STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265417	A. Building B. Wing	04/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sherbrooke Village	4005 Ripa Avenue Saint Louis, MO 63125

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 0697 Level of Harm - Actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. Based on observation, interview and record review, the facility failed to provide reasonable accommodation or intervention for pain management for two of two residents (Residents #118 and #2). One resident had uncontrolled pain for 20-hours after being discharged from a local hospital with a pelvic fracture. The facility did not administer any pharmacological or non-pharmacological approaches for pain control. The facility nurse did not try to get orders for pain medication from the on-call provider (Resident #118). Facility staff also failed to provide pain control interventions for one resident during a wound treatment (Resident #2). The sample was 24. The census was 121. Review of the facility's Pain Management policy dated 11/22, showed:-Policy: The Facility will use a systematic approach to Pain Management; Recognition, Evaluation, Treatment, & Monitoring of Pain. Individuals experiencing Pain may receive Pharmacological/Non-Pharmacological Interventions to assist in Pain Management. The Facility will provide Employees Education on Pain Management & Opioid Overdose.-Responsibility: Nursing personnel (Registered Nurse (RNs) and Licensed Practical Nurses (LPNs), Nursing Administration, Assistant Director of Nursing (ADON) and Director of Nursing (DON);-Procedure: Recognition: Evaluate/Prevent:-Recognize when Resident is experiencing Pain & Identify circumstances when Pain can be anticipated;-Evaluate Resident for Pain on admission and Routine Evaluations;-Manage/Prevent Pain, consistent with the Comprehensive Evaluation and Plan of Care;-Current Professional Standards of Practice, & Resident's Goals/Preferences;Observation for nonverbal indicators:-- Negative Vocalization (e.g., groaning, crying, whimpering, screaming);--Skin Conditions;-Verbal descriptors:--Hurting/Aching;--Burning;--Spasms;--Soreness, Tenderness, Discomfort, Pins, Needles;-Pain Evaluation: Nursing will complete a Pain Evaluation Tool, appropriate for the resident's cognitive status, to assist with evaluation of a resident's pain;-Evaluation of Pain by the Licensed Nurse or Medical Provider;--History of Pain & Treatment:---Non-Pharmacological, Pharmacological, & Alternative Medicine (CAM) Treatment;---Response/Effective to Treatment;---Ask the Resident to Rate the Intensity of his/her pain using a numerical scale, verbal or visual descriptor that is appropriate and preferred by the resident;---Reviewing the resident's current medical conditions (e.g., pressure injuries, diabetes with neuropathic pain, immobility, infections, amputation, oral health conditions, CVA (cerebrovascular accident, stroke), venous and arterial ulcers, and multiple sclerosis chronic disease of the central nervous system));---Identifying Key Characteristics of Pain:---Duration;---Frequency;--Location;---Timing;---Pattern (e.g., constant, or intermittent);---Radiation;-Obtaining Descriptors of Pain (e.g., stabbing. aching, pressure, spasms);-Identifying activities, Resident care or treatment that precipitate or exacerbate pain and those that reduce or eliminate pain;-Impact of Pain on Activities of Daily Living (ADLs) (e.g., sleeping, social activities, physical activity and mobility, emotions, intimacy, appetite, and mood, etc.);--Current Prescribed Pain Medications, Dosage, Frequency, Treatments, & Modalities;-Pain Management & Treatment:--Based on the Evaluation, Nursing in collaboration with the Physician/Prescriber, other health care professionals, the resident and/or the resident's representative will develop, implement, monitor, and revise as necessary interventions to prevent/manage a resident's pain beginning at admission;- Factors Influencing Treatment:--Cause, location, & severity of pain;--Resident's medical condition;--Resident's current medications;-General principles for analgesics (pain (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0697 Level of Harm - Actual harm Residents Affected - Few	medication):--Evaluate the resident's medical condition, current medication regimen, cause and severity of the pain and course of illness to determine the most appropriate analgesic for pain therapy;--Consider evidence-based practice tools to assist in the evaluation of the residents pain;--Consider administering medication routinely instead of as needed (PRN) or combining longer acting medications with PRN medications for breakthrough pain;--Utilize the most effective and least invasive route for analgesic administration (e.g., oral (PO), anal, topical (on the skin), injection (below skin), infusion pump and/or transdermal);--Use lower doses of medication initially and titrate slowly upward until comfort is achieved;--Reassess and adjust the medication dose to optimize the resident's pain relief while monitoring the effectiveness of the medication and work to minimize or manage side effects;--Review medical conditions which may require several analgesics and/or adjuvant medications; Documentation will clarify the rationale for a treatment regimen and acknowledge associated risks;--Opioids will be prescribed and dosed in accordance with current professional standards of practice and manufacturers' guidelines to optimize their effectiveness and minimize their adverse consequences;--Nursing will notify practitioner if the resident's pain is not controlled by the current treatment regimen. 1.Review of Resident #118's discharge hospital paperwork dated 3/16/26 at 12:44 P.M., showed:-The resident was admitted to hospital for small facture (Fx) in the pubic symphysis (part of the pelvis);-Diagnoses: Left groin pain, chronic bilateral low back pain, obesity. diabetes, closed Fx of pelvis, and intractable (difficult to resolve) pain;-Goals: Control pain, maximize quality of life, and minimize further functional decline;-Strategies:--Activity/exercise program recommendation;--Conservative stepwise pain medicine strategy with multi-disciplinary approach;--Recommend healthy lifestyle strategies and compensatory methods as needed. Review of the hospital's After Visit Summary sheet (AVS), dated 3/16/26 at 2:33 P.M., showed:-Take these medications;- Acetaminophen 500 milligrams (mg) tablet commonly known as: Tylenol, take two tablets (1,000 mg total) by mouth every (Q) six hours as needed for pain. Last time this was given: 650 mg on 3/16/26 at 10:53 A.M.;- Cyclobenzaprine 10 mg tablet commonly known as: Flexeril take one tablet (10 mg total) by mouth three times a day (TID) as needed for muscle spasms, for muscle spasms. Last time this was given: 10 mg on 3/16/26 at 9:32 A.M.;- Hydromorphone 2 mg tablet commonly known as: Dilaudid take one tablet (2 mg total) by mouth every three hours PRN for pain. Last time this was given was 3 mg on 3/16/26 at 12:56 P.M.;- Gabapentin 600 mg tablet commonly known as: Neurontin (treats nerve pain) take two tablets (1,200 mg total) by mouth three times a day. Last time this was given 1,200 mg on 3/16/26 at 9:32 A.M. Review of the nurse progress note dated 3/16/26 at 4:38 P.M., showed a note by RN GG: Resident arrived at facility today via ambulance accompanied by two Emergency Medical Services (EMS) workers. Resident is alert & oriented (A&O) x4 (person, place, time and situation), able to make needs known and able to understand others. Admitting diagnosis is left groin pain. Residents does have a pubic, sacral (triangle bone of the spine), and lumbar (vertebra/spine) (L5) fracture. The resident is continent of bowel and bladder. The history (Hx.) of hypothyroidism (thyroid gland fails to produce sufficient hormones, slowing the body's metabolism), fibromyalgia (chronic disorder characterized by widespread musculoskeletal pain, fatigue, sleep disturbances, and cognitive issue), chronic bilateral low back pain without sciatica (nerve), osteoporosis (weakened bones), deep vein thrombosis (DVT, red blood cells that block of the in the vein), groin pain, coronary artery disease (CAD, narrowing or blockage of the heart), stroke and diabetes. RN GG said medications were verified with in-house Nurse Practitioner (NP) T. The only new orders given was to make Protonix (treat stomach acid) twice a day (BID) instead of once a day. Another new order for albuterol sulfate HFA (prescription bronchodilator inhale) 90 micrograms (mcg) inhaler. Resident is currently in bed, no acute distress noted at this time. Review of the electronic physician's order sheet (ePOS) dated 3/2026, showed:-An order dated 3/17/26 at 2:00 P.M., Tylenol Extra Strength Oral Give 1000 mg by mouth pharmacy tablet 500 mg-An order dated 3/16/26 at 2:15 P.M., Hydromorphone HCl Oral Give one tablet by mouth pharmacy tablet 2 mg;-An order dated 3/16/26 at 2:15 P.M., Cyclobenzaprine HCl Oral tablet 10 (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	mg;-An order dated 3/17/26 at 6:00 A.M., Gabapentin Tablet 600 mg. Review of the Medication Administration Record (MAR) dated 3/2026, showed:-Gabapentin Tablet 600 mg, Give 1200 mg by mouth three times a day for neuropathy (nerve damage), start date 3/17/26 6:00 A.M., discontinue date 3/19/26 8:34 A.M.; given one out of one time;-Cyclobenzaprine HCl Oral Tablet 10 mg, give 10 mg by mouth every eight hours as needed for muscle spasms, start date 3/16/26 at 2:15 P.M., discontinue date 3/19/26 at 8:34 A.M., not given on 3/16 or 3/17 as ordered;-Tylenol extra strength PO table 500 mg give 1,000 mg PO Q six hours as PRN for pain, start date 3/16/26 at 2:00 P.M., discontinue date 3/19/26 at 8:34 A.M.; medication not administered on 3/16 or 3/17;-Hydromorphone HCl PO tablet 2 mg, give one tablet PO Q three hours as PRN for pain, start date 3/16/26 at 1:56 P.M., discontinue date 3/19/26 at 8:34 A.M., medication not administered on 3/16 or 3/17. Review of the nurse progress note skilled evaluation on 3/16/26 at 9:20 P.M., showed: Resident's pain: pain Issue: #001: New. Location: Generalized. Pain score: 4 (on a scale of 1-10). Dull. Aching. Frequency: Intermittent. PRN medication provided. See MAR for details. Mood is pleasant, no unwanted behaviors witnessed. Resident sleeps through the night. Resident's psycho-spiritual needs are met. Review of the facility's Pain Level Summary dated 3/17/26 at 12:18 A.M., showed the resident's pain level was a 4 out of 10. Review of the facility's Pain Level Summary dated 3/17/26 at 5:33 A.M., showed the resident's pain level was a 10 out of 10, entered by RN HH. Review of RN HH's progress note on 3/17/26 at 6:45 A.M., showed the resident told staff he/she was in excruciating pain. The resident said he/she been awake crying all night, which he/she has slept a little bit but has been awake. RN HH said the resident has been on their call light to request that Certified Nurses Assistants (CNAs) re-reposition him/her frequently just to move himself/herself back to the position he/she was in before staff moved him/her to begin with. The resident told staff he/she is a CNA themselves, but we have told him/her that they are a patient now and can't think of himself/herself as a CNA now. The resident won't leave the pillows positioned in the places that the CNAs put them in to keep him/her positioned in, and as soon as resident urinates, he/she wants changed at that moment. RN HH placed a call to the exchange to notify him of the increased pain the resident had. Nurse Partitioner R is on call, awaiting return call. Review of the nurse progress notes on 3/17/26, showed:-At 7:10 A.M., spoke to NP R and his/her recommendation was to send the patient back to discharged hospital for pain management immediately; -At 8:14 A.M., EMS notified; -At 9:01 A.M., EMS arrived at facility to transport resident to local hospital. During an interview on 4/9/26 at 12:50 P.M., RN GG said his/her primary goal during an admission are vitals (blood pressure, temperature, pain and respirations), weight and skin assessment. He/she will orientate the residents to the facility and provide them with their call light. When a resident complains of pain, RN GG will let the doctor know about the pain, then the doctor would provide new orders. RN GG put the orders in the electronic medical record (EMR) and faxed other narcotic (pain meds prescribed by a doctor) prescriptions to be signed by the doctor. RN GG said he/she cannot pull medication from the eKit (emergency supply of medications), it's out of his/her control. If there was an order for Tylenol, that could be pulled from eKit. RN GG did not recall the resident, the resident did not complain of pain, nor did he/she request medication to help control his/her pain. RN GG would not know if the resident was in pain due to his/her shift ended at 7:30 P.M. RN GG did recall the next day the resident was being sent out and he/she assisted RN HH by notifying EMS a transfer was necessary. RN GG said the medical doctor will not sign scripts that authorize narcotics until the next day. Residents need to understand that the facility will not have their pain medication at the facility. During an interview on 4/10/26 at 8:03 A.M., RN HH said he/she did not remember that specific resident without the resident's records in hand. RN HH cannot be positive if the resident had an order for Tylenol, however, had the resident had an order, he/she would have administered the medication. RN HH said the resident might have informed the nurse that the medication won't work. RN HH should have documented the Tylenol administration. The pharmacy usually drops medications off at the facility around 4:00 A.M. RN HH would normally place a call to the pharmacy to see the precise drop off time. RN HH can pull from the Ekit after he/she obtains an order. (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	RN HH was in the resident's room a lot that night. RN did not recall if the prescribed narcotic came on the morning drop. RN HH said they typically call the physician to see if there is alternative medication that staff can get out of the eKit. RN HH was unfamiliar with what was pre-stocked in the eKit; he/she guessed Dilaudid was in there. During an interview on 4/10/26 at 8:14 A.M., Vendor 2 (pharmacy) said they did not have Resident #118's name or date of birth in their records for this facility. During an interview on 4/10/26 at 8:43 A.M., CNA II said the resident did ask for pain medications that night but never said he/she was in pain. Any time a resident says they are in pain, CNA II reports it to the nurse. During an interview on 4/10/26 at 8:43 A.M., Certified Medical Technician (CMT) JJ said, he/she did not recall the residents, they come and go quickly over there. CMT JJ usually informs the nurse when pain medications are not delivered, however, staff can pull from the eKit. First, staff need to make sure the medical doctor (MD) signs the script, which authorizes staff to pull from the eKit. If the MD did not sign the script for the pharmacy, the pharmacy won't deliver it. During an interview on 4/10/26 at 11:53 A.M., the Administrator said the facility only uses the one pharmacy; which is vender 2, out of KC. During an interview on 4/10/26 at 12:43 P.M., the DON said she expected the staff to verify medications and fax required scripts in a timely manner. If the script is at the pharmacy and signed, then the staff can pull the medication from the eKit. The DON would expect the staff to call the physician to obtain an alternative medication that is available to aid with the resident's pain. At the time of an admission, staff need to make sure a signed script comes with the patient when they are discharged from the hospital. The DON would expect her staff to do everything possible before sending the resident out for pain to the hospital. She would expect them to call the exchange and notify the pharmacy for why medications are delayed. DON would expect a non-pharmacological approach for repositioning and for staff to add documentation. The DON would expect the staff to be proactive by requesting the hospital provide/fill the script for the resident prior to discharge. During an interview on 4/13/26 at 11:16 A.M., NP R said she received an email about a new admission who had an order for Dilaudid, but the order was not signed. The staff requested to send the resident back to the discharged hospital for pain management. NP R said that the nurses are responsible to contact the physician or exchange to obtain pain medication. The pain medication should have been addressed during regular hours when the provider was on the office, and staff are told to ask the discharged hospitalist for medications to be brought with them. NPs cannot order/prescribe opioids. Even if they could, this facility needs to have a hard copy on file, not a verbal order. NP R would have tried other topical pain medication that possibly could have helped the pain. Since the facility did not have pain medication on hand, NP R chose to send the resident back to the hospital at the resident's request. NP R said the Flexeril and Tylenol maybe could have helped. These medications are in the eKit. NP R would have provided some sort of new order if there were options. NP R said his/her exchange message was pubic fracture, no pain and crying, who request to return to the hospital. 2. Review of Resident #2's admission Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 9/22/25, showed:-Diagnoses included: Aphasia (impaired talking and understanding language), elevated blood pressure, end stage renal disease (severe kidney failure), and dependence of dialysis;-Cognitively intact; hearing loss, other reduced mobility, muscle weakness, falls, diabetes,-Fully dependent on staff for ADLs;-Pain was present occasionally. Review of the electronic physician's order sheet dated 3/2026, showed:-An order dated 1/15/26, Hydrocodone-Acetaminophen (Vicodin) (pain medication) oral Tablet 5-325 mg Q six hours for pain as needed;-An order dated 1/15/26, Pain Scale 1-10 Q shift;-An order dated 1/15/26, Acetaminophen PO tablet 500 mg, give two tablets by mouth every six hours as needed for pain; elevated temperature. During an interview on 4/6/26 at 3:07 P.M., the resident said there had been a wound on his/her coccyx for two to three months. The wound did get better but then got worse again. Review on 4/7/26 at 9:00 A.M., of the resident's care plan, in use at the time of the survey, showed:-The care plan did not address the pain on his/her coccyx related to the pressure ulcer;- Focus: Resident is at risk for pressure ulcer that development related to reduced mobility, (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	episodes skin, free of redness, blisters or of incontinence;-Goal: Resident will have intact skin, free of redness, blister or discoloration by/through review date;-Interventions: Educate family, care givers as to cause skin breakdown, including transfers, positioning requirements, good nutrition, and frequent repositioning, shift weight every 15 minutes, the resident needs Q two hourly turns, more often as needed or requested. Review of the MAR dated 4/2026, showed:-An order dated 1/15/26, showed: Acetaminophen PO tablet 500 mg, give two tablets by mouth every six hours as needed for pain; elevated temperature; the medication was not administered for 14 out of 14 possible opportunities;-Hydrocodone-Acetaminophen oral tablet 5-325 mg Q six hours for pain;--The resident received the medication eight out of 12 possible opportunities;--The resident received pain medication on 4/9/26 at 7:00 A.M. Observation on 4/9/26 at 11:27 A.M., showed the Wound Nurse asked the resident if he/she is alright? The resident said, It hurts, there are two spots on my hip bone and anus. Observation and interview on 4/9/26 at 11:40 A.M., showed CNA T and CMT V used a mechanical lift to put the resident back to bed. CNA T said the resident does have a PRN pain medication. CNA T told the resident Go ahead and scream or yell. Do what you need to. When CNA T and CMT V turned the resident, he/she hollered and moaned. CNA T said, We tried not to hurt you. During an interview on 4/9/26 at 11:40 A.M., CMT V said when he/she works, the resident complained about pain frequently. CMT V shared the resident's complaint with the nurse but was unsure if the nurse administered any pain medication. During an interview on 4/9/26 at 11:40 A.M., CNA T said when the resident had pain, they would tell the nurse, but they were unsure if the nurse administered any pain medication. Observation on 4/9/26 at 12:00 P.M., showed the resident said, Man, I have so many sore spots. CMT V asked the resident what hurt? The resident said, It's so sore, oh my god! While the Wound Nurse continued to cleanse wounds, the resident continued to yell out in pain. At 12:14 P.M., the wound cleansing process was stopped, due to pain medication needed to be administered. During an interview on 4/9/26 at 12:14 P.M., the Wound Nurse said she would contact the provider for new orders related to pain management. During an interview on 4/12/26 at 12:00 P.M., the DON said she expected the staff to address the resident's comments of pain and administer medications as ordered. 2807190

