STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265404	A. Building B. Wing	03/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Maywood Terrace Living Center	10300 East Truman Rd Independence, MO 64052

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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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview and record review, the facility failed to ensure safe storage and labeling of narcotic medication to include the date and resident's name when opened for one sampled resident (Resident #18) and one supplemental resident (Resident #37) out of 13 sampled residents and 12 supplemental residents that were stored in one of one medication carts; failed to ensure there were no expired medications in the medication room refrigerator, failed to ensure that expired medical dressing supplies were disposed of, failed to ensure an opened insulin pen was dated, labeled, and properly stored, failed to ensure that resident's personal food and drink items, supplements, and medications were not stored in the same refrigerator and failed to ensure proper defrosting was done in one out two medication storage rooms. The facility also failed to ensure the refrigerators were properly cleaned and medications were stored in a clean and sanitary environment to maintain drug integrity and prevent contamination in two out of two medication storage rooms. The facility census was 49 residents.Review of the facility Medication Administration policy dated April 2019 showed:-Insulin pens are clearly labeled with the resident's name or other identifying information. -Prior to administering insulin with an insulin pen, the nurse verifies that the correct pen is used for that resident.-The expiration/beyond use date on the medication label is checked prior to administering.-When opening a multi-dose container, the date opened should be recorded on the container. Review of the facility's Medication Storage of the Facility policy dated 7/1/24, did not address any types of medications other than controlled (a drug or chemical whose manufacture, possession, and use is regulated by a government and hold the risk of abuse or dependence). Review of the facility's maintenance and cleaning log form dated 3/14/17, showed a blank form with no entries for refrigerator cleanings. The forms indicated the refrigerators were to be cleaned every month. 1. Review of Resident #18's admission record showed he/she was receiving hospice care/services (a special kind of care that focuses on a person's quality of life and dignity as they near the end of their life) related to a stroke. Review of the resident's physician order sheet (POS) dated March 2026 showed:-Morphine Sulfate (Concentrate) Oral Solution 20 milligrams/milliliters (mg/ml) (Morphine Sulfate), give 0.25 ml by mouth every one hour as needed for air hunger and pain ordered on 12/16/25.-Morphine Sulfate (Concentrate) Solution 20 mg/ml give 0.25 ml by mouth three times a day for increased pain and agitation ordered on 3/8/26. -Lorazepam (used to manage anxiety, terminal agitation, restlessness, and severe shortness of breath) Concentrate 2 mg/ml give 0.25 ml by mouth every three hours for increase pain and agitation was ordered on 3/7/26. (continued on next page)

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

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of the resident's nursing medication administration record (MAR) dated 3/1/26 to 3/31/26 showed:-Morphine as needed was given 3/3/26 and was effective. -New order for scheduled morphine was dated 3/7/26. -Refer to medication administration related to morphine. Observation on 3/9/26 at 12:38 P.M., of the resident's morphine bottle showed:-Licensed Practical Nurse (LPN) B and Regional Nurse had a potential concern due to a possible color change with the resident's morphine. -The resident's bottle of morphine had no date on the bottle or on the box when the medication was opened. During an interview on 3/9/26 at 12:38 P.M. LPN B said he/she would replace the resident's morphine medication out of the facility's emergency medication kit (E-Kit). Observation on 3/9/26 at 1:13 P.M., of medication administration by LPN B showed: -He/she had obtained house stock bottle of morphine out of the E-Kit and entered new medication data into the facility new electronic monitoring system and electronic narcotic medication accountability system, (replaced paper tracking of controlled substance medications). -LPN B gave the resident a scheduled dose of morphine 0.25 ml three times a day for pain and shortness of air. Observation on 3/9/26 at 1:30 P.M., of the west nurse's medication cart, with LPN B showed the resident had an open box of lorazepam (used to treat anxiety) 2 mg/ml the bottle was not labeled with the resident's name or dated when it was opened. 2. Review of Supplemental Resident #37's admission record showed he/she admitted with a diagnosis of encephalopathy (a broad term for any disease, damage, or malfunction of the brain that alters mental state, causing symptoms like confusion, memory loss, and personality changes). Review of the resident's POS dated 2/21/26 showed:-Morphine Sulfate (Concentrate) Solution 20 mg/ml Give 0.25 ml by sublingually every four hours as needed for moderate pain and shortness of air.-Morphine Sulfate (Concentrate) Solution 20 mg/ml Give 0.50 ml by sublingually every four hours as needed for mild pain and shortness of air.-Morphine Sulfate (Concentrate) Solution 20 mg/ml Give 0.75 ml by sublingually every four hours as needed for moderate pain and shortness of air. -Morphine Sulfate (Concentrate) Solution 20 MG/ML Give 1ml by sublingually every four hours as needed for moderate pain and shortness of air.-Hospice services discontinued on 3/9/26. Observation on 3/9/26 at 1:30 P.M., of the west nurse's medication cart, with LPN B showed the resident had a box with morphine 20mg/ml there was no date on the box or bottle when it was opened. 3. Observation on 3/9/26 at 1:15 P.M. of the north unit medication storage room showed:-Excessive ice buildup in the freezer section of the refrigerator that needed defrosting.-The medication refrigerator had visible debris, dried spills, and residue on the interior surfaces.-One opened ice cream dessert cup in the medication refrigerator.-One can of soda/energy drink in the door of the medication refrigerator.-The medication refrigerator contained food, drink, supplements, and medications.-15 bagged and unbagged bisacodyl (fast-acting, stimulant laxatives used to relieve occasional constipation) suppositories that expired on 3/27/25, 10/07/25 and 1/16/26.-There were food items that included packaged snacks, on the counter.-Multiple wound care bandages that expired in October 2025.-One NovoLog insulin pen on the counter unlabeled, undated, not in the original pharmacy bag with a pen needle still attached.-The overall condition of the room lacked a routine and thorough cleaning as evidenced by visible dust and residue on the surfaces and the floor. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	4. Observation on 3/9/26 at 2:12 P.M. of the west medication storage room showed the medication refrigerator had visible debris, dried spills, as well as residue and dust on interior surfaces and the floor. There was paper/cardboard on the floor. 5. During an interview on 3/9/26 at 12:56 P.M. Certified Medication Technician (CMT) D said: -Medication should be dated when opened on the box and the medication bottle. -CMT's were only allowed to administer scheduled narcotics.-The facility had a new control substance electronic accountability system. During an interview on 3/9/26 at 1:32 P.M., LPN A said:-He/She was not sure what the cleaning or defrosting schedule was.-Expired items should not be kept in the refrigerator.-Supplements and medications should be in separate refrigerators.-There should not be personal food items in the same refrigerator with medications and supplements.-All medications should have been labeled.-There should not have been an insulin pen unlabeled, undated, with the needle still attached on the counter. During an interview on 3/9/26 at 1:40 P.M. LPN B said:-Medication should be labeled with the resident's name and the date it was opened on the medication container (storage box) and the bottle of medication. -The facility had a new medication electronic accountability system for controlled substances. -The system required licensed nurses and CMT's to enter the electronic medication control substance medication system when a controlled substance medication had been given and tally the amount left. During an interview on 3/13/26 at 11:35 P.M., LPN C said:-He/She was not sure what the cleaning and defrosting schedule was.-The housekeeping department was responsible for cleaning the refrigerators.-He/She would not expect medications, supplements, and residents' personal food and drink items to be stored in the same refrigerator.-There should never be food or unlabeled medication, such as insulin pens and needles on the medication room counter.During an interview on 3/13/26 at 12:15 P.M., Housekeeper B said:-The housekeeping department was responsible for cleaning the medication refrigerators.-The cleaning schedule was twice a month.-The defrosting schedule was every two weeks. During an interview on 3/13/26 at 12:24 P.M., the DON said:-The medication refrigerators should be cleaned weekly.-The medication refrigerators should be defrosted as needed.-The night shift nurse was responsible for making sure this was done.-He/She would not expect medications, supplements, and residents' personal food and drink items to be stored in the same refrigerator.-There should never be food or unlabeled medication, such as insulin pens and needles on the medication room counter. During an interview on 3/16/26 at 12:58 P.M., the Director of Nursing (DON) said:-He/she would expect licensed nurses and CMT's to ensure medications were labeled with the resident's name and the date the medication was opened on the container and the bottle. -Night nursing staff were responsible for auditing the medication cart for safe storage and labeling of medications.

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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. Based on observation and interview, the facility failed to maintain nozzles of the dishwasher spray wand free of debris; failed to maintain the vent over the clean side of the dishwasher free of a heavy buildup of dust; failed to discard one damaged mitten; failed to ensure there was an air gap between the drain from the ice machine and the floor drain; failed to ensure the container of utensils didn't have debris at the bottom of the utensil container; failed to ensure the lemon juice was refrigerated; failed to ensure the light fixtures in the kitchen were free from a dust buildup; failed to have the correct kind of sanitizer test strips available; failed to maintain two cutting boards free from numerous grooves and indentations; failed to ensure both light bulbs for the range hood illuminated; and failed to use a three step process to wash the food processor after use, in the upstairs kitchenette. This practice potentially affected all residents. The facility census was 49 residents. 1. Observation on 3/9/26 from 10:34 A.M. to 10:42 A.M., during the initial kitchen observation showed:-A buildup of dust inside the vent over the clean side of the dishwasher. -One damaged mitten.-The absence of an air gap between the drainage pipe from the ice machine and the floor drain.-One bottle of lemon juice that was unrefrigerated.-The presence of dust on the light fixtures over the freezer and the dishwashing area.2. Observation on 3/12/26 from 6:11 A.M. to 9:09 A.M., during the breakfast meal preparation showed:-A buildup of dust inside the vent over the clean side of the dishwasher. -One damaged mitten.-The absence of an air gap between the drainage pipe from the ice machine and the floor drain.-One bottle of lemon juice that was unrefrigerated.-The presence of dust on the light fixtures over the freezer and the dishwashing area.-The presence of a pink substance in the ice machine.-The presence of debris on the bottom of the utensil container.-The absence of chlorine test strips to match their chosen sanitizer of chlorine.-One yellow cutting board damaged and with stains that could not be removed.-One light bulb on the range hood that was not illuminated.-Numerous indentations on the cutting board at the steam table.-The handle of the margarine brush was damaged and not able to be cleaned.-The Dietary Manager (DM) used a one step process without dishwashing liquid, to wash the food processor in the upstairs kitchenette.3. During an interview on 3/12/26 at 11:07 A.M. the DM said:-He/She took over as the DM two weeks ago.-The lemon juice had set out for about two weeks. -The dietary department had not started a program of regular inspection for the cutting boards.-The light bulb had been out for a couple of months. -He/She just washed the food processor and did not use any dishwashing liquid because it was done that way in the past.-He/She did not notice there was dust on the light fixtures.-He/She had to order to the test strips.-He/She had worked for about a year at the facility and the cutting board at the steam table had those indentations for all that time-He/She needed to throw out the mitten with the holes. -The handle for the margarine brush was very damaged from being melted so many times.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure infection control practices to prevent cross contamination were implemented during resident indwelling urinary catheter (a flexible, thin tube inserted into the bladder to drain urine when a person cannot urinate naturally) and incontinence care for two sampled resident (Resident #5, and #6) and during wound care for one sampled resident (Resident #6); failed to ensure appropriate hand hygiene was performed during incontinence care for one resident (Resident #35); failed to ensure staff provided care in a manner to prevent infection or the possibility of infection when staff did not use the proper Enhanced Barrier Precaution (EBP) signage for one resident with an indwelling medical device (Resident #10) and failed to ensure that the Personal Protection Equipment (PPE) carts in hall were adequately stocked; failed to ensure proper sanitation of shared medical equipment before use, between residents and after use for one sampled resident (Resident #41) and one supplemental resident (Resident #48); failed to maintain a sanitary environment when basins used for resident care, were stored directly on the bathroom floor for two sampled residents (Resident #35 and #10) who were dependent on staff for Activities of Daily Living (ADLs) and incontinence care; failed to ensure appropriate infection prevention and control techniques and maintain aseptic (essential infection control practices, such as hand hygiene, PPE use, and creating a sterile field, designed to prevent healthcare-associated infections (HAIs) practices during administration of eyes drops for one supplemental resident (Resident #46) and failed to perform proper hand hygiene and apply gloves before he/she picked up food with his/her hand and placed it into the residents' mouth for one supplemental resident (Resident #19) out of 13 sampled residents and 12 supplemental residents; and failed to complete tuberculosis (TB-a contagious, often severe infection primarily affecting the lungs caused by Mycobacterium tuberculosis bacteria) testing timely upon hire for five of 9 sampled employees. The facility census was 49 residents.Review of the facility Handwashing policy and procedure dated October 2022, showed there was no documentation showing when the nursing staff should wash or sanitize their hands during resident care. It showed how to wash hands. Review of the facility Catheter Care policy and procedure dated October 2022, showed:-The staff should wash hands and explain the procedure to the resident. -Place a towel under the catheter tubing before washing. Apply soap to the washcloth and clean around meatus (the urethral opening and the external portion of a urinary catheter to prevent infections), avoiding tugging the catheter, moving in one direction, away from the meatus. Use a clean cloth for each stroke. Rinse around the meatus and use a clean cloth for each stroke. -With a clean dry towel dry around the meatus. Rinse at least 4 inches of the catheter nearest the meatus, moving away from the meatus. Use a clean cloth for each stroke. With a clean dry towel, dry at least 4 inches of the catheter nearest to the meatus, moving away from the meatus. Remove and discard gloves and wash hands. Review of the facility's Enhanced Barrier Precautions policy dated 3/20/24 showed:-Enhanced barrier precautions (EBP) refer to an infection control intervention designed to reducetransmission of multidrug-resistant organisms that employs targeted gown and gloves use during highcontact resident care activities.-All staff receive training on enhanced barrier precautions upon hire and at least annually and are expected to comply with all designated precautions.-The facility will have the discretion on how to communicate to staff which residents requirethe use of EBP, as long as staff are aware of which residents require the use of EBP prior toproviding high-contact care activities.-Enhanced barrier precautions will be initiated for residents with any of the following:I. Wounds (e.g., chronic wounds such as pressure ulcers, diabetic foot ulcers, unhealedsurgical wounds, and chronic venous stasis ulcers) and/or indwelling/implanted medicaldevices (e.g., central lines, po11s, urinary (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	catheters, feeding tubes,tracheostomy/ventilator tubes) even if the resident is not known to be infected orcolonized with a MDRO.II. Infection or colonization with a CDC-targeted MDRO when Contact Precautions do nototherwise apply.-Make gowns and gloves available immediately near or outside of the res ident's room. Note:face protection may also be needed if performing activity with risk of splash or spray (i.e.,wound irrigation, tracheostomy care).-Ensure access to alcohol-based hand mb in every resident room (ideally both inside andoutside of the room).-Provide education to residents and visitors.- Place a yellow sticker or magnet on the name plate of the resident's door to identify the needof EBP. A medical equipment sanitation policy was requested but not provided at the time of exit. Review of the facility's Eye Drop Administration policy revised on 09/17/25 showed:- Equipment Required:A. Eye drop medication.B. Gauze pad, cotton ball, or tissue.C. Examination gloves.D. Barrier (e.g., disposable tray or plastic cup).E. Medication Administration Record (MAR).F. Waste receptacle.G. Drug reference (available in facility).-If administering medications to both eyes, use a different gloved finger to apply pressure to the inner tear duct. If the eye medication is an antibiotic or anti-viral and the resident has an active eye infection, change gloves between eyes. If one eye is infected, treat the infected eye last. A donning gloves policy was requested but not provided. The facility only provided a list of instructions on how to don gloves. 1. Review of Resident #6's admission record showed he/she admitted with the following diagnoses:-Stage IV pressure injury/wound (a severe, full-thickness wound involving extensive tissue loss, with directly exposed muscle, tendon, or bone) to the coccyx (tail bone area).-Had an indwelling urinary catheter. Review of the resident's admission Minimum Data Set (MDS- a federally mandated assessment tool completed by facility staff for care planning) dated 1/5/26 showed:-Usually understands may miss some or part/intent of message but comprehends most conversation.-admitted with an indwelling catheter. -admitted with pressure wound. Review of the resident's Care Plan initiated on 1/19/26 and revised on 3/3/26 and 3/11/26 showed:-The resident had wounds. --Wound care and treatment to wound as ordered by prescriber. -The resident was on EBP related to wounds and indwelling catheter initiated on 3/11/26. --Direct care staff were to follow EBP and to utilize gowns and gloves for all personal cares. -He/she had an indwelling urinary catheter: 18 French (Fr a measure of the outer diameter of a catheter) with a 10 cubic centimeters (cc) balloon due to pressure ulcer to the coccyx. --Position urinary catheter bag and tubing below the level of the bladder and way from entrance room door. Review of the resident's Physician Order Sheet (POS) dated March 2026 showed:-EBP related to wounds. Wear gown and gloves for all high contact resident care activities, was ordered on 1/9/26. -Irrigate urinary catheter with 30 milliliters (ml) of normal saline as needed for occlusion, was ordered on 11/19/25.-Change urinary catheter: 18 Fr with a 10 ml [NAME] bulb, related to Stage IV pressure injury as needed for occlusion or leakage and one time a day starting on the 25th and ending on the 25th every month, was ordered on 11/19/25. -Nursing staff were to cleanse the resident wound to the sacrum with wound cleanser/normal saline pat dry with 4x4 gauze pad and pack wound with collagen particles powder, then cover the wound with a dry dressing, change dressing every dayshift and as needed if soiled, was ordered on 3/6/26. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Observation on 3/10/26 at 10:08 A.M., of the resident's care showed Certified Nursing Assistant (CNA) A:-Entered the resident's room and put on gloves then proceeded to empty the resident's foley catheter drainage bag. -Laid the graduate container on top of the mattress at the foot of the resident's bed while empty the drainage bag. -Emptied the graduate container in the toilet, removed the gloves and sanitized his/her hands. -Was waiting on another staff member to assist with resident care and transfer. Observation on 3/10/26 at 10:15 A.M., of the resident's catheter care showed:-The resident had no signage posted for EBP. -CNA A and CNA B entered the resident room with no gown applied and grabbed clean gloves from box. -CNA A dropped one of the gloves and then grabbed the glove off the ground and put it on his/her hand. -CNA A proceed to provide urinary catheter care and incontinent care for the resident, with the glove that had been dropped on the ground. -CNA A completed the care in the front and with same gloved hands turned the resident to his/her side and completed incontinent care to the resident's bottom. -CNA B placed the resident's urinary catheter bag on his/her mattress at the foot of the bed during personal cares (at the level of the bladder).-CNA A removed his/her soiled gloves and without sanitizing his/her hands, placed clean gloves on his/her hands. -CNA B reentered the room placed clean gloves on his/her hands without washing or sanitizing his/her hands.-Resident care was completed by CNA A. -CNA A and CNA B removed the soiled gloves and washed their hands with soap and water prior to leaving the resident's room. Observation on 3/10/26 at 10:30 A.M., of the resident's wound care showed:-The Infection Control Preventionist (ICP) and Licensed Practical Nurse (LPN) A entered the resident's room and applied gown and gloves. -The old dressing was falling off and was removed by LPN A.-The coccyx wound had no drainage noted and was the size of quarter. -LPN A provided wound care he/she cleansed the wound with wound cleanser, with same gloved hands, he/she applied collagen particles powder with fingertips of gloved hand into the resident's wound bed. -With the same gloves, LPN A applied the dry dressing. -He/she removed the gloves and washed his/her hands prior to leaving the area. During an interview on 3/10/26 at 2:40 P.M. with CNA A and CNA B said:-They were supposed to wash or sanitize their hands upon entering the resident's room, after they leave the room, after removing their gloves and after completing a dirty task. -The resident's catheter bag could not be on the floor, so they used the basin to put it in when the resident is in bed. During an interview on 03/13/26 at 11:58 A.M., CNA D said: -He/she would wash his/her hands upon entry of the resident room and before leaving the room. -He/she would sanitize or wash hands before and after incontinent care or catheter care.-He/she did not always sanitizer his/her hands between glove changes, only if visibly soiled gloves.-He/she should not use gloves that have dropped on the ground, he/she would have obtained a new clean glove. -He/she would apply clean gloves and place a barrier on the ground before placing the graduate container on top then empty the catheter drainage bag into the graduate. -Resident's on EBP would have an isolation cart that would have gown, gloves, mask, booty's if needed to provide direct contact care. During an interview on Review of 3/16/26 10:04 A.M., the MDS Coordinator/ICP and Regional Registered Nurse (RN) said:-He/She would expect care staff to sanitize or wash hands from a dirty to clean process, after complete incontinent care and between each glove change or when gloves were visibly soiled. -Residents with indwelling catheter would be on EBP and signage should be posted on the resident's door.-He/She would expect care staff who provided direct resident catheter care to wear a gown, gloves, mask and if need safety glasses if potential splatter.-He/She would expect care staff to change gloves and sanitize their hands from the dirty to clean process.-He/She would expect (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	care staff to not use a glove it was dropped on the floor. -He/She would expect wound care treatment of collagen particles powder to be applied with clean gloved hands. During an interview on 3/16/26 at 11:53 A.M., LPN A said:-He/She should have changed gloves between a dirty to clean process and then sanitized his/her hands between each glove change. -He/She should have removed the dirty gloves and sanitized his/her hands then applied new clean gloves prior to applying the collagen particles powder to the wound bed. During an interview on 3/16/26 at 12:58 P.M., the Director of Nursing (DON) said:-He/She would expect facility staff to always position the urinary catheter bag and tubing below the bladder. -He/She would expect all care staff to perform hand hygiene between each glove change and from a dirty to clean process.-If gloves were visibly soiled then he/she would expect care staff to remove gloves, sanitize hands, then apply new clean gloves to hands. -He/She would expect care staff not to use any gloves that had fallen on the ground. -He/She would expect nursing staff to apply wound care treatment of collagen particles powder with clean gloved hands and should not place collagen particles powder in wound bed with dirty/soiled gloves. 2. Review of Resident #35's face sheet showed the resident was admitted with the following diagnoses:-Chronic Obstructive Pulmonary Disease (COPD inflammatory lung disease that causes obstructed airflow from the lungs, resulting in breathing difficulties).-Heart failure (CHF the heart can't pump blood well enough to meet your body's needs).-Morbid Obesity with Alveolar Hypoventilation (a condition where severe obesity (BMI ≥30) causes chronically low oxygen and high carbon dioxide levels in the blood due to impaired breathing.-Obstructive Sleep Apnea (OSA a serious sleep disorder where breathing repeatedly stops and starts due to throat muscles relaxing and blocking the airway).-Mixed Simple and Mucopurulent Chronic Bronchitis (a long-term inflammatory condition affecting the bronchi, characterized by persistent cough and mucus production).-Chronic Respiratory Failure with Hypoxia (a long-term inability of the respiratory system to properly oxygenate blood and eliminate carbon dioxide, often due to COPD, neuromuscular disorders, or obesity).-Chronic Respiratory Failure with Hypercapnia (too much carbon dioxide (CO2) in your blood. If your body can't get rid of carbon dioxide, a waste product, there isn't room for your blood cells to carry oxygen).-Dyspnea (shortness of breath or difficulty breathing).-Personal history of other diseases of the respiratory system.-Osteoarthritis (most common form of arthritis when the protective cartilage that cushions the ends of the bones wears down over time). Review of the resident's admission MDS dated [DATE], showed:-The resident was cognitively intact.-He/She was dependent on staff for eating, toileting, bathing, dressing, personal hygiene, and mobility.-He/She had lower extremity impairment on one side. Review of the resident undated care plan showed:-The resident was dependent on staff for meeting physical needs related to physical limitations.-He/She has an ADL self-care performance deficit and was dependent on two staff for personal hygiene. Observation on 3/9/26 at 10:50 A.M. showed three basins uncovered lying on the bathroom floor. Observation on 3/10/26 at 10:26 A.M. showed three basins uncovered lying on the bathroom floor. Observation on 3/11/26 at 11:10 A.M. during incontinence care showed:-CNA J entered the resident's room to do incontinence care, donned (put on) gloves without performing hand hygiene and adjusted the blinds closed.-Doffed (took off) gloves and threw into trash.-Donned gloves without performing (continued on next page)

