out of compliance.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview, and record review, facility staff failed to remove and discard discontinued medication and improperly labeled medication from one of three medication carts and two of two medication rooms. The facility census was 52.1. Review of the facility's policy titled Injectables and Irrigating Solutions, undated, showed all multiple dose vials shall be dated and initialed upon opening. Once the seal is broken and punctured on Insulin, it shall be discarded after 28 days.Review of the facility's policy titled Medications, Storage of, undated showed all medications must be stored at or near the nurse's station in a locked cabinet, a locked medication room, or a locked mobile medication cart. No discontinued or outdated biologicals may be retained for use.2. Observation on 01/12/26 at 1:30 P.M., showed the supply room contained one bottle of Vitamin E 180 milligrams (mg) with an expiration date of 09/25.3. Observation on 01/12/26 at 1:30 P.M., showed the 100/200/300 medication room contained:-One opened vial of Tuberculosis (TB) solution open and undated; -One opened bottle of Lorazepam 2 mg/milliliter (ml) for Resident #59 in a cup not labeled by the pharmacy;-One opened bottle of Lorazepam 2 mg/milliliter (ml) for Resident #63 in a cup not labeled by the pharmacy.4. Observation on 01/12/26 at 1:30 P.M., showed the 100/300 hall medication cart contained:-One bottle of Mylanta with an expiration date of 07/25;-One bottle of Aspirin 325 mg with an expiration date of 10/25;-One Lispro Insulin pen open and undated;-One Lantus Insulin pen open and undated;-Two Lispro Insulin pens open and undated;-One Tresiba Insulin pen open and undated;-One Lantus Insulin pen open and undated;-One Aspart Insulin pen open and undated.5. During an interview on 01/12/26 at 2:10 P.M., Registered Nurse (RN) F said staff are expected to date medications when opened. RN F said all Insulin pens and TB solution should be dated when opened. RN F said the staff member who opens the medications is responsible to date the medication. RN F said he/she does not know why the medications were not dated when opened but should have been. RN F said all staff are expected to check expiration dates prior to administering medications to a resident. RN F said staff should never give a resident an expired medication. RN F said expired medications should be removed and destroyed when found. During an interview on 01/14/26 at 2:13 P.M., Licensed Practical Nurse (LPN) C said whoever opens a medication should date the medication. LPN C said all insulins and TB solutions should be dated when opened. LPN C said it is the responsibility of the staff member administering medications to check for the expiration date prior to administering the medication. LPN C said staff should never give a resident an expired medication. During an interview on 01/14/26 at 3:40 P.M., the Director of Nursing (DON) said he/she expects all insulins and TB solutions to be dated when opened. The DON said whoever opens the medication should date the medication. The DON said all staff administering medication should check the expiration dates prior to administration and should never administer expired medications. The DON said if a medication is expired staff are expected to remove it and properly destroy it. The DON said he/she was new to the position. During an interview on 01/14/26 at 4:00 P.M., Administrator A said whoever opens a medication should date the medication. Administrator A said he/she expects all insulins and TB solutions to be dated when opened. Administrator A said all staff administering medication should check the expiration date prior to administering a medication and should never give a resident an expired medication. Administrator A said if a medication is expired staff are expected to remove it and properly destroy it. Administrator A said he/she was new to the position.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, facility staff failed to use appropriate hand hygiene to prevent the spread of bacteria for two residents (Resident #14 and #13) out of two sampled residents. Facility Staff failed to use enhanced barrier precautions (EBP) (an infection control practice that requires staff to wear personal protective equipment (PPE), gowns, gloves, and/or eye protection), and/or failed to have EBP signs posted for two residents (Resident #13 and #51) out of five sampled residents. Facility staff failed to ensure sanitary conditions for a urinary drainage bag (a container to hold urine) when staff failed to keep the container off the floor for one resident (Resident #16) out of two sampled residents. The Facility census was 52. 