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure one resident was treated in a dignified manner (Resident #98), and failed to ensure staff followed the facility's cell phone policy, which affected 4 residents (Residents #12, #3, #100 and #140). The sample size was 24. The census was 121. Review of the facility's resident rights policy, dated 1/28/26, showed:-Policy: The facility shall treat residents with kindness, respect, and dignity and ensure resident rights are being followed. The resident/resident representative will be informed of their rights upon admission. Review of the facility's employment policies and procedures, undated, showed:-Personal cell phones: Use of personal cell phones or other similar devices while on duty is prohibited. Employees must understand that our first priority is the care and welfare of the residents. Use of personal cell phones is limited to breaks and meal periods. Ringers are to be silenced while on duty, and employees may not initiate or receive calls or text messages while caring for a resident or conducting company business. If the facility determines that an employee engages in personal cell phone/texting use during work hours, he or she may be subject to disciplinary action, up to and including termination. 1.Review of Resident #98's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 3/24/26, showed:-Cognitively intact;-Diagnoses included Parkinson's disease, dementia, and chronic obstructive pulmonary disease (COPD), a lung disease that cause the airway to become constricted and difficult to breathe. Observation on 4/7/26 at 745 A.M., showed the resident at the end of a hallway leading to the 300/400 dining room. The resident sat in his/her wheelchair. Certified Nursing Assistant (CNA) F walked by the resident. The resident asked CNA F to help him/her into the dining room. CNA F walked over to the resident and said he/she could not push him/her because the resident did not have his/her foot pedals. The resident looked at the aide but did not move. CNA F told the resident to use his/her feet and move towards the dining room. The resident moved a couple of feet but stopped. Unknown Aide LL walked by and asked the resident if he/she needed help. CNA F said to the aide that the resident could not find his/her foot pedals in his/her room today, and they could not push him/her without them. CNA F then turned to the resident and told the resident to move his/her feet again. The aide told the resident he/she was capable of moving his/her feet and could get him/herself to the dining room. The resident moved another couple of feet and then stopped. He/She looked at the aides with an uncomfortable look on his/her face. Unknown Aide LL then assisted the resident into the dining room. During an interview on 4/10/26 at 7:57 A.M., CNA J said if a resident asked for help, staff should have assisted the resident or found someone who could. During an interview on 4/10/26 at 8:02 A.M., Licensed Practical Nurse (LPN) K said if a resident asked for help, staff should have assisted the resident and should not have told the resident they would not help. During an interview on 4/10/26 at 1:05 P.M., the Administrator and Director of Nursing (DON) said residents should be treated and spoken to in a dignified manner. If a resident asked for help, they would have expected for staff to assist them. 2. Review of Resident #12's quarterly MDS, dated [DATE], showed:-Diagnoses included aphasia (impaired talking and understanding language), paraplegia (impaired motor and sensory in lower extremities), hemiplegia (severe or complete paralysis of one side of the body), hemiparesis (partial weakness or reduced movement on one side of the body) and dementia;-Severe cognitive impairment. Observation on 4/8/26 at 2:44 P.M., of the main dining room during lunch, showed CNA L sat next to the resident at a table in the dining room. While he/she fed the resident, he/she had ear buds in his/her ears and was looking at his/her phone. During an interview on 4/10/26 at 9:12 A.M., CNA L said cell phones were not to be used in resident care areas. He/She said on 4/8/26, he/she was on his/her phone while feeding the resident and was checking a text message. During an interview on 4/10/26 at 1:09 P.M., the Administrator and DON said staff should never be on their phones while feeding a resident or (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	assisting residents in the dining room. 3. Review of Resident #3's quarterly MDS, dated [DATE], showed:-Diagnoses included COPD, muscle weakness, depression, and anxiety;-Cognitively intact. During an interview on 4/06/26 at 10:40 A.M., the resident said staff were on their phones a lot. He/She said staff used their phones and headphones while providing care. 4. Review of Resident #100's quarterly MDS, dated [DATE], showed:-Diagnoses included congestive heart failure, type two diabetes, chronic kidney disease, and major depressive disorder;-Cognitively intact. During an interview on 4/06/26 at 12:13 P.M., the resident said staff used their cell phones in the hallways. He/She said staff were on their phones a lot. 5. Review of Resident #140's quarterly MDS, dated [DATE], showed:-Diagnoses included depression, anxiety, and hypertension;-Cognitively intact. During an interview on 4/06/26 at 10:39 A.M., the resident said staff had phones out while providing care and took phone calls during care. 6. Observation on 4/08/26 at 11:00 A.M., showed CNA L sat in the 300 hallway lounge on the couch. Multiple residents were in the room. He/She was texting on his/her cell phone. Observation on 4/9/26 at 6:24 A.M., showed CNA G sat on a couch in the 300 hallway lounge. He/She sat next to a resident. He/She had headphones on and was looking at his/her phone. Observation on 4/9/26 at 6:53 A.M., showed CNA G in the hallway wearing headphones while looking at his/her phone. 7. During the resident council meeting on 4/7/26 at 2:34 P.M. five residents attended the group resident council meeting. The residents said there had been concerns noted to administration during previous resident council meetings regarding staff treating residents in a dignified manner. Residents reported care staff often come in and would turn the call light system off, telling residents I'm not your aide and then leaving without telling another staff member they required care. Staff were often heard laughing, talking loudly, or yelling at one another on the resident halls during the night shift, and have been observed on their cell phones while providing care. Resident council members noted this made them feel as if their dignity in the facility was diminished during these instances. 8. During an interview on 4/10/26 at 7:57 A.M., CNA J said staff was expected to be off of their cell phones in resident care areas. He/She said staff should only use their cellphones in the break room. 9. During an interview on 4/10/26 at 8:02 A.M., LPN K said cell phones were only to be used in the break room. He/She said staff should not be on their phones in resident care areas. 10. During an interview on 4/10/26 at 1:05 P.M., the Administrator and DON said cell phones and headphones should not be used in resident care areas. 28017622807190

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	265417	A. Building B. Wing	04/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sherbrooke Village	4005 Ripa Avenue Saint Louis, MO 63125

