STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265462	A. Building B. Wing	11/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Beloved Health and Rehabilitation Center	328 Munger Lane Hannibal, MO 63401

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 32899 Based on observation, interview, and record review, the facility failed to provide care in a manner that enhanced resident dignity and ensured full recognition of individuality for two residents (Resident #20 and #36), in a review of 20 sampled residents. The facility census was 87. Review of the facility policy Respect/Dignity/Right to have Personal Property, dated 11/1/22, showed the following: -It is the policy of the facility to provide care and services in such a manner to acknowledge and respect resident rights. -Exercising rights means that residents have autonomy and choice, to the maximum extent possible, about how they wish to live their everyday lives and receive care, subject to the facility's rules, if those rules do not violate a regulatory requirement. -The resident has a right to be treated with respect and dignity. 1. Review Resident #20's Care Plan, last revised 6/12/24, showed the following: -The resident required one to two staff to assist with transfers; -The resident required staff assistance with choices and supervision, cueing, encouragement and physical assistance for dressing; -Required staff participation of one to two staff for toileting and personal hygiene. Review of the resident's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument to be completed by the facility staff, dated 9/12/24, showed the following: -Moderately impaired cognition; -No behaviors or rejection of care; -Required substantial to maximum assistance for transfers and personal hygiene; (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Partial to moderate assist with dressing; -Dependent for toileting; -Always incontinent of bladder and bowel. Observations on 11/18/24 showed the following: -At 1:15 P.M. the resident sat in his/her wheelchair in the dining room eating lunch with three other residents at the table. A large puddle of liquid lay on the floor directly under the resident's chair. There was a strong smell of urine. Multiple staff walked around and past the resident's table, serving trays and drinks; -The puddle of liquid remained under the resident's wheelchair from 1:15 P.M. until 1:45 P.M. as the resident continued to eat his/her lunch. Three residents sat at the resident's table and other residents and staff were in the dining room; -At 1:45 P.M. staff pushed the resident to his/her room, removed his/her visibly urine soiled pants and saturated incontinence brief and toileted the resident. Observation on 11/20/24 at 8:40 A.M. showed the following: -The resident sat in his/her wheelchair in his/her room eating breakfast that sat on the over-the-bed table; -The resident wore only a shirt that was wet along the bottom edges, an incontinence brief and socks; -The resident's bed was closest to the window in the room. The privacy curtain was not pulled between the resident and his/her roommate, whose bed faced the resident. The roommate lay awake in his/her bed; -Staff opened and closed the door leaving the resident visible to the hallway. During interview on 11/20/24 at 8:40 A.M., the resident said the following: -He/She was cold; -Staff sat him/her up with no clothes and a wet shirt. They could have at least thrown a blanket over him/her: -His/Her shirt was wet from urine; -He/She had to lose his/her modesty along time ago after moving to the facility. During an interview on 12/4/24 at 3:30 P.M Certified Nurse Assistant (CNA) I said the following: (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Residents should not be in the dining room for extended periods of time with a puddle of urine under their chairs. Staff should remove them, clean them up and return them to the dining room to finish their meal; -Staff should not get residents up for breakfast in only a wet t-shirt and incontinence brief. Although there were some residents who preferred to get up without pants on, they should at least be covered with a blanket so they were not exposed. During an interview on 11/26/24 at 3:58 P.M. the Director of Nursing said the following: -Staff should not leave a resident in the dining room if they had a large puddle of urine under them. He/She expected staff to remove the resident, clean and dry them and return them to finish their meal; -Staff should not get a resident up for breakfast and sit them in a chair in only a soiled shirt and an incontinent brief. Residents should be dressed or have something covering them. 38016 2. Review of Resident #36's care plan, revised 01/22/24, showed the resident required supervision and some staff assistance to eat. Review of the resident's annual MDS, a federally mandated assessment completed by staff, dated 7/26/24, showed the following: -Cognitively intact; -Required supervision and touch assistance of staff with eating. Observation on 11/25/24 at 6:05 P.M.-6:25 P.M., showed the following: -The resident sat in a geri-chair at the dining room table; -The resident's divided plate rested on the resident's stomach. The resident attempted to hold the divided plate with one hand and attempted to feed himself/herself with the other hand. The resident's hands were shaking. The resident's silverware was wrapped on the table out of the resident's reach; -The resident received a mechanical soft diet which consisted of ground meat, hash browns, and a chocolate chip cake; -The resident attempted to scoop food with his/her hands, but his/her hands were shaking. The resident had small particles of food all over his/her face, stomach, and down the sides of his/her chair; -The resident attempted to feed himself/herself but was only able to get very little food to his/her mouth. An unidentified staff walked by the resident 6:07 P.M. and did not offer assistance; (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-At 6:22 P.M., Nurse Assistant (NA) E asked the resident if he/she needed help. The resident said, yes, but my food was all over me. NA E went to take the resident's plate, and the resident grabbed his/her cake from the plate and said, Please don't take my cake. The resident took the cake from the plate and NA E put the plate on the table. NA E did not offer to assist the resident to eat his/her cake. During an interview on 11/25/24, at 6:23 P.M., the resident said most of the time he/she could not reach his/her food. There was only one staff who helped him/her with his/her food consistently. He/She would like help because he/she was hungry and could not get all of the food to his/her mouth. He/She felt like a child with food all over him/her; it was embarrassing. During an interview on 11/25/24, at 6:30 P.M., Nurse Assistant (NA) E said he/she thought the resident could feed himself/herself. The staff do not usually feed the resident. During an interview on 11/26/24 at 3:58 P.M., the DON said the following: -Staff should treat residents with dignity and respect; -Staff should assist residents to remain clean and well groomed to maintain their dignity. MO244988 MO245438

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32899 Based on observation, interview and record review, the facility failed to provide adequate means of dining furniture/equipment for three residents (Resident #10, #36, and #80) of 20 sampled residents, in order to allow the residents to reach their food and drinks. The residents use a reclining chair on wheels and cannot sit up to the table. The residents sat parallel to the table and had to twist to reach items or place their plates on their laps to try to feed themselves. The facility census was 87. Through an email correspondence on 12/09/24 at 9:57 A.M., the Director of Nursing (DON) replied the facility had no policy for choices/self determination. 38016 1. Review of Resident #36's care plan, revised 01/22/24, showed the resident needed supervision and touch assistance with eating. Review of the resident's annual Minimum Data Set (MDS), a federally mandated assessment completed by staff, dated 7/26/24, showed the following: -Cognitively intact; -No behaviors and did not reject care; -Dependent on staff for bed mobility, transfers with a mechanical lift, and dependent on staff for wheelchair mobility. Review of the resident's quarterly MDS, dated [DATE], showed the resident needed partial assistance with eating and was dependent on staff for upper body dressing. Observation on 11/18/24, at 12:21 P.M., showed the following: -The resident sat reclined in a geri-chair (reclining chair on wheels) at the dining room table; -The geri chair was positioned parallel to the dining room table; -The resident reached across his/her body and reached to access her meal; -The resident could not reach his/her water or dessert; -Observation showed the support in the center of the table would not allow the resident's geri-chair to roll up to and allow the resident to face the table. Observation on 11/25/24, at 6:05 P.M.-6:25 P.M., showed the following: -The resident sat reclined in a geri-chair positioned parallel to the dining room table; (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Observation showed the support in the center of the table would not allow the resident's geri-chair to roll up to and allow the resident to face the table; -The resident was not close to the table and could only reach his/her plate which he/she pulled off the table and placed on his/her stomach; -The resident's divided plate rested on the resident's stomach. The resident attempted to hold the divided plate with one hand and feed himself/herself with the other hand. The resident's hands shook. The resident's silverware was wrapped on the table out of the resident's reach; -The resident attempted to scoop food with his/her hands, but his/her hands were shaking. -The resident could not reach his/her silverware which remained rolled in a napkin on the table; -The resident had small particles of food all over his/her face, stomach, and down the sides of his/her chair; -The resident attempted to feed himself/herself but was only able to get very little food to his/her mouth. An unidentified staff walked by the resident 6:07 P.M. and did not offer assistance; -At 6:22 P.M., the resident said, my food is all over me; -The resident took the cake from the plate and NA E put the plate on the table. -The resident could no longer reach his/her plate. During an interview on 11/25/24, at 6:23 P.M., the resident said most of the time he/she could not reach his/her food at mealtimes. 2. Review of Resident #80's quarterly MDS, dated [DATE], showed the following: -Severe cognitive impairment; -Unclear speech; rarely/never understood; -Sometimes understands others; -Functional range of motion limitations in both upper and both lower extremities; -Dependent on staff for all activities of daily living (ADLs); -Used a wheelchair. Observation on 11/18/24, at 12:30 P.M., showed the following: -The resident sat reclined in his/her geri-chair in the dining room; -The resident's geri-chair was positioned parallel to the table; (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Observation showed the support in the center of the table would not allow the resident's geri-chair to roll up to and allow the resident to face the table. -The resident's right arm showed contractures, the resident's left arm was parallel with the table and he/she could only reach items on the edge of the table; -The resident could not reach his/her drinks. Observation on 11/18/24, at 01:23 P.M., showed staff removed the resident from the dining room table. The resident did not consume the food on the side of the plate he/she could not reach which contained his/her potato and cabbage. The resident's coffee and juice were also out of the resident's reach and remained full when staff took the resident from the table. Observation on 11/21/24, at 8:38 A.M., showed the following: -The resident sat reclined in a geri-chair in the dining room; -Observation showed the support in the center of the table would not allow the resident's geri-chair to roll up to and allow the resident to face the table. -The resident's right arm showed contractures, the resident's left arm was parallel with the table and he/she could only reach items on the edge of the table; -The resident could not reach his/her drinks. Observation on 11/25/24, at 5:43 P.M., showed the following: -The resident sat reclined in a geri-chair in the dining room; -Observation showed the support in the center of the table would not allow the resident's geri-chair to roll up to and allow the resident to face the table. -The resident's right arm showed contractures, the resident's left arm was parallel with the table and he/she could only reach items on the edge of the table; -The resident could not reach his/her water, juice, or his/her nutritional shake. 3. Review of Resident #10's quarterly MDS, dated [DATE] showed the following: -Moderately impaired cognition; -Set up or clean up only for eating; -Dependent for transfers; -No ambulation; -Used a wheelchair; (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-No limitation in range of motion. Review of the resident's POS, dated 11/2024 showed the following: -Type II diabetes mellitus (uncontrolled blood glucose) and tremors (involuntary, quivering movements); -Consistent carbohydrate diet, regular texture. Review of the resident's care plan, last revised 11/8/24 showed the following: -Extensive assist with activities of daily living; -At nutritional risk related to use of mechanically altered diet; -Allow time to complete task and intervene as needed; -Provide assistance as needed; -Serve diet as ordered, encourage appropriate intake of foods and fluids. Observation on 11/18/24 at 1:00 P.M. showed the resident sat in a partially reclined broda chair (a specialized tilt in space chair) positioned parallel to the corner of a dining table. Observation on 11/20/24 at 1:35 P.M. showed the following: -The resident sat in a partially reclined broda chair which was positioned at the corner of a dining table in the main dining room; -The resident stretched to reach the dessert plate and then asked the surveyor to move his/her entree so that he/she could reach it; -The surveyor alerted staff to assist the resident to reach his/her plate of food; -The resident's broda chair was not positioned upright and was positioned to allow the resident to reach his/her food comfortably. He/She awkwardly reached for and scooped his/her food. During an interview on 11/25/24 at 10:33 A.M. the resident said it was hard for him/her to reach his/her food and feed him/herself when he/she was not sitting close to the table and positioned upright. During an interview on 11/25/24, at 6:30 P.M., Nurse Assistant (NA) E said he/she thought the staff put the geri-chairs sideways (parallel) to the table because the support in the center of the table would not allow the chairs go under the table allowing the residents to sit up to the table. During an interview on 11/26/24 at 3:58 P.M. the Director of Nurses said the following: -Residents should be positioned upright in their chairs when eating; (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-The broda chairs and wheelchairs should be in a full upright position; -If a chair could not be positioned under a table adequately, staff should supply an over-the-bed table; -Staff should assist the residents with eating as needed.

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F 0567 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to manage his or her financial affairs. 38016 Based on record review and interview, the facility failed to ensure resident funds were placed in an account separate from the facility operating account. The facility did not provide residents with refunds of their personal funds from the operating account in a timely manner for six residents (Resident #9, #27, #30, #69, #77 and #301). The facility census was 87. Record review of the facility maintained Accounts Receivable Aging Report, dated 11/19/24, showed the following residents with personal funds held in the facility operating account. Resident Amount Held in Operating Account #9 $100.00 #27 $3,708.00 #30 $1,928.00 #69 $22,638.51 #77 $1,072.00 #301 $156.00 Total $29,602.51 During an interview on 11/25/24, at 5:40 P.M., Business Office Manager (BOM) #2 said she was not sure what the amounts on the A/R report were, she would have to check and get back to State Agency (SA) staff. The BOM did not provide any additional information on the details of the amounts shown as money the facility owed to the residents.

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F 0568 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Properly hold, secure, and manage each resident's personal money which is deposited with the nursing home. 38016 Based on record review and interview, the facility failed to maintain a system to ensure the resident trust fund account was managed in accordance with proper accounting principles by not maintaining an accurate accounting of all monies held in the resident trust fund account and by not reconciling each month. The facility also failed to provide quarterly statements to the residents. The facility managed funds for 27 residents. The facility census was 87. 1. Record review of the facility maintained attempted reconciliation forms, for the period 11/01/23 - 10/31/24, excluding 03/2024, showed the attempted reconciliations did not reconcile to the residents' current balance at the time of reconciliation. 2. During an interview on 11/25/24, at 5:40 P.M., Business Office Manager (BOM) #2 said she did not find any reconciliations of the resident trust account from the previous BOM so there wass only September 2024 and October 2024 reconciliations to review. 3. Record review on 11/21/24 of the facility maintained quarterly statements showed no quarterly statements were given to the resident/financial guardian. 4. During an interview on 11/25/24, at 5:40 P.M., the Business Office Manager (BOM) #2 said the following: -She could not find any evidence quarterly statements were given to the residents; -She had not been able to provide quarterly statements because she was unable to verify the residents' balances related to money missing found during her audit; -She did not know if the residents' balances were correct at this time.

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F 0570 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Assure the security of all personal funds of residents deposited with the facility. 38016 Based on record review and interview, the facility failed to maintain a surety bond sufficient to ensure the protection of resident funds. The facility census was 87. Review of the facility maintained Resident Trust Bank Statements for the period 11/2023 through 10/2024, excluding 03/2024, showed an average monthly balance of $5,470.41. Review of the facility maintained Accounts Receivable (A/R) Aging Report, dated 11/19/24, showed the facility held a balance of resident funds in the amount of $29,602.51. Review on 12/19/24 of the Department of Health and Senior Services approved bond list showed the facility had a $50,000 approved bond, making the bond insufficient by $2,500.00. During an interview on 11/25/24, at 5:40 P.M., Business Office Manager (BOM) #2 said she did not know the A/R amounts would increase the amount of the bond needed. She was new to this role and did not know about how all of it worked.

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F 0572 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Give residents a notice of rights, rules, services and charges. 47008 Based on observation, interview and record review, the facility failed to ensure resident rights were posted on the 100 hall. Residents on the 100 Hall resided on a locked, secured unit. The facility also failed to ensure resident rights were reviewed with residents at least annually. The facility census was 87. Review of the facility's undated policy, Admission Contract and Authorization for Treatment, showed the following: -The following is a statement of resident's rights under federal and state regulations; -The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibility during the stay in the facility; -Each resident admitted to the facility, or his/her guardian or legally qualified representative, shall be fully informed of his/her rights and responsibilities as a resident and of all facility rules governing resident conduct and responsibilities. These rights shall be reviewed annually with each resident, guardian, or legally qualified representative, either in a group session or individually; -Information regarding resident rights and facility rules shall be posted in a conspicuous location in the facility. 1. During the resident council meeting on 11/20/24 at 2:21 P.M., seven out of eight residents in attendance said staff do not verbally go over resident rights or review resident rights with them. None of the residents present at the resident council meeting resided on the A Hall. Review of the resident council meeting notes, dated 09/19/24 and 11/15/24 (the only notes provided by the facility), showed no documentation of any resident rights topic discussion. Observation of A Hall (100 hall,a locked, secured unit) on 11/20/24 at 9:15 A.M., 11/21/24 at 8:40 A.M. and 11/25/24 at 10:35 A.M., showed no resident rights posted in the unit. During a telephone interview on 11/26/24 at 2:08 P.M., the Social Services Director (SSD) said the previous Activity Director had conducted the resident council meetings. She had attended the resident council meetings in the past and had never witnessed staff discuss resident rights with the residents. During a telephone interview on 11/26/24 at 3:58 P.M. and 12/05/24 at 9:08 A.M., the Director of Nursing (DON) said the previous Activity Director was in charge of resident council meetings and she never reviewed resident rights with the residents. She would expect resident rights to be discussed during resident council meetings. Resident rights were supposed to be reviewed annualy with all residents and/or guardians. When the information was reviewed, a form was supposed to be signed and then scanned into the resident's chart. Currently resident rights were not being reviewed verbally by any staff member in the facility. (continued on next page)

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F 0572 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During a telephone interview on 11/26/24 at 5:08 P.M., Administrator 1 said he expected the resident rights to be posted on the 100 hall, and he expected staff to discuss the resident rights during resident council meetings.

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Beloved Health and Rehabilitation Center	328 Munger Lane Hannibal, MO 63401

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F 0577 Level of Harm - Potential for minimal harm Residents Affected - Many	Allow residents to easily view the nursing home's survey results and communicate with advocate agencies. 47008 Based on observation, interview and record review, the facility failed to post the results of the most recent survey and complaint investigations in a place readily accessible to all residents. The facility also failed to keep the survey binder up to date with all survey and complaint investigation results. The facility census was 87. Review of the facility undated policy, Admission Contract and Authorization for Treatment, showed the following: -Examination or survey results, resident has the right to examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility; -The results must be made available by the facility in a place readily accessible to the residents and the facility must post a notice of their availability. 1. During the resident council meeting on 11/20/24 at 2:21 P.M., seven of eight residents in attendance said they were not aware they could see the results of the annual inspections/surveys or any complaint investigation. They did not know where the book with the results was kept. Observations of the front foyer area of the facility, on 11/20/24 at 6:30 A.M. and 11/21/24 at 8:00 A.M., showed survey results located on a table. The resident area was a secure area, located behind a locked door, which required a four digit pin in order to enter and exit the area without sounding an alarm. Residents did not have access to this area where the survey binder was available, without staff assistance. Review of the survey binder showed no documentation of the following: -Statement of Deficiency (SOD) of 11/30/21; -Plan of Correction (POC) for SOD of 11/30/21; -SOD of 12/07/22; -POC for SOD of 12/07/22; -SOD of 01/05/23; -POC for SOD of 01/05/23; -SOD of 11/03/23; -POC for SOD of 11/03/23; (continued on next page)

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F 0577 Level of Harm - Potential for minimal harm Residents Affected - Many	-POC for SOD of 12/06/23; -SOD of 02/07/24; -POC for SOD of 02/07/24; -SOD of 03/28/24; -POC for SOD of 03/28/24; -SOD of 04/18/24; -POC for SOD of 04/18/24; -SOD of 05/29/24; -POC for SOD of 05/29/24; -SOD of 06/02/24; -POC for SOD of 06/02/24; -SOD of 06/18/24; -POC for SOD of 06/18/24; -POC for SOD of 08/02/24. -SOD of 09/10/24; -POC for SOD of 09/10/24. Observations of the A-hall, locked, secured unit, on 11/20/24 at 9:15 A.M., 11/21/24 at 8:40 A.M. and 11/25/24 at 10:35 A.M., showed no survey results located or accessible to residents in this area. During an interview on 11/21/24 at 3:00 P.M. and 4:30 P.M., Administrator 1 said there was one survey binder in the building and it was located by the front door. There was no survey binder on A hall. Residents could not leave their living area without a staff member entering a code to let them out of the locked area. A-hall was a locked area. The survey binder should contain the last survey results and any complaint investigation. The binder should also contain any citations from the survey and complaint investigations. The survey binder was not up to date and he was responsible for ensuring the survey binder was up to date.

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38016 Based on interview and record review, the facility failed to give appropriate Centers for Medicare and Medicaid Services (CMS) Skilled Nursing Facility (SNF) Advance Beneficiary Notice (ABN) (CMS-10055) and the CMS Notice of Medicare Non-Coverage (NOMNC) (CMS-10123) in writing with all required information to three residents (Residents #245, #391, and #246), reviewed in a sample of three residents, when the facility initiated discharge from Medicare Part A Services when benefit days were not exhausted. The facility census was 87. Through an email correspondence on 12/09/24 at 9:57 A.M., the Director of Nursing (DON) replied the facility had no policy for ABN and NOMNC notices. The facility followed the regulatory guidelines related to these areas. 1. Review of Resident # 245's face sheet shows the resident has a durable power of attorney (DPOA) for health and financial decisions, and the resident admitted to the facility on [DATE]. Review of the resident's admission Minimum Data Set (MDS), a federally mandated assessment completed by staff, dated 04/12/24, showed the resident was rarely or never understood and rarely or never understands. The resident was unable to complete the cognitive interview and the resident has severe cognitive impairment. Review of the resident's census showed he/she started on Medicare Part A services 04/05/24, and his/her last covered day determined by the facility showed 5/3/24 Review of the resident's ABN, showed Medicare part A may not cover services because the resident was not participating. Options 1, 2, 3 on the form were blank (Option 1: I want the services and to bill Medicare and I am responsible for payment if Medicare does not pay; Option 2: I want the services but do not bill Medicare, and I am responsible for payment; Option 3: I do not want the services, so there will be no services to pay). The notice was signed by the resident, not the resident's DPOA, and did not have the date the notice was signed (or the date the resident received the notice). Review of the resident's NOMNC, showed services would end on 5/3/24. The NOMNC did not contain the resident's name, the Quality Improvement Organization (QIO) number (the phone number to appeal the decision if the resident chose to) was not filled in, it said {insert QIO name and toll-free number of QIO}. The notice did not contain the date staff gave the NOMNC to the resident, or the date when the resident signed the NOMNC. 2. Review of Resident #391's face sheet, showed the resident had a DPOA for financial and health care decisions, and the resident admitted to the facility on [DATE]. Review of the resident's census showed he/she started on Medicare Part A services 09/23/24, and his/her last covered day determined by the facility showed 10/31/24. (continued on next page)

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the resident's ABN, showed Medicare Part A may not cover services because the resident was not participating and wants to be taken off therapy. Options 1, 2, 3 on the form were blank (Option 1: I want the services and to bill Medicare and I am responsible for payment if Medicare does not pay; Option 2: I want the services but do not bill Medicare, and I am responsible for payment; Option 3: I do not want the services, so there will be no services to pay). The notice was signed by the the resident's DPOA on the day services ended 10/31/24 (No prior notice of payer change). Review of the resident's NOMNC, showed services will end on 10/31/22 (incorrect year). The NOMNC did not contain the resident's name, the Quality Improvement Organization (QIO) number (the phone number to appeal the decision if the resident chose to) was not filled in, it said {insert QIO name and toll-free number of QIO}. The notice was signed by the DPOA on the date the services were discontinued (10/31/24) (Not in advance of payer change). 3. Review of Resident #246's face sheet showed the resident admitted to the facility on [DATE]. The resident was responsible for himself/herself. Review of the resident's census shows he/she started a Medicare Part A stay on 05/02/24, and his/her last covered Medicare Part A day was 07/02/24. The facility was unable to locate an ABN or NOMNC for the resident's Medicare Part A stay. 4. During an interview on 11/20/24, at 9:53 A.M., the Business Office Manager #2 said the following: -The ABN and NOMNC requested for Resident #246 were not found; -She was now responsible for giving the ABN and NOMNC notices when residents will be discharged from Medicare Part A; -She was not working at the facility when Resident #245's, and #246's notices were given; -With Resident #391, she had just started and used the forms the facility had, she did not realize the QIO number was not listed; -ABN and NOMNC notices should be given three days prior to discontinuing services if possible to allow notice for the resident/resident representative to know about payer changes; -She was just learning the process for the ABN and NOMNC notices; -If resident's were unable to understand or make decisions, their guardian or DPOA should be the ones to sign the notices.

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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** 38016 Based on observation and interview, the facility failed to ensure the facility was clean and the ceilings and walls were in good repair. The facility failed to ensure the facility was free of persistent strong urine odors and failed to ensure bathroom vents were free from a heavy accumulation of dust and debris. The facility census was 87. Review of the facility policy, Safe/Clean/Comfortable/Homelike Environment, dated 11/1/22, showed the following: -The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and support for daily living safely; -The facility must provide a safe, clean, comfortable, and homelike environment, allowing the resident to use his/her personal belongings to the extent possible; -Housekeeping and maintenance services are necessary to maintain a sanitary, orderly, and comfortable interior. 1. Observation on 11/18/24 at 1:47 P.M., showed the ceiling in occupied resident room [ROOM NUMBER] had an area measuring approximately 2.5 feet by 2.5 feet, which had areas of peeling paint and was discolored light brown. Observation on 11/18/24 at 2:18 P.M., showed the ceiling in occupied resident room [ROOM NUMBER] had an area measuring approximately 1.5 feet by 2 feet, which had areas of paint that had blistered from the surface of the ceiling and was discolored light brown. Observation on 11/18/24 at 3:08 P.M., showed the ceiling in occupied resident room [ROOM NUMBER] had an area measuring approximately 2 feet by 1 foot, which had areas of blistered paint and was discolored light brown. Observation on 11/18/24 at 3:20 P.M., showed the ceiling in occupied resident room [ROOM NUMBER] had an area measuring approximately 4 feet by 2 feet, which had areas of the ceiling that were discolored light brown. Observation on 11/21/24, at 09:12 A.M., showed occupied room [ROOM NUMBER] with a rectangle shaped hole in the wall where staff accessed plumbing, and a large area on the wall painted with irregular edges a different color than the rest of the wall. During an interview on 11/21/24 at 8:34 A.M., the Maintenance Director said the following: -He had an app on his phone where employees could put in work order requests if there was an item that maintenance needed to address; -He did not have a list of needed repairs; he kept a list of the needed repairs in his head; (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-He currently only had one outstanding job to be completed (an outlet in a resident's room that needed to be repaired); -He did not have any work orders for the 100 hallway; -He did ongoing maintenance in the building when he had time. During an telephone interview on 11/26/24 at 3:58 P.M., the Director of Nursing (DON) said she did not know the ceilings on 100 hall were in disrepair. She expected any repairs needed for the ceilings on the 100 hall to be completed. During an interview on 11/26/24 at 5:13 P.M., Administrator 1 said he expected the Maintenance Director to keep a log of all of the repairs needed in the facility. He expected staff to have repaired the ceilings on the 100 hall. 2. Observation on 11/18/24, at 10:00 A.M., showed a very strong urine odor permeated throughout the dining room. Observation on 11/18/24, at 10:20 A.M., showed a strong urine odor on the B hall. The odor was strongest at the beginning of the hall and around room [ROOM NUMBER] and room [ROOM NUMBER]. Observation on 11/19/24, at 9:30 A.M., showed a strong urine odor in the dining room and on the B hall. Observation on 11/19/24, at 11:45 A.M., showed a strong urine odor in occupied room [ROOM NUMBER]. During an interview on 11/19/24, at 11:45 A.M., Resident #44 said the following: -The dining room and the B hall always smells like urine; -They do not take resident's to the bathroom often enough, -They will get his/her roommate up in the morning and it might be 4-6 hours before they toilet him/her and he/she would be saturated; -Their room often smelled like urine because his/her roommate cannot communicate when he/she needs to be changed and the staff do not check on him/her often enough. Observation on 11/25/24, at 10:23 A.M., showed a strong urine odor in the dining room. During an interview on 11/25/24, at 6:10 P.M., Resident #36 said it always smells like pee, he/she was not sure why. During an interview on 11/25/24, at 6:30 P.M., Certified Nurse Aide (CNA) R said the following: -He/She has noticed the urine smell in the dining room and on B and C halls; (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-He/She felt like resident wheelchairs were not cleaned well after residents were incontinent. Some resident urinate their clothing. The dirty utility room on the B hall can have a strong urine odor due to saturated linens; -He/She did not know of anyone addressing the urine odors at this time. 3. Observations on 11/18/24 from 9:45 A.M. to 3:40 P.M., during the life safety code tour of the facility, showed the following: -The bathroom vent in room A3 had a heavy accumulation of dust; -The bathroom vent in room A4 had a heavy accumulation of dust; -The bathroom vent in room A7 had a heavy accumulation of dust; -An 8-inch by 8-inch vent in the B hall shower room had a moderate accumulation of dust; -The bathroom vent in room B8 had a heavy accumulation of dust; -The bathroom vent in room B12 had a moderate accumulation of dust; -The bathroom vent in room C5 had a moderate accumulation of dust; -The bathroom vent in room C8 had a heavy accumulation of dust; -The bathroom vent in room C12 had a heavy accumulation of dust; -The bathroom vent in room D1 had a heavy accumulation of dust; -The bathroom vent in room D2 had a moderate accumulation of dust; -The bathroom vent in room D5 had a heavy accumulation of dust; -The bathroom vent in room D8 had a moderate accumulation of dust; -The vent in the restroom near the staff time clock and locker area had a heavy accumulation of dust; -An 18-inch by 18-inch vent in the staff breakroom had a moderate accumulation of dust. During an interview on 11/20/24 at 12:38 P.M., the Maintenance Director said he deep cleaned the vents monthly and dusted them off weekly but hadn't had a chance to clean or dust them lately. The staff who cleaned resident rooms were also supposed to help with cleaning the vents but that didn't always happen. 47008

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Protect each resident from the wrongful use of the resident's belongings or money. 38016 Based on interview and record review, the facility failed to ensure resident money was free from misappropriation for ten residents (Resident #13, #25, #30, #31, #52, #67, #72, #85, #88 and #243) when Business Office Manager #1 removed and used resident funds in the amount of $6,117.21, for his/her personal use. The deficiency has the potential to affect any resident the facility managed funds for at the time of Business Office Manager #1's employment. The facility census was 87. Review of the facility policy Abuse and Neglect, dated 12/28/23, showed the following: -To outline procedures for reporting and investigating complaints of abuse, neglect and misuse of funds/property, and to define terms of types of abuse/neglect and misappropriation of funds and property. -To ensure immediate reporting all of abuse allegations to the Administrator of designee and the Director of Nursing or designee and outside persons or agencies. -To establish actions related to the alleged perpetrator and to ensure investigation and assessment of all residents involved is completed; -Misuse of funds/property: The misappropriation or conversion of a resident's funds or property for another person's benefit. This includes, but is not limited, to theft of money from bank accounts and theft of money from residents; -This Facility is committed to protecting our residents from abuse by anyone including, but not limited to; -Facility staff, other residents, consultants, volunteers, and staff from other agencies providing services to the individual, family members or legal guardians, friends, or any other individuals; -The Facility will identify and correct by providing interventions in which misappropriation of resident property is more likely to occur; -The Facility will identify events, patterns and trends that may constitute abuse and investigate thoroughly, notifying the Administrator and the proper authorities. Review of the facility self report sent on 11/08/24, showed the following: -It was reported to the administrator that the resident trust for the facility had funds that were not accounted for after an audit was conducted; -On 08/21/24, a check for $4,007.00 from the resident trust account was cashed and on 08/23/24 another check for $2,110.21 was cashed and allegedly distributed to residents; -No receipts were made available proving residents received these funds; (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Business Office Manager (BOM) #1 alleged that he/she gave out the funds but did not have residents sign receipts confirming that they were given the funds. -An investigation started and the following enacted: -BOM #1 was suspended pending investigation -Police Notified Report# 2024-22816 -Facility will reimburse funds and placed in residents' accounts. 1. Review of the facility reported investigation, showed a check by Business Office Manager (BOM) #1. Check #1269 was endorsed with Petty Cash Beloved. Check #1273 was endorsed by BOM #1. 2. The money was not accounted for in the resident trust account. When the facility interviewed BOM #1, he gave the facility a hand written accounting saying he gave the following residents the following amounts: -Resident #13, $27.00; -Resident #31, $20.00; -Resident #88, $30.00; -Resident #243, $50.00; -Resident #25, $50.00; -Resident #30, $600.00; -Resident #72, $50.00; -Resident #52, $3,000.00; -Resident #85, $50.00; -Resident #67, $30.00. 3. During an interview over the phone on 12/10/24, at 2:09 P.M., Resident #52 said BOM #1 never gave the resident $3,000.00. He/She had no money in the resident trust account. He/She has his/her own bank account and paid his/her own room and board and got his/her own cash if needed from his/her private bank account. He/She gives give the facility $3,000 for his/her room and board. 4. During a telephone interview on 12/10/24 at 2:12 P.M., Resident #13 said he/she did not remember receiving any cash in August 2024 from BOM #1. (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	5. During a telephone interview on 12/10/24 at 2:14 P.M., Resident #72 said he/she was not sure if he/she received $50 from BOM #1 in August 2024. 6. During a telephone interview on 12/10/24 at 2:15 P.M., Resident #85 said he/she did not receive $50 from BOM #1 in August 2024. He/She did not start getting his/her money until November 2024. 7. During a telephone interview on 12/10/24 at 2:18 P.M., Resident #31 said he/she was not sure if he/she received $27 from BOM #1 in August 2024. 8. During a telephone interview on 12/10/24 at 2:14 P.M., Resident #67 said he/she did not recall receiving $30 from BOM I in August 2024. 9. Review of BOM #2's written statement, dated 11/21/24, showed the following: -After closing the resident trust in November, this writer began auditing resident trust for the month of August due to amount of turnover during the month; -During auditing this writer found two checks that had no receipts to verify that funds were given to residents; -Reported finding to ADM #1; -ADM #1 and BOM #2 interviewed BOM #1. He/She said he/she was making corrections but was unable to explain the transaction; -BOM #1 told BOM #2 and ADM #1 that he gave the residents cash in an effort to balance the resident trust; -BOM #1 was unable to provide any documentation or receipts to corroborate his/her claim; -Resident #52 said BOM #1 never gave him/her any cash, and he/she did not have any funds in the resident trust account; -BOM #1 was terminated. 10. Review of the Administrator (ADM) #1's written statement, dated 11/21/24, showed the following: -It was reported by BOM #2 there was a discrepancy in the resident trust and that it appeared funds were given out but there were no receipts to back up or verify the transactions; -We they approached BOM #1 about these transactions, he/she could not give an explanation, but said the funds were given to the residents in an attempt to balance the resident trust; -ADM #1 and BOM #2 interviewed Resident #52 who said he/she did not receive $3000 from BOM #1; -BOM #1 was terminated. 11. During an interview on 11/25/24, at 5:40 P.M., BOM #2 said the following: (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-She has not been able to verify the resident's balances related to money missing found during her audit; -She does not know if the resident's balances are correct at this time; -When she started at the facility she discovered in August the balance in the resident trust dropped. Upon investigation she found two large checks with corrections in the memo. Upon her investigation and review there were no signed receipts where the residents received the funds; -The investigation for resident funds showed BOM #1 wrote checks for $4007 and a check for $2110.21 with corrections in the memo; -The $6117.21 amount was not accounted for, the facility was still in the process of auditing and was not sure if there was more money that is not accounted for or not, and do not know the exact resident balances; -BOM #1 was terminated, and the facility reported the findings to the state agency and law enforcement; -During BOM #2's investigation, BOM #1 hand wrote he had given some residents cash. BOM #1 said he gave one of those residents, Resident #52, $3000. When she interviewed Resident #52, he/she said he/she has never had money in the resident fund account, he/she has his/her own bank account; -Resident #52 told BOM #2, BOM #1 never gave the resident any money. During an interview on 11/21/24, at 10:45 A.M., ADM #1 said he terminated BOM #1 because he wrote checks from the resident trust account and BOM #1 could give no explanation where the funds were. MO245046 49528