1. Review of the facility policy titled, Handwashing, undated, showed the policy did not contain direction for staff on when to wash hands while performing resident care.Review of the facility policy titled, Enhanced Barrier Precautions to Infection Control Guidance, dated March 2024, showed the purpose is to prevent broader transmission of Multidrug-resistant organisms (MDRO), a germ that is resistant to many antibiotics) and to help protect patients with chronic wounds and indwelling devices. EBP should be implemented for the period of their stay or until wounds have resolved or indwelling medical devices have been removed. Residents who require EBP are residents with an indwelling medical device including the following: central venous catheter, urinary catheter, feeding tube, tracheostomy, and residents with a wound, regardless of their MDRO status. Use EBP when providing high-contact resident care activities such as bathing/showering, transferring residents from one position to another, providing hygiene, changing bed linens, changing briefs or assisting with toileting, caring for or using an indwelling medical device, and performing wound care. Gloves and applying and removing of gown are required when conducting high-contact resident care activities that are listed above. The policy did not contain direction for EBP signage. 2. Observation on 01/12/26 at 8:31 A.M., showed Nurse Assistant (NA) J entered resident #14's room, did not wash his/her hands and applied gloves. The NA assisted the resident to bed, wiped the resident's face, removed his/her gloves, gave the resident a drink, and left the resident's room without washing his/her hands. During an interview on 01/13/26 at 9:27 A.M., NA J said he/she usually uses hand sanitizer before going in a resident room when exiting the room. He/She said he/she forgot to sanitize his/her hands before he/she left the room. He/She said not performing hand hygiene is an infection control issue. 3. Review of Resident #13's Quarterly Minimum Data Set (MDS), a federally mandated assessment tool dated 10/31/25, showed staff assessed the resident with severe cognitive impairment and did not have an indwelling urinary catheter.Review of resident's medical record showed staff documented the resident returned from the hospital on [DATE] with a urinary catheter in place.Observation on 01/11/26 at 11:17 A.M., showed the resident in bed. A catheter bag hung on the side of the bed. The room did not have an EBP sign to alert staff of needed PPE.Observation on 01/12/26 at 8:26 A.M., showed the resident in bed. A catheter bag hung on the side of the bed. The room did not have an EBP sign to alert staff of needed PPE.Observation on 01/13/26 at 8:43 A.M., showed Certified Nurse Assistant (CNA) L and CNA A entered Resident #13's room to perform catheter care. CNA A did not wash hands before he/she applied gloves. Staff assisted the resident to bed. CNA L removed his/her gloves, did not wash hands, and put on a clean pair of gloves. CNA L performed frontal perineal care and catheter care, removed gloves, did not wash hands, reapplied a clean pair of gloves and performed posterior perineal care. CNA L and CAN A did not wear gowns during resident care. During an interview on 01/13/26 at 8:55 A.M., CNA L said he/she should have performed hand hygiene between gloves changes. He/She said he/she didn't think about it and didn't have any hand sanitizer handy at the time. The CNA said he/she should have followed EBP and worn a gown during the resident's care, but he/she did not. He/She said there is usually a sign on the door that alerts staff that a resident requires EBP. He/She said it's infection control concern not to use the appropriate PPE and not perform adequate hand hygiene. During an (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	interview on 01/13/26 at 9:21 A.M., CNA A said he/she should have performed hand hygiene before he/she put gloves on. He/She said he/she realizes he/she should have worn a gown during care, but he/she did not think about it. He/She said there is usually an EBP sign on the door to alert staff. He/She said residents with wounds and catheters require EBP during cares. 