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Maywood Terrace Living Center	10300 East Truman Rd Independence, MO 64052

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	hand hygiene and lowered the head of the resident's bed using the bed remote.-Removed the resident's linens and gown the pulled down resident's brief and cleaned the resident's front perineal area with wipes, removed additional wipes from the package with the same hand that perineal care was done with, turned resident to his/her right side and cleaned buttock area from front to back with wipes.-Doffed gloves and did not perform hand hygiene, moved wipes package and touched resident, did not perform hand hygiene.-Donned gloves, turned resident to his/her left side, completely removed dirty brief from under the resident, cleaned the resident front to back with wipes, removed additional wipes with the same hand used for perineal care, with the same gloves on, put a clean brief in place under the resident and applied barrier cream from tube.-Rolled the resident flat on his/her back and adjusted the brief around them.-With the same gloves on, continued to fasten the brief on the resident and adjusted his/her gown over them.-Doffed gloves, did not perform hand hygiene, picked up and moved the trash can with bare hands, removed package of wipes from bed, touched bedside table to move it, adjusted the head and foot of bed using the remote, adjusted the resident's nasal cannula (a lightweight, flexible tube used to deliver supplemental oxygen to patients with breathing difficulties) back into his/her nose, adjusted the bed again using the remote, removed blanket from the bed.-Without performing hand hygiene, donned gloves and collected the trash bag from the can and took out of room to the soiled utility room.-Returned to room and without gloves on, placed a new liner into the trash can. Did not perform hand hygiene.-Removed another blanket from the bed and took it out of the room to the dirty linen room without gloves on. During an interview on 3/11/26 at 1:00 P.M., CNA J said:-He/She had received training on hand hygiene during onboarding. The types of hand hygiene that could be performed were hand washing or using hand sanitizer.-He/She could use some additional training.-Whichever hand that was used for perineal care should not be switched with clean hand that had not.-Hand hygiene should have been done when changing gloves, after they were removed and before putting on a new pair.-After performing incontinence care, gloves should be removed, hand hygiene performed, new gloves should be put on before resuming contact with the resident or their things. Observation on 3/12/26 at 2:18 P.M. showed three basins uncovered lying on the bathroom floor. During an interview on 3/13/26 at 11:15 A.M., CNA H said:-Hand hygiene should be performed between glove changes and before and after cares.-The same hand used for peri-care should not be used to grab clean wipes.-Staff should not touch residents' belongings after performing peri care and before removing gloves and performing hand hygiene.basins should never be on the floor and uncovered. They should be kept at bedside or behind toilet. During an interview on 3/13/26 at 11:35 A.M., the LPN B said:-He/She would perform hand hygiene between gloves changes, before and after care and use hand sanitizer every third person in general.-The same hand used to perform peri-care should not be used to grab clean wipes.-Resident's belongings should not be touched with dirty gloves on.-Basins should not be kept on the floor at any time and should be kept in a trash bag tied to the bathroom handrail. During an interview on 3/13/26 at 12:24 P.M., the DON said:-Training on infection control was given through Relias (a comprehensive, cloud-based learning platform to improve employee performance, ensure regulatory compliance, and enhance patient care) and monthly in-services.-Hand hygiene should be performed before resident contact, after performing care and after glove changes.-He/She would not expect staff to touch anything in a resident's room during peri-care and return to peri-care without a glove change and hand hygiene being performed.basins should never be on the floor and uncovered. Nursing staff should make sure of this. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 3/13/26 at 11:50 A.M. LPN B said:-Residents who required EBP were those with catheters, wounds, feeding tubes (a medical device used to deliver nutrition, fluids, and medication directly into the stomach or small intestine), tracheostomies (an opening (stoma) in the neck into the trachea (windpipe) to establish a direct, stable airway) and any opening leading to outside of the body.-There should be signage outside the room of all resident's who are on EBP.-The signage should contain what reason the resident is on EBP and what PPE is necessary.-The PPE carts should contain gowns, face masks, eye shields, gloves, biohazard bags and booties.-The wound care nurse and all nursing staff are responsible for making sure the carts are stocked.-Some of the risks of not following EBP protocol and using the proper PPE would be spreading bacteria and infection.- Basins and commode specimen hats should not be on the floor in the bathroom. During an interview on 03/13/26 at 12:24 P.M. the DON said:-Training on EBP has been given through Relias, in-services and through Performance Improvement Project (PIP- a structured, data-driven initiative used within QAPI (Quality Assurance and Performance Improvement) to improve care, safety, or services).-Residents who require EBP include tracheostomies, feeding tubes, foley catheters, wounds and openings on the body.-There should be signage outside the room of all residents who are on EBP.-Gloves, gowns, face shields, and masks should be stocked in the PPE carts.-Night shift nurses are responsible for making sure the carts are stocked.-A risk of not following EBP protocol and using the proper PPE would be infection.- Basins and commode specimen hats should not be on the floor in the bathroom. 4. Review of Resident #41's face sheet showed the resident was admitted with the following diagnoses:-Atrial Fibrillation (A-Fib abnormal heart rhythm).-Hypertensive heart disease with heart failure (chronic high blood pressure forces the heart to work harder, causing the left ventricle to thicken (hypertrophy) and eventually become too weak or stiff to pump effectively).-Hypertension (high blood pressure).-Peripheral Vascular Disease (a slow-developing condition where narrowed blood vessels, usually arteries, restrict blood flow to the limbs).-Dementia (a progressive organic mental disorder characterized by chronic personality disintegration, confusion, disorientation, stupor, deterioration of intellectual capacity and function, and impairment of control of memory, judgment, and impulses)-Anxiety.-Chronic Kidney Disease (CKD- long-term, progressive loss of kidney function, often causing waste buildup and fluid retention primarily caused by diabetes and high blood pressure). Review of the resident's Quarterly MDS dated [DATE] showed:-The resident had moderate cognitive impairment.-He/She had active diagnoses of heart failure, hypertension, kidney failure and dementia. Review of the resident's POS dated 3/12/26 showed:-Amlodipine Besylate oral tablet 5 milligrams (mg) by mouth one time per day for hypertension. Hold if blood pressure is less than 110/55 or heart rate (pulse) is less than 55. Notify physician of held medications.-Aspirin oral tablet chewable 81 mg give one tablet by mouth one time a day for prophylaxis (for prevention) related to atrial fibrillation, hypertensive heart disease with heart failure and peripheral vascular disease. Observation on 3/11/26 at 11:40 A.M. showed Certified Medication Technician (CMT) C applied a shared, blood pressure wrist cuff to the resident's left wrist to obtain a blood pressure reading without sanitizing it prior to use. The blood pressure was obtained, and the blood pressure cuff was not sanitized after use. 5. Review of Resident # 48's face sheet showed he/she was admitted with the following diagnoses:-A-Fib.-Heart failure.-Hypertensive Chronic Kidney Disease (a condition where high blood pressure causes long-term damage to the kidneys). (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of the resident's admission MDS dated [DATE] showed:-The resident had moderate cognitive impairment.-He/She had active diagnoses including Atrial Fibrillation and heart failure. Review of the resident's POS dated 3/12/26 showed:-Amiodarone HCl oral tablet 200 mg give one tablet by mouth one time a day for Congestive Heart Failure (CHF- a chronic, progressive condition where the heart cannot pump blood efficiently, causing fluid buildup in the lungs and body) and Atrial Fibrillation.-Metoprolol Tartrate oral tablet 25 mg give one tablet by mouth two times per day for hypertension. Hold if systolic (the top number measures the pressure in the arteries when the heart beats) blood pressure is less than 110 or pulse less than 60. Observation on 3/11/26 at 12:38 P.M. showed CMT C applied a shared, blood pressure wrist cuff to the resident's left wrist in order to obtain a blood pressure reading without sanitizing it prior to use. The blood pressure was obtained, and the blood pressure cuff was not sanitized after use. During an interview on 3/11/26 at 12:45 P.M. CMT C said:-He/She received an in-service on infection control around December 2025 from the former Administrator.-The wrist blood pressure cuff was shared medical equipment and should be sanitized before and after use for each resident. During an interview on 3/13/26 at 11:50 A.M., LPN B said the blood pressure cuff was shared medical equipment and should sanitized before and after use for each resident. During an interview on 3/13/26 at 12:24 P.M., the DON said he/she would expect for shared medical equipment like wrist blood pressure cuffs to be sanitized before and after use and between residents. 6. Review of Resident #46's face sheet showed the resident was admitted with the following diagnoses:-Absolute Glaucoma (he final, end-stage of untreated or uncontrolled chronic glaucoma, characterized by total blindness, severe pain, and extremely high intraocular pressure).-Age related Osteoporosis (bone disease characterized by decreased density and strength, often causing no symptoms until a fracture occurs).-Need for assistance with personal care.-Muscle weakness. Review of the resident's Quarterly MDS dated [DATE] showed:-He/She had moderate cognitive impairment.-He/She was dependent on staff for mobility, dressing, bathing, personal and oral hygiene.-He/She had medically complex conditions. Review of the resident's POS dated 3/12/26 showed:-Artificial Tears Ophthalmic Solution 1% instill one drop in both eyes two times a day for dry eyes.-Carteolol HCl Ophthalmic Solution 1% instill one drop in both eyes in the morning for absolute glaucoma. Review of the resident's undated care plan showed:-He/She was very hard of hearing; staff were to use low tones when speaking and speak close to his/her ear.-He/She had impaired visual function; staff were to monitor and document any signs or symptoms of acute eye problems and tell him/her where they are placing items and be consistent. Observation on 3/11/26 at 11:50 A.M. showed:-CMT C washed his/her hands appropriately, applied gloves, administered Artificial Tears eye drops to both of the resident's eyes, applied and held pressure to inner corner of the left eye with the right index finger of gloved hand with no barrier between glove and resident's eye area. -Repeated this on the right eye with the same gloves on.-Removed gloves and performed hand hygiene. Observation on 3/11/2026 at 12:23 P.M. showed:-CMT C returned to the room, performed hand hygiene, donned gloves, administered Carteolol (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ophthalmic eye drops to both of resident's eyes, applied and held pressure to the inner corner of left eye with the right index finger of gloved hand and without a barrier between the glove and the resident's eye area. -Repeated this on the right eye with the same gloves on.-Removed gloves and performed hand hygiene. During an interview on 3/11/26 at 12:45 P.M. CMT C said:-He/She received an in-service on infection control December 2025, from the previous Administrator.-He/She should not have applied pressure to inner eye area with bare gloves and should have put a barrier between glove and the resident's eye such as tissue instead.-Not doing this would run the risk of cross contamination, because of all the things he/she touched with the gloves on prior.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to maintain the plumbing system to ensure the hot water temperatures were kept at or above 105 F (degrees Fahrenheit) in resident rooms 31, 34, 25, 23, 24, 19; and below 120 F in resident room [ROOM NUMBER], 13, 12, 11, 9, 7, and 4; failed to install an inline temperature gauge (a thermometer which provides real-time, precise monitoring for liquids or gases within pipes, hoses, and industrial systems) on the water heaters which served the [NAME] and North halls; failed to place handles on the faucets on the janitor's closets. The practice of not maintaining the system to ensure the temperature of hot water, stayed within the range of 105 F to 120 F, potentially affected all residents. The facility census was 49 residents. Review of the facility's undated weekly temperature log guidelines, showed:-Check two random rooms per wing for proper water temperatures.-Resident rooms should reach water temperature of 105 F to 120 F, maximum.-If a resident room's water temperature was below 105 F, look for a cold-water mix at a fixture such as a whirlpool, shower faucet, or chemical additive machine, turn the cool side off. If a low water temperature still occurred, call for service.-If a resident rooms water temperature was above 120 F, adjust the water heater, look for a hot water leak, or check mixing valves. If high water temperature still occurred, call for service.-Kitchen and laundry room temperatures should reach 140 F, unless low temperature chemicals were being used.-When it was necessary to replace a faucet, make sure it was replaced with a double lever faucet.1. Review of water temperatures documented by the facility on 2/27/26, showed:-At 10:45 A.M., the hot water temperature in an unknown resident room was 119.1 F.-At 10:52 A.M. the hot water temperature in resident room [ROOM NUMBER] was 111.3 F.-At 11:15 A.M., the hot water temperature in resident room [ROOM NUMBER] was 111.7 F.-At 11:18 A.M. the hot water temperature in resident room [ROOM NUMBER] was 107.2 F.Review of water temperatures documented by the facility on 3/2/26, showed:-At 10:58 A.M., the hot water temperature in resident room [ROOM NUMBER] was 106.7 F.-At 11:15 A.M. the hot water temperature in resident room [ROOM NUMBER] was 117.3 F.-At 11:18 A.M., the hot water temperature in resident room [ROOM NUMBER] was 105.0 F.-At 11:21 A.M. the hot water temperature in resident room [ROOM NUMBER] was 110.5 F.Review of water temperatures documented by the facility on 3/11/26, showed:-At 7:43 A.M., the hot water temperature in resident room [ROOM NUMBER] was 101.0 F.-At 7:56 A.M. the hot water temperature in resident room [ROOM NUMBER] was 107.3 F.-At 8:31 A.M., the hot water temperature in resident room [ROOM NUMBER] was 108.9 F.2. Observation on 3/10/26 of hot water temperatures with the Maintenance Director and Maintenance Person B showed the following temperatures did not get to or exceed 105 F after the water was flowing for two minutes or more:-At 9:19 A.M., the hot water temperature in resident room [ROOM NUMBER] was 101.9 F.-At 9:23 A.M., the hot water temperature in resident room [ROOM NUMBER], was 102.2 F.-At 9:39 A.M., the hot water temperature in resident room [ROOM NUMBER], was 102.2 F. -At 9:52 A.M., the hot water temperature in resident room [ROOM NUMBER], was 101.6 F.-At 10:00 A.M., the hot water temperature in resident room [ROOM NUMBER], was 102.7 F.-At 10:19 A.M., the hot water temperature in resident room [ROOM NUMBER], was 90.5 F.Observation on 3/10/26 of hot water temperatures with the Maintenance Director and Maintenance Person B showed the following temperatures exceeded 120 F after the water was flowing for two minutes or more:-At 11:09 A.M., the hot water temperature in resident room [ROOM NUMBER] was 123.9 F.-At 11:15 A.M., the hot water temperature from sink in the [NAME] Hall Shower room was 123.9 F and there was a leak from the sink in the [NAME] Hall shower room.-At 11:29 A.M., the hot water temperature in resident room [ROOM NUMBER], was132.2 F. -At 11:47 A.M., the hot water temperature in resident room [ROOM NUMBER], was 126.3 F. -At 11:55 A.M., the hot water temperature in resident room [ROOM NUMBER], was 125.2 F. -At 11:58 A.M., the hot water temperature in resident room [ROOM (continued on next page)