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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, interviews and record review, the facility failed to ensure wheelchairs for two residents (Resident #1 and Resident #109), the [NAME] Hall living room carpet, and the Lodge common area were maintained in a clean, comfortable and homelike environment. The sample size was 24. The census was 121.During an interview on 4/10/26 at approximately 7:00 A.M., the Administrator said the facility did not have a policy on cleaning wheelchairs or a wheelchair cleaning schedule. 1. Review of Resident #1's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 4/2/26, showed:-Cognitively intact;-Used a wheelchair;-Diagnoses included heart failure, high blood pressure, and renal (kidney) failure. Observation on 4/6/26 at approximately 12:00 P.M., showed the resident sat in his/her wheelchair in his/her room. The resident's wheelchair had thick amounts of dust, food particles and hair on the wheelchair frame and wheels. During observation and interview on 4/8/26 at 11:10 A.M., and 4/9/26 at 9:01 A.M., the resident sat in his/her wheelchair. The resident's wheelchair had a thick amount of dust, food particles and hair on the wheelchair frame and wheels. The resident said staff have never cleaned his/her wheelchair. 2. Review of Resident #109's quarterly MDS, dated [DATE], showed:-Cognitively intact;-Used a wheelchair;-Diagnoses included heart failure, diabetes, and renal failure. Observation on 4/6/26 at approximately 9:00 A.M., showed the resident sat in his/her wheelchair and propelled him/herself through the facility's front lobby. The resident's wheelchair had a thick amount of dust and food particles on the wheelchair frame and wheels. During an observation and interview on 4/6/26 at 10:01A.M. and 4/8/26 at 11:20 A.M. the resident sat in his/her wheelchair in his/her room. The resident's wheelchair had a thick amount of dust and food particles on the wheelchair frame and wheels. The resident said he/she has never had his/her wheelchair cleaned. During an interview on 4/10/26 at 7:30 A.M., Licensed Practical Nurse (LPN) W said there was no wheelchair cleaning schedule, and the staff wiped the wheelchairs down as needed. During an interview on 4/10/26 at 9:30 A.M., Certified Nursing Assistant (CNA) X said the wheelchairs were cleaned by night shift and staff should clean the wheelchairs based on the resident's shower days. The residents' wheelchairs should be cleaned for the residents. During an interview on 4/10/26 at 12:34 P.M., the Director of Nursing (DON) said the night shift was expected to clean resident wheelchairs according to the day the residents' showers were scheduled. She would expect the residents' wheelchairs to be cleaned as scheduled and as needed. 3. Observation on 4/6/26 at 10:40 A.M. and 4/7/26 at 10:45A.M., showed the carpet in the [NAME] Hall living room had a large maroon colored stain located in front of the couches. During an interview on 4/8/26 at 11:30 A.M. CNA CC said the maroon spot was when a resident fell and bled on the carpet. The stain had been there a few days. During an interview on 4/7/26 at 12:40 P.M., the Environmental Services (EVS) Director said he was the only one that cleaned the carpets and was made aware of the stain on 4/7/26. It was his daily routine to check the carpets for any stains or issues. During an interview on 4/10/26 at 12:35 P.M., the Administrator and the DON said they would expect staff to try to clean the area after the incident occurred with a special blood cleaner the facility had on hand and place a request into the specialized computer software that notified the appropriate departments such as housekeeping or maintenance when issues arose. They expected all floors and carpets to be cleaned. Stained carpet was not homelike. 4. Observation on 4/6/26 at 8:31 A.M., 4/7/26 at 9:52 A.M., 4/9/26 at 12:50 P.M., and 4/10/26 at 9:46 A.M., showed a pest control glue trap sat on the folding tables in the windowed space across from the Lodge therapy gym. During interview on 4/10/26 at 10:32 A.M. Housekeeping Aide M said housekeeping staff cleaned the common areas on the Lodge daily, and pest control traps should not be left out on the tables, as it was not considered a homelike environment. During interview on 4/10/26 at 12:32 P.M. the Administrator and DON said they would expect all glue traps and pest control interventions to be removed from tabletops or surfaces in resident common areas.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. Based on interview and record review, the facility failed to send a copy of the transfer and discharge notices to the representative of the Office of the State Long-Term Care Ombudsman (resident advocate) for 11 out of 12 months. The census was 121.Review of the facility's Discharge and Transfer policy, last revised 9/17/25, showed a copy of a transfer or discharge notice must be provided to the Ombudsman. Review of the facility's admission and Discharge Report, dated 6/26/24 through 4/6/26, showed 39 residents discharged from the facility. Review of the Social Service Director's (SSD) monthly e-mails sent to the Ombudsman's office showed:-No transfer or discharge notifications were sent to the Ombudsman's office in April 2025, May 2025, June 2025, July 2025, August 2025, September 2025, October 2025, November 2025, December 2025, January 2026, and February 2026. During an interview on 4/8/26 at 2:15 P.M., the SSD said she was aware that she had missed a couple of months sending the transfer and discharge list to the Ombudsman's office. The SSD said it was her responsibility and the expectation was to send the information to the Ombudsman's office. During an interview on 4/10/26 at 12:34 P.M., the Administrator said she expected the SSD to send the required documentation for discharges and transfers to the Ombudsman's office.

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure one resident received one on one activities (Resident #5) and failed to ensure two residents had activities provided (Residents #3 and #140). In addition, the facility failed to ensure activities were provided on the 300 hallway and failed to ensure activities posted on the activity calendar for the [NAME] hallway were conducted. The sample size was 24. The census was 121. Review of the facility's activities policy, dated 9/14/23, showed:-Policy: It is the policy of the facility to provide an ongoing program to support residents in their choice of Activities based on their comprehensive evaluation, care plan, & preferences. Facility-sponsored group, individual, & dependent activities will be designed to meet the interest of and support the physical, mental, and psychosocial well-being of each resident, as well as encourage both independence and interaction within the facility;-Procedure: Activities will include individual, small, and large group activities as well as indoor/outdoor activities, activities away from the facility, religious programs, exercise programs, community activities, social activities, in-room activities, individualized activities, and educational programs. 1. Review of Resident # 5's quarterly Minimum Data Set (MDS) a federally mandated assessment tool completed by facility staff, dated 3/23/26, showed:-Severe cognitive impairment;-Dependent on staff for toilet hygiene, personal hygiene, upper and lower body dressing, bed to chair and chair to bed transfers;-Diagnoses included depression, anxiety, heart failure and kidney disease. Review of the residents' care plan, in use at the time of survey, showed:-Focus: Requires assist for meeting emotional, intellectual, physical and social needs;-Interventions: One-to-one room visits and activities if unable to attend out of room activities. Preferred activities are pet visits. Review of the facility's list of residents on one-on-one activities, showed Resident #5 listed to receive one-on-one activities. Review of the Preferred Activities of the Residents List, showed the resident was to receive pet visits on Thursdays for 15 minutes. Review of the documentation provided by the facility's Activity Director (AD), showed a handwritten note on a plain piece of paper, dated 2/25/26. The activities staff talked with the resident about his/her family and the resident's cat for 15 minutes.-No further documentation of the resident's one on one visits was provided. During an interview on 4/9/26 at 10:30 A.M., the resident said he/she was never brought out by staff for activities. He/ She would have liked to see the staff member's dog again. The resident said his/her TV hasn't been working consistently due to the facility roof being worked on. The resident used to play cards and would like to do that again if possible. During an interview on 4/10/26 at 12:34 P.M., the Director of Nurses (DON) said that 15 minutes of pet therapy once a week was not adequate or acceptable. She would expect the resident to be brought out of his/her room if the resident requests for activities. She would expect some other type of meaningful one on one activity that the resident likes. The DON would also expect documentation of the one on one activities when they occur. 2. Review of Resident #3's quarterly MDS, dated [DATE], showed:-Diagnoses included chronic obstructive pulmonary disease (COPD, lung disease), muscle weakness, depression, and anxiety;-Cognitively intact. During an interview on 4/7/26 at 9:30 A.M., the resident said there were not enough activities provided. He/She said a lot of the activities felt babyish. 3. Review of Resident #140's quarterly MDS, dated [DATE], showed:-Diagnoses included depression, anxiety, and hypertension;-Cognitively intact. During an interview on 4/7/26 at 9:35 A.M., the resident said not enough activities were provided. He/She said staff told the residents the activity department was short staffed, and that is why activities were not being done. 4. Observations on 4/7/26 at 9:30 A.M., and 10:05 A.M., showed no activities being done on the 300 hallways. 5. Observations on 4/9/26 at 10:00 A.M. and 10:30 A.M., showed no activities being done on the 300 hallways. 6. Review of the activities calendar for [NAME] Hall, dated April 2026, showed:-On 4/7/26 at 10:00 A.M., Morning [NAME] and at 11: 00 A.M., Nails and Tales;-On 4/8/26 at 9:00 A.M., Morning Prayers; at 10:00A.M., Noodle Balls and at 11:00 A.M., Hungry Hippos (game). Observation on 4/7/26 (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	at 10:15 A.M., showed the residents on [NAME] Hall sat in front of the TV watching an animated movie. No morning [NAME] occurred. At approximately 11:00 A.M., the residents on [NAME] Hall sat in front of the TV watching an animated movie while the Environmental Service Director used a loud cleaning machine on the carpeted area near the TV. No Nails and Tales occurred. Observation on 4/8/26 at 11:20 A.M., showed the residents on the [NAME] Hall sat in front of the TV watching an animated movie. No Hungry Hippo game occurred. During an interview on 4/7/26 at 11:00 A.M. Licensed Practical Nurse (LPN) E said activities never occurred on the [NAME] Hall. The residents that live on the [NAME] Hall frequently had behaviors. Especially in the evening the residents started to sundown (increased confusion that occurs late in the evening), and they needed something to do. The popcorn machine located on the [NAME] Hall has not been used in months. The [NAME] Hall needed an activities person full time to assist with the residents' behaviors and provide emotional support to the residents. The residents on [NAME] Hall were rarely brought over to the other side of the building where some activities did occur. During an interview on 4/8/26 at 11:30 A.M., Certified Nursing Assistant (CNA) CC said the activities calendar was a lie and a hoax. No activities occurred on the [NAME] Hall. The residents on [NAME] Hall needed activities to assist with their behaviors and provide some type of fun in their lives. No morning prayer, no noodle balls or Hungry Hippo occurred on 4/8/26. There was usually only two staff members on the [NAME] Hall, so it was difficult for the nursing staff to provide activities when there was other care related task they had to complete and maintain resident safety. 7. During an interview on 4/8/26 at 4:26 P.M., the AD director said she has been short-staffed and the activities for one on one and the [NAME] Hall activities were not being completed. The AD was aware that the activities on all the halls were not being done consistently. The AD said she was also working in central supply, so she was stretched thin. She was aware the residents required and requested more activities than they currently were receiving. On [NAME] Hall, the AD was hoping that some of the staff would take the initiative and do some type of activities on their own. 8. During an interview on 4/10/26 at 12:34 P.M., the Administrator and the DON said activities were expected to occur even when the activities department staff were short staffed. The activities were expected to be meaningful, intellectually stimulating and age appropriate.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure medications were stored securely on locked medication carts, and to ensure medication and treatment carts were free from storage of personal items, expired medications, and improperly labeled medications. Five medication carts were observed and problems were found with each. The census was 121. Review of the facility's Storage of Medications policy, dated 11/18, showed:Policy: Medications and biologicals are stored safely, securely, and properly, following manufacturer's recommendations or those of the supplier. The medication supply is accessible only to licensed nursing personnel (Registered Nurse (RN), Licensed Practical Nurse), pharmacy personnel, or staff members lawfully authorized to administer medications;-Procedure: Medication rooms, carts, and medication supplies are locked when not attended by people with authorized access;-AII medications dispensed by the pharmacy are stored in the container with the pharmacy label;-Medications labeled for individual residents are stored separately from floor stock medications when not in the medication cart;-Potentially harmful substances such as urine test reagent tablets, household poisons, cleaning supplies, disinfectants, are clearly identified and stored in a locked area separately from medications;-Outdated, contaminated, or deteriorated medications and those in containers that are cracked, soiled, or without secure closures are immediately removed from inventory, disposed of according to procedures for medication disposal, and reordered from the pharmacy, if a current order exists;-Storage areas are kept clean, well-lit, and free of clutter and extreme temperatures andhumidity;-Medication storage conditions are monitored at least quarterly (or as agreed upon between the facility and pharmacy) by the consultant pharmacist or pharmacy designee and corrective action taken if problems are identified;-Expiration Dating (beyond-use dating);--Expiration dates of dispensed medications shall be determined by the pharmacist at the time of dispensing;--Drugs dispensed in the manufacturer's original container will be labeled with the manufacturer's expiration date;--Certain medications or package types, such as intravenous (IV) solutions, multiple-dose injectable vials, ophthalmics (products related to the eye), nitroglycerin (used to treat chest pain) tablets, blood sugar testing solutions and strips, once opened, require an expiration date to insure medication purity and potency. 1. Observation on 4/7/26 at 3:07 A.M., of the 400 Hall treatment cart, showed:-The cart was unlocked;-The top drawer contained a Slim [NAME] meat stick, two Lantus (insulin glargine, a long-acting insulin) insulin pens without an open date, and one insulin pen with no identification or open date;-The second drawer contained one multi-vitamin liquid bottle with an open date of 7/20/15 and expiration date of 2/27, one multi-vitamin liquid bottle with no open date, one open bottle of Geri-Kot (senna, a laxative) with no open date, and one tube of diclofenac sodium (nonsteroidal anti-inflammatory) with no patient label;-The last drawer contained an open bottle of Miralax (stool softener) with no open date. 2. Observation on 4/7/26 at 3:33 A.M., of the 400 Hall CMT cart, showed:-The top drawer contained the following:--An undated, unlabeled medication cup with a white pill inside;--Two blister packs of Zofran (nausea) 4 milligrams (mg) with no patient labels;--One blister pack of loperamide (antidiarrhea) 2 mg with no patient label;--A bottle of hand lotion;--An open container of vanilla pudding, dated 4/6/26 at 6:00 P.M.;--A bottle of Lumigan eye drops (used to treat glaucoma) with no open date;--A bottle of dorzolamide hydrochloride-timolol maleate ophthalmic solution (eye drops used to treat eye pressure) with no open date;-The third drawer contained a container of Vitamin B with no open date;-The fourth drawer contained 18 loose pills of various sizes, colors, and shapes. 3. Observation on 4/7/26 at 3:07 A.M., of the [NAME] Hall nurse cart, showed:-The cart was unlocked;-The top drawer contained a bottle of nitroglycerin with no patient name; -The second drawer contained the following:--Five 24 gauge (g) needles with an expiration date (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	of 11/1/23;--Four 22g needles with an expiration date of 10/23;--One culture swab with an expiration date of 6/25;--One bottle of artificial tears (eye drops) with an expiration date of 4/25;-The bottom drawer contained a bottle of sore throat spray with no patient label and a blister pack of loperamide 2 mg with no patient label and an expiration date of 6/25. 4. Observation on 4/7/26 at 3:07 A.M., of the [NAME] Hall treatment cart, showed:-An open package of Xeroform (sterile dressing) with no label;-Zinc oxide (barrier cream) ointments with no patient labels;-Hydrophilic wound barrier cream with no patient label. 5. Observation on 4/7/26 at 4:31 A.M., on the dementia unit cart, showed:-Two boxes of Assure Dose Control (calibrating glucometers) solution with an expiration date of 2/22/26;-One box of Assure Dose Control solution with an expiration date of 6/22/24; one box expiration date of 6/22/24;-A blister pack of risperidone (antipsychotic medication) 2mg with no patient label;-Six loose pills of various sizes, colors, and shapes;-Four boxes of Systane (eyedrop) solution with an expiration date of 12/24. 6. During an interview on 4/7/26 at 3:07 A.M., LPN MM, said any open medication without a date should be discarded. All medications need a patient identifier. Medication carts should not include pills left out from their packaging. During an interview on 4/7/26 at 3:52 A.M., LPN OO said medication carts should not be left unlocked. 7. During an interview on 4/7/26 at 3:52 A.M., Assistant Director of Nursing (ADON) NN said nurses are responsible for ensuring their carts are clean. During an interview on 4/7/26 at 4:41A.M., ADON NN said outdated glucometer solution could cause incorrect glucose readings by showing the reading is elevated or too low. This could cause staff to perform the wrong/incorrect treatment. He/She expected nurses to be vigilant and discard any medications on their carts that are expired. 8. During an interview on 4/10/26 at 12:43 P.M., DON said she expected medication and treatment carts to be free from clutter, pills, and expired supplies.