4. Review of Resident #51's Annual MDS, dated [DATE], showed staff assessed the resident as cognitively intact, and does not receive dialysis (life-sustaining treatment for kidney failure that filters waste). Review of the resident's care plan, revised 10/29/25, showed staff documented the resident required dialysis three times a week, was at risk for infection due to a dialysis shunt (a surgically created connection between an artery and a vein, typically in the arm, designed to provide high-volume blood flow for effective dialysis), and did not contain direction for EBP.Review of the resident's POS, dated 01/11/26, showed and order dated 07/12/24 for dialysis on Monday, Wednesday and Friday. Observation on 01/11/26 at 11:30 A.M., showed the resident's room did not have EBP signage. Observation on 01/12/26 at 08:15 A.M., showed the resident's room did not have EBP signage. Observation on 01/13/26 at 8:13 A.M., showed the resident's room did not have EBP signage. Observation on 01/14/26 at 11:10 A.M., showed the resident's room did not have EBP signage. During an interview on 01/12/26 at 8:15 A.M., NA H said the resident was at dialysis. During an interview on 01/12/26 at 12:15 P.M., Licensed Practical Nurse (LPN) C said the resident goes to dialysis three times a week. During an interview on 01/14/26 at 2:13 P.M., LPN C said he/she has been at the facility a couple of months and has not had EBP training. LPN C said he/she does not know what EBP is used for. LPN C said he/she does not know who is responsible to place the EBP signs on resident doors. During an interview on 01/14/26 at 3:40 P.M., the Director of Nurse (DON) said it is the responsibility of the charge nurse, the Assistant Director of Nursing (ADON) and himself/herself to ensure EBP signs are placed on the doors of the residents who require EBP. The DON said EBP are for residents who have wounds, catheters, receive tube feeding, have a colostomy, and receive dialysis. The DON said the EBP signs should be used to direct staff when they need to use the precautions. The DON said if there is not a sign on the door the staff may not know what Personal Protective Equipment (PPE) is required. During an interview on 01/14/26 at 4:00 P.M., administrator A said the ADON is responsible to ensure the EBP signs are placed on the doors of the residents who require EBP. Administrator A said he/she was aware some of the residents who required EBP did not have signs on their doors. Administrator A said the ADON has been attempting to get the signs placed for those who require it but had not got them all placed yet. 5. Review of the facility policy titled, Catheter, emptying a urinary drainage bag, undated, directed staff to keep the drainage bag and tubing off the floor at all times to prevent contamination and damage. 6. Review of Resident #16's admission MDS, dated [DATE], showed staff assessed the resident with severe cognitive impairment and has an indwelling urinary catheter. Review of the resident's care plan, revised 12/02/25, showed the resident required an indwelling urinary catheter. Review of the resident's Physician's Order Sheet (POS), dated 01/11/26, showed:-11/06/25: Catheter care every shift;-12/05/25: Catheter change monthly on the 25th. Observation on 01/11/26 at 11:34 A.M., showed the resident in bed with his/her urinary catheter bag on the floor. Observation on 01/11/26 at 3:16 P.M., showed the resident in bed. The resident's urinary catheter bag hung on the side of the bed and touched the floor. Observation on 01/13/26 at 8:11 A.M., showed the resident in bed. The resident's urinary catheter bag hung on the side of the bed and touched the floor. Observation on 01/14/26 at 8:10 A.M., showed the resident in bed. The resident's urinary catheter bag hung on the side of the bed and touched the floor. During an interview on 01/14/26 at 2:13 P.M., LPN C said a catheter bag should never touch the floor. LPN C said if a catheter bag touches the floor, it can cause contamination and an infection. LPN C said he/she did not know the resident's catheter bag had touched the floor. LPN C said staff should ensure there is always a barrier between the catheter bag and the floor.During an interview on 01/14/26 at 3:40 P.M., the DON said a resident's catheter bag should never touch the floor. The DON said this could cause contamination of the bag which could lead to the resident getting an infection. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The DON said staff should ensure there is always a barrier between the catheter bag and floor. During an interview on 01/14/26 at 4:00 P.M., Administrator A said a resident's catheter bag should never touch the floor. Administrator A said if a catheter bag touches the floor, it can cause a resident to get an infection due to contamination. Administrator A said he/she was not aware the catheter bag had touched the floor.