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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
Maywood Terrace Living Center	10300 East Truman Rd Independence, MO 64052

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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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, the facility failed to maintain the floor in the restroom of resident room [ROOM NUMBER] in good repair; failed to maintain the fans free of a heavy buildup of dust in resident rooms [ROOM NUMBER], Resident #10's room, Resident #9's room, the therapy room, and failed to prevent a torn sling (a specialized fabric harnesses used with mechanical lifts to safely transfer individuals with limited mobility between beds, wheelchairs, toilets, and showers) from being used to transfer Resident #3. This practice potentially affected at least 15 residents who reside in or used those areas. The facility census was 49 residents. 1. Observation on 3/10/26 at 9:30 A.M., showed a 10 inch (in.) long by 0.5 in wide area of floor damage in the restroom of resident room [ROOM NUMBER].During an interview on 3/10/26 at 9:30 A.M., the Maintenance Director said that floor damage had been there for as long as he/she had worked at the facility.2. Observation on 3/10/26 at 9:39 A.M., showed a fan with a heavy buildup of dust in resident room [ROOM NUMBER].Observation on 3/10/26 at 9:52 A.M., showed a fan with a heavy buildup of dust in resident room [ROOM NUMBER]. During an interview on 3/10/26 at 9:53 A.M. the District Housekeeping Manager said the fans should be cleaned every 2 weeks.Observation on 3/10/26 at 9:56 A.M. showed a fan with a heavy buildup of dust in Resident #10's room.During an interview on 3/10/26 at 9:57 A.M., Resident #10, a resident who was identified by his/her Admission's Minimum Date Set (MDS-- a federally mandated assessment tool completed by the facility for care planning) dated 2/4/26, as a resident who was cognitively intact, said he/she had the fan for a few weeks, and the housekeeping department had not cleaned it.Observation on 3/10/26 at 10:06 A.M., showed a fan with a heavy buildup of dust in Resident #9's room.During an interview on 3/10/26 at 10:07 A.M., Resident #9, a resident identified by the quarterly MDS dated [DATE], as a resident who was cognitively intact, said the last time his/her fan was cleaned was in the summer of 2025.Observation on 3/10/26 at 10:19 A.M., showed a fan with a heavy buildup of dust in resident room [ROOM NUMBER].3. Review of Resident#3's face sheet showed diagnoses which included:-Chronic Obstructive Pulmonary Disease (COPD--a progressive, incurable lung disease that makes breathing difficult by damaging airways and air sacs).-Morbid obesity.-Discogenic back pain (pain originates from damaged or degenerated intervertebral discs, often causing chronic, localized axial low back pain, particularly when sitting, bending).-Bilateral primary osteoarthritis (the most common chronic joint disease, caused by the breakdown of cartilage leading to pain, swelling, and reduced mobility).-Reduced mobility. Review of the resident's annual MDS dated [DATE] showed he/she:-Was cognitively intact. -Was dependent on two or more facility staff for moving from a sitting to lying position, sitting to standing transfers, chair to bed transfers, for toileting, -Did not have the ability to walk.-Was dependent on two or more facility staff for mobility in a wheelchair. Observation on 3/10/26 at 9:42 A.M., showed a torn sling in a chair in the resident's room During an interview on 3/10/26 at 9:42 A.M., the resident said: -The sling in the chair was the sling staff used to transfer him/her. -He/she told them that a different sling was needed because it was torn.Observation on 3/12/26 at 2:03 P.M., showed the resident was sitting in his/her wheelchair in the therapy room with the torn sling under him/her. During an interview on 3/12/26 at 2:05 P.M., the resident said:-The staff used the sling to transfer him/her from his/her bed to the wheelchair.-He/She told them to get rid of the sling on 3/10/26. During an interview on 3/12/26 at 2:09 P.M., the Physical Therapist Assistant said the sling that was used for the resident needed to be replaced. During an interview on 3/12/26 at 2:12 P.M., Licensed Practical Nurse (LPN) B said he/she would check the sling for any holes or rips that jeopardized the safety of the resident.During an interview on 3/12/26 at 2:24 P.M., Certified Nursing Assistant (CNA) E said:-He/she took a sling out of the clean utility closet. -He/she used that sling to transfer the resident.-He/she did not check to see if the sling was torn or ripped.-He/she should have checked for (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	damage to the sling. During an interview on 3/12/26 at 2:35 P.M., the Director of Nursing (DON) said he/she would expect CNAs to check for rips or tears and that the handles were attached, and the loops of the sling were in order.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to accurately assess and document resident care areas on the Facility Matrix for two sampled residents (Resident #3 and #35) for respiratory care, opioid and insulin use and failed to ensure an accurate assessment was completed and behavior was selected as a care plan area for one sampled resident (Resident #53) with known and documented behaviors prior to and after admission out of 13 sampled residents. The facility census was 49 residents. 1. Review of Resident #53's Face Sheet showed the resident was admitted with diagnoses that included:-Neurocognitive disorder (a progressive, incurable brain disease characterized by abnormal deposits of protein, known as Lewy bodies, in neurons. It causes severe cognitive decline, fluctuating attention, recurrent visual hallucinations, and motor symptoms).-Diabetes.-High cholesterol.-High blood pressure. Review of the resident's Nursing Notes from the transferring nursing facility dated 1/21/26 to 2/16/26 showed:-The facility was monitoring the resident for behaviors including wandering, anxiety (a normal human reaction to stress, involving feelings of fear, dread, uneasiness, and tension, often accompanied by physical symptoms like rapid heart rate, muscle tension, and sweating) and depression. The resident received Ativan (anti-anxiety medication) three times daily for anxiety/behavior.-1/21/26 nursing staff gave the resident a baby doll and asked the resident to babysit and the resident was excited to do so stating he/she would take good care of him/her.-1/29/26 the resident was in another resident's room going through their belongings. Staff redirected the resident out of the room. The resident was difficult to redirect and became agitated. The resident refused to sit down in front of the nursing station and continued to wander.-2/6/26 the resident remained up through the night and did not go to bed until 3:30 A.M. -2/15/26 at 9:20 A.M., the resident was going into other resident rooms, grabbing their possessions. Staff tried to redirect the resident, and the resident resisted and began screaming, crying and yelling. At 9:45 A.M., the resident entered another resident's room while staff was getting that resident dressed and refused to leave. The nurse redirected the resident out of the room.-2/18/26 the resident was seen wandering toward the exit door and was accompanied by the therapist back to his/her area. Staff placed a wanderguard (a specialized wander management system used in senior living and memory care facilities to monitor residents with cognitive impairments, such as dementia) and placed the resident on one-to-one monitoring due to his/her high elopement risk. Review of the resident's Elopement Evaluation dated 2/27/26 showed the resident:-Did not have a history of elopement while at home.-Had a history of attempting to leave the facility without informing staff.-Wandered and verbally expressed the desire to go home, packed belongings to go home or stayed near an exit door.-Wandering behavior was not goal directed, and the behavior was likely to affect the safety, privacy or well-being of self/others. Review of the resident's Behavior Notes showed:-On 2/27/26 at 4:10 P.M., The resident had been in and out of resident rooms going through other resident's belongings. The resident had been hard to redirect. The resident had been trying to touch other residents throughout the shift. The resident had been redirected throughout the shift. The resident was alert/oriented to self only. The resident had been resistant to care throughout shift. Monitoring was to continue.-On 2/27/26 at 7:41 P.M., The resident had increased agitation, had been attempting to push other residents in wheelchair. The resident had been taking other residents belongings and wondering in and out of other resident rooms. The resident was resistant to redirection. The resident had been offered snacks and different activities with quickly returning to what he/she was doing prior to being redirected. When the resident (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	was being redirected, he/she became combative with staff. This nurse called the Nurse Practitioner (NP) on duty who said to give the resident prn order of Ativan every 6hrs. Power of Attorney (POA) aware of new order at that time.-On 2/28/26 at 10:21 P.M., The resident had periods of restlessness. The PRN Ativan was effective. The resident was resting at that time. Review of the resident's Physician's Order Sheet (POS) dated March 2026, showed physician's orders for:-Trazodone 50 milligram (mg) give 1 tablet by mouth at bedtime for insomnia (active 2/26/26).-Buspirone 5 mg give 1 tablet by mouth three times daily for anxiety (active 2/26/26).-Divalproex Sodium 250 mg give 1 tablet by mouth twice daily for mood (active 2/26/26).-Lorazepam 0.5 mg give 1 tablet by mouth three times daily for anxiety/behaviors (active 2/26/26).-Lorazepam 0.5 mg give 1 tablet by mouth every 6 hours as needed for anxiety/agitation (active 2/27/26). Review of the resident's Behavior Notes showed:-On 3/1/2026 at 3:56 P.M., The resident continued to have restless behavior. The resident had received Ativan as per order. The resident would have positive effects from medication for a while and would begin to have restless behaviors such as going through other resident belongings and pushing other residents in wheelchairs. The resident became combative when staff attempted to redirect him/her to other activities. The resident was coloring in the public dining room.-On 3/1/26 at 7:19 P.M., The resident had been agitated and restless throughout the evening. The resident had received Ativan with no results at this time. The resident had been unable to be redirected. The resident pushed at staff when staff had attempted to redirect him/her. The resident did take his/her baby doll and was walking around with the doll at that time.-On 3/1/26 at 7:45 P.M., This nurse called the nurse practitioner about the resident's agitation. The nurse practitioner gave a new order to increase Depakote to three times daily and Ativan to four times daily. This nurse called the resident's responsible party, who stated understanding and thanked nursing staff for care given to the resident. Review of the resident's Care Plan dated 3/1/26, showed the resident had a behavior management plan with a goal to monitor /manage the resident's undesirable behaviors and keep the resident safe. Interventions showed:-Attempt an alternate time to provide care refused, per resident's preference.-Consult pastoral care, as needed.-Educate resident/representative on the necessity of care attempted to provide.-Ensure the safety of resident and others.-Monitor for signs/symptoms of infection.-Re-orient resident to person, place, time and situation.-NOTE: The care plan did not show the behaviors the resident had exhibited prior to admission and since admission (restlessness, agitation, combativeness/pushing staff, infringing on resident personal space, interfering with cares) and did not address specific interventions implemented to address pre-identified behaviors (coloring/reading, snacks baby doll, medication). Review of the resident's POS dated March 2026, showed:-Divalproex Sodium 250 mg give 1 tablet by mouth three times a day for mood (active 3/1/26).-Lorazepam 0.5 mg give 1 tablet by mouth four times a day for anxiety/behavior (active 3/1/26). Review of the resident's Behavior Notes showed on 3/4/26 at 1:40 P.M., The resident was unaware of other residents' personal space several times throughout this shift. The resident continued to need to have redirection from infringing on other residents' personal space. Review of the resident's admission Minimum Data Set (MDS-a federally mandated assessment tool to be completed by facility staff for care planning) dated 3/4/26, showed the resident: -Had severe cognitive impairment with inattention.-Was inattentive, but had no behavior symptoms, hallucinations (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	or delusions.-Had no verbal or physically aggressive behaviors towards others. -NOTE: The MDS did not show behaviors that were exhibited by the resident that were documented and submitted to the facility upon admission (resident had behavior symptoms and combativeness toward staff). Review of the resident's Behavior Notes showed:-On 3/5/26 at 4:28 P.M., The resident continued to attempt to touch other residents. The resident was taking other residents belongings. The resident had been pacing back and forth on the unit throughout the day.-On 3/9/26 at 3:06 P.M., The resident continued to have restless behaviors. This nurse notified the nurse practitioner who gave a new order to increase Busbar to three times daily. The nurse notified the resident's responsible party and was okay with the medication adjustment. Observation and interview on 3/9/26 at 10:11 A.M., showed the resident was not in his/her room. He/she was standing at the nursing station dressed for the weather without odor. He/She was not wearing shoes or socks and was ambulating independently around the nursing station. The resident was inquisitive but was not able to be interviewed. Licensed Practical Nurse (LPN) A said:-The resident was new to the facility and had only been on the locked unit 2-3 weeks.-The resident refused to wear socks or shoes.-The resident usually wandered throughout the unit and had wandered into resident's rooms, so they tried to monitor him/her to prevent that behavior. Observation on 3/10/26 at 2:52 P.M., showed:-The resident was wandering on the unit without socks or shoes on. -The resident was walking around the nursing station and nursing staff was interacting with him/her. During an interview on 3/10/26 at 2:52 P.M. Certified Nursing Assistant (CNA) B said:-They usually tried to keep the resident active by giving him/her linen to fold, there was a magazine that he/she liked to look at and they gave that to him/her, or a puzzle or snacks to occupy the resident.-The resident would engage in activities but he/she had a very short attention span so it was only for short time periods that they would occupy his/her attention.-LPN A brought a stack of towels for the resident to fold and CNA A brought the resident a grilled cheese sandwich with an orange soda and encouraged the resident to sit down and eat (which the resident did and was not agitated or anxious). During an interview on 3/10/26 at 2:52 P.M. CNA A said: -The resident used to be a CNA at the facility, and he/she liked to help with tasks in the unit and wanted to help other residents. -Staff usually could not get the resident to sit through the lunch period so they would give him/her snacks throughout the day so he/she would eat. -The resident would invade other resident's personal space, and they didn't like it, but he/she thought it was because the resident used to be a CNA. -The resident could become agitated at times and difficult to redirect.-The resident was very pleasantly eating her snack while staff was socializing with her. -The resident's relative came to visit him/her this afternoon around lunch time. They had to watch him/her because he/she would wander into resident rooms, but they watched him/her, so he/she did not get into anyone's room. Observation on 3/11/26 at 10:34 A.M., showed:-The resident was dressed for the weather without odor. -He/She was standing at the table in the dining/activity area with a stuffed animal and was talking to one of his/her peers. -He/She then began walking around the room. Staff went over to him/her and began to involver him/her in a game activity. -The resident then put the game away after about seven minutes, got a magazine, sat down and began reading it-looking at the pictures. After a few minutes, the resident stood up and started to push in chairs at the main table then tried to interact with peers who ignored him/her. -He/She picked up his/her stuffed animal from the table and walked over to two peers who were putting together a puzzle and looking at magazines, and they did (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	not interact with him/her and told him/her to go away. -At 11:05 AM nursing staff took the resident out of the dining/activity area and took him/her to the nurse's station to interact directly with him/her. The resident did not show any symptoms of aggression agitation or anxiety. During an interview on 3/11/26 at 2:58 P.M., the MDS Coordinator said:-He/She was newly hired to the facility and the MDS assessments were not all up to date.-He/She was behind on completing the MDS assessments on the residents.-MDS assessments should be accurate and reflect the resident's health status.-The MDS assessment identified the problem areas that determined the care plan/interventions, so it needed to accurately reflect the resident health, behaviors and abilities. -Information they received about the resident should be included when completing the MDS assessment and care planning. -Care Plans should be comprehensive and accurately reflect the resident's care needs and interventions.-The facility matrix was supposed to show the health care areas of the resident that come from the MDS Assessment. -The facility matrix was as up to date as he/she was aware of. During an interview on 3/16/26 at 10:18 A.M., the Director of Nursing (DON) said:-He/She expected MDS Assessments to be timely and they should represent what the resident looked like at the time it was completed.-The resident matrix should reflect the current status of the resident also. -The resident's initial care plan should be based on the assessment and the care areas that were triggered.-The care plan should be updated as the resident's needs and health status changed. -If they were made aware of the resident's behaviors upon the resident's admission, it should have been reflected on the MDS assessment, and the behaviors and interventions should have been on the resident's initial care plan.-As the resident's behaviors occurred/changed, they should update the care plan and care plan interventions.-He/She expected the facility matrix to be current. 2. Review of Resident #3's face sheet showed the resident was admitted with diagnoses that included:-Chronic Obstructive Pulmonary Disease (COPD- a disease process that decreases the ability of the lungs to perform ventilation).-Major depressive disorder (a state of intense sadness or despair that has advanced to the point of being disruptive to an individual's social functioning and/or activities of daily living).-Morbid (severe) obesity (excessive body fat that severely impairs health, increasing risks for diabetes, heart disease, and hypertension).-Anxiety.-Reduced mobility. Review of the resident's Annual MDS dated [DATE] showed:-The resident was cognitively intact.-He/She was dependent on staff for help with eating, bathing, dressing, mobility and personal hygiene.-There was no diagnosis of Diabetes.-It was not indicated that the resident was receiving insulin injections.-It was not indicated that the resident received oxygen therapy. Review of the resident's undated care plan showed:-There was no focus, goal or interventions related to Diabetes or insulin use.-The resident had COPD with the following interventions:--Give aerosol or bronchodilators (a drug that causes widening of the bronchi)as ordered.--Monitor for difficulty breathing on exertion and remind resident not to push beyond endurance.--Monitor for signs and symptoms of respiratory insufficiency.--Monitor/document/report as needed any signs and symptoms of respiratory infection. Review of the resident's POS dated 3/12/26 showed:-Blood glucose monitoring two times per day. Call physician if blood sugar was less than 70 or greater than 400.-Oxygen at three liters (L) via nasal cannula with exertion as need for COPD.-Oxygen-change ear wraps every night shift every Thursday.-Oxygen-tubing and humidifier change every night shift every Thursday.-Albuterol Sulfate HFA inhalation aerosol solution one puff inhale every 6 hours as needed for shortness of air related to (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure the care plan for Activities of Daily Living (ADL's) included the preference for bathing/showering was assessed and documented for one sampled resident (Resident #24); and failed to ensure bathing was completed and documented twice weekly by nursing staff for five sampled residents (Resident #32, #24, #3, #10, and #35) out of 13 sampled resident's. The facility census was 49 residents. Review of the facility's ADL's Policy and Procedure revised in April 2025 showed:-Residents are provided with care, treatment, and services as appropriate to maintain or improve their ability to carry out activities of daily living (ADLs).-Appropriate care and services are provided for residents who are unable to carry out ADLs independently, with the consent of the resident, and in accordance with the plan of care, to include appropriate support and assistance with personal hygiene to include bathing, dressing, grooming, and oral care).-If the resident refuses care and treatment the facility staff were to inform:--The resident and/or representative of the risks and benefits of the proposed care or treatment; and the resident has been offered alternative interventions to minimize further decline; and the refusal and details of the interventions refused are documented in the resident's clinical record. Review of the facility's blank Skin Monitoring: Comprehensive Certified Nursing Assistant (CNA) Shower Review form showed:-Perform a visual assessment of the resident's skin when giving a shower. Report any abnormal looking skin (as described below) to the charge nurse immediately. Forward any problems to the Director of Nursing (DON) for review. Use this form to show the exact location and description of the abnormality. Using the body image chart below, describe and graph all abnormalities by number. -CNA signature and date shower and assessment was completed. -Document if toenails or fingernails needed trimmed.-If resident was shaved. -Charge nurse signature and charge nurse assessment and intervention.-Director of Nursing (DON) signature. -NOTE: If the resident refused their shower/bath, the charge nurse must be notified after two attempts, and the charge nurse should ask a third time. If the resident still refused, resident must sign below indicating refusal. If the resident was unable to sign, write unable to sign and have two staff members witness, including charge nurse. 1. Review of Resident #32's admission Record showed he/she had the following diagnoses:-Acquired absence of right and left leg below the knee (amputation of lower extremities).-Stroke affecting right side of the body. Review of the resident's Electronic Medical Record (EMR) showed his/her scheduled bath days were on Tuesday and Friday during the day shift. Review of the resident's Care Plan initiated on 6/23/25 showed:-The resident had self-care performance deficit. -He/she required assistance from facility care staff for showering. Review of the resident's Skin Monitoring: Comprehensive CNA Shower Review form dated 2/13/26 showed:-A handwritten printed signature of the CNA that provided shower and was dated of 2/13/26.-Did not have documentation of the type of personal care provided and no charge nurse signature for review of the shower form. -NOTE: The facility was not able to provide additional documentation that showers were provided two times a week from 2/14/26 to 3/13/26. Review of the resident's EMR under task dated 2/13/26 to 3/13/26 showed the resident required assistance from staff for shower/bathing care dated 2/13/26. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Maywood Terrace Living Center	10300 East Truman Rd Independence, MO 64052

