STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rancho Rehab and Healthcare Center	615 Rancho Lane Florissant, MO 63031

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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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures to prevent abuse, neglect, and theft. 35394 Based on interview and record review, the facility failed to ensure newly hired employees were screened to rule out the presence of a Federal Indicator, with the Certified Nurse Aide (CNA) Registry for five staff members. A sample of eight employees hired were reviewed. The facility hired at least 80 new employees since the last survey. The census was 79. Review of the facility's Staff Screening policy, dated 10/22/24, showed the following: -Policy: The Facility will utilize reasonable and prudent criminal background screening and reference checks for prospective staff, contractors/consultants, registry/temporary staff, and volunteers; -Prior to employment or commencement of a contract, the Facility will verify and document or obtain a copy, if applicable, of the following information that may include, but not limited to: -Previous and/or current employer regarding work history, allegations of abuse against resident, employee or others; -Criminal Background Checks; -National Sex Offender Public Website; -Office of Inspector General (DIG) Exclusion Screening; -State exclusion screening, if applicable; -Current Licenses and Certifications; -References; -Disclosure of information (i.e., self-disclosure of any criminal convictions or actions that exclude them from any government healthcare program; (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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-The Facility will not employee or engage with an individual who has been found guilty of abuse, neglect, exploitation, or mistreatment or misappropriation of property by a court of law or who has a finding in the state nursing aide registry concerning abuse, neglect, exploitation, mistreatment of residents or misappropriation of resident property, or has had a disciplinary action in effect taken again his/her professional license. 1. Review of Employee's D's file, showed the following: -Hire date: 9/4/24; -No CNA registry check performed. 2. Review of Employee's C's file, showed the following: -Hire date: 10/3/24; -No CNA registry check performed. 3. Review of Employee B's file, showed the following: -Hire date: 12/23/24; -No CNA registry check performed. 4. Review of Employee A's employee file, showed the following: -Hire date: 1/12/25; -No CNA registry check performed. 5. Review of Employee's E's file, showed the following: -Hire date: 1/22/25; -No CNA registry check performed. 6. During an interview on 3/11/25 at 12:00 P.M., the Human Resources employee said he/she is responsible for completing the employee background check upon hire. He/She was unaware of the CNA registry check. 7. During an interview on 3/11/25 at 3:41 P.M., the Administrator said Human Resources completes the background checks and if something triggers, management should be notified. She expected the CNA registry to be checked upon hire.

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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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35394 Based on interview and record review, the facility failed to ensure two residents received an accurate assessment, reflective of the residents' status at the time of assessment, by failing to identify the residents' dialysis treatments (Residents #53 and #62). The sample was 18. The census was 79. Review of the facility's Resident Assessment Instrument (RAI) Process policy, dated 10/24/22, showed: -Purpose: To ensure that the Resident Assessment Instrument is used, in accordance with specified format and timeframes, in conducting comprehensive assessments as part of an ongoing process through which the facility identifies each resident's preferences and goals of care, functional and health status, strengths and needs, as well as offering guidance for further assessment once problems have been identified; -The facility will utilize the Resident Assessment Instrument process as the basis for the accurate assessment of each resident's functional capacity and health status, as outlined in the Center for Medicare and Medicaid Services (CMS) RAI Minimum Data Set (MDS, a federally mandated assessment instrument completed by facility staff) 3.0 Manual; -The assessment process must include direct observation and communication with the resident, as well as communication with licensed and non-licensed direct care staff members on all shifts; -Each resident's assessment will be coordinated by and certified as complete by a registered nurse, and all individuals who complete a portion of the assessment will sign and certify to the accuracy of the portion of the assessment he or she completed; -All information recorded within the MDS Assessment must reflect the resident's status at the time of the Assessment Reference Date (ARD). 1. Review of Review #53's medical record, showed a diagnosis of acute renal failure. Review of the resident's quarterly MDS, dated [DATE], showed: -Diagnosis included renal failure; -Special treatments and programs: Dialysis was not documented. Review of the resident's Physician's Orders Sheet (POS), dated March 2025, showed: -An order, dated 12/29/23, dialysis location, Monday, Wednesday, Friday at 5:30 chair time, first day of treatment 1/3/24; -An order, dated 12/29/23, for regular diet, regular texture, liberal renal diet, no bananas or orange juice; (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-An order, dated 10/3/24, enhanced barrier precautions related to dialysis; -An order, dated 10/29/24, to monitor bruit (swooshing sound heard with a stethoscope) and thrill (vibration felt by palpation), signs and symptoms of infections, bleeding every shift; -An order, dated 2/7/25, to monitor dialysis site dressing for drainage, bleeding, or signs and symptoms of infection. Check bruit and thrill every shift. Report any drainage, bleeding or signs and symptoms of infection to dialysis provider and primary physician; -An order, dated 2/7/25, to monitor vital signs before and after dialysis treatment. Complete communication form, send with resident, collect form upon resident return. Report any abnormalities to dialysis provider and primary physician two times a day, every Monday, Wednesday and Friday. Review of the resident's care plan, in use during survey, showed: -Focus: Resident has renal failure and on dialysis at dialysis location on Monday, Wednesday, and Friday, 5:30 chair time; -Goal: Resident will have no signs and symptoms of complications related to fluid overload; -Interventions: Dietary consult to regulate protein and potassium intake; -Give medications as ordered by physician; -Monitor lab reports of electrolytes and report to physician. 2. Review of Resident #62's quarterly MDS, dated [DATE], showed: -admitted to the facility: 11/28/23; -Diagnoses included stroke, end stage renal disease (ESRD, chronic irreversible kidney failure), heart failure, diabetes; -Special treatment and services received while a resident: Dialysis, left blank. Review of the resident's physician order sheet, dated 3/7/25 showed an order for dialysis on Mondays, Wednesdays, and Fridays with a chair time at 11:00 A.M., start date 11/28/23. Review of the resident's care plan, showed: -Problem: Resident needs hemodialysis related to chronic kidney disease, end stage renal disease, dependence on renal dialysis at a local dialysis center. An outside contracted transportation company is used to transport the resident who attends Mondays, Wednesdays, and Fridays with a chair time of 11:00 A. M.; -Goal: Resident will have no signs or symptoms (s/sx) of complications from dialysis through the review date; (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Interventions included: Do not draw blood or take blood pressure in arm with graft. Monitor for dry skin and apply lotion as needed. Monitor labs and report as needed (PRN) any s/sx of infection to access site: Redness, swelling, warmth or drainage. Monitor/document/ report PRN for s/sx of the following: Bleeding, hemorrhage, bacteremia (infection in the blood), septic shock. Monitor/document/ report PRN new/worsening peripheral edema (is a condition of abnormally large fluid volume in the circulatory system or in tissues between the body's cells (interstitial spaces)). Work with the resident to relieve discomfort for side effects of the disease and treatment (cramping, fatigue, headache, itching, anemia, bone demineralization, body image change and role disruption.) 3. During an interview on 3/11/25 at 12:35 P.M., the Director of Nursing (DON) and Regional Nurse Consultant said the Administrator and regional corporate staff were responsible for completing the MDS at this time. The facility does not have an MDS Coordinator. The DON would expect the MDS to be accurate. 4. During an interview on 3/11/25 at 3:31 P.M., the Administrator said she would expect all resident MDS assessments to be accurate. 40291