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F 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Regularly inspect all bed frames, mattresses, and bed rails (if any) for safety; and all bed rails and mattresses must attach safely to the bed frame. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, facility staff failed to complete entrapment assessments for six residents (Resident #3, #7, #8, #27, #38, and #50) who used bed rails out of 21 sampled residents. The facility census was 52. 1. Review of the facility's policy titled Bed Rails, undated, showed when installing or maintaining bed rails, staff should follow manufacture's recommendations and specifications for applicable bed rails, mattresses, and bed frames. Staff will conduct regular inspections of all bedframes, mattress, and bed rails, to identify possible entrapment.2. Review of Resident #3's Quarterly Minimum Data Set (MDS), a federally mandated assessment tool, dated 10/30/25, showed staff assessed the resident as cognitively intact and restraints not used.Review of the resident's care plan, revised 10/20/25, showed staff documented the resident to use bilateral grab bars on the bed to assist with repositioning and transfers. Review of the resident's medical record did not contain an entrapment assessment.Observation on 01/11/26 at 1:30 P.M., and 3:14 P.M., showed the resident's bed with bilateral grab bars.Observation on 01/12/26 at 2:22 P.M., showed the resident in bed with bilateral grab bars in the upright position on the bed.Observation on 01/13/26 at 2:05 P.M., showed the resident in bed with bilateral grab bars in the upright position on the bed. 3. Review of Resident #7's admission MDS, dated [DATE], showed staff assessed the resident as Cognitively intact and restraints not used.Review of the resident's care plan, dated 10/03/25, showed it did not contain direction for the use of grab bars. Review of the POS, dated 01/11/26, showed it did not contain orders for the use of grab bars. Review of the resident's medical record showed the record did not contain entrapment measurements. Observation on 01/11/26 at 12; 45 P.M., showed the resident in bed with the right grab bar in upright position on the bed.Observation on 01/12/26 at 9:56 A.M., showed the resident in bed with the right grab bar in upright position on the bed.Observation on 01/14/26 at 8:11 A.M., showed the resident in bed with the right grab bar in upright position on the bed.4. Review of Resident #8's Quarterly MDS, dated [DATE], showed staff assessed the resident as cognitively intact and restraints not used.Review of the resident's care plan, revised 10/28/25, showed bilateral grab bars on the bed to assist with mobility.Review of the resident's medical record showed the record did not contain entrapment measurements. Observation on 01/11/26 at 11:26 A.M. and 3:15 P.M.,, showed the resident in bed with bilateral grab bars in the upright position on the bed.Observation on 01/12/26 at 8:09 A.M., and 11:35 A.M., showed the resident in bed with bilateral grab bars in the upright position on the bed.Observation on 01/13/26 at 8:09 A.M., and 2:00 P.M., showed the resident in bed with bilateral grab bars in the upright position on the bed.Observation on 01/14/26 at 8:05 A.M., and 11:12 A.M., showed the resident in bed with bilateral grab bars in the upright position on the bed.5. Review of Resident #27's Quarterly MDS, dated [DATE], showed staff assessed the resident as cognitively impaired, required substantial/maximal assistance to roll left to right, sit to lying position, and lying to sitting on side of bed.Review of the resident's medical record showed the record did not contain entrapment measurements. Observation on 01/11/26 at 11:35 A.M., showed the resident in bed with a left assist bar in the upright position on the bed. Observation on 1/12/26 at 9:05 A.M., showed the resident's bed had an assist bar on the left side in the upright position. Observation on 01/14/26 at 8:51 A.M., showed the resident's bed had an assist bar on the left side in the upright position. 6. Review of Resident #38's Quarterly MDS, dated [DATE], showed staff assessed the resident as severely cognitively impaired, dependent on staff for rolling left to right, sit to lying position, and lying to sitting on side of bed.Review of the resident's care plan, revised 12/25/25, showed bilateral grab bars to assist staff with turning from side to side and repositions in bed.Review of the resident's medical record did not contain entrapment measurements. Observation on 1/11/26 at 2:40 P.M., showed the resident in bed with a grab bar in the upright position on the right side of the bed. Observation on 1/13/26 at 2:23 P.M., showed the (continued on next page)

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F 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	resident in bed with a grab bar in the upright position on the right side of the bed.Observation on 1/14/26 at 2:53 P.M., showed the resident in bed with a grab bar in the upright position on the right side of the bed.7. Review of Resident #50's Quarterly MDS, dated [DATE], showed staff assessed the resident as cognitively intact, required supervision or touch assistance for rolling left to right, sitting to lying position, and lying to sitting on side of bed.Review of the resident's care plan, revised 12/25/25, showed bilateral grab bars to assist with self-repositioning and transfers in/out of bed.Review of the resident's medical record showed the record did not contain entrapment measurements. Observation on 01/11/26 at 12:57 P.M., showed