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Develop and implement policies and procedures to prevent abuse, neglect, and theft. 49528 Based on interview and record review, the facility failed to review the Nurse Aide Registry for a Federal Indicator (which would disqualify an individual from working in the facility) for nine of ten newly hired employees reviewed. The facility census was 87. Review of the facility's policy, Abuse and Neglect, dated 12/28/23, showed the facility would not employ individuals who have been convicted of abusing, neglecting or mistreating individuals. Potential employees are screened for a history of abuse, neglect or mistreating a resident. 1. Review of the Maintenance Director's employee file showed the following: -Date of hire 01/05/24; -No documentation the facility completed a Nurse Aide Registry check. 2. Review of Certified Nurse Assistant (CNA) K's employee file showed the following: -Date of hire 10/23/24; -No documentation the facility completed a Nurse Aide Registry check. 3. Review of Certified Medication Technician (CMT) L's employee file showed the following: -Date of hire 11/6/24; -No documentation the facility completed a Nurse Aide Registry check. 4. Review of Registered Nurse (RN) M's employee file showed the following: -Date of hire 11/18/24; -No documentation the facility completed a Nurse Aide Registry check. 5. Review of Housekeeper N's employee file showed the following: Date of hire 10/23/24; -No documentation the facility completed a Nurse Aide Registry check. 6. Review of [NAME] O's employee file showed the following: -Date of hire 8/13/24; -No documentation the facility completed a Nurse Aide Registry check. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	7. Review of the Business Office Manager's employee file showed the following: -Date of hire 11/27/23; -No documentation the facility completed a Nurse Aide Registry check. 8. Review of the Housekeeping Supervisor's employee file showed the following: -Date of hire 10/16/24; -No documentation the facility completed a Nurse Aide Registry check. 9. Review of Laundry aide P's employee file showed the following: -Date of hire 10/8/24; -No documentation the facility completed a Nurse Aide Registry check. During an interview on 11/20/24 at 3:40 P.M., Human Resources R said the following: -All new hires are checked through the Family Care Safety Registry (FCSR). If not registered she would register them and get a highway patrol criminal background check, employee disqualification list (EDL), and Sam.gov; -For CNA's she will check for active licensure through a public perform search (Trainer Meet Up) (TMU) (a public website to check the status of CNA and CMT certifications); -For licensed nurses she will check for active licenses through Nursys. -He/She was unaware that all employees should be checked against the Nurse Aide Registry. During an interview on 11/25/24 at 6:00 P.M., the Director of Nursing said she was not aware of the process of new hire checks or the Nurse Aide Registry checks. During an interview on 11/25/24 at 6:15 P.M., administrator 1 said the Nurse Aide Registry check should be completed on all newly hired nurse aides (NA) or CNAs.

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F 0620 Level of Harm - Potential for minimal harm Residents Affected - Some	Not require residents to give up Medicare or Medicaid benefits, or pay privately as a condition of admission; and must tell residents what care they do not provide. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38016 47008 Based on interview and record review, the facility failed to review and provide an admission agreement to one resident's (Residents #241's), guardian upon the resident's admission to the facility, in a review of 20 sampled residents. The facility census was 87. Review of the undated facility admission packet showed the following: -Admission contract and authorization for treatment: The admission contract and authorization for treatment (contract) is made and entered into on this (date of admission) between (Resident) and the facility, a secured long term care facility with secured/locked unit for special needs residents; -Payment agreement sections to include: Private pay resident, Medicare resident, Medicaid resident, and third party payor; -Resident responsibilities; -Facility responsibilities; -Arbitration of disputes; -Agreements and acknowledgements included: Attachment A. Admission policy; Attachment B. Ancillary charges; Attachment C. Responsibility for payment; Attachment D. Facility rules and regulations; Attachment E. Disclosure and information form; Attachment F. Bed hold policy; Attachment G. Resident rights; Attachment H. Advance directives; Attachment I. Reporting changes that affect your social security payment; Attachment J. Applying for and using Medicare nd Medicaid; (continued on next page)

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F 0620 Level of Harm - Potential for minimal harm Residents Affected - Some	Attachment K. Authorization to hold resident's funds; Attachment L. Smoking policy; Attachment M. Resident grievance procedure; Attachment N. Assignment of medical benefits and authorization; Attachment O. Authorization for release of medical records; Attachment Q. Resident's resources disclosure; Attachment R. Assignment of physical therapy, occupational therapy, and speech therapy benefits and authorization for treatment/information release; Attachment S. Consent to waiver - Medicare Part A benefits; Attachment T. Consent to the use and disclosure of health information for treatment, payment, or healthcare operations; Attachment U. Code status; Attachment V. Revolving immunization consent form. 1. Review of Resident #241's face sheet showed the following: -The resident admitted to the facility on [DATE]; -The resident had a guardian. Review of an email sent by the Director of Nursing (DON), dated 12/04/24, showed the facility was unable to locate an admission contract for the resident. During an interview on 12/06/24 at 1:15 P.M., the resident's guardian said the following: -The resident admitted to the facility on [DATE]; -He/She did not believe he/she signed an admission agreement with the facility; -He/She could not find an admission agreement for the resident in his/her records. During an interview on 11/26/24 at 5:13 P.M., Administrator 1 said the following: -Normally admission personnel would explain the admission agreement, but he had not assigned the task to a specific staff member; -He would have been responsible for Resident #241's admission contract.

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F 0623 Level of Harm - Potential for minimal harm Residents Affected - Many	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38016 Based on interview and record review, the facility failed to provide a written notice of transfer to the resident and/or the resident's representative and failed to notify the State Ombudsman when three residents (Residents #242, #33 and #31), in a review of 20 sampled residents, and one additional resident (Resident #68) were transferred to the hospital. The facility census was 87. The facility did not provide a policy addressing written notification to the resident, the resident representative and the State Ombudsman when a resident was transferred to the hospital. 1. Review of Resident #68's face sheet showed the resident's family member was his/her responsible party. Review of the resident's Nurses Notes, dated 11/16/24, showed the following: -The resident complained of chest, neck and heel pain and wanted transferred to the hospital; -Physician notified of resident's pain; -Orders received to send the resident to the emergency room for evaluation via ambulance. Review of the resident's census sheet showed the resident was transferred to the hospital on 11/16/24 and was admitted . Review of the resident's medical record showed no evidence staff provided the resident's representative with a written notice of transfer when the resident was transferred to the hospital on 11/16/24. Review of the resident's census sheet showed the resident returned to the facility 11/22/24. 2. Review of Resident #242's face sheet showed the resident had a guardian. Review of the resident's Progress Note, dated 05/25/24 at 10:39 P.M., showed the following: -The resident said he/she tried to strangulate himself/herself but the string from the sweat pants broke; -He/She said he/she did not want to live anymore; -The resident's guardian was notified and permission was given to send the resident to the hospital for an evaluation; -The resident was transported to the hospital via facility transportation. (continued on next page)

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F 0623 Level of Harm - Potential for minimal harm Residents Affected - Many	Review of the resident's medical record showed no documentation facility staff provided the resident and/or the resident's representative a written notice of transfer when the resident was transferred to the hospital on 05/25/24. Review of the resident's Progress Note, dated 06/14/24 at 3:22 P.M., showed the resident returned to the facility by medicaid transport. Review of the resident's Progress Note, dated 07/13/24 at 11:36 P.M., showed the following: -The resident said he/she was tired of everything and he/she no longer wanted to be here or to be alive; -He/She said he/she would kill himself/herself if that was what it took to get out of here; -The resident's guardian was notified and permission was given to send the resident to the hospital for an evaluation; -The resident was transported to the hospital by ambulance. Review of the resident's medical record showed no documentation facility staff provided the resident and/or the resident's representative a written notice of transfer when the resident was transferred to the hospital on 07/13/24. Review of the resident's progress note, dated 07/14/24 at 6:01 P.M., showed the resident returned to the facility. Review of the resident's progress note, dated 10/08/24 at 8:00 P.M., showed the following: -The resident swallowed batteries; -The resident's guardian was notified and permission was given to send the resident to the hospital for an evaluation; -Emergency Medical Service (EMS) on the way. Review of the resident's medical record showed no documentation facility staff provided the resident and/or resident representative a written notice of transfer when the resident was transferred to the hospital on 10/08/24. Review of the resident's census sheet showed the resident returned to the facility on [DATE]. 3. Review of Resident #33's Face Sheet showed the resident had a guardian. Review of the resident's Progress Note, dated 05/02/24 at 4:11 P.M., showed staff approached the resident and told the resident that his/her guardian called and would like the resident to be sent to the emergency room (ER) for evaluation due to the resident calling his/her guardian and stating his/her suicidal ideation. (continued on next page)

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F 0623 Level of Harm - Potential for minimal harm Residents Affected - Many	Review of the resident's census sheet showed the resident was transferred out of the facility (to the hospital) on 05/02/24. Review of the resident's medical record showed no documentation facility staff provided the resident and/or the resident's representative a written notice of transfer when the resident was transferred to the hospital on 05/02/24. Review of the resident's progress notes, dated 05/14/24 at 8:23 A.M. showed the resident was readmitted into the facility. 4. Review of Resident #31's Face Sheet showed the resident had a guardian. Review of the resident's Progress Note, dated 03/17/24 at 7:07 P.M., showed the following: -At approximately 5:00 P.M., staff was called to the resident's hall; -The resident was on the floor and was diaphoretic (sweating) and had gasping respirations; -The resident's oxygen level was 52 percent on arrival. Oxygen was applied and was ineffective; -Staff called the ambulance to transport; -Staff called the resident's legal guardian and left a message with the answering service. Review of the resident's medical record showed no documentation facility staff provided the resident and/or the resident's representative a written notice of transfer when the resident was transferred to the hospital on 03/17/24. Review of the resident's Progress Notes, dated 03/18/24 at 4:26 P.M. showed the resident was returned from the hospital. Review of the resident's Progress Note, dated 07/16/24 at 3:08 P.M., showed the following: -The resident went to a physician appointment and became short of breath; -The physician's office notified the ambulance to transfer the resident to the hospital; -The resident was sent to the hospital for an evaluation; -A voicemail was left for the legal guardian. Review of the resident's medical record showed no documentation facility staff provided the resident and/or the resident's representative a written notice of transfer when the resident was transferred to the hospital on 07/16/24. Review of the resident's Progress Notes, dated 07/19/24 at 6:33 P.M. showed the resident returned to the facility from the hospital. (continued on next page)

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F 0623 Level of Harm - Potential for minimal harm Residents Affected - Many	Review of the resident's Progress Note, dated 07/26/24 at 10:39 A.M., showed the following: -The resident went sent to the hospital due to increased anxiety, shortness of breath and new onset hip pain; -The resident's guardian was contacted. Review of the resident's medical record showed no documentation facility staff provided the resident and/or the resident's representative a written notice of transfer when the resident was transferred to the hospital on 07/26/24. Review of the resident's Progress Notes, dated 07/29/24 at 5:38 P.M. showed the resident returned to the facility from the hospital. Review of the resident's Progress Note, dated 08/04/24 at 11:02 P.M., showed the following: -The resident went sent to the hospital by ambulance for shortness of breath, weakness and complaints of discomfort; -The resident was admitted to the hospital's step down unit for congestive heart failure (CHF) (chronic condition that occurs when the heart can't pump enough blood to meet the body's need) exacerbation (worsening) and bradycardia (low heart rate). Review of the resident's medical record showed no documentation facility staff provided the resident and/or the resident's representative a written notice of transfer when the resident was transferred to the hospital on 08/04/24. Review of the resident's census sheet showed the resident returned to the facility 9/26/24. 5. During an interview on 11/13/24 at 1:10 P.M., the State Ombudsman said the facility sent logs of residents who were transferred/discharged in February 2024 and March 2024. He/She had not received any other transfer/discharge logs from the facility. During an interview on 11/20/24 at 2:45 P.M. , the Director of Nursing (DON) said the following: -She could not find any documentation to show staff completed a written notice of transfer for Residents #242, #33, #31 and #68; -The Social Services Director (SSD) was responsible to send the notice of transfer to the resident or the guardian; -The SSD was responsible for notifying the State Ombudsman when a resident was transferred/discharged . (continued on next page)

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F 0623 Level of Harm - Potential for minimal harm Residents Affected - Many	During interviews on 11/25/24 at 3:35 P.M. and on 11/26/24 at 5:08 P.M., Administrator 1 said he could not find any notice of transfer/discharge documentation for the residents who had been transferred to the hospital. The SSD was responsible for sending the notice of transfer/discharge to the residents or the guardians. He expected the SSD to send the notice of transfer/discharge to the resident or his/her guardian when a resident was transferred to the hospital. He expected the SSD to send a monthly report of any residents transferred/discharged to the State Ombudsman. During an interview on 11/26/24 at 2:08 P.M., the SSD said she did not know she was responsible for sending any notice of transfer/discharge to the resident or guardian when a resident was transferred to the hospital. As far as she knew, there had been no notice of transfer/discharge sent to anyone. She had not sent any monthly report to the State Ombudsman listing the residents who had been transferred/discharged . 47008 49528

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F 0625 Level of Harm - Potential for minimal harm Residents Affected - Many	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. 38016 Based on interview and record review, the facility failed to provide a written notice of the bed hold policy with required information to the resident and/or resident representative at the time of transfer to the hospital for three residents (Residents #242, #33, and #31), in a review of 20 sampled residents, and one additional resident (Resident #68). The facility census was 87. A request for a facility Bed Hold Policy was made but the facility was unable to provide a policy. 1. Review of Resident #242's face sheet showed the resident had a guardian who was his/her responsible party. Review of the resident's progress note, dated 05/25/24 at 10:39 P.M., showed the following: -The resident stated he/she had tried to strangulate him/herself but the string broke from his/her sweat pants; -He/She stated he/she did not want to live anymore; -The resident's guardian was notified and permission was given to send the resident to the hospital for an evaluation; -The Director of Nursing (DON), and the primary care Nurse Practitioner (NP) was notified; -The resident was transported to the hospital via facility transportation. Review of the resident's medical record showed no documentation facility staff provided the resident and/or resident representative with a copy of the facility's bed hold policy/agreement when the resident transferred to the hospital on 05/25/24. Review of the resident's progress note, dated 06/14/24 at 3:22 P.M., showed the resident returned to the facility Review of the resident's progress note, dated 07/13/24 at 11:36 P.M., showed the following: -The resident said he/she was tired of everything and he/she no longer wanted to be here or to be alive; -He/She would kill him/herself if that is what it takes to get out of here; -The resident's guardian was notified and permission was given to send the resident to the hospital for an evaluation; -The psychiatric NP was notified and agreed to send him/her to the hospital for an evaluation; (continued on next page)

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F 0625 Level of Harm - Potential for minimal harm Residents Affected - Many	-The Director of Nurses (DON), and the primary care NP was notified; -The resident was transported to the hospital by ambulance. Review of the resident's medical record showed no documentation facility staff provided the resident and/or resident representative with a copy of the facility's bed hold policy/agreement when the resident transferred to the hospital on 07/13/24. Review of the resident's progress note, dated 07/14/24 at 6:01 P.M., showed the resident returned to the facility. Review of the resident's progress note, dated 10/08/24 at 8:00 P.M., showed the following: -The resident swallowed batteries; -The resident reported swallowing the AAA battery that was in his/her mouse for his/her computer; -The resident's guardian was notified and permission was given to send the resident to the hospital for an evaluation; -Police and Emergency Medical Service (EMS) on the way. Review of the resident's medical record showed no documentation facility staff provided the resident and/or resident representative with a copy of the facility's bed hold policy/agreement when the resident was transferred to the hospital on 10/08/24. Review of the resident's census sheet showed the resident returned to the facility 10/09/24. 2. Review of Resident #33's face sheet showed the resident had a guardian who was his/her responsible party. Review of the resident's progress note, dated 05/02/24 at 4:11 P.M., showed the following: -The resident was approached by staff stating the guardian called and would like the resident sent to the emergency room (ER) for evaluation due to the resident calling his/her guardian and reporting suicidal ideation; -The psychiatric NP was notified; -Administration was notified. Review of the resident's census sheet showed the resident transferred out of the facility on 05/02/24. Review of the resident's medical record showed no documentation facility staff provided the resident and/or resident representative with a copy of the facility's bed hold policy/agreement when the resident was transferred to the hospital on 05/02/24. (continued on next page)

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F 0625 Level of Harm - Potential for minimal harm Residents Affected - Many	Review of the resident's progress notes, dated 05/14/24 at 8:23 A.M. showed the resident was readmitted (returned from the hospital) into the facility. 3. Review of Resident #31's face sheet showed the resident had a guardian who was his/her responsible party. Review of the resident's progress note, dated 03/17/24 at 7:07 P.M., showed the following: -At approximately 5:00 P.M. called to the resident's hall; -The resident was on the floor and was diaphoretic (sweating) and had gasping respirations; -Ambulance was called to transport; -Resident's legal guardian called and a message left with the answering service; -Report called to the hospital and administrator. Review of the resident's medical record showed no documentation facility staff provided the resident and/or resident representative with a copy of the facility's bed hold policy/agreement when the resident transferred to the hospital on 03/17/24. Review of the resident's progress notes, dated 03/18/24 at 4:26 P.M. showed the resident returned from the hospital. Review of the resident's progress note, dated 07/16/24 at 3:08 P.M., showed the following: -The resident went to a physician appointment and became short of breath; -The physician's office notified the ambulance to transfer the resident to the hospital; -The resident was sent to the hospital for an evaluation; -A voicemail was left for the legal guardian. Review of the resident's medical record showed no documentation facility staff provided the resident and/or resident representative with a copy of the facility's bed hold policy/agreement when the resident transferred to the hospital on 07/16/24. Review of the resident's progress notes, dated 07/19/24 at 6:33 P.M. showed the resident returned from the hospital. Review of the resident's progress note, dated 07/26/24 at 10:39 A.M., showed the following: -The resident went to the hospital due to increased anxiety, shortness of breath and new onset hip pain; -Guardian contacted; (continued on next page)

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F 0625 Level of Harm - Potential for minimal harm Residents Affected - Many	-Primary care physician notified. Review of the resident's medical record showed no documentation facility staff provided the resident and/or resident representative with a copy of the facility's bed hold policy/agreement when the resident transferred to the hospital on 07/26/24. Review of the resident's progress notes, dated 07/29/24 at 5:38 P.M. showed the resident returned from the hospital by facility transportation. Review of the resident's progress note, dated 08/04/24 at 11:02 P.M., showed the following: -The resident went to the hospital by ambulance for shortness of breath, weakness and complaints of discomfort; -The resident was admitted to the hospital's step down unit for congestive heart failure (CHF) (chronic condition that occurs when the heart can't pump enough blood to meet the body's need) exacerbation (worsening) and bradycardia (low heart rate) Review of the resident's medical record showed no documentation facility staff provided the resident and/or resident representative with a copy of the facility's bed hold policy/agreement when the resident was transferred to the hospital on 08/04/24. Review of the resident's census sheet showed the resident returned to the facility 09/26/24. 4. Review of Resident #68's face sheet showed the resident's family member was his/her responsible party. Review of the resident's Nurses Notes, dated 11/16/24, showed the following: -The resident complained of chest, neck and heel pain and wanted to be transferred to the hospital; -Physician notified of resident's pain; -Orders received to send the resident to the emergency room for evaluation via ambulance. Review of the resident's census sheet showed the resident was transferred to the hospital on 11/16/24 and was admitted . Review of the resident's medical record showed no documentation the facility notified the resident's guardian of the facility's bed hold policy in writing upon the resident's transfer to the hospital on 11/16/24. Review of the resident's census sheet showed the resident returned to the facility 11/22/24. (continued on next page)

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F 0625 Level of Harm - Potential for minimal harm Residents Affected - Many	During a telephone interview on 11/26/24 at 2:08 P.M., the Social Services Director (SSD) said she did not know she was responsible for sending bed hold notices to the resident or guardian when a resident was transferred to the hospital. As far as she knew, there had been no bed hold notice sent to anyone. During an interview on 11/20/24 at 2:45 P.M. , the Director of Nurses (DON) said the following: -She could not find any documentation for the bed hold policy; -The SSD had been responsible for sending the bed hold notice to the resident and guardian; -She did not know why the tasks were not being completed by SSD. During an interview on 11/25/24 at 3:35 P.M. and 11/26/24 at 5:08 P.M., Administrator 1 said he could not find any notice of bed hold documentation for the residents who had been transferred to the hospital. The SSD was responsible for sending the bed hold notice to the resident or guardian. He would expect the bed hold notice to be sent to the resident or guardian upon transfer to the hospital. 47008 49528

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32899 Based on record review and interview, the facility failed to complete a comprehensive Minimum Data Set (MDS), a federally mandated assessment instrument, in the time frame required by Centers for Medicare and Medicaid (CMS) for two residents (Residents #4, and #241), in a sample of 20 residents, and for one additional resident (Resident #243). The facility census was 87. Review of the Resident Assessment Instrument (RAI) manual, revised October 2024, showed the following: -The Annual assessment is a comprehensive assessment for a resident that must be completed on an annual basis (at least every 366 days) unless an significant change in status assessment (SCSA) has been completed since the most recent comprehensive assessment was completed. -The assessment reference date (ARD) must be set within 366 days after the ARD of the previous Omnibus Budget Reconciliation Act (OBRA) comprehensive assessment (ARD of previous comprehensive assessment + 366 calendar days) and within 92 days since the ARD of the previous OBRA Quarterly assessment (ARD of previous OBRA Quarterly assessment + 92 calendar days). -The MDS completion date (item Z0500B) must be no later than 14 days after the ARD (ARD + 14 calendar days). -For the Admission assessment, the MDS Completion Date (Z0500B) must be no later than 13 days after the Entry Date (A1600). -Assessment Transmission: Comprehensive assessments must be transmitted electronically within 14 days of the Care Plan Completion Date (V0200C2 + 14 days). (By day 35) 1. Review of Resident #4's face sheet showed the resident was admitted to the facility on [DATE]. Review of the resident's admission Minimum Data Set, dated dated [DATE], showed the assessment was completed and submitted to Centers for Medicare Services (CMS). Review of the resident's quarterly MDS, dated [DATE], showed it was completed and submitted to CMS. Review of the resident's quarterly MDS, dated [DATE], showed it was completed and submitted to CMS. Review of the resident's quarterly MDS, dated [DATE], showed it was completed and submitted to CMS. Review of the resident's quarterly MDS, dated [DATE], showed it was completed and submitted to CMS. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the resident's quarterly MDS, dated [DATE], showed it was completed and submitted to CMS. Review of the resident's quarterly MDS, dated [DATE], showed it was completed and submitted to CMS. Review showed no evidence staff completed a comprehensive assessment since his/her admission assessment dated [DATE]. 2. Review of Resident #241's face sheet showed the resident was admitted to the facility on [DATE]. Review of the CMS data base showed the resident's entry MDS, dated [DATE], was completed and submitted. Review of the resident's electronic medical record, MDS section, showed an admission assessment was opened on 11/21/24, but it was not completed or submitted. (The admission assessment was due to be completed on 10/31/24.) Review of the CMS database on 11/25/24, showed the resident's admission assessment had not been completed or submitted as required. 3. Review of Resident #243's face sheet showed the resident was admitted to the facility on [DATE]. Review of the resident's admission MDS, dated [DATE], showed only Section A Identification Information was completed. The remaining sections of the assessment were not completed. Review showed no evidence staff completed a comprehensive assessment for the resident. 4. During an interview on 11/26/24, at 3:28 P.M., the Director of Nursing said she expected the MDS Coordinator to complete MDS assessments within the required timeframes as directed by the RAI manual. 38016 49528

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident when there is a significant change in condition **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38016 Based on observation, interview and record review, the facility failed to complete a significant change status assessment (SCSA) Minimum Data Set (MDS), a federally mandated assessment, required to be completed by facility staff, for two residents (Residents #36 and #80), in a review of 20 sampled residents. This assessment should have been completed within 14 days after the facility determined, or should have determined, there had been a significant change (major decline or improvement in the resident's status) in the resident's physical or mental condition which had an impact on more than one area of the resident's health status and required interdisciplinary review and/or revision of the care plan. The facility census was 87. Review of the Long Term Care Facility RAI User's Manual, version 3.0 showed a significant change is a decline or improvement in a resident's status that: -Will not normally resolve itself without intervention by staff or by implementing standard disease-related clinical interventions, is not self-limiting; -Impacts more than one area of the resident's health status; -Requires interdisciplinary review and/or revision the care plan. -Significant Change in Status Assessment (SCSA) was appropriate if there was a consistent pattern of changes, with either two or more areas of decline, or two or more areas of improvement. This may include two changes within a particular domain (e.g., two areas of Activity of daily living (ADL) decline or improvement). -An SCSA is required to be performed when a terminally ill resident enrolls in a hospice program (Medicare-certified or State-licensed hospice provider) or changes hospice providers and remains a resident at the nursing home. The ARD must be within 14 days from the effective date of the hospice election (which can be the same or later than the date of the hospice election statement, but not earlier than). An SCSA must be performed regardless of whether an assessment was recently conducted on the resident. This is to ensure a coordinated plan of care between the hospice and nursing home is in place. A Medicare-certified hospice must conduct an assessment at the initiation of its services. This is an appropriate time for the nursing home to evaluate the MDS information to determine if it reflects the current condition of the resident, since the nursing home remains responsible for providing necessary care and services to assist the resident in achieving their highest practicable well-being at whatever stage of the disease process the resident is experiencing. 1. Review of Resident #36's annual MDS, a federally mandated assessment completed by staff, dated 7/26/24, showed the following: -Cognitively intact; (continued on next page)

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Diagnosis include depression, deep vein thrombosis (blood clot), neurogenic bladder (a condition that causes bladder control issues due to damage to the nervous system) , obstructive uropathy (condition that occurs when urine is blocked from draining normally through the urinary tract), depression, chronic obstructive pulmonary disease (COPD); -Regular diet; -Requires partial assistance from staff for eating and upperbody dressing. Review of the resident's quarterly MDS, dated [DATE], showed the following: -Moderate cognitive impairment; -Dependent on staff for eating and upper body dressing; -New mechanically altered diet. Review of the resident's electronic medical record showed it did not include a significant change in status assessment after the resident had several changes including decline in cognition, ability to partially feed himself/herself, and a new mechanically altered diet. Observation on 11/25/24, at 6:05 P.M.-6:25 P.M., showed the following: -The resident sat in a geri-chair at the dining room table; -The resident's divided plate rested on the resident's stomach. The resident attempted to hold the divided plate with one hand and attempted to feed himself/herself with the other hand. The resident's hands were shaking. The resident's silverware was wrapped on the table out of the resident's reach. -The resident received a mechanical soft diet which consisted of ground meat, hash browns, and a chocolate chip cake; -The resident attempted to scoop food with his/her hands, but his/her hands were shaking. The resident had small particles of food all over his/her face, stomach, and down the sides of his/her chair; -The resident attempted to feed himself/herself but was only able to get very little food to his/her mouth. 2. Review of Resident #'80's admission Minimum Data Set (MDS), a federally required assessment completed by staff, dated 03/09/24, showed the following: -Severe cognitive impairment; -Diagnosis: Stroke, deep vein thrombosis (DVT) (blood clot), pneumonia, aphagia (inability to speak), malnutrition, depression, post traumatic stress disorder (PTSD); -No pain medication scheduled or as needed; (continued on next page)