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the resident's admission Minimum Data Set (MDS - a federally mandated assessment instrument completed by facility staff for care planning) dated 3/10/26 showed.-He/She was cognitively intact. -He/she was able to make his/her needs known.-Required assistance of facility staff for ADL's including bathing. During an interview on 3/10/26 at 9:50 A.M., the resident said:-He/she required assistance from facility staff for all personal care. -He/she was not getting baths/showers two times a week. -He/she did not remember when his/her last shower was. 2. Review of Resident #24's admission Face Sheet showed he/she was admitted with the following diagnoses: -Paraplegia (paralysis that affects your legs, but not your arms).-Neuromuscular Dysfunctional bladder (loss of bladder control caused by nerve damage from illnesses or injuries). -Suprapubic urinary catheter (a flexible tube inserted into the bladder through the abdominal wall). Review of the resident's initial MDS dated [DATE] showed the resident was admitted to the facility on [DATE]. Review of the resident's Care Plan initiated on 2/13/26 showed: -The resident did not have patience for assistance.-There was no ADL care plan that included the type of assistance the resident required during baths/showers.-There was no care plan that included the resident's preference for baths/showers and personal cares. Review of the resident's admission MDS initiated on 2/20/26 showed:-He/She was cognitively intact. -Had difficulty communicating his/her needs.-NOTE: The facility had not submitted the resident's admission MDS as of 3/16/26. Review of the resident's Skin Monitoring: Comprehensive CNA Shower Review form dated 2/13/26 and 3/10/26 showed: -Had wrong resident first name listed and hand printed signature of the CNA completed the resident shower. -Did not have the type of personal care provided and no charge nurse signature for review of the resident's CNA skin monitoring and shower review form. -The resident had documentation of two showers out of eight scheduled opportunities.-NOTE: The facility did not have any additional documentation of any showers provided and completed or documentation that showers were refused from 2/14/26 to 3/9/26. During an interview on 3/10/26 at 11:15 A.M., the resident said:-He/she had concerns with not getting assistance with resident care and bathing.-Required assistance with transfers from the bed to the wheelchair. -He/she had difficulty with speech and in his/her expression of needs at times. 3. Review of Resident #10's face sheet showed the resident was admitted on [DATE] with the following diagnoses:-Muscle weakness.-Unspecified lack of coordination.-Abnormal posture.-Need for assistance with personal care. Review of the resident's annual MDS dated [DATE] showed:-The resident was cognitively intact.-He/She had upper extremity impairment on one side and lower extremity impairment on both sides.-He/She required substantial/maximal assistance for bathing. Review of the resident's undated care plan showed the resident did not have a care plan for ADLs for the resident's cares. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the resident's paper bath sheets dated February 2026 to March 2026 showed:-Between 2/11/26 and 2/28/26 the resident did not receive four baths out of six opportunities.-Between 3/1/26 and 3/10/26 the resident did not receive any baths out of three opportunities. Review of the resident's EMR showed:-The resident did not receive six baths out of nine opportunities. -Staff documented not applicable on 2/18/26, 2/20/26, 2/25/26, 2/28/26, 3/4/26 and 3/7/26. Observation on 3/9/26 at 10:21 A.M., showed the resident had an odor and was lying in the bed with hair uncombed and greasy. During an interview on 3/9/26 at 10:21 A.M. the resident said:-He/She did not get showers all the time when he/she was supposed to get them.-He/She would like to get showers in the evening, but the facility was short staffed and couldn't do it, so they always offered them in the morning. 4. Review of Resident #35's face sheet showed the resident was admitted with the following diagnoses:-Morbid (severe) obesity.-Body Mass Index (BMI) 50.0-59.9, Adult. Review of the resident's admission MDS dated [DATE] showed:-The resident was cognitively intact.-He/She had lower extremity impairment on one side.-He/She was dependent on staff for bathing. Review of the resident's undated care plan showed:-He/She had an ADL self-care performance deficit related to activity intolerance and impaired balance.-He/She was totally dependent on staff to provide showers. Review of the resident's paper bath sheets dated February 2026 to March 2026 showed:-Between 2/11/26 and 2/28/26 the resident did not receive four baths out of six opportunities.-Between 3/1/26 and 3/10/25 the resident did not receive two baths out of three opportunities. Review of the resident's EMR showed:-The resident did not receive six baths out of nine opportunities. -Staff documented not applicable on 2/11/26, 2/14/26, 2/20/26, 2/25/26, 2/28/26 and 3/03/26. During an interview on 3/9/26 at 10:50 A.M., the resident said:-He/She was not getting baths on a regular basis.-There was not enough staff to make sure everyone got their baths.-The facility did not have a bath aide for a long time.-He/She preferred to have baths after he/she had received his/her scheduled pain medication because he/she was stiff and sore before then.-He/She often felt dirty and wished she/he could get bathed twice per week. 5. Review of Resident #3's face sheet showed the resident was admitted with the following diagnoses:-Morbid (severe) obesity due to excess calories.-Body Mass Index (BMI) 50.0-59.9, Adult.-Bilateral osteoarthritis (a degenerative disease of the bones and joints) of hip.-Reduced mobility. Review of the resident's annual MDS dated [DATE] showed:-The resident was cognitively intact.-He/She had bilateral extremity impairment.-He/She required substantial/maximal assistance by staff for bathing. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the resident's undated care plan showed:-The resident's bath days were Tuesday and Friday on evening shift.-ADL/Functionality as a focus area but no interventions related to bathing. Review of the resident's paper bath sheets dated February 2026 and March 2026 showed:-Between 2/11/26 and 2/28/26 the resident did not receive four baths out of six opportunities.-Between 3/1/26 and 3/10/26 the resident did not receive two baths out of three opportunities. Review of the resident's EMR showed:-The resident did not receive five baths out of nine opportunities. -Staff documented not applicable on 2/11/26, 2/18/26, 2/20/26, 2/28/26 and 3/4/26. During an interview on 3/9/26 at 11:28 A.M., the resident said:-He/She did not always get a shower twice per week. -He/She would like to receive a shower twice a week. -He/She preferred showers in the evening or at night, but the staff was too busy.-His/Her hair was messy and uncombed, and he/she did not like that. 6. During an interview on 3/11/26 at 2:10 P.M., Administrator said: -Resident #32 and Resident #24 were scheduled for two baths a week.-He/She had transcribed information from the resident's EMR, under CNA task section onto Resident #32's and Resident #24's Skin Monitoring: Comprehensive CNA Shower Review forms. -Resident #32 and Resident #24 were missing documentation of showers/baths given or refused.-He/she would expect the assigned CNA's to complete shower sheets and also document care provided in the resident's EMR under the CNA task. During an interview on 3/13/26 at 11:15 A.M., CNA H said:-Residents should get showers two days per week on their bath days unless they refused.-Resident's bath times should be made according to their preference.-He/She could find the resident's preferences in the care plan, shower book or by asking the resident.-Each resident was assigned bath days and times.-If a resident asked for a different bath time, he/she would try to come back.-He/She was assigned five to six baths per shift.-If he/she was not able to get all the baths done, they would let the charge nurse know and try the next day. During an interview on 3/13/26 at 11:35 A.M., Licensed Practical Nurse (LPN) B said:-Residents could choose when they wanted to take baths.-He/She could find preferences on the clinical assessment that was done during admission and could be found under the assessments tab.-He/She was aware that Resident #35 would prefer showers after his/her pain medication had been given and not in the morning.-Residents should be care planned for ADLs which included bathing/showering.-If a resident did not get their showers, they would get it the next shift or the next day.-There was enough staff to get showers done when they showed up. During an interview on 3/13/26 at 11:58 A.M., CNA D said:-The facility had just hired a new shower aide, that would be assigned resident baths Monday through Friday. -Currently, the resident's assigned CNA was responsible to ensure the resident's baths/showers were completed during day shift. -He/she would document on the resident's shower sheet and in the resident's EMR under CNA Task section for shower or bath that was provided or refused. -He/she was not aware Resident #32 had refused personal cares to include showers. -Resident #24 seemed to get frustrated easily during all personal cares but was not aware if he/she had any missed any showers. During an interview on 3/13/26 at 12:24 P.M., the DON said:-Residents could choose when they wanted to take their baths. -He/She recommended that staff let him/her, the Administrator or the charge nurse know if there was a problem with the scheduling of baths so they could reassess the (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	schedule.-Resident bath schedules could be found in bath binder at the nurse's station.-Bath sheets should be filled out completely and were ultimately turned into him/her.-He/She tried to encourage showers at varying times with Resident #10, but he/she refused.-All residents should be care planned for ADLs that included bathing.-If a resident did not receive a bath due to staff call offs, they would try to figure out scheduling for the next day.-If a resident refused, staff was to try again later. Staff needed to be reeducated on how to document refusals.-The nursing staff and he/she were responsible for making sure that showers/baths were getting done. During an interview on 3/13/26 at 12:24 A.M., the Administrator said:-If a resident did not get their bath/shower on their scheduled day, then staff should let the charge nurse know immediately, he/she or the DON would try to reschedule with the resident.-He/She believed that some of the staff was possibly confusing not applicable with refusal when charting.-The facility was currently doing Performance Improvement Project (PIP) – (in long-term care is a structured, data-driven initiative used by nursing homes and care facilities to identify specific areas of concern) audits for showers. During an interview on 3/13/26 at 2:17 P.M., LPN B said:-He/She was not aware of Resident #32 refusing cares or showers.-Resident #24 had a history of refusal of care.-He/she would have the resident sign the shower form for any refusal of care/showers. -The assigned CNA would be expected to document in the resident's EMR under CNA task any care provided and any refusal of cares. -CNA's were to notify nursing staff of any refusal of cares. During an interview on 3/16/26 at 10:14 A.M., the MDS Coordinator said: -He/she was behind on completing MDS and care plan updates to include admission since 2/2026 since February when other nursing management staff no longer working at the facility. -admission MDS and comprehensive care plan should be completed within 7-14 days after admission. -Resident #24 admission MDS and Care areas had not been completed and submitted as of 3/16/26. During an interview on 3/16/26 at 12:58 P.M., the DON said:-The facility did not have an assigned shower aide at that time of review. -The CNA assigned to the resident would be responsible for providing and documenting showers/bath provided or refused. -He/She was still learning the resident's scheduled bath days and preferences. -Resident #24 had a history of refusal of care and he/she had to beg the resident to change clothes daily and let staff assist the resident with personal cares. -He/she had stayed late to ensure Resident #32 was given a shower if needed. -CNA staff were responsible for documenting showers/baths on the shower sheet and in the resident's EMR under CNA task.

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F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Post nurse staffing information every day. Based on observation, interview and record review, the facility failed to post the facility census and actual hours worked for Registered Nurses (RN's), Licensed Practical Nurses (LPNs), Certified Medication Technicians (CMTs) and Certified Nursing Assistants (CNAs) directly responsible for resident care per shift and to update the posting daily for view by residents, family members and visitors. The facility census was 49 residents. Policies for all areas of staffing were requested on 3/16/26 and were not received at the time of exit.1. Observation on 3/9/26, 3/13/26 and 3/16/26 showed there was no posting of the facility staffing that included facility name, date, census, the total number and actual hours worked per shift for licensed and unlicensed staff responsible for resident care.Review of the facility staffing sheet dated 3/9/26 showed the facility had no documentation of the facility census for the day and night shifts. Observation on 3/10/26 showed the facility staffing sheet did not document the actual hours worked for Registered Nurses (RN's) for the day or night shift and did not document the facility census for the night shift.Observation on 3/11/26 showed the facility staffing sheet did not document the facility census for the day or night shifts.Observation on 3/12/26 showed the facility staffing sheet did not document the facility census for the day or night shifts.Review of the facility staffing sheet dated 3/13/26 showed the facility had no documentation of the actual hours worked for RNs for the day or night shift and did not document the facility census for the day or night shifts.During an interview on 3/13/26 at 12:24 P.M., the Administrator said:-The facility did not currently have a Staffing Coordinator.-He/She often acted in that role.-Staffing sheets should be posted daily and filled out completely.-Copies of daily nursing sheets were kept in a binder at the nurse's stations.-Either he/she or the Director of Nursing (DON) would be responsible for this.Review of the facility staffing sheet dated 3/16/26 showed the facility had no documentation of the facility census for the day or night shifts.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, the facility failed to ensure hot foods on room trays for at least 5 residents on the [NAME] Hall were maintained at or above a temperature of 120 F (degrees Fahrenheit). The facility census was 49 residents. 1. Observation on 3/12/26 at 8:16 A.M., showed the pancakes were 152.7 F and the sausage patties were 170.6 F on the steam table. Observation on 3/12/26 at 9:01 A.M., showed the food cart was loaded with the meals for room trays and was delivered to the [NAME] Hall for delivery to the residents. Observation on 3/12/26 at 9:17 A.M., showed the pancakes had a temperature of 88.7 F and the sausage had a temperature of 85.8 F on a room tray that was refused by a resident.Observation on 3/12/26 at 9:24 A.M., showed the pancakes had a temperature of 86.3 F on a room tray that refused by Resident #18.During an interview on 3/12/26 at 9:26 A.M., Certified Medication Technician (CMT) C said:-He/She usually worked the day shift.-Had not seen anyone from the dietary department come to the halls and check the temperatures of the room trays.During an interview on 3/12/26 at 9:55 A.M., the Dietary Manager (DM) said:-He/She had not sent anyone from the dietary department to the halls to check the temperatures of the room trays.-In the past there had been complaints about cold food on the room trays.-When he/she was hired as the DM, he/she was not trained on the state regulations.During an interview on 3/13/26 at 1:24 P.M., Resident #32, a resident identified by the admission Minimum Data Set (MDS-- a federally mandated assessment tool completed by the facility for care planning) dated 2/27/26 as cognitively intact, said:-He/she had been served cold food in the past.-All the meals, but especially the French fries and the meat loaf had been cold at some point.-He/she received cold food at least three times per week.-When he/she received cold food he/she was not happy.-He/She no longer had access to the microwave.During an interview on 3/13/26 at 1:45 P.M., Resident #39, a resident identified by the quarterly MDS dated [DATE], as cognitively intact, said:-He/She had been served cold food in the past.-The lunch meals were the ones that were cold most of the time, but only when he/she ate in his/her room.-He/she received cold food three or four times a week.-When he/she received cold food he/she was not happy.During a phone interview on 3/18/26 at 1:16 P.M., the Registered Dietitian (RD) said he/she would expect that someone from the dietary dept would check the temperatures of room trays on an interval basis.