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35394 Based on observation, interview and record review, the facility failed to ensure the physician orders were accurately recorded and updated for three sampled residents (Residents #46, #18 and #6) out of 18 sampled residents. The facility failed to serve Resident #46 with physician ordered double portions. The facility also failed to ensure oxygen tubing was dated and oxygen equipment was covered per infection control standards for Resident #18. In addition, the facility failed to obtain documentation of Resident #18's cardiology progress notes from the most recent appointment when Resident #18 received a blood pressure machine that reported results directly to the cardiologist. The facility also failed to ensure Resident #6's neurological checks (medical assessments used to evaluate the function and health of the nervous system) were completed and maintained in the medical record. The census was 79. Review of the facility's Physician's Orders policy, dated 10/24/22, showed: -Purpose: This will ensure that all physician orders are complete and accurate; -Policy: The Medical Records Department will verify that physician orders are complete, accurate and clarified as necessary; -Telephone Orders: A Licensed Nurse will record telephone orders on the telephone order sheet with the date, time and signature of the person receiving the order or in the Electronic Health Record (EHR); -The Medical Record Department staff mails an original copy to the physician promptly for signature; -The order is transcribed onto the Physician's Order Form at the time the order is taken; -A copy of the Physician Order form that was sent to the Attending Physician is maintained in the medical record until the form signed by the physician is returned; -Once the signed copy is returned to the Facility, it is taped to the telephone order sheet in the resident's medical record by the Medical Record Department staff; -The copy is then removed from the medical record by the Medical Record Department staff and destroyed; -Physician orders will include the following: Name of the prescriber; -The name of the resident; -The date and time the order was received; -The signature of the Licensed Nurse receiving and documenting the order, if by telephone; (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Medication orders will include the following: Name of the medication; -Dosage; -Frequency; -Duration of order; -The route and the condition/diagnosis for which the medication is ordered, if applicable; -Other orders will include a description complete enough to ensure clarity of the physician's plan of care; -Physician orders will only include abbreviations that have been approved by the Facility; -Whenever possible, the Licensed Nurse receiving the order will be responsible for documenting and implementing the order. Review of the facility's Oxygen Administration policy, dated 10/24/22, showed: -Initiation of Oxygen: A physician's order is required to initiate oxygen therapy, except in an emergency situation. The order shall include: -Oxygen flow rate; -Method of administration (e.g. nasal cannula); -Usage of therapy (continuous or PRN); -Titration instructions (if indicated); -Indication for use; -In an emergency situation or when a physician's order cannot be immediately obtained, oxygen may be initiated by a Licensed Nurse in the presence of acute chest pain or any other acute situation in which hypoxia is suspected; -A physician is to be contacted as soon as possible after initiation of oxygen therapy in emergency situations, for verification and documentation of the order for oxygen therapy consultation, and further orders; -Infection Control: All oxygen tubing, humidifiers, masks, and cannulas used to deliver oxygen: -Are for single resident use only; -Will be changed weekly and when visibly soiled, or as indicated by state regulation. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Oxygen items will be stored in a plastic bag at the resident's bedside to protect the equipment from dust and dirt when not in use. 1. Review of Resident #46's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 2/10/25, showed: -Cognitively intact; -Diagnoses included malnutrition; -Weight: 93 pounds; -Loss of 5% or more in the last month or loss of 10% or more in the last six months: No or unknown. Review of the resident's medical record, showed a diagnosis of severe protein-calorie malnutrition and body mass index (BMI) 19.9 or less (normal BMI, 18.5 and 24.9). Review of the resident's care plan, in use during survey, showed: -Focus: Resident has potential nutritional problem and has a diagnosis of malnutrition with interventions in place; -Goal: Resident will maintain adequate nutritional status as evidenced by maintaining weight within 5% of (specify baseline), no signs and symptoms, and consuming at least 50% of at least two meals daily; -Interventions: Encourage intake at meal times to assist in weight maintenance 10/4/24; -Weigh per facility protocol; -Registered Dietician to evaluate and make diet change recommendations as needed. Review of the resident's electronic Physician's Orders Sheet (ePOS), dated March 2025, showed an order, dated 3/26/24, for double portions at every meal. Review of the resident's progress notes, showed: -On 2/17/24, resident remains on weekly weights. Updated weight: 94.8 pounds. This is a 1.4 pound increase since last assessment. Registered Dietician (RD) recommended double portions last assessment. Will recommend again. Continue with house supplement and health-shake. Meal intakes vary between 0-100%, most documented at 51-100%. Continue with weekly weight checks. RD will continue to follow as needed (PRN); -On 2/27/25, resident with 11% weight loss since September 2024. Weight 105.2 pounds, down now to 93.6 pounds. Weight up and down a pound or so this month. Continues a regular diet with heath shake at meals and house supplement at bedtime. Also getting double portions at meals. Continues mirtazapine for appetite stimulation. Intakes have been 25-100% of meals lately. Will continue current interventions and double portions. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 3/5/25 at 12:14 P.M., showed the resident in his/her room, assisted by staff with eating. He/She did not receive double portions. Observation and interview on 3/10/25 at 11:40 A.M., showed the resident in his/her room, assisted by staff with eating. The resident's meal ticket showed regular diet. Double portion was not documented on the meal ticket. During an interview at 11:57 A.M., Certified Nurse Aide (CNA) BB said the resident received regular diet with regular portions. During an interview on 3/11/25 at 12:35 P.M., the Director of Nursing (DON) and Regional Corporate Consultant said if there are diet order changes, the DON communicates to the Dietary Manager. The resident's diet order change to double portions was communicated to dietary. She expected the resident's diet order to be accurate on the meal time ticket and received as ordered. 2. Review of Resident #18's quarterly MDS, dated [DATE], showed: -Cognitively intact; -Diagnoses included anemia, coronary artery disease (CAD, blocked or narrowed arteries), heart failure, hypertension (high blood pressure), renal failure, neurogenic bladder (condition that affects the bladder's ability to function properly), urinary tract infection, diabetes, hyperkalemia (high potassium levels in the blood), hyperlipidemia (high level of lipids in the blood), hemiplegia (paralysis or weakness on one side of the body), seizure disorder, malnutrition, asthma and respiratory failure; -Administered anticoagulants; -Received continuous oxygen. Review of the resident's care plan, in use during survey, showed: -Focus: Resident has heart failure, CAD, and hypertension (high blood pressure); -Goal: Resident will be free of peripheral edema (accumulation of fluid causing swelling in tissues perfused by the peripheral vascular system, usually in the lower limbs); -Interventions: Give cardiac medications as ordered; -Monitor/document/report as needed (PRN) any signs and symptoms of congestive heart failure. Review of the resident's Medication Administration Record (MAR), dated March 2025, showed the following orders and administration: -An order, dated 1/5/25, change all oxygen tubing weekly on Sunday was documented as completed on 3/2 and 3/9/25; -An order, dated 3/9/25, clean C-Pap machine, tubing, and mask with soap and water, every night shift, every Sunday was documented as completed on 3/9/25. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the resident's progress notes, showed on 1/24/25, resident has a heart/vascular appointment on 1/28/25 at 12:45 P.M. Observation and interview on 3/6/25 at 2:53 P.M., showed the resident in bed with continuous oxygen. Oxygen was set at 2 liters (L) per nasal cannula. The oxygen tubing was not dated. The resident had a C-Pap machine and blood pressure machine on the night table. The C-Pap mask was uncovered. Observation and interview on 3/7/25 at 12:51 P.M., showed the resident in his/her room, eating his/her meal. The C-pap mask was on the night table, uncovered. The mask fell on the floor during observation. His/Her continuous oxygen was set at 2L per nasal cannula. The oxygen tubing was not dated. The resident said he/she had a blood pressure machine he/she received from the cardiologist during the January 2025 appointment. He/She was supposed to take his/her blood pressure and the results are sent to the cardiologist. They took the blood pressure once when he/she first received the blood pressure machine. Review of the resident's medical record, showed no documentation of the resident's heart/vascular appointment, blood pressure machine or instructions for usage. Review of the resident's progress notes, showed no further documentation of the resident's heart/vascular appointment on 1/28/25 through 3/9/25. During an interview on 3/11/25 at 12:35 P.M., the DON and Regional Corporate Consultant said they expected medical records to be accurate and complete. If a resident goes to an outside appointment, they expected staff to document it and save the documentation in the medical record if received. It depends on where they are going and what is being done. The progress notes from the outside physician are expected to be in the medical record. It is important for the facility to document outside medical visits and treatment plans so they can follow up with a plan. Missing documentation from an outside provider could impact the continuity of care. They expected staff to follow physician's orders. 4. Review of Resident #6 quarterly MDS, dated [DATE], showed: -Severe cognitive impairment; -Set-up help only with eating -Independent with bed mobility; -Walking not attempted due to medical condition; -Diagnoses included heart disease, hypertension, hyperlipidemia, diabetes, peripheral vascular disease (PVD, poor circulation), dementia, malnutrition and depression. Review of the resident's fall risk assessments showed: -8/2/24, score was 13: The resident was a moderate fall risk; -8/20/24, score was 13; The resident was a moderate fall risk; (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-9/19/24, score was 15; The resident was a high fall risk; -9/24/24, score risk 19; The resident was a high fall risk. -10/17/24, score risk 7: The resident was a moderate fall risk. Review of the resident's progress notes, dated 9/24/24 at 1:12 P.M., showed the resident had an unwitnessed fall. Upon assessment, the resident was noted to be sitting upright in bed. The resident had a bloody mouth laceration to top and bottom lip. The resident also had had bruising and swelling to left cheek and discoloration near his/her left eye. Resident denied any pain. Resident stated he/she had fell out of his/her chair. He/She didn't go back. Vitals (VS) was taken and was within normal limits. Call placed to the Physician and responsible party, no answer. Nurse was awaiting return call. Resident placed on neuro checks for further monitoring. Resident rested in bed at that time. No other injuries noted at that time. Resident had call light and fluids within reach. Review of the neurological flow sheet, dated 9/19/24, showed one out of 14 opportunities to document neuro checks left blank. Review of the resident's progress notes, dated 9/19/24 at 3:08 P.M., showed the resident has had two falls this day. The resident was attempting to stand and transfer him/herself from the wheelchair and was unable to complete the transfer him/herself and this resulted in a fall. The resident had been educated and advised to ask for assistance with any transfers and resident had verbalized understanding. Call placed to the resident's family member to notify, answered following questions and concerns and the nurse was thanked for the call. The resident was noted to have no apparent injury. The call light remained within reach; no further concerns noted. Placed a call to the physician to notify and received new orders for labs. Lab requisition completed. Review of the neurological flow sheet, dated 9/24/24, showed four out of 14 opportunities to document neuro checks were left blank. During an interview on 3/10/25 at 11:08 A.M., Licensed Practical Nurse (LPN) A said if a resident fell , he/she would assess the resident and complete the fall risk assessment. If the fall was unwitnessed or if the resident hit their head, neuro checks should be completed every shift for three days. Neuro checks are completed on paper. MO00247075 MO00250058 MO00249603 40291

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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** 40291 45083 Based on observation, interview and record review, the facility failed to provide activities of daily living (ADL) care for three residents by failing to ensure one resident received his/her showers as scheduled (Resident #38) and failed to ensure residents were clean and odor free (Residents #38, #2 and #6). The sample was 18. The census was 79. 1. Review of Resident #38's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 2/27/25, showed: -Cognitively intact; -Required substantial/maximal assistance with shower/bath; -Required set-up or clean assistance with personal hygiene; -Occasional urinary incontinence; -Frequent bowel incontinence; -Diagnoses included heart disease, high blood pressure, traumatic brain injury, anxiety disorder and manic depression. Review of the resident's care plan, in use at time of survey, showed: -Focus: Resident has an ADL self-care performance deficit; -Goal: Resident will maintain current level of function in ADLs; -Interventions: Limited assist in bathing/showering, bed mobility, dressing, oral care, toilet use, and transfer. Observation and interview on 3/5/25 at 12:50 P.M., showed the resident had a strong urine and body odor. The resident said he/she was supposed to have showers twice a week, on Mondays and Thursdays during the day shift, but did not have one on Monday, 3/3/25 due to a towel shortage. Observation and interview on 3/7/25 at approximately 1:30 P.M., showed the resident's hair was greasy and he/she continued to have strong body odor. He/She said he/she did not get a shower the day prior, 3/6/25. During an interview on 3/11/25 at 9:27 A.M., the resident said he/she received a shower on Monday, 3/10/25. He/She said he/she had a shower because there were state surveyors in the facility. He/She said it was an ongoing issue where staff did not provide showers and sometimes with no reasons explained. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of resident's record, showed no shower sheets for 3/3/25 and 3/6/25. During an interview on 3/10/25 at 10:50 A.M., Certified Nurse Aide (CNA) I said the resident was compliant with showers. He/She said no resident missed their showers due to towels or linens shortage. He/She said the CNAs were responsible for providing the showers. Showers are given two to three times a week. If a resident refused his/her shower, CNA I would tell the nurse, document it in the chart and write it on the shower sheet. 2. Review of Resident #2's quarterly MDS, dated [DATE], showed: -Severe impairment; -Dependent on staff with shower/bath, personal hygiene, and toileting; -Always incontinent of bladder and bowel; -Rejection of care: behavior not exhibited; -Diagnoses included diabetes, seizure disorder, traumatic brain injury and malnutrition. Review of the resident's care plan, in use at time of survey, showed: -Focus: Resident has an ADL self-care performance deficit; -Goal: Resident will maintain current level of function through the review date; -Interventions: Resident requires dependent assist by staff with bathing, bed mobility, eating, dressing, personal hygiene, toilet use, and transfers. Observation on 3/10/25 at 11:34 A.M., showed the resident sat in his/her Broda chair (positioning chair), on top of a Hoyer pad (mechanical lift pad). His/Her disposable brief was heavily soiled, and shredded in multiple spots. A strong urine and body odor emanated from the resident. During an interview on 3/11/25 at 12:32 P.M., CNA FF said he/she was the resident's assigned staff that day. Yesterday, the resident's Hoyer pad smelled horribly like urine, so he/she changed the pad. The resident pulls on his/her clothes as well as his/her briefs and tears his/her briefs. CNA FF said the resident should be clean and odor free. 3. Review of Resident #6's quarterly MDS, dated [DATE], showed: -Severe impairment; -Required substantial/maximal assistance with shower/bath; -Required supervision with personal hygiene; -Required partial/moderate assistance with toileting; (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Rejection of Care: Behavior of this type occurred one to three days; -Occasionally incontinent of bladder; -Frequently incontinent of bowel; -Diagnoses included heart disease, high blood pressure, high cholesterol, peripheral vascular disease (PVD, poor circulation), diabetes, dementia and depression. Review of the resident's care plan, in use at time of survey, showed: -Focus: Resident has an ADL self-care performance deficit related to dementia and weakness; -Goal: Resident will maintain current level of function through the review date; -Interventions: Limited assist in bathing/showering and personal hygiene. Supervision with bed mobility, dressing, eating, toilet use, and transfer. Observations, showed: -On 3/7/25 at 10:15 A.M., the resident sat on his/her bed. A strong urine and body odor was noted; -On 3/10/25 at 3:15 P.M., the resident sat on his/her bed. A strong urine and body odor was noted; -On 3/11/25 at 10:54 A.M., the resident lay on his/her bed. A strong urine and body odor was noted; -On 3/11/25 at 12:20 A.M., the resident laid on his/her bed. A strong urine and body odor was noted. A heavily soiled bed mat was thrown across the foot rail of the resident's bed. It was covered with deep yellows spots/stains. Some appeared to be wet as well as dry. During an interview on 3/11/25 at 12:20 P.M., CNA OO said he/she worked the day shift. He/She was familiar with the resident and worked with him/her but was not assigned to him/her today. He/She said the room smelled like strong urine. CNA OO pointed to the bed mat, and said the smell could have possibly came from it. He/she said he/she would not touch it with his/her bare hands because it may not have been clean. The resident gets his/her showers, but most of the times, he/she refused them. The resident's favorite line was that his/her family member would be there and they would do it. The resident could dress him/herself so sometimes he/she may get something out of his/her dirty linen and put it back on. The linen is changed at least twice a week when the residents are showered on shower days and when they are messed up. During an interview on 3/10/25 at 11:08 A.M., Licensed Practical Nurse (LPN) A said residents get showers twice a week. If a resident refused their showers, he/she would notify the Assistant Director of Nursing (ADON), document it on the shower sheet and notify the family. During an interview on 3/10/25 at 12:08 P.M., LPN B said residents receive showers twice a week. If a resident refused, he/she would document it and notify the physician and family. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	4. During an interview on 3/11/25 at 3:41 P.M., the Director of Nursing (DON) said she expected residents to be clean, dry and odor free. She was not aware of any issues with towels not being available. She expected residents to receive a shower at least twice a week.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 35394 Based on observation, interview and record review, the facility failed to ensure a motorized wheelchair was in working order after it was reported to facility staff that there were broken or missing parts (Resident #29). The sample was 18. The census was 79. Review of the facility's Maintenance Work Orders policy, dated 10/24/22, showed: -Purpose: To protect the health and safety of residents, visitors, and Facility Staff; -Policy: Maintenance work orders shall be completed in an effort to sustain maintenance services as a priority; -Procedure: To enable the Maintenance Department to prioritize tasks PE - 02 - Form A - Work Order Form or other similar document will be filled out and forwarded to the Director of Maintenance; -Department directors/supervisors are responsible for completing such work orders and forwarding them to the Director of Maintenance; -Work order requests are reviewed during stand-up meetings; -Emergency requests are given priority; -Emergency requests should be delivered directly to the Director of Maintenance; -The Director of Maintenance will maintain completed Work Orders chronologically in a binder in the Director of Maintenance's office. Review of Resident #29's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 3/4/25, showed: -Cognitively intact; -Impairment on both sides of the lower and upper extremity; -Uses motorized wheelchair; -Diagnoses of neurogenic bladder, wound infection, paraplegia and malnutrition. Review of the resident's care plan, in use during survey, showed: -Focus: Resident has limited physical mobility related to paraplegia due to prior gunshot wound; -Goal: The resident will remain free of complications related to immobility, including contractures, thrombus formation, skin-breakdown, fall related injury; (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Interventions: Locomotion: The resident uses a motorized wheelchair independently; -Provide supportive care, assistance with mobility as needed. Document assistance as needed. During observation and interview on 3/10/25 at 11:35 A.M., the resident said he/she wanted his/her wheelchair fixed. He/She reported it to staff in the past two months. The left arm rest was broken off as well as the padding that rests against the back of the left arm. The resident pulled out a large bag of materials that came from the wheelchair. He/She said the parts are in the bag. The right wheel was busted open. There was approximately an 8 inch opening to the back of the wheel, exposing the inside material of the wheel. The resident said the battery does not work. It does not hold a charge. If it is not fully charged before taking it off the charger, the motorized wheelchair will not work or will stop working. It just dies. The resident had the motorized wheelchair for over a year. He/She was shot in the left arm, so he/she has muscle spasms. Since he/she cannot use the left arm rest, he/she had to rest his/her arm on his/her lap. It is uncomfortable. He/She also uses the foot board of his/her bed in place of the left arm rest to aid in positioning or transferring self from wheelchair to bed. The wheel makes the motorized wheelchair wobbly when in use. During an interview on 3/10/25 at 11:45 A.M., Certified Nurse Aide (CNA) CC said he/she reported the wheelchair on the resident's behalf during the time the resident reported it. He/She spoke to therapy, found the manufacturer book, and called them. The manufacturer company said they would only supply parts, not fix it. He/She told therapy what he/she was told, but they did not follow up. During an interview on 3/10/25 at 3:29 P.M., Physical Therapist Assistant (PTA) DD said if a resident had broken parts or missing parts to the wheelchair, they would do an evaluation. Therapy would help as a third party. They can also go to maintenance to see if they are able to help. They can go through Social Services, so they can direct them to a new chair. If the resident was in therapy, they would order it. He/She believed the resident's wheelchair was brought to their attention this past fall or winter. They tried to figure out who the manufacturer was. The resident did not have insurance with therapy. The resident had the wheelchair before he/she was admitted . They did not know who to call about the chair, either the manufacturer or the company that gave him/her the wheelchair, but the resident could not find it and did not have information for them. They tried to get ahold of the company on the resident's behalf. The last director was taking care of it, but he/she was not there anymore. During an interview on 3/11/25 at 3:36 P.M., the Social Services Director said he/she received the manufacturer book from the resident. The resident said it was under warranty and it needed to be fixed. He/She believed maintenance looked at it too, but could not find out what was wrong with it. He/She did not remember the arm rest was broken off and did not remember if it was like that back then. During an interview on 3/11/25 at 7:49 A.M., the Maintenance Director said it was not reported to him the resident had a wheelchair that needed repairs. If a resident needed a repair, they would check to see if the wheelchair was under warranty because he did not want to repair or mess with it if it messes up the warranty. He would also contact corporate to check what he would be able to do and ensure it was safe to make repairs on the wheelchair. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 3/11/25 at 12:35 P.M., the Director of Nursing (DON) said the resident comes to her office and he/she never mentioned anything about his/her wheelchair. The DON never noticed anything wrong with the wheelchair. If a resident needed repairs to their wheelchair, the DON would put it in TELs (web-based technology that helps with various aspects of building operations) and alert maintenance which alerts their phone. It could be therapy or the manufacturer that makes repairs. She expected staff to assist with helping the resident with fixing the wheelchair and give options to the resident on repairing the wheelchair. It is not appropriate for a resident to have a broken wheel or missing arm rests. She expected staff to ensure the resident was safe in the wheelchair. 40291