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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, interview, and record review, the facility failed to ensure food was served to residents at a safe and appetizing temperature (Residents #3, # 23, #76, #100 and #140). The sample was 24. The census was 121. Review of the facility's meal service temperature log, undated, showed:-Hot food needs to maintain at 135 degrees Fahrenheit (F) or above in steamtable;-Cold food needs to maintain at 41 degrees F or below. 1. Observation on 4/8/26 at 12:56 P.M., of lunch on the memory care unit, showed:-Soup measured 126.8 degrees F;-Meatballs measured of 129.3 degrees F. Observation on 4/9/26 at 8:54 A.M., of 300 hall breakfast trays, showed:-Cream of wheat measured 80 degrees F;-Scrambled egg measured 109 degrees F;-Biscuits and gravy measured 111.1 degrees F. 2. Review of Resident #3's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 3/30/26, showed:-Cognitively intact;-Diagnoses included chronic obstructive pulmonary disease (COPD, lung disease), muscle weakness, depression, and anxiety. During an interview on 4/6/26 at 10:30 A.M., the resident said the food is always served cold. 3. Review of Resident #23's quarterly MDS, dated [DATE], showed:-Cognitively intact;-Diagnoses included dementia, muscle weakness, and quadriplegia (paralysis of all four limbs and the torso). During an interview on 4/6/26 at 9:09 A.M., the resident said his/her food is normally served cold when he/she eats in his/her room. 4. Review of Resident #76's quarterly MDS, dated [DATE], showed:-Cognitively intact;-Diagnoses included muscle weakness, seizures, chronic kidney disease, and heart failure. During an interview on 4/6/26 at 10:02 A.M., the resident said his/her food is served cold most days. 5. Review of Resident #100's quarterly MDS, dated [DATE], showed:-Cognitively intact;-Diagnoses included heart failure, diabetes, chronic kidney disease, and depression During an interview on 4/06/26 at 12:17 P.M., the resident said his/her room trays are normally served cold. 6. Review of Resident #140's quarterly MDS, dated [DATE], showed:-Cognitively intact;-Diagnoses included depression, anxiety, and high blood pressure. During an interview on 4/06/26 at 10:29 A.M., the resident said the food is always served cold. 7. During an interview on 4/10/26 at 9:05 A.M., the Dietary Supervisor said she expected food to be served to residents at a safe and palatable temperature. 8. During an interview on 4/10/26 at 12:58 P.M., the Administrator and Director of Nursing (DON) said they expected food to be delivered to the residents at a safe and palatable temperature. 2806805

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure staff exhibited appropriate infection control practices while providing feeding assistance to one resident (Resident #12). In addition, the facility failed to ensure food was served from a clean steam table on the [NAME] Hall. The sample was 24. The census was 121. 1. Review of Resident #12's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 2/6/26, showed:-Severe cognitive impairment;-Diagnoses included aphasia (language impairment), paraplegia (paralysis of lower portion of the body and of both legs), hemiplegia (paralysis on one side of the body), hemiparesis (weakness on one side of the body), and dementia. Observations on 4/8/26, of the main dining room during lunch, showed-At 12:44 P.M., Certified Nursing Assistant (CNA) L sat next to the resident at a table in the dining room. He/She scooped up a spoonful of soup, blew on the spoonful of soup and fed it to the resident. He/She continued to blow on the resident's soup spoon until the resident was finished with his/her soup;-At 12:58 P.M., CNA L cut up the resident's meatballs and blew on the spoon before feeding the meatballs to the resident. During an interview on 4/10/26 at 1:02 P.M., the Director of Nursing (DON) said she expected nursing staff to set food aside if it is too hot to feed to the resident. Staff blowing on the resident's food is an infection control concern and should not be done. 2. Review of the facility's [NAME] Hall daily cleaning schedule, undated, showed tasks included clean and sanitize prep tables. Observation on 4/6/26 at 11: 35 A.M., showed the [NAME] Hall steam table with brown, dried, and baked-on food around the steam wells. The steam well water was cloudy with sediment floating in it. The splash guards were cloudy and had dried, crusted liquid on them. Observation on 4/8/26 at 11:10 A.M., showed the [NAME] Hall steam table with brown, dried, and baked-on food around the steam wells. The steam table well water was cloudy and with sediment floating in it. The splash guards were cloudy and had dried, crusted liquid on them. Dietary Aide BB turned on the steam table. During an interview, Dietary Aide BB said he/she knew the steam table was filthy. He/She had already gotten in trouble about it for not cleaning it. He/She did not have enough time to clean the steam table like it should be cleaned. During an interview on 4/8/26 at 11:40 A.M., CNA CC said the steam tables have looked dirty for months. Dietary staff are responsible for cleaning the steam tables. During an interview on 4/10/26 at 1:02 P.M., the Administrator and DON said they expected the steam table on [NAME] Hall to be cleaned after every use.

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. Based on observation, interview and record review, the facility failed to provide reasonable accommodation of individual needs and preferences by failing to ensure a call light was in reach for one resident (Resident #98). The sample was 24. The census was 121.During an interview on 4/10/26 at approximately 7:00 A.M., the Administrator said the facility did not have a call light policy. Review of Resident's # 98's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 3/24/26, showed:-Cognitively intact;-Dependent on staff for toileting hygiene;-Frequently incontinent of bowel and bladder;-Diagnoses included Parkinson's disease, dementia, and chronic obstructive pulmonary disease (COPD), a lung disease that cause the airway to become constricted and difficult to breathe. Review of the resident's care plan, in use at the time of survey, showed:-Focus: The resident has a risk of falls due to a history of falls and gait problems:-Interventions: Be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed; The resident needs a prompt response to all requests for assistance. Observation and interview on 4/6/26 at approximately 9:00 A.M., showed the resident lay in bed and was heard from the hall yelling Nurse. The resident said he/she had been yelling for help for about 30 minutes because he/she needed to use the bathroom. At 10:01 A.M., the resident lay in bed and had a strong odor of stool present. The resident's call light was wrapped around the bed frame and out of the resident reach. The resident said he/she could not reach his/her light and needed help going to the bathroom. At 10:32 A.M., the resident lay in bed. The resident's call light was wrapped around the resident's bed frame and out of the resident's reach. The resident said he/she was soiled and wet and no one had been in to check on him/her and he/she could not reach his/her call light. At 11:04 A.M., the resident lay in bed with a strong odor of stool and urine. The residents' breakfast tray was still in his/her room and the call light was wrapped around the bed frame. The resident said he/she could not reach the call light and needed help getting cleaned up. Observation on 4/7/26 at 6:25 A.M., and 7:15 A.M., showed the resident lay in bed with his/her eyes closed. The resident's call light was tucked in between the cushion of a recliner that was located next to the resident's bed. The call light was positioned about two feet away from the resident. During an interview on 4/10/26 at 9:30 A.M. Certified Nursing Assistance (CNA) X and Licensed Practical Nurse (LPN) K said the call light should be within the residents reach at all times. After providing care the staff should make sure the residents had their call light in reach. During an interview on 4/10/26 at 12:34 P.M., the Director of Nurses (DON) said all residents' call lights were expected to be within reach at all times.