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F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. Based on interview and record review, the facility failed to provide the required 12 hours of nurse aide in-service training either at the time of hire or within the last 12 months that included the topics of dementia (a progressive mental disorder causing confusion, and impairment of control, memory, judgement, and impulses), Abuse, Neglect and Exploitation (ANE) and behavior management (focuses on person-centered, non-pharmacological approaches to address challenging behaviors (e.g., aggression, wandering) as communication of unmet needs) for four out of five sampled nursing staff Certified Nursing Assistants (CNA D and CNA J), Licensed Practical Nurse (LPN) C and Registered Nurse (RN) A. The facility's census was 49 residents. A policy for staffing competencies and in-service training was requested on 03/16/26 but has not been provided to date.1. Review of CNA D's Relias (a computer-based training program presented and tracked training topics and hours) course completion history dated March 2025 to March 2026 and in-services documentation dated March 2025 through February 2026 showed:-He/She was hired on 2/2/26.-His/Her Relias course completion history showed he/she completed 0.0 hours for required topics during the dates listed above.-There was no in-service documentation showing completion of the required topics or number of hours met.2. Review of CNA J's Relias course completion history dated March 2025 to March 2026 and in-services documentation dated March 2025 through February 2026 showed:-He/She was hired on 2/12/26.-He/She completed Relias training on 2/12/26 titled Managing Aggressive Behaviors, no hours were provided.-His/her Relias course completion history showed he/she completed 0.0 hours for the Dementia and ANE topics.-There was no in-service documentation showing completion of the required topics or number of hours met.3. Review of LPN C's Relias course completion history dated March 2025 to March 2026 and in-services documentation dated March 2025 through February 2026 showed:-He/She was hired on 3/5/26.-His/Her Relias course completion history showed he/she completed 0.0 hours for required topics during the dates listed above.-There was no in-service documentation showing completion of the required topics or number of hours met.4. Review of RN A's Relias course completion history dated March 2025 to March 2026 and in-services documentation dated March 2025 through February 2026 showed:-He/She was hired on 2/18/24.-He/She completed in-service training for Dementia and ANE during the dates listed above, no completion times were recorded.-His/Her Relias course completion history showed he/she completed 0.0 hours for Behavior Management.-There was no in-service documentation showing completion of Behavior Management or number of hours met.5. During an interview on 3/13/26 at 11:15 A.M., CNA H said:-He/She had received training through Relias online during orientation.-He/She had not attended any in person in-services to date.-The staff was responsible for making sure they completed all Relias training.During an interview on 3/13/26 at 11:35 A.M., LPN B said:-He/She received all training through Relias and in-services.-In-services were usually held monthly.-There had not been a skills fair since he/she had worked here.-The staff was responsible for making sure they completed all Relias training.During an interview on 3/16/26 at 12:24 P.M., the Director of Nursing (DON) said:-CNAs should have at least 12 hours of training in the required topic areas.-All staff should receive training in Alzheimer/Dementia care, ANE and behavior management either upon hire or within at least past 12 months.-He/She ensured this training was completed through Relias training, in-services and during onboarding of new staff.-There had not been any skills checkoffs done with nursing staffing in the past year, but he/she intended on having them annually.-The skills checkoffs should include basic skills and required training.-He/She was responsible for making sure required training and skills checkoffs were done.During an interview on 3/16/26 at 12:24 P.M., the Administrator said:-He/She had been operating in their role since 2/2/2026.-He/She was responsible for making sure that training was given.-The facility plans to include Performance Improvement Projects (PIPs) which were mandatory Quality Assurance and Performance Improvement (QAPI) initiatives for long term care (LTC) facilities to address care quality.

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record interview, the facility failed to ensure the right to be informed when one sampled resident (Resident # 41) out of 13 sampled residents, was not provided information demonstrating the risks and/or benefits of the medication Xanax (a medication used to treat anxiety caused by depression (a mental health condition creating persistent feelings of sadness, hopelessness, and loss of interest in activities), anxiety disorders and panic disorder. The facility census was 49 residents. Review of the facility's Resident Rights policy, undated, showed:-The resident has the right to be fully informed in a language which he or she can understand.-The resident has the right to be informed of and participate in his or her treatment.-The resident has the right to be informed in advance, by the attending physician or other practitioner or professional, of the risks and benefits of proposed carte, of treatment and treatment alternatives or treatment options and to choose the alternative or option he or she prefers.-The resident has the right to be informed in advance of changes to the plan of care.Review of the facility's Psychotropic Medication Use policy, dated February 2025, showed:-Prior to initiating the use of, increasing the dose of, or switching to a different psychotropic medication,the staff and physician will review the following with the resident/representative prior to obtainingdocumented consent or refusal:a. non-pharmacological alternatives.b. the indications and rationale for the recommendation.c. the potential risks and benefits (including possible side effects, adverse consequences, and black boxwarnings); andd. the resident's/representative's right to accept or decline the treatment.1. Review of the Resident #41's face sheet, dated 3/12/26, showed:-The resident was admitted on [DATE] and re-admitted on [DATE].-The resident was diagnosed with anxiety.Review of the residents quarterly Minimum Data Set (MDS- a federally mandated assessment instrument completed by facility staff for care planning) dated 12/31/25, showed:-The resident was cognately intact.-The resident was taking antipsychotic medication.Review of the resident's Physician Order Summary, dated March 2026, showed the resident was ordered Xanax oral tablet 0.5 milligrams (mg), give 0.5 mg by mouth three times a day for anxiety.Review of the resident's Electronic Health Record (EHR) showed no evidence the resident was informed of the risks and/or benefits of Xanax.Review of the resident's undated Care Plan showed h/she did not have a focus, goals, or interventions for taking antipsychotic or antianxiety medications.During an interview on 3/11/26 at 11:40 A.M., the resident said:-He/She didn't always get medications on time.--Note: the facility uses a liberalized medication pass.-He/She knew he/she was taking medication for anxiety but did not remember the name of the medicine.-He/She did not remember anyone explaining the risks and/or benefits of the medication or signing a consent before starting the medication.During an interview on 03/13/26 at 11:35 A.M., Licensed Practical Nurse (LPN) B said:-The process to inform the resident and/or resident representative of the intended benefits and potential side effects of the resident's medication regimen consisted of having the resident sign a consent form for antipsychotic medication use that listed all the benefits and side effects and care plan the use.-Residents who took antipsychotic medications should sign a consent form that stated all risks and benefits.-The resident did not have a care plan and did not have a signed consent form for antipsychotic medication use.During an interview on 3/13/26 at 12:24 P.M., the Director of Nursing (DON) said:-The resident should have received and signed a consent form for psychotropic medication use with all the risks and benefits explained.-The resident should have had a care plan for psychotropic drug use but did not.

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	265404	A. Building B. Wing	03/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Maywood Terrace Living Center	10300 East Truman Rd Independence, MO 64052

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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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure bedrails were provided and utilized in accordance with resident needs, physician orders, and care plan for one sampled resident (Resident #3) who was approved for the use of bedrails out of 13 sampled residents. The facility census was 49 residents. A bedrail policy was requested on 3/16/26 and was not provided at the time of exit. 1. Review of Resident #3's face sheet showed he/she was admitted on [DATE] with the following diagnoses:-Chronic pain (lasts months or years and can affect any part of your body).-Morbid obesity (a severe form of obesity characterized by a body mass index (BMI) of 40 or higher, or a BMI of 35 or higher with obesity-related health complications).-Bilateral primary Osteoarthritis of hip (a common, progressive degenerative joint disease characterized by the breakdown of articular cartilage, the tissue that cushions joint ends).-Anxiety disorder (excessive, uncontrollable fear or worry that interferes with daily life, lasting for months).-Reduced mobility (the ability to move freely and independently, encompassing joint range of motion, muscle strength, and neuromuscular coordination).Review of the resident's annual Minimum Data Set (MDS - a federally mandated assessment tool completed by the facility for care planning) dated 12/19/25, showed:-He/She was cognitively intact.-He/She needed assistance with activities of daily living.-He/She was dependent on staff assistance with transfers.Review of the resident's bedrail assessment dated [DATE] showed:-Side rail placement was recommended on both sides of the resident's bed and were to serve as an enabler to promote independence. -The resident had expressed a desire to have side rails/assist bar.Review of the resident's Physician Order Sheet (POS) dated March 2026 showed:-May have bedrails for assistance with bed positioning and self-mobility, consent and therapy screen complete. Ordered on 4/23/25.-May have grab bars for bed for self-repositioning. Ordered on 2/19/26.-Continue skilled Physical Therapy (PT) three times per week for 30 days. Ordered 2/26/26.-Occupational Therapy (OT) clarification order: OT to see patient four times a week for 30 days for therapeutic exercise, therapeutic activity, neuromuscular re-education, self-care training, group as indicated. Ordered on 3/6/26.Review of the resident's undated care plan showed:-The resident required a full body mechanical lift for transfers related to immobility secondary to bilateral hip osteoarthritis.-The resident used bedrails daily.-Interventions included:--U rail on bed to aid in bed mobility.--Ensure valid consent on chart prior to initiating bedrail.--He/She used bedrails for bed mobility and enabled him/her to move. Observation on 3/9/26 at 11:28 A.M., showed:-The resident was lying in bed resting.-There were no rails of any kind installed on his/her bed or on floor parallel to the resident's bed.During an interview on 3/9/26 at 11:28 A.M. the resident said he/she:-Was not able to change positions in bed on his/her own and needed to call for assistance to do so.-Had been assessed by PT and approved for the use of bedrails since March 2025.-Attended therapy during the week in order to maintain and build strength for mobility.Observation on 3/16/26 at 11:24 A.M., showed:-The resident was lying in bed resting.-There were no rails of any kind installed on his/her bed or on floor parallel to the resident's bed.-The resident was not able to change position in bed independently.During an interview on 3/16/26 at 11:24 A.M. the resident said he/she:-Having bedrails and/or an assist bar would help him/her by strengthening his/her arms; help him/her reposition in bed; help him/her to sit up in bed; and help him/her to transfer himself/herself in and out of bed without assistance.-Not having bedrails or an assist bar caused him/her to call for assistance for all of those things instead of being able to do them by himself/herself and helping to maintain some of his/her independence.-It was depressing, overwhelming and made him/her feel helpless. -It is very important that he/she could transfer himself/herself to the wheelchair and toilet and turn on his/her own.-He/She did not like the fact that he/she had to be changed in bed after an incontinent episode.-NOTE: Th resident became upset and began crying.During an interview on 3/16/26 at 11:28 A.M., Licensed Practical Nurse (LPN) B said:-The resident would benefit from bedrails because it (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	would help him/her to reposition himself/herself while in bed and help with self-transfers.-He/She understood the process for a resident to obtain bedrails was for a nurse to complete an assessment form in Point Click Care (PCC cloud-based healthcare technology platform and Electronic Health Record (EHR) system, specifically built for the long-term and post-acute care), then therapy performed an assessment, then it went to the Corporate Regional Nurse.-He/She was not sure how long the process for bedrails should take.-He/She would expect a resident who had an order for bedrails since April 2025, would have them installed by now.-He/She was not sure why the bedrails had not been installed.-He/She re-initiated the process in February 2026 that had not been completed the prior year.-He/She was aware that it was the resident's desire to maintain and increase his/her independence.-He/She was aware that the resident was feeling depressed and helpless not being able to change position in bed or transfer himself/herself in order to be able to go to the bathroom without calling and asking staff for assistance.During an interview on 3/16/26 at 12:20 P.M., the Maintenance Director said:-The process for a resident getting bedrails installed was, it was discussed in morning meeting, it went through the therapy department for assessment, a physician's order was obtained, then he/she got the work order which was recorded in the logbook.-All new beds came with rails so there was no need to order them.-He/She kept them on hand.-Ultimately the nurses and Director of Nursing (DON) were responsible for making sure the process was done.-He/She remembered the resident bedrail order being brought up in a meeting some time ago but had not received a work order for it as of today.-He/She did not have a current bedrail work order for the resident.During an interview on 3/16/26 at 12:42 P.M., the Physical Therapy Assistant (PTA) said:-The resident was receiving PT and OT on multiple days every week for strengthening, transferring from back to lying on side of bed, lower extremity muscle strength and standing frame strengthening for lower body strength.-The process for a resident to receive bedrails was that therapy would do an assessment, therapy would decide if they were appropriate, nursing would do assessment, a physician's order would be obtained then maintenance would install them.-This information was documented in the therapy charting system under the resident narrative.-He/She would expect that the entire process to be completed within two weeks.-He/She would expect that a resident who had an order for bedrails since April 2025 to have them installed by now.-The resident had expressed concern about not receiving his/her bedrails.During an interview on 3/16/26 at 12:49 P.M., the DON said:-The resident would benefit from having bedrails because they would be able to help with turning during cares and dressing.-The process for a resident receiving bedrails was, the nurse completed an assessment form in PCC.-After they got an ok from therapy, maintenance was supposed to write it down in the maintenance log, but he/she had personally never seen it. They also used WhatsApp (a messaging application that allowed users to send texts, voice notes, images, videos, documents, and make video/audio calls over the internet) to communicate work orders to the maintenance department.-This process should take 48 hours at the most.-He/She was aware that the resident wanted bedrails.-There was no reason the resident's bedrails should not be installed.-He/She was not aware that the resident was feeling depressed and helpless not being able to change position in bed or transfer by himself/herself to be able to go to the bathroom without calling and asking staff for assistance.-He/She was not sure if the facility had any bedrails on hand.-He/She needed to check with the Maintenance Director to see where they were in the process to get the resident's bedrails installed.

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F 0569 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify each resident of certain balances and convey resident funds upon discharge, eviction, or death. Based on interview and record review, the facility failed to ensure Third Party Liability (TPL- a form which is sent to Missouri (MO) Health Net, which gives an accounting of the remaining balance of that resident's funds in the resident trust account) forms were completed and sent to Missouri (MO) Healthnet (a state agency which administers the provision and payment of services for Missouri's Medicaid program) within 30 days of death for two discharged residents (Resident #101 and #102). The facility census was 49 residents. 1. Review of Resident #101's Resident Trust Transaction History dated 2/1/26 through 3/11/26, showed he/she:-Passed away on 2/1/26.-Had $20.15 left in his/her account.During an interview on 3/11/26 at 12:01 P.M., the Business Office Manager (BOM) said:-He/She did not submit a TPL on behalf of the resident.-There has been a lot of change around the facility, so somethings got dropped.2. Review of Resident #102's Resident Trust Transaction History dated 12/1/25 through 3/11/26, showed he/she:-Passed away on 1/19/26.-Had $0.00 in his/her account at the time of death.During an interview on 3/11/26 at 12:26 P.M., the BOM said there were a lot of changes during the time of the death of the resident.