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35394 40291 Based on interview and record review, the facility failed to ensure residents who received dialysis (procedure to remove waste products and excess fluid from the blood when the kidneys are not working properly) services had written communication with the dialysis center. The facility identified two residents who received dialysis services. Two residents were sampled (Resident #62 and #53), and issues were found with both residents. The sample was 18. The census was 79. Review of the facility's Dialysis Care policy, dated 10/24/22, showed: -Purpose: To provide care for residents diagnosed with renal disease requiring ongoing dialysis treatments; -Policy: -The facility will be responsible for the overall care delivered to the resident, monitoring of the resident prior to and after the completion of each dialysis treatment, and providing all non-dialysis needs of the resident including during the time period when the resident was receiving dialysis; -The facility maintains a contract with a dialysis service provider which addresses communications between the facility and the provider; -The facility will arrange dialysis care for residents as ordered by the attending physician; -Procedure: -Dialysis arrangements: -The facility will arrange for dialysis care for such residents as ordered by the attending physician; -The facility will arrange transportation to and from the dialysis provider, as well as for meals (if necessary), medication administration, and a method of communication between the dialysis provider and the facility; -Communication and Collaboration: -The nursing staff, dialysis provider staff, and the attending physician (dialysis staff) will collaborate on a regular basis concerning the resident's care as follows: -Nursing staff will communicate pertinent information in writing to dialysis staff which may include: (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Any medication changes; -Any recent changes in condition; -The resident's tolerance of dialysis procedures; -The dialysis provider will communicate in writing to the facility: -The resident's current vital signs (blood pressure, pulse, respirations, and temperature); -Pre and post weight; and -Any problems encountered while the resident was at the dialysis provider; -Nursing staff may use NP-225-Form A- Nurse Dialysis communication record to convey information to the dialysis provider; -Documentation: -All documentation concerning dialysis services and care of the dialysis resident will be maintained in the resident's medical record. Review of the facility's Matrix, received on 3/5/25, showed dialysis was not identified for Residents #53 and #62. 1. Review of Resident #62's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 12/25/24, showed: -admitted to the facility: 11/28/23; -Diagnoses included stroke, end stage renal disease (ESRD, chronic irreversible kidney failure), heart failure, diabetes, hypertension (high blood pressure), hyperlipidemia (high cholesterol), hemiplegia, or hemiparesis (muscle weakness or partial paralysis on one side of the body that can affect the arms, legs, and facial muscles); -Special treatment and services received while a resident: Dialysis, left blank; Review of the resident's care plan, in use during the survey, showed: -Problem: Resident needs hemodialysis related to chronic kidney disease, end stage renal disease, dependence on renal dialysis at a local dialysis center. MTM transport and attends Mondays, Wednesdays, and Fridays with a chair time of 11:00 A.M.; -Goal: Resident will have no signs or symptoms (s/sx) of complications from dialysis through; (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Interventions included: Do not draw blood or take blood pressure in arm with graft (permanent access point for dialysis). Monitor for dry skin and apply lotion as needed. Monitor labs and report as needed (PRN) any s/sx of infection to access site: Redness, swelling, warmth or drainage. Monitor/document/ report PRN for s/sx of the following: bleeding, hemorrhage, Bacteremia (bacteria in the blood), septic shock (a life-threatening condition that happens when your blood pressure drops to a dangerously low level after an infection). Monitor/document/report PRN new/worsening peripheral edema (swelling). Work with the resident to relieve discomfort for side effects of the disease and treatment. (Cramping, fatigue, headache, itching, anemia, bone, demineralization, body image change and role disruption.) Review of the resident's physician's order sheet (POS), dated March 2025, showed: -An order, dated 11/28/23, for dialysis on Mondays, Wednesdays, and Fridays with a chair time at 11:00 A.M. ; -An order, dated 11/28/23, to monitor dialysis site right upper chest port dressing for drainage, bleeding, or signs and symptoms of infection. Notify physician of any changes every shift for ESRD. Report any drainage, bleeding or signs and symptoms of infection to dialysis provider and primary physician; -An order, dated 11/28/23, to monitor vital signs daily. Report any abnormalities to dialysis provider and primary physician every day and evening shifts every Monday, Wednesday and Friday. -An order, dated 9/24/24, enhanced barrier precautions related to dialysis; -An order, dated 2/5/25, for regular diet, regular texture, regular consistency. Review of the resident's medical record, showed dialysis communication sheets for the resident for 2/10/25, 3/5/25, and 3/7/25. Further review of the resident's medical record, showed no further written communication with the dialysis center. Review of the resident's progress notes dated 2/26/25 at 1:05 P.M., showed the resident left for dialysis with outside transport company. He/She was in no acute distress prior to transfer. The resident's access showed no signs or symptoms of infection, and no bleeding noted. Dressing to the access at right chest clean and dry. The resident's dialysis paperwork sent with him/her. During an interview on 3/6/25 at 12:38 P.M., the resident said he/she received dialysis treatment three times a week on Mondays, Wednesdays, and Fridays for ESRD. 2. Review of Resident #53's quarterly MDS, dated [DATE], showed: -Diagnosis included renal failure; -Special treatments and programs: Dialysis was not documented. Review of the resident's care plan, in use during survey, showed: (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Focus: Resident has renal failure and on dialysis at dialysis location on Monday, Wednesday, and Friday, 5:30 chair time; -Goal: Resident will have no signs and symptoms of complications relate to fluid overload; -Interventions: Dietary consult to regulate protein and potassium intake; -Give medications as ordered by physician; -Monitor lab reports of electrolytes and report to physician. Notify if serum potassium is over 5.5. Review of the resident's POS, dated March 2025, showed: -An order, dated 12/29/23, for regular diet, regular texture, liberal renal diet, no bananas or orange juice; -An order, dated 12/29/23, dialysis location, Monday, Wednesday, Friday at 5:30 chair time, first day of treatment 1/3/24; -An order, dated 10/3/24, enhanced barrier precautions related to dialysis; -An order, dated 10/29/24, to monitor bruit and thrill, signs and symptoms of infections, bleeding every shift; -An order, dated 2/7/25, to monitor dialysis site dressing for drainage, bleeding, or signs and symptoms of infection. Check bruit and thrill every shift. Report any drainage, bleeding or signs and symptoms of infection to dialysis provider and primary physician; -An order, dated 2/7/25, to monitor vital signs before and after dialysis treatment. Complete communication form, send with resident, collect form upon resident return. Report any abnormalities to dialysis provider and primary physician two times a day, every Monday, Wednesday and Friday. Review of the resident's progress notes, showed: -On 1/15/25, the resident went Leave of Absence (LOA) to dialysis this AM (morning); -On 2/21/25, the resident expressed concerns about his/her trips for dialysis. Social Services called transportation company and made his/her trips to dialysis to be indefinitely. Resident made aware. Review of the resident's medical record, dated 3/1/25 through 3/10/25, showed no dialysis communication sheets for dialysis appointments on 3/3/25, 3/5/25, and 3/7/25. 3. During an interview on 3/7/25 at 1:23 P.M., the Regional Nurse Consultant said if there were no dialysis communication sheets in the medical record, it was not completed. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	4. During an interview on 3/11/25 at 12:35 P.M., the Director of Nursing (DON) and Regional Nurse Consultant said nursing was responsible for ensuring the dialysis communication sheets were completed. Nursing also addressed it in the nurse's notes. They would expect communication sheets to be in the medical record. The importance of the communication sheets was for nursing to know how the dialysis was tolerated and the condition the resident was in when returning to the facility.