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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 ensure services provided met professional standards of practice by not following physician orders for daily weights for one resident (Resident #1), and by leaving medications, including pain, blood pressure, and seizure medications in a medicine cup in the resident's room for the family member to administer (Resident #13) . The sample size was 24. The census was 121.Review of the facility's Physician Orders policy, dated 9/28/22, showed:-Policy: To provide guidance and ensure physician orders are transcribed and implemented in accordance with professional standards, state and federal guidelines. The licensed nurse is required to record the order in the electronic medical record (EMR), the physician order sheets (POS) and on the appropriate medication administration record (MAR) and treatment administration record (TAR). Review of the facility's Medication Administration-General Guidelines, dated 12/17, showed: Policy: Medications are administered as prescribed in accordance with good nursing principles and practices and only by legally authorized personal to do so. Personnel authorized to administer medications do so only after they have properly orientated to the facility's medication distribution system (procurement, storage, handling, and administration). The facility has sufficient staff and medication distribution system to ensure safe administration;-Preparation:--Medications are prepared only by licensed nursing (Registered Nurse (RN), Licensed Practical Nurse (LPN), medical, pharmacy or other personnel authorized by state laws and regulations to prepare and administer medications;--The need for crushing medications should be indicated on the residents' orders and the Medication Administration Record (MAR) so that all personnel administering medications are aware of this need and the consultant pharmacist can advise on safety issues and alternatives, if appropriate, during medication regimen reviews;-Administration: Medications are administered only by licensed nursing, medical, pharmacy or other personnel authorized by slate laws and regulations to administer medications. 1. Review of Resident #1's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 4/2/26, showed:-The resident is cognitively intact;-Diagnoses included heart failure, high blood pressure, and renal failure. Review of the resident's care plan, in use at the time of survey, showed:-Focus: The resident has congestive heart failure (CHF), when the heart muscle is too weak to pump blood efficiently causing fluid to accumulate in the body.-Interventions: Check daily weight and fax a weekly log to the cardiac clinic. Review of the residents POS dated, 4/6/26, showed an order dated 11/1/25, Check daily weight and fax weekly weight log to the Heart Failure Clinic; Notify the physician or Nurse Practitioner (NP) if a weight gain of three pounds in 24 hours or five pounds in three days occurs; The nurse is to document signs and symptoms of fluid retention related to CHF as needed. Review of the residents' weights, dated March 2026, showed no daily weight documented on: 3/1/26, 3/4 through 3/9/26, 3/11 through 3/16/26, 3/21 through 3/26/26, and 3/31/26. Review of the residents' weights dated 4/1 through 4/6/26, showed no daily weight documented on 4/2 through 4/4/26. During an interview on 4/8/26 at 11:10 A.M., the resident said the staff did not weigh him/her daily. During an interview on 4/10/26 at 7:30 A.M., Licensed Practical Nurse (LPN) W said the night shift aides were expected to obtain daily weights. The nurses should document the weights in the EMR under the weight tab. During an interview on 4/10/26 at 9:30 A.M., Certified Nursing Assistant (CNA) X said the night shift aides were responsible for obtaining the daily weights and giving the weights to the nurse to document in the EMR. During an interview on 4/10/26 at 12:34 P.M., the Director of Nursing (DON) said she would expect staff to follow physician orders and obtain daily weights and document the weights in the EMR. The DON said she was aware the resident had CHF and required daily weights. 2. Review of the Resident's #23's Quarterly MDS, dated [DATE], showed:-Severe cognitive impairment;-Dependent on staff for all ADLs;-Diagnoses included Parkinson disease (a progressive, incurable neurological movement disorder caused by the loss of (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	dopamine-producing neurons in the brain), diabetes, chronic obstructive pulmonary disease (COPD), dysphagia (impaired swallowing), pressure ulcer of left hip, stage four (a severe, full-thickness wound extending to exposed bone, tendon, or muscle, often featuring deep tissue damage, tunneling, and high infection risk), pressure ulcer of the left lower back, stage three (full-thickness skin injury appearing as a deep, open, crater-like wound where subcutaneous fat is visible), pressure ulcer of sacral region, stage three and diabetes. Review of the resident care plan, in use at the time of survey, showed the care plan did not address if the resident's family members were allowed to administer prescribed medications. Review of the resident's POS, dated 3/25/26, showed:- An order, dated 12/12/25, for sodium chloride (salt tablet) by mouth (PO) 1 milligrams (mg);- An order, dated 8/21/25, for carbidopa-levodopa (Parkinson medication) PO 25-100 mg three times daily;- An order, dated 8/21/25, for metoprolol tartrate (elevated blood pressure (BP)12.5 mg PO twice daily;-An order, dated 8/22/25, for gabapentin (nerve pill) capsule 300 mg, give one capsule PO daily;-An order, dated 8/22/25, to crush / sprinkle all meds every shift;-An order, dated 8/22/25, for a multivitamin (vitamin) PO daily;-An order, dated 8/22/25, for metformin (controls diabetes) PO tablet 1,000 mg;-An order, dated 8/22/25, for sertraline (mood stabilizer) PO tablet 100 mg, give one tablet daily;-An order, dated 8/22/25, for divalproex sodium (seizure) one capsule delayed release sprinkles 125 mg PO twice a day;-An order, dated 2/25/26, for tramadol (pain) tablet 50 mg, give one tablet every 12 hours. Observation on 4/9/26 at 8:49 A.M., showed the resident's family member in the resident's room, who fed him/her breakfast. The resident's bedside table had a medicine cup, with apple sauce, crushed medications and a spoon. No staff was present in the resident's room. During an interview on 4/9/26 at 8:51 A.M., Certified Medication Technician (CMT) LL said the resident would not accept medication from staff the resident did not recognize. CMT LL said he/she handed the medicine cup to the family member to feed it to the resident between bites of breakfast, but did not remain in the room to see if the resident took the medication. At 8:57 A.M., CMT LL said the medicine cup included the following medications: multivitamin, Vitamin C, Metoprolol, Tramadol, Gabapentin, iron, sodium, Metformin, Quetiapine, Sertraline, Carbidopa-Levodopa, and Depakote. During an interview on 4/10/26 at 12:43 P.M., the DON said she expected staff to administer residents' medications. Family members should never administer medications to residents. If staff provided a prepared medication cup to a family member, the staff member must remain at the resident's side. The DON said the resident was at risk for elevated blood pressure, seizures, and unmanaged pain because the staff member did not verify that the medications were taken.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. Based on observation, interview and record review, the facility failed to ensure residents received appropriate activity of daily living (ADL, daily care) care to meet the needs of residents by leaving one incontinent resident (Resident #98) soiled and wet for an extended period. The sample was 24. The census was 121.Review of the facility's Perineal Care (cleansing of the genitals and anal area) policy, undated, showed:- Perineal care which includes care of the external genitalia and the anal area, should be offered during the daily bath and it the resident is incontinent for urine or stool; The procedure promotes cleanliness and prevents infection. It also removes irritating and odorous secretions. Review of Resident's # 98's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 3/24/26, showed:-Cognitively intact;-Dependent on staff for toileting hygiene;-Required partial to moderate assist from staff for personal hygiene;-Frequently incontinent of bowel and bladder;-Diagnoses included Parkinson's disease, dementia, and chronic obstructive pulmonary disease (COPD), a lung disease that cause the airway to become constricted and difficult to breathe. Review of the residents' care plan, in use at the time of survey, showed:Focus: The resident has occasional episodes of bowel and bladder incontinence and is at risk for infection and skin breakdown;-Interventions: Assist the resident to the bathroom as desired; Offer to use the toilet before and after meals and at bedtime; Clean perineum after each incontinent episode. Observation and interview on 4/6/26 at approximately 9:00 A.M., showed the resident lay in bed and was heard from the hall yelling Nurse. The resident said he/she had been yelling for help for about 30 minutes because he/she needed to use the bathroom. At 10:01 A.M., the resident lay in bed and had a strong odor of stool present. The resident's call light was wrapped around the bed frame and out of the resident's reach. The resident said he/she could not reach his/her light and needed help going to the bathroom. At 10:32 A.M., the resident lay in bed. The resident's call light was wrapped around the resident's bed frame and out of the resident's reach. The resident said he/she was soiled and wet and no one has been in to check on him/her and he/she could not reach his/her call light. At 11:04 A.M., the resident lay in bed with a strong odor of stool and urine. Certified Nursing Assistant (CNA) DD and Licensed Practical Nurse (LPN) K entered the resident's room and had the resident turn to his/her right side. CNA DD removed the resident's brief. The resident's brief and bed pad were saturated with urine. The resident also had a large amount of diarrhea in his/her brief. The resident said he/she had not been changed all night or morning. During an interview on 4/10/26 at 7:30 A.M., Licensed Practical Nurse (LPN) W said incontinent residents were checked on every one to two hours. The CNA's and the nurses all made rounds on the incontinent residents to ensure they were clean, dry and odor free. Having the resident wait for over two hours to be cleaned was too long of a time. During an interview on 4/10/26 at 9:30 A.M., CNA X said incontinent residents were to be rounded on every two hours to ensure they were clean and dry. Resident #98 used the bathroom and should have been offered to use the restroom when the resident requested. Frequent checks were important so that the resident did not get skin breakdown. During an interview on 4/10/26 at 12:34 P.M., the Director of Nurses (DON) expected the staff to check on incontinent residents every two hours. She expected the residents to be clean, dry and odor free. 28068052807190280457929781 88