the resident in bed with assist bars in the upright position on both side of the bed.Observation on 01/12/26 at 8:25 A.M., showed the resident in bed with assist bars in the upright position on both side of the bed.Observation on 01/14/26 at 8:58 A.M., showed the resident in bed with assist bars in the upright position on both side of the bed.8. During an interview on 01/14/26 at 2:13 P.M., Licensed Practical Nurse (LPN) C said he/she does not know who is responsible to complete the entrapment measurements. LPN C said he/she knows they should be completed when staff initially put any grab bars on the residents' beds, but he/she does not know how often they should be updated. LPN C said if grab bars are not on the bed properly it could cause a resident to get hung in the rail and potentially cause the resident harm. During an interview on 01/14/26 at 3:00 P.M., the maintenance staff said he/she is new, this is his/her first long-term care maintenance job, and he/she has only been at the facility for three weeks. The maintenance staff said he/she does not know who is responsible to complete the entrapment measurements or when the measurements should be completed. He/She said he/she does not complete entrapment measurements when he/she installs the grab bars on the beds. During an interview on 01/14/26 at 3:40 P.M., the Director of Nursing (DON) said he/she does not know who is responsible to complete the bed rail entrapment measurements. The DON said the entrapment measurements should be updated he/she thinks quarterly with the care plan review. The DON said if entrapment measurements are not completed regularly, it could potentially lead to a resident getting stuck in the rail and injured. During an interview on 01/14/26 at 4:00 P.M., Administrator A said he/she does not know who is responsible to complete the entrapment measurements at this facility. Administrator A said the entrapment measurements should be completed and/or updated quarterly. Administrator A said if entrapment measurements have not been completed since October 2025, then the facility is out of compliance. Administrator A said if entrapment measurements are not completed timely a resident could potentially end up getting hung in a bed rail, possibly injured or even die.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. Based on interviews and record review, facility staff failed to initiate and complete a thorough investigation of misappropriation of resident funds which affected one resident (Resident #64) of five sampled. The facility census was 52.1. Review of the facility's policy titled Abuse Prohibition Protocol Manual, undated, showed staff were directed to:-Resident has the right to be free from abuse, neglect, misappropriation of property, and exploitation; -Administrator or designee must report to the state survey agency no later than two hours after an allegation is made;-The facility must take the following actions in response to an alleged violation of abuse, neglect, exploitation, or mistreatment: -Thoroughly investigate the alleged violation; -Prevent further abuse, neglect, exploitation, or mistreatment from occurring while the investigation is in process; -Take appropriate corrective action as the result of the investigation findings.2. Review of Resident #64's Significant Change Minimum Data Set (MDS), a federally mandated assessment tool, dated 04/23/25, showed staff assessed the resident as cognitively intact. Review of the facility's prior abuse and neglect investigations did not contain documentation staff completed an investigation for the misappropriation. Review of Housekeeper O's employee file showed a hire date of 11/13/17 and termination date of 09/16/25. During an interview on 01/13/26 at 9:45 A.M., the detective said he/she had been notified by another officer that the resident's family had reported multiple fraudulent charges on the resident's credit card over an extended period. The detective said Housekeeper O was caught using the resident's credit card at a gas pump and then going inside the gas station and using his/her personal card inside. During an interview on 01/13/26 at 3:30 P.M., Administrator B said he/she worked at the facility until 10/15/25. Administrator B said the facility had not been made aware of any incidents with the resident's credit card until after the resident had been discharged . Administrator B said he/she started an investigation, but he/she did not know what happened to the investigation or if it had been finished. Administrator B said when he/she spoke to Housekeeper O and he/she denied making the fraudulent changes. During an interview on 01/14/26 at 4:00 P.M., Administrator A said he/she did not work at the facility at the time of the incident. Administrator A said he/she started at the facility on 11/03/25. Administrator A said he/she did not know anything about this incident or facility reported incident until the survey team started annual survey. Administrator A said if a report of misappropriation of a resident's money had been made to the facility, he/she would expect the Administrator to complete a detailed investigation, document the investigation, and keep the investigation at the facility. Administrator A said he/she would also expect a facility reported incident to be reported to DHSS timely. Administrator A said a detailed investigation should have been completed to determine if there were any other residents affected and to prevent other residents from being victims. Administrator A said he/she would have expected an all-staff in-service for abuse, neglect, and misappropriation completed at the time of the report as well. Administrator A said the facility discourages residents from keeping valuable in their rooms, and they do have a lock box in the BOM office for residents to lock items up. Complaint #2616438