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. 45083 Based on interview and record review, the facility failed to provide eight hours of Registered Nurse (RN) coverage on 18 out of 30 days reviewed for staffing. This had the potential to cause unmet health needs for all residents. The census was 79. Review of the Nursing Department - Staffing, Scheduling & Postings policy, revised 10/24/22, showed the facility must use the services of a Registered Nurse for at least 8 consecutive hours a day, 7 days per week, unless a waiver applies. Review of the facility's daily staffing schedule, dated 2/10/25 through 3/11/24, showed no RN coverage on the following dates: 2/11/25, 2/12/25, 2/14/25, 2/15/25, 2/16/25, 2/18/25, 2/19/25, 2/20/25, 2/23/25, 2/24/25, 2/27/25, 2/28/25, 3/1/25, 3/4/25, 3/5/25, 3/6/25, 3/9/25 and 3/10/25. During an interview on 3/11/25 at 8:52 A.M., the Human Resources (HR) personnel said the facility did not have RN coverage for at least 8 hours a day on some days due to no RNs were available to work. She said the facility should have an RN at least 8 hours a day, seven days a week. During an interview on 3/11/24 at 2:33 P.M., the Director of Nursing (DON) said aside from her, RN S was the only regular RN in the facility. RN T worked on some days as a Quality Assurance (QA) nurse. There were no RNs in the facility when RN S and RN T were not scheduled to work. The DON said they were actively hiring for RNs. She expected the facility to have RNs at least 8 hours a day, 7 days a week. MO00247075 MO00250058 MO00249603

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Rancho Rehab and Healthcare Center	615 Rancho Lane Florissant, MO 63031

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 45083 Based on observation, interview and record review, the facility failed to provide an as needed (PRN) controlled pain medication, as ordered by the prescriber, to meet the needs of one sampled resident (Resident #38). The census was 79. Review of Resident #38's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 2/27/25, showed: -Cognitively intact; -Required substantial/maximal assistance with shower/bath; -Occasional urinary incontinence; -Frequent bowel incontinence; -Diagnoses included heart disease, high blood pressure, traumatic brain injury, anxiety disorder and manic depression. Review of the resident's care plan, in use at time of survey, showed: -Focus: Resident is on pain medication therapy, opioid analgesics related to chronic neck pain, lower back pain, and right leg pain; -Goal: Resident will be free of any discomfort or adverse side effects from pain medication; -Interventions: Administer analgesic medications as ordered by physician. Review of the resident's order summary, dated 12/5/24, showed a physician order of oxycodone-acetaminophen (Percocet, used for moderate to severe pain) oral tablet 5-325 milligrams (mg). Give 1 tablet by mouth every 6 hours as needed for pain. Review of the resident's Medication Administration Record (MAR) for the month of March 2025, showed the ordered pain medication was last administered on 3/1/25 due to the resident's leg pain level of 8 (severe pain on a scale 0-10). During an interview on 3/5/25 at 12:50 P.M., the resident said he/she was in pain, but the Percocet medication was not available for a few days already. He/She likes to take it every six hours as ordered. He/She was told by the staff that they were waiting for the pharmacy to deliver the medication. He/She said Percocet was the only pain medicine that relieved his/her pain. The resident had an order for PRN Tylenol but said it did not do much with his/her pain. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 3/10/25 at 10:40 A.M., the resident said he/she had not received the Percocet yet due to unavailability. He/She asked the nurse every day and was told there was no delivery from the pharmacy. During an interview on 3/10/25 at 10:45 A.M., Licensed Practical Nurse (LPN) A said they were still waiting for the Percocet to be delivered by the pharmacy. He/She said there was no refill order from the physician, and usually took longer due to the resident had an outside provider who prescribed the pain medication. LPN A said the physician and pharmacy were contacted and followed-up. The resident had alternative pain medications such as Tylenol and Clonazepam (used as a muscle relaxant). LPN A explained the situation to the resident. The resident refused Tylenol when offered. Review of the resident's records, showed no documentation the physician and pharmacy had been contacted regarding the Percocet. During an interview on 3/10/25 at 3:45 P.M., the Director of Nursing (DON) and the Regional Nurse Consultant (RNC) said they were not aware the resident's medication ran out and the resident had been asking for it. During an interview on 3/11/25 at 10:39 A.M., the pharmacy technician said the resident's Percocet was last refilled on 2/20/25, for 30 tablets. The pharmacy did not do automatic refills for PRN medications. The pharmacy technician said the facility did not request for a refill until this morning of 3/11/25. During an interview on 3/11/25 at 10:45 A.M., the RNC said when PRN medications needed refills, staff should contact the physician so the prescription will be sent to the pharmacy. She expected staff to follow-up and document in the progress notes. She said it was the first time she was made aware of the issue. The resident did not report to her personally. The RNC said she will follow-up with the DON and would check the nurses' documentation of the resident's pain assessment. During an interview on 3/11/25 at 10:55 A.M., the resident said it had been about two weeks not receiving Percocet. He/She was told by the nurse the medicine was not delivered yet. During an interview on 3/11/25 at 10:59 A.M., the DON was not aware of the issue prior to today. She interviewed LPN A, who reported that the resident never complained of pain. The DON showed a copy of the MAR that showed resident's pain levels were documented as zeros. The Assistant Director of Nursing (ADON) was responsible for following-up with pharmacy for medication refills. The facility had been having issues with the pharmacy not delivering the medications as ordered. During an interview on 3/11/25 at 11:03 A.M., the ADON said the physician and pharmacy had been notified about the resident's Percocet and the medication was on its way to the facility. The floor nurses had to report to her when PRN medications were depleted. It was documented in the resident's record that the facility contacted the physician and pharmacy regarding the issue. The ADON was unable to show or provide documentation prior to 3/11/25. The narcotic sheet of the Percocet was not provided per request from the ADON. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation and interview on 3/11/25 at 11:30 A.M., showed the resident was in the dining area with his/her head down on the table. He/She was having sciatic pain, especially in the left leg. The facility did not provide a heat/cold pack. He/She repositioned him/herself in the wheelchair to alleviate the pain. The resident said he/she did not want to run out of Percocet again. The facility and the pharmacy should make sure it would not reoccur. During an interview on 3/11/25 at 12:14 P.M., the Strategic Account Manager (SAM) and the Pharmacist Director said they used to partial-fill medications, but as of 3/6/25, the pharmacy will fill the entire prescription. The facility requested cart audits but there is no one in the area. The pharmacy is working on scheduling the audit. When the facility receives a new order, the order is entered into the facility's electronic health records. The pharmacy then receives the order and it will be processed. Controlled medication refills are filled 30 days at a time. If the controlled medication was a PRN medication, the pharmacy will send 30 tablets at a time. The facility can call or fax over controlled medication refills. If there are no refills left on the script, the pharmacy will call and fax the physician to try to obtain a new prescription. If the facility calls the pharmacy to request a refill, the pharmacy will tell the facility to contact the physician also. If the pharmacy does not hear back from the physician, they will reach out again. A prescription is good for 6 months. If a prescription had 90 tabs, the pharmacy would send 30 tablets at a time for a PRN order. When the medication is refilled, they will send out 30 more tablets if the refill was requested within 6 months. The pharmacy received Resident #38's prescription on 1/28/25. A refill was requested on 2/20/25, the pharmacy sent out 30 tablets. The pharmacy received a new script on 2/26/25 for 100 tablets. The facility did not request a refill until this morning and the medication was sent out today. During an interview on 3/11/25 at 3:41 P.M., the DON said residents are assessed for pain every shift. The DON expected the resident's narcotic pain medication to be available. On 3/12/25 at 11:06 A.M., the DON said the facility had Percocet available in their emergency kit if the resident needed it. There was a prescription for Percocet of 100 tablets that was sent to the pharmacy on 2/20/25. She said the facility requested for refills on 2/28/25 but was notified it was too soon for refills. The DON said she would provide documentation of the facility's communication with the pharmacy. No documentation was provided.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. 35394 Based on interview and record review, the facility failed to assure they followed their policy to act on any irregularities noted by the pharmacist during the monthly Medication Regimen Review (MRR), which affected five out of five residents sampled for unnecessary medications review (Residents #53, #42, #6, #38 and #51). The census was 79. Review of the facility's Drug Regimen Review policy, dated 10/24/22, showed: -Policy: The pharmacist will review each resident's medication regimen at least once a month to identify irregularities and to identify clinically significant risks and/or actual or potential adverse consequences which may result from or be associated with medications; -The pharmacist will report any irregularities to the attending physician and the facility's Medical Director and Director of Nursing (DON), and these reports must be acted upon; -Procedure: The pharmacist must review each resident's medication regimen at least once a month; -The pharmacist performing the DRR will review the resident's medical record to appropriately monitor the medication regimen and verify the medication each resident is taking is clinically indicated; -The Consulting Pharmacist will note in the resident's medical record that the pharmacy medication review regimen was completed; -If no irregularities were identified during the review, the pharmacist includes a signed and dated statement to that effect; -The consulting Pharmacist will report any irregularities such as unnecessary drugs (which include but are not limited to excessive dosage, excessive duration, inadequate monitoring, inadequate indications for use or adverse consequences of use) to the Facility's Medical Director, Director of Nursing, and the Attending Physician; -Irregularities must be addressed in a separate, written report. The report will include the resident's name, the relevant drug, and the irregularity the pharmacist identified; -The report may be in paper or electronic form; -The report will be submitted within 3 business days of review, unless the irregularity is an emergent issue requiring immediate action. If the irregularity is emergent, the Attending Physician will be contacted as soon as practicable from the time the irregularity is identified; -The pharmacist does not need to document a continuing irregularity in the report each month if the Attending Physician has documented a valid clinical rationale for rejecting the pharmacist's recommendations, unless warranted by a change in the resident's condition or other circumstances; (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-The Attending Physician will respond to any irregularities reported by the pharmacist by reviewing the irregularities and documenting in the resident's medical record that the irregularity has been reviewed, and what, if any, action has been taken to address it; -The Medical Director and DON will also review the pharmacist's report if any irregularities are identified. 1. Review of Resident #53's medical record, showed: -Diagnoses included psychotic disorder with delusions due to known psychotic condition; -An order, dated 5/21/24, Aripiprazole (antipsychotic) oral tablet 5 milligram (mg). Give 5 mg by mouth in the morning related to psychotic disorder with delusions due to known physiological condition; -An order, dated 12/20/23, Sertraline (antidepressant) HCl oral tablet 50 mg. Give one tablet by mouth in the evening related to psychotic disorder with delusions due to known physiological condition. Review of the resident's care plan, in use during survey, showed: -Focus: Resident uses psychotropic medications; -Goal: Resident will be/remain free of psychotropic drug related complications; -Interventions: Administer psychotropic medications as ordered by physician. Monitor for side effects and effectiveness every shift; -Educate resident/family/caregivers about risks, benefits, and the side effects and/or toxic symptoms. Review of the resident's Pharmacy Consultant Notes, dated 10/22/24, 11/22/24, 12/16/24 and 1/27/25, showed see report. Review of the resident's medical record, showed no documentation of the resident's pharmacy recommendations. 2. Review of Resident #42's medical record, showed: -Diagnoses included aphasia (language disorder), schizophrenia (disorder that affects a person's ability to think, feel, and behave clearly), major depressive disorder and insomnia; -An order, dated 1/14/25, Trazodone (antidepressant and sedative) HCl tablet 50 mg. Give one tablet by mouth at bedtime for insomnia every bedtime for sleep; -An order, dated 12/10/24, Clozapine (antipsychotic) oral tablet 100 mg. Give one tablet by mouth, two times a day related to undifferentiated schizophrenia; (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-An order, dated 12/10/24, Duloxetine (antidepressant) HCl capsule delayed release particles 20 mg. Give one capsule by mouth, one time a day for depression related to major depressive disorder. Review of the resident's care plan, in use during survey, showed: -Focus: Resident takes medications with black box warnings: Anticonvulsants and Antipsychotics; -Goal: Resident will not suffer from adverse reactions to these medications; -Interventions: All nursing staff to be aware of black box warning. These can be found under Physician's Orders Sheet (POS)/Medication Administration Record (MAR) of the medications; -Medications as ordered; -Assess resident and intervene if adverse reactions occur; -Abnormal Involuntary Movement Scale (AIMS, rating scale to measure involuntary movements) assessments quarterly and as needed. Review of the resident's Pharmacy Consultant Notes, dated 9/17/24, 10/21/24, 11/20/24, 12/13/24 and 1/27/25, showed see report. Review of the resident's medical record, showed no documentation of the resident's pharmacy recommendations. 3. Review of Resident #6's medical record, showed: -Diagnoses included major depressive disorder; -An order, dated 1/2/24, Amitriptyline (antidepressant) HCl oral tablet 50 milligram (mg). Give one tablet mg by mouth at bedtime related to depression with pain; -An order, dated 9/26/23, Lorazepam (antianxiety) oral tablet 0.5 mg. Give one tablet by mouth two times a day related to anxiety disorder related to post traumatic stress disorder (PTSD). Review of the resident's care plan, in use during survey, showed: -Focus: Resident uses psychotropic medications related to depression and anxiety; -Goal: Resident will be/remain free of psychotropic drug related complications; -Interventions: Administer psychotropic medications as ordered by physician. Monitor for side effects and effectiveness every shift. -Educate resident/family/caregivers about risks, benefits, and the side effects and/or toxic symptoms. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the resident's consultant pharmacist's medication review, dated 9/17/24, showed the following recommendation: -Resident has been taking amitriptyline (anti-depressant). Please evaluate the current dose and consider a dose reduction; -Resident with good response, maintain the current dose. Review of the resident's medical record, from 9/1/24 to current, showed monthly medication reviews completed on 9/17/24 and 1/27/25. Further review of the resident's medical record, showed no further documentation of monthly medication reviews or pharmacy recommendations 4. Review of Resident #38's medical record, showed: -Diagnoses included traumatic subarachnoid hemorrhage (tSAH, is a bleeding into the space between the brain and the arachnoid membrane), bipolar disorder and anxiety disorder; -An order, dated 1/26/25, Caplyta (antipsychotic) oral capsule 42 mg. Give 42 mg by mouth at bedtime related to bipolar disorder, current episode depression, mild or moderate severity; -An order, dated 8/23/22, Clonazepam (antidepressant) tablet 0.5 mg. Give 1 tablet by mouth two times a day for anxiety; -An order, dated Risperidone (antipsychotic) tablet 1 mg. Give 1 mg by mouth at bedtime related to bipolar disorder; -An order of Trazodone (antidepressant) tablet 100 mg. Give 1 tablet by mouth at bedtime related to bipolar disorder. Review of the resident's care plan, in use during survey, showed: -Focus: Resident has psychiatric diagnosis which will affect his/her mood at times; -Goal: Resident will demonstrate effective coping behavior; -Interventions: Assess the resident for suicidal tendencies as needed, assess medication, psychiatric evaluation as needed; Review of the resident's Pharmacy Consultant Notes, dated 9/19/24, 10/21/24, 11/20/24, 12/13/24 and 1/27/25, showed MRR complete- See report. Review of the resident's medical record, showed no follow-up documentation of the resident's pharmacy report or recommendations on the dates stated above. 5. Review of Resident #51's medical record, showed: (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Diagnoses included major depressive disorder (MDD), and schizoaffective disorder (mental health condition including schizophrenia and mood disorder (bipolar) symptoms); -An order, dated 7/1/24, Divalproex Sodium (used to treat the manic phase of bipolar disorder) oral tablet 250 mg. Give 1 tablet by mouth one time a day related to MDD; -An order, dated 6/14/24, Olanzapine (antidepressant) oral tablet 10 mg. Give 1 tablet by mouth in the evening related to MDD; -An order, dated 8/20/24, Risperdal (Risperidone) tablet 1 mg. Give 1 tablet by mouth at bedtime for depression related to MDD; -An order of Trazodone tablet 50 mg. Give 1 tablet by mouth at bedtime related to MDD. Review of the resident's care plan, in use during survey, showed: -Focus: Resident uses psychotropic medications related to sleep, depression and mood; -Goal: Resident will remain free of psychotropic drug related complications, including movement disorder, discomfort, hypotension (low blood pressure) gait disturbance, constipation/impaction or cognitive/behavioral impairment; -Interventions: Administer psychotropic medications as ordered by physician. Monitor for side effects and effectiveness every shift. Consult with pharmacy, physician to consider dosage reduction when clinically appropriate at least quarterly. Discuss with physician, family regarding ongoing need for use of medication. Review behaviors/interventions and alternate therapies attempted and their effectiveness as per facility policy. Review of the resident's Pharmacy Consultant Notes, dated 9/17/24, 10/21/24, 11/20/24 and 12/13/24, showed MRR complete- See report. Review of the resident's medical record, showed no follow-up documentation of the resident's pharmacy report or recommendations on the dates stated above. 6. During an interview on 3/11/25 at 12:58 P.M., the Regional Nurse Consultant (RNC) said the facility did not have a tracking system of pharmacy reviews. She expected the pharmacy consultant and facility staff to complete the documentation and/or report following the pharmacy monthly reviews. 40291 45083