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Resident unable to complete the pain interview, and the staff assessment of pain is not completed; -99 pounds (lbs.); -Pocketing, and loss of fluids/food -Tube feeding is 50% or more of nutrition intake; -Mechanically altered diet; -Edentulous; -Unstageable wound. Review of the resident's quarterly MDS, dated [DATE] , showed the following: -Scheduled pain medication; -106 lbs. (significant weight gain); -No unhealed wounds coded. Review of the resident's quarterly MDS, dated [DATE] , showed the following: -115 lbs. (significant weight gain 14% weight gain in 180 days) -New antipsychotic (medication for hallucinations and delusions) medication and anticoagulant (blood thinner) medication administered routinely. Review of the resident's MDS's showed a significant weight gain, healed wounds, and new scheduled pain medication and review of the resident's medical record did not include a significant change in condition assessment for the resident. During an interview on 11/26/24, at 3:28 P.M., the Director of Nursing said she expected the MDS Coordinator to complete significant change in condition (SCSA) MDS's as directed by the RAI manual.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38016 Based on interview and record review, the facility failed to accurately code the Minimum Data Set (MDS), a federally mandated assessment completed by staff, according to the Resident Assessment Instrument (RAI) manual for four sampled residents (Residents #30, #80, #19 and #65), in a review of 20 sampled residents. The facility census was 87. Review of the Resident Assessment Instrument (RAI) Manual, dated October 2023, showed the following: -Medicare and Medicaid participating long-term care facilities are required to conduct comprehensive, accurate, standardized and reproducible assessments of each resident's functional capacity and health status. -The RAI process has multiple regulatory requirements. Federal regulations require that (1) the assessment accurately reflects the resident's status (2) a registered nurse conducts or coordinates each assessment with the appropriate participation of health professionals (3) the assessment process includes direct observation, as well as communication with the resident and direct care staff on all shifts; -It is important to note here that information obtained should cover the same observation period as specified by the MDS items on the assessment, and should be validated for accuracy (what the resident's actual status was during that observation period) by the IDT completing the assessment. As such, nursing homes are responsible for ensuring that all participants in the assessment process have the requisite knowledge to complete an accurate assessment. -Physical Restraints: Any manual method or physical or mechanical device, material or equipment attached or adjacent to the resident's body that the individual cannot remove easily, which restricts freedom of movement or normal access to one's body (State Operations Manual, Appendix PP); -Bed rails include any combination of partial or full rails (e.g., one-side half-rail, one-side full rail, two-sided half-rails or quarter-rails, rails along the side of the bed that block three-quarters to the whole length of the mattress from top to bottom, etc.). -Bed rails used with residents who are immobile. If the resident is immobile and cannot voluntarily get out of bed because of a physical limitation or because proper assistive devices were not present, the bed rails do not meet the definition. 1. Review of Resident #30's annual Minimum Data Set (MDS), a federally required assessment instrument completed by staff, dated 06/01/24, showed the following: -Cognition section, interview not completed because the resident was rarely understood or understands; -Staff assessment of cognitive section documented the resident was independent with decision making and consistent/reasonable; (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Section A communication section documented the resident was always understood and always understands; -Section D marked interview should not be completed because the resident was rarely understood or understands; -The resident's MDS showed inconsistencies and failed to include required interviews with the resident. Review of the resident's quarterly MDS, dated [DATE], showed the following: -Cognition section, interview not completed because the resident was rarely understood or understands; -Staff assessment of cognitive section documented the resident was independent with decision making and consistent/reasonable. -Section A communication section documented the resident was always understood and always understands; -Section D marked interview should not be completed because the resident was rarely understood or understands; -The resident's MDS showed inconsistencies and failed to include required interviews with the resident. During an interview on 11/18/24 at 1:14 P.M., the resident was able to have a conversation about his/her preferences and spoke to the surveyor staff easily about recent and appropriate topics. The resident easily completed an interview. 2. Review of Resident #80's medical record showed a Preadmission Screening and Resident Review (PASARR - an assessment completed on resident's with mental illness to ensure needs are met by the facility), dated 12/05/23. Review of the medical record showed the document was scanned into the resident electronic medical record with his/her admission paperwork and labeled appropriately. Review of the resident's face sheet showed the resident admitted to the facility on [DATE]. Review of the resident's entry MDS, showed the resident admitted to the facility on [DATE]. Review of the resident's discharge return anticipated MDS, dated [DATE], showed the resident transferred to the hospital. Review of the resident's entry MDS, showed the resident admitted to the facility on [DATE]. Review of the resident's admission MDS, dated [DATE], showed the following -Severe cognitive impairment; (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Diagnoses included stroke, deep vein thrombosis (blood clot), pneumonia, aphagia (inability to speak), malnutrition, depression and post traumatic stress disorder (PTSD); -Inattention; -No PASARR. Review of the resident's admission MDS, dated [DATE], showed the following: -Severe cognitive impairment; -Diagnoses of stroke, deep vein thrombosis, pneumonia, aphagia, malnutrition, depression and PTSD; -Inattention; -No PASARR. Review of the resident's admission MDS, dated [DATE], showed the following: -Severe cognitive impairment; -Diagnoses of stroke, deep vein thrombosis, pneumonia, aphagia, malnutrition, depression and PTSD; -Inattention; -No PASARR. Review of the resident's medical record showed no documentation of the resident being sent out to the hospital or need for a re-admission between 02/02/24 and 03/09/24. (The resident did not require an admission assessment on 02/12/24 or 03/09/24 and a PASARR had been completed). 3. Review of Resident #19's annual MDS, dated [DATE], showed the following: -Severe cognitive impairment; -Diagnoses included hemiplegia (paralysis on one side of the body), total brain injury (TBI), seizure disorder, aphasia (inability to speak effectively); -Rarely/Never understood or understands; -No behaviors or rejection of care; -Limited functional range of motion in one upper and one lower extremity; -Uses wheelchair; -Requires substantial/maximal assistance from staff to roll left and right, sit to lying and lying to sitting on side of bed; (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Dependent on staff for oral hygiene, toileting hygiene, shower/bathe, upper body dressing, lower body dressing, putting on/taking off footwear, personal hygiene, sit to stand, chair/bed-to-chair transfer and tub/shower transfer; -Bedrail coded as restraint. Observation on 11/19/24 at 12:25 P.M., showed the resident in his/her wheelchair, the resident was not able to move his/her right side and sat on a mechanical lift pad. The resident was not able to make significant body changes. Observation on 11/25/24 at 10:45 A.M., showed the following: -The resident was in bed; -The resident had 1/2 padded side rails on both upper sides of his/her bed in the upright position. During an interview on 11/25/24 at 10:55 A.M., Licensed Practical Nurse (LPN) B said the following: -The resident was unable to make significant position changes on his/her own; -Staff use a mechanical lift to transfer the resident; -The resident's bed rail was not considered a restraint because it did not prevent the resident from doing anything. The resident was marked as having a restraint, and the resident was not restrained. 4. Review of Resident #65's undated face sheet showed the following: -admitted on [DATE]; -His/Her diagnoses included Parkinson's disease (a disorder of the central nervous system that affects movement, often including tremors). Review of the resident's admission orders dated 09/01/22 showed the resident had diagnoses of Covid 19, weakness, falls, depression, tremor and nicotine dependence. Review of the resident's May 2023 Physician Order Sheets (POS), showed the resident had diagnoses that included atherosclerotic heart disease coronary artery disease (CAD) (coronary arteries struggle to supply the heart with blood due to plaque buildup, narrowing the arteries). Review of the resident's quarterly MDS, dated [DATE], showed the resident had diagnoses that included CAD, hip fracture, depression and respiratory failure. The resident's MDS did not accurately reflect the resident's diagnoses as it did not include the diagnosis of Parkinson's Disease. Review of the resident's June 2024 physician order sheets (POS) showed no order for antipsychotic medication. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the resident's June 2024 medication administration record (MAR) showed no documentation staff administered antipsychotic medication to the resident. Review of the resident's physician's annual wellness progress note, dated 06/05/24 showed no documentation of the resident taking an antipsychotic medication. Review of the resident's quarterly MDS, dated [DATE], showed the following: -Diagnoses included CAD, hip fracture, depression and respiratory failure; the resident's MDS did not accurately reflect the resident's diagnoses as it did not include Parkinson's Disease; -Antipsychotic medication review under section N medications was marked that antipsychotics were received on a routine basis; the resident's MDS did not accurately reflect the resident's medication use as the resident did not receive antipsychotics. Review of the resident's September 2024 POS showed no order for antipsychotic medication. Review of the resident's September 2024 MAR showed no documentation staff administered antipsychotic medication to the resident. Review of the resident's physician's progress note, dated 09/03/24 showed no documentation of the resident taking an antipsychotic medication. Review of the resident's annual MDS, dated [DATE] showed the following: -Diagnoses included CAD, hip fracture, depression, respiratory failure and gastroesophageal reflux disease (GERD) (digestive disease in which stomach acid or bile irritates the food pipe lining); no diagnoses of Parkinson's disease; the resident's annual MDS did not accurately reflect the resident's diagnoses; -Antipsychotic medication review under section N medications, was marked that antipsychotics were received on a routine basis; the resident's MDS did not accurately reflect the resident's medication use as the resident did not receive antipsychotics. During an interview on 12/09/24 at 8:15 A.M., the MDS coordinator, said the following: -She obtained diagnoses from the electronic medical record-medical diagnosis section, physicians history and physical, or hospital records; -She was unaware the diagnoses for Resident # 65 were not always correct; -Section N antipsychotic medication review information was obtained from the physicians orders for Resident #65; -She was unable to provide an explanation why the antipsychotic medication review was not correct on the MDS for Resident #65. During an interview on 11/26/24 at 3:58 P.M., the Director of Nursing (DON), said the following: (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-The MDS coordinator completes the assessments offsite; the assessment process does not include direct observation of the resident by the MDS Coordinator; -She expected the MDS's to be coded accurately according to the RAI manual. 47008 49528

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32899 Based on observation, interview, and record review, the facility failed to develop and implement a comprehensive care plan for three residents (Resident #241, #7, and #80), in a review of 20 sampled residents. The facility census was 87. During an interview the Director of Nurses (DON) said the facility did not have a policy for completing care plans. Review of the Resident Assessment Instrument (RAI) manual, dated [DATE], showed the following: -The admission Minimum Data Set (MDS) must be completed by the 14th day after admission, admission day being day one; -The comprehensive care plan must be completed no later than seven days after the completing of the admission MDS; -The overall care plan should be oriented towards: -Assisting the resident in achieving his/her goals, goals should be measurable. -Individualized interventions that honor the resident's preferences. -Addressing ways to try to preserve and build upon resident strengths. -Preventing avoidable declines in functioning or functional levels or otherwise clarifying why another goal takes precedence. -Managing risk factors to the extent possible or indicating the limits of such interventions. -Applying current standards of practice in the care planning process. -Evaluating treatment of measurable objectives, timetables and outcomes of care. 8. Respecting the resident's right to decline treatment. -Offering alternative treatments, as applicable. -Using an interdisciplinary approach to care plan development to improve the resident's abilities. -Involving the resident, resident's family and other resident representatives as appropriate. -Assessing and planning for care to meet the resident's goals, preferences, and medical, nursing, mental and psychosocial needs. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Involving direct care staff with the care planning process relating to the resident's preferences, needs, and expected outcomes. 1. Review of Resident #241's Pre-Admission Screening/Resident Review (PASARR) (a comprehensive evaluation by the appropriate state-designated authority that determines whether the individual has mental (MD), intellectual disability (ID), or a related condition, determines the appropriate setting for the individual, and recommends any specialized services and/or rehabilitative services the individual needs) Level II Evaluation, dated [DATE], showed the following: -The resident needed or continued to need the following supports and services: -Behaviors needed to be address in the nursing facility's plan of care included attention seeking behaviors, suicidal ideations, wandering, hallucinations, delusions, abnormal thought processes, suspiciousness and paranoia. -Assess and plan for the level of supervision required to prevent harm to self or others. Review of the resident's Face Sheet showed he/she admitted to the facility on [DATE]. Review of the resident's Care Plan, dated [DATE], showed the following: -The resident had a behavior problem; -He/She would remain free from serious injury to self or others now and through the next review; -Interventions included: black box warning for medication, education on medication, and activities that interest and accommodates the resident's status; (Review showed the care plan did not include interventions to prevent harm to self or others. The care plan did not include attention seeking behaviors, suicidal ideations, wandering, hallucinations, delusions, abnormal thought processes, suspiciousness and paranoia as directed on his/her PASARR screening dated [DATE].) Review of the resident's admission Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated [DATE], showed the following: -The resident was cognitively intact; -No behaviors directed towards self or others; -The resident had a diagnosis of depression and schizophrenia. Review of the resident's progress notes, dated [DATE] at 7:53 A.M., showed the following: -The resident attempted to leave the unit; -The resident was educated and redirected; (continued on next page)

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	265462	A. Building B. Wing	11/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Beloved Health and Rehabilitation Center	328 Munger Lane Hannibal, MO 63401

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-When staff tried to redirect the resident, he/she said he/she had wanted to self harm, but he/she had no plan; -The resident was placed on one-on-one staff supervision. Review of the resident's care plan showed no documentation staff updated the care plan to identify the resident made threats of self-harm and updated the care plan with interventions to address these threats. Review of the resident's progress notes, dated [DATE] at 4:39 P.M., showed the following: -The resident exhibited increased physical aggression towards facility property and had made threats toward staff; -The staff had difficulty redirecting the resident; -The guardian gave permission for medication administration and for the resident to be sent to the hospital if needed; -The resident was given a medication and placed on one-on-one. Review of the resident's care plan showed no documentation staff updated the care plan to identify the resident had physical aggression and updated the care plan with interventions to address this behavior. Review of the resident's progress notes, dated [DATE] at 10:45 P.M., showed the following: -The resident said he/she felt suicidal related to having a bad day thing about his/her deceased family member; -The resident was placed on one-on-one with a staff member; -The resident was refusing to take any medication to help him/her calm down; -The resident's guardian was notified and he/she said the resident had an obsession with going to a hospital for no reason, and he/she would rather the resident to be given medication and to stay at the facility under staff supervision. Review of the resident's care plan showed no documentation staff updated the care plan to identify the resident had suicidal thoughts and had an obsession with going to the hospital for no reason. Review showed no documentation the facility updated the care plan with interventions to address these behaviors. Observation on [DATE] at 2:40 P.M. showed the resident was in his/her room. Hall Monitor V provided one-on-one monitoring of the resident. During an interview on [DATE] at 2:40 P.M., the resident said he/she was on one-on-one because he/she reported to staff he/she wanted to commit suicide and he/she had a plan. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the resident's progress notes, dated [DATE] at 11:15 P.M., showed the following: -The resident voiced concerns of suicidal ideations during medication administration; -The resident was placed on one-on-one in the line of sight with hall staff for remainder of medication pass on the hall. -The resident threw his/her headphones and hit the wall with his/her fist. Review of the resident's progress notes, dated [DATE] at 11:17 P.M., showed the following: -The resident said he/she had a plan to cut himself/herself with a fork in the room he/she had saved; -The staff removed the fork from his/her room; -The psychiatrist on call ordered a psychiatric evaluation and an evaluation of the resident's hand from hitting the wall; -The guardian was notified and had expressed concerns of this being residents normal behavior; -Emergency medical services was contacted to take the resident to the hospital. Review of the resident's care plan showed no documentation staff updated the care plan to identify the resident had physical aggression and had suicidal ideations with a plan. The care plan did not include interventions to address these behaviors. During an interview on [DATE] at 1:15 P.M., the resident's guardian said the following: -The resident had a history of going to the hospital for suicidal ideation and attention seeking behaviors; -The resident had a history of suicidal ideations with a plan. 2. Review of Resident #7's face sheet showed the resident was admitted to the facility on [DATE]. Review of the resident's Physician Orders Sheet (POS), dated [DATE], showed the following: -Regular diet with pureed texture and regular liquid; -Diagnoses included dementia, Parkinson's disease (disorder affecting movement), dysphagia (difficulty swallowing), and muscle weakness. Review of the resident's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument to be completed by the facility, dated [DATE], showed the following: -Partial to moderate assist for bed mobility; (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Dependent on staff for transfers; -Used a manual wheelchair; -Supervision to touch assist of one to two for dressing; -Dependent of staff for toilet use; -Substantial to maximum assist for personal hygiene; -Partial to moderate assist with oral hygiene; -Mechanically altered diet. -Set up or clean up only for eating; -Always incontinent of bladder and bowel; Review of the resident's care plan, last revised on [DATE], showed the following: -The resident had an activities of daily living (ADLs) self care performance deficit; -The resident's care plan did not address the type of assistance the resident needed to perform transfers, bathing, toileting, incontinence care, eating, bathing, dressing, mobility and oral hygiene. Observation on [DATE] at 1:53 P.M. showed the following: -Certified Nurse Assistant (CNA) I and Nurse Assistant (NA) E pushed the resident in /his/her wheelchair to his/her room to perform cares; -CNA I applied a gait belt and transferred the resident to the bed. NA E assisted by moving the resident's legs onto the bed; -CNA I assisted the resident to roll to his/her side, removing the resident's pants, and urine soiled incontinence brief and then performed incontinence care on the resident. During an interview on [DATE] at 1:50 P.M., CNA I said the resident required assistance from one to two staff for transfers, bed mobility, perineal care and personal hygiene. 3. Review of Resident #'80's admission Minimum Data Set (MDS), a federally required assessment completed by staff, dated [DATE], showed the following: -Severe cognitive impairment; -Diagnosis include a stroke, blood clot, post traumatic stress disorder (PTSD); -Signs of minimal depression; (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Unclear speech rarely/never understood; -Sometimes understands; -Functional range of motion limitations in both upper and both lower extremities; -Dependent all activities of daily living (ADLs); -Uses a wheelchair; -Always incontinent; -weight of 99 pounds; -No restorative nursing; -Scheduled pain regimen, unable to do pain interview, staff assessment not completed. Review of the resident's Care Plan, dated [DATE], did not include pain, PTSD, communication needs, or the resident's contractures which caused the functional range of motion limitations. Review of the resident's quarterly MDS, dated [DATE], showed the resident had scheduled pain medication, PTSD, communication issues, and limitations with functional range of motion in all extremities. Review of the resident's quarterly MDS, dated [DATE] ,showed the resident had scheduled pain medication, PTSD, communication issues and limitations with functional range of motion in all extremities. Review of the resident's Care Plan, last updated [DATE], did not include pain, PTSD, communication, and limitations with functional range of motion in all extremities. Review of the resident's Physician's Orders, dated [DATE], showed the following: -Tramadol (narcotic pain medication) 20 mg two times daily for pain; -Ropinirole 0.25 mg two times a day for restless leg syndrome; -Acetaminophen (pain reliever) 500 mg, give two tablets every six hours as needed for pain. Observation on [DATE], at 08:45 A.M., showed the following: -CNA R and NA E provided care to the resident; -The resident had severe contractures of the right arm and leg; -The resident's body was not aligned, his/her back was curved, with the right leg and right arm drawn up; (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-When CNA R and NA E rolled the resident side to side the resident's body did not relax and it stayed in a drawn up/flexed position; -The resident grimaced, moaned in pain, and guarded his/her right leg grabbing his/her right leg with his/her left hand every time the staff moved him/her, and moved his/her arms to stop staff from turning him/her in a guarding motion. During an interview on [DATE], at 8:55 A.M., CNA R said the resident was in pain because of his/her contractures. Once he/she was in a certain position he/she did not complain, but it hurt the resident every time they moved him/her. He/She was not sure what pain medication the resident was getting. The resident has had trauma and you have to speak to him/her slowly and reassure him/her as you provide care or he/she will refuse care. There are certain things that make the resident upset, like if you touch his/her feet without warning him/her, or move him/her without explanation. The resident could understand and answer questions by nodding. You just have to know how the resident communicated to be able to take care of him/her. During an interview on [DATE], at 11:25 P.M., Certified Medication Technician (CMT) D said the following: -The resident had Tramadol for pain; -If residents have pain there should be information for that resident's pain on the resident's care plan; -The resident has bad contractures that caused him/her pain when staff moved him/her. During an interview on [DATE], at 10:55 A.M., Licensed Practical Nurse (LPN) B said the following: -Staff are expected to reposition and try to make resident's experiencing pain comfortable; -Staff are expected to ask the resident about pain every shift; -The CMTs ask residents about pain and report pain to the nurse; -Staff should attempt non medication and medication interventions for resident's experiencing pain; -If pain was not controlled staff after interventions are exhausted, staff are expected to notify the resident's physician -CNR R was good at communicating with the resident. He/She knew what the resident was trying to communicate. Review of the resident's Care Plan did not include information on how to effectively manage the resident's pain, how to communicate with the resident, treat his/her contractures, or the resident's triggers related to his/her PTSD. During an interview on [DATE] at 3:58 P.M., the DON said the following: (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-A comprehensive care plan should be completed upon admission; -Care plans should be updated quarterly and as needed with incidents or changes; -The nurses and the Assistant Director of Nurses were responsible for updating care plans. 38016

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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. 16760 Based on interview and record review, the facility failed to follow a physician's order to decrease a psychotropic medication for one resident (Resident #73), in a review of 20 sampled residents. The census was 87. Review of Resident #73's care plan, last revised 10/4/24, showed the following: -Diagnoses included anxiety, bipolar disorder (high to low mood swings), depression and schizophrenia (disability to think, feel and behave clearly); -The resident had history of verbal aggression, rejection of medication, rejection of care, disruptive behaviors, delusional behaviors and aggressive behaviors and altercations with peers; -Administer medications as ordered. Review of the resident's Physician Order Sheet (POS), dated 11/2024 showed an order for diazepam 10 mg one tablet by mouth three times daily (original order dated 7/24/24). Review of the pharmacist consultation report, dated 10/23/24, showed on 11/17/24, the physician agreed with and signed the recommendation to decrease the resident's bedtime dose of 10 mg diazepam to 5 mg. Review of the resident's Physician's Orders, dated November 2024, showed no documentation staff updated the resident's orders to reflect the new order obtained on 11/17/24 for diazepam 5 mg at bedtime. Review of the resident's Medication Administration Record (MAR), dated 11/2024, on 11/25/24 at 10:45 A.M. showed the following: -Diazepam 10 mg by mouth three times daily (original order dated 7/24/24); -Staff administered 10 mg of diazepam (instead of 5 mg as ordered on 11/17/24) at bedtime from 11/17/24 through 11/24/25. During an interview on 11/26/24 at 3:30 P.M., the Director of Nursing said the following: -She expected staff to change the order on the POS and MAR when a new order was obtained; -The nurse in charge of caring for the resident was responsible for ensuring the POS and MAR were updated with the new orders if a physician approved a pharmacist recommendation.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32899 Based on observation, interview, and record review, the facility failed to ensure staff provided assistance with activities of daily Living (ADLs) to six residents (Resident #36, #80, #19, #67, #10, and #83), in a review of 20 sampled residents, to maintain proper grooming, nutrition, and personal and oral hygiene. The census was 87. Review of the facility policy Incontinence Care, dated 11/01/2022, showed the following: -Check the resident at least every two hours, and assist with toileting as needed, if the resident is not on a specified program. -Provide peri care after each incontinent episode. -Change briefs and pads promptly when they are wet or soiled. Review of the facility policy Personal Care, Hygiene, and Grooming, dated 11/01/22, showed the following: -The most important aspect of maintaining good health is good hygiene. -Personal hygiene which is also referred to as a personal care includes all the following: bathing, showering, hair care, nail care, oral hygiene, dental care, and shaving. -Grooming is essential for the well being of the resident. -Bathing - Residents are bathed according to preferences, including the time of day, and day of the week, bed bath, tub bath, or shower or partial bath. -Hair Care -Hair is to be always clean and well-groomed. -Comb the resident's hair before taking them out of their room. -Report to the charge nurse any unusual condition of the scalp, including open areas, dry flaking skin, or excessive amount of hair falling out. -Nail Care - Clean hands and well-groomed nails prevent infection. Nail care includes keeping nails trimmed and file, no jagged or broken nails, cleaning underneath to remove debris, hangnails trimmed, no chipped or worn nail polish. -Shaving -All residents are to be shaved daily unless they have specified otherwise or have a trimmed beard. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Check female residents for shaving needs including excessive chin hairs. -Oral Hygiene: -Assist residents with brushing their teeth daily -Assist residents with brushing teeth when they get up in the morning and before the residents go to bed. -Dressing and Undressing - Clean off or change clothing after meals if soiled with food or liquids. Offer clothing protectors during meals to prevent soiling and staining. -Peri Care Guidelines: -Help residents to lay on their back; -Wash and dry upper thighs with towel when completed. -Wash and dry frontal perineal area; -Position resident on side exposing buttocks -Clean rectal area over buttocks using a different part of the washcloth or a clean moistened wipe. -Rinse and dry area thoroughly. 1. Review of Resident #36's care plan, revised 01/22/24, showed the following: -The resident preferred three showers a week in the evening; -The resident required assistance with his/her ADL care including bathing, grooming, toileting and transfers. Review of the resident's annual Minimum Data Set (MDS), a federally mandated assessment completed by staff, dated 7/26/24, showed the following: -Cognitively intact; -No behaviors and did not reject care; -Dependent on staff for bed mobility, transfers with a mechanical lift, toilet use and bathing, manual wheelchair and dependent on staff for wheelchair mobility; -Indwelling catheter; -Always incontinent of bowel. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the resident's quarterly MDS, dated [DATE], showed the resident needed partial assistance with eating and was dependent on staff for upper body dressing. Review of the resident's shower sheet, dated 11/11/24, showed the resident received a shower. Review of the resident's shower sheet, dated 11/14/24, showed Certified Nurse Assistant (CNA) R gave the resident a shower. During an interview on 11/25/24, at 6:30 P.M., CNA R said the following: -He/She just fills out the shower sheets at the end of the day; -The shower sheet may not be accurate because he/she fills them out in a hurry; -He/She had to do a bed bath (on 11/14/24) because the resident wanted to go to Bingo and didn't have time for a full shower. Review of the resident's medical record and shower sheets showed no documentation the resident received a shower on 11/15/24 through 11/18/24. Observation on 11/18/24 at 12:21 P.M., showed the following: -The resident sat in a geri-chair (reclining chair on wheels) at the dining room table; -The resident's hair was greasy with white flakes. During interview on 11/18/24 at 12:21 P.M., the resident said the following: -He/She had not had a real shower in two weeks; -Last week (on 11/14/24) he/she was in activities, so he/she missed his/her shower because he/she wanted to go to Bingo; -Since he/she went to Bingo, the staff only did a partial bath and washed his/her under arms and private area; -He/She wanted a shower, but the staff only offered the partial bed bath so he/she didn't get his/her hair washed; -His/Her hair felt gross and he/she felt itchy; -Staff tried to get out of doing his/her full shower and always tried to do a partial bed bath. Observation on 11/25/24, at 6:05 P.M.-6:25 P.M., showed the following: -The resident sat in a geri-chair at the dining room table; (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-The resident's divided plate rested on the resident's stomach. The resident attempted to hold the divided plate with one hand and attempted to feed himself/herself with the other hand. The resident's hands were shaking. The resident's silverware was wrapped on the table out of the resident's reach. -The resident received a mechanical soft diet which consisted of ground meat, hash browns, and a chocolate chip cake; -The resident attempted to scoop food with his/her hands, but his/her hands were shaking. The resident had small particles of food all over his/her face, stomach, and down the sides of his/her chair; -The resident attempted to feed himself/herself but was only able to get very little food to his/her mouth. An unidentified staff walked by the resident 6:07 P.M. and did not offer assistance; -At 6:22 P.M., Nurse Assistant (NA) E asked the resident if he/she needed help. The resident said, yes, but my food was all over me. NA E went to take the resident's plate, and the resident grabbed his/her cake from the plate and said, Please don't take my cake. The resident took the cake from the plate and NA E put the plate on the table. NA E did not offer to assist the resident to eat his/her cake. During an interview on 11/25/24 at 6:23 P.M., the resident said most of the time he/she could not reach his/her food. There was only one staff who helps him/her with his/her food consistently. He/She would like help because he/she was hungry and could not get all of the food to his/her mouth. 2. Review of Resident #80's care plan, dated 06/04/24, showed the resident was totally dependent on staff for bathing. Review of the resident's quarterly MDS, dated [DATE], showed the following: -Severe cognitive impairment; -Unclear speech; rarely/never understood; -Sometimes understands others; -Functional range of motion limitations in both upper and both lower extremities; -Dependent on staff for all activities of daily living (ADLs); -Used a wheelchair; -Always incontinent. Observation on 11/18/24, at 12:30 P.M., showed the following: -The resident sat in up in his/her geri chair (a reclining chair with wheels) in the dining room; (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-The resident's hair was disheveled, he/she had long unkempt facial hair with a brown substance in the hair, and his/her fingernails were long with black debris under them; -The resident smelled like urine and there was yellow liquid on the floor under his/her chair; -The resident's shirt was soiled with debris, and he/she had white flakes on his/her face and shirt. Observation on 11/21/24, at 8:38 A.M., showed the following: -The resident sat in a geri chair in the dining room; -The resident's hair was disheveled; -There were wet areas on the floor under his/her chair; -The resident had long facial hair and dried debris on his/her face; -The resident had long black hair from his/her nostrils; -The resident's fingernails were very long with black debris under the nails. During an interview on 11/25/24 at 03:55 P.M., the resident's family member said when he/she visited, the resident smelled like urine. He/She smelled the urine, even if he/she was not close to the resident. The resident always liked to be clean shaven and shaved every day. 3. Review of Resident #19's Care Plan, dated 08/25/23, showed the following: -The resident was able to use the bathroom with extensive assistance; -The resident was frequently incontinent of bowel and bladder; -The resident would utilize urinal on occasion if provided and available; -The resident was dependent for peri care; -The resident was totally dependent on staff for toilet use; -The resident required one staff participation with personal hygiene. Review of the resident's annual MDS, dated [DATE], showed the following: -Severe cognitive impairment; -Diagnoses included hemiplegia (paralysis one side of the body), total brain injury, seizure disorder, and aphasia (inability to express themselves by speaking); -Rarely/Never understood or understands; (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Beloved Health and Rehabilitation Center	328 Munger Lane Hannibal, MO 63401

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Vision highly impaired; -No behaviors or rejection of care; -Limited functional range of motion in one upper and one lower extremity; -Dependent on staff for toileting hygiene, shower/bathe, and personal hygiene; -Always incontinent of bowel and bladder. Observation on 11/19/24, at 12:26 P.M., showed the following: -The resident sat in his/her wheelchair at the dining room table; -The resident's hair was greasy, and he/she had white particles on his/her hair and face; -The resident smelled like urine. During an interview on 11/19/24, at 2:51 A.M., the resident's roommate, Resident #44, said the staff get the resident up early most days and never lay him/her down or change him/her. Their room always smelled like urine. He/She thought the resident's mattress and wheelchair were saturated with urine because the resident had to wait so long for staff to change him/her. Observation on 11/25/24, at 10:45 A.M., showed the following: -The resident lay in his/her bed; -The resident's room and bed smelled like urine; -The resident had white flakes in his/her hair and on his/her face. During an interview on 11/25/24, at 12:22 P.M., the resident's durable power of attorney said the resident was not always clean, often there were urine odors and the resident's clothing was saturated with urine. 4. Review of Resident #67's Care Plan, last updated 8/5/24, showed the following: -The resident was at risk for impaired skin integrity related to incontinence and decreased mobility; -Check the resident for incontinence; wash, rinse and dry the perineum; -One staff assist with personal hygiene. Review of the resident's quarterly MDS, dated [DATE] showed the following: -Required substantial to maximum assist with personal hygiene and toileting; (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Always incontinent of bladder and bowel. Observation on 11/20/24 at 6:27 A.M. showed the following: -The resident lay in his/her bed; -CNA T removed the resident's urine soiled incontinence brief and cleaned the resident's buttocks and anal area with disposable wipes; -He/She applied a clean incontinence brief and did not clean the resident's front genitalia, groin or inner thighs which were soiled with urine. During an interview on 12/6/24 at 1:49 P.M., CNA T said all areas of the resident's skin (front and back genitalia, thighs and stomach) in contact with urine should be cleaned during incontinence care. During an interview on 11/26/24 at 3:30 P.M., the Director of Nurses (DON) said she expected staff to clean all areas of the skin soiled from incontinence. 5. Review of Resident #10's quarterly MDS, dated [DATE], showed the following: -Moderately impaired cognition; -Supervision or touch assist for oral hygiene. Review of the care plan, last revised 11/8/24 showed the following: -Required extensive assist with ADLs, including hygiene; -Provide assistance as needed. Observation on 11/21/24 at 10:10 A.M. showed the following: -The resident lay in bed after eating his/her breakfast in bed; -The resident had missing and broken teeth, and his/her teeth were yellowed with food-like build up at the base of gum lines; -CNA I and the facility facilitator entered the room and performed incontinence care, transferred the resident to his/her geri-chair, and then finished with morning cares for the resident; -CNA I and the facilitator did not offer or assist the resident with oral care. During an interview on 11/21/24 at 3:20 P.M., the resident said staff do not offer to help him/her with oral care unless he/she asked. During an interview on 12/4/24 at 3:30 P.M., CNA I said the following: (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Staff should offer oral care in the morning, after each meal if preferred, and at bedtime; -If residents have no teeth, staff should offer a toothette or mouthwash; -Oral care would be considered part of the morning cares. During an interview on 11/26/24 at 3:58 P.M., the DON said the following: -Staff should provide oral care should be provided in the morning when getting a resident out of bed, after meals and at bedtime; -If the resident has no teeth, she expected staff to use toothettes or mouthwash. 6. Review of Resident #83's care plan, dated 04/09/24, showed the following: -His/Her diagnoses included generalized muscle weakness and the need for assistance with personal care; -The resident required assistance with activities of daily living task which included bathing, transfer, and grooming; -Staff were to allow time to complete task and intervene as needed. Review of the resident's quarterly MDS, dated [DATE], showed the following: -The resident was cognitively intact; -He/She required supervision or touch assistance with his/her personal hygiene; -He/She had no behaviors and did not reject care. Observation on 11/18/24 at 1:01 P.M., showed the following: -The resident had facial hair about 0.5 inches in long covering his/her face and neck; -He/She had white flakes on his/her face. During interview on 11/19/24 at 12:06 P.M. and 1:33 P.M., the resident said the following: -He/She wanted to be clean shaven; -Staff had to help him/her shave; -He/She wanted to be shaved every day and staff did not have time to assist him/her with shaving; -His/Her face itched and it did not feel good. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 11/19/24 at 9:03 A.M., showed the resident had been shaved and had a mustache. The resident still had long hair stubble on his/her neck and cheeks and was not clean shaven. Observation on 11/25/24 at 11:38 A.M., showed the resident had a mustache, he/she had whiskers on his/her cheeks and neck and was not clean shaven. During an interview on 11/25/24 at 11:54 A.M., CNA I said the following: -He/She had to shave the resident; -The resident did not want his/her mustache shaved, but liked the rest of his/her face to be clean shaven. During an interview on 11/25/24 at 12:27 P.M., Licensed Practical Nurse (LPN) B said the following: -The resident needed staff to help him/her shave; -The resident should be clean shaven if he/she preferred. MO245274 MO245289 MO244988 38016 47008

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38016 Based on observation, interview, and record review, the facility failed to assist two residents (Residents #44 and 33), in a review of 20 sampled residents, to obtain vision services when the residents asked for an appointment. The census was 87. The facility provided no policy for vision services/appointments upon request. 1. Review of Resident #44's face sheet showed he/she was his/her own responsible party. Review of the resident's admission (readmission) Minimum Data Set (MDS), a federally required assessment completed by staff, dated 1/25/24, showed the resident was cognitively intact. During an interview on 11/19/24, at 11:45 A.M., the resident said he/she requested an appointment for the eye doctor and was waiting to go to the eye doctor for over a year. He/She could not see far away, and things up close were also fuzzy. He/She could not see the clock most of the time and had trouble reading normal print. He/She was supposed to have glasses. His/Her insurance only covered visits to one location. The transportation person knew for over a year and had not made him/her an appointment at this location. During an interview on 11/21/24, at 2:15 P.M., the transportation/central supply staff said he/she was not aware of an appointment for the resident to see the eye doctor. He/She did not know why the resident did not see the eye doctor that came to the facility. The resident had requested to go to Wal-Mart for an appointment. 2. Review of Resident #33's face sheet showed he/she had a guardian. Review of the resident's Physician Order, dated 10/07/24, showed an order for ophthalmic (eye) consults to evaluate and treat as indicated. Review of the ophthalmic appointment list, generated on 10/15/24, showed the following: -A provider saw residents at the facility on 10/17/24; -The resident's name was not on the list of residents scheduled for a vision appointment on this day. Review of the resident's quarterly MDS, dated [DATE], showed the following: -The resident wore glasses; -The resident's vision was adequate with glasses. During an interview on 11/18/24 at P.M., the resident said he/she needed a vision appointment due to a change in his/her vision. His/Her glasses needed an updated prescription because he/she could not see very well to color his/her pictures. (continued on next page)