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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, facility staff failed to provide care, to maintain personal hygiene and grooming for three residents (Resident #5, #16, and #46) out of 21 sampled. The facility census was 52.1. Review of the facility's policy titled Daily Care Needs, undated showed assist a resident to do as much of his/her care needs as possible. Encourage self-care when possible. 2. Review of Resident #5's Quarterly Minimum Data Set (MDS), a federally mandated assessment tool, dated 12/02/25, showed staff assessed the resident with severe cognitive impairment, did not have behaviors or refuse care, and independent with all Activities of Daily Living (ADL's). Review of the resident's care plan, revised 05/21/25, showed staff were directed to monitor facial hair and remove as needed. Observation on 01/11/26 at 11:53 A.M., showed the resident with long facial hair. Observation on 01/12/26 at 8:07 A.M., showed the resident with long facial hair. Observation on 01/13/26 at 8:14 A.M., showed the resident with long facial hair. Observation on 01/14/26 at 8:04 A.M., and 11:14 A.M., showed the resident with long facial hair. 3. Review of Resident #16's admission MDS, dated [DATE], showed staff assessed the resident with severe cognitive impairment, did not have behaviors or refuse care, and required extensive assistance with hygiene, dressing and bathing.Review of the resident's care plan, dated 12/02/25, showed staff documented the resident required assistance from two staff for all ADL's and staff are to provide clean appropriate clothing daily. Observation on 01/11/26 at 11:34 A.M., showed the resident wore a grey sweatshirt and with long facial hair. Observation on 01/12/26 at 8:12 A.M., showed the resident wore the same grey sweatshirt as the day before and long facial hair. Observation on 01/13/26 at 8:11 A.M., and 1:54 P.M., showed the resident wore the same grey sweatshirt he/she had on two days prior and long facial hair. Observation on 01/14/26 at 8:10 A.M., and 11:09 A.M., showed the resident wore the same grey sweatshirt and long facial hair. 4. Review of Resident #46's Quarterly MDS, dated [DATE], showed staff assessed the resident with severe cognitive impairment, did not have behaviors and did not refuse care, independent with dressing and required moderate assistance for hygiene and bathing. Review of the resident's care plan, dated 09/26/25, showed the resident required supervision and assistance by staff for all ADLs. Provide clean appropriate clothing daily.Observation on 01/11/26 at 11:37 A.M., showed the resident wore a green sweatsuit and long facial hair. Observation on 01/12/26 at 8:10 A.M., and 1:30 P.M., showed the resident wore the same green sweatsuit as the day before and had long facial hair. Observation on 01/13/26 at 8:09 A.M., showed the resident wore the same green sweatsuit and had long facial hair. Observation on 01/14/26 at 8:07 A.M., showed the resident wore the same green sweatsuit for three days and had long facial hair. 5. During an interview on 01/14/26 at 2:13 P.M., Licensed Practical Nurse (LPN) C said the aides are responsible to assist the residents to change their clothes and shave. LPN C said the charge nurse is expected to ensure the aides complete the cares for each resident. LPN C said he/she expects a resident to be shaved with his/her shower and as needed. LPN C said he/she expects resident's clothes to be changed every day and as needed when soiled. LPN C said he/she was not aware the resident's clothes were not changed, and they had not been shaved. LPN C said if residents refuse cares another staff member should try and if the resident continues to refuse staff should document the refusals. During an interview on 01/14/26 at 3:40 P.M., the Director of Nursing (DON) said the aides are responsible to assist residents to change their clothes and shave. The DON said the charge nurse is responsible to ensure the aides complete the cares needed for each resident. The DON said he/she expects residents to change their clothes daily and as needed when soiled for their dignity. The DON said staff should assist residents to shave as needed, but especially with the resident's showers. The DON said he/she was not aware the resident's clothes were not changed nor were their faces not shaved The DON said if a resident refuse cares another staff member should make an attempted. The DON said if the resident continues to refuse, he/she expects the staff to document the refusal.During an (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	interview on 01/14/26 at 4:00 P.M., Administrator A said he/she expects staff to assist residents to change their clothes daily and as needed when soiled. Administrator A said a resident should not wear the same clothes for more than one day. Administrator A said the aides are responsible to assist residents to shave when needed and the charge nurse is responsible to ensure the aides complete the care. Administrator A said he/she was not aware the resident's clothes were not changed nor were their faces not shaved Administrator A said if a resident refuse cares another staff member should make an attempted. Administrator A said if the resident continues to refuse, he/she expects the staff to document the refusal. Complaint#: 2652199, 2626155