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42247 45083 Based on observation, interview and record review, the facility failed to ensure a medication error rate of less than 5%. Out of 30 opportunities observed, three errors occurred during medication administration for one resident (Resident #7), resulting in a 10% error rate. The census was 79. Review of the facility's Medication Administration Policy, dated October 24, 2022, showed: -Medication will be administered by a licensed nurse per the order of an attending physician or licensed independent practitioner, or as consistent with state law; -Nursing staff will keep in mid the seven rights of medication when administrating medications: the right medication, the right amount, the right resident, the right time, the right route, the right indication and the right outcome; -Additional considerations: the resident has right to know what the medication does; the resident has the right to refuse the medication (unless court ordered) and the rule of three, the licensed nurse administering medications will perform three checks comparing the physician's order, pharmacy label, and Medication Administration Record (MAR); - The resident's MAR will be reviewed for allergies and/or special considerations for administration including accepted professional standards and principles and vital sign parameters and lab results as appropriate; -Any discrepancies identified during the first, second, and/or third check must be resolved prior to the administration of any medication; -The licensed nurse will chart the drug; time administered and initial his/her name with each medication administration and sign full name and title on each page of the MAR; -Whenever a medication is held for any reason, the licensed nurse will initial the appropriate area on the MAR and circle his/her initials. The licensed nurse will document the reason the medication was held on the back of the MAR; -The time and dose of the drug or treatment administered to the resident will be recorded in the resident's individual medication record by the person who administers the drug or treatment. Review of the facility's Medication Error policy, dated 10/24/2022, showed: -Definition: the preparation or administration of medications or biologicals which is not in accordance with the prescriber's order; -A medication error may be the administration or omission of medication to the wrong resident, at the wrong time, at the wrong dose, via the wrong route or which is not currently prescribed; (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Errors related to the administration of medications or treatments will be reported to the Director of Nursing (DON) services, the attending physician, and the Administrator. Review of Resident #7's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 1/28/25, showed: -Cognitively intact; -Diagnoses included heart failure, high blood pressure, and stroke. Review of the order summary report, showed: -A physician order dated 1/22/25: Aldactone 25 milligrams (mg), give 12.5 by mouth one time a day for congestive heart failure; -A physician order dated 7/2/24: Jardiance 10 mg, give 10 mg by mouth one time a day for heart failure; -A physician order dated 8/16/23: senna 8.6 mg, give 8.6 mg by mouth in the morning for constipation. Review of the MAR, dated 3/1/25 through 3/31/25, showed: - A physician order for: Aldactone 25 mg, give 12.5 mg by mouth one time a day for congestive heart failure; -A physician order for: Jardiance 10 mg, give 10 mg by mouth one time a day for heart failure; -A physician order for: senna 8.6 mg, give 8.6 mg by mouth in the morning for constipation. Observation on 3/6/25 at 8:40 A.M., showed the resident's Jardiance and Aldactone blister pack cards were empty. No refill cards were available in the cart. Certified Medication Technician (CMT) Q said he/she would place an order to the pharmacy and would notify the nurse. The CMT marked the code number 9 (indicated Other/See Progress Notes) with his/her initials in the MAR for the medications, Aldactone and Jardiance. The CMT did not obtain the medication senna 8.6 mg from the cart. He/She marked a check with initials in the MAR, indicating it was given. The CMT administered the other medications to the resident and did not inform the resident of the unavailable medications, Aldactone and Jardiance. During an interview on 3/6/25 at approximately 9:05 A.M., the resident said he/she never missed any doses of medications, unless he/she chose not to take them. His/Her medications were always available as ordered. He/She only refused the inhalers today but took all his/her pills. Review of the resident's nursing notes, dated 3/6/25 at 10:34 A.M., showed staff documented the pharmacy was called to reorder medications Jardiance and Aldactone and requested for stat run. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation and interview on 3/7/25 at 11:40 A.M., showed one blister pack card each of Aldactone 25 mg and Jardiance 10mg located in the cart. Each card had one tablet taken out. CMT R said he/she administered those two medications that morning. CMT R said they used a stock bottle of senna 8.6 mg for the resident. There was not a bottle of senna in the cart. He/She thought someone took the bottle from the cart. CMT R used the bottle from the other cart. During an interview on 3/10/25 at 11:08 and 11:27 A.M. Licensed Practical Nurse (LPN) A said if the medications ran out and were not given as scheduled, they marked the MAR as not given, then called the physician and the pharmacy. When administering the medications, he/she asked the resident if they would take their medication, if the resident said yes, he/she would check the physician order, pop out the medication, administer the medication and document it. If the resident refused or did not take the medication, he/she would use the key code on the MAR, to enter a code to indicate the reason the resident did not take the medication. A blank on the MAR would indicate the medication was not administered or someone forgot to document it. If the code said see a nurses note there should be a corresponding nurses note. The MAR would automatically generate a progress note. If the medication was out of stock, he/she would check the e-kit to see if the medication was available. LPN A said the facility always had stock bottles of senna and it should always be available. If the medication was not available in the e-kit, he/she would document the medication was not administered, and notify the physician and responsible party (RP), and call the pharmacy to reorder the medication. If the physician /RP was notified it would be documented in the progress notes. If a stat run was requested, the medications were supposed to be delivered to the facility immediately, but the pharmacy never delivered stat orders. During an interview on 3/10/25 at 3:44 P.M., the Regional Nurse Consultant (RNC) said medications should be refilled before running out. The DON said if medications were not available, staff should call the physician to request an alternative if needed, then call the pharmacy. During an interview on 3/12/25 at 10:06 A.M., the pharmacy technician said the resident's Jardiance 10 mg medication was delivered to the facility on [DATE] at 6:32 P.M., The resident's Aldactone 25 mg medication was picked up by the pharmacy driver on 3/6/25 at 12:25 P.M. The pharmacy technician was unable to provide the actual time the medication was delivered. During an interview on 3/11/25 at 3:41 P.M. the Director of Nursing said she would expect for the medication rate to be less than 5% and for medications to be administered timely and per physician orders.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. 42247 Based on observation, interview and record review, the facility failed to ensure residents were free from significant medication errors. The facility failed to ensure one resident's (Resident #11) treatment plan was transcribed on the physician order sheet. This failure resulted in one anti-seizure medication not being adjusted for 46 days. The sample was 18. The census was 79. Review of the facility's Physician Order policy, dated 10/24/2022, showed: -Purpose: this will ensure that all physician orders are complete and accurate; -Telephone orders: a licensed nurse will record telephone orders on the telephone order sheet with the date, time and signature of the person receiving the order or in the electronic health record (EHR); -The order is transcribed onto the physician's order form at the time the order is taken; -Whenever possible, the licensed nurse receiving the order will be responsible for documenting and implementing the order; -Medication/treatment orders will be transcribed onto the appropriate resident administration record. Orders pertaining to other health care disciplines will be transcribed onto the appropriate communication system for the discipline; -The policy failed to show how new orders are entered into the EHR when the Physician (MD)/Nurse Practitioner (NP) visited the facility. Review of the facility's Medication Error policy, dated 10/24/2022, showed: -Definition: the preparation or administration of medications or biologicals which is not in accordance with accordance with: the prescribers order, accepted professional standards and principles which apply to professionals providing services; -Accepted professional standards and principles include the various practice regulations in the state, and current commonly accepted health standards established by the national organizations, boards, and councils; -A medication error may be the administration or omission of medication: at the wrong dose; -Errors related to the administration of medications or treatments will be reported to the Director of Nursing (DON) services, the attending physician, and the Administrator. Review of Resident #11's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 2/3/25, showed: -Cognitively intact; (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Diagnoses included: dementia and seizure disorder. Review of the care plan, in use at the time of survey, showed: -Focus: resident is at risk for adverse side effects (ASE) of medications use as evidence by: resident takes medication with black box warning (highest safety warning), anti convulsant; -Goal: will not experience ASE of medication use through the review date; -Interventions: meds as ordered; -Focus: resident had an actual fall on 12/27/24; -Goal: resident will resume usual activities without further incident through review date; -Interventions: emergency room evaluation; medication adjustments. During an interview on 3/10/25 at 9:45 A.M., the resident said he/she knew his/her medications and sometimes staff omitted some of his/her medications or part of the dose. The resident said he/she took two pills to equal the dose, and staff would only administer one pill. If his/her seizure medications were missed he/she might have a seizure. About three or four months ago he/she had seizure blackouts. Review of the progress notes, dated 11/9/24 through 11/13/24 showed: -On 11/9/24 at 3:20 P.M., the nurse was called to resident room. Resident was noticed having seizure activity. Resident was coming around and went into another seizure, stayed with resident until resident was able to respond with telling his/her name and stated he/she wanted to go to bingo. Responsible party notified, and the doctor was called and stated to send the resident to the hospital. 911 was called and arrived. Resident said he/she did not want to go; -On 11/11/24 at 11:48 A.M., NP N note, chief complaint: resident evaluated for reports of seizure activity. Context: resident observed having seizure and facility reported resident refused to go to the hospital. Plan: increase Keppra (anti-seizure medication) to 1000 milligrams (mg) by mouth twice daily (BID); -On 11/13/24 at 10:50 A.M., NP N note, chief complaint: resident requested visit due to seizure activity. Context: resident request medication review as he/she believes he/she did not receive an increase in seizure medication as discussed. Plan: increase Keppra to 100 mg by mouth BID. Review of the Medication Administration Record dated 11/1/24 through 11/30/24, showed: -A physician order for: levetiracetam (Keppra) 500 mg give one tablet twice daily for anticonvulsant. Start date was 12/16/23; -Documentation showed the medication was administrated 11/1/24 through 11/30/24; -Keppra was not increased to 1000 mg BID on 11/11/24. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the MAR, dated 12/1/24 through 12/28/24, showed: - A physician order for: levetiracetam 500 mg give one tablet twice daily for anticonvulsant. Discontinue date was 12/27/24; -Documentation showed levetiracetam 500 mg was administered BID from 12/1/24 through 12/27/24; -A physician order for: Keppra 500 mg give two tablets by mouth BID for seizures. Start date was 12/28/24. Review of the resident's progress notes dated 12/27/24 at 10:20 A.M., showed at approximately 10:00 A.M., resident noted lying on the floor supine (lying on his/her back) in front of wheelchair. Alert and responsive. Resident was transferred into wheelchair with two assists. Hematoma (a pool of blood that has leaked out of a blood vessel and is trapped in the surrounding tissues) noted on left side of skull. Resident began to clonic seizure (rhythmic jerking movements of the arms and legs) immediately after transfer lasting two minutes. Resident then came to and was wheeled to nurse station for evaluation. 911 was called. Paramedics arrived to transfer resident to hospital at 10:15 A.M. Resident arrived at facility about 9:00 P.M. via ambulance accompanied by emergency medical service (EMS). Only change in orders was Keppra 500 mg take two tablets (1000 mg) BID. MD notified. During an interview on 3/10/25 at 9:45 A.M., the resident said his/her Keppra was increased in December after he/she returned from the hospital. During an interview on 3/11/25 at 9:19 A.M., NP M said NP N was no longer with the company. When NP N was at the facility, he/she placed orders in his/her plan of treatment, but did not enter the orders into the EHR. NP N was responsible for entering his/her orders into the system. The orders written in NP N's plan of treatment should have been placed into the system. During an interview on 3/10/25 at 11:05 A.M. Licensed Practical Nurse (LPN) A said the nurse or the unit manager entered the orders into the EHR. Some of the MDs/NPs would write a telephone order and give it to the staff to enter the order. Some would give the nurse a verbal order to enter into the system. During an interview on 3/10/25 at 12:08 P.M., LPN B said the MD/NP had access to the EHR and they entered their own orders. The nurse entered the lab orders into the lab computer and binder. During an interview on 3/11/25 at 3:41 P.M., the DON said she would expect for the orders listed in the NP's plan to be entered into the system. The NPs no longer enter their orders into the system. They write their orders on a piece of paper for the facility staff to enter into the system. The DON would expect for staff and providers to follow the facility's policies and procedures.