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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** Based on observation, interview, and record review, the facility failed to meet professional standards of practice when staff obtained the blood pressure (the force of circulating blood pushing against the walls of your arteries as the heart pumps it around the body) using a wrist cuff while the residents' arms remained in a dependent (lowered) position, which could result in inaccurate readings for two sampled residents (Resident #41 and #48) out of 13 sampled residents. The facility census was 49 residents. A policy for blood pressure equipment usage was requested but not provided by the date of exit. 1. Review of Resident #41's face sheet showed the resident was admitted to the facility with the following diagnoses:-Hypertensive (high blood pressure) heart disease with heart failure (the heart cannot pump enough blood to meet the body's needs).-Essential Hypertension.-Hypertensive heart and chronic kidney disease with heart failure (a complex condition where long-term high blood pressure causes severe cardiac strain and kidney dysfunction).Review of the resident's Quarterly Minimum Data Set (MDS- a federally mandated assessment instrument completed by facility staff for care planning) dated 12/31/25, showed:-The resident was moderately cognitively intact.-He/She had active diagnoses of heart failure, hypertension, renal failure and Dementia (progressive organic mental disorder characterized by chronic personality disintegration, confusion, disorientation, stupor, deterioration of intellectual capacity and function, and impairment of control of memory, judgment, and impulses).Review of the resident's Physician Order Sheet (POS) dated March 2026 showed:-Amlodipine Besylate oral tablet 5 milligram (mg) give one tablet by mouth one time a day for hypertension. Hold if blood pressure was less than 110/55 or heart rate was less than 55. Notify Nurse Practitioner (NP)/Medical Doctor (MD) of held medications.-Aspirin oral tablet chewable 81 mg give one tablet by mouth one time a day for prophylaxis (action taken as a prevention) related to hypertensive heart disease with heart failure.Observation on 3/11/26 at 11:40 A.M. showed Certified Medication Technician (CMT) C, during medication pass:-Applied a wrist blood pressure cuff to the resident's left arm and obtained a blood pressure reading while the resident's arm was in a dependent position, below the level of the heart. -He/She did not reposition or support the resident's arm at heart level during the procedure.2. Review of Resident #48's face sheet showed the resident was admitted with the following diagnoses:-Hypertensive chronic kidney disease.-Heart failure.Review of the resident's admission MDS dated [DATE] showed:-The resident was moderately cognitively impaired.-He/She had an active diagnosis for heart failure.Review of the resident's POS dated March 2026 showed Metoprolol Tartrate oral tablet 25 mg give one tablet by mouth two times per day for hypertension. Hold if systolic blood pressure (SBP- measures the maximum force exerted by your arteries when the heart contracts) was less than 110 or pulse was less than 60.Observation on 3/11/26 at 12:38 P.M. showed CMT C, during medication pass:-Applied a wrist blood pressure cuff to the resident's left arm and obtained a blood pressure reading while the resident's arm was in a dependent position, below the level of the heart. -He/She did not reposition or support the resident's arm at heart level during the procedure.-He/She held the resident's metoprolol medication due to reading of 98/86. He/she did not recheck it.3. During an interview on 3/11/26 at 12:45 P.M, CMT C said:-The proper way to take a blood pressure using a wrist cuff was to have the resident relax the arm, not talk and not have legs crossed.-The wrist cuff should be held at the level of the heart while being used.During an interview on 3/13/26 at 12:24 P.M., the Director of Nursing (DON) said the wrist blood pressure cuff should be held at the level of the heart when being used for best accuracy.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. Based on observation, interview and record review, the facility failed to ensure the resident's urinary catheter (a flexible, thin tube inserted into the bladder to drain urine when a person cannot urinate naturally) drainage bag (a medical device that connects to a catheter to collect urine draining from the bladder) was placed below the resident's bladder during a transfer and during incontinence care for one sampled resident (Resident #5); and failed to ensure a suprapubic urinary catheter (is a flexible tube inserted into the bladder through the abdominal wall) tubing was not dragging on the ground while up in wheelchair; failed to ensure the suprapubic catheter was addressed in a care plan; and failed to ensure Enhanced Barrier Precaution (EBP, for residents with chronic wounds or indwelling medical devices during high-contact resident care activities regardless of their multidrug-resistant organism status) signage was on the resident's door for one sampled resident (Resident #24)out of 13 sampled residents. The facility census was 49 residents. Review of the facility Catheter policy and procedure dated October 2022, showed:-The staff should wash hands and explain the procedure to the resident. -Place a towel under the catheter tubing before washing. Apply soap to the washcloth and clean around meatus (the urethral opening and the external portion of a urinary catheter to prevent infections), avoiding tugging the catheter, moving in one direction, away from the meatus. Use a clean cloth for each stroke. Rinse around the meatus and use a clean cloth for each stroke. -With a clean dry towel dry around the meatus. Rinse at least 4 inches of the catheter nearest the meatus, moving away from the meatus. Use a clean cloth for each stroke. With a clean dry towel, dry at least 4 inches of the catheter nearest to the meatus, moving away from the meatus. Remove and discard gloves and wash hands.-The policy did not show where the catheter bag should be placed. 1. Review of Resident #5's Face Sheet showed the resident was admitted with diagnoses including:-Cerebral palsy (a group of permanent neurological disorders that affect movement, muscle tone, and posture due to abnormal brain development or damage, typically occurring before, during, or shortly after birth).-Diabetes.-Dementia (progressive or persistent loss of intellectual functioning, especially with impairment of memory and abstract thinking, and often with personality change)-Cognitive communication deficit.-Urinary tract infection (history) and urinary retention (the inability to fully or partially empty the bladder, causing urine to build up, which can lead to pain, pressure, and potential kidney damage). Review of the resident's list of Minimum Data Set (MDS-a federally mandated assessment tool to be completed by facility staff for care planning) showed the resident's MDS had not been completed. Review of the resident's Care Plan dated 1/5/26 showed he/she:-Had a self-care deficit.-Was dependent on staff for all his/her physical needs.-Needed two persons to assist with transfers and toileting. -Used a mechanical full body lift for transfers that required two people to assist with transfers.-Had an indwelling catheter for urine retention and staff was supposed to position the resident's catheter below the level of the bladder and away from the entrance to his/her room door. Review of the resident's Physician's Order Sheet (POS) dated March 2026, showed physician's orders for:-Urinary catheter 16 French (Fr) 30 cubic centimeters (cc) (references an indwelling catheter, featuring a 16 Fr diameter tube for draining urine and a large 30 cc balloon designed to secure the catheter, often used post-operatively for bladder retention) as needed for occlusion or leakage related to urine retention.-Change catheter anchor one time daily on Sunday for catheter care.-Urinary catheter care every shift for urinary retention. -Irrigate with 30cc to 50cc of normal saline (salt water) every shift for catheter care.-Change catheter drainage bag once daily on Sunday for catheter care. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the resident's Infection Note dated 3/7/26 showed:-The resident was receiving an antibiotic for treatment of a urinary tract infection.-His/Her catheter was draining clear yellow urine. -The resident was alert and oriented to person and place, was taking fluids well and denied urinary pain. Observation on 3/10/26 at 2:25 P.M., showed the resident was sitting up in a specialized positioning wheelchair in the dining room. The resident's catheter bag was below the resident's bladder in a privacy bag at the side of his/her wheelchair. Certified Nursing Assistant (CNA) A took the resident to his /her room and said he/she was going to transfer the resident so he/she could perform incontinence care. CNA B entered the resident's room and sanitized his/her hands. Both CNA A and CNA B put gowns on and gloved. The following occurred:-CNA A took the resident's catheter bag out of the privacy bag and placed the catheter bag on the resident's lap. He/She then hooked the lift sling onto the lift.-CNA A and CNA B then lifted the resident up from his/her wheelchair and moved the resident to his/her bed.-CNA B assisted with positioning the resident as CNA A lowered the resident to his/her bed. -CNA B then removed the resident's catheter bag from his/her lap and held it while the resident was being lowered then he/she placed the resident's catheter bag at the foot of the resident's bed which was at the level of the resident's bladder. -CNA A and CNA B rolled the resident to the side to remove the sling from under him/her then began to perform incontinence care on the resident. -CNA B removed the resident's brief. CNA A opened the cleansing cloths and used one wipe one swipe process to clean the resident from front to back. -CNA A did not clean down the resident's catheter tubing. He/She left the resident open to air without briefs.-CNA A then removed the resident's catheter bag from the bed and put it in the basin on the floor. He/She then covered the resident and lowered the resident's bed.-Both CNA A and CNA B removed and discarded their gloves. CNA A then sanitized his/her hands prior to exiting the resident's room. -CNA B gathered the trash and went outside of the resident's room to discard the trash bag then washed his/her hands. During an interview on 3/10/26 at 2:40 P.M. CNA A said:-When transferring the resident, he/she placed the resident's catheter bag in the resident's lap, but it shouldn't have been there because it was supposed to be below the resident's bladder. -When the resident was in bed, he/she forgot to place the resident's catheter bag at the side of his/her bed below his/her bladder. -The resident's catheter bag should always be kept below the bladder, so the urine did not flow back into the resident's urinary tract.-He/She did not remember whether he/she cleaned down the resident's catheter tubing. During an interview on 3/13/26 at 12:29 P.M., Licensed Practical Nurse (LPN) A said:-The resident's catheter bag should be placed below the resident's bladder at the side of the lift or one of the CNA staff could hold the catheter bag in their hand but below the resident's bladder, so it did not backflow into the resident's bladder.-The resident's catheter bag should never be placed on the resident's lap or on his/her bed because the resident had a history of urinary tract infections and was highly susceptible for risk of urinary infections. -As the nursing staff lowered the resident to his/her bed the resident's catheter bag should have been kept below the bladder. When they lowered the resident into his/her bed, they should have put the resident's catheter bag below his/her bladder at the side of his/her bed.-During catheter care nursing staff should clean the resident from front to back then clean down the catheter tubing, away from the bladder, with a clean cloth.-The resident's catheter bag should never be touching the floor and should always be covered. During an interview on 3/16/26 at 10:18 A.M. Director of Nursing (DON) said:-The catheter bag should be placed below the bladder but should not drag the floor or be placed on the floor. -During catheter care they should clean the resident's peri area and then wipe down the catheter tubing away from the (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	resident's peri area.-During a transfer the catheter bag should always be below the bladder, not on the resident's lap or on the bed. -The nursing staff should have kept the resident's catheter below his/her bladder by placing it on the bedframe once they transferred him/her to his/her bed. 2. Review of Resident #24's admission Face Sheet showed he/she was admitted with diagnoses of: -Paraplegia (-is paralysis that affects your legs, but not your arms.-Neuromuscular Dysfunctional bladder (a loss of bladder control caused by nerve damage from illnesses or injuries). -Suprapubic urinary catheter (is a flexible tube inserted into the bladder through the abdominal wall). Review of the resident's Care Plan initiated on 2/13/26 showed: -He/she was at risk for impaired urinary elimination. -The resident was on EBP.-NOTE: The resident did not have a care plan for his/her suprapubic catheter as of 3/16/26. Review of the resident's admission Minimum Data Set (MDS - a federally mandated assessment instrument completed by facility staff for care planning) initiated on 2/20/26 showed:-He/she was cognitively intact.-Indwelling catheter was checked marked.-He/She had difficulty communicating his/her needs.-NOTE: The facility had not submitted the resident's admission MDS as of 3/16/26. The MDS was 2 1/2 weeks late. Review of the resident's Physician Order Sheet (POS) dated March 2026 showed: -Enhanced Barrier Precautions related to a suprapubic catheter and wounds ordered on 2/12/26. -Provide urinary catheter care every shift. -Urinary Catheter: may use a leg drainage bag, with an 18 French (Fr a measure of the outer diameter of a catheter) 30 cubic centimeter (cc) bulb, connected to urinary drainage bag, and nursing staff to change catheter with insertion tray and change urinary bag & band every month, ordered on 2/12/26.-Urinary Catheter: 18 Fr, with a 30cc bulb provide catheter care maintenance every shift as ordered and as needed for occlusion or leakage ordered on 2/25/26.-Irrigate urinary catheter with 50-60 cc of normal saline every shift for catheter care was ordered on 2/25/26.-Change urinary catheter bag and anchor band every week on Sunday. Review of the resident's Health Status Notes dated 3/9/2026 at 9:40 A.M., showed he/she was being transported to a doctor's appointment, when his/her suprapubic catheter came out (dislodged). This nurse advised the van driver to take the resident to the local hospital emergency room to have the suprapubic catheter replaced. This nurse had notified the DON and the resident's family member. Both verbalized understanding of situation. Observation on 3/10/26 at 11:42 A.M., of the resident showed:-He/she was up in his/her wheelchair. -His/her urinary catheter drainage bag was in a privacy bag and secured under his/her wheelchair. Review of the resident's Order Note dated 3/10/2026 at 5:54 P.M., as a late entry showed the resident had approximately 850 milliliters (ml) of bright yellow urine emptied from foley bag. Observation on 3/11/26 at 10:10 A.M., of the resident showed: -The resident was in bed with his/her eyes closed. -Suprapubic urinary catheter drainage bag was hung on the right side of the bed frame. -The catheter drainage bag was not placed in a privacy bag and was noted to have darker tea colored urine in the drainage bag. Observation on 3/13/26 at 12:20 P.M., of the resident showed:-He/She was up in his/her wheelchair propelling himself/herself down the hallway.-The urinary catheter tubing was dragging on ground underneath his/her wheelchair.-The resident's urinary catheter tubing was getting taggled up with (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	resident feet while propelling in his/her wheelchair. Observation on 3/13/26 at 12:23 P.M., of the resident showed:-He/She had wheeled himself/herself to the dining room for lunch. -The resident had wheeled over his/her urinary catheter drainage tubing and had blocked the flow of urine in the tubing. -He/she then backed up from table and again rolled over urinary catheter drainage tubing a few times while waiting for lunch. -The resident's wheelchair left wheel sat on top urinary catheter tubing kinking the tube while eating lunch. Observation on 3/13/26 at 12:39 P.M., of the resident showed:-He/she had propelled himself/herself outside to smoke while the urinary catheter drainage tube dragged on the ground. -The resident and an unknown staff member were outside while the resident smoked. -The resident's urinary catheter tubing laid on the ground while outside. -He/she had darker yellowish urine in the urinary catheter drainage tubing. -There was no obvious leakage of liquids. Observation on 3/13/26 at 12:47 P.M. of the resident showed:-Unknown staff member and resident attempted to come back inside the facility.-The resident's urinary catheter tubing was dragging on the ground and was getting tangled underneath the wheels and footrest, as the resident tried to enter the building. -As the resident wheeled over the urinary catheter drainage tubing, an unknown kitchen staff member stopped the resident and said to the resident that his/her urinary catheter tubing was dragging the ground and was tangled up in the wheels. -The kitchen staff member applied gloves and readjusted the urinary catheter tubing, so it was safely secured under his/her wheelchair and was able to enter the facility. During an interview on 3/13/26 at 11:58 A.M., CNA D said: -The resident's urinary catheter tubing should be secured under the wheelchair and should not be dragging or touching the ground. -Residents on EBP should have signage posted and direct care provider were to wear gloves and gowns. During an interview on 3/13/26 at 2:17 P.M., LPN B said:-He/she did not notice the resident's tubing dragging until he/she saw kitchen staff assisting the resident. -Urinary catheter tubing should not be dragging on the ground and should be secured under the wheelchair. During an interview on 3/16/26 at 10:04 A.M., Acting Infection Control Preventionist (ICP) and Regional Registered Nurse (RN) said:-Residents with suprapubic catheter should be placed on EBP and signage should be posted on the door. -While providing direct catheter care, the use of gown, gloves, mask and if need safety glasses for potential of splatter were required.-Urinary catheter tubing should be placed securely underneath the wheelchair with the drainage bag in a dignity bag along with excess tubing. -If the resident's urinary catheter tubing had been dragging on the ground and was run over with his/her wheelchair, he/she would expect nursing staff to have changed the drainage bag and tubing. -He/She would expect nursing staff to complete a full resident assessment to ensure the suprapubic catheter was in place and functioning as it should. During an interview on 3/16/26 10:14 A.M., MDS Coordinator said: -He/she was behind on completing MDS's and updating the resident's care plan. -The admission MDS and admission comprehensive care plan should be completed within 7-14 days after admission. -The resident's admission MDS and care areas had not been completed and submitted as of 3/16/26.-The resident's admission comprehensive care plan had not been completed as of 3/16/26. During an interview on 3/16/26 at 11:53 A.M., LPN A said:-The catheter drainage bag and tubing should not be dragging on the ground.-If the catheter drainage bag was found to have been dragging on (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the ground staff needed to change the catheter and tubing. During an interview on 3/16/26 at 12:58 P.M., the DON said:-The catheter drainage bag and tubing placement should be kept secured under the wheelchair.-The residents catheter tubing should never touch the ground. -He/She would expect staff to position the catheter tubing, so it was not touching the ground underneath the resident wheelchair. -He/She would expect to have an up-to-date MDS and care plan for the resident's suprapubic catheter.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. Based on observation, interview and record review, the facility failed to properly store and properly label respiratory equipment to include nasal cannula (a lightweight, flexible tube with two prongs inserted into nostrils used to deliver supplemental oxygen to people with breathing difficulties) and nebulizer mask/mouthpiece (a medical devices that fits over the nose and mouth, delivering liquid medication as a fine mist to the lungs) and tubing when not in use; and failed to ensure monitoring and weekly changing of oxygen nasal cannula tubing that was dated 6/26/25 for one sampled resident (Resident #32) who was at risk for respiratory distress out of 13 sampled residents. The facility census was 49 residents.Review of the facility's Oxygen safety policy revised on July 2024 showed: -Do not store oxygen cylinders in any resident room or living area.-Ensure oxygen cylinders in use were on approved carts or stands, and were attached to the residents' beds Review of the facility Administering Medications through a Small Volume (Handheld) Nebulizer revised October 2012 showed:-When equipment is completely dry, store in a plastic bag with the resident's name and the date on it.-Change equipment and tubing every seven days, or according to facility protocol.-Disinfect outside of the compressor between residents, according to manufacturer's instructions. 1. Review of Resident #32 admission record showed he/she had diagnoses of: -Acquired absence of right and left leg below the knee (amputation of lower extremities).-Stroke affecting right side of the body.-Chronic Obstructive Pulmonary Disease (COPD) with acute exacerbation (is a sudden worsening of symptoms-increased breathlessness, cough, or sputum production-beyond normal day-to-day variations).Review of the resident's Care Plan initiated on 6/23/25 showed:-The resident had self-care performance deficit. -The resident had altered respiratory status/difficulty breathing related to diagnosis of COPD.-Did not have care plan related use of oxygen nightly or use of nebulizer treatments as needed. Review of the resident's physician order sheet (POS) dated March 2026 showed: -He/She had an order for oxygen to run at 3 liter/minute via nasal canula every night related to COPD, was ordered on 1/11/26.-Change tubing weekly and wash filter weekly with mild soap and water, weekly on Thursday. -Tubing was to be dated and stored in a bag when not in use. Change tubing every Thursday during day shift, was ordered on 1/15/26.-Nebulizer tubing changed weekly on Thursday. Date and bag tubing when in use every day shift every Thursday was ordered on 1/15/26.-Albuterol Sulfate nebulization solution (2.5 milligram (MG)/3 milliliter (ml) 0.083% give 2.5 mg inhale orally via nebulizer every 6 hours as needed for shortness of breath, was ordered on 1/11/26. Review of the resident's medication administration record (MAR) and treatment administration record (TAR) dated 3/1/26 to 3/31/26 showed no documentation of oxygen tubing and nebulizer tubing had been changed weekly.Observation on 3/9/26 at 11:26 A.M., of the resident's room showed: -The bed was in the left corner of the room.-The nasal cannula (NC) was draped over the O2 cylinders (is also known as oxygen tanks in the medical field, are containers that store compressed oxygen gas) tank and not in a storage bag. -The NC tubing was dated 6/26/25.Review of the resident's admission Minimum Data Set (MDS - a federally mandated assessment instrument completed by facility staff for care planning) dated 3/10/26 showed.-The resident was cognitively intact. -He/she was able to make his/her needs known.-Required assistance of staff for activities of daily living (ADL) including bathing. -Required dialysis services time of admission.Observation on 3/10/26 at 9:11 A.M., of the resident's room showed: -He/She was not in the room. -He/She had O2 cylinders in a metal frame stand with nasal cannula tubing connected, the tubing was dated 6/26/25. -Had a nebulizer mask and tubing hung on the O2 cylinder tank.-No respiratory tubing storage bag found in room. During an interview on 3/12/26 at 8:20 A.M., the resident said:-He/she did use the oxygen per nasal cannula sometimes at night. -He/she did not remember the last time he/she had used the nebulizer machine. Observation on 3/12/26 at 8:20 A.M. showed:-The resident's O2 nasal cannula tubing dated 6/26/25.-The tubing was connected to O2 cylinder. -The tubing was not stored in plastic bag. During an interview on 3/13/26 at 11:58 A.M., Certified Nursing Assistant (CNA) D said: (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The resident had been using O2 at nighttime.-O2 tubing was to be monitored by nursing staff and tubing changed by nursing staff. -O2 tubing and nebulizer tubing should be stored in a labeled bag. During an interview on 3/13/26 at 2:17 P.M., Licensed Practical Nurse (LPN) B said:-Oxygen tubing and masks should be dated.-Oxygen tubing and masks should be stored in a bag with the resident's name and date. -The resident's O2 tubing and nebulizer tubing/mask should be stored in a plastic bag when not in use. -The night shift would be responsible to change the O2 and nebulizer tubing every week on Sunday.-He/she not aware the resident still had O2 in room. The last time he/she remembered the resident using O2 was back in July 2025. -He/she was not aware the resident had O2 with nasal cannula tubing dated 6/26/25 in his/her room.-The resident had not been getting nebulizer treatments. During an interview on 3/16/26 at 12:58 P.M., the Director of Nursing (DON) said:-The night shift staff were responsible for changing out respiratory tubing to include nasal cannula and nebulizer masks every week on Sunday. -O2 tubing and nebulizer tubing should be stored in dated plastic bag when not in use. -All staff would be responsible for monitoring to ensure respiratory supplies were stored properly when not in use.-He/she was not aware the resident had nasal cannula tubing dated 6/26/25 and was not aware there was an O2 cylinder in the room.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. Based on observation, interview and record review the facility failed to secure and obtain a signed copy of the dialysis (a treatment to remove extra fluid and waste when kidneys fail) contract; and failed to ensure dialysis communication forms were completed and reviewed by facility staff and the dialysis clinic for one sampled resident (Resident #32) out 13 sampled residents. The facility census was 49 residents. Review of the blank dialysis communication form located at the west nursing station showed: -A reminder to complete the top section of the dialysis communication form.-To ensure the bottom section was completed by dialysis, if returned uncompleted then call dialysis for the documentation.1. Review of Resident #32's admission record showed the resident had the following diagnoses:-Stage 4 chronic kidney disease (CKD, is a severe, advanced condition (eGFR 15-29) indicating significant kidney damage, acting as the final stage before failure).-Congested Heart Failure (CHF the heart can't pump enough blood, which can cause fluid buildup).Review of the resident's care plan initiated on 6/23/25 showed:-The resident needed hemodialysis related to stage four hypertensiveCKD, he/she had fluid overload or potential fluid volume overloadwith diagnosis of dialysis.-Recommendation for fluid restriction limit of 2000 milliliter (ml) daily related to fluid overload secondary to CHF. Review of the resident's dialysis communication forms dated 2/4/26 to 2/17/26 showed: -The middle portion was not completed by the dialysis staff on the forms dated 2/4/26, 2/6/26, 2/9/26, 2/11/26, 2/13/26 and 2/17/26.-The last portion was to be completed by facility staff and signed by nursing was left blank on the forms dated 2/4/26, 2/6/26, 2/9/26, 2/11/26, 2/13/26 and 2/17/26.Review of the resident's alert note dated 2/20/26 at 3:41 P.M. showed: -The resident had come to staff after he/she returned from dialysis stating he/she did not feel well and reported Nausea/Vomiting.-The nurse had the resident lay down.-After 30 minutes the resident started to scream and yell for his/her mother. He/She kept yelling Mama get me up, please Mama please get me up. -The nurse went into the resident's room to complete an assessment. -The resident's left arm, where he/she had a new dialysis fistula/shunt (a procedure that connects an artery to a vein in preparation for dialysis) placed about one week ago, was hot to touch upon palpation, shiny and bleeding. -The nurse held pressure upon noticing the area was bleeding and called emergency medical services (EMS) and received a new physician's order to send the resident to the hospital to evaluate and treat.Review of the resident's dialysis communication form dated 2/27/26 showed: -Dialysis had not completed the middle portion.-The last portion to be completed by facility staff and signed by nursing was left blank.Review of the resident's admission Minimum Data Set (MDS - a federally mandated assessment instrument completed by facility staff for care planning) dated 3/10/26 showed.-He/She was cognitively intact. -He/She was able to make his/her needs known.-He/She required assistance of facility staff for activities of daily living (ADL) including bathing. -He/She required dialysis services.Review of the resident's physician order sheet (POS) dated March 2026 showed: -Dialysis clinic care on Monday, Wednesday, and Friday. Contact the dialysis clinic as needed and complete the dialysis communication form and send with the resident on the morning of dialysis. The form was to be completed by facility and dialysis clinic staff. Was ordered on 1/12/26.-Check dialysis site for bleeding and signs or symptoms of infection every shift ordered on 1/11/26. -Obtain weights and vital signs pre and post dialysis, record on the dialysis communication form two times a day every Monday, Wednesday, and Friday ordered on 1/12/26.-Remove the dressing from the dialysis port one time a day, every Tuesday, Thursday, and Saturday ordered on 1/13/26. Review of the resident's dialysis communication form dated 3/1/26 to 3/12/26 showed: -Only received one form dated 3/2/26.-Dialysis did not complete the middle portion.-The last portion to be completed by facility staff and signed by nursing was left blank. -There were no forms received dated 3/4/26, 3/6/26, 3/9/26, and 3/11/26.During an interview on 3/11/26 at 11:32 A.M. the resident said:-He/She just returned to the facility from the dialysis clinic. -He/she had an upper chest catheter port and dialysis shunt in his/her left arm. -Nursing staff had not checked (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	either site yet. -He/she did not have a copy of the completed dialysis communication sheet for 3/11/26. Observation on 3/12/26 at 7:49 A.M., of the resident showed:-The MDS Coordinator assessed the resident's shunt dressing on his/her left arm and right chest area central line catheter.-The dressings were intact. -The MDS Coordinator checked the resident blood sugar, the result was 172, sliding scale insulin order showed the resident required one unit of insulin which the resident declined. -The MDS Coordinator said he/she would document monitoring the shunt, the central line catheter, and blood sugar in the resident's treatment administration record (TAR).During an interview on 3/12/26 at 11:54 A.M., the Regional Nurse said:-The facility did not have a dialysis policy or current contract for dialysis services at that time.-The facility had changed administrative staff and were not able to find the current contract for the dialysis center. -The facility had contacted the dialysis company and the person who would have access to the contract was out of the country. During an interview on 3/13/26 at 2:17 P.M., Licensed Practical Nurse (LPN) B said:-The resident had a dialysis binder that he/she took with him/her on dialysis days.-The facility staff completed the top portion of the communication sheet and sent it with the resident in the binder. -He/she did not check the dialysis binder and night staff were responsible for completing the top portion of the dialysis communication form. -He/she would expect staff to complete the resident weight, vital signs and fistula monitoring (essential for ensuring the longevity and function of a dialysis access, typically involving daily self-checks (look, listen, feel) and regular clinical surveillance. Key signs of a healthy fistula include a consistent vibrating thrill and a whoosh sound bruit), before and after dialysis and on non-dialysis days. -Staff was responsible to check the resident's dialysis access site, for thrill and bruit and the chest catheter port dressing was intact and not bleeding. -Staff was responsible to review the dialysis communication sheet after each dialysis clinic day. During an interview on 3/16/26 at 12:58 P.M., the Director of Nursing (DON) said:-The dialysis communication form was to be completed pre and post dialysis by facility staff. -The facility sent the resident with the top portion of the communication form completed.-The form did not always return with the resident completed by dialysis. -He/She would expect staff to contact dialysis to have the form completed and returned. -He/She would expect staff to have documentation of the nursing assessment of the resident pre and post dialysis care. -He/She would expect staff to document on the resident's communication form, in the resident progress notes and on the TAR.