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to provide adequate treatment and services for two residents with pressure ulcers (wounds related to prolonged pressure on bony prominences) (Resident #2 and #13) and interventions to prevent pressure ulcers for one resident (Resident #23). The facility failed to provide ordered treatments and a timely wound consult for Resident #2. The facility failed to provide dressing changes when dressings were saturated, for Resident #13. The facility failed to provide Residents #13 and #23 with low air loss mattresses set to the correct settings, which would put the residents at risk for increased pressure on bony prominences. The sample size was 24. The census was 121. Review of the facility's Wound Management policy, dated 11/22, showed:-Policy: To promote wound healing of various types of wounds, the facility will provide evidence-based treatments in accordance with current Standards of Practice and Physician orders;Procedure: Wound Management:- Wound treatment will be provided in accordance with Physician's order;--Cleansing method;--Type of dressing;--Frequency of dressing change;-Charge Nurse will notify Physician in the absence of treatment orders;-Dressing changes may be provided outside of the frequency parameter in certain situations;-- Urine, feces, or other bodily fluids have saturated through the dressing;-- Dressing is dislodged;--Dressing is soiled;- Wound dressings will be applied in accordance with manufacturer's recommendations.-Treatment selection will be based on the etiology of the wound;--Pressure injuries will be differentiated from non-pressure wounds;- Treatments will be documented on the Treatment Administration Record (TAR).-The effectiveness of treatments will be monitored through ongoing evaluation of the wound(s).--Considerations modification:--Lack of progression towards healing.--Changes in wound characteristics.--Changes in the resident/resident representative's preferences/goals (e.g., comfort care associated with end of life in accordance with his/her rights. 1. Review of Resident #2's admission Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated [DATE], showed:-Diagnoses included: Aphasia (impaired talking and understanding language), elevated blood pressure, end stage renal disease (severe kidney failure), and dependence of dialysis;-Cognitively intact;-Fully dependent on actives of daily living (ADLs)-Number of pressure ulcers: Zero are present, none present upon admission.-Pressure reducing device for bed. Review of the Braden Scale for Predicting Pressure Ulcer Risk, effective date of [DATE] at 7:30 P.M., showed a score of 17 which meant the resident was At Risk for developing a pressure ulcer. Review of the resident's care plan, in use at the time of the survey, showed:- Focus: Resident is at risk for pressure ulcer development related to reduced mobility;-Goal: Resident will have intact skin, free of redness, blister or discoloration by/through review date;-Interventions: Educate family, care givers as to causes of skin breakdown, including transfers, positioning requirements, good nutrition, and frequent (Freq) repositioning, shift weight every (Q)15 minutes, the resident needs Q two hour (HR) turns more often as needed or requested. Review of the electronic physician's order sheet dated 3/26, showed:-An order date of [DATE], showed: Wound care: Coccyx (tailbone) Cleanse wound with wound cleanser and allow to dry. Apply calcium (Ca+) alginate (AG) (highly absorbent, seaweed-derived fibers used for moderate-to-heavy exuding wounds, such as ulcers and burns) cut to fit wound bed and cover with bordered gauze island dressing (sterile adhesive bandage) each shift and as needed (PRN) if soiled or nonintact;-An order date [DATE], showed: Wound Care: Perineal (around genitals) area-apply zinc oxide (barrier cream) to perineal area four times daily and PRN after each incontinent episode;-An order date [DATE], showed: Complete Skin Observation Tool Form on night shift on Monday. Completion of this form will satisfy the order. Review of the TAR dated 3/2026, showed:- Wound care: Coccyx, cleanse wound with wound cleanser and allow it to dry. Apply calcium alginate cut to fit wound bed and cover with bordered gauze island wound dressing; staff missed one treatment out of 18 opportunities. Review of the skin observation (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	tool dated [DATE], showed: The resident has redness noted to the sacrum (back part of pelvic bone) and coccyx area, zinc oxide applied as ordered, skin tear (ST) to left hand, dressing (drsg) dry and intact, no new skin issues noted at this time. Review of the skin observation tool dated [DATE], showed: Treatment (Tx) orders for current skin issues. Skin warm, dry and intact. No new skin issues observed, barrier cream applied to coccyx after incontinent episode;- Resident has open area on coccyx that appears to have some tunneling. Packed with calcium alginate and covered with bordered gauze;-Coccyx, pressure with measurements of 3 centimeters (cm) by 2.5 cm. Review of the nurse's progress note on [DATE] at 7:43 P.M., showed the Aide reported an open area on the resident's coccyx appeared to be worsening. When this nurse went in to assess he/she observed open area on coccyx that appeared to have some tunneling (a severe, chronic wound that forms narrow, deep tracts or channels extending from the wound bed into subcutaneous tissue or muscle), 3 cm length by 2 cm width. This nurse covered area with calcium alginate and covered with bordered gauze. The nurse reported the change in condition to Nurse Practitioner (NP) Q who ordered a wound consult and to leave the area covered until new orders are given. Wound nurse also notified. Review of the Wound Nurse progress note on [DATE] at 7:50 A.M., showed: Resident assessed on [DATE] following report from charge nurse of worsening open area to coccyx. Per report, aide noted decline in appearance of area. Upon assessment, open wound to coccyx noted measuring 1. 7 cm by 2.2 cm by 0.1 cm with no concern for tunneling. Wound bed yellow fibrinous exudate (drainage). Area cleansed and dressed in calcium alginate and covered with bordered gauze for protection. Resident tolerated assessment and intervention without difficulty and will continue to be monitored closely for any further changes in condition. Charge nurse notified. Review of the TAR dated 4/2026, showed:-Wound care: Coccyx, cleanse wound with wound cleanser and allow it to dry. Apply calcium alginate cut to fit wound bed and cover with bordered gauze island;-Wound treatment missed two out of 14 opportunities. Review of the Nurse progress note on [DATE] at 6:33 P.M., showed the resident was seen for weekly wound assessment of coccyx. Wound red and yellow with no drainage noted at this time. Wound measures 2.3 cm by 2.1 cm by 0.1 cm. Educated resident on offloading pressure to area, but resident does not like to lie in bed and wants to remain in wheelchair (WC). Charge nurse notified. Review of the Nurse progress note on [DATE] at 2:32 P.M., showed: Wound care: Coccyx - Cleanse wound with wound cleanser and allow to dry. Apply calcium alginate cut to fit wound bed and cover with bordered gauze island dressing each shift and PRN if soiled or nonintact. Nurse was unable to complete the dressing changed and notified NP T. During an interview on [DATE] at 3:07 A.M., the resident said there has been a wound on his/her coccyx for two to three months. The wound did get better but then got worse again. Observation on [DATE] at 11:27 A.M., showed the Wound Nurse asked the resident if he/she was alright? The resident said, It hurts, there are two spots on my hip bone and anus. The resident's bed had a regular mattress. Observation on [DATE] at 11:40 A.M., showed Certified Nursing Assistant (CNA) T and Certified Medical Technician (CMT) V used the Hoyer (mechanical lift) to put the resident back to bed. The coccyx dressing was dated 4/9, but very soiled and dried. Another wound just above the coccyx was open and not covered with a bandage or dressing. During an interview on [DATE] at 11:40 A.M., CMT V said when he/she worked, the resident complained about pain frequently. CMT V said he/she shared the resident's complaint with the nurse, but CMT V was unsure if the nurse administered any pain medication. During an interview on [DATE] at 11:40 A.M., CNA T said they told the nurse about the pain but were unsure if the nurse administered any pain medication. Observation on [DATE] at 12:00 P.M., with the Wound Nurse, showed a coccyx wound and deep tissue injury (DTI) between 3-6 o'clock (location of the injury in comparison to the wound). The resident continued to yell in pain. At 5-6 o'clock there was a skin tear. A steady stream of blood flowed from the open wounds. During an interview on [DATE] at 12:00 P.M., the Wound Nurse said the resident is being followed by an outside wound clinic. The resident had an appointment set up, but the Wound Nurse was not sure of the date. The wound started [DATE] as a skin tear. The Wound Nurse first saw the wound on [DATE]. When the resident was scheduled to see the wound (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	specialist, the resident was out of the facility due to dialysis appointments. That was why the resident needed to see an outside wound specialist. The resident has a donut (a pillow with a hole in the center) because he/she does not like the facility cushions. There are no orders from the medical doctor or wound doctor currently for the new wound above the coccyx, due to the wound starting off as a skin tear. The Wound Nurse said the coccyx measurements were 5.1 cm by 1.9 cm by 0.4 cm, negative for tunneling. The Wound Nurse read off the date on the bandage that read date 4/9. At 2:09 P.M., the Wound Nurse said the Wound Nurse NP gave new orders for the adhesive concern above the coccyx wound, the wound treatment was changed, and they will plan to continue care with an outside wound clinic. During an interview on [DATE] at 12:00 P.M., the Director of Nursing (DON) said, she expected staff to follow physician's orders. The DON did not know if the wounds were pressure or non-pressure without review of the resident's chart. The facility social worker should schedule any appointments outside the facility as soon as possible. When the wound became worse, the staff should have notified someone to clarify if the treatment should remain intact or if new orders were required. Staff just made the appointment for an outside wound clinic, the appointment is scheduled for [DATE] at 8:30 A.M. The care plan should have been updated with interventions. The DON was unaware if the staff thought about or attempted to change the resident's dialysis days to accommodate the wound specialist days in the facility. A physician's order is required for a resident to obtain a low air mattress (LAL). 2. Review of the Resident's #13's quarterly MDS, dated [DATE], showed:-Diagnoses included Parkinson disease (is a progressive, incurable neurological movement disorder caused by the loss of dopamine-producing neurons in the brain), pressure ulcer of left hip, stage 4 (a severe, full-thickness wound extending to exposed bone, tendon, or muscle, often featuring deep tissue damage, tunneling, and high infection risk), pressure ulcer of left lower back, stage 3 (full-thickness skin injury appearing as a deep, open, crater-like wound where subcutaneous fat is visible, but muscle, tendon, or bone are no),, pressure ulcer of sacral region, stage 3, diabetes, non-pressure chronic ulcer of skin of other sites with flat layer exposed (wound not on bony prominence), chronic obstructive pulmonary disease (ineffective breathing (COPD), dysphagia (impaired swallow) and severe protein - calorie malnutrition (a critical deficiency in protein intake-often coupled with inadequate caloric consumption);-Severe cognitively impairment (impaired brain function);-Dependent on staff for all ADLs;-Incontinent bowel and bladder;-Weight of resident is 117 pounds (lbs.);-Number of stage 3 pressure ulcers that were not present on admission, three;-Number of stage 3 pressure ulcers present on admissions, one;-Number of stage 4 pressure ulcers present, zero;-Skin and Ulcer/Injury Treatments included: Pressure reducing device for bed;-No other Treatment listed, such as turning and repositioning, nutrition or hydration intervention, pressure ulcer/injury care, or application of ointments/medication marked on MDS. Review of the Vendor 1 operations manual, dated 11/2017, showed:-The mattress must be set according to the resident's weight, comfort, and clinical condition to ensure proper immersion and pressure redistribution;-The guidelines instructed staff to utilize the AHCPR (Agency for Health Care Policy and Research) hand-check method to confirm appropriate firmness (25-40 millimeter (mm) or 1 to 1.5 inches between the resident and mattress surface) to prevent bottoming out;-Improper firmness settings, kinked air lines, excessive linen layering, or failure to follow operational modes may negatively affect pressure redistribution and increase the risk for skin breakdown;-The mattress is only one component of care and must be used in conjunction with appropriate repositioning, skin assessment, and wound care practices;-Linen Note: Deep-pocketed sheets are recommended (not included). Multiple layering of linens or under pads beneath the resident can negatively affect the mattress's pressure management capabilities and should be avoided unless recommended by a caregiver. Review of the facility's Braden Scale for Predicting Pressure Ulcer Risk, effective date of [DATE] at 1:39 P.M., showed: a score of 12 which meant the resident was High Risk for developing a pressure ulcer. Review of the resident's care plan in use at the time of survey, showed:-Focus: Resident has a pressure ulcer sacrum stage 4, left lower back stage 4, left hip stage 4, left hand stage 4; family has been noted to (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	be removing the wound drsg at times and education has been provided to family;-Goal: The resident's pressure ulcers will show signs of healing and remain free from infection by/through review date. Resident is responding to antibiotics (ABT) for wound infection. Wound is showing improvement;-Interventions: Administer treatments as ordered and monitor for effectiveness, Access/record/monitor wound healing, measurements length, width and depth where possible. Assess and document status of wound perimeter, wound bed and healing progress. Report improvements and declines to the medical doctor (MD); LAL, Q two HR turns, weekly Tx to include measurements of each area of skin breakdown's width, length, depth and type of tissue and exudate. Review of the electronic physician's order sheet dated [DATE], showed:-An order dated [DATE], showed: Complete skin observation tool form on day shift Q Tuesday. Completion of this form will satisfy the order;-An order dated [DATE], showed: Bilateral heel protectors to be worn at all times, Q shift;-An order dated [DATE], showed: Turn resident Q two hours;-An order dated [DATE], showed: Wound Care: Sacrum - Cleanse wound with Dakin's full strength (a potent, broad-spectrum antiseptic designed to treat and prevent skin and tissue infections) and allow it to dry. Skin prep periwound (skin around the wound). Apply gentamicin ointment (a prescription, broad-spectrum aminoglycoside antibiotic used to treat primary and secondary bacterial skin infections, such as impetigo, infected burns, cuts, or skin ulcers) and Ca+ and AG with silver (highly absorbent, antimicrobial, conformable wound dressing made from seaweed fibers and ionic silver. It manages moderate to heavy exudate by turning into a gel) cut to fit to wound bed and fill cavities lightly, cover bordered gauze daily and PRN if soiled/nonintact Q shift;-An order dated [DATE], showed wound Care: left (L) lower back - Cleanse with Dakin's full strength. Pat dry. Skin prep to periwound. Apply gentamicin and calcium alginate cut to fit to wound bed and fill cavities lightly, cover with gauze island dressing daily and PRN if soiled/nonintact Q Day shift and night;-An order dated [DATE], showed: Wound Care: L hip - Cleanse with Dakin's full strength. Pat dry. Skin prep to periwound. Apply gentamicin, Santyl (a prescription debriding agent used to remove necrotic (dead) tissue from chronic dermal ulcers and severe burns), and calcium alginate cut to fit to wound bed and fill cavities lightly, cover with gauze island dressing daily and PRN if soiled/nonintact Q Day and night shift;- An order dated [DATE], showed: Wound Care: L hand- Cleanse with wound cleanser. Skin prep periwound. Apply calcium alginate silver cut to fit to wound bed and cover with bordered gauze island daily and PRN if soiled or non-intact Q shift;-An order dated [DATE], showed: Provide air mattress on his/her bed -sacral wound with eschar (dry, dead tissue) and bony prominences/L hip and L elbow with stage 1 (reddened but intact skin) pressure wound(s). Review of the Medication Administration Recorded (MAR), and TAR dated 4/26, showed bilateral heel protection to be worn at all times Q shift; marked as completed for 11 of 12 opportunities. During an interview on [DATE] at 8:18 A.M., Family Member A said the resident was admitted to the facility about 1 1/2 years ago. The wounds were not healing due to the staff not changing the dressing frequently, and the family needing to come in to feed the resident. The wounds have so much heavy drainage. The wounds on the hip and tailbone are infected. There is so much drainage repeatedly, and the dressings are only changed daily. You can see the drainage on the sheets. Family Member A would prefer the wounds to be changed twice daily (BID), not just daily. Observation on [DATE] at 8:18 A.M., showed a LAL mattress on his/her bed. The resident lay turned towards the door in bed with a wedge (medical device to keep resident on side, relieves pressure to tailbone). Right (R) dressing dated 4/5, 7:00 A.M.-7:00 P.M., serosanguinous (thin, light red) drainage shown through the dressing. The resident wore bilateral heel protective boots. There was a bandage on the resident's L great toe and coccyx. There was a large amount of drainage on the resident's blanket. Observation on [DATE] at 12:35 P.M. and [DATE] at 9:29 A.M., showed the LAL mattress pump set at 9, which meant the weight was set for 500 lbs. Observation on [DATE] at 6:52 A.M., showed the resident in bed with protective boots on. The LAL mattress was set at 9, which accommodated a 500 lb. person. The resident lay on his/her right side, exposing his/her L lateral hip. The L lateral hip dressing was saturated and bulky, dated 4/7. Observation on [DATE] at 8:24 A.M., (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	showed the resident's left lateral hip dressing saturated and bulky. Observation on [DATE] at 8:57 A.M., showed staff in the room. The bed was set at 9, which showed a weight for a 500 lb. person, and the resident was soiled. At 9:03 A.M., The Wound Nurse told staff to clean the resident up. When CNA AA unfastened the brief, the left lateral hip dressing was saturated to the point it was dislodged from the actual site of the wound. There was dried drainage on the blanket that was under the resident's buttocks. At 9:07 A.M., the CNA exited the room. At 9:11 A.M, CNA ZZ returned with the Wound Nurse. The resident was soiled from fecal material. Staff pulled the resident over and wound had solid, dried drainage visible on the island dressing dated [DATE]. The blanket was folded hotdog way and placed under the resident's lower back. At 9:23 A.M., the left lateral island dressing was bulky yellow and coming off the wound where it had dried. The left lower back dressing was white with dried drainage marks on the island dressing. Durning an interview on [DATE] at 8:57 A.M., CNA AA said the resident was soiled and his/her wounds just leak. At 9:11 A.M., CNA AA said staff fold the blanket to make it easier to pull/elevate the resident higher in bed. CNA AA used the blanket because it was the first thing he/she saw. Observation on [DATE] at 9:01 A.M., showed the resident's LAL mattress set at 9; a setting needed for a 500 lb person. Durning an interview on [DATE] at 9:23 A.M., the Wound Nurse said the dressings were compromised by edges folded in on themselves. The Wound Nurse said the resident defecated, and pink to red tissue appeared through the brief. The drainage was seropurulent (wound drainage or discharge that is a mixture of serum (clear, thin fluid) and pus (thick, opaque fluid)). The resident was on two rounds of antibiotic for about six weeks. The left-hip has a stage 4 pressure ulcer; measurements of 4.7 cm by 5.5 cm, with 95 % granulation (new tissue growth) slough (mass of dead tissue separating from living skin) 5% pink tissue around with tunneling (at 11o'clock, 4.5 cm undermine (pocket) from 11:00 o'clock to 2:00 o'clock with the deepest being 2.5 cm. A resident's brief can hold moisture and possibly compromise wound dressings. The Wound Nurse would need to check the facility's policy, but the family requested a brief be left on. The residents' lower back wound measurements were 4.5cm by 6.5 cm by 0.4 cm, with the deepest point at 2:00 o'clock. The floor nurses should use the PRN order when they notice the dressings are compromised/ soiled. The sacrum had serosanguinous drainage, and they used full Dakin Solution to cleanse the wound. The wound had macerated (skin that is white, wrinkled, soggy, or soft due to prolonged exposure to moisture, such as wound exudate, sweat, or urine) edges. The resident's tailbone was actively bleeding with a steady stream. There is a deep tissue pressure injury at 9 o'clock with granulation some epithelia (appearing light pink or white, this is aregenerative process) tissue with no slough. The Wound Nurse will call the MD for new orders related to the new breakdown from 7:00-11:00 o' clock. The new breakdown could be caused from the adhesive from the dressing. The measurements are 11.6 cm by 8.4 cm with undermining from 1:00-5:00 o'clock, 2.3 cm, depth 0.1 cm. The Wound Nurse said the left great toe was new to him/her, and the site is not open. The resident's left hand has a wound which they use wound cleaner, skin prep, silver AG and gauze dressing. The left hand wound measured 2.4 cm by 1.6 cm by 0 .3 cm and undermining depth of 0.3 cm. The LAL mattress is to prevent more skin break down. The Wound Nurse was unfamiliar with the mattress setting. The settings are given to the charge nurse and there should be an order. If there are no orders, he/he would expect the nurse to obtain orders. The Wound Nurse said the setting at 9 is needed for a 500 lb. person, and the resident is not suited for this setting. The setting is too high and could risk the wounds getting worse. The Wound Nurse would need to brush up on the policy and setting requirements while obtaining an MD order. The Wound Nurse was unsure if the folded blanket could cause any risk to the wounds, but the blanket was used to prevent shearing to the resident. During an interview on [DATE] at10:43 A.M., the DON said the facility does not have a specific low air matters policy, and they are going around the building to get the names of the manufacturers to call and get their recommendations. After that they will contact the MD to obtain new recommended settings for each individual resident. There was no monitoring of the LAL settings prior to the survey begun this week, and there were no problems brought to the facility's attention. Staff can utilize a flat (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	sheet with a LAL mattress, but Resident #13 should not have a blanket under him/her. At 10:48 A.M., the DON read the setting of the pump was on 9 for 500 lbs. The blanket did not allow the bed to function properly. Review of the nurse's progress note dated [DATE] at 3:19 P.M., showed an order from MD to set LAL mattress setting according to the resident's weight. Observation on [DATE] at 8:14 A.M., showed the resident had a blanket folded under him/her and bed set at 1. The resident did not have his/her right protective heel boots on. During an interview on [DATE] at 9:04 A.M., Family Member B said he/she changed the wound dressings because they were soaked. 3. Review of Resident #23's quarterly MDS, dated [DATE], showed:-Diagnoses included dementia, muscle weakness, and quadriplegia (paralysis of all four limbs and the torso);-Cognitively intact. Review of the resident's care plan, in use at the time of the survey, showed:-Focus: The resident is at risk for pressure ulcer development due to quadriplegia, incontinence and assistance needed with bed mobility;-Goal: The resident will have intact skin, free of redness, blisters or discoloration by/through review date;-Interventions: Follow facility policies/protocols for the prevention/treatment of skin breakdown. Inform the resident/family/caregivers of any new area of skin breakdown. The resident needs assistance to turn/reposition at least every two hours, more often as needed or requested. Review of the Vendor 3 operations manual, undated, showed:-Indications: pump and mattress system, is indicated for the prevention and treatment of any and all stage pressure ulcers when used in conjunction with a comprehensive pressure ulcer management program. It can be used in a hospital, homecare, or other healthcare environment.-Operating instructions: determine the patient's weight and set the control knob to that weight setting on the control unit. Review on [DATE] at 8:46 A.M., the resident's weight summary, showed the resident's most recent weight, taken on [DATE], was 181.5 pounds. Review of the resident's physician's orders summary (POS), dated 4/2026, showed:-No order for air loss mattress usage or settings. Observation on [DATE] at 2:06 A.M., showed the resident awake in bed. The mattress was set to 320 with normal pressure. Observation on [DATE] at 4:54 A.M., showed the resident awake in bed. The mattress was set to 320 with normal pressure. Observation on [DATE] at 6:25 A.M., showed the resident in bed awake. The mattress was set to 320 with normal pressure. 4. During interviews on [DATE] at 12:43 P.M. and 1:16 P.M., the DON said the physician orders should indicate firmness and to check every shift. The correct settings are based on the resident's weight and manufacturer's recommendations. She would expect the mattress settings to be checked by nursing staff every shift. The DON expected the staff to use PRN orders for wound Tx. 5. During an interview on [DATE] at 11:23 A.M., The Medical Director said he was unsure if a high/firm bed setting could make the wounds worse. He would expect the staff to use the PRN order if the dressing was compromised, saturated or coming off; that is the purpose of the PRN order. He would expect staff to follow physician's orders and facility policy.