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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. 42247 Based on observation, interview and record review, the facility failed to ensure drugs and biologicals were labeled and stored per acceptable standards of practice. The facility had two medication rooms, six medication carts and one treatment cart. Both medication rooms, three medication carts and the treatment cart were reviewed, and issues were found with all. The census was 79. Review of the facility's Medication Storage Policy, dated 2007, showed: -Medications and biologicals are stored properly, following manufacturer's or provider pharmacy recommendations, to keep their integrity and to support safe, effective drug administration. The medication supply shall be accessible only to licensed nursing personnel, pharmacy personnel, or staff members lawfully authorized to administer medications; -Intravenously (IV, administered into a vein) administered medications are stored separately from orally administered medications, under appropriate temperature and sterility conditions, and following the manufacturer's recommendations; -Insulin products should be stored in the refrigerator until opened. Note the date on the label for insulin vials and pens when first used. The opened insulin vial may be stored in refrigerator or at room temperature. Opened insulin pens should be stored at room temperature; -Outdated, contaminated, discontinued or deteriorated medications and those in containers that are cracked, soiled, or without secure closures are immediately removed from stock, disposed of according to procedures for medication disposal; - Medication storage conditions are monitored on a regular basis as a random quality assurance (QA) check. As problems are identified, recommendations are made for corrective action to be taken. 1. Observation and interview on 3/6/25 at 10:30 A.M., showed the medication room on the west side had one liter of 0.45% on Sodium (Na) Chloride (Cl) (Intravenous (IV) fluids) (used to replenish lost water and salt in your body), with an expiration date of 10/24. The medication refrigerator freezer was observed frosted over, with very thick build-up of ice. About a half-full bottle of Coke soda was placed in the freezer. Licensed Practical Nurse (LPN) A said the soda did not belong to a resident. The refrigerator door had approximately a centimeter opened gap when locked due to the thick ice build-up in the freezer. The refrigerator also had a one liter bag of NaCl 0.9% IV fluids. LPN A said he/she was not aware if it was an active order, and IV bags should not be in the refrigerator. 2. Observation and interview on 3/6/25 at 10:56 A.M., showed the Certified Medication Technician (CMT) cart on the west side, in the top drawer, had 2 brown pills in an unlabeled medication cup. CMT L said they were for himself/herself. In the bottom drawer, the following medication bottles were observed: -A 200 tablet bottle of sodium chloride 1 gram, opened and undated, expired 2/25; (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-A 300 tablet bottle of aspirin (used for pain and helps prevent heart attack or stroke) 81 milligram (mg), unopened, expired 12/24; -A 300 tablet bottle of allergy relief 10 mg, opened, undated, expired 2/25; -A 6 tablet bottle of calcium + D3 (calcium supplement) 600 mg/10 microgram (mcg), opened 2/25, expired 11/24. 3. Observation and interview on 3/6/25 at 11:00 A.M., showed the nurse's medication cart on the west side had two open vials of insulin, and eight out of 21 insulin pens were undated. LPN A said he/she did not know when the insulin was opened. One of the undated insulins pen's date must have rubbed off and another insulin pen must have come in last night and was put on the cart instead of the refrigerator. LPN A said insulin should be dated when it was opened by the person who opened it. If insulin was not dated, the nurse could possibly give expired insulin. When insulin was received from the pharmacy, it should be placed in the refrigerator until it was opened. 4. Observation and interview on 3/6/25 at 11:20 A.M., showed the the top drawer of the nurse medication cart on the east side in had one pink pill in an unlabeled medication cup, six open vials of insulin with no date and 10 out of 12 opened undated insulin pens. LPN B said he/she did not know what the pre-popped medication was or who it belonged to. If a medication was popped and not administered, the medication cup should be labeled with the resident's name on it. If the medication was refused, the medication should be discarded. Insulin should be dated by whomever opened the insulin. He/She did not know when the insulin was opened. 5. Observation on 3/6/25 at 11:23 A.M., showed the treatment cart had four tubes of Dermasyn (antibacterial wound gel), opened and undated. Three of the tubes were dated 10/24. 6. Observation on 3/6/25 at 11:38 A.M., showed the medication room refrigerator's freezer on the east side was frosted over with a very thick ice build observed. A pint-size ice cream was stuck in the freezer's ice buildup. 7. During an interview on 3/10/25 at 3:44 P.M., and on 3/11/25 at 3:41 P.M., the Director of Nursing (DON) said insulin pens and vials should be dated when opened and used within 28 days after opening. The stock medications should also be dated when opened and should be within manufacturers' expiration dates. Staff should not pre-pop and not leave unlabeled medications in the medication cart drawers. Staff should discard expired medications. The DON would expect for medications to be stored per manufactures guidelines and per the facility's policy and she would expect for staff to follow the policies and procedures. 45083

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide timely, quality laboratory services/tests to meet the needs of residents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35394 Based on interview and record review, the facility failed to ensure a process was in place for physician ordered laboratory tests to be completed and results received in a timely manner for four residents (Residents #42, #18, #46 and #11). The sample was 18. The census was 79. Review of the facility's Laboratory, Diagnostic, and Radiology services policy, dated 10/24/22, showed: -Policy: Laboratory, diagnostic and radiology services will be coordinated pursuant to an order by a physician, physician assistant, nurse practitioner or clinical nurse specialist in accordance with the scope of practice under state law; -The Facility is responsible for the quality and timeliness of services provided by the laboratory, diagnostic or radiology provider; -The ordering practitioner will be notified of results that fall outside of clinical reference or expected normal ranges per the ordering practitioner's order; -The Facility will assist in making transportation arrangements, as indicated, to and from the applicable provider; -Procedure: Laboratory, diagnostic and radiology services ordered will be documented on the 24-Hour Report or electronic health record, to ensure that services are coordinated and results are received timely; -Any orders labeled STAT (immediately) will be followed up on during the same shift; -The Director of Social Services or designee will coordinate transportation to and from the service provider, as indicated; -The ordering practitioner will be notified of results that fall outside of clinical reference or expected normal ranges per the ordering practitioner's order; -Critical values will be reported immediately to the ordering practitioner; -Critical values (also referred to as panic values or crisis values) are those that, if untreated, could be life threatening or place the resident at serious risk; -If the ordering practitioner does not immediately respond to communication of critical values, the licensed nurse will contact the Facility's Medical Director for direction and orders, as indicated; -The licensed nurse will document the time when results were reported to the ordering practitioner and the ordering practitioner's response or additional orders, if any; -Update resident's Care Plan as needed; (continued on next page)