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia. Based on interview and record review, the facility failed to ensure residents with a diagnosis of Dementia (a progressive organic mental disorder characterized by chronic personality disintegration, confusion, disorientation, stupor, deterioration of intellectual capacity and function, and impairment of control of memory, judgment, and impulses) had a personalized care plan to ensure services to promote the resident's highest level of functioning and psychosocial needs for one sampled resident (Resident #41) out of 13 sampled residents. The facility census was 49 residents. Review of the facility's Dementia-Clinical Protocol policy showed:-For the individual with confirmed Dementia, the Interdisciplinary Team (IDT) would identify a resident-centered care plan to maximize remaining function and quality of life.-The IDT would identify and document the resident's condition and level of support needed during care planning and review changing needs as they arose.1. Review of Resident #41's face sheet showed the resident was admitted with the following diagnoses:-Unspecified dementia (a progressive organic mental disorder characterized by chronic personality disintegration, confusion, disorientation, stupor, deterioration of intellectual capacity and function, and impairment of control of memory, judgment, and impulses).-Other symptoms and symptoms involving cognitive functions and awareness.-Cognitive communication deficit.-Delusional disorders (a type of mental health condition in which a person can't tell what's real from what's imagined).-Amnesia (refers to the loss of memories, including facts, information and experiences).-Hallucinations (the experience of seeing, hearing, feeling, or smelling something that does not exist).-Major Depressive Disorder (a state of intense sadness or despair that has advanced to the point of being disruptive to an individual's social functioning and/or activities of daily living).Review of the resident's Quarterly Minimum Data Set (MDS - a federally mandated assessment instrument completed by facility staff for care planning) dated 12/31/25, showed he/she:-Had moderate cognitive impairment.-Had a diagnosis of Dementia.-Was often socially isolated.-Needed supervision or touching assistance with bathing, tub/shower transferring, walking and turning.-Had a diagnosis of Depression (a common, serious mood disorder characterized by persistent sadness, loss of interest in activities).-Was taking antipsychotic medications (medications designed to treat psychotic symptoms such as hallucinations, delusions, and disorganized thinking) on a routine basis.-Was taking antidepressant medications (medications used to treat depression, anxiety disorders, and other conditions like chronic pain or insomnia).Review of the resident's undated care plan showed he/she:-Dementia was not addressed in the care plan.-Had an activities of daily living (ADL are activities related to personal care. They include bathing or showering, dressing, getting in and out of bed or a chair, walking, using the toilet, and eating) self-care performance deficit.-Had impaired thought processes related to Dementia with interventions to communicate with his/her family/caregivers regarding resident's capabilities and needs and discuss concerns about confusion, disease process and nursing home placement with her family/caregivers.During an interview on 3/13/26 at 12:12 P.M., the Director of Nursing (DON) said:-He/She would expect a resident with a Dementia diagnosis would have it recorded on the MDS.-He/She would expect a resident with a Dementia diagnosis would be care planned for that diagnosis.-The resident's care plan was not person centered or complete.-Types of areas that should be included in a care plan for Dementia care would include daily orientation, constant monitoring, frequent checks and assistance with ADL's.-The nursing staff would know how to care for a resident with Dementia by looking at the report sheet that should be on each unit which contained individual care needs as well as the resident's diagnoses, but no one was using them right now.-The MDS Coordinator was responsible for updating the resident's care plan.During an interview on 3/13/26 at 2:10 P.M., the MDS Coordinator said:-The process for selecting care areas was to use the information from the resident's hospital records and ask them for additional information if needed, any information that came with them upon admission, in house assessments and progress notes. -He/She would ask (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the nurses to fill out functional abilities (GG) section of the MDS when available.-He/She was told during training, if a resident was not being treated for Dementia with medication, then he/she could not record it on the MDS.-The DON was helping him/her to get caught up on the MDS's and make corrections. They tried to look at MDS's daily.-The resident should be care planned for Dementia.-He/She was responsible for updating the resident's care plan.

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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. Based on interview, and record review, the facility failed to ensure to follow standard of practice and safe administration/use of a Basaglar insulin KwikPen (a disposable, prefilled insulin pen containing insulin glargine a long-acting insulin used to manage blood sugar levels. The subcutaneous pen-injector provides 24-hour basal insulin coverage) for one supplemental resident (Resident #21), out of 12 supplemental residents. The facility census was 49 residents. Review of the facility's Administering Medications Policy revised on April 2019 showed: -Medications are administered in a safe and timely manner, and as prescribed.-The individual administering the medication checks the label THREE (3) times to verify the right resident, right medication, right dosage, right time and right method (route) of administration before giving the medication.-Insulin pens containing multiple doses of insulin are for single-resident use only. Changing the needle does not make it safe to use insulin pens for more than one resident.-Insulin pens are clearly labeled with the resident's name or other identifying information. -Prior to administering insulin with an insulin pen, the nurse verifies that the correct pen is used for that resident.1. Review of Resident #21's admission record showed the resident had a diagnosis of Type II Diabetes Mellitus without complications (is your body does not use insulin properly this was called insulin resistance). Review of the resident's Annual Minimum Data Set (MDS - a federally mandated assessment instrument completed by facility staff for care planning) dated 12/15/25 showed:-He/she was cognitively intact.-Required insulin. Review of the resident's electric medical record for drug information sheet, dated 2/4/26 showed for Basaglar KwikPen:-Remove all pen needle covers before injecting a dose (there may be two covers). If you were not sure what type of pen needle you had or how to use it, talk with the doctor.-Do not move this drug (insulin) from the pen to a syringe.Review of the resident's physician's order sheet (POS) dated March 2026 showed: -Basaglar KwikPen subcutaneous solution pen-injector 100 Unit/milliliters (ml) (Insulin Glargine) Inject 30 units subcutaneously (SQ) in the morning related to type II Diabetes Mellitus without complications was ordered on 9/16/25. Observation on 3/12/26 at 10:05 A.M., of the resident's insulin administration showed:-The Director of Nursing (DON) cleaned the rubber tip of the prefilled insulin pen and accessed the insulin with a syringe needle through the hub.-After accessing the insulin pen with the syringe, he/she pushed air into the pen prior to drawing up the prescribed amount of insulin. -He/She drew up 30 units into the insulin syringe from the Basaglar KwikPen. -He/She gave the 30 units per syringe into the resident's left arm. During an interview on 3/12/2026 10:25 A.M., the resident said:-He/she did not remember if nursing had to draw up insulin out of insulin pen prior to 3/12/26. -He/She did not have concerns or felt he/she had a change in condition after the insulin was administered. During an interview on 3/12/26 at 10:30 A.M., the DON said: -The facility did not have correct needle tips for the resident's Basaglar KwikPen.-He/She had been instructed at another facility if there was no needle for the insulin pen, an insulin syringe could be used to draw out the amount needed from the insulin pen.-He/She had added air to the pen prior to drawing up insulin.-He/She was not aware of any adverse effects or damage to the insulin pen when insulin was drawn out with a syringe. -He/she was not aware of the facility policy related to insulin pen administration. During an interview on 3/12/26 at 10:49 A.M., Pharmacist A said: -He/She would expect staff to follow the standard of practice and follow written physician orders on method of administration. -The resident's order was to use the insulin pen with needle pen cap.-He/She would expect staff to ensure the facility had the required needle tips for insulin injector pens. -It would not be best practice to inject air into the insulin pen. -It was required to prime and waste two units of insulin from the pen prior to dialing up the required amount of insulin needed. -Since staff added air to the insulin pen future dosages given to the resident could have been affected. During an interview on 3/13/26 at 2:17 P.M., Licensed Practical Nurse (LPN) B said:-The staff was able to get vial insulin out of the emergency kit if needed. -Should never access the insulin pen with another syringe.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Maywood Terrace Living Center	10300 East Truman Rd Independence, MO 64052

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. Based on observation, interview and record review, the facility failed to ensure pureed (food that is blended, chopped, mashed, or strained until it becomes a soft and smooth consistency) sausage for one sampled resident (Resident #22) was at a smooth consistency; and failed to ensure the recipe for pureed sausage included the quantities of liquids or thickeners needed. This practice affected one resident. The facility census was 49 residents. 1. Review of the facility recipe for pureed sausage, dated 2025 showed:-Ingredients: 1 cooked sausage patty.-Directions: Place the number of servings needed, from the regular prepared recipe into a clean and sanitized food processor and blend until smooth.--If the consistency needed thinning, gradually add an appropriate hot liquid (i.e. broth, gravy, hot milk, sauce, reserved cooking liquid).--If the consistency needed thickening: alternate adding commercial thickener with processing.-Check product consistency periodically until smooth, lump free and extremely thick.-Maintain minimum holding temperature of 135 F (degrees Fahrenheit)-NOTE: Follow any facility policies/procedures, such as the puree volume method procedure to ensure a correct portion was served.Observation on 3/12/26 at 8:24 A.M., showed:-The Dietary Manager (DM) placed two patties of sausage in the food processor. -The DM had no recipe book open at the time he/she made the pureed sausage.-He/She added an unmeasured amount of gravy to the food processor.-He/she processed the sausage for about 30-40 seconds.Observation on 3/12/26 at 8:27 A.M., during a taste test showed:-The pureed sausage was not smooth.-There were many bits of meat present. During an interview on 3/12/26 at 10:11 A.M., the DM said:-He/she needed a new food processor.-It worked for mechanical soft, but not for pureed foods. During a phone interview on 3/18/26 at12:29 P.M., the Registered Dietitian (R.D.) said:-He/she left information with facility personnel regarding the need for a food processor replacement after his/her last visit to the facility on 2/27/26.-The format of the recipe may have changed.-He/She had not had a chance to train the DM in making the pureed foods as the DM was not there on the day he/she went to the facility.