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. During an interview on 11/25/24 at 12:27 P.M., Licensed Practical Nurse (LPN) B said nurses and the transportation/central supply staff could make appointments for a resident. If a resident requested an appointment, he/she would send an email to the Director of Nursing (DON) and to the transportation/central supply staff so everyone was on the same page with appointments. Residents should have a vision appointments if they requested the appointments. Staff had not told him/her Resident #33 had requested a vision appointment. During an interview on 11/25/24 at 11:19 A.M., the transportation/central supply staff said the following: -Nursing staff normally tell him/her when a resident needed an appointment; -He/She then made an appointment for the resident; -The facility used services provided by a provider who came to the facility, but sometimes the guardian would not want the resident seen by this provider; -Depending on the resident's insurance, sometimes the resident had to see a vision provider from the community; -If there was any information to be filled out for the visual appointment, the social services director (SSD) would email the paperwork to the guardian to fill out and sign; -The guardian would return the completed paperwork to him/her and he/she would make the appointment and forward the necessary paperwork; -Resident #33 did not have a scheduled vision appointment. During an interview on 11/26/24 at 2:08 P.M., the Social Services Director (SSD) said she interviewed residents weekly to see if there are any medical concerns. If a resident asked for an appointment, she told nursing and transportation/central supply staff. Neither Resident #33 or Resident #44 had asked for a vision appointment. During an interview on 12/10/24 at 5:15 P.M., the Director of Nurses said the following: -The transportation/central supply staff was responsible for arranging appointments for residents; -She expected a resident to have a vision appointment if they have asked for one or needed an appointment; -She was unaware Resident #33 needed a vision appointment. 47008

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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate foot care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38016 Based on observation, interview and record review, the facility failed to ensure proper treatment and care to maintain foot health for three residents (Resident #19, #80, and #44) in a sample of 20 residents. The facility census was 87. Review of the facility policy Personal Care, Hygiene, and Grooming, dated 11/01/2022, showed the following: -Personal hygiene includes nail care; -Clean hands and well-groomed nails prevent infection; -Nail care includes keeping nails trimmed and file, no jagged or broken nails, cleaning underneath to remove debris, hangnails trimmed, no chipped or worn nail polish; -Nail care for residents with diabetes will be provided by the nurse; -Nail trimmers must be cleaned with an alcohol wipe between residents; -Change gloves and wash hands between every resident when providing nail care. 1. Review of the facility Resident Podiatry List, dated 11/14/24, showed the following: -Resident #19's last visit was 07/31/24; -Resident #80 and #44 were not on the list to be seen by the podiatrist. 2. Review of Resident #19's Care Plan, dated 08/25/23, showed the following: -The resident required one staff participation with personal hygiene; -The resident's guardian has requested the resident only receive fingernail and toenail care/cutting by a podiatrist; -Monitor nail growth and set appointments with podiatry as ordered and as needed; -Resident will receive nail care by a Podiatrist only. Review of the resident's annual Minimum Data Set (MDS), a federally required assessment completed by staff, dated 07/09/24, showed the following: -Severe cognitive impairment; -Diagnosis of hemiplegia (paralysis one side of the body) and total brain injury; (continued on next page)

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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Rarely/Never understood or understands; -Dependent on staff for personal hygiene. Observation on 11/25/24, at 10:45 A.M., showed the resident had long toenails curved over the end of his/her toes. During an interview on 11/25/24, at 10:55 A.M., Licensed Practical Nurse (LPN) B said the following: -The resident's toenails were long; -He/She thought the resident was supposed to see the podiatrist. During an interview on 11/25/24, at 12:22 P.M., the resident's durable power of attorney said the following: -The resident was to see a podiatrist routinely; -He/She did not know the last time the resident saw the podiatrist. -The facility was supposed to set up routine toenail trims with the podiatrist. 3. Review of Resident #80's admission MDS, dated [DATE], showed the following: -Severe cognitive impairment; -Diagnosis included stroke; -Dependent on staff for all activities of daily living (ADLs). Review of the resident's quarterly MDS, dated [DATE] , showed no changes in ADL care. Review of the resident's quarterly MDS, dated [DATE] , showed no changes in ADL care. During an interview on 11/25/24 at 03:55 P.M., the resident's family member said the facility was supposed to routinely trim the resident's fingernails and toenails. Observation of the resident on 11/21/24, at 08:45 A.M., showed the following: -The resident's fingernails were very long with black debris under the nails; -The resident's toenails were very long and causing pressure into other toes. 4. Review of Resident #44's admission MDS, dated [DATE], showed the following: -Cognitively intact; (continued on next page)

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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-No behaviors or rejection of care; -Required supervision/touch assistance from staff members for hygiene. During an interview on 11/19/24, at 02:51 P.M., the resident said he/she needed to see the podiatrist. He/She had been asking staff and was diabetic. His/Her toes hurt when he/she wore shoes because his/her toenails were long and shoes put pressure on them. Observation on 11/19/24, at 2:55 P.M., showed the resident's toe nails were thick and long. The resident's second toe nail was putting pressure against the next toe. 5. During an interview on 11/20/24, at 6:45 A.M., Certified Nurse Assistant (CNA) R said if a resident is diabetic or has thick toenails the nurse had to clip them. The nurse decides if the resident needs to be referred to the podiatrist. During an interview on 11/25/24, at 10:55 A.M., LPN B said the following: -Staff let him/her know if a resident needed their fingernail or toenails cut; -If a resident was diabetic and had complicated toenails then they are referred to the podiatrist; -Social Services and transportation staff handle the list for residents to have special services completed. During an interview on 11/25/24 at 11:19 A.M., the transportation/central supply staff member said the following: -The nursing staff normally tell him/her when a resident needed an appointment; -He/She would then make an appointment for the resident. During an interview on 11/26/24, at 3:58 P.M., the Director of Nurses (DON) said the following: -CNAs are expected to provide basic nail care to residents during bathing and as needed; -The licensed staff would provide nail care for diabetic residents; -Residents who have thick or complicated nails are referred to the transportation staff member to be scheduled for regular podiatry appointments.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38016 Based on observation, interview and record review, the facility failed to provide restorative nursing services to assist three residents (Resident #19, #80 and #4), in a review of 20 sampled residents, in attaining or maintaining their highest level of functioning. The facility failed to prevent further decline of limited range of motion or development/worsening of contractures (shortening and hardening of muscles, tendons or other tissue, often leading to deformity and rigidity of joints). The facility failed to develop restorative plans with goals, frequency of task, number of repetitions, length of time, or direction to staff to meet resident needs. The facility census was 87. Review of the facility policy, Range of Motion, dated 08/15/22, showed the following: -The facility will ensure that a resident who enters the facility without a limited range of motion does not experience a reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; -If a reduction of range of motion is unavoidable, this must be defined by the resident's physician and documented in the resident's chart; -The facility will ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion; -The Restorative Nursing department will: -Assess each resident's range of motion on admission, with every scheduled resident assessment, and with any significant change of condition; -Prescribe range of motion exercises for residents as needed, identifying: -Active or Passive; -Times and days to be performed; -Joints to be exercised; -Number of repetitions to be performed; -The Unit Nurse will: -Ensure that Nursing Assistants assist residents to perform range of motion exercises as prescribed and document in the resident's record that the exercises were performed; -Inform the Restorative Nursing department when a resident's range of motion needs further assessment; (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Nursing Assistants must: -Assist residents to perform range of motion exercises as prescribed; -Document in the resident's record that exercises were performed; -Notify the Charge Nurse of any changes in the resident's ability to perform the exercises and of any pain the resident experiences with exercises; -Active Range of Motion - Exercises the resident does without any physical help or support; Most residents will need reminding to do the exercises, cueing or supervision of the entire exercise sequences; -Passive Range of Motion - Performed for the resident by a staff member; -A resident may require a combination of active and passive range of motion exercises. 1. Review of Resident #'80's admission Minimum Data Set (MDS), a federally required assessment instrument completed by staff, dated 03/09/24, showed the following: -Severe cognitive impairment; -Diagnoses include stroke and blood clot; -Unclear speech rarely/never understood; -Sometimes understands; -Functional range of motion limitations in both upper and both lower extremities; -Dependent all activities of daily living (ADLs); -Uses a wheelchair; -No restorative nursing; -Scheduled pain regimen, unable to do pain interview, staff assessment not completed. Review of the resident's medical record showed no documentation that a Restorative Nursing department had assessed the resident's range of motion at admission with a suggested/prescribed range of motion exercise plan for the resident per facility policy. There was no restorative nursing department and no documentation that a licensed nurse evaluated the resident for need of restorative nursing. Review of the resident's Care Plan, dated 06/04/24, did not include pain or functional range of motion limitations in both upper and lower extremities. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the resident's quarterly MDS, dated [DATE], showed the resident had scheduled pain medication, functional range of motion limitations in both upper and lower extremities and no range of motion or restorative nursing. Review of the resident's quarterly MDS, dated [DATE], showed the resident had scheduled pain medication, functional range of motion limitations in both upper and lower extremities and no range of motion or restorative nursing. Review of the resident's Care Plan, last updated 11/01/24, did not include pain, functional range of motion limitations in both upper and lower extremities and no range of motion or restorative nursing. Review of the resident's electronic medical record showed no documentation of a restorative nursing plan or range of motion documentation. Observation on 11/21/24 at 8:45 A.M., showed the following: -Certified Nurse Assistant (CNA) R and Nurse Assistant (NA) E provided care to the resident; -The resident had severe contractures of the right arm and leg and used his/her left arm to move his/her right arm and leg; -The resident's body was not aligned, his/her back was curved, with the right leg and right arm drawn up; -When CNA R and NA E rolled the resident side to side, the resident's body did not relax and it stayed in a drawn up/flexed position; -The resident grimaced, moaned in pain and guarded his/her right leg, grabbing his/her right leg with his/her left hand every time the staff moved him/her, and moving his/her arms to stop them from turning him in a guarding motion; -Neither CNA R or NA E provided ROM exercises during cares. During an interview on 11/21/24 at 8:55 A.M., CNA R said the resident was in pain because of his/her contractures. Once he/she was in a certain position, he/she did not complain, but it hurt the resident every time they moved him/her. He/She was not sure what pain medication the resident was getting. No one provided ROM for resident's with contractures because the facility did not have restorative nursing. 2. Review of Resident #19's Care Plan, dated 09/22/23, showed the following: -Risk for pain and discomfort related to hemiparesis (paralysis one side of the body), and seizure activity; -Monitor/record/report to nurse if resident complains of pain; (continued on next page)

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	265462	A. Building B. Wing	11/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Beloved Health and Rehabilitation Center	328 Munger Lane Hannibal, MO 63401

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Passive Range of Motion (PROM): Staff to perform PROM to all extremities once daily seven days per week; -Range each extremity five reps while supporting joint; -Encourage resident to communicate any pain/discomfort during program; -Stop range if resident reports pain and notify nurse; -Document minutes program provided in POC (the electronic medical record). Review of the resident's care plan, dated 10/03/23, showed the care plan for the resident's PROM for contractures was canceled. Review of the resident's annual MDS, dated [DATE], showed the following: -Severe cognitive impairment; -Diagnoses of hemiplegia (paralysis one side of the body), total brain injury, seizure disorder, aphasia (inability to express themselves by speaking); -Rarely/Never understood or understands; -No behaviors or rejection of care; -Limited functional range of motion in one upper and one lower extremity; -Requires substantial/maximal assistance from staff to roll left and right, sit to lying and lying to sitting on side of bed; -Dependent on staff for oral hygiene, toileting hygiene, shower/bathe, upper body dressing, lower body dressing, putting on/taking off footwear, personal hygiene, sit to stand, chair/bed-to-chair transfer and tub/shower transfer; -No scheduled or as needed pain medication; -Staff assessment of pain is blank (did not answer yes or no, questions not answered). Review of the resident's Nursing Progress Notes, dated 08/10/24 at 11:00 P.M., showed the following: -Resident returned from the emergency room with diagnosis of humeral fracture; (fracture of a bone in the arm); -Sling in place to right upper extremity; -New medication for Norco (narcotic pain medication) 5/325 milligrams (mg) every six hours as needed for pain. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the resident's Nursing Progress Notes, dated 08/16/24 at 2:01 P.M., showed a provider ordered Voltaren gel (a topical anti inflammatory medication) one percent (%) to right shoulder every eight hours as needed for pain and a new order for mechanical lift transfers. Review of the resident's Nursing Progress Notes, dated 08/19/24 at 2:57 P.M., showed the resident had fluid shift from the shoulder to the forearm even with repositioning and elevation. Physician, guardian and orthopaedic physician notified of new edema. Review of the resident's Care Plan, updated 08/26/24, showed the following: -Pillow placed under right upper extremity for stabilization; -The resident has limited physical mobility; -The resident will maintain current level of mobility (specify: able to walk with walker unassisted, one person assist for 15 feet (ft)) through review date. Target Date: 01/07/2025; -The resident's care plan did not include any direction for caring for the resident's flaccid and contracted right leg, or any range of motion/instructions related to the resident's fractures and new mobility limitations in addition to previous hemiplegia. Review of the resident's radiology report, dated 09/30/24, showed a fracture of the distal radius (bone in the fore arm where it connects to the wrist) with mild posterior angulation (Colles fracture-a break in the radius bone of the wrist that occurs when the broken end of the bone bends backward). Review of the resident's Orthopaedic Note, dated 10/10/24, showed the following: -Resident being seen for evaluation of right wrist symptoms that have been going on for two weeks; -Symptoms include swelling; -Swelling at the wrist on examination; -Healing fracture of the right shoulder proximal humerus (a break in the upper arm bone near the shoulder joint); -Right wrist volatile minimally angulated fracture; -Both fractures are in the flaccid (hanging loose or limp) right upper extremity; -Plan: Os-Cal D 500 twice daily (calcium supplement), splint on the right wrist for the radius fracture for four weeks, lymphedema sleeve (a compression sleeve to reduce swelling), have physical therapy evaluate and specify the lymphedema sleeve needed might be ideal to manage the swelling, acetaminophen (Tylenol) for pain as needed; -Revisit in six weeks. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the resident's November 2024 (current) physician orders showed they did not include orders for physical therapy, a lymphedema sleeve or acetaminophen. Observation of the resident on 11/19/24 at 12:26 P.M., showed the following: -The resident sat in a wheelchair at the dining room table; -The resident had a sling on his/her right arm. The sling was not placed properly and the resident's arm was not resting in the sling. The resident's arm was straight and the sling cut into the resident's forearm; The resident's hand had four plus edema; (a severe case of pitting edema, a condition where the skin retains fluid and appears indented after pressure is applied); -The resident was not wearing a lymphedema sleeve; -The resident repeated the numbers 1, 2, 1, 2, 5, 4; -The resident nodded yes when asked if he/she was in pain; -The resident grabbed his/her right arm with his/her left hand and when the resident moved his/her right arm, he/she winced and moaned in pain; -The state agency reported the resident's signs of pain to staff. Review of the resident's electronic medical record, dated 10/03/23-11/20/24, showed no documentation of any restorative nursing services or PROM provided by the facility. During an interview on 11/19/24 at 12:45 P.M., the Director of Nursing (DON) said the resident had fractures in the shoulder and wrist. The resident was not supposed to have a sling on and it was not placed properly. She let the nurse know the resident was in pain and his/her edema was worse. The resident was supposed to get therapy to apply a lymphedema sleeve, but he/she had not had a therapy evaluation yet. The resident's PROM had been canceled on the resident's care plan because the facility did not have a restorative aide. During an interview on 11/20/24, at 1:45 P.M., The Director of Nurses said the following: -The resident had limitations to his/her range of motion on the right side, and had some contractures; -The resident does not get PROM or restorative nursing because the facility does not have restorative nursing staff; -Staff are expected to treat the resident's pain and edema; -She was not sure why the resident had the sling on yesterday; -The resident had Tramadol and hydrocodone for pain control; -The resident's wrist fracture was a spiral shaped fracture and would not be repaired surgically; (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-The resident could answer yes and no questions; when the resident said numbers, the resident was expressing there was an issue; -The facility was supposed to be getting the resident a lymphedema sleeve and working with therapy. Observation on 11/25/24 at 10:45 A.M., showed the following: -The resident lay in his/her bed; -His/Her right arm was positioned partially under his/her body; -The resident grabbed and pulled at his/her right arm with his/her left hand, while wincing, moaning and saying 1, 2, 1, 2; -The resident's right arm and hand were swollen (four plus); more swollen than the observation on 11/19/24; -There was a distinct deep crease between the forearm and hand from the increased edema. During an interview on 11/25/24, at 10:55 A.M., Licensed Practical Nurse (LPN) B said the following: -Staff are expected to position the resident's right arm on a pillow; -Staff are expected to ask the resident about pain every shift; the resident had had pain frequently since the fractures; -The facility does not have restorative nursing. During an interview on 11/25/24 at 12:22 P.M., the resident's durable power of attorney said he/she was concerned about the resident arm, and was also concerned because the resident' was not getting ROM or strengthening exercises to his/her legs. 3. Review of Resident #4's admission MDS, dated [DATE], showed the following: -Cognitively intact; -Diagnoses: paraplegia (paralysis from the waist down); -No behaviors or rejection of care; -No restorative nursing: -Requires partial/moderate assistance from staff for upper body dressing and to roll left and right, -Requires substantial/maximal assistance from staff for sit to lying, lying to sitting on the side of bed, to wheel wheelchair 150 feet and 50 feet with two turns; (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Dependent on staff for toileting hygiene, shower/bathe, lower body dressing, footwear and chair/bed-to-chair transfer; (the MDS did not include the resident's limited range of motion in both lower extremities; he/she was paralyzed from the waist down). Review of the resident's medical record showed no documentation that Restorative Nursing had assessed the resident's needs on admission with a suggested/prescribed range of motion exercise plan for the resident. Review of the resident's quarterly MDS, dated [DATE], showed no restorative nursing and no range of motion issues. Review of the resident's quarterly MDS, dated [DATE], showed the following: -New impairments to range of motion, both lower extremities; -Independent with lower body dressing, independent to wheel 50 feet with two turns and 150 feet, upper body dressing; -Requires partial/moderate assistance from staff for toilet hygiene and putting on/taking off footwear; -No restorative nursing. Review of the resident's quarterly MDS, dated [DATE], showed no changes to range of motion and no restorative nursing. Review of the resident's quarterly MDS, dated [DATE], showed showed no changes to range of motion and no restorative nursing. Review of the resident's quarterly MDS, dated [DATE], showed no changes to range of motion and no restorative nursing. During an interview on 11/19/24 at 2:39 P.M., the resident said he/she was a paraplegic (paralysis to both legs). He/She would like restorative nursing to prevent contractures in his/her legs, but the facility does not have a restorative program. The staff will not assist him/her when he/she asked for assistance and say he/she was independent and needed to do things for himself/herself. He/She can do most things himself/herself but cannot do effective range of motion on his/her legs by himself/herself. During an interview on 11/25/24 at 10:55 A.M., LPN B said the facility no longer had restorative nursing, so if there was a decline in range of motion they would have to consult therapy. During an interview on 11/20/24 at 1:30 P.M., the Director of Nursing said the facility did not have a restorative program because the facility did not have a restorative aide. For Resident #30, #80 and #4, the staff just try to do good positioning. The facility has a walk to dine program, but Resident #30, #80 and #4 cannot walk.

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32899 Based on observation, interview, and record review, the facility failed to ensure interventions were in place to prevent injuries/accidents for four residents (Residents #6, #7, and #20). Resident #6 had a history of self harm and swallowing batteries. The facility failed to ensure the resident did not have accessibility to batteries. The resident swallowing four triple A batteries and required treatment at the hospital. The facility also failed to ensure staff transported Resident #7, #15 and #20 in their wheelchairs with foot rests, failed to ensure two residents (Residents #243 and #250) did not smoke near hazardous items, and failed to ensure chemicals were kept secured and not accessible to residents. The facility census was 87. During an interview on 11/25/24 at 2:46 P.M. the Administrator said the facility did not have a policy for protective oversight/preventing accidents/hazards, safety when propelling wheelchairs, safety when transporting residents in the facility van or storage of toxics. Record review of the facility's undated smoking policy showed the following: -The facility shall establish and maintain safe resident smoking practices; -Prior to, or upon admission, residents shall be informed about any limitations on smoking, including designated smoking areas; -Metal containers, with self-closing cover devices, shall be available in smoking areas; -Ashtrays shall only be emptied into designated receptacles. 1. Review of Resident #6's progress notes, dated 7/28/24, showed the resident was at the nurse's station with four batteries and told staff he/she was depressed and wanted to swallow them but decided not to and to notify staff. Director of Nursing (DON) notified. Review of the resident's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument to be completed by the facility and dated 9/4/24 showed the following: -Short and long term memory intact; -Moderately independent with with daily decisions, some difficulty in new situations only; -No behaviors impacting self or others; -Used a wheelchair or scooter; -Independent with locomotion on unit; -Supervision to touch assist with eating; (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	-Received antipyschotic, antianxiety, antidepressants the last seven days of the look back period. Review of the resident's progress notes showed the following: -On 9/22/24 at 8:10 P.M., staff reported the resident swallowed four batteries. Resident on 1:1, 911 notified and resident sent per ambulance to the hospital; -On 9/23/24, call to hospital for update on resident who was admitted . Four non-eroded batteries were removed from the resident's stomach. Resident on 1:1, psychiatric evaluation in the morning. Review of the resident's care plan, last revised 9/25/24, showed the following: -Mood problem related to diagnosis of bipolar and depression; -History of self harm and swallowing batteries as a way of self harm; -Remove from situations as needed; -Behavioral health consults as needed. Review of a resident contract, dated 10/22/24, created by the facility and signed by the resident, showed the resident agreed to no longer cause harm to himself/herself by swallowing anything or trying to hurt himself/herself in any way. Review of the resident's Physician Order Sheet (POS), dated 11/2024, showed the following: -Diagnoses included post traumatic stress disorder (difficulty recovering after a traumatic event) (PTSD), bipolar disorder (high and low mood swings) and anxiety (worry and fear); -Allergies included lithium. Review of a standard progress note from the resident's Licensed Social Case Worker (LSCW), dated 11/12/24, showed the resident denied having any thoughts of suicide, but he/she did have thoughts of harming himself/herself after he/she had a flashback last Friday. Therapist informed staff the resident was having thoughts of hurting himself/herself. Review of the resident's progress notes showed the following: -On 11/19/24 at 9:00 P.M. (a late entry), the resident was at the nurse's station reporting to have ingested a foreign object. Order to send the resident to the hospital; -On 11/20/24 at 11:58 A.M., call from case manager who reported they were able to recover one battery. During an interview on 11/21/24 at 2:13 P.M., Certified Nurse Assistant (CNA) R said the following: -He/She was aware of the resident swallowing batteries in the past, but did not know the resident had swallowed them a second time; (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	-He/She was not educated to search the resident's room for batteries; -He/She was not aware of any rules related to batteries such as counting or securing them. During an interview on 11/21/24 at 2:30 P.M., Licensed Practical Nurse (LPN) B said the following: -He/She did not know if the resident was allowed to have a remote control; -He/She was not aware of any routine room checks, daily, weekly or other to check for batteries; -He/She was not sure of any inservices related to the incident. During an interview on 11/21/24 at 3:00 P.M. Registered Nurse S said the following: -He/She knew the resident was 1:1 after the September incident ingesting batteries; -He/She had not been inserviced on anything related specifically to batteries; -Batteries were not to be laying out, they were locked and kept in the maintenance department. During an interview on 11/25/24 at 5:25 P.M the Director of Nurses (DON) said the following: -After the first incident in September the facility put the resident on 1:1, inserviced staff, updated the care plan, obtained the guardian's permission to search the resident's room, notified psych and consult completed, and started counseling services; -She had not conducted any investigation regarding the resident's latest incident. She had only talked with two licensed nurses; -They did not know where the resident got the batteries. During an interview on 11/26/24 at 11:35 A.M., the resident said the following; -He/She was depressed and wanted to kill himself/herself on the day he/she swallowed batteries (11/19/24); -He/She felt like he/she wanted to die because Thursday was the anniversary of him/her being sexually, mentally and physically abused; -He/She swallowed four triple A batteries while in his/her room before being sent to the hospital; -He/She obtained the batteries from his/her three remote controls (two for his/her television and one for his/her dvd player); -He/She had not told anyone he/she was going to swallow the batteries before he/she did it but did tell the nurse 30-45 minutes afterward; (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	-The only time the facility had kept his/her remotes from him/her was when he/she was on 1:1 the last time he/she swallowed batteries. He/She has had his/her remotes (with batteries) in his/her room ever since. During an interview on 11/26/24 at 12:46 P.M. the Social Service Director said the following: -He/She became familiar with the resident in September when she took over this position; -She knew holidays and birthdays were triggers for the resident; -She was not instructed to look for remotes or batteries but did not see a remote in the resident's room; -When the resident was on 1:1 after the last incident the facility had his/her remote. 2. Review of Resident #3's quarterly MDS, dated [DATE] showed the following: -Moderately impaired cognition; -Used walker and wheelchair; -Independent with ambulation and transfers; -No falls since admission or prior assessment. Review of the resident's care plan, last revised 11/1/24 showed the following: -Diagnoses included seizures and muscle weakness; -At risk for and history of falls; -Used a wheelchair and rollator walker. Review of the resident's progress notes showed the following: -On 11/19/24 at 2:57 P.M. nurse received report from hospital as resident to return to the facility today; -On 11/19/24 at 6:34 P.M. showed the resident returned from the hospital via the facility transporter. During an interview on 11/21/24 at 11:50 A.M. the transporter said the following: -He/She had one resident (Resident #3), who liked to sit on his/her walker in the van during transport and he/she always transported the resident this way; -He/She would secure the walker to the floor of the van with (ratchet type) straps (which were bolted to the floor) to keep it from moving; (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	-He/She had not secured a seatbelt around the resident as there was no way with a walker. 3. Review Resident #20's care plan, last revised 6/12/24 showed the following: -Impaired cognition and impaired thought processes related to Alzheimer's disease progression; -One to two staff assist with transfers; -History of falls, risk for falls; -Monitor placement of feet while assisting resident in wheelchair to reduce resident from planting her feet to stop the wheelchair suddenly causing the resident to propel forward to the floor. When staff is assisting resident in the wheelchair, staff should assist slowly and listen to the resident. If the resident says he/she needs to stop, staff need to stop to see what the resident is needing to reduce him/her from putting his/her feet down, causing him/her to fall forward. (2/22/23). Review of the resident's quarterly MDS dated [DATE], showed the following: -Moderately impaired cognition; -No behaviors or rejection of care; -Substantial to maximum assist for transfers; -Independent with locomotion in wheelchair on unit; -No falls since admission or prior assessment. Review of the resident's fall risk assessment, dated 10/23/24 showed the resident was a high risk (score of 30) for falls. Review of the resident's POS dated 11/2024 showed diagnoses included dementia (memory loss) and repeated falls. Observation on 11/18/24 at 1:45 P.M. showed LPN C pushed the resident in his/her wheelchair from the dining room to the resident's room without any foot rests on the wheelchair. The resident wore grippy socks and his/her feet drug the floor. The staff member did not encourage the resident to lift his/her feet. During an interview on 11/26/24 at 3:19 P.M. LPN C said staff should not push residents in their wheelchairs without foot rests. During an interview on 11/26/24 at 3:30 P.M. the Direct of of Nurses (DON) said the following: -Resident #6 should not have had remotes with batteries in his/her possession, she would have expected staff to monitor for this, staff met with the resident daily. She did not feel like the facility was able to provide protective oversight for the resident; (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	-Staff should not push residents in wheelchair without foot rests as they could put their feet down and be thrown from the chair; -She would not expect staff to transport a resident, while the resident sat on the seat of their walker, in the facility van. Residents should sit in a seat with their seatbelt fastened. During an interview on 11/25/24 at 6:30 P.M. the Administrator said the following: -The first time Resident #6 swallowed batteries and returned from the hospital they put the resident 1:1 indefinitely and gave a 30 day discharge notice. As the weeks passed, the resident became better and they had him/her sign a behavior contract which said he/she would not self harm again. They slowly removed the 1:1, stopping the night 1:1 at first. The SSD was assigned to meet with the resident and he/she had a psych consult and started counseling; -The social service person met with the resident several times a week (but not daily) to check on him/her; -The facility could not provide inservice records related to the resident swallowing batteries in September as they did not have any records. 4. Observation on 11/18/24 at 3:28 P.M., in the courtyard outside the B and C halls, showed four unidentified residents and one staff member sat under the pavilion and smoked cigarettes. A barbecue grill with a connected propane tank that was located within one foot of two of the residents. Observation on 11/20/24 at 9:09 A.M., in the courtyard outside the B and C halls, showed the following: -Resident #243 sat alone under the pavilion and smoked a cigarette; -A barbecue grill with a connected propane tank was located within five feet of the resident; -A sign on the inside of the door to the courtyard read, Attention!!! No resident can be outside in the courtyard without staff being present with them, no exceptions!!! Observation on 11/20/24 at 10:18 A.M., in the courtyard outside the B and C halls, showed the following: -Resident #250 smoked a cigarette approximately three feet from the door; -Signs posted on the exterior walls near the door read, No Smoking; -Two oxygen cylinders sat in a holder, located on the interior side of the door, approximately 15 feet from where Resident #250 smoked a cigarette. During an interview on 11/20/24 at 12:38 P.M., the Maintenance Director said smoking should not occur around hazardous items such as propane or oxygen tanks. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	5. Observations on 11/18/24 at 3:33 P.M. and on 11/20/24 at 9:09 A.M., in the courtyard outside the B and C halls, showed residents entered and exited the courtyard through a facility door. Residents routinely sat under the pavilion and smoked cigarettes. An unlocked shed, approximately 10-foot by 10-foot in size, was located near the pavilion in the courtyard and contained several bottles of nail polish remover. The label of one bottle read, Warning: harmful if ingested, keep out of reach of children. During an interview on 11/20/24 at 12:38 P.M., the Maintenance Director said items such as nail polish remover should be stored in a secure manner and inaccessible to residents. The facility's former activity director, who resigned over the weekend, was responsible for ensuring these items were stored securely. 38016 MO245438 MO245274