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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate foot care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide foot care and treatment in accordance with professional standards of practice for two residents (Residents #60 and #98). The sample was 24. The census was 121.Review of the facility's Podiatry (foot specialty) Services policy, revised 2/16/26, showed:-Policy: The facility will assist in arranging for residents as needed;-Responsibility: Social Worker (SW) and Licensed Nurse;-Procedure: On admission and as needed, the Licensed Nurse evaluates feet and toenails for any abnormalities. The Licensed Nurse will notify the resident's medical provider of any needs for podiatry services and obtain and order for podiatry consultation. The Licensed Nurse will notify Social Services (SS) of the need for arranging podiatry services. SS will arrange for podiatry services, including transportation if needed. The Administrator will engage the services of a properly licensed podiatrist to serve facility residents. 1. Review of Resident #60's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 3/12/26, showed:-Severe cognitive impairment;-Dependent on staff for putting on and taking off footwear and bathing;-Diagnoses included stroke and high blood pressure. Review of the resident's care plan, in use at the time of survey, showed no documentation regarding foot care. Review of the resident's physician order sheet (POS), dated 4/9/26, showed:-An order, dated 1/14/26, for diabetic nail and foot care every week on nights, every Monday;-No order for podiatry consult. Review of the podiatrist's appointment list, dated 2/25/26, showed the resident not listed. Review of the resident's shower sheet, dated 4/6/26, showed staff circled Yes for resident needed toenails trimmed. Observation on 4/7/26 at 6:07 A.M., showed the resident in bed with tight black socks on his/her feet that created indentations in the resident's ankles. Certified Nurse Aide (CNA) MM removed the resident's socks. The resident's feet had extremely dry skin, with thick flakes of dry skin coming off when the socks were removed. The resident's toenails were long and thick, approximately 1.5 inches (in) long, and curled over the tops of the resident's toes. During an interview on 4/10/26 at 7:30 A.M., Licensed Practical Nurse (LPN) W said he/she had been giving the resident weekly foot care. He/She checked the resident's heels and applied lotion without removing the resident's socks. He/She was not aware that the resident's toenails were long but remembered someone mentioned the resident had long toenails on admission, back in January 2026. 2.Review of Resident's #98's quarterly MDS, dated [DATE], showed:-Cognitively intact;-Required partial to moderate assistance from staff with putting on and taking off footwear;-Diagnoses included Parkinson's disease (progressive neurological disorder), dementia, and chronic obstructive pulmonary disease (COPD, lung disease). Review of the resident's care plan, in use at the time of survey, showed:-Focus: The resident has diabetes and is at risk for high blood glucose (sugar) levels, infections, and delayed wound healing;-Interventions: Check the body for all breaks in skin and treat promptly as ordered by the physician;-The resident's care plan did not address foot care. Review of the podiatrist's appointment list, dated 2/25/26, showed the resident not listed. Review of the resident's POS, dated April 2026, showed no order for podiatry consult. Observation on 4/6/26 at 11:04 A.M., showed the resident in bed. LPN K removed the resident's socks. The resident's feet were extremely dry, with thick flakes of skin falling off when the resident's socks were removed. The resident's toenails were thick and approximately 0.5 in long. During an interview, the resident said he/she has not seen a podiatrist. 3. During an interview on 4/10/26 at 9:30 A.M., CNA X said during routine bathing and daily care, residents' feet should be cleaned, lotion should be applied, and clean socks should be applied. If there were issues with the resident's feet, the CNA should let the nurse know. 4. During an interview on 4/10/26 at 7:30 A.M., LPN W said nurses can file toenails but if they are too thick or if the resident is diabetic, the resident should be placed on the podiatry list. He/She expected the CNA who completed any type of bathing activity for the resident to let the nurse know if the resident required toenail trimming. He/She (continued on next page)

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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	expected CNAs to apply lotion to residents' feet when giving a bath or changing the resident's socks. 5. During an interview on 4/10/26 at 12:34 P.M., the Director of Nursing (DON) said she expected nursing staff to identify any foot issues with the resident during bathing and skin assessments. She expected the nurses to place residents on the podiatrist list as needed. She expected staff to apply lotion to dry feet and file or trim the residents' toenails if needed.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on observation, interview and record review, the facility staff failed to use a gait-belt during a transfer for one resident (Resident #93). The sample size was 24. The census was 121. Review of the facility's Gait Belt Transfer policy dated 10/22, showed:-Policy: The Facility will utilize a Gait Belt for Residents who require one assist with Transfer to promote safety during Resident Transfers;-Responsibility: Nursing Assistants, Licensed Nurses (Licensed Practical Nurse (LPN) and Registered Nurses (RN), Nursing Administration, Assistant Director of Nursing (ADON) and Director of Nursing (DON);-Procedure:--Place Gait Belt around the Resident's waist over their clothing with the buckle forward;--Buckle/Fasten the Gait Belt;-- Slide open hand below belt to ensure the Gait Belt is snug but not too tight;-- Position your body close to the Resident; Face to Face;--Transfer Resident by firm grip on the Gait Belt with an underhand grip. Review of Resident's #98's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 3/24/26, showed:-Cognitively intact;-Uses a wheelchair;-Dependent on staff for toileting hygiene;-Requires partial to moderate assist from staff from siting to the standing position and bed to chair and chair to bed transfers;-Frequently incontinent of bowel and bladder;-Diagnosis include Parkinson's disease, dementia, and chronic obstructive pulmonary disease (COPD), a lung disease that cause the airway to become constricted and difficult to breathe. Review of the residents' care plan, in use at the time of survey, showed:-Focus: The resident has ADL performance deficit related to activity intolerance;-Interventions: Transfers with one staff member assist. Observation and interview on 4/6/26 at 11:04 A.M., showed the resident lay in bed with a strong odor of stool and urine. Certified Nursing Assistant (CNA) DD and Licensed Practical Nurse (LPN) K entered the room and assisted the resident with getting the resident cleaned and dressed. CNA DD placed the resident's wheelchair next to the resident's bed and instructed him/her move to the side of the bed and to stand up. CNA DD held the resident under his/her left arm and the resident held onto the wheelchair with his/her right hand. The resident had difficulty standing up straight and moving his/her feet. LPN K and CNA DD held onto the back of the resident's pants and had the resident pivot into the wheelchair. LPN K and CNA DD did not use a gait belt for the resident's transfer. LPN K said they messed up and said that he/she and CNA DD should have used a gait belt on the resident. The gait belt was used to provide a safe transfer in case the resident's legs gave out or he/she started to fall. During an interview on 4/10/26 at 9:30 A.M., CNA X said a gait belt was required anytime a resident required assistance getting out of bed or chair. CNA X said Resident #98 required a gait belt for transfers. It was to provide safety for the residents in case they started to fall. During an interview on 4/10/26 at 12:34 P.M., the DON said staff was expected to use a gait belt on all residents that required assistance with transfers and ambulation.