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Laboratory, diagnostic and radiology results will be maintained as part of the resident's medical record. 1. Review of Resident #42's annual Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 1/9/25, showed: -Moderate cognitive impairment; -Diagnoses included high blood pressure, diabetes, arthritis, Alzheimer's disease, aphasia (language disorder), seizure disorder, depression, schizophrenia (disorder that affects a person's ability to think, feel, and behave clearly) and asthma; -Administered antidepressants and antipsychotic; -Antipsychotics were administered on a routine basis. Review of the resident's care plan, in use during survey, showed: -Focus: Resident takes medications with black box warnings: Anticonvulsants and Antipsychotics; -Goal: Resident will not suffer from adverse reactions to these medications; -Interventions: All nursing staff to be aware of black box warning (highest safety warnings). These can be found under Physician's Orders Sheet (POS)/Medication Administration Record (MAR) of the medications; -Medications as ordered; -Assess resident and intervene if adverse reactions occur. Review of the resident's Physician's Orders Sheet (POS), dated March 2025, showed: -An order, dated 11/25/24, for Clozapine (antipsychotic) every month. -An order, dated 12/10/24, Clozapine oral tablet 100 milligrams (mg). Give one tablet by mouth, two times a day related to undifferentiated schizophrenia. Review of the resident's medical record, showed: -On 9/25/24, Clozapine lab was completed and reported on 9/29/24 -No further documentation of a monthly Clozapine lab since September 2024. Review of lab results, received on 3/10/25 at 12:52 P.M., showed Clozapine lab was not completed. Review of the U.S. Food and Drug Administration (FDA) website, showed patients taking Clozapine require tests to detect emergent agranulocytosis or neutropenia (a life threatening condition that involves having severely low levels of white blood cells). (continued on next page)

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Review of Resident #18's quarterly MDS, dated [DATE], showed: -Cognitively intact; -Diagnoses included anemia, coronary artery disease (CAD, blocked or narrowed arteries), heart failure, hypertension (high blood pressure), renal failure, neurogenic bladder (condition that affects the bladder's ability to function properly), urinary tract infection, diabetes, hyperkalemia (high potassium levels in the blood), hyperlipidemia (high level of lipids in the blood), hemiplegia (paralysis or weakness on one side of the body), seizure disorder, malnutrition, asthma and respiratory failure; -Administered anticoagulants; -Receives continuous oxygen. Review of the resident's care plan, in use during survey, showed: -Focus: Resident utilizes medications with Black Box warning; -Goal: Resident will remain free of adverse reactions associated with utilizing black box medications; -Interventions: Administer medications as ordered; -Licensed nursing staff will monitor resident at least daily; -Licensed staff will report signs and symptoms adverse reactions to resident's provider immediately; -Focus: Resident has heart failure, CAD, and hypertension (high blood pressure); -Goal: Resident will be free of peripheral edema; -Interventions: Give cardiac medications as ordered; -Monitor/document/report as needed (PRN) any signs and symptoms of congestive heart failure. Review of the resident's POS, dated March 2025, showed an order, dated 1/31/25, for Complete Blood Count (CBC, blood test that provides information about cells in the body)/Comprehensive Metabolic Panel (CMP, blood test that measures 14 different substances in the body yearly, magnesium, uric acid, parathyroid hormone (PTH), lipid, and vitamin D. Review of the resident's medical record, showed no documentation of a CMP, CBC, magnesium, uric acid, PTH, lipid or vitamin D as of 3/11/25. 3. Review of Resident #46's quarterly MDS, dated [DATE], showed: -Cognitively intact; (continued on next page)

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Diagnoses included anemia, Crohn's disease (chronic inflammatory bowel disease), aphasia and malnutrition; -Receives antidepressant, opioid, antiplatelet and hypoglycemic (low blood sugar) medications. Review of the resident's POS, dated March 2025, showed: -An order, dated 1/14/25, please check thyroid-stimulating hormone (TSH), A1C, B12, folate, and vitamin D levels; -An order, dated 2/21/25, please check TSH, A1C (a blood test that reflects your average blood glucose levels over the past 3 months), vitamin D, B12, folate, iron levels. Review of the resident's care plan, in use during survey, showed: -Focus: Resident is on diuretic therapy; -Goal: Resident will be free of any discomfort or adverse side effects of diuretic therapy; -Interventions: Report pertinent lab results to physician (especially hematocrit (HCT, measures the percentage of red blood cells) Na+ (sodium), and K+ (potassium). Review of the resident's medical record, showed no documentation of a CMP, CBC, magnesium, uric acid, PTH, lipid, or vitamin D as of 3/11/25. Review of the resident's lab results, received on 3/10/25 at 12:52 P.M., showed on 2/20/25, a CMP and CBC lab was ordered. Resident refused (first attempt). Review of the resident's medical record, showed no recent lab result for TSH, A1C, vitamin D, B12, folate, iron levels as of 3/11/25. 4. Review of Resident #11's quarterly MDS, dated [DATE], showed: -Cognitively intact; -Diagnoses included: dementia and seizure disorder. Review of the care plan, in use at the time of survey, showed: -Focus: resident is at risk for adverse side effects (ASE) of medications use as evidence by (AEB) by resident takes medication with black box warning-anti convulsant; -Goal: will not experience ASE of medication use through the review date; -Interventions: meds as ordered. Review of the order summary sheet, dated 3/5/25, showed (continued on next page)

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-An order for: Divalproex Sodium ER 24 hour (Depakote, anticonvulsant), 500 milligrams, give two tablets by mouth at bedtime, start date was 10/17/24. Review of the progress notes, dated 11/5/24 through 11/11/24 showed: -On 11/9/24 at 3:20 P.M., the nurse was called to resident room. Resident was noticed having a seizure activity. Resident was coming around and went into another seizure, stayed with resident until resident was able to respond with telling his/her name and stated he/she wanted to go to bingo. Responsible Party (RP) notified, and the doctor was called and stated to send the resident to the hospital. 911 was called and arrived. Resident said he/she did not want to go. -On 11/11/24 at 11:48 A.M., NP note, chief complaint: resident evaluated for reports of seizure activity; Plan: Depakote level (blood test used to measures the amount of valproic acid (Depakote) is in the blood), CBC and CMP next lab day, -On 11/13/24 at 10:50 A.M., NP note, chief complaint: resident requested visit due to seizure activity; Plan: Depakote level, CBC and CMP next lab day. Review of the labs provided by the facility dated 11/1/24 through 11/30/24, showed, a Depakote level, CBC and CMP was completed on 11/8/24. There were no other labs for November provided. Review of the progress notes dated 12/11/24 showed at 11:50 A.M. NP note: chief complaint: resident evaluated for follow up following seizure; Plan: Depakote level. Review of the labs provided by the facility showed no Depakote level was drawn in December. During an interview on 3/11/25 at 8:30 A.M., the DON said the nurse practitioner who entered his/her notes in the progress notes plan was no longer at the facility. During an interview on 3/11/25 at 9:19 A.M., NP M said NP N was no longer with the company. When NP N was at the facility, he/she was placing orders in his/her plan of treatment but was not entering the orders into the system. NP N was responsible for entering his/her orders into the system. The orders written in NP P plan should have been placed into the system. During an interview on 3/11/25 at 3:41 P.M., the Director of Nursing (DON) said she would expect for the orders listed in the NP plan to be entered into the system. The NPs are no longer entering the orders into the system. They are writing all their orders on a piece of paper for the facility staff to enter into the system. The DON would expect for staff and providers to follow the facility's policies and procedures. 5. During an interview on 3/10/25 at 11:05 A.M. Licensed Practical Nurse (LPN) A said the nurse, or the unit manager entered the orders into the computer. Some of the Medical Doctors (MD)/Nurse Practitioners (NP)s will write a telephone order and give it to the staff to enter the order into the computer and some will give the nurse a verbal order. 6. During an interview on 3/10/25 at 12:08 P.M., LPN B said the MD/NP have access to the computer and they enter their own orders into the computer. The nurse entered the lab orders into the lab computer and binder. (continued on next page)

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	7. During an interview on 3/11/25 at 12:35 P.M., the Director of Nursing (DON) and Regional Nurse Consultant said the Assistant Director of Nursing (ADON) and DON are responsible for entering the lab order into the system. At the end of the day, they print the log for blood draws on Monday, Wednesday, and Friday when lab tech arrives. They are placed into a binder so they know what labs are to be drawn and for which resident. They check daily for completed labs. They ensure that the results for the entire lab are completed for the physician to see, not partial results. If a resident refuses lab draw, the lab attempts three times and document it on the results. It will say resident refusal. Sometimes there is a progress note that the resident refused. The DON expected refusals to be documented in the nursing notes or in the lab result. She expected staff to refer to the policy in regards to when to contact the physician.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40291 Based on observation and interview, the facility failed to store food in accordance with professional standards for food service safety by failing to label, date, and cover food and failed to ensure an expired gallon of milk was discarded as indicated. The facility also failed to ensure kitchen equipment and the floor were kept clean during three of five days of observation. In addition, the facility failed to maintain records of dish washing temp logs as well as chloride testing logs. These deficient practices had the potential to affect all residents who consumed food from the facility kitchen. The census was 79. 1. Observation of the kitchen on [DATE] at 11:37 A.M., [DATE] at 3:33 P.M., and [DATE] at 11:15 A.M., showed the following: -Dry storage room: -A bucket of peanut butter without a date; -An opened bottle of lemon juice without a date; -A bag of egg noodles, with a twist tie at the end without a date; -A bag of brown sugar, opened at the end, not closed and exposed to air without a date; -A bag of powder sugar wrapped in plastic and without a date; -A bag of macaroni noodles wrapped in plastic and without a date; -A bag of spaghetti noodles wrapped in plastic and without a date; -Two opened bottles of honey without a date; -Two packages of white powdery substances wrapped in plastic and without a date; -An opened bottle of soy sauce without a date; -A bag of toffee, opened and folded over and without a date; -A opened package of marshmallows wrapped in plastic wrap without a date.; -Freezer: -Two packages of waffles, opened at the end, not closed and exposed to air without a date; -A zip locked bag contained chicken breast without a date; (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-A box contained a blue bag of frozen carrots which was opened and exposed to air; -A blue bag contained frozen peas, opened and exposed to air; -A bag of frozen mixed vegetables, opened and exposed to air. Observation on of the dry storage [DATE] at 11:37 A.M. and [DATE] at 3:33 P.M., showed: -An opened bottle of Worchester sauce, without a date; -An opened package of pork flavored gravy wrapped in plastic without a date; -An opened package of brown gravy wrapped in plastic no date. 2. Observations of the walk-in cooler on [DATE] at 11:37 A.M., and [DATE] at 3:33 P.M., showed a gallon of whole milk with a expiration date of [DATE]. Observation of the walk-in cooler on [DATE] at 11:37 A.M., [DATE] at 3:33 P.M., and [DATE] at 11:15 A.M., showed an opened container of grated parmesan cheese without a date. 3. Observations of the stand-alone cooler on [DATE] at 11:37 A.M., and [DATE] at 3:33 P.M., , showed: - An opened bottle of buttermilk dressing without a date; -An opened tub of soft spread margarine without a date. 5. Observation of the kitchen on [DATE] at 11:37 A.M. and [DATE] at 3:33 P.M., and [DATE] at 11:15 A.M., showed the following: -The stove: -Heavy caked-on stains on the stove burners; -Heavy caked-on stains along the front of the stove; -The oven: -Heavy caked-on stains along the front inside door; -Heavy caked -on stains along the bottom, and sides of oven; -The floor dirty with debris and stains on the floor; -The floor dirty with debris and food in beside the stove and under the sink. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	7. Observation of the kitchen on [DATE] at 11:37 A.M. and [DATE] at 3:33 P.M., [DATE] at 11:15 A.M., and [DATE] at 11:35 A.M., showed no temperature testing strips for the dishwasher nor any logs for temperature testing. During an interview on [DATE] at 11:45 A.M., Dish Service Worker (DSW) GG said he/she did the dishes and he/she didn't use chloride strips. They were out. He/She also said he/she didn't record anything on a log sheet. 8. During interviews on [DATE] at 10:43 A.M. and 11:55 A.M., the Dietary Manager (DM) said he did not have a February or [DATE] cleaning schedule. He had been trying to get things together. The general cleaning of the equipment in the kitchen was done daily. They wipe down the stations, swept and mopped the floor as well as mopped the walk-ins and the dry storage room. They tried to do the deep cleaning on Mondays, Wednesdays, and Fridays. On Fridays, staff pulled everything out the coolers and freezer and cleaned the racks and organized those areas. Normally the MD and [NAME] HH would do this. He would expect for all food and drinks to be properly labeled, dated and stored, and for all expired items to be discarded. He would expect for all kitchen equipment to be clean and floors to be clean and free of debris. The DM said he didn't know why DSW GG said they didn't have any strips. He did have chloride test strips, which were used to test chloride in the water. They should test the chloride and record it on a log sheet. The last time temperatures were taken was last Friday. They were supposed to record temperatures during the cleaning cycles after every meal. The temperature log sheets wouldn't be up to date. He didn't have a copy of the temperature log sheet. He couldn't remember what the temperatures should read at during the wash and rinse cycles. He didn't have any copies of the logs for testing the chloride.