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. Based on observation, interview and record review, the facility failed to serve one sampled resident (Resident #24) out of 13 sampled residents, a meal that was compatible with his/her chosen preferences. The facility census was 49 residents. 1. Review of Resident #24's meal ticket dated 3/12/26, showed the resident:-Was to receive a regular diet and a regular texture.-Had a statement of double portions.-Was to receive NO PORK OF ANY KIND. Observation on 3/12/26 at 8:58 A.M., showed the resident was served a plate with pork sausage and pancakesDuring an interview on 3/12/26 at 9:09 A.M., the resident, who was identified by his/her admission Minimum Date Set (MDS a federally mandated assessment tool completed by the facility for care planning) dated 2/20/26, as a resident who was cognitively intact, said eating pork was against his/her religion.During an interview on 3/12/26 at 9:58 A.M., the Dietary Manager (DM) said:-He/She did not have a substitute meat for pork for the two residents that did not eat pork.-He/She was told by the resident's relative the resident did not eat pork as part of his/her religious practice.During a phone interview on 3/15/26 at 7:36 A.M., the Resident's Relative said:-The resident did not eat pork.-He/she told staff at the care planning meeting on 3/3/26 the resident did not eat pork.-The facility staff including the Administrator, the DM, and the Director of Nursing (DON) were at the care plan meeting.During an interview on 3/16/26 at 10:01 A.M., the DM said:-There were two residents who absolutely did not consume pork products.-The facility's food supplier had adequate substitutes.-He/she attended the care plan meeting for the resident, and he/she remembered the resident's relative had mentioned the resident did not consume pork due to his/her religious preference.

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. Based on observation, interview and record review, the facility failed to ensure Hospice care and services were documented in the resident's Hospice record and communicated to the facility staff to ensure coordination of care for one sampled resident (Resident #7) out of 13 residents. The facility census was 49 residents. Review of the facility's Hospice policy and procedure dated July 2017, showed:-Their facility had an agreement in place with at least one Medicare certified hospice to ensure the residents who wish to participate in a hospice program may do so. -Hospice providers who contract with this facility must have a written agreement with the facility outlining in detail the responsibilities of the facility and the hospice agency and are held responsible for meeting the same professional standards and timeliness of service as any contracted individual or agency associated with the facility.-In general, it is the responsibility of the hospice to manage the resident's care as it relates to the terminal illness and related conditions, including: determining the appropriateness of hospice care, changing the level of services provided when it is deemed appropriate, providing medical direction, nursing and clinical management of the terminal illness, providing spiritual, bereavement and/or psychosocial counseling and social services as needed; and providing medical supplies, durable medical equipment, and medications as necessary for the palliation of pain and symptoms. -In general, it is the responsibility of the facility to meet the resident's personal care and nursing needs in coordination with the hospice representative and ensure that the level of care provided is appropriately based on the individual resident's needs. These responsibilities include twenty-four hour room and board, administering the prescribed therapies, including therapies determined by hospice and detailed in the hospice plan of care; notifying hospice about significant changes in the resident's physical, mental, social or emotional status, clinical complications that suggest a need to alter the plan of care, a need to transfer the resident from the facility for any reason or resident death; communicating with the hospice provider and documenting to ensure the needs of the resident are addressed and met 24 hours daily; and reporting any alleged violations involving mistreatment, abuse or neglect including injuries of unknown source and misappropriation of resident property by hospice personnel to the hospice administration immediately upon awareness of the alleged violation.1. Review of Resident #7's Face Sheet showed the resident was admitted with diagnoses that included:-Spinal stenosis (narrowing of the spaces within your spine (spinal canal), which puts pressure on the spinal cord and nerves, usually in the neck or lower back).-Protein calorie malnutrition (a severe nutritional deficiency caused by a lack of sufficient calories and protein intake, leading to muscle wasting, weight loss, and impaired body function).-Pain.-Long term use of opiates.-Dementia (a condition characterized by progressive or persistent loss of intellectual functioning, especially with impairment of memory and abstract thinking, and often with personality change, resulting from organic disease of the brain).-History of falling.-Delusional disorder (a type of serious mental illness (psychosis) characterized by the presence of one or more false, unshakable beliefs (delusions).-Anxiety (a normal human reaction to stress, involving feelings of fear, dread, uneasiness, and tension, often accompanied by physical symptoms like rapid heart rate, muscle tension, and sweating).-Failure to thrive (syndrome of global decline, most common in older adults, characterized by unintentional weight loss, poor nutrition, dehydration, inactivity, and depression).Review of the resident's Care Plan dated 5/28/25, showed the resident had a terminal illness and was receiving Hospice services. It showed the goal was to maintain the resident's dignity and autonomy at the highest level through the review date. Interventions showed:-Adjust provision of activities of daily living (bathing, dressing, toileting, eating, mobility) to compensate for resident's changing abilities. Encourage participation to the extent the resident wished to participate.-Assess resident coping strategies and respect resident wishes.-Encourage resident to express feelings, listen with non-judgmental acceptance, compassion.-Encourage support system of family and (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	friends.-Review resident's living will and ensure it was followed. Involve family in discussion.-He/She was on Hospice services (vendor information and contact was documented) with a diagnosis of Dementia.-Work cooperatively with the Hospice team to ensure the resident's spiritual, emotional, intellectual, physical and social needs were met.-Work with nursing staff to provide maximum comfort for the resident.Review of the resident's Hospice Contract dated 5/28/25, showed:-The resident was admitted to Hospice services on 5/28/25 for palliative care.-The agreement that it was the Hospice provider's responsibility to provide services at the same level and to the same extent as those services would be provided if the resident were in their own home.-The Hospice vendor's responsibilities included providing medical direction and management of the resident's nursing care, counseling (including spiritual, dietary and bereavement), social work, provision of medical supplies, durable medical equipment and drugs necessary for the palliation of pain and symptoms associated with the terminal illness and related conditions, and all other hospice services that are necessary for the care of the resident's terminal illness and related conditions.-The Hospice shall furnish to the facility a copy of the resident's Hospice plan of care and medical history. Hospice shall promptly communicate in writing, any changes in the Hospice plan of care to the facility, which shall incorporate them into the facility's plan of care on the resident. Hospice shall specify the inpatient services to be furnished.-Patient care management and decisions concerning a resident's plan of care are the ultimate responsibility of the Hospice interdisciplinary group; however, the assumption of such responsibility shall not serve to release the facility from their responsibility for services provided by the facility.-The patient coordinator for Hospice shall coordinate the services provided to the resident by reviewing the plan of care and scheduling interdisciplinary group meetings as necessary. Review of the resident's Hospice record showed:-The resident was admitted to Hospice on 5/29/25 for diagnoses including senile degeneration of the brain.-The resident's Hospice services included a Bath Aide twice weekly, Nurse twice monthly, Chaplin and Social Worker as needed.-The resident's physician's orders were most recently dated July 2025 with no further updated documented.-The resident's most recent Hospice care plan showed no updates since July 2025.-The resident's interdisciplinary notes showed no updates since July 2025.-The most recent recertification for Hospice services was dated 1/15/2026 with a diagnosis of senile degeneration of the brain. It showed the resident was no longer able to use utensils and needed assistance with eating (finger foods only) had a poor appetite, muscle rigidity, tremors, slept 16 out of 24 hours daily, had exertion, poor endurance and low activity. It showed the resident's generalized pain was managed with Norco (a prescription medication combining hydrocodone (an opioid pain reliever) and acetaminophen (a non-opioid pain reliever) and Morphine (narcotic drug obtained from opium and used medicinally to relieve pain). It showed the resident continued to be eligible for Hospice services.-The residents Hospice disciplinary notes showed the most recent nursing visit note was dated January 2026, and the most recent Chaplin note was dated 3/11/26.-There were no notes showing when the Hospice Bath Aide was visiting or had visited the resident.--There were no bath aide notes. -There was no evidence showing the Hospice staff scheduled to visit the resident documented their visits and what occurred during their visits.Review of the resident's quarterly Minimum Data Set (MDS-a federally mandated assessment tool to be completed by facility staff for care planning) dated 12/15/25, showed the resident:-Was alert and oriented without long- or short-term memory loss.-Had little interest, feeling tired and feeling depression symptoms.-Had upper and lower extremity impairment on both sides, and sed a wheelchair for mobility.-Was independent with eating and transferring, needed partial to moderate assistance with toileting, bathing, dressing and did not walk.-Received Hospice services.Review of the resident's Progress Notes showed:-On 2/3/26 Nursing called Hospice to inform them the resident had been complaining of pain control and staff are not managing it very well. They sent a nurse out at 8:00 P.M. He/She increased the resident's Fentanyl from 25mcg to 50mcg. Hospice nurse said they would cover the resident's first box of medication, but the resident would need to make a payment to the pharmacy. The nurse notified the resident's responsible party because (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the resident would not receive another box of medication patches.-On 2/4/26 The nurse left a message for the resident's responsible party regarding a prescription balance to be paid. The responsible party called the pharmacy to see if there was a balance, they told her no. The resident's responsible party was coming into the facility and would speak with staff to find out what was going on.-On 2/14/26 Late Entry: The resident's Ativan and liquid Morphine had arrived at the facility. The nurse would notify Hospice to order Norco and Ativan tablets.-On 2/27/26 the nurse on unit called Hospice and informed them the resident only had 2 tablets of Morphine left. Hospice nurse stated they would refill Morphine 100mg tablets.Review of the resident's Physician's Order Sheet (POS) dated March 2026, showed:-Resident admitted to Hospice under diagnosis of senile degeneration of the brain (9/23/25).-Morphine Sulfate ER Tablet Extended Release 100 milligrams (mg) Give 1 tablet by mouth every 8 hours for moderate pain (12/24/25).-Morphine Sulfate oral solution 100 mg/5 milliliters (ml) give 1 ml by mouth every 1 hours as needed for breakthrough pain; shortness of air/air hunger (1/21/26).-Fentanyl Transdermal (on the skin) patch 72 Hour 50 micrograms (mcg) per hour. Apply 1 patch transdermally (on top of the skin) at bedtime every 3 day(s) for moderate pain (3/5/26).-Hydrocodone-Acetaminophen 10-325 mg give 1 tablet by mouth every 4 hours for pain (5/29/25).Observation and interview on 3/10/26 at 9:20 A.M., showed the resident was sitting up in his/her bed. The resident's call light was within reach and on his/her tray table were several personal items, beverages and snacks. Nursing staff brought his/her breakfast in at 9:21 A.M. The resident only wanted scrambled eggs and bacon and requested soda which the staff accommodated. The resident said:-He/She was in pain, had just received his/her pain medication and was waiting for it to start working. -He/She was on Hospice and only took pain medications now. -His/Her pain was being managed as well as they could now.-Nursing staff had been trying to manage it, and they had changed some of his/her medications.-Whenever he/she did not receive his/her pain medication, he/she called Hospice and then it showed up at the facility. -He/She now received Fentanyl patch and liquid Morphine to better manage pain.-He/She said he/she liked the Hospice staff, and they were supposed come in twice weekly to give a shower but usually they only came in twice monthly. -The facility nursing staff gave him/her a bath yesterday and they gave most of his/her showers.-The Hospice bath aide was not coming weekly. During an interview on 3/10/26 at 3:12 P.M., Licensed Practical Nurse (LPN) A said:-The resident had pain, and they had noticed he/she had been complaining that bugs were crawling on and biting him/her.-They removed all his/her linen, gave him/her a shower and looked for any/all bugs and there were none. He/She said they notified Hospice. -Hospice had recently ordered anti-anxiety medication and the resident was also receiving a lot of pain medication (Morphine, Ativan, Hydrocodone and a Fentanyl patch) which may have caused the itching.-Hospice was trying to manage his/her pain and this was the resident's baseline pain management because he/she had been on pain medication for quite a while. -Hospice was now changing the resident's psychotropic medications to try to better manage his/her anxiety. -They had problems getting the resident's pain medications from the facility pharmacy (the facility formulary would not fill his/her medications directly) so they called to obtain them through Hospice. If he/she noticed that any of the resident's pain medications were getting low, he/she called Hospice, and they would order the pain medications and had it sent to the facility.-Hospice usually provided the resident's medication once he/she informed Hospice the resident was low or out of pain medication. -The Hospice nurse was supposed to come in to visit the resident once weekly and when the Hospice nurse came into the facility and he/she was working, he/she had spoken with the nurse about the resident's care and treatment, any changes in treatment and he/she and had made the nurse aware of any medications that the resident was getting low on or needed to be refilled.-The Hospice vendor was supposed to be managing his/her medications, but he/she did not know why they were not aware of when the resident needed his/her medication refilled.-He/she always had to notify them of when the resident's medication needed to be refilled.-As soon as he/she notified Hospice, they would send the medication within 24 hours. -If they ran out of the resident's pain medication, he/she would pull it from the (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	emergency kit (E-kit- a small, sealed supply of prescribed medications kept providing fast, immediate relief for end-of-life symptoms like pain, anxiety, or nausea) so the resident did not go without receiving pain medication.-There was never an instance when the resident had not had pain medication, and he/she tried to stay ahead of the resident's pain, so it never became an issue. -Most recently, the Hospice physician wrote the order for additional pain medication (liquid Morphine), and they had to verify the order through the facility physician, and then they would move forward with the order and Hospice would have it delivered. -He/She did not know when the Hospice bath aide came, but the resident was receiving baths from the facility nursing aides. He/She had not seen a Hospice bath aide since February 2026.-The resident had a Hospice book that the Hospice staff were supposed to use to document their care and services in, but he/she was not sure if they documented every time, they came in to visit the resident or not, they were supposed to.-The resident's Hospice provider was not being proactive about managing the resident's medications or he/she would not have to contact them to let them know that the resident was running low.-The resident's Hospice provider was not being proactive regarding any changes with his/her anxiety, and they were not as attentive to the resident as other Hospice providers in the facility were.-He/She spoke to the resident about a month ago about changing Hospice providers and the resident did not want to change at that time. During an observation and interview on 3/11/26 at 11:45 A.M., Certified Medication Technician (CMT) A said:-He/She gave the resident Hydrocodone this morning at 7:56 A.M. and the resident was scheduled to receive it again during the afternoon medication pass. -He/She let LPN A know that the resident was having more pain, and he/she was coming in to assess the resident and provide additional pain medication (Morphine).-At 11:48 A.M. LPN A went to assess the resident and decided to give additional pain medication to the resident.-CMT A said the resident had severe pain and complained of breakthrough pain. -The Hospice nurse had been there a few times, and he/she had spoken to the Hospice nurse at least once to discuss the resident's pain, and the Hospice nurse said they were trying to look at how to better manage his/her pain. -The resident had a Fentanyl patch and liquid Morphine that was ordered, and it seemed to help so they were trying to manage it better. -He/She thought the Hospice nurse came in weekly but was not sure.-He/She did not know how often the Hospice bath aide came in, but the facility nursing staff had been giving the resident's baths and he/she thought the resident received a shower yesterday.During an interview on 3/11/26 at 2:12 P.M., the Administrator and Regional Corporate Nurse said:-Hospice was responsible for the formulary for the resident's pain medications because they were related to his/her Hospice diagnosis. They were responsible for ordering the medications and sending them to the facility.-The facility was responsible for ensuring the medications were ordered and providing the medications to the resident. -The Hospice nurse was supposed to come in weekly and document their notes in the resident's Hospice communication record. -The Hospice bath aide was supposed to come to provide bathing to the resident twice weekly.-This resident was the only resident in the facility with this Hospice vendor.During an interview on 3/12/26 at 12:54 P.M., the MDS Coordinator said:-The resident's Hospice nurse was supposed to come in at least weekly, and the bath aide was supposed to come in usually twice weekly.-Regarding the resident's pain management, Hospice was who ordered the resident's pain medication, but they communicated to Hospice if there were concerns with the resident's pain management. Once they received the physician's order, they confirmed with the resident's physician and then Hospice would send the medication.-The resident could not miss a dose of Morphine, so they had to stay on top of that in order to manage his/her pain adequately and to prevent withdrawal symptoms.-They usually had to notify Hospice when the resident needed a refill on pain medications.-Typically, when a resident was on Hospice, Hospice should be monitoring the resident's medication and refilling the script as needed.-When the Hospice nursing staff or bath aide came in to see the resident, they were expected to document a note indicating what the visit was for and what occurred during the visit in the resident's Hospice book.-Yesterday the Hospice Chaplin visited the resident, and he/she documented his/her visit in the resident's Hospice book.-Typically, (continued on next page)

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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 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	there was conversation with the Hospice provider and the facility charge nurse while Hospice was in the building. The facility nurse should also document any medication or care related changes and then relay that information to Hospice to give to the resident's primary care physician.-He/She would expect the Hospice bath aide to document in the Hospice record when they bathed the resident or if the resident refused their bath. The Hospice bath aide should also fill out the facility shower sheet and turn that into the charge nurse before they left.-Since the facility was responsible for the overall care of the resident, they should check to ensure the Hospice documentation was up to date and current and that the notes were documented.During an interview on 3/12/26 at 2:45 P.M., the Corporate Regional Nurse said:-He/She followed up with the Hospice provider by phone and they told him/her that since the resident was a charity case (and they were not charging the resident for Hospice services) they did not have to follow the rules for documentation.-He/She informed the Hospice provider that they still had to provide documentation that they were providing services and what occurred during their visit.-Hospice was supposed to provide documentation of every visit regardless of the billing because they were providing services to the resident, and this was in the contract they had with the Hospice provider. -He/She informed them that they had not provided their nursing or bathing documentation, and they still needed to do so. -The Hospice provider sent the nursing documentation from 9/22/25 to 3/5/26 and it was placed in the resident's Hospice record.During an interview on 3/16/26 at 10:18 A.M., the Director of Nursing (DON) said:-The Hospice vendors each had a binder for each resident they provided services to in the facility.-The Hospice nursing staff that came into visit were supposed to document anything they did in the binder and let the nursing staff know of any progress or changes in condition, coordinate services, and participate in care planning. -Hospice was responsible for sending the bath aide twice weekly.-The Hospice bath aide was supposed to document in the Hospice notes and document on the facility bath sheets every time they visited.-He/She was ultimately responsible for ensuring that Hospice was documenting in the binder and ensuring the coordination of care was being done.