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F 0697 Level of Harm - Actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38016 Based on observation, interview, and record review, the facility failed to consistently assess pain, document why pain medications were not administered when pain was identified, failed to medicate prior to treatment, failed to develop a care plan to implement appropriate pain interventions during and prior to care that elicited pain, and failed to address a sling causing pain for three residents (Resident #19, #36, and #80) in a review of 20 sampled residents, when the residents displayed signs of pain and some were not able to verbalize pain. Resident #19 had fractures and swelling of his/her right extremity, and the resident's sling was placed incorrectly. The resident verbalized distress with his/her limited speech and staff failed to use ordered interventions to assist the resident who showed facial grimacing, guarding, and expressed his/her arm hurt. Resident #80 grimaced, moaned, and guarded limbs with extreme contractures during care and staff failed to identify pain and administer medications ordered for pain control. Resident #36 said the staff never asked him/her about his/her pain and did not administer medications or interventions ordered by the physician for pain, and he/she was in pain all of the time. The facility census was 87. Review of the facility policy Pain Care and Management, dated 11/30/22, showed the following: -The facility's Pain Care Committee consists of the Director of Nursing, Restorative Nurse, MDS Coordinator, and Quality Assurance Nurse/Designee; -QA will meet as needed to examine the effectiveness of the facility's pain care program -Comprehensive pain assessments must be completed with: -Every scheduled resident assessment; -A significant change in the resident's condition; -Any change in the resident's level or frequency of pain; -Any change in the resident's response to pain medications; -A specialized pain assessment must be used for residents with cognitive and/or communication deficits, that includes monitoring for indicators of pain, such as: -Grimacing, crying, or frowning; -Guarding or protecting a body part; -Groaning, grunting, moaning, sighing, or tense voice; -Pain assessments must include: -Location of pain; (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	-Description of pain in the resident's own words and/or using a pain scale -Frequency of pain, usual level of pain; -What alleviates pain -What exacerbates pain; -Measurement of how pain effects areas of the resident's life, such as activities of daily living, sleep appetite, and mood; -Pain management should be based on the resident's changing needs and responses. -For residents with daily or chronic pain, maximum pain relief is achieved with around the clock medications and PRNs for breakthrough pain. -Pain medications are more effective when given before activities or treatments that exacerbate pain. -Non-pharmacological measures should be used along with pharmacological measures for maximum pain relief and include repositioning; -Care Planning - the care plan should be based on in-depth assessment of the resident's pain and treatment history, are individualized to his particular needs and preferences; -Pain care plans must be updated with any change in the resident's level or frequency of pain. -New interventions must be implemented when old interventions are ineffective. -Monitoring when the Unit Nurse administers a pain medication, she must document in the resident's Medication Administration Record (MAR), chart, and pain monitoring flow sheet, and on the 24 Hour Report: -Why the pain medication was administered - signs and symptoms observed or the resident's specific complaint of pain; -What non-pharmacological interventions were used; -Effectiveness of the medication and interventions -Cognitively impaired residents must be observed for pain at regular intervals. 1. Review of Resident #19's Care Plan, dated 09/22/23, showed the following: -Risk for pain and discomfort related to hemiparesis (paralysis one side of the body), and seizure activity; -Monitor/record/report to nurse if resident complains of pain; (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	-Notify physician if interventions are unsuccessful or if current complaint is a significant change from residents past experience of pain; -Administer analgesia Tylenol as per orders; -Anticipate the resident's need for pain relief and respond immediately to any complaint of pain; -Assess resident every shift for pain. Review of the resident's annual Minimum Data Set (MDS), a federally required assessment completed by staff, dated 07/09/24, showed the following: -Severe cognitive impairment; -Diagnosis of hemiplegia (paralysis one side of the body), total brain injury, seizure disorder, aphasia (inability to express themselves by speaking); -Rarely/Never understood or understands; -No behaviors or rejection of care; -Limited functional range of motion in one upper and one lower extremity; -Requires substantial/maximal assistance from staff for roll left and right, sit to lying, lying to sitting on side of bed; -Dependent on staff for oral hygiene, toileting hygiene, shower/bathe, upper body dressing, lower body dressing, putting on/taking off footwear, personal hygiene, sit to stand, chair/bed-to-chair transfer, and tub/shower transfer; -Always incontinent of bowel and bladder; -No scheduled or as needed pain medication; -Staff assessment of pain is blank (did not answer yes or no, questions not answered). Review of the resident's Nurses Progress Notes, dated 08/09/24, at 4:20 P.M., showed the following: -Resident approached nurses station saying, one, two, one, two which staff interpreted as the resident was in distress; -Resident nodded yes having right sided pain and left leg pain; -Tylenol administered; -Left message for physician. (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	Review of the resident's Nurses Progress Notes showed no documentation staff assessed to determine if Tylenol administered on 08/09/24, at 4:20 P.M., was effective in relieving the resident's pain. Review of the resident's Nurses Progress Note, dated 08/10/24, at 4:56 P.M., showed the following: -Resident's DPOA (durable power of attorney) concerned with the edema in the resident's right arm; -Right arm swollen considerably more than the left arm; -Resident sent to the emergency room . Review of the resident's Nursing Progress Notes, dated 08/10/24, at 11:00 P.M., showed the following: -Resident returned from the emergency room with diagnosis of humeral fracture; (fracture of a bone in the arm); -Sling in place to right upper extremity; -New medication for Norco (narcotic pain medication) 5/325 mg every six hours as needed for pain. Review of the resident's Nursing Progress Notes, dated 08/16/24, at 2:01 P.M., showed a provider ordered Voltaren gel (a topical anti inflammatory medication) 1% to right shoulder every eight hours for pain, and new order for mechanical lift transfers. Review of the resident's Nursing Progress Notes, dated 08/19/24, at 2:57 P.M., showed the resident has had fluid shift from the shoulder to the forearm even with repositioning and elevation. Physician, guardian and orthopaedic physician notified of new edema. Review of the resident's Care Plan, updated 08/26/24, showed the following: -(Added 08/26/24 for fracture that occurred 08/10/24); -Resident returned from the emergency room with a diagnosis of a right humeral fracture with a sling in place to the right upper extremity; -Norco 5/325 mg every six hours as needed for pain; -Pillow placed under right upper extremity for stabilization. Review of the resident's Nursing Progress Notes, dated 09/02/24, at 2:10 P.M., showed the physician office faxed regarding the resident having increased swelling in the right hand. Resident's arm elevated and resident given pain medication as displaying he/she was in pain. Review of the resident's Nursing Progress Notes, dated 09/05/24, at 2:10 P.M., showed the following: -Resident pointed to his/her right side for the nurse; (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	-Complaints of pain under his/her right breast down his/her right side; -White patches on his/her side and arm, physician notified. Review of the resident's physician's orders, dated 09/06/24, showed the resident may wear sling to right arm/shoulder when up in the wheelchair to minimize swelling for two weeks then discontinue. Review of the resident's Nursing Progress Notes, dated 09/28/24, at 1:52 P.M., showed the physician ordered to discontinue hydrocodone five days after 09/23/24, then begin Tramadol 50 mg every six hours for pain. Review of the resident's Nursing Progress Notes, dated 09/30/24, at 10:31 A.M., showed the following: -Right arm and hand was swollen and tender to touch; -Resident cries out in pain if right arm is lifted. Review of the resident's Nursing Progress Notes, dated 09/30/24, at 5:01 P.M., showed the following: -Resident received an order for right arm and hand being swollen: -Ice pack for 24 hours and to get an X-ray of the right arm; -Orders sent. Review of the resident's radiology report, dated 09/30/24, showed a fracture of the distal radius (bone in the fore arm where it connects to the wrist) with mild posterior angulation (Colles fracture-a break in the radius bone of the wrist that occurs when the broken end of the bone bends backward). The radiologist wrote that it was difficult to determine the age of the fracture given the severe osteopenia. (reduced bone mass). Review of the resident's quarterly MDS, dated [DATE], showed the resident had no scheduled or as needed pain medication and staff did not assess the resident's pain. (Pain section was blank). Review of the resident's Orthopaedic Note, dated 10/10/24, showed the following: -Resident being seen for evaluation of right wrist symptoms that have been going on for two weeks; -Symptoms include swelling; -Swelling at the wrist on examination; -Healing fracture of the right shoulder proximal humerous (a break in the upper arm bone near the shoulder joint); -Right wrist volatile minimally angulated fracture; (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	-Both fractures are in the flaccid (hanging loose or limp) right upper extremity; -Plan: Os-Cal D500 twice daily (calcium supplement), splint on the right wrist for the radius fracture for four weeks, lymphadema sleeve (a compression sleeve to reduce swelling), have physical therapy specify might be ideal to manage the swelling, acetaminophen (Tylenol) for pain as needed; -Revisit in six weeks. Review of the resident's physician orders did not include the splint on the resident's wrist, orders for physical therapy, a lymphedema sleeve, or acetaminophen. Review of the resident's Medication Administration Record, dated 11/05/24, showed the resident had a pain level of two (on a scale of 1-10 with 10 being the worst pain possible), and staff administered Tramadol 50 mg for pain. Review of the resident's Medication Administration Record, dated 11/06/24, on day shift showed staff documented NA on the resident's pain score. Review of the resident's Medication Administration Record, dated 11/07/24, on night shift showed staff documented 1 on the resident's pain score. Review of the resident's Medication Administration Record, 11/08/24, on night shift showed staff documented 1 on the resident's pain score. Review of the resident's Medication Administration Record, 11/08/24, showed the resident had a pain level of six and staff administered Tramadol 50 mg for pain. Review of the resident's Medication Administration Record, 11/09/24, on day shift showed staff documented 3 on the resident's pain score. Review of the resident's Medication Administration Record, 11/09/24, showed the resident had a pain level of three and staff administered Tramadol 50 mg for pain. Review of the resident's Nurses Progress Notes showed no documentation staff assessed to determine if Tylenol administered on 08/09/24 at 4:20 P.M., was effective in relieving the resident's pain. Review of the resident's Medication Administration Record, 11/12/24, at 4:35 P.M. showed the resident had a pain level of four and staff administered Tramadol 50 mg for pain. Review of the resident's Nursing Progress Notes, dated 11/12/24, at 3:34 P.M., showed the following: -Faxed physician in regard to Tramadol 50 mg order; -Resident used Tramadol six times last month and three times this month so far, medication requires a new prescription, physician response requested to continue or discontinue medication. (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	Review of the resident's Nursing Progress Notes, dated 11/12/24, at 4:26 P. M., showed the physician responded to fax for Tramadol and wanted to continue the medication, a new prescription was sent to the pharmacy. Review of the resident's Nursing Progress Notes, dated 11/12/24, at 7:11 P.M., showed the resident received Tramadol 50 mg at 4:35 P.M., and it was effective 0. Review of the resident's Medication Administration Record, 11/19/24, on day shift showed staff documented 0 on the resident's pain score. Observation of the resident on 11/19/24, at 12:26 P.M., showed the following: -The resident sat in a wheelchair at the dining room table; -The Resident had a sling on his/her right arm. The sling was not placed properly and the resident's arm was not resting in the sling. The resident's arm was straight and the sling cut into the resident's forearm. The resident's hand had 4+ edema; (a severe case of pitting edema, a condition where the skin retains fluid and appears indented after pressure is applied); -The resident repeated the numbers 1, 2, 1, 2, 5, 4; -The resident nodded yes when asked if he/she was in pain; -The resident grabbed his/her right arm and when the resident moved his/her arm he/she winced and moaned in pain; -The surveyor reported the resident's signs of pain to staff. During an interview on 11/19/24, at 12:45 P.M., the Director of Nursing (DON) said the resident has fractures in the shoulder and wrist. The resident was not supposed to have a sling on and it was not placed properly. She let the nurse know the resident was in pain and his/her edema was worse. The resident was supposed to get therapy to apply a lymphedema sleeve. Review of the resident's Orders Administration Note (Nursing Progress Note generated from the Medication Administration Record), dated 11/19/24, at 2:30 P.M., showed staff administered Tramadol 50 mg for pain (over one and half hours after pain was reported by the surveyor). Review of the Resident's Nurses Progress Notes, dated 11/19/24, at 7:10 P.M., showed staff documented unknown on the follow up pain assessment from the previous Tramadol administration on 11/19/24, at 2:30 P. M. Review of the resident's Orders Administration Note, dated 11/20/24, at 12:16 P.M., showed staff administered Tramadol 50 mg for pain. Review of the Resident's Nurses Progress Notes, dated 11/20/24, at 1:24 P.M., showed staff documented unknown on the follow up pain assessment from the previous Tramadol administration on 11/19/24, at 2:30 P. M. (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	During an interview on 11/20/24, at 1:45 P.M., The DON said the following: -Staff are expected to treat the resident's pain and edema; -She was not sure why the resident had the sling on yesterday; -The resident has Tramadol and hydrocodone for pain control; -The resident's wrist fracture was a spiral shaped fracture and would not be repaired surgically; -The resident could answer yes and no questions, when the residents said numbers, the resident was expressing there was an issue; -The facility was supposed to be getting the resident a lymphedema sleeve and working with therapy. Observation on 11/25/24, at 10:45 A.M., showed the following: -The resident lay in his/her bed; -His/her right arm was positioned partially under his/her body; -The resident grabbed and pulled at his/her right arm, while wincing, moaning and saying 1, 2, 1, 2; -The resident's right arm and hand were swollen 4++, more swollen than the last observation on 11/19/24; -There was a distinct deep crease between the forearm and hand from the increased edema; -The surveyor reported to Licensed Practical Nurse (LPN) B. During an interview on 11/25/24, at 10:55 A.M., LPN B said the following: -Staff are expected to position the resident's arm on a pillow; -Staff are expected to ask the resident about pain every shift, the resident has had pain frequently since the fractures; -The resident can answer yes and no questions appropriately; -The resident has an order for Tramadol for pain and should receive the medication every six hours if he/she was in pain; -The Certified Medication Technicians (CMTs) ask resident's about pain and report pain to the nurse; -No one has reported the resident's pain today. (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	During an interview on 11/25/24, at 11:25 P.M., CMT D said the following: -The resident had Tramadol for pain; -The Certified Nurse Assistants or the nurse tells him/her if a resident was in pain; -If a resident was in pain they try non medication methods to address pain and medication interventions to attempt to lessen a resident's pain; -Pain medication should be administered as soon as the staff are made aware of the pain; -Pain scores are documented as zero unless a resident complains of pain. They do not always ask the resident if they are in pain. During an interview on 11/25/24, at 12:22 P.M., the resident's durable power of attorney said the following: -The resident recently had fractures; -He/She expected staff to attempt to control the resident's pain. The resident had as needed PRN medication to administer. Staff should try to keep the resident's arm elevated on pillows; -The resident could not speak effectively to communicate so he/she expected staff to ask the resident yes or no questions to assess his/her pain every shift. Review of the resident's Medication Administration Record, on 11/25/24, at 3:00 P.M., showed no documentation staff administered pain medication to the resident following the observation on 11/24/24 at 10:45 A.M. Review of the resident's record showed there were no therapy orders since the fractures were found, and no orders for a lymphedema sleeve on the resident's physician orders sheet. 2. Review of Resident #36's care plan, revised 04/15/24, showed the following: -Resident is at risk for increased pain and discomfort related to related to diagnosis of chronic pain; - Anticipate the resident's need for pain relief and respond immediately to any complaint of pain; - Evaluate the effectiveness of pain interventions; -Review for compliance, alleviating of symptoms, dosing schedules and resident satisfaction with results, impact on functional ability and impact on cognition. Review of the resident's annual MDS, a federally mandated assessment completed by staff, dated 7/26/24, showed the following: (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	-Cognitively intact; -Diagnosis included depression; -Minimal symptoms of depression; -No delusions, no hallucinations; -No behaviors, no rejection of care; -Dependent on staff for bed mobility, transfers with a mechanical lift, toilet use and bathing, manual wheelchair and dependent on staff for wheelchair mobility; -Schedule pain medication regimen, has received as needed pain medication, and non medication interventions for pain; -Pain present, frequently and rates his/her pain a 3 on a 1-10 scale; -Shortness of breath with exertion, and when lying flat. Review of the resident's quarterly MDS, dated [DATE], showed the following: -Schedule pain medication regimen, has received as needed pain medication, and non medication interventions for pain; -Pain present, frequently and rates his/her pain a 3 on a 1-10 scale. Review of the resident's Physician's Order Sheet, dated November 2024, showed the following: -Gabapentin (medication for nerve pain) 600 mg four times a day; -Tylenol (pain medication) 650 mg every six hours as needed for discomfort; -Cyclobenzipine (medication for muscle spasms) 10 mg every eight hours as needed for muscle spasms; -Tramadol 50 mg every eight hours for pain as needed; -Baclofen 10 mg twice daily for pain; Review of the resident's MAR, dated 11/01/24-11/18/24, showed staff documented the resident's pain a 0 on every day and night shift. The resident has not received any PRN medications for pain. (Tylenol, Cyclobenzipine, or Tramadol). During an interview on 11/18/24, at 12:16 P.M., the resident said his/her pain is an eight or a nine all the time and he/she felt his/her pain was not controlled. The resident did not remember the last time he/she did not have pain. He/She has a lot of stomach and abdominal pain, and phantom pain from his/her leg amputations. The resident said staff do not ask him/her about his/her pain, but the pain was always there. The pain made it hard to sleep, or focus on what he/she was doing. (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	3. Review of Resident #'80's admission Minimum Data Set (MDS), a federally required assessment completed by staff, dated 03/09/24, showed the following: -Severe cognitive impairment; -Diagnosis include a stroke, blood clot, pneumonia, aphagia, malnutrition, depression, post traumatic stress disorder (PTSD); -Signs of minimal depression; -Unclear speech rarely/never understood; -Sometimes understands; -Functional range of motion limitations in both upper and both lower extremities; -Dependent all activities of daily living (ADLs); -Uses a wheelchair; -Always incontinent; -99 pounds; -No restorative nursing; -Scheduled pain regimen, unable to do pain interview, staff assessment not completed. Review of the resident's Care Plan, dated 06/04/24, did not include pain. Review of the resident's quarterly MDS, dated [DATE], showed the resident has scheduled pain medication. Review of the resident's quarterly MDS, dated [DATE] ,showed the resident has scheduled pain medication. Review of the resident's Care Plan, last updated 11/01/24, did not include pain. Review of the resident's Physician's Orders, dated November 2024, showed the following: -Tramadol 20 mg two times daily for pain; -Ropiniolol 0.25 mg two times a day for restless leg syndrome; -Acetaminophen 500 mg, give two tablets every six hours as needed for pain. Review of the resident's MAR, dated 11/01/24-11/09/24, showed the staff documented the resident's pain a 0 three shifts per day. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Beloved Health and Rehabilitation Center	328 Munger Lane Hannibal, MO 63401

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F 0697 Level of Harm - Actual harm Residents Affected - Few	Review of the resident's MAR, dated 11/10/23-11/18/24, showed the MAR changed to be a check off and no pain score values were documented. Review of the resident's MAR, dated 11/01/24-11/18/24, showed the staff did not administer the resident's Acetaminophen. Observation on 11/21/24, at 08:45 A.M., showed the following: -Certified Nurse Assistant (CNA) R and Nurse Assistant (NA) E provided care to the resident; -The resident had severe contractures of the right arm and leg; -The resident's body was not aligned, his/her back was curved, with the right leg and right arm drawn up; -When CNA R and NA E rolled the resident side to side the resident's body did not relax and it stayed in a drawn up/flexed position; -The resident grimaced, moaned in pain, and guarded his/her right leg grabbing his/her right leg with his/her left hand every time the staff moved him/her, and moving his/her arms to stop them from turning him in a guarding motion. During an interview on 11/21/24, at 8:55 A.M., CNA R said the resident was in pain because of his/her contractures. Once he/she was in a certain position he/she did not complain, but it hurt the resident every time they moved him/her. He/She was not sure what pain medication the resident was getting. During an interview on 11/25/24, at 11:25 P.M., CMT D said the following: -The resident had Tramadol for pain; -The CNA or the nurse tells him/her if a resident was in pain; -If residents are in pain, they use non medication methods and pain medication to attempt to lessen the resident's pain; -Pain medication should be administered as soon as the staff are made aware of the pain; -Pain scores are documented as zero unless a resident complains of pain. Staff do not always ask residents if they are in pain. During an interview on 11/25/24, at 10:55 A.M., LPN B said the following: -Staff are expected to reposition and try to make resident's experiencing pain comfortable; -Staff are expected to ask the resident about pain every shift; -The CMTs ask resident's about pain and report pain to the nurse; (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	-Staff should attempt non medication and medication interventions for resident's experiencing pain; -If pain is not controlled staff after interventions are exhausted, staff are expected to notify the resident's physician. During an interview on 11/25/24, at 6:55 P.M., the DON said the following: -If a resident was in pain then staff are expected to administer as needed pain medications as soon as they are aware of the pain; -Staff are expected to assess a resident's pain every shift, not just assume if nothing is reported there was no pain. Staff are expected to ask or assess the resident for signs and symptoms of pain; -Uncontrolled pain was expected to be reported to the physician; -The facility reviews residents with increased pain during morning meetings, there was no pain care committee; -The charge nurse was responsible to ensure resident's pain was managed appropriately. MO245289

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32899 Based on observation, interview, and record review, the facility failed to assess residents for risk of entrapment prior to placement of bedrails, document alternatives attempted prior to bed rail placement, complete entrapment zone measurements, or obtain written consent from the residents and/or their guardians prior to use for two residents (Residents #19 and #20), who used side rails, in a review of 20 sampled residents. Resident #19 had quarter bed rails assessed but half-rails were present on his/her bed. The census was 87. During an interview on 11/25/24 at 2:00 P.M., the Director of Nursing (DON) said the facility did not have a policy for entrapment risks and bed rail use. 1. Review of Resident #20's Bed Measurement Device assessment form, dated 11/14/22, showed the following: -Zone one, quarter one = 4.25 inches (<4.75 inches within the rail); -Zone two, no measurements; -Zone three, quarter one =4.375 inches (<4.25 inches under the rail and the mattress); -Zone four and five, no measurements; -Zone six, quarter one = eight (end of rail/foot/head board with no recommendation); -Zone seven, quarter one = three (mattress/head/foot board with no recommendations); -The form did not include a pass or fail grade; -It did not specify assist rails, quarter rails or half rails; -It did not address the reason for the rails. Review of the resident's medical record showed no documentation staff assessed the resident's risk of entrapment. Review of the resident's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument, completed by facility staff, dated 09/12/24, showed the following: -Moderately impaired cognition; -Substantial to maximum assist for bed mobility and transfers; -No falls since re-entry or prior assessment. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the resident's Fall Risk Assessment, dated 10/23/24, showed the resident was at high risk for falling. Review of the resident's physician order sheet (POS), dated 11/2024, showed the following: -Diagnoses included dementia and repeated falls; -Grab bars/side rails times two for bed mobility, increased independence, safety and transfers (original order dated 12/13/22). Review of the resident's Care Plan, last revised 11/01/24, showed the following: -The resident was at risk for falls. He/She had a history of putting himself/herself on the floor; -Repeated falls noted with the last one on 08/29/23; -The resident requested assist rails in upright position for repositioning and feeling of safety; -The resident used assist rails to turn and reposition in bed (01/22/23). Observations showed the following: -On 11/20/24 at 7:15 A.M., the resident lay in his/her bed. The resident had assist rails (in the upright position) on both sides of this/her bed. The left side of the resident's bed was against the wall; -On 11/25/24 at 10:35 A.M., the resident lay in his/her bed. The assist rails were in the upright position on both sides of his/her bed. Review of the resident's electronic medical record on 11/25/24 showed the following: -The only side rail entrapment assessment was completed on 11/14/22; -There were no recent assessments and no entrapment zone measurements for the mattress/bed. -There was no documentation to show the facility discussed the risk/benefits of the assist bars with the resident. During an interview on 12/2/24 at 3:13 P.M., the Director of Nurses said the following: -The facility did not have any assessments or consents for the assist rails for Resident #20; -Side rail assessments should be completed quarterly. 2. Review of Resident 19's face sheet, showed the resident has a Durable Power of Attorney (DPOA) for health care decisions. Review of the resident's Informed Consent for Bed Rail Use, undated, showed the following: (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-1/4 bed rails on both upper sides of the bed; -Recommend bed rails up when resident is in bed; -Two boxes on the form for I do consent and I do not consent: both boxes are blank; -The resident's signature was on the form but did not include a date; -The staff member completing the form did not sign or date the form. Review of the resident's Side Rail Utilization Assessment, undated, showed the following: -The resident had not requested the bed rails; -The resident's legal guardian/representative had not requested the bed rails; -Two quarter rails were requested; -Resident/Representative was informed of bed rail risk; -The resident does not attempt to get out of bed; -The resident does not have trunk control; -The resident cannot roll on side independently; -The resident does not have decreased safety awareness or confusion; -Alternatives to bed rails attempted section is blank; -Quarter rails on both upper sides of the bed recommended; -Epileptic syndrome (seizures) and hemiplegia (paralysis to one side of the body). Review of the resident's care plan, updated 12/23/21, showed padded side rails both sides of the bed for bed mobility. Review of the resident's care plan, updated 02/08/22, showed padded side 1/2 rails (not 1/4 rails like the consent and assessment showed) on both sides of the bed for safety and to assist with bed mobility. Observe for injury or entrapment related to side rail use. Reposition as needed to avoid injury. Review of the resident's annual MDS, dated [DATE], showed the following: -Severe cognitive impairment; -Diagnosis hemiplegia (paralysis on one side of the body), total brain injury (TBI), seizure disorder, aphasia (inability to speak); (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Rarely/Never understood or understands; -Vision highly impaired; -No behaviors or rejection of care; -Limited functional range of motion in one upper and one lower extremity; -Requires substantial/maximal assistance from staff to roll left and right, sit to lying and lying to sitting on side of bed; -Dependent on staff to sit to stand, chair/bed-to-chair transfer and tub/shower transfer; -Always incontinent of bowel and bladder; -Bed rails used as restraints daily. Review of the resident's quarterly MDS, dated [DATE], showed no changes. Review of the resident's POS, dated 11/06/24, showed may use 1/4 side rails bilaterally to promote repositioning and (seizure precautions) due to epileptic syndrome and hemiplegia. Review of the resident's Bed Measurement Device assessment form, dated 11/08/24, showed the following: -Zone one, pass; -Zone two, pass; -Zone three, pass; -Zone four pass; -Zones five, six and seven showed documentation of n/a or not applicable; -The form did not include specific measurements; -It did not specify assist rails, quarter rails or half rails; -It did not address the reason for the rails. Review of the resident's care plan, last revised 11/26/24, showed the following: -The resident uses 1/4 siderails due to epileptic syndromes, hemiplegia and to promote independence while in bed; -Encourage use of side rails to promote independence in repositioning in bed. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 11/25/24 at 10:45 A.M., showed the resident lay in his/her bed with padded half rails in the raised position to both upper sides of the bed; the resident had been assessed for 1/4 rails. During an interview on 11/25/24 at 10:55 A.M., Licensed Practical Nurse (LPN) B said the following: -The resident had half bed rails that were padded on his/her bed because the resident had seizures; -He/She was not sure what special interventions the resident had for entrapment risk, or if the resident had been assessed for an entrapment risk; -Staff had to roll the resident and used the mechanical lift for transfers; -He/She does not know who assessed for resident entrapment risk or when those assessments are re-evaluated. During an interview on 11/25/24 at 12:22 P.M., the resident's DPOA said the following: -He/She gave consent (did not indicate if this was verbal or written) for use of bed rail because the resident liked to hold on to the bed rail when staff turn him/her; -He/She felt the resident was at risk for entrapment and wanted the resident checked on often for his/her seizure activity and to make sure he/she was not caught in the bed rail; -The facility had not reviewed the risks and benefits of bed rails with him/her. The resident's medical record did not contain evidence of evaluation of bed rail use or entrapment risk assessments. The assessments completed were signed by the resident who was unable to make decisions for him/herself, and were not dated. The assessments listed quarter rails but the resident was observed to have half rails on his/her bed. The MDS listed the bed rails as a restraint, but there were no restraint assessments or interventions on the resident's care plan or other areas of the resident's medical record. During an interview on 11/25/24 at 2:00 P.M. and 12/02/24 at 3:13 P.M., the Director of Nurses said the following: -Staff are expected to try alternates before side rails are placed; -Consents should be obtained from the resident or responsible party; -Entrapment risk should be determined on the side rail assessment; -All they questions should be answered on the assessment forms; -Bed rail entrapment risks are expected to be on the care plan; -Bed rails are not restraints unless they limit what the resident can do or have access to their body; (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Side rail assessments should be completed quarterly. 38016