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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 one resident (Resident #74) with an external urinary collection device (a noninvasive external tube that drains the urine from the bladder) had appropriate physician orders to include catheter care instructions and monitoring. The sample was 24. The census was 121.Review of the facility's Lippincott Nursing Procedure Book, External Urine Collection Device Use, ninth edition, page 324, published 9/2/22, showed:-External urine collection device serves as an alternative to indwelling urinary catheters (sterile tube inserted into the bladder to drain urine) in cooperative residents who don't have signs of urinary retention;-An external urine collection device designed for male residents consist of a condom catheter or other device secure to the shaft of the penis and connected to a leg bag or drainage bag;-Complications are commonly due to equipment malfunction or trauma from improper application and removal can include penile irritation, skin breakdown, swelling, ischemic (dead) tissue loss and infection;-Document the assessment finding before, during, and after device use;-Record urinary output as directed by the facility;-Document the resident's tolerance of the procedure, an intervention implemented, and the resident's response to those interventions;-If the practitioner was contacted, record the date, time and information conveyed as well as any information received;-Document teaching provided to the resident and the resident's family, and their understanding of that teaching and any need for follow up teaching. Review of Resident #74's annual Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 3/10/26, showed:-Moderate cognitive impairment;-Dependent on staff for toileting hygiene;-External or indwelling catheter: Not checked;-Always incontinent of bowel and bladder;-Diagnoses included stroke and neurogenic bladder (a condition that makes it difficult to empty the bladder). Review of the resident's care plan, in use at the time of survey, showed:-Focus: The resident has episodes of bowel and bladder incontinence;-Interventions included: Assist to bathroom as desired or indicated. Cleanse peri-area (genital and rectal area) after each incontinent episode.-The resident's care plan did not address an external urinary draining device. Review of the resident's physician order sheet, dated 4/7/26, showed no orders related to the resident's external urinary drainage device. Observation on 4/7/26 at 10:15 A.M., showed a pink basin on the resident's floor containing a urinary drainage bag filled with yellow urine. The catheter tubing was laying on the floor, and a condom catheter was attached to the end of the tubing. Grey duct tape was attached to the condom catheter. During an interview, Certified Nursing Assistant (CNA) O said the resident's family member placed a condom catheter on the resident and secured it with duct tape every evening. The resident had been wearing a condom catheter at night for over a month. CNA O thought the nurses knew about it. Every morning, he/she carefully removed the condom catheter and duct tape from the resident's genitals to ensure that the resident's skin did not become damaged. CNA O did not empty the resident's drainage collection bag; he/she let the resident's family member do it. During an interview on 4/7/26 at 1:00 P.M., Licensed Practical Nurse (LPN) S said he/she was not aware the resident had been wearing a condom urinary catheter and that a family member had been securing it with duct tape. LPN S expected the staff to have notified the nurse about this so that the family could be educated and the physician could be notified. Monitoring of the condom urinary device should include skin assessments, output amounts, and the characteristics of the urine to ensure an infection was not occurring. There should be physician orders for all urinary catheters and devices, and the use of a urinary catheter should be added to the resident's care plan. During an interview on 4/10/26 at 7:30 A.M., LPN W said he/she was not aware the resident was wearing a condom urinary device at night. There should be documentation and physician orders related to the resident's condom urinary device. LPN W expected staff to inform the nurse that duct tape was being applied to the resident's condom urinary device by a family member. During an interview on 4/7/26 at 12:10 P.M., the Director of Nursing (DON) said she (continued on next page)

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	265417	A. Building B. Wing	04/10/2026

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Sherbrooke Village	4005 Ripa Avenue Saint Louis, MO 63125

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	was not aware the resident's family member was applying a condom urinary drainage device and securing it with duct tape. She expected staff to let the nurse or herself know that was occurring. She expected documentation of this in the progress notes, and for staff to document skin checks, physician orders, and monitoring related to the external urinary drainage device. She expected education to be completed with the resident's family member about the use of duct tape on the urinary catheter. 2804579

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to be free from medication errors of less than 5%. The facility's medication error rate was 11.11% with three errors out of 27 opportunities observed. Staff failed to monitor one resident's blood pressure (BP) prior to administration of Midodrine (a medication to treat low BP) (Resident #86). Staff also used improper technique and failed to follow the facility's policy when they instilled eyedrops for two different types of eye medications without pausing in between types of eyedrops, for one resident (Resident #92). The sample was 24. The census was 121. Review of the facility's Physician Orders policy dated 9/22, showed:-Policy: To provide guidance and ensure physician orders are transcribed and implemented in accordance with Professional Standards, State & Federal Guidelines.-Responsibility: Licensed Nurses, Nursing Administration, & Director of Nursing;-Physician Orders shall be provided by Licensed Practitioners (Physicians, Nurse Practitioners, & Physician's Assistants) authorized to prescribe orders.-Orders must be recorded in the Medical Record by the licensed nurse authorized to transcribe such orders;-Physician orders must be documented clearly in the medical record. The required components of a complete order;-Date and time of order;-Name of practitioner providing order;-Name and strength of medication/treatment;-Quantity/Duration;-Dosage/Frequency;-Route of administration;-Indication/Diagnosis;-Stop Date, indicated;-Physician orders that are missing required components, are illegible or unclear must be clarified prior to implementation. 1.Review of Resident #86's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 3/12/26, showed:-Severely impaired cognition;-Partial to moderate assistance required with activities of daily living (ADLs);-Diagnoses included: Dementia, hearing loss (HOH), and hypotension (low blood pressure). Review of the resident's care plan, in use at the time of survey, showed:-Focus: Hypotension;-Goal: Will remain free of complications related to hypotension through review date;-Interventions: Encourage adequate fluid intake and a healthy diet, give medications as ordered. Monitor for side effects and effectiveness. Review of the resident's physician orders sheet (POS) dated 4/6/26, showed;-An order date on 9/24/24, Midodrine 10 milligrams (mg) by mouth (PO) three times day (TID),-No order to check BP TID before administering Midodrine. Observation on 4/7/26 at 6:01 A.M., showed Certified Medication Technician (CMT) KK popped out a Midodrine tablet from the blister pack and into the medicine cup. CMT KK handed the resident the cup, and the resident swallowed the medication. CMT KK did not take a BP prior to the medication administration. During an interview on 4/7/26 at 6:01 A.M., CMT KK said he/she does not know what Midodrine medication is used for. The CMT said he/she really messed that up. He/She should have taken the resident's blood pressure first. CMT KK went back to take the resident's BP, and it was 130/74. Review of the medication administration record (MAR), dated 4/26, showed: During an interview on 4/10/26 at 12:34 P.M., the Director of Nursing (DON) said she expected staff to monitor residents' blood pressures prior to administration of any medications that require blood pressure checks. 2. Review of the facility's Eye Drop Administration policy dated 12/2017, showed:-Purpose: To administer ophthalmic solution/suspension into the eye in a safe, accurate, and effective manner;-Procedure: For general guidelines on medication administration, refer to 7.1: Equipment and supplies for administering medications and 7.2 medications administration-general guidelines; --Tilt resident's head slightly back;--With a gloved finger, gently pull-down lower eyelid to form pouch, while instructing residents to look up. Place other hand against resident's forehead to steady. Hold inverted medication bottle between the thumb and index finger and press gently to instill prescribed number of drops into pouch'' near outer corner of eye. Do NOT let tip of dropper touch the eye or any other surface. If resident blinks or drop lands on cheek, repeat administration;-While the eye is closed, use one finger to compress the tear duct in the inner [NAME] (inner canthus) of the eye for one to two minutes. This reduces systemic absorption of the medication. Alternatively, the resident may keep his/her eyes (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	closed for approximately three minutes.'--Wipe off tears or excess solution with clean gauze, cotton ball, or tissue;--If another drop of the same or different medication is prescribed for administration in the same eye at the same time, wait 10 minutes, then repeat procedure above. Review of the Dorzolamide HCI- Timolol Mal manufactures dated 2024, showed:-When used with another eye drop, wait at least 5 minutes (min) before or after usage;-Step 1: Tear of safety seal;-Step 2: Unscrew the cap by lid and turn counterclockwise;-Step 3: Tilt your head back. Gently pull lower eyelid downwards to form a pocket between your eyelid and eye, while looking upward;-Step 4: Turn bottle upside down;-Step 5: Place the dropper tip of the bottle to your eye but be careful not to touch your eye with it. Gently press the bottle lightly with thumb or index finger until a single drop comes falls into your eye;- Step 5: Repeat steps 4 and 5 per physician's order. Review of Resident #92's MDS, dated [DATE], showed:-Severely impaired cognition;-Resident requires maximal assistance with ADLs from staff;-Diagnoses included: Kidney disease, hypertension (elevated blood pressure), Alzheimer's, Aphasia (language disorder-impaired words spoken, understood, and written), seizures (electrical disconnect between the neurons);-No diagnosis of glaucoma (pressure behind the eye). Review of the resident's care plan, in use at the time of survey, showed it did not address the need/reason for eye drops (gtts). Review of the resident's POS dated 4/6/26, showed;-An order dated 9/9/25, for Dorzolamide HCI- Timolol Mal (lowers ocular eye pressure related to (r/t) glaucoma) Ophthalmic (eye) Solution 2-0.5% instill both (ou) TID;-An order dated 9/9/25, for Brimonidine Tartrate ((treats glaucoma, ocular pressure) Ophthalmic Solution 0.2 %, instill 1 gtts in ou TID a day for glaucoma. Observation on 4/7/26 at 5:49 A.M., showed CMT KK pried the resident's eyelid open, while the resident resisted. CMT KK instilled one gtt of Brimonidine solution into the resident's eye and repeated the same process on the opposite eye. CMT KK held the second bottle of eye gtts, the dorzolamide timolol solution. CMT KK did not pause for any extended amount of time in between eye gtts and repeated the previous process above. During an interview on 4/7/26 at 5:49 A.M., CMT KK said the residents does not usually sleep this hard, and the resident had a hard time waking up this morning. During an interview on 4/10/26 at 12:43 P.M., the DON said she expected staff to follow policy and procedure regarding the facility's eye drop administration policy. The proper technique would be hand hygiene, gloves next and then pull the eyelid down and instill a drop into the eyelid. Then staff should wipe the extra solution off with a Kleenex and pause for 3-5 minutes between eye solutions. 28068052804579

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on observation, interview, and record review, the facility failed to maintain medical records that were complete and accurately documented in accordance with acceptable professional standards and practices when staff documented treatments as completed when they had not been administered for one resident (Resident #23). The sample was 24. The census was 121. Review of Resident #23's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 3/30/26, showed:-Cognitively intact;-Diagnoses included dementia, muscle weakness, and quadriplegia (paralysis of all four limbs and the torso). Review of the resident's physician's order summary (POS), dated April 2026, showed:-An order, dated 1/5/26, for wound to right great toe. Morning shift, cleanse with wound cleanser, pat dry and apply dry dressing every 3 days until healed;-An order, dated 2/8/26, to change oxygen tubing weekly on Sunday evening shift;-An order, dated 3/10/26 for oxygen at 3 liters (L) via nasal canula (NC) as needed. Review of the resident's treatment administration record (TAR), dated April 2026, showed:-On 4/2/26, staff documented the wound treatment to the right great was completed;-On 4/5/26, staff documented the oxygen tubing change was completed. Observation on 4/6/26 at 9:05 A.M., showed the resident's oxygen tubing dated 3/15/26. During an interview, the resident said he/she used oxygen as needed. He/She had a wound on his/her right toe and he/she was unsure when the dressing was last changed. Observation on 4/7/26 at 6:54 A.M., showed the resident in bed. The dressing on the resident's right great toe was dated 3/26/26. During an interview on 4/10/26 at 8:08 A.M., Licensed Practical Nurse (LPN) K said the resident's right great toe wound was healed and the dressing was being used as a preventative measure. The dressing should be changed per the physician's orders. Staff should only mark the oxygen tubing change as completed if the tubing was changed. During an interview on 4/10/26 at approximately 7:00 A.M., the Administrator said he did not have a policy regarding medical record documentation accuracy. During an interview on 4/10/26 at 1:03 P.M., the Administrator and Director of Nursing (DON) said staff should not document treatments or orders as completed if they were not administered.

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F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. Based on interview and record review, the facility failed to ensure Certified Nurse Aides (CNAs) employed at the facility for more than a year received no less than 12 hours of in-service training per year, for two of five sampled employees. The census was 121.Review of the facility's Facility Assessment, dated 1/30/26, showed:-Staff Training/Education and Competencies:-Competencies covered annually:--Activities of daily living (ADLs);--Disaster planning;--Medication administration;--Measurements (vitals, intake, output);--Resident assessment;--Caring for people with dementia, Alzheimer's disease, and cognitive impairments;--Caring for people with mental and psychosocial disorders;--Non-pharmacological management of responsive behaviors;--Caring for residents with trauma/post-traumatic stress disorder (PTSD);-The facility assessment did not identify how many training hours were required annually for CNAs. 1. Review of CNA EE's employee record, showed:-Hire date 7/18/17;-On 4/6/26, the first day of survey, CNA EE completed 15.5 hours of training between 4:25 P.M. and 6:20 P.M. 2. Review of CNA FF's employee record, showed:-Hire date 9/1/24;-3.5 hours of training completed between 9/1/24 and 9/1/25. 3. During an interview on 4/10/26 at 10:31 A.M., CNA N said CNAs are provided training education through an online portal. Facility Administration sets certain courses to be completed, and CNAs are expected to complete 12 hours of training per year, from hire date to hire date. He/She assumed the facility Director of Nursing (DON) was responsible for auditing and ensuring training hours were completed. 4. During an interview on 4/10/26 at 12:35 P.M., the DON and Administrator said they expected all CNAs working at the facility to be provided 12 hours of continuing education on a yearly basis. Training should be completed gradually throughout the year and staff should not complete all training in one day, as this can impact staff's comprehension of the material.