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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** 42247 Based on observation, interview and record review, the facility failed to follow acceptable infection control standards by not implementing Enhanced Barrier Precautions (EBP, an infection control intervention designed to reduce the transmission of multidrug-resistant organisms (MDROs) that employs targeted gown and glove use during high contact resident care activities) as recommended by the Centers for Disease Control and Prevention (CDC) and required by the Centers for Medicare and Medicaid Services (CMS), for one resident (Resident #15) with wounds requiring treatments, gastrostomy tubes (g-tube, a tube that is surgically inserted into the abdomen and is used for liquid nutrition and medications) and when staff provided care for one resident on EBP (Resident #235) then provided care on another resident wearing the same gown (Resident #11) and when staff failed to perform hand hygiene between dirty and clean areas for one resident (Resident #37). The sample was 18. The census was 79. Review of the facility's Standard and Enhance Barrier Precautions Policy, dated 4/1/24, showed: -Purpose: To ensure the use of appropriate personal protective equipment to improve infection control as required in the care of residents. -Definitions: Enhanced Barrier Precautions (EBP) refers to an infection control intervention designed to reduce transmission of multidrug-resistant organisms (MDRO) that employs targeted gown and glove use during high contact resident care activities that are associated with a high risk of MDRO colonization when contact precautions do not otherwise apply and/or transmission such as presence of indwelling devices (feeding tube) and wounds or presence of unhealed pressure ulcers; -Standard Precautions refers to the infection prevention practices that apply to all residents, regardless of suspected or confirmed diagnosis or presumed infection status. Standard precautions are based on the principle that all blood, body fluids, secretions, excretions except sweat, regardless of whether they contain visible blood, non-intact skin, and mucous membranes may contain transmissible infectious agents. -Standard Precautions apply to the care of all residents regardless of suspected or confirmed presence of infectious diseases; -Standard precautions: hand hygiene refers to hand washing with soap (anti-microbial or non-antimicrobial) or using alcohol-based hand rubs (gels, foams, rinses) that do not require access to water; Gloves (clean, non-sterile) are worn when direct contact with blood, body fluids, mucous membranes, non-intact skin, and other potentially infected material is anticipated; a gown is worn to protect skin and prevent soiling of clothing during procedures and resident care activities that are likely to generate splashes or sprays of blood, body fluids, secretions, or excretions or cause soiling of clothing; -EBP should be used for any residents who meet the above criteria, wherever they reside in the facility; (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-For residents whom EBP are indicated, EBP should be used when performing the following high contact resident care activities: dressing; providing hygiene; changing briefs or assisting with toileting. Review of the facility's Perineal Care Policy, dated 10/24/2022, showed: -Purpose: To maintain cleanliness of the genital area, to reduce odor, and to prevent infection or skin breakdown; -Procedure: wash hands, prepare equipment, provide privacy, put on gloves, provide peri care, turn resident to side, wash, rinse and dry buttocks, remove wet linen, provide dry linens/brief, remove gloves, put on clean gloves, clean and return all equipment to its proper place, placed soiled linen in proper container, remove gloves and wash hands. 1. Review of Resident #15's significant change Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 1/20/25, showed: -Moderately impaired cognition; -Had a feeding tube; -Diagnoses included stroke, heart failure, high blood pressure, diabetes, dementia, hemiplegia (paralysis on one side of the body) or hemiparesis (weakness on one side of the body). Review of the care plan, in use at the time of survey, showed: -Focus: EBP placement related to enteral nutrition (method of feeding that uses the gastrointestinal (GI) tract to deliver nutrition and calories)/colostomy (a surgical procedure that brings one end of the large intestine out through the abdominal wall); -Goal: help to reduce or preventable spread of MDRO; -Interventions: handwashing before and after personal protective equipment (PPE) donning; provide PPE. Ensure that gowns, gloves and other PPE are readily available outside the room; signage posted outside of room door to indicate the type of precautions and required PPE. Observation on 3/5/25 at 11:22 A.M., showed an EBP sign on the resident's door. Certified Nurse Aide (CNA) O and CNA P entered the resident's room, performed hand hygiene and put gloves on. Then, staff rolled the resident side to side to perform peri care (care to the surface area between the thighs, extending from the pubic bone to tail bone) for the resident, without wearing a gown. 2. Review of Resident #235's admission MDS, dated [DATE], showed: -Should Brief Interview for Mental Status be conducted - attempt to conduct interview with all residents? blank; -Dependent-(helper does all the effort. Resident does none of the effort to complete the activity) for toileting hygiene and lower body dressing; (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Had a feeding tube; -Diagnoses included stroke, high blood pressure, diabetes, schizophrenia (serious mental illness that affects how a person thinks, feels, and behaves). Review of Resident #11's quarterly MDS, dated [DATE], showed: -Cognitively intact; -Dependent for toileting hygiene and lower body dressing; -Diagnoses included dementia and seizure disorder. Observation on 3/7/25 at approximately 6:15 A.M., showed Resident #235 lay in bed on his/her back. The resident was incontinent of bowel. CNA E and CNA D entered the resident's room, performed hand hygiene and put on gowns and gloves. Resident #235 was turned side to side and peri care was performed. CNA E gathered the trash and left the room with the trash, wearing his/her gown. CNA E discarded the trash and entered Resident #11's room, wearing the same gown. There was no EBP sign on the resident's door. CNA E put two pairs of gloves on, sprayed peri wash on the resident's peri area and performed peri care. CNA E removed the soiled brief from under the resident and removed one pair of gloves. Then, he/she tucked a new brief under the resident and assisted the resident to roll over and fastened the brief. CNA E removed his/her gloves, removed his/her gown and left the room. 3. Review of Resident #37's quarterly MDS, dated [DATE], showed: -Cognitively intact; -Impairment on both sides of lower extremities; -Dependent on rolling left and right; -Dependent on activities of daily living (ADL); -Diagnoses included high blood pressure, neurogenic bladder (a condition that affects the bladder's ability to function), diabetes, and multiple sclerosis (a chronic, autoimmune disease that affects the brain and spinal cord). Observation on 3/7/25 at 10:18 A.M., showed Licensed Practical Nurse (LPN) G assisted LPN F to provide the resident's wound care. The resident had multiple wounds located on the buttocks, both legs/shins and heels. When LPN F provided the treatment for wounds on the resident's legs, LPN G lifted the feet and heels, touching the wounds, so LPN F could access the wound areas. After touching the affected areas, LPN G touched the resident and repeatedly rubbed the resident's back with dirty gloves on. He/She also touched the resident's bed and covered the resident with the clean linens after providing wound care, while still wearing the same dirty gloves. LPN G did not remove or change gloves in between contact with dirty and clean areas. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4. During an interview on 3/10/25 at 10:50 A.M., CNA I said he/she knew if a resident was on isolation by the sign on the door, he/she could check the chart, or the information is provided during their morning meeting. If a resident had an EBP sign on the door, he/she would wear gloves and a gown every time he/she entered the resident's room or if he/she provided catheter care. The gown should be taken off before leaving the room and should not be worn into another resident's room. Staff should not wear two pair of gloves at a time 5. During an interview on 3/10/25 at 12:08 P.M., LPN B said staff knew which residents are on isolation precautions by the stuff outside the door. If a resident was on EBP, staff should wear a gown and gloves while providing direct patient care. The gown should be removed before leaving the room. Staff should not double glove. 6. During an interview on 3/10/25 at 3:45 P.M., the Director of Nursing (DON) said the residents who had urinary catheters, wounds, intravenous lines (used to give medicines, fluids, blood products, or nutrition into the bloodstream), and on dialysis were required to be on EBP rooms. Staff should apply gloves and gown when providing care to residents in EBP rooms. The staff should not wear gowns in the halls and should not wear the same gowns from one room to the other. She expected staff to change gloves and apply hand hygiene in between contact with dirty and clean. On 3/11/25 at 3:41 P.M., the DON said she expected staff to follow the CDC guidelines for infection control and the facility's policies and procedures. 45083 MO00247075

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F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. 45083 Based on interview and record review, the facility failed to ensure they had a system in place to track the required Certified Nurse Aide (CNA) 12 hours annual education (in-services). The facility identified 10 CNAs who worked for the facility for at least one year. Eight CNAs (CNA U, CNA V, CNA W, CNA X, CNA Y, CNA J, CNA Z, CNA H), and two Certified Medication Technicians (CMTs), (CMT L and CMT AA) were sampled. The facility failed to document the length of time the training was provided for all sampled staff. The census was 79. 1. Review of CNA U's employee file showed: -Date of hire: 10/19/21; -One in-service was completed; -The in-service failed to show the length of time the training was provided. 2. Review of CNA V's employee file, showed: -Date of hire: 10/19/21; -Twelve in-services were completed; -The in-services failed to show the length of time the training was provided. 3. Review of CMT L's employee file, showed: -Date of hire: 10/19/21; -Thirteen in-services were completed; -The in-services failed to show the length of time the training was provided. 4. Review of CNA W's employee file, showed: -Date of hire: 4/11/22; -Ten in-services were completed; -The in-services failed to show the length of time the training was provided. 5. Review of CNA X's employee file, showed: -Date of hire: 8/15/22; (continued on next page)

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F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-Three in-services were completed; -The in-services failed to show the length of time the training was provided. 6. Review of CNA Y's employee file, showed: -Date of hire: 10/27/22; -Seven in-services were completed; -The in-services failed to show the length of time the training was provided. 7. Review of CNA J's employee file, showed: -Date of hire: 5/22/23; -Seventeen in-services were completed; -The in-services failed to show the length of time the training was provided. 8. Review of CNA Z's employee file, showed: -Date of hire: 7/2/23; -Two in-services were completed; -The in-services failed to show the length of time the training was provided. 9. Review of CNA H's employee file, showed: -Date of hire: 9/21/23; -Six in-services were completed; -The in-services failed to show the length of time the training was provided. 10. Review of CMT AA's employee file, showed: -Date of hire: 10/2/23; -Six in-services were completed; -The in-services failed to show the length of time the training was provided. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265402	A. Building B. Wing	03/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rancho Rehab and Healthcare Center	615 Rancho Lane Florissant, MO 63031

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	11. During an interview on 3/11/25 at 1:59 P.M., the Director of Nursing (DON) said the facility did not track the time for the in-services and they would not be able to tell if the CNAs or CMTs had received the required 12 hours of education or not. She said the facility provided in-services for the CNAs every month and every class was allotted for one hour, but there was no duration of in-services tracked or documented. Some of the sampled staff did not have the 12 hours in-services in a year. She expected staff to have the required education and for the hours to be tracked.