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38016 Based on observation, interview and record review, the facility failed to ensure there was sufficient and competent nursing staff to meet resident needs. The facility consistently had less nursing staff than indicated in the facility assessment. During a resident council meeting, three residents (Resident #4, #74 and #83), voiced concerns of call lights not being answered in a timely manner on night shift and on the weekends. The facility failed to provide restorative nursing to three residents (Resident #19, #80, and #4) in a sample of 20 residents who had contractures when the facility did not employee a restorative aide. The census was 87. Review of the facility's Facility Assessment, dated 11/26/24, showed the average daily facility staffing plan included: -One Hall Monitor; -Two Certified Nurse Assistants (CNA)'s; -Six Certified Medication Technicians (CMT)'s; -Six Licensed Practical Nurses (LPN)s; -One Registered Nurse Director of Nursing (RN/DON). 1. Review of the staffing sheets show the employees work 12 hours shifts unless otherwise noted. Review of the facility's Punch Detail, dated 10/26/24 (Saturday), showed the following: -One Hall Monitor on day shift; -Three CNA's on day shift; -Three CNA's on night shift; -Two CMT's on day shift; -One LPN on day shift; -Two LPN's on night shift; -One RN on day shift for eight hours; The facility had four less CMT shifts covered than the facility assessment indicated; The facility had three less LPN shifts covered than the facility assessment indicated. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility's Punch Detail, dated 10/27/24 (Sunday), showed the following: -One Hall Monitor on day shift; -Four CNA's on day shift; -Three CNA's on night shift; -One CMT on day shift; -One LPN on day shift; -One LPN on night shift; -One RN on day shift for eight hours; The facility had five less CMT and four less LPN shifts covered than the facility assessment indicated. Review of the facility's Punch Detail, dated 11/02/24 (Saturday), showed the following: -Three Nurse Assistant (NA)'s on day shift; -Two CNA on night shift, and one additional CNA worked six hours on night shift; -One CMT on day shift; -Two LPN on night shift; -One RN on day shift; The facility had one less hall monitor shift, one half shift less of CNA hours, five less CMT shifts and four less LPN shifts covered than the facility assessment indicated. Review of the facility's Punch Detail, dated 11/03/24 (Sunday), showed the following: -Three NA's on day shift; -Three CNA's on night shift; -One half shift CMT on day shift (six hours); -One LPN on night shift; -One RN on day shift; The facility had one less hall monitor shift, five and a half less CMT shifts and five less LPN shifts covered than the facility assessment indicated. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility's Punch Detail, dated 11/09/24 (Saturday), showed the following: -One NA on day shift; -One NA on night shift; -Four CNA's on day shift; -Two CNA's on night shift; -One CMT on day shift, and one CMT for seven hours; -One LPN on day shift; -One LPN on night shift; -One RN on day shift for eight hours. The facility had four less CMT shifts and four less LPN shifts covered than the facility assessment indicated. Review of the facility's Punch Detail, dated 11/10/24 (Sunday), showed the following: -One Nurse Assistant (NA) on day shift; -One NA on night shift; -Four CNA's on day shift; -Two CNA's on night shift; -One CMT on day shift, and one CMT for seven hours; -One LPN on day shift; -Two LPN's on night shift; -One RN on day shift for eight hours. The facility had one less hall monitor shift, four less CMT shifts and three less LPN shifts covered than the facility assessment indicated. Review of the facility's Punch Detail, dated 11/16/24 (Saturday), showed the following: -One Hall Monitor on day shift; -Two NA's on day shift; (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Two CNA's on day shift; -Three CNA's on night shift; -A five hour shift for a CMT on day shift; -One LPN on day shift; -One LPN on night shift; -One RN on day shift; The facility had five shifts and five hours less CMT shifts and four LPN shifts covered than the facility assessment indicated. Review of the facility's Punch Detail, dated 11/17/24 (Sunday), showed the following: -One Hall Monitor on day shift; -Two NA's on day shift; -Two CNA's on day shift; -Three CNA's on night shift; -One CMT on day shift; -One LPN on day shift; -Two LPN on night shift; -One RN on day shift; The facility had five less CMT shifts and three less LPN shifts covered than the facility assessment indicated. 2. During a group interview on 11/20/24 at 2:41 P.M., showed the following: -Resident # 4 said the he/she had to wait a long time for staff assistance during the night. One of the night staff members would not assist him/her and he/she would have to wait a long time for help from another staff member; -Resident #75 said he/she had to wait longer for staff assistance during the nights and especially on weekends; -Resident #83 said he/she had to wait a long time for staff assistance during the night and weekend shifts. He/She said the call light would be answered, but staff would not return to help him/her. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. Review of Resident #'80's admission Minimum Data Set (MDS), a federally required assessment instrument completed by staff, dated 03/09/24, showed the following: -Severe cognitive impairment; -Diagnoses include stroke and blood clot; -Unclear speech rarely/never understood; -Sometimes understands; -Functional range of motion limitations in both upper and both lower extremities; -Dependent all activities of daily living (ADLs); -Uses a wheelchair; -No restorative nursing; -Scheduled pain regimen, unable to do pain interview, staff assessment not completed. Review of the resident's medical record showed no documentation that a Restorative Nursing department had assessed the resident's range of motion at admission with a suggested/prescribed range of motion exercise plan for the resident per facility policy. There was no restorative nursing department and no documentation that a licensed nurse evaluated the resident for need of restorative nursing. Review of the resident's Care Plan, dated 06/04/24, did not include pain or functional range of motion limitations in both upper and lower extremities. Review of the resident's quarterly MDS, dated [DATE], showed the resident had scheduled pain medication, functional range of motion limitations in both upper and lower extremities and no range of motion or restorative nursing. Review of the resident's quarterly MDS, dated [DATE], showed the resident had scheduled pain medication, functional range of motion limitations in both upper and lower extremities and no range of motion or restorative nursing. Review of the resident's Care Plan, last updated 11/01/24, did not include pain, functional range of motion limitations in both upper and lower extremities and no range of motion or restorative nursing. Review of the resident's electronic medical record showed no documentation of a restorative nursing plan or range of motion documentation. Observation on 11/21/24 at 8:45 A.M., showed the following: -Certified Nurse Assistant (CNA) R and Nurse Assistant (NA) E provided care to the resident; (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-The resident had severe contractures of the right arm and leg and used his/her left arm to move his/her right arm and leg; -The resident's body was not aligned, his/her back was curved, with the right leg and right arm drawn up; -When CNA R and NA E rolled the resident side to side, the resident's body did not relax and it stayed in a drawn up/flexed position; -The resident grimaced, moaned in pain and guarded his/her right leg, grabbing his/her right leg with his/her left hand every time the staff moved him/her, and moving his/her arms to stop them from turning him in a guarding motion; -Neither CNA R or NA E provided ROM exercises during cares. During an interview on 11/21/24 at 8:55 A.M., CNA R said the resident was in pain because of his/her contractures. Once the resident was in a certain position, he/she did not complain, but it hurt the resident every time they moved him/her. He/She was not sure what pain medication the resident was getting. No one provided ROM for resident's with contractures because the facility did not have restorative nursing. 4. Review of Resident #19's Care Plan, dated 09/22/23, showed the following: -Risk for pain and discomfort related to hemiparesis (paralysis one side of the body), and seizure activity; -Monitor/record/report to nurse if resident complains of pain; -Passive Range of Motion (PROM): Staff to perform PROM to all extremities once daily seven days per week; -Range each extremity five reps while supporting joint; -Encourage resident to communicate any pain/discomfort during program; -Stop range if resident reports pain and notify nurse; -Document minutes program provided in POC (the electronic medical record). Review of the resident's care plan, dated 10/03/23, showed the care plan for the resident's PROM for contractures was canceled. Review of the resident's annual MDS, dated [DATE], showed the following: -Severe cognitive impairment; -Diagnoses of hemiplegia (paralysis one side of the body), total brain injury, seizure disorder, aphasia (inability to express themselves by speaking); (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Rarely/Never understood or understands; -No behaviors or rejection of care; -Limited functional range of motion in one upper and one lower extremity; -Requires substantial/maximal assistance from staff to roll left and right, sit to lying and lying to sitting on side of bed; -Dependent on staff for oral hygiene, toileting hygiene, shower/bathe, upper body dressing, lower body dressing, putting on/taking off footwear, personal hygiene, sit to stand, chair/bed-to-chair transfer and tub/shower transfer; -No scheduled or as needed pain medication; -Staff assessment of pain is blank (did not answer yes or no, questions not answered). Review of the resident's Nursing Progress Notes, dated 08/10/24 at 11:00 P.M., showed the following: -Resident returned from the emergency room with diagnosis of humeral fracture; (fracture of a bone in the arm); -Sling in place to right upper extremity; -New medication for Norco (narcotic pain medication) 5/325 milligrams (mg) every six hours as needed for pain. Review of the resident's Nursing Progress Notes, dated 08/16/24 at 2:01 P.M., showed a provider ordered Voltaren gel (a topical anti inflammatory medication) one percent (%) to right shoulder every eight hours as needed for pain and a new order for mechanical lift transfers. Review of the resident's Nursing Progress Notes, dated 08/19/24 at 2:57 P.M., showed the resident had fluid shift from the shoulder to the forearm even with repositioning and elevation. Physician, guardian and orthopaedic physician notified of new edema. Review of the resident's Care Plan, updated 08/26/24, showed the following: -Pillow placed under right upper extremity for stabilization; -The resident has limited physical mobility; -The resident will maintain current level of mobility (specify: able to walk with walker unassisted, one person assist for 15 feet (ft)) through review date. Target Date: 01/07/2025; -The resident's care plan did not include any direction for caring for the resident's flaccid and contracted right leg, or any range of motion/instructions related to the resident's fractures and new mobility limitations in addition to previous hemiplegia. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the resident's radiology report, dated 09/30/24, showed a fracture of the distal radius (bone in the fore arm where it connects to the wrist) with mild posterior angulation (Colles fracture-a break in the radius bone of the wrist that occurs when the broken end of the bone bends backward). Review of the resident's Orthopaedic Note, dated 10/10/24, showed the following: -Resident being seen for evaluation of right wrist symptoms that have been going on for two weeks; -Symptoms include swelling; -Swelling at the wrist on examination; -Healing fracture of the right shoulder proximal humerus (a break in the upper arm bone near the shoulder joint); -Right wrist volatile minimally angulated fracture; -Both fractures are in the flaccid (hanging loose or limp) right upper extremity; -Plan: Os-Cal D 500 twice daily (calcium supplement), splint on the right wrist for the radius fracture for four weeks, lymphedema sleeve (a compression sleeve to reduce swelling), have physical therapy evaluate and specify the lymphedema sleeve needed might be ideal to manage the swelling, acetaminophen (Tylenol) for pain as needed; -Revisit in six weeks. Review of the resident's November 2024 (current) physician orders showed they did not include orders for physical therapy, a lymphedema sleeve or acetaminophen. Observation of the resident on 11/19/24 at 12:26 P.M., showed the following: -The resident sat in a wheelchair at the dining room table; -The resident had a sling on his/her right arm. The sling was not placed properly and the resident's arm was not resting in the sling. The resident's arm was straight and the sling cut into the resident's forearm; The resident's hand had four plus edema; (a severe case of pitting edema, a condition where the skin retains fluid and appears indented after pressure is applied); -The resident was not wearing a lymphedema sleeve; -The resident repeated the numbers 1, 2, 1, 2, 5, 4; -The resident nodded yes when asked if he/she was in pain; -The resident grabbed his/her right arm with his/her left hand and when the resident moved his/her right arm, he/she winced and moaned in pain; (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-The surveyor reported the resident's signs of pain to staff. Review of the resident's electronic medical record, dated 10/03/23-11/20/24, showed no documentation of any restorative nursing services or PROM provided by the facility. During an interview on 11/19/24 at 12:45 P.M., the Director of Nursing (DON) said the resident had fractures in the shoulder and wrist. The resident was not supposed to have a sling on and it was not placed properly. She let the nurse know the resident was in pain and his/her edema was worse. The resident was supposed to get therapy to apply a lymphedema sleeve, but he/she had not had a therapy evaluation yet. The resident's PROM had been canceled on the resident's care plan because the facility did not have a restorative aide. During an interview on 11/20/24, at 1:45 P.M., The Director of Nurses said the following: -The resident had limitations to his/her range of motion on the right side, and had some contractures; -The resident does not get PROM or restorative nursing because the facility does not have restorative nursing staff; -Staff are expected to treat the resident's pain and edema; -She was not sure why the resident had the sling on yesterday; -The resident had Tramadol and hydrocodone for pain control; -The resident's wrist fracture was a spiral shaped fracture and would not be repaired surgically; -The resident could answer yes and no questions; when the resident said numbers, the resident was expressing there was an issue; -The facility was supposed to be getting the resident a lymphedema sleeve and working with therapy. Observation on 11/25/24 at 10:45 A.M., showed the following: -The resident lay in his/her bed; -His/Her right arm was positioned partially under his/her body; -The resident grabbed and pulled at his/her right arm with his/her left hand, while wincing, moaning and saying 1, 2, 1, 2; -The resident's right arm and hand were swollen (four plus); more swollen than the observation on 11/19/24; -There was a distinct deep crease between the forearm and hand from the increased edema. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 11/25/24, at 10:55 A.M., Licensed Practical Nurse (LPN) B said the following: -Staff are expected to position the resident's right arm on a pillow; -Staff are expected to ask the resident about pain every shift; the resident had had pain frequently since the fractures; -The facility does not have restorative nursing. During an interview on 11/25/24 at 12:22 P.M., the resident's durable power of attorney said he/she was concerned about the resident arm, and was also concerned because the resident' was not getting ROM or strengthening exercises to his/her legs. 5. Review of Resident #4's admission MDS, dated [DATE], showed the following: -Cognitively intact; -Diagnoses: paraplegia (paralysis from the waist down); -No behaviors or rejection of care; -No restorative nursing: -Requires partial/moderate assistance from staff for upper body dressing and to roll left and right, -Requires substantial/maximal assistance from staff for sit to lying, lying to sitting on the side of bed, to wheel wheelchair 150 feet and 50 feet with two turns; -Dependent on staff for toileting hygiene, shower/bathe, lower body dressing, footwear and chair/bed-to-chair transfer; (the MDS did not include the resident's limited range of motion in both lower extremities; he/she was paralyzed from the waist down). Review of the resident's medical record showed no documentation that Restorative Nursing had assessed the resident's needs on admission with a suggested/prescribed range of motion exercise plan for the resident. Review of the resident's quarterly MDS, dated [DATE], showed no restorative nursing and no range of motion issues. Review of the resident's quarterly MDS, dated [DATE], showed the following: -New impairments to range of motion, both lower extremities; (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Independent with lower body dressing, independent to wheel 50 feet with two turns and 150 feet, upper body dressing; -Requires partial/moderate assistance from staff for toilet hygiene and putting on/taking off footwear; -No restorative nursing. Review of the resident's quarterly MDS, dated [DATE], showed no changes to range of motion and no restorative nursing. Review of the resident's quarterly MDS, dated [DATE], showed showed no changes to range of motion and no restorative nursing. Review of the resident's quarterly MDS, dated [DATE], showed no changes to range of motion and no restorative nursing. During an interview on 11/19/24 at 2:39 P.M., the resident said he/she was a paraplegic (paralysis to both legs). He/She would like restorative nursing to prevent contractures in his/her legs, but the facility did not have a restorative program. The staff will not assist him/her when he/she asked for assistance and say he/she was independent and needed to do things for himself/herself. He/She can do most things himself/herself but cannot do effective range of motion on his/her legs by himself/herself. During an interview on 11/25/24, at 10:55 A.M., LPN B said the facility no longer has restorative nursing so if there was a decline in range of motion they would have to consult therapy. During an interview on 11/20/24, at 1:30 P.M., the Director of Nursing said there was no restorative program because the facility did not have a restorative aide. For the residents listed the staff just try to do good positioning. The facility has a walk to dine program but Resident #30, #80 and #4 cannot walk. During an interview on 11/26/24 at 3:28 P.M., the Director of Nursing said the facility was not staffed to her preferences to make sure everything got done, The facility used to use agency and may have to start using agency again. When they are short, they try to prioritize what needs to be done. 47008

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F 0728 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure that nurse aides who have worked more than 4 months, are trained and competent; and nurse aides who have worked less than 4 months are enrolled in appropriate training. 38016 Based on interview and record review, the facility failed to ensure four nurse aides (NA) (NA U, NA Q, NA V and NA W) completed a nurse aide training program within four months of their employment as an NA in the facility. The facility also failed to ensure 16 hours of instructional training covering communication, infection control, safety/emergency procedures, residents' rights and promoting independence before any resident interaction for one NA (NA F) in a sample of five NA employee files reviewed. The facility census was 87. Review of the facility's policy, Nurse Assistants/Certified Nurse Assistants, undated, showed the following: -This policy defines the qualifications, roles and restrictions for Nursing Assistant (NA) Students and Certified Nursing Assistants (CNA) at the facility; -It ensures compliance with Missouri Department of Health and Senior Services (DHSS), Centers for Medicare & Medicaid Services (CMS) and the Missouri Nursing Practice Act; -This policy applies to all Nursing Assistant Students, Certified Nursing Assistants, and supervisory staff: -Enrollment in a State-Approved Training Program: Be actively enrolled in a CNA training program approved by DHSS (Department of Health and Senior Services); -Complete at least 16 hours of instructional training coveting communication, infection control, safety/emergency procedures, residents' rights, and promoting independence before any resident interaction; -To qualify as a CNA, the individual must successfully complete: -75 hours of state-approved instructional training; -100 hours of supervised on-the-job training; -Pass the CNA certification exam administered by a DHSS-approved third-party test administrator. The policy did not define how long the NA had to complete the course, or what happened if staff did not complete the course. 1. Review of NA U's employee files showed the following: -His/Her employment as an NA started on 12/12/23 (approximately eleven months prior); -No documentation he/she had completed CNA training or had received a CNA certification. (continued on next page)

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F 0728 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of the facility's staffing sheets showed the NA worked as a Nurse assistant on 11/24/24. 2. Review of NA Q's employee files showed the following: -His/Her employment as an NA started on 01/08/24 (approximately nine months and two weeks prior); -No documentation he/she had completed CNA training or had received a CNA certification. Review of the facility's staffing sheets showed the NA worked as a Nurse assistant on 11/24/24. 3. Review of NA V's employee files showed the following: -His/Her employment an an NA started on 04/04/24 (approximately seven months and three weeks); -No documentation he/she had completed CNA training or had received a CNA certification. Review of the staffing sheets for November 2024 showed the employee working on the locked unit or on the D hall with mentally ill residents. The employee file did not clearly define the title and qualified roles of the employee. 4. Review of NA W's employee files showed the following: -His/Her employment as an NA started on 06/24/24 (approximately five months prior); -No documentation he/she had completed CNA training or had received a CNA certification. Review of the staffing sheets for November 2024 showed the employee working on the locked unit or on the D hall with mentally ill residents. The employee file did not clearly define the title and qualified roles of the employee. 5. Review of NA F's employee, showed a hired date of 10/08/24. The employee file did not contain documentation of 16 hours of instructional training covering communication, infection control, safety/emergency procedures, residents' rights, or promoting independence before any resident interaction. Review of the facility staffing sheets showed NA F last worked as a Nurse Assistant, having contact with residents, on 11/21/24. NA F's punch details showed the employee worked seven other shifts in November 2024 as a nurse assistant. 6. During an interview on 4/16/24, at 10:21 A.M., the Director of Nursing said the following: -The facility had four nurse assistants; -The NAs completed CNA training classes online and the clinical hours in the building; (continued on next page)

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F 0728 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-Registered Nurse (RN) A and human resources (HR) coordinated their training to ensure it was completed timely; -The last HR person was not tracking very well and the new HR person just started, so he/she probably did not know where the NAs were with their training. During an interview on 11/20/24 at 2:00 P.M., RN A said the following: -She provides NA training for the facility and worked part time doing education; -She confirmed all of the NAs' start dates; -NAs were expected to be certified within four months of their start date; -She worked part time and only worked to do the education; the HR person in the role before did not keep good records of the education; the new HR person has only been here a short time and did not know who the nurse aides were; -NA's are expected to complete 16 hours of instructional training coveting communication, infection control, safety/emergency procedures, residents' rights, and promoting independence before any resident interaction; -NA U was not employed by the facility from 08/29/24 to 10/07/24, so the facility thought that started his/her time over; -She was not sure if NA Q started as a nurse assistant or if he/she started as a hall monitor, so it wouldn't be as long as it looked but was not sure since NA Q was only listed as a NA; -NA V is now only doing hall monitor but is still listed in HR as a NA; -NA W was now only doing hall monitor but is still listed in HR as a NA; -She did not know how long NA V and NAW worked as a NA or if the facility was out of compliance with their time as a NA, the previous HR employee did not track well; -NA F did not do his/her 16 hours at the facility; he/she started at another facility and the facility did not obtain documentation of his/her 16 hours of training from the other facility. During an interview on 11/20/24 at 2:45 P.M., the HR coordinator said she had only been employed a week and did not know what a nurse assistant was. During an interview on 11/20/24 at 3:15 P.M., Administrator 1 said HR and RN A oversaw the NA certification process. There has been a change in HR staff, and the last HR did not track training well.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. 47008 Based on interview and record review, the facility failed to provide documentation of a policy and procedure for monthly drug regimen reviews and failed to ensure the physicians for three residents (Residents #242, #50, and #33) provided a timely response to the pharmacist's recommendations to decrease the dosage of medications used to treat mental health disorders. The facility census was 87. The facility did not provide a policy to address the facility's system for the monthly drug regimen reviews, including time frames for different steps in the process, steps the pharmacist must take when he/she identifies an irregularity that requires urgent action, and expectations for the physicians to respond timely to identified irregularities/recommendations. 1. Review of Resident #50's face sheet showed the resident's diagnoses included schizophrenia (a mental disorder characterized by disruptions in thought processes, perceptions, emotional responsiveness, and social interactions) and anxiety disorder. Review of the resident's Critical Care Pharmacy, Note to Attending Physician/Prescriber, dated 09/13/24, showed the following: -The resident received the following medication used for psychiatric condition: Hydroxyzine (a medication used to treat anxiety) 50 mg three times daily; -Pharmacist recommended dose reduction to: Hydroxyzine 50 mg twice daily and 25 mg at bedtime; -Physician/Prescriber response was left blank. Review of the resident's Critical Care Pharmacy, Note to Attending Physician/Prescriber, dated 10/24/24, showed the following: -The resident received the following medication used for psychiatric condition: Hydroxyzine 50 mg three times daily; -Pharmacist recommended dose reduction to: Hydroxyzine 50 mg twice daily and 25 mg at bedtime. Review of the resident's consulting pharmacy note, dated 10/24/24 showed the pharmacy recommendation was refaxed to the nurse practitioner, awaiting a response. Review of the resident's Physician Order Summary, dated November 2024, showed an order for hydroxyzine oral tablet 50 mg, give one tablet three times a day for schizophrenia. Review of the resident's consulting pharmacy note, dated 11/03/24 showed the pharmacy recommendation was refaxed to the nurse practitioner, awaiting a response. Review of the resident's consulting pharmacy note, dated 11/11/24, showed the pharmacy recommendation was refaxed to the nurse practitioner, awaiting a response. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Review of Resident #33's face sheet showed the resident's diagnoses included schizophrenia and bipolar disorder (a mental illness that causes extreme mood swings, or shifts in energy, activity, and thinking). Review of the resident's Critical Care Pharmacy, Note to Attending Physician/Prescriber, dated 10/22/24, showed the following: -The resident received the following medication used for psychiatric condition: Olanzapine (a medication used to treat the symptoms of schizophrenia) 10 mg three times daily; -Pharmacist recommended dose reduction to: Olanzapine 10 mg two times daily and 7.5 mg at bedtime. Review of the resident's consulting pharmacy note, dated 10/24/24 showed the pharmacy recommendation was refaxed to the nurse practitioner, awaiting a response. Review of the resident's Physician Order Summary, dated November 2024. showed an order for olanzapine oral tablet 10 mg, give one tablet three times a day for bipolar, revised on 11/12/24. Review of the resident's consulting pharmacy note, dated 11/02/24, showed the pharmacy recommendation was refaxed to the nurse practitioner, awaiting a response. Review of the resident's consulting pharmacy note, dated 11/11/24, showed the pharmacy recommendation was refaxed to the nurse practitioner, awaiting a response. 3. Review of Resident #242's face sheet showed the resident's diagnoses included schizophrenia and anxiety disorder (a condition that causes excessive feelings of fear, worry, dread, and uneasiness). Review of the resident's Critical Care Pharmacy, Note to Attending Physician/Prescriber, dated 09/12/24, showed the following: -The resident received the following medication used for psychiatric condition: Olanzapine 10 milligram (mg) in the morning and 15 mg at bedtime; -Pharmacist recommended dose reduction to: Olanzapine 10 mg two times daily; -Physician/Prescriber response was left blank. Review of the resident's Critical Care Pharmacy, Note to Attending Physician/Prescriber, dated 10/21/24, showed the following: -The resident received the following medication used for psychiatric condition: Olanzapine 10 mg in the morning and 15 mg at bedtime; -Pharmacist recommended dose reduction to: Olanzapine 10 mg two times daily. Review of the resident's consulting pharmacy note, dated 10/24/24 showed the pharmacy recommendation was refaxed to the nurse practitioner, awaiting a response. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the resident's Physician Order Summary, dated November 2024, showed the following: -Olanzapine 10 mg, give one tablet by mouth one time a day for anxiety; -Olanzapine 15 mg, give one tablet by mouth at bedtime related to schizophrenia. Review of the resident's consulting pharmacy note, dated 11/02/24 showed the pharmacy recommendation was refaxed to the nurse practitioner, awaiting a response. Review of the resident's consulting pharmacy note, dated 11/11/24, showed the pharmacy recommendation was refaxed to the nurse practitioner, awaiting a response. Review of the resident's consulting pharmacy note, dated 11/18/24, showed the pharmacy recommendation was reviewed and the practitioner disagrees (to the pharmacist's recommendations) due to patient constant voiced thoughts of self harm, repeated hospitalization , and ingestion of batteries. 4. During an interview on 11/21/24 at 2:40 P.M., the Director of Nurses (DON) said the following: -When the pharmacist made recommendations, staff faxed the recommendations to the provider; -The pharmacist recommendations were faxed to the long-term psychiatric provider several times; -If there was no response, the facility continued to fax the recommendations until a response was given; -She did not address the lack of response with the medical director for additional guidance.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47008 Based on interview and record review, the facility failed to ensure one resident (Resident #50), in a review of 20 sampled residents, received dental services when the resident was diagnosed with an abscessed tooth and was to be seen by a dentist. The facility census was 87. The facility provided no policy for dental services/appointments upon request. Review of Resident #50's face sheet showed he/she had a guardian. Review of the resident's progress note, dated 07/09/24 showed the following: -The resident was seen on the primary care physician's rounds; -The resident had complaints of left lower jaw pain secondary to dental abscess; -The resident had swelling in his/her left lower mandible (jaw bone) due to dental abscess; -The diagnosis was dental abscess; -The plan was to order an antibiotic and narcotic pain medication along with a dental appointment; -The physician signed the encounter on 07/09/24 at 10:32 A.M. Review of the resident's progress note, dated 07/09/24 at 11:04 A.M., showed the following: -The resident had been seen by his/her primary care physician (PCP); -New orders were received for an antibiotic four times daily for seven days and Percocet 5/325 as needed for pain for an abscessed tooth; -Resident also being set up with dentist; -Legal guardian notified of new orders with understanding voiced. Review of the resident's medical record showed no documentation of a dental appointment since 07/09/24. Review of the dental appointment list, generated on 11/18/24, showed the following: -The list was a preliminary list; -360 care was scheduled to see residents at the facility on 12/10/24; -The resident's name was not on the list as scheduled for a dental appointment. (continued on next page)

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 11/18/24 at 2:13 P.M. and 11/20/24 at 9:27 A.M., the resident said he/she needed a dental appointment due to bad teeth and an abscess. His/Her tooth had been hurting for about one week. He/She told Certified Medication Technician (CMT) D a week ago he/she needed a dental appointment. His/Her tooth had been hurting when he/she chewed food on the left side of his/her mouth. He/She had to eat his/her food on the opposite side of the tooth due to pain. He/She had broken wisdom teeth which were still in his/her mouth. The physician said he/she needed a dental appointment in July. He/She had not had a dental appointment since he/she was admitted on [DATE]. The facility has not addressed his/her dental concerns. During an interview on 11/20 /24 at 1:45 P.M., Registered Nurse S said the nurse who had rounded with the PCP no longer worked at the facility. If the physician had recommended the resident needed a dental appointment, the nurse should have followed up with the Social Services Director (SSD) for guardian authorization. During an interview on 11/25/24 at 12:27 P.M., Licensed Practical Nurse B said nurses could make appointments for a resident and the transportation/central supply staff member can also make appointments. If a resident requested an appointment, he/she would send an email to the DON and to the transportation/central supply staff member so everyone was on the same page with appointments. Residents should have a dental appointments if they are requested. Resident #50 had not requested a dental appointment. Staff had not told him/her Resident #50 had requested a dental appointment. During an interview on 11/25/24 at 11:19 A.M., the transportation/central supply staff member said the following: -The nursing staff normally tell him/her when a resident needed an appointment; -He/She then would make an appointment for the resident; -The dental provider required three pages of information to be filled out and an authorization would need to be signed. If a resident had a guardian, he/she would get the three pages to the Social Services Director (SSD) to email to the guardian; -Upon guardian completion, the paperwork would be returned to him/her and he/she would make the dental appointment and forward the necessary paperwork; -Resident #50 did not have a scheduled dental appointment; -He/She had worked at the facility since April 2024 and he/she had not scheduled a dental appointment for Resident #50. During an interview on 11/26/24 at 2:08 P.M. and 12/09/24 at 2:03 P.M., the Social Services Director (SSD) said she interviewed residents weekly to see if there are any medical concerns. If a resident had asked for an appointment she would tell nursing and transportation/central supply staff member. Resident #50 had not asked for a dental appointment. She had no documentation from July 2024 showing the resident's guardian was contacted for authorization for a dental appointment. During an interview on 12/10/24 at 5:15 P.M., the Director of Nurses (DON), said the following: (continued on next page)

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Guardians are notified of the services provided by 360 care, which include, dental, vision, podiatry and audiology. If the guardian does not wish to use this company, services could be provided by other providers in the community; -The transportation/central supply staff member was responsible for obtaining appointments for residents; -She expected a resident to have a dental, podiatry, and vision appointment if they have asked for one or need an appointment; -She was unaware Resident #50 needed a dental appointment; -Resident #50 had not had a dental appointment since he/she was admitted .

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. 34536 Based on observation, interview and record review, the facility failed to ensure staff prepared and served the correct portion size of food items to residents with a physician's order for a pureed diet, failed to ensure staff prepared and served the correct portion size of food items to residents with a physician's order for a mechanical soft diet and failed to ensure staff prepared and served the correct food items to residents with a physician's order for a regular diet. The facility census was 87. 1. Review of the Diet Type Report, dated 11/18/24, showed two residents had a physician's order for a pureed diet. Review of the Diet Spreadsheet for lunch on 11/18/24 (Week 3, Day 16) showed residents on a pureed diet were to receive the following items: -Pureed smothered pork chop with gravy (#8 dip or 1/2 cup serving); -Pureed buttered cabbage (4-ounce or 1/2 cup serving); -Pureed buttered dinner roll (#20 dip or 3 and 1/5-tablespoon serving). Observation on 11/18/24 between 12:30 P.M. to 1:47 P.M. during the lunch meal service, showed staff served residents with a physician's order for a pureed diet, 3-ounces of pureed pork instead of 4-ounces and also served 3-ounces of pureed cabbage instead of 4-ounces as directed by the diet spreadsheet. Staff also did not prepare or serve pureed dinner rolls as directed by the diet spreadsheet. 2. Review of the Diet Type Report, dated 11/18/24, showed 15 residents had a physician's order for a mechanical soft diet. Review of the Diet Spreadsheet for lunch on 11/18/24 (Week 3, Day 16) showed residents on a mechanical soft diet were to receive the following items: -Ground smothered pork chop with gravy (#8 dip or 1/2 cup serving); -Potato salad (4-ounce or 1/2 cup serving); -Soft chopped buttered cabbage (4-ounce or 1/2 cup serving); -Soft dinner roll, one each. Observation on 11/18/24 between 12:30 P.M. to 1:47 P.M. during the lunch meal service, showed staff served residents with a physician's order for a mechanical soft diet, a 2-ounce serving of ground pork chop instead of 4-ounces, served large leaves of cabbage instead of chopped cabbage, and served mashed potatoes instead of potato salad. Staff did not prepare or serve soft dinner rolls as directed by the diet spreadsheet. (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	3. Review of the Diet Type Report, dated 11/18/24, showed 70 residents had a physician's order for a regular diet. Review of the Diet Spreadsheet for lunch on 11/18/24 (Week 3, Day 16) showed residents on a regular diet were to receive the following items: -Smothered pork chop (3-ounce serving); -Red skin potato salad (4-ounce or 1/2 cup serving); -Buttered cabbage (4-ounce or 1/2 cup serving); -Apple cobbler (#6 dip or 2/3 cup serving); -Dinner roll, one each. Observation on 11/18/24 between 12:30 P.M. to 1:47 P.M. during the lunch meal service, showed staff did not prepare or serve dinner rolls as directed by the diet spreadsheet. Observation on 11/18/24 at 1:49 P.M. of a surveyor requested sample test tray showed staff served no dinner roll. 4. During an interview on 11/18/24 at 10: 26 A.M. and on 11/19/24 at 9:30 A.M., the Dietary Manager said the following: -She had been the dietary manager since September 2024; -Staff should refer to the production sheet and spreadsheet when selecting serving utensils; -All food items listed for each diet should be prepared and served by staff according to the spreadsheet; -She met with the cook prior to each meal to ensure staff prepared all items listed on the menu.

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38016 Based on observation, interview, and record review, the facility failed to serve food to the residents that accommodated their preferences for three residents (Residents #83, #53, and #74), in a review of 20 sampled residents. The facility census was 87. 1. Review of Resident #83's Face Sheet showed he/she was his/her own responsible party. Review of the resident's quarterly MDS, dated [DATE], showed the following: -The resident was cognitively intact; -He/She had a mechanically altered diet. Review of the resident's Physician Order Summary (POS), dated 10/01/23 through 11/30/24, showed the resident had a dietary order for mechanical soft texture. Review of the resident's Care Plan, revised on 11/12/24, showed the following: -The resident was at risk of aspiration; -Serve diet as ordered. Observation on 11/18/24 at 12:40 P.M., showed staff served the resident chili, cabbage and mashed potatoes with gravy. The resident ate all of the chili and cabbage and did not touch the mashed potatoes with gravy. During interview on 11/18/24 at 1:01 P.M. and 11/25/24 at 11:38 A.M., the resident said he/she did not like gravy on his/her food. He/She told staff in the past that he/she did not want gravy on his/her food, and staff said he/she had a mechanical soft diet and gravy had to be served on his/her food. He/She would prefer staff did not serve gravy on his/her potatoes. During an interview on 11/25/24 at 11:43 A.M., the Dietary Manager said she was not sure of the resident's dislikes. She looked at the resident's dietary preference list and the resident disliked spicy food. The resident's diet was mechanical soft. No one had told her the resident did not like gravy or that the resident did not want gravy on his/her potatoes. She could serve broth on his/her meat and leave the gravy off of his/her potatoes. Review of the resident's dietary menu, dated 11/25/24, showed the resident had a regular diet with a mechanical soft texture and disliked spicy food. 2. Review of Resident #53's POS, dated November 2024, showed an order for a regular diet with mechanical soft texture. (continued on next page)

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the resident's care plan, last revised 11/12/24, showed the resident was at risk for aspiration and prescribed a mechanical soft diet; During an interview on 11/18/24 at 11:20 A.M., the resident said the following: -The kitchen put brown gravy all of his/her food and he/she hated it; -He/She spoke with several staff regarding this issue, but they continued to add the gravy. Observation on 11/19/24 at 12:45 P.M. showed the following: -The resident sat at the dining table and staff served a meat entree covered with brown gravy; -The resident was upset and asked staff why he/she had to have gravy on everything. Staff went to the kitchen window and returned to the resident. Staff told the resident the dietary staff said it was because of the type of diet he/she was on; -The resident then asked the staff for the substitute, an enchilada; -Staff brought the resident an enchilada with brown gravy covering the entire entree; -The resident attempted to scrape the gravy from the enchilada. During an interview on 11/19/24 at 12:55 P.M., the resident said the meal did not taste like an enchilada with the gravy on it and it was not appetizing at all. 3. Review of Resident #74's quarterly MDS, dated [DATE], showed the following: -Moderately impaired cognition; -Mechanically altered diet. Review of the resident's POS, dated November 2024, showed the resident was on a regular diet with mechanical soft texture. Review of the resident's care plan, last revised 11/1/24, showed the following: -Served diet as ordered, encourage appropriate intake of foods and fluids, offer substitutes for dislikes; -Dietary consult if indicated; -Diet change to regular mechanical soft diet. During an interview on 11/18/24 at 11:30 A.M., the resident said the kitchen staff put gravy on all of his/her food and he/she did not like it. He/She had told many different staff but they keep adding gravy to everything. (continued on next page)

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4. During an interview on 11/25/24 at 2:40 P.M., the Dietary Manager said the following: -She had been the dietary manager since September 2024; -She did not have a list of residents' preferences; -She had not interviewed any residents about their likes or dislikes since taking over; -She was not aware the residents did not want gravy on their meat; -She expected staff to inform her if residents complained of receiving gravy on their food; -The kitchen staff should not put brown gravy on an enchilada. They should substitute some other sauce to make it appetizing; During an interview on 11/26/24 at 3:58 P.M., the DON said the following: -Residents should have a choice in what foods they eat; -The dietary manager should have spoken with residents regarding their likes and dislikes; -He/She would expect substitutions to be offered if residents did not like something; -He/She would expect for staff to have residents sign a waiver if they were refusing physician ordered diets.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 34536 Based on observation, interview and record review, the facility failed to ensure the walk-in cooler fan shrouds were free of a buildup of debris; failed to ensure a chest freezer was maintained to keep food items frozen solid; failed to ensure food items were labeled, dated, and closed/sealed; failed to ensure dishware was not stacked and stored wet; and failed to ensure the ice machine was free of a buildup of black debris. The facility census was 87. 1. Observation on 11/18/24 at 10:24 A.M. showed two blue fan shrouds inside the walk-in cooler in the kitchen had a moderate buildup of fuzzy debris. 2. Observation on 11/18/24 at 10:38 A.M. of the thermometer inside the chest freezer, located inside the hot water heater/storage room in the kitchen, showed the temperature inside the freezer was 8 degrees Fahrenheit (F). The freezer contained an unopened box of pie shells, an unopened box of breaded fish, containers of whipped topping and a cardboard box of cookie dough (individual cookies) The packages of whipped topping were soft and were not frozen solid, and the cookie dough was soft to touch and not frozen solid. 3. Observation on 11/18/24 at 10:44 A.M. in the food preparation area showed the following: -A 12-ounce plastic container of Italian seasoning sat on a shelf above the food preparation counter. The lid was not closed and was open to air; -A 28-ounce box of wheat cereal sat on a shelf above the food preparation counter. The pour spout was not closed and was open to air. Observation on 11/18/24 at 11:40 A.M., showed a clear plastic bottle sat on a shelf next to the microwave. The lid was missing and the bottle had plastic wrap covering the top. [NAME] debris was visible on the plastic wrap. The bottle was not labeled or dated. Observation on 11/19/24 at 8:20 A.M. showed an unsealed plastic bag of cheese puffs sat on a metal shelf next to the microwave. Observation and interview on 11/19/24 at 8:40 A.M. on A Hall inside room A-11, showed an open unsealed bag of pizza rolls in the freezer. The freezer was not equipped with a thermometer. Observation on 11/19/24 at 9:00 A.M. of the refrigerator in the clean utility room showed the following: -A thermometer inside displayed a temperature of +48 degrees F; -Four bowls of pureed PB&J were not dated; -One burrito or soft taco from a fast food restaurant was very hard and was not dated; (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-A large plastic zipper bag containing several peanut butter and jelly sandwiches was not dated; -The thermometer inside the freezer was broken and not functional; -There was no temperature log sheet available for monitoring the unit's refrigerator or freezer temperatures. 4. Observation on 11/18/24 at 10:47 A.M. showed a stack of ten large baking sheets sat on a storage shelf. Water droplets were visible in between the baking sheets when separated. Observation on 11/18/24 at 10:50 A.M. showed a stack of seven medium-sized steam table pans sat on a storage rack next to the handwashing sink. Water droplets were visible in between the pans when separated. Observation on 11/19/24 at 8:25 A.M. showed a stack of six steam table pans sat on the green storage rack next to the handwashing sink. Water droplets were visible in between the pans when separated. 5. Observation on 11/18/24 at 11:47 A.M. showed an ice machine located in the staff break room adjacent to the kitchen. The water filter, dated 6/21, located behind the ice machine, had a heavy buildup of white and tan crusty debris on the exterior and water line connection. A buildup of black-colored debris was located inside the ice machine on the white plastic piece over the accumulated ice below. 6. During an interview on 11/19/24 at 9:15 A.M., the Dietary Manager said the following: -The facility did not have a policy manual for the kitchen or dietary department; -She was unsure who was responsible for cleaning the fan shrouds in the walk-in cooler; -Food items should be labeled with an opened date and an end date; -Leftovers were good for seven days; -The food item name should be written on the dissolvable stickers; -Food items should be closed or sealed; -No one checked the temperatures of the refrigerator or freezer in the clean utility room; -She was unsure who was responsible for checking for labels and dates on food items in the clean utility room; -Dietary staff should date the snacks, and dietary cleaned out old snacks daily (i.e. sandwiches, etc.); -Refrigerator temperatures should be maintained between 30-40 degrees F; -Freezer temperatures should be maintained at least -10 degrees F or at least below zero; (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-She was unaware the chest freezer in the hot water heater storage room was reading +8 degrees F or that items inside were not frozen; -She was unaware the temperature inside refrigerator in the clean utility was running high. Dietary staff was not monitoring temperatures of this unit and this had been accidentally overlooked. She was unaware the thermometer in the freezer was broken; -Dishware should be inverted after washing to allow items to air dry before storage or stacking. Hard to dry items such as steam table pans and baking sheets should be stood up vertically to dry fully; -Dietary staff was not responsible for maintaining or cleaning the ice machine. Maintenance staff was responsible for these tasks. She was unsure who was responsible for changing the water filter. During an interview on 11/19/24 at 10:29 A.M., the Maintenance Supervisor said he was unsure who was responsible for changing the water filter on the ice machine. Dietary staff was responsible for cleaning the ice machine.

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Administer the facility in a manner that enables it to use its resources effectively and efficiently. 38016 Based on observation, interview, and record review, the administration of the facility failed to use resources effectively to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. The facility census was 87. 1. Observation and review during the survey process from 11/18/24 through 11/21/24 and 11/25/24 showed the following: -No yearly staff education regarding care of residents with dementia; -No yearly staff education on abuse and neglect; -No yearly required training hours for certified nursing assistants; -No education calendar was completed; -No staff member was monitoring staff education hours; -Review of the staff training did not show required training was completed for all staff or nurse aides/certified nurse assistants; -The facility failed to ensure payroll based journal (PBJ) data was entered and submitted timely; -The facility failed to ensure dietary services were provided to meet residents individual requests on an ongoing basis; -The facility failed to ensure medication orders were followed through with; the facility had not ensured medication were available for administration as ordered; -The facility failed to ensure quality of care issues regarding management of foot care and services to prevent decline in mobility and range of motion were consistently provided; -The facility was not providing service to prevent resident's with contractures from getting worse; -The facility failed to keep a resident safe by not putting into place any interventions to keep the resident from obtaining/swallowing batteries; -The facility failed to provide adequate pain management to ensure residents were comfortable and free of pain; -The facility failed to provide protective oversight and to consistently provide safety measures to prevent injuries; (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-The facility failed to consistently provide assistance with activities of daily living to meet the needs of individual residents; -Facility staff failed to consistently follow infection control measures; -The facility failed to ensure reasonable accommodation of needs, preferences and choices of residents were met; -The facility failed to ensure Advance Beneficiary Notices (ABN) were completed and provided when needed and as required; -The facility failed to provide quarterly statements for the residents' trust account; -The facility failed to maintain accurate records for the residents' trust account; -The facility failed to ensure residents' funds were not misappropriated; -The facility failed to refund resident money on the accounts receivable report; -The facility failed to ensure residents fully understood what a binding arbitration agreement was; -The facility failed to keep the floors and walls in good repair and failed to maintain a homelike environment in the facility; -The facility failed to provided sufficient staffing to ensure residents needs were met; -The facility failed to provided oversight to ensure a notice of transfer to the hospital or bed hold policy was being provided to a resident and/or the resident representative; -The facility did not ensure staff completed required assessments timely and accurately; -The facility failed to ensure pharmacy reviews were received and followed up on; -The facility failed to ensure admission contracts were completed with one resident admission; -The facility failed to follow their legionella policy; -The facility failed to ensure there was a water management team; -The facility failed to monitor their water temperatures for legionella management; -The facility failed to screen residents for legionella as indicated; -The facility failed to ensure a process was in place to ensure pneumonia vaccines were offered and administered; -The facility failed to ensure a survey book was available for the resident's to review with recent statements of deficiencies that was up to date; (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-The facility failed to ensure the resident rights were posted on A hall; -The facility failed to ensure residents had dental, podiatry and vision appointments as ordered or requested; -The facility was not able to provide all requested policies. During an interview on 11/20/24 at 2:00 P.M., Administrator 1 said the facility did not have most of the policies requested by the survey staff. The facility had not completed the policies for the facility. The facility has had many changes in management, so the systems were not all in place to ensure everything was getting done.

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F 0847 Level of Harm - Potential for minimal harm Residents Affected - Some	Inform resident or representatives choice to enter into binding arbitration agreement and right to refuse. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47008 Based on interview and record review, the facility failed to provide documentation to show staff clearly explained the binding arbitration agreement process (a private process where disputing parties agree that one or several individuals can make decisions about the dispute after receiving evidence and hearing arguments) to two residents (Residents #44 and #241), in a review of 20 sampled residents, and two additional residents (Residents #4 and #46). The facility census was 87. During an interview on 11/25/24 at 2:46 P.M., the Administrator 1 said the facility did not have a policy for binding arbitration agreements. Review of the undated facility admission packet showed the following: -Arbitration of Dispute: The parties understand that any dispute under this contract will be determined by submission to arbitration as provided by Missouri law, and not by a lawsuit or resort to court process except as Missouri law provides for judicial review of arbitration proceedings. The parties understand that they would have had a right or opportunity to litigate disputes through a court and to have a judge or jury decide their case, but they choose to have any disputes resolved through arbitration. Both parties to this contract, by entering into this contract, are giving up their constitutional right to have disputes decided in a court of law before a jury or judge, and instead are accepting the use of arbitration. -a. Kinds of disputes: The parties agree that any claim or dispute between the parties, and any claim by either of the parties against any agent, employee, successor, or assign of the other, including, to the full extent permitted by applicable law, third parties who are not signatories to this contract, whether related to this agreement or otherwise, including past, present, and further claims and disputes, and including any dispute as to the validity or applicability of this arbitration agreement, shall be resolved by binding arbitration; -b. Interstate commerce: The parties agree and intend that this arbitration agreement, the contract and the resident's stays at facility substantially involve interstate commerce. Accordingly, the parties stipulate that this arbitration agreement and any proceedings thereunder shall be governed by the Federal Arbitration Act, 9 U.S.C. 1 16, and shall preempt any inconsistent State law; -c. American Arbitration Association rules: Arbitration under this contract shall be binding arbitration administered by the American Arbitration Association in accordance with the American Arbitration Association's rules then in effect. Judgement upon the award rendered by the arbitrator(s) may be entered in any court which has jurisdiction thereof; (continued on next page)

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F 0847 Level of Harm - Potential for minimal harm Residents Affected - Some	-d. Sole decision maker: The arbitrator is empowered with the sole jurisdiction to, and shall, resolve all disputes, including without limitation, any disputes about the making, validity, enforceability, scope, interpretation, voidability, unconscionability, preemption, severability and/or waiver of this arbitration agreement or the contract, as well as resolve the parties' underlying disputes, as it is the parties' intent to completely avoid involving the court system. The arbitrator shall not have jurisdiction to certify any person as a representative of a class of persons and claims of persons not directly taking part in arbitration; -e. Severability, integration and survival: Any term, phrase or provision contained in this arbitration agreement is severable, and in the event any of them is found to be void, invalid or unenforceable for any reason, this arbitration agreement shall be interpreted as if such term, phrase or provision were not contained herein, and the remaining provisions of this arbitration agreement shall not be affected by such determination and shall remain in full force and effect. The arbitration agreement represents the parties' entire agreement regarding disputes, supersedes any other agreement relating to disputes, and it may only be changed in writing signed by all parties. This arbitration agreement shall remain in full force and effect notwithstanding the termination, cancellation or natural expiration of this contract; -f. Right to Change Your Mind. This arbitration agreement may be canceled by written notice sent by certified mail to Facility's Administrator from you within thirty (30) calendar days of Resident's date of admission. If the alleged acts underlying a dispute occur before the cancellation date, this arbitration agreement shall be binding with respect to those alleged acts. If not canceled, this arbitration agreement shall be binding on Resident for this and all of Resident's other admissions to this Facility without any need for further renewal; -g. Not a Condition. This arbitration agreement shall not be a precondition to the furnishing of services under this Contract; -The undersigned parties each agree to be bound by the terms, obligations and conditions set forth above; -Resident has received the above indicated Resident's Rights notifications and concurs with the terms of this Agreement. Review of the facility provided admission agreement showed the arbitration agreement did not include language which prohibited or discouraged the resident or representative from communicating with federal, state, or local officials, and was not written in a form, manner or language which was easily understood. 1. Review of Resident #4's face sheet showed he/she was his/her own responsible party and was admitted on [DATE]. During an interview on 11/20/24 at 2:21 P.M., the resident said the following: -He/She was his/her own responsible party; -He/She was unsure what arbitration meant and was unsure if he/she signed any agreement. The facility had not specifically explained anything to him/her about arbitration. (continued on next page)

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F 0847 Level of Harm - Potential for minimal harm Residents Affected - Some	Review of the resident's medical record showed no documentation staff clearly explained the arbitration agreement/process with the resident. 2. Review of Resident #44's face sheet showed he/she was his/her own responsible party and was admitted on [DATE]. During an interview on 11/25/24 at 3:45 P.M., the resident said the following: -He/She was his/her own responsible party; -He/She was unsure if he/she signed any agreement and could not remember if anyone at the facility had specifically explained anything to him/her about arbitration. Review of the resident's medical record showed no documentation staff clearly explained the arbitration agreement/process with the resident. 3. Review of Resident #46's face sheet showed he/she was his/her own responsible party and was admitted on [DATE]. During an interview on 11/25/24 at 3:50 P.M., the resident said the following: -He/She was his/her own responsible party; -He/She had been a resident for about one year; -He/She was unsure if he/she signed any arbitration agreement; -He/She could not recall a staff member specifically discussing the arbitration agreement with him/her. Review of the resident's medical record showed no documentation staff clearly explained the arbitration agreement/process with the resident. 4. Review of Resident #241's face sheet showed he/she had a guardian and was admitted on [DATE]. Review of the resident's medical record showed no documentation staff clearly explained the arbitration agreement/process with the resident. During an interview on 12/06/24 at 1:15 P.M., the resident's guardian said the following: -The resident was admitted to the facility on [DATE]; -He/She did not believe he/she signed an arbitration agreement with the facility; -He/She did not remember if any staff member from the facility explained the arbitration agreement with him/her. During a phone interview on 11/26/24 at 5:13 P.M., Administrator 1 said the following: (continued on next page)

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F 0847 Level of Harm - Potential for minimal harm Residents Affected - Some	-No one explained the arbitration agreement to Resident #241's guardian; -Normally, the admission personnel would explain the arbitration agreement, but he had not assigned the task to a staff member; -He would have been responsible for explaining the arbitration agreement to the resident's guardian. 5. During an interview on 11/19/24 at 9:35 A.M., Administrator 1 said there was an arbitration agreement in the admission packet. He thought Business Office Manager 2 completed the arbitration agreements, but he was not sure. During an interview on 11/25/24 at 5:37 P.M., the Business Office Manager 2 said the following: -She was not responsible for the arbitration agreement; -The Social Service Director (SSD) was responsible to review the arbitration agreements with the residents/responsible parties. During interviews on 11/26 24 at 2:08 P.M. and 12/09/24 at 2:03 P.M., Social Services Director (SSD) said the following: -She had been doing social services since September 2024; -She had never completed a resident admission at the facility and was not know who was responsible; -She did not know what arbitration meant.

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F 0851 Level of Harm - Potential for minimal harm Residents Affected - Many	Electronically submit to CMS complete and accurate direct care staffing information, based on payroll and other verifiable and auditable data. 38016 Based on interview and record review, facility staff failed to electronically submit to Centers for Medicare and Medicaid Services (CMS), a complete and accurate direct care staffing information to the Payroll Based Journal (PBJ) data from April 1, 2024 through June 30, 2024. The facility census was 87. The facility provided no policy regarding PBJ upon request. 1. Review of the CMS PBJ Staffing Data Report, dated 11/12/24, showed no staffing data reported for the period of April 1, 2024 through June 30, 2024. During an interview on 11/20/24 at 11:00 A.M., the Business Office Manager (BOM) said she was new to the facility. She was not employed during the reporting time on the report (when data submission was due for April 1, 2024 through June 30, 2024). Since starting at the facility she has had difficulty signing into the system and missed a deadline to submit PBJ data. During an interview on 11/20/24 at 11:11 A.M., Administrator #1 said it was the BOM's responsibility to submit PBJ data. He was not sure when PBJ data was submitted and when it was not. There had been turnover in the BOM role and they had difficulties getting new BOM staff signed into the CMS system. 49528

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32899 Based on observation, interview, and record review, the facility failed to ensure Tuberculin Skin Tests (TST) were completed and documented in accordance with the requirements for Tuberculosis (TB) (infectious bacterial disease that affects the lungs) testing for long-term care employees for six employees, in a review of ten employees, when the facility did not ensure the first-step TST was read on or prior to the employee's start date (first date of compensation). The facility failed to develop and implement a Legionella (bacteria found in water which can cause Legionnaires' disease, a serious type of pneumonia caused by Legionella bacteria that infect the lungs after being inhaled from water or soil.) Prevention Program. The facility failed to ensure staff performed proper hand hygiene when providing incontinence care to one resident (Resident #67), in a review of 20 sampled residents, and failed to ensure all parts of the urinary catheter drainage system was maintained off the floor for one resident (Resident #74), who had a history of urinary tract infections. The facility census was 87. 1. Review of the facility policy, Tuberculosis Testing (New Hires), revised 11/25/24, showed the following: -Orientation training will consist of three days of training with Human Resources (HR) or (preorientation) training on-site; -Staff will not be allowed to have any contact with residents during the preorientation period. They will have to fully complete preorientation training first; -All staff will receive the first dose of TB solution (first-step TST) on the first day of preorientation training and will have that dose read on the third day of training. 2. Review of the Maintenance Director's employee file showed the following: -First-step TST was administered on 01/09/24; -First time card punch (first date of paid compensation) was on 01/10/24; -First-step TST was read on 01/11/24; 3. Review of Certified Medication Technician (CMT) L's employee file showed the following: -First-step TST was administered on 11/04/24; -First time card punch was on 11/04/24; -First-step TST was read on 11/07/24. 4. Review of Housekeeper N's employee file showed the following: -First-step TST was administered on 10/23/24; (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-First time card punch was on 10/23/24; -First-step TST was read on 10/25/24. 5. Review of [NAME] O's employee file showed the following: -First time card punch was on 08/07/24; -He/She had a negative chest x-ray completed on 08/16/24. 6. Review of Laundry Aide P's employee file showed the following: -First-step TST was administered on 10/09/24; -First time card punch was 10/09/24; -First-step TST was read on 10/11/24. 7. Review of Certified Nurse Assistant (CNA) H's employee file showed the following: -First-step TST was administered on 10/9/24; -First time card punch was 10/9/24; -First-step TST was read on 10/11/24. 8. During an interview on 11/20/24 at 3:40 P.M. and 12/05/24 at 3:47 P.M., Human Resources Staff R said the following: -Staff complete the first-step TST on the first day of orientation and read the results prior to the new employee's actual working day; -Staff get paid for preorientation; -She was unaware staff could not receive paid compensation until the first-step TST had been read. During an interview on 11/25/24 at 12:45 P.M., Administrator 1 said the following: -New employees start employment with Human Resource orientation for three days; -The first-step TST was administered on the first day of orientation; -The first-step TST was read on the third day of orientation. 9. Review of the undated facility policy, Water Management Program, showed it only addressed what to do in the event of an outbreak and no instruction regarding regular monitoring and maintenance. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of the Centers for Medicare and Medicaid Services (CMS) Survey and Certification (S&C) letter 17-30, dated 06/02/17 and revised on 06/09/17, showed the following: -The bacterium Legionella can cause a serious type of pneumonia called LD in persons at risk. Those at risk include persons who are at least [AGE] years old, smokers, or those with underlying medical conditions such as chronic lung disease or immunosuppression. Outbreaks have been linked to poorly maintained water systems in buildings with large or complex water systems including hospitals and long-term care facilities. Transmission can occur via aerosols from devices such as shower heads, cooking towers, hot tubs, and decorative fountains; -Facilities must develop and adhere to policies and procedures that inhibit microbial growth in building water systems that reduce the risk of growth and spread of Legionella and other opportunistic pathogens in water; -CMS expects Medicare certified healthcare facilities to have water management policies and procedures to reduce the risk of growth and spread of Legionella and other opportunistic pathogens in building water systems. An industry standard calling for the development and implementation of water management programs in large or complex building water systems to reduce the risk of legionellosis was published in 2015 by American Society of Heating, Refrigerating, and Air Conditioning Engineers (ASHRAE). In 2016, the CDC and its partners developed a toolkit to facilitate implementation of this ASHRAE Standard (https://www.cdc.gov/Legionella/maintenance/wmp-toolkit.html). Environmental, clinical, and epidemiological considerations for healthcare facilities are described in this toolkit; -Surveyors will review policies, procedures, and reports documenting water management implementation results to verify that facilities: -Conduct a facility risk assessment to identify where Legionella and other opportunistic waterborne pathogens (e.g. Pseudomonas, Acinetobacter, Burkholderia, Stenotrophomonas, nontuberculous mycobacteria, and fungi) could grow and spread in the facility water system; -Implement a water management program that considers the ASHRAE industry standard and the CDC toolkit, and includes control measures such as physical controls, temperature management, disinfectant level control, visual inspections, and environmental testing for pathogens; -Specify testing protocols and acceptable ranges for control measures, and document the results of testing and corrective actions taken when control limits are not maintained. Review of the Centers for Disease Control and Prevention Legionella Environmental Assessment Form, undated, showed Legionella generally grow well between 77 degrees Fahrenheit (F) and 113 degrees F. The optimal growth range for Legionella is between 85 degrees F and 108 degrees F. Growth slows between 113 degrees F and 120 degrees F, and Legionella begin to die above 120 degrees F. Growth also slows between 68 degrees F and 77 degrees F, and Legionella become dormant below 68 degrees F. 10. Review of the facility Water Management binder on 11/21/24, showed the following: -Legionnaire flushing log sheet was to be completed weekly; no evidence in the binder that this had ever been completed; (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-Temperature checks (no indication of hot or cold) were to be completed weekly on the 100 hall, 200 hall, 300 hall, 400 hall, dietary, laundry, beauty shop, 100 hall shower, 200 hall shower, whirlpool, lobby bathroom, 100 hall bathroom and 200 hall bathroom; no documentation of cold water temperature checks in these areas for October 2024 or November 2024. (Review showed no documentation staff checked the hot water temperature in the laundry, beauty shop, 100 hall shower, 200 hall shower, whirlpool, lobby bath, 100 hall bathroom or 200 hall bathroom for October 2024 or November 2024); -Mixer valve inspection was to be completed weekly. (Review showed no evidence this had ever been completed); -Legionella water management meeting form showed staff was to document the meeting time, location, topics discussed, include the water management team members present in attendance and documented notes. (Review showed no evidence in the binder that meetings had been held or that this form had ever been completed). The facility did not provide any documentation to show the water management team conducted a risk assessment annually and did not provide any documentation of a water flow diagram of the facility. Observation on 11/20/24 at 9:11 A.M. in the bathroom for rooms A3 and A5 on the A hall (100 hall), showed flecks of a dark material came out of a cold water faucet when it was turned on. During an interview on 11/21/24 at 10:50 A.M., the Maintenance Director said he checked the hot water temperatures for the past two months. He checked the water temperature in the kitchen, the dishwasher and random rooms on each hall daily. He did not document in which resident rooms he/she took the water temperatures. He never checked the cold water temperature in the building. There was no water management team at the facility, and there had been no water management team meetings since he had been employed at the facility. He knew there were bathtubs in the facility that were not in use, but he had never flushed any of the bathtubs. He should have had a water management book, but he did not. A member of the management team just brought a binder into the facility and gave it to the Administrator. He did not know if the facility had a water mixing valve and if there was one, he had never inspected it. He had never checked the water temperature in the laundry room. He has never checked the chlorine level of the water coming into the facility. He did not know were the water entered the building or how it flowed throughout the building. He had never checked the water faucets for sediment. During an interview on 11/21/24 at 5:06 P.M., the Infection Preventionist (IP) said she did not know if she was on the water management team. She had never been to a water management team meeting. To test a resident for Legionella, she would assess to see if a resident had a cough or respiratory symptoms, then Legionella would be checked by getting a chest x-ray. To test for Legionella had to do with the water and there would have to be a water test yearly. During an interview on 11/26/24 at 3:58 P.M., the Director of Nursing (DON) said there was no water management program being completed at the facility. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 11/21/24 at 4:30 P.M., Administrator 1 said someone from the corporate office put the water management binder in his office. Someone from their corporate office was supposed to provide training for the water management program. Currently, there was no water management program being completed at the facility. There had been no water management team meetings and he was responsible to make sure the facility was following a water management program. 11. Review of the facility policy, Hand Hygiene, dated 11/1/22, showed the following: -All employees are responsible for maintaining adequate hand hygiene by adhering to specific infection control practices. -Employees will use waterless hand rub or soap and water to clean their hands: -Before having direct contact with residents; -Before donning gloves and after removing gloves; -After contact with a resident's intact skin; -After contact with a resident's non-intact skin, wound dressings, secretions, excretions, mucous membranes, if hands are not visibly soiled; -When moving from a contaminated body site to a clean body site during patient care; -When hands are visibly soiled. 12. Review of Resident #67's care plan, last updated 8/5/24, showed the following: -Check the resident for incontinence. Wash, rinse and dry the perineum; -One staff to assist with personal hygiene. Review of the resident's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by the facility, dated 10/3/24, showed the following: -Required substantial to maximum assist with bed mobility, personal hygiene and toileting; -Always incontinent of bladder and bowel. Observation on 11/20/24 at 6:27 A.M. showed the following: -The resident lay in his/her bed; -CNA T entered the room and without washing his/her hands, put on gloves, picked up the mat from on the floor and moved the bed away from the wall; (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-CNA T unfastened the urine soiled incontinence brief, rolled the resident to his/her right side, and cleaned the resident's buttocks and anal area with disposable wipes. He/She laid the soiled wipes directly on the resident's air mattress before moving them to a plastic bag. He/She tucked two urine soiled bath blankets under the resident. -Without removing the gloves he/she wore to provide incontinence care, CNA T placed a clean incontinence brief under the resident, removed the resident's soiled gown from the resident's arm and head, touched the resident's hip and legs to roll the resident to his/her left side, and secured the incontinence brief on the resident. During an interview on 12/6/24 at 1:49 P.M., CNA T said the following: -He/She should wash his/her hands upon entering the room, when he/she changed his/her gloves and upon exiting a resident's room; -He/She should change his/her gloves when they were soiled and after providing perineal care; -He/She should place used perineal wipes directly into a plastic bag and not on the resident's mattress. He/She should have disinfected the mattress after he/she placed the wipes on the resident's mattress. During an interview on 11/26/24 at 3:58 P.M., the DON said the following: -She expected staff to wash their hands upon entering the room, when their hands were soiled, when changing gloves and upon exiting the room; -Staff should change their gloves when they become soiled; -Staff should not touch clean surfaces with soiled gloves/hands; -Staff should not place soiled incontinence wipes on a resident's mattress, but should put the wipes in a bag. 13. Review of Resident #74's quarterly MDS, dated [DATE], showed the resident had a urinary catheter. Review of the resident's Physician's Orders, dated November 2024, showed the following: -Diagnoses included urinary tract infection. -The resident had a urinary catheter. Change monthly and PRN (as needed). Review of the resident's care plan, last revised 11/17/24, showed the following: -The resident had a urinary catheter; -The care plan did not address keeping the urinary drainage bag off the floor. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Observation on 11/18/24 at 11:30 A.M., showed the resident lay on his/her back in the bed. The urinary drainage bag hung from the bed frame and touched the floor. Observation on 11/20/24 at 7:20 A.M., showed the resident lay on his/her back in the bed. The urinary drainage bag hung from the bed frame and touched the floor. During an interview on 12/4/24 at 3:30 P.M., CNA I said no part of a urinary drainage system should touch the floor. The bed should be raised high enough so the drainage bag did not touch the floor. During an interview on 11/26/24 at 3:58 P.M., the DON said no part of a urinary drainage system should touch the floor. 47008

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32899 Based on interview and record review, the facility failed to ensure staff provided education and offered, administered, or obtained the signed refusal for the pneumococcal immunization for four residents (Resident #7, #74, #18 and #44) and failed to track immunization history for at least one resident (Resident #7), in a review of 20 sampled residents. The census was 87. Review of the facility policy Pneumonia Vaccine - Pneumococcal Immunization - PPV, revised 12/20/22, showed the following: -PPV should be administered to all residents in the facility unless it is contraindicated or refused; -The Director of Nursing /Designee will maintain a log of all residents on the unit for a record of the immunization process that includes columns for: -Resident name and room number -That the resident/ family member was given information about the vaccine and its benefits and possible side effects; -Date vaccine administered; -Vaccine refused or contraindicated, and reason why; -Temperature for three consecutive days; -Side effects noted; -Document in the EMR Immunization Tab[-The Infection Preventionist and or Designee will use the EMR to record immunization information; -The Unit Nurse will determine if the resident has been previously vaccinated; -Review the resident's EMR to determine whether the resident has been previously vaccinated. If vaccination status is unknown, proceed to the next step; -Ask the resident if he/she received the vaccine outside of the facility or before coming to the facility. If vaccination status is still unknown, proceed to the next step; -If the resident is unable to answer, then ask the same question of the responsible party/legal guardian; -If vaccine status cannot be determined, administer the vaccination to the resident according to standards of clinical practice if it is not refused or contraindicated; (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-The Unit Nurse must refer residents who are immunocompromised to the Infection Control Nurse as the are complex criteria for determining when the booster dose will be administered; -The Infection Preventionist will record all of the resident's log information in the resident's EMR I 0. The Infection Control Nurse will: -Order the Pneumococcal vaccine. -Stay current with information from the CDC on immunization. -Reviewcurrent product information from the vaccine manufacturer. -Distribute the vaccine to the units. -Educate the health care team on: -Pneumonia -Protocols for vaccine administration -Contraindications to vaccine administration -Possible side effects of vaccine administration -Monitor the Immunization Log and the unit practices to make sure the immunization process meets clinical standards of care. 1. Review of Resident #7's face sheet showed the following: -admitted [DATE]; -The resident was over [AGE] years of age; -Diagnoses included asthma, Alzheimer's disease and chronic viral hepatitis C. Review of the resident's quarterly Minimum Data Set (MDS) a federally mandated assessment instrument to be completed by the facility and dated 9/11/24 showed the following: -Short and long term memory problem; -Pneumococcal immunization not up to date and not offered. Review of the resident's electronic medical record (EMR) on 11/18/24 showed no documentation staff administered any pneumococcal immunizations. Review of the resident's EMR showed no documentation the facility offered any pneumococcal immunization per the CDC recommendations after the resident was admitted . The record also showed no documentation of education, consent form, signed refusal or history of a pneumococcal immunization. (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Review of Resident #18's face sheet showed an initial admitted [DATE] and the latest admitted [DATE]. Review of the resident's quarterly MDS, dated [DATE], showed the resident's pneumococcal immunization was up to date, however no date was listed. Review of the resident's EMR showed no documentation of education or signed consent/refusal form. 3. Review of Resident #74's face sheet showed an admitted [DATE]. The resident was over [AGE] years of age. Review of the resident's quarterly MDS, dated [DATE] showed the following: -Moderately impaired cognition; -Pneumococcal immunization not up to date and resident refused. Review of the resident's EMR on 11/18/24 showed no documentation of a pneumococcal immunization. Review of the resident's EMR showed the resident refused the Prevnar 20 immunization, however there was no documentation of any dated and signed refusal or education. 4. Review of Resident #44's face sheet showed he/she admitted to the facility 07/21/24, Review the resident's readmission Minimum Data Set (MDS), a federally required assessment completed by staff, dated 1/25/24, showed the following: -Cognitively intact; -Diagnosis included heart failure, renal (kidney) insufficiency, respiratory failure and chronic obstructive pulmonary (respiratory) disease; -Shortness of breath at rest, with exertion and lying flat, -Uses tobacco; -Oxygen use; -Pneumococcal vaccine not up to date: not offered. Review of the resident's medical record showed no documentation of education, consent form, signed refusal or history of a pneumococcal immunization. 5. Review of a PNA vaccination list provided by the facility and undated, showed a list of residents in the facility and what pneumonia immunization they had received with the date administered. It also listed if they had refused with no date recorded. Residents #7, #44 and #74 were not included on the list. (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 11/20/24 at 1:40 P.M. the Infection Preventionist (IP) said the following: -She and the Director of Nurses (DON) were responsible for ensuring immunizations were completed and up to date; -She knew they needed to review who has had and who needed the pneumonia vaccine and they were working on this; -They needed to complete an audit to see who needed what immunization, notify the physician and get the specific order. During an interview on 11/25/24 at 3:58 P.M. the DON said the following: -The Assistant Director of Nurses (A)DON and Social Services were responsible for obtaining a resident's immunization history; -Nursing (DON and the IP) should be offering needed immunizations on admission or within the first ten days after the admitted .; -All residents' pneumococcal immunizations should be up to date. 38016

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32899 Based on interview and record review, the facility failed to ensure residents were educated and offered or obtained consent or refusal of the COVID 19 immunization for two residents (Resident #7, #74) in a review of 20 sampled residents. The census was 87. Review of the facility Policy/ Procedure titled Influenza Immunization - Flu Vaccine- COVID Immunizations, last revised on 11/22/22 showed the following: -The Infection Control Nurse will give the Charge Nurse a log of all residents on the unit for a record of the immunization process that includes columns for: -Resident name and room number -That the resident/ family member was given information about the vaccine and its benefits and possible side effects; -Date vaccine administered; -Vaccine refused or contraindicated, and reason why; -The Charge Nurse will monitor the log daily to make sure it is being filled out correctly. When the log is completed, the Charge Nurse will give it to the Infection Control Nurse; -The Infection Control Nurse will: -Stay current with information from the CDC on Influenza immunization and COVID-19 Updates; -Distribute the vaccine to the units; -Monitor the Immunization Log in the EMR and the unit practices to make sure the immunization process meets clinical standards of care; -Review the EMRs immunization logs after the facility's immunization process is completed. 1. Review of Resident #7's face sheet showed the following: -admitted [DATE]; -The resident had a guardian. Review of the resident's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument to be completed by the facility, dated 9/11/24, showed the resident had short and long-term memory problems. (continued on next page)

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the resident's medical record on 11/18/24 showed no documentation of any COVID-19 immunizations. Review of the resident's medical record showed no documentation the facility offered any COVID-19 immunizations per the CDC immunization recommendations after the resident was admitted . The record also showed no documentation of education provided, consent form, signed refusal, or documentation of contraindications for the immunization. 2. Review of Resident #74's face sheet showed the resident admitted to the facility on [DATE]. The resident was his/her own responsible party. Review of the resident's quarterly MDS, dated [DATE], showed the resident had moderately impaired cognition. Review of the resident's immunization record on 11/18/24 showed no documentation of any COVID-19 immunizations. Review showed the resident refused the COVID-19 immunization, however, there was no documentation to show when he/she refused. Review of the resident's medical record showed no documentation staff provided the resident with education regarding the risk/benefits of the COVID-19 immunization. During an interview on 11/20/24 at 1:40 P.M., the Infection Preventionist (IP) said the following: -She and the Director of Nurses (DON) were responsible for ensuring immunizations were completed and up to date; -They needed to complete an audit to see which residents needed immunizations and to notify the physician and get the specific order. They had just recently discussed getting this started. During an interview on 11/25/24 at 3:58 P.M., the DON said the following: -The ADON and Social Services Staff were responsible for obtaining immunization history; -Staff were to obtain an order, provide education, and ensure consents/refusals were signed -Nursing (DON and the IP) should offer immunizations on admission or within the first ten days after the admitted ; -All residents immunizations should be up to date.

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32899 Based on observation, interview, and record review, the facility failed to maintain a call light at each resident's bedside for the residents to call staff for assistance, affecting two resident (Residents #28 and #68), in a review of 20 sampled residents. The facility census was 87. Review of the facility policy, resident call system, dated 08/02/24, showed the following: -Each resident room will be provided with a call light in the event they require assistance from staff; -Each resident room should be equipped with at least two (four for the Quad rooms) call lights so that each resident can request staff assistance; -All call lights should be within reach of each resident; -All staff are expected to respond to call lights, or let the necessary personnel know the lights are going off and residents require assistance. 1. Review of the resident #67's care plan last revised 8/5/24 showed the following: -Required extensive assist for activities of daily living; -Two staff assist with transfers and mechanical lift; -Resident non-weight bearing; Review of the resident's quarterly Minimum Data Set, (MDS), a federally mandated assessment instrument dated 10/3/24, showed the following: -Cognitively intact; -Dependent for transfers. Review of the resident's Physician Order Sheet (POS) dated 11/2024 showed the following: -Diagnoses included left femur (large bone of the upper leg) fracture and abnormal posture; -Wheelchair bound as tolerated; -May use broda chair (a special reclining chair) when up. Observation on 11/20/24 at 3:23 P.M. showed the following: -The resident screamed Help! loudly and repeatedly for over three to five minutes; (continued on next page)

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-The resident lay in his/her reclined broda chair which sat semi-parallel to his/her bed. The resident said he/she was very uncomfortable, could not put his/her legs down and could not get into bed without help; -The resident's call light lay at the foot of the bed and out of the resident's reach; -No staff responded until the surveyor reported to nursing that the resident needed help per the resident's request. During an interview on 11/20/24 at 3:23 P.M., the resident said he/she was screaming for help because he/she could not reach his/her call light. This made him/her feel helpless. 2. Review of Resident #28's Care Plan, revised 06/06/24, showed the following: -He/She had diagnosis of dementia, Parkinson's disease (disorder of the central nervous system that affects movement, often including tremors), anxiety, depression, and schizophrenia (mental illness); -Impaired cognitive function/dementia; -Communication problem due to hearing deficit and cognitive impairment; -At risk for falls related to behaviors or wandering, use of psychotropic medications, and poor safety awareness; -Be sure call light is within reach when in room and encourage resident to use it. Review of the resident's quarterly MD, dated 09/02/24, showed the following: -Moderate assistance with sitting to lying and lying to sitting; -Dependent on staff for transfers. Observation on 11/19/24 at 9:20 A.M., showed the resident lay in bed sleeping. The resident's call light was under the resident's mattress and not accessible to the resident. Observation on 11/20/24 at 8:35 A.M., showed the resident lay in bed on his/her right side. The resident's call light was under his/her mattress and not accessible for the resident to use. Observation on 11/20/24 at 1:20 P.M., showed Nurse Aide (NA) E assisted the resident to bed, covered the resident with a sheet and blanket, and left the room. The resident's call light remained under the resident's mattress and not accessible for the resident to use. Observation on 11/21/24 at 8:30 A.M. and 1:52 P.M. showed the resident lay in bed on his/her right side. The resident's call light was under the resident's mattress and not accessible for the resident to use. (continued on next page)

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 11/25/24 at 10:26 A.M. and 6:50 P.M., showed the resident lay in bed on his/her right side. His/Her call light was on the floor out of his/her reach. During an interview on 11/21/24 at 8:35 A.M., NA E said the resident's call light should be in the resident's reach. During an interview on 11/21/24 at 8:47 A.M., Certified Nurse Aide (CNA) H said he/she usually gave the call light to the resident. He/She just did not notice it was under the resident's mattress. All residents should have their call light in reach. 3. Review of Resident #68's undated Care Plan showed the following: -He/She had diagnosis of psychotic disorder with delusions (mental illness), anxiety, depression, dementia, urinary retention, chronic pain syndrome, traumatic brain injury, contracture unspecified joint; -At risk for falls; -Resident had informed staff if they do not get him/her up when he/she wants to get up, he/she will try to get up without assistance. -Be sure call light is in reach and encourage the resident to call for assistance. Review of the resident's quarterly MDS, dated [DATE], showed the following: -Required maximal assistance with rolling side to side and to sitting to lying; -Dependent with transfers and sit to stand; -Incontinent of bowels. Observation on 11/25/24 at 10:35 A.M. and 6:17 P.M., showed the resident lay in bed on his right side. The resident's call light hung over the foot board of the bed and was not within the resident's reach. During an interview on 11/25/24 at 6:00 P.M., the Director of Nursing (DON) said call lights should be in reach of all residents at all times while in their room or bathrooms. During an interview on 11/25/24 at 6:15 P.M., Administrator 1 said call lights should be in reach for all residents. 38016 49528

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F 0941 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop, implement, and/or maintain an effective training program that includes effective communications for direct care staff members. 38016 Based on interview and record review, the facility failed to ensure all employees completed communication training for three employees (Certified Medication Technician (CMT), CMT J, and CNA R) in a sample of four employee files reviewed. The facility identified specific training needs in the facility assessment, and did not have documentation or evidence the required training was completed. The facility census was 87. Review of the Facility Assessment, dated 09/26/24, showed the the following: -Staff training, education, and competencies: Describe the staff training/education and competencies that are necessary to provide the level and types of support and care needed for your resident population; -Include staff certification requirements as applicable, testing policies, and your competency evaluations; -Training required - new hires: -Additional training for care givers (Nursing and Activities) - 2 hours: -Care of cognitively impaired - 1.0 hour - Required by Medicare Rules of Participation; -Communicating with older adults with dementia - 1.0 hours - Required by Rules of Participation; -Annual education included: -May - Communication and chain of command; -December sessions included Communication, Social Services. The facility did not provide evidence of an education/compliance calendar following request. 1. Review of CMT D's employee education record showed a hire date of 11/15/22. Review of CMT D's education record showed no documentation communication training was completed on hire or annually. 2. Review of CMT J's employee education record showed a hire date of 07/26/23. Review of CMT J's education record showed no documentation communication training was completed on hire or annually. 3. Review of CNA R's employee education record showed a hire date of 01/24/24. (continued on next page)

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F 0941 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of CNA R's education record showed no documentation communication training was completed on hire or annually as directed in the facility assessment. During an interview on 11/20/24, at 1:30 P.M., the Director of Nursing (DON) said the following: -Employee education was expected to be completed on new hire and annually as directed by the Facility Assessment; -Topics for education are expected to include regulatory required trainings, and areas identified by the facility assessment specific to the resident population; -Human Resources (HR) coordinated the new hire training and records the new hire training; -The HR staff was new, and was not tracking any prior education; -Registered Nurse (RN) A assisted with education on hire and with the Nurse Assistants (NA); -Most of the new hire and annual education was handled through an online education site, where education could be scheduled, completed, and recorded; -She left the facility for a time period and had not evaluated if all of the staff were up to date on required education. During an interview on 11/20/24, at 1:30 P.M., the RN A said the facility was putting together an education calendar to include all the subject matter that was required by regulation and education subjects identified by the facility assessment, but it was not complete at this time.

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F 0942 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that staff members are educated on resident rights and facility responsibilities to properly care for its residents. 38016 Based on interview and record review, the facility failed to ensure all employees received training on resident rights. The facility identified specific training needs in the facility assessment, and did not have documentation or evidence the required training was completed for three of four employees reviewed (Certified Medication Technician (CMT) D, CMT J, and CNA R), or a current plan to ensure the training would be completed. The facility census was 87. Review of the Facility Assessment, dated 09/26/24, showed the the following: -Staff training, education, and competencies: Describe the staff training/education and competencies that are necessary to provide the level and types of support and care needed for your resident population; -Include staff certification requirements as applicable, testing policies, and your competency evaluations; -Training required - new hires: -All Employees - 5.75 hours; -Abuse/Resident Rights - 1.25 hours; -Resident rights - .50 hours - Required by Medicare Rules of Participation; -All staff annual training - courses and inservices: -Resident Rights - .50 hours - required by Medicare Rules of Participation; -Schedule for annual training: -Human Resources (HR)/Resident Rights/Abuse - available beginning of January and due April 30; -All departments are required to have resident rights education; -March - Resident rights/compassionate care guidelines. 1. Review of CMT D's employee education file showed a hire date of 11/15/22. -His/Her employee file did not include a general orientation checklist; -In-Service education training on 11/15/22, included resident rights; -CMT D's education file did not include annual resident rights education for the year of 11/18/23-11/28/24 as directed by the facility assessment. (continued on next page)

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	265462	A. Building B. Wing	11/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Beloved Health and Rehabilitation Center	328 Munger Lane Hannibal, MO 63401

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F 0942 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Review of CMT J's employee education file showed a hire date of 07/26/23. Review of the CMT J's education record showed no documentation of education on resident rights on hire or annually as directed in the facility assessment. 3. Review of CNA R's employee education file showed a hire date of 01/24/24. Review CNA R's education record showed no documentation of education on resident rights on hire as directed in the facility assessment. During an interview on 11/20/24, at 1:30 P.M., the Director of Nursing (DON) said the following: -Employee education was expected to be completed on new hire and annually as directed by the Facility Assessment; -Topics for education are expected to include regulatory required trainings, and areas identified by the facility assessment specific to the resident population; -Human Resources (HR) coordinated the new hire training and records the new hire training; -The HR staff was new, and was not tracking any prior education; -Registered Nurse (RN) A assisted with education on hire and with the Nurse Assistants (NA); -Most of the new hire and annual education was handled through an online education site, where education could be scheduled, completed, and recorded; -She left the facility for a time period and had not evaluated if all of the staff were up to date on required education. During an interview on 11/20/24, at 1:30 P.M., the RN A said the facility was putting together an education calendar to include all the subject matter that was required by regulation and education subjects identified by the facility assessment, but it was not complete at this time.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0943 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Give their staff education on dementia care, and what abuse, neglect, and exploitation are; and how to report abuse, neglect, and exploitation. 38016 Based on interview and record review the facility failed to provide training for abuse, neglect, exploitation, and misappropriation of resident property and the reporting and prevention of incidents of abuse, neglect, exploitation, and misappropriation of resident property for three employees (Certified Medication Technician (CMT) D, CMT J, and Certified Nurse Assistant (CNA) R) of four employee records reviewed, as directed in the facility assessment and the facility's Abuse and Neglect policy. The facility census was 87. Review of the Facility Assessment, dated 09/26/24, showed the the following: -Staff training, education, and competencies: Describe the staff training/education and competencies that are necessary to provide the level and types of support and care needed for your resident population; -Include staff certification requirements as applicable, testing policies, and your competency evaluations; -Training required - new hires: -All Employees, Abuse/Resident rights - 1.25 hours, and preventing, recognizing and reporting abuse - .75 hours - required by Elder Justice Act and Medicate Rules of Participation; -All staff annual training - courses and inservices: -Preventing, recognizing and reporting abuse - .75 hours - required by Elder Justice Act and Medicare Rules of Participation; -Schedule for annual training: -Human Resources (HR)/Resident Rights/Abuse - available beginning of January and due April 30; -All departments, abuse and neglect; -February - Abuse and neglect. Review of the facility's policy, Abuse and Neglect Policy, dated 12/28/23, showed the following: -Training: - Employees are trained through-orientation and ongoing training on issues related to abuse prohibition practices, such as; dealing with aggressive residents, reporting allegations without fear of reprisal, recognizing signs of burn out, frustrations or stress that may lead to abuse and the definition that constitutes abuse; neglect and misappropriation of resident property; (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0943 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-During orientation of new employees, the facility will cover at least the following topics: -Sensitivity to resident rights and resident needs and what constitutes physical, sexual, verbal and mental abuse; -Staff obligations to prevent and report abuse, neglect and theft: and how to distinguish theft from lost items and willful abuse from insensitive staff actions should be corrected through counseling and additional training; -How to assess prevent, and manage aggressive, violent, and/or catastrophic reactions of residents in a way that protects both residents and staff; -How to recognize and deal with burnout, frustration, and stress that may lead to inappropriate responses or abusive reactions to residents; -Reporting of Abuse and their obligations under law when receiving an allegation of abuse, neglect, or theft; -This training will be done on the facility's learning management system (Relias) with the training on residents rights and the training on preventing and reporting abuse; -On an annual basis, staff will receive a review of the above topics through training on the learning management system. 1. Review of CMT D's employee file, showed the employee's date of hire was 11/15/22. Review of education completed from 11/18/23-11/18/24, showed the CMT did not attend training on identification, reporting, and prevention of incidents of abuse, neglect, exploitation, and misappropriation of resident property in the last year. 2. Review of CMT J's employee file, showed the employee's date of hire was 07/26/23. Review of education completed from 7/26/23-11/18/24, showed the CMT did not attend training on identification, reporting, and prevention of incidents of abuse, neglect, exploitation, and misappropriation of resident property when hired or in the last year. 3. Review of CNA R's employee file, showed the employee's date of hire was 01/24/24. Review of education completed from 01/24/24-11/18/24, showed the CMT did not attend training on identification, reporting, and prevention of incidents of abuse, neglect, exploitation, and misappropriation of resident property when hired or in the last year. During an interview on 11/20/24, at 1:30 P.M., the Director of Nursing (DON) said the following: -Employee education was expected to be completed on new hire and annually as directed by the Facility Assessment; (continued on next page)

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F 0943 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Topics for education are expected to include regulatory required trainings, and areas identified by the facility assessment specific to the resident population; -Human Resources (HR) coordinated the new hire training and records the new hire training; -The HR staff was new, and was not tracking any prior education; -Registered Nurse (RN) A assisted with education on hire and with the Nurse Assistants (NA); -Most of the new hire and annual education was handled through an online education site, where education could be scheduled, completed, and recorded; -She left the facility for a time period and had not evaluated if all of the staff were up to date on required education. During an interview on 11/20/24, at 1:30 P.M., the RN A said the facility was putting together an education calendar to include all the subject matter that was required by regulation and education subjects identified by the facility assessment, but it was not complete at this time.

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F 0944 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Conduct mandatory training, for all staff, on the facility's Quality Assurance and Performance Improvement Program. 38016 Based on interview and record review, the facility failed to ensure that Quality Assurance Performance Improvement (QAPI) process training was completed for all staff. The facility identified specific training needs in the facility assessment. The facility did not have documentation or evidence the required training was completed for two employees of four employees (Certified Medication Technician (CMT) D and CMT J) (of employees who have been working at the facility for at least one year) reviewed, or a current plan to ensure the training would be completed. The facility census was 87. Review of the Facility Assessment, dated 09/26/24, showed the the following: -Staff training, education, and competencies: Describe the staff training/education and competencies that are necessary to provide the level and types of support and care needed for your resident population; -Include staff certification requirements as applicable, testing policies, and your competency evaluations; -November - QAPI plan review; -December sessions include QAPI plan. 1. Review of CMT D's employee file, showed the employee's date of hire was 11/15/22. Review of CMT D's education record showed no documentation CMT D completed QAPI process training. 2. Review of CMT J's employee file, showed the employee's date of hire was 07/26/23. Reivew of CMT J's education record showed no documentation CMT J completed QAPI process training. During an interview on 11/20/24, at 1:30 P.M., the Director of Nursing (DON) said the following: -Employee education was expected to be completed on new hire and annually as directed by the Facility Assessment; -Topics for education are expected to include regulatory required trainings, and areas identified by the facility assessment specific to the resident population; -Human Resources (HR) coordinated the new hire training and records the new hire training; -The HR staff was new, and was not tracking any prior education; -Registered Nurse (RN) A assisted with education on hire and with the Nurse Assistants (NA); (continued on next page)

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F 0944 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Most of the new hire and annual education was handled through an online education site, where education could be scheduled, completed, and recorded; -She left the facility for a time period and had not evaluated if all of the staff were up to date on required education. During an interview on 11/20/24, at 1:30 P.M., the RN A said the facility was putting together an education calendar to include all the subject matter that was required by regulation and education subjects identified by the facility assessment, but it was not complete at this time.

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F 0945 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Include as part of its infection prevention and control program, mandatory training that includes written standards, policies, and procedures for the program. 38016 Based on interview and record review, the facility failed to ensure all employees completed education on infection control. The facility identified specific training needs in the facility assessment. The facility did not have documentation or evidence the required training was completed for four of four employees (Certified Medication Technician (CMT) D, CMT J, Certified Nurse Assistant (CNA) R and CNA I) reviewed, or a current plan to ensure the training would be completed. The facility census was 87. Review of the Facility Assessment, dated 09/26/24, showed the the following: -Staff training, education, and competencies: Describe the staff training/education and competencies that are necessary to provide the level and types of support and care needed for your resident population; -Include staff certification requirements as applicable, testing policies, and your competency evaluations; -Other inservice training: -Handwashing, peri-care, ostomy care, catheter care, bowel and bladder (B&B) training, glove usage; -All departments: -Blood borne pathogens, Occupational Safety and Health Administration (OSHA) requirements, proper disposal of contaminated items, Mock OSHA survey; -All staff annual training: -October - Infection control/enhanced barrier precautions; -Infection control is not included on the new hire education topics. Review of the facility's infection control policies, did not include evidence the facility identified an infection control training program to include the following required areas: -The facility's surveillance system was designed to identify possible communicable disease or infections before they can spread to other persons in the facility; -When and to who possible incidents of communicable disease or infections in the facility should be reported; -How and when to use standard precautions, including proper hand hygiene practices and environmental cleaning and disinfection practices; (continued on next page)

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F 0945 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-How and when to use transmission-based precautions for a resident, including but not limited, to the type and its duration of use depending upon the infectious agent or organism involved; -Occupational health policies, including circumstances under which the facility must enforce work restrictions and when to self-report illness or exposures to potentially infectious materials; and -Proper infection prevention and control practices when performing resident care activities as it pertains to particular staff roles, responsibilities and situations. 1. Review of CMT D's employee file, showed a date of hire of 11/15/22. Review of in-service education completed from 11/15/23-11/15/24, showed CMT D attended the following: -Personal Protective Equipment (PPE)/handwashing on 09/13/24; -Enhanced barrier on 10/30/24. Review of CMT D's education record showed no other infection control training. The CMT's education record did not include evidence of any infection control education completed on hire, or education in October that included infection control/enhanced barrier precautions as directed by the facility assessment. 2. Review of CMT J's employee file, showed a date of hire of 07/26/23. Review of in-service education completed from 07/26/23-07/26/24, showed the CMT attended the following: -Learn at lunch presentation guidelines and implementation Enhanced Barrier Precaution (EBP) on 05/31/24, -Enhanced barrier on 11/01/24. Review of CMT J's Relias transcript, provided by the facility, dated 11/25/24, showed the following: -The education modules completed from 07/26/23-07/26/24 included: -Modules completed on 05/09/24 included, About Infection Control and Prevention - 1 hour; CMT J's education record did not include evidence of infection control training completed on hire. 3. Review of CNA R's employee file, showed a date of hire of 01/24/24. Review of the CNA's employee file showed no documentation of infection control training on hire. 4. Review of CNA I's employee file, showed a date of hire of 01/24/24. (continued on next page)

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F 0945 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the CNA's employee file showed no documentation of infection control training on hire. During an interview on 11/20/24, at 1:30 P.M., the Director of Nursing (DON) said the following: -Employee education was expected to be completed on new hire and annually as directed by the Facility Assessment; -Topics for education are expected to include regulatory required trainings, and areas identified by the facility assessment specific to the resident population; -Human Resources (HR) coordinated the new hire training and records the new hire training; -The HR staff was new, and was not tracking any prior education; -Registered Nurse (RN) A assisted with education on hire and with the Nurse Assistants (NA); -Most of the new hire and annual education was handled through an online education site, where education could be scheduled, completed, and recorded; -She left the facility for a time period and had not evaluated if all of the staff were up to date on required education. During an interview on 11/20/24, at 1:30 P.M., RN A said the following: -The CNA/NA's have computerized training that included their 12 hours of training they have to complete by the end of the year. She was not sure if the staff had completed the required trainings; -The facility was putting together an education calendar to include all the subject matter that was required by regulation and education subjects identified by the facility assessment, but it was not complete at this time; -She completed infection control training for new hires, HR was responsible to record that training.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0946 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide training in compliance and ethics. 38016 Based on interview and record review, the facility failed to ensure all staff completed compliance and ethics training. The facility identified specific training needs in the facility assessment. The facility did not have documentation or evidence the required training was completed for two of four employees (Certified Medication Technician (CMT) D and CMT J - employees who had been working at the facility for at least one year), and one Certified Nurse Assistant (CNA) R, of two employees newly hired in the last year, or a current plan to ensure the training would be completed. The facility census was 87. Review of the Facility Assessment, dated 09/26/24, showed the the following: -Staff training, education, and competencies: Describe the staff training/education and competencies that are necessary to provide the level and types of support and care needed for your resident population; -Include staff certification requirements as applicable, testing policies, and your competency evaluations; -Training required - new hires: - All Employees - 5.75 hours; Compliance - two hours, compliance and ethics training - one hour - required by law and CIA; -All staff annual training - courses and inservices: -Compliance training - one hour - required by law and CIA; -Schedule for annual training: -Compliance/Health Insurance Portability and Accountability Act (HIPAA) - available beginning of September and due December 31; -All departments: -HIPAA, corporate compliance, codes, elopements, needle sticks, abuse and neglect, workplace violence, reporting incidents,, resident rights, abuse and neglect, proper reporting of problems. 1. Review of CMT D's employee file, showed the employee's date of hire was 11/15/22. Review of CMT D's education record showed no documentation of completion of compliance and ethics training on hire or annually. 2. Review of CMT J's employee file, showed the employee's date of hire was 07/26/23. (continued on next page)

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F 0946 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of CMT J's education record showed no documentation of completion of annual compliance and ethics training. 3. Review of Certified Nurse Assistant (CNA) R's employee file, showed the employee's date of hire 01/24/24. Review of CNA R's education record did not include compliance and ethics training for new hire training (the employee had not completed a year of employment) as directed in the facility assessment. During an interview on 11/20/24, at 1:30 P.M., the Director of Nursing (DON) said the following: -Employee education was expected to be completed on hire and annually as directed by the Facility Assessment; -Topics for education were expected to include regulatory required trainings, and areas identified by the facility assessment specific to the resident population; -Human Resources (HR) coordinates the new hire training and records the new hire training; -The HR staff present was new, and do not track prior education; -Registered Nurse (RN) A assisted with education for new hires and with the Nurse Assistants (NA); -Most of the new hire and annual education was handled through an online education site, where education could be scheduled, completed, and recorded; -She left the facility for a time period and had not evaluated if all of the staff were up to date on required education. During an interview on 11/20/24, at 1:30 P.M., the RN A said the following: -She provided new hire training for corporate compliance; -HR was responsible to record new hire training; -The facility was putting together an education calendar to include all the subject matter that was required by regulation and education subjects identified by the facility assessment, but it was not complete at this time.

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F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. 38016 Based on interview and record review, the facility failed to ensure each Certified Nurse Aide (CNA) had no less than 12 hours of in-service education per year based on their individual performance review, calculated by hire date. The facility identified two Certified Medication Technicians (CMTs) employed by the facility for more than a year (no CNAs or NAs had been employed for a year). Two CMTs (CMT J and CMT D), were sampled and two out of two did not have the required 12 hours of in-service education, or training for abuse. One CMT of two did attend an in-service that included the topic of abuse, but there was no agenda provided, depth or scope of the training. None of the two sampled staff attended an in-service that included the topic of dementia. One of the two sampled CMT's attended an in-service for behaviors, but there was no agenda, depth, or scope of the training. None of the two sampled attended an in-service regarding care of the cognitively impaired resident. The facility census was 87. Review of the Facility Assessment, dated 09/26/24, showed the the following: -Staff training, education, and competencies: Describe the staff training/education and competencies that are necessary to provide the level and types of support and care needed for your resident population; -Include staff certification requirements as applicable, testing policies, and your competency evaluations; -CNA - Inservice hours and Relias (computer training); -Training required - new hires: -All Employees: - Abuse/Resident rights; -Preventing, recognizing and reporting abuse - .75 hours - required by Elder Justice Act and Medicare Rules of Participation; -Additional training for care givers (Nursing, Social Services, and Activities): -Care of cognitively impaired - 1.0 hour - Required by Medicare Rules of Participation; -Communicating with older adults with dementia - 1.0 hours - Required by Rules of Participation; -All staff annual training - courses and inservices: -Preventing, recognizing and reporting abuse - .75 hours - required by Elder Justice Act and Medicare Rules of Participation; (continued on next page)

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F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Schedule for annual training: -HR/Resident Rights/Abuse - available beginning of January and due April 30; -Other inservice training: -Dementia education; -All departments: -Abuse and neglect, proper reporting of problems; -CNA (no less than 12 hours per year); -Alzheimer's/Dementia: January; -Care for residents with Alzheimer's, dementia, mental illness; -February - Abuse and neglect, -June - Alzheimer's and cognitive disorders. Review of the facility's Abuse and Neglect Policy, dated 12/28/23, showed the following: -Training: -Employees are trained through-orientation and ongoing training on issues related to abuse prohibition practices, such as; dealing with aggressive residents, reporting allegations without fear of reprisal, recognizing signs of burn out, frustrations or stress that may lead to abuse and the definition that constitutes abuse; neglect and misappropriation of resident property; -During orientation of new employees, the facility will cover at least the following topics: -Sensitivity to resident rights and resident needs and what constitutes physical, sexual, verbal and mental abuse; -Staff obligations to prevent and report abuse, neglect and theft: and how to distinguish theft from lost items and willful abuse from insensitive staff actions should be corrected through counseling and additional training; -How to assess prevent, and manage aggressive, violent, and/or catastrophic reactions of residents in a way that protects both residents and staff; -How to recognize and deal with burnout, frustration, and stress that may lead to inappropriate responses or abusive reactions to residents; -Reporting of Abuse and their obligations under law when receiving an allegation of abuse, neglect, or theft; (continued on next page)

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	265462	A. Building B. Wing	11/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Beloved Health and Rehabilitation Center	328 Munger Lane Hannibal, MO 63401

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F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-This training will be done on the facility's learning management system (Relias) with the training on residents rights and the training on preventing and reporting abuse; -On an annual basis, staff will receive a review of the above topics through training on the learning management system. 1. Review of CMT D's employee file, showed the employee's date of hire was 11/15/22. Review of education completed from 12/07/22-11/18/24, showed CMT D attended the following: -Transfers and mechanical lifts on 08/16/24, (did not include agenda, specifics of topics covered, or length of time to complete the education); -Personal Protective Equipment (PPE)/handwashing on 09/13/24, (did not include time of to complete the education); -Enhanced barrier on 10/30/24, (did not include agenda, specifics of topics covered, or time to complete the education); -Policy review CMT on 11/14/24, (did not include agenda, specifics of topics covered, or time to complete the education). Four-Total of four hours on education completed if one hour in length (per DON interview) in the last year. The education record did not include the amount of time or depth of the subjects reviewed, or if 12 hours of education was completed. Review of education completed from 11/18/23-11/18/24, showed CMT D did not attend training on identification, reporting, and prevention of incidents of abuse, neglect, exploitation, and misappropriation of resident property in the last year. The documentation did not include if training on dementia was covered in the education. The documentation did not include if care of the cognitively impaired resident was covered in the education. 2. Review of CMT J's employee file, showed the employee's date of hire was 07/26/23. Review of in-service education completed from 11/18/23-11/18/24, showed CMT J attended the following: -Learn at lunch presentation guidelines and implementation Enhanced Barrier Precaution (EBP) on 05/31/24, (did not include agenda, specifics of topics covered, or time spent completing the presentation); -Transfers and mechanical lifts on 08/16/24, (did not include agenda, specifics of topics covered, or time spent completing the education); -Enhanced barrier on 11/01/24, (did not include agenda, specifics of topics covered, or time spent completing the education); (continued on next page)

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F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Policy review CMT on 11/14/24, (did not include agenda, specifics of topics covered, or time spent completing the education). During an interview on 11/20/24 at 1:30 P.M., the DON said each training which was conducted by in-service method noted in CMT J's file was one hour in length. Review of CMT J's Relias transcript, provided by the facility, dated 11/25/24, showed the following: -The education modules completed from 07/26/23-07/26/24 included: -Modules completed on 05/09/24 included: -About infection control and prevention - 1 hour; -Respecting diversity in the workplace, self paced, - 1 hour; -Transfers: Mechanical lifts - .07 hours - 4.2 minutes; -Assisting with transfers and ambulation - 0.13 hours - 7.8 minutes; -Personalized learning: OSHA requirements - 1 hour; -Module completed on 05/14/24, transfers: using a gait belt - 0.05 hours - 3 minutes; -Module completed on 08/27/24, About mental health: Common conditions and disorders - 1 hour; -Modules completed on 09/01/24 included: -Assisting with self-administration of medications: The basics - 1 hour; -Transfers: Sliding board - 0.03 hours - 1.8 minutes; -Transfers: Assist to/from shower - 0.07 hours - 4.2 minutes; -Module completed on 09/03/24, Basics of medication management - 1 hour; -Total of 5 hours and 21 minutes education completed. CMT J's documented training showed a total of 9 hours and 21 minutes of training completed in the last year. The education did not include the amount of time (for facility provided education), depth of the subjects reviewed, or if 12 hours of education was completed. Review of education completed from 11/18/23-11/18/24, showed the CMT did not attend training on identification, reporting, and prevention of incidents of abuse, neglect, exploitation, and misappropriation of resident property in the last year. The documentation did not include if training on dementia was covered in the education. The documentation did not include if care of the cognitively impaired was covered in the education. (continued on next page)

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F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 11/20/24, at 1:30 P.M., the Director of Nursing (DON) said the following: -Employee education was expected to be completed on hire and annually as directed by the Facility Assessment; -Topics for education were expected to include regulatory required trainings, and areas identified by the facility assessment specific to the resident population; -Human Resources (HR) coordinated the new hire training and records the new hire training; -HR staff present was new, and did not track any prior education; -Registered Nurse (RN) A assisted with education on hire and with the Nurse Assistants (NA); -Most of the new hire and annual education was handled through an online education site, where education could be scheduled, completed, and recorded; -NA's, CNA's, and CMT's were expected to complete 12 hours of training per year to include the regulator required areas and subjects identified in the facility assessment; -She left the facility for a time period and had not evaluated if all of the staff were up to date on required education. During an interview on 11/20/24, at 1:30 P.M., RN A said the following: -She provided some of the new hire training -HR was responsible to record new hire training; -She did not track all employee training (she did track NA training); -NA's, CNA's and CMT's were expected to complete 12 hours of training annually; -The facility was putting together an education calendar to include all the subject matter that was required by regulation and education subjects identified by the facility assessment, but it was not complete at this time.

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F 0949 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide behavior health training consistent with the requirements and as determined by a facility assessment. 38016 Based on interview and record review, the facility failed to ensure that an effective training program was in place for all new and existing staff. The facility identified specific training needs in the facility assessment, the facility did not have documentation or evidence the required training was completed for two employees (Certified Medication Technician (CMT) D and CMT J) of two employee education files (of employees who had been working at the facility for at least one year), and for two additional employees (CNA I and CNA R), (who had not been employed by the facility for one year) reviewed, or a current plan to ensure the training would be completed. The facility also failed to include behavioral health training for new hires or annually when the facility had a locked unit for residents with mental illness and behavior issues, and a provided care for a resident population with mental illness and behavior concerns identified in the facility assessment. The facility census was 87. Review of the Facility Assessment, dated 09/26/24, showed the the following: -Services offered by the facility include: Manage the conditions and medication-related issues causing psychiatric symptoms and behavior. Identify and implement interventions to help support individuals with issues such as dealing with anxiety, cognitive impairment, intellectual or developmental disabilities, care of individuals with depression, post traumatic stress disorder, schizoaffective/schizophrenia disorder (severe mental illness causes hallucinations, and delusions), bipolar disorder (severe change in moods from depressive to manic), personality disorder, and other psychiatric diagnosis; (continued on next page)

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F 0949 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	CMT J's education record did not include behavioral health training for new hire or annual training. 3. Review of Certified Nurse Assistant (CNA) I's employee file, showed the employee's date of hire 01/24/24. The CNA's education record did not include behavioral health training for new hire training (the employee had not completed a year of employment). 4. Review of Certified Nurse Assistant (CNA) R's employee file, showed the employee's date of hire 01/24/24. The CNA's education record did not include behavioral health training for new hire training (the employee has not completed a year of employment). 5. During an interview on 11/20/24, at 1:30 P.M., the Director of Nursing (DON) said the following: -Employee education was expected to be completed on hire and annually as directed by the Facility Assessment; -Topics for education are expected to include regulatory required trainings, and areas identified by the facility assessment specific to the resident population; -Human Resources (HR) coordinates the new hire training and records the new hire training; -The HR staff at the facility were new and did not track any prior education; -Registered Nurse (RN) A assisted with education on hire and with the Nurse Assistants (NA); -Most of the new hire and annual education was handled through an online education site, where education could be scheduled, completed, and recorded; -She left the facility for a time period and had not evaluated if all of the staff were up to date on required education. During an interview on 11/20/24, at 1:30 P.M., RN A said the following: -The CNA/NA's have computerized training that included their 12 hours of training they have to complete by the end of the year. She was not sure if the staff had completed the required trainings; -The facility was putting together an education calendar to include all the subject matter that was required by regulation and education subjects identified by the facility assessment, but it was not complete at this time.