STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265471	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/06/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Buffalo Prairie Center for Rehab and Healthcare	631 West Main Street Buffalo, MO 65622

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide housekeeping services necessary to maintain a sanitary, orderly, and comfortable interior when odors, stains, dirty floors, and overflowing trashcans were present in resident use areas. The facility census was 40. Review of the facility policy titled, Cycle Cleaning, The Compliance Store, LLC., dated 06/15/25, showed the following:-It is the policy of this facility to identify the functional areas in the facility that require cleaning and to use cycle cleaning schedules to outline the frequencies and maintain regularly scheduled environmental service tasks;-Routine cleaning of environmental surfaces and non-critical resident care items shall be performed according to predetermined schedule and shall be sufficient to keep surfaces clean and dust free;-Specific areas include hallways, dayrooms, dining rooms, showers, utility, bathrooms, and resident's rooms;-The frequency of cleaning and disinfection of the facility environment may vary according to the type of surfaces to be cleaned, the number of individuals in the area, the amount of activity in the area, and the risk to residents;-The environmental services manager is responsible to ensure that cycle cleaning is maintained.Review of the facility policy titled, Routine Cleaning and Disinfection, The Compliance Store, LLC., dated 06/15/25, showed the following:-It is the policy of this facility to ensure the provision of routine cleaning and disinfection to provide a safe, sanitary environment and to prevent the development and transmission of infections to the extent possible;-Routine cleaning and disinfection of frequently touched or visibly soiled surfaces will be performed in common areas, resident rooms, and at the time of discharge;-Dry cleaning procedures will be conducted before wet procedures;-Clean from areas that are visibly clean and least likely to be contaminated to areas usually visibly dirty;-Clean from top to bottom (bring dirt from high levels down to floor levels);-Clean from back to front areas;-Clean prior to disinfection as recommended by the manufacturer of the product(s) being used;-Disinfectant solution will be prepared fresh daily and changed frequently in order to ensure effectiveness;-Follow manufacturer recommendations for dilution and frequency of changing of disinfectant solution;-Follow manufacturer recommendations regarding appropriate contact time to ensure adequate disinfection;-Clean and disinfect any equipment that enters the room before use in another location;-Staff will ensure cleaning carts are checked and stocked with necessary supplies at the beginning of each shift.1. Observations on 01/30/26, beginning at approximately 10:35 A.M., of Buffalo Blvd. Hall showed the following:-The floor had a large dried-up, splatter stain with a shiny, white crust-looking edging to it;-At the exit door, there was a large pile of dried leaves accumulated;-room [ROOM NUMBER], had a pillow on the floor, next to and on-top of food crumbs, at the window side of the bed. Several napkins, tissues, a clear cup, and an empty, green, apple-pie box were on the floor, under and to the left side of the bed;-Between rooms [ROOM NUMBERS] was an orange cap that had fallen from a med cart, as well as a single, blue, plastic glove.2. Observations on (continued on next page)

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

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

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	01/30/26, beginning at approximately 10:35 A.M., of Memory Lane Hall/Unit showed the following:-There was a strong urine odor upon entering;-The dining room trash can, at the end of the serving counter, was overflowing, with trash and napkins on the floor, surrounding the can;-The TV/Visiting area, located in the dining room, showed Resident #4 reclined in a chair. Next to him/her was a wheeled, side-table cart, that was heaping over with trash including two soda cans, several rolled up tissues, and some wadded up wrappers;-There were food crumbs, tissues, and an elastic hair band just under the left-front of the recliner, on the floor;-room [ROOM NUMBER] had tissue and food crumbs on the floor;-room [ROOM NUMBER], had a large stained, discoloration on the floor, resembling the shape of a rope. Beside bed two, next to the window, there was popcorn, food crumbs, and wadded trash items on the floor;-room [ROOM NUMBER], both bed one and two, had overflowing trashcans. There were stains across the floor that looked like splatter marks. Bed two had a straw, straw wrapper, Q-Tip wrapper, tissues, and bottle cap laying under the bed;-room [ROOM NUMBER] had dried floor splatters on the floor at the foot of the bed, the trashcan was full of trash overflowing, and there were tissue, wrappers, and other discarded items on the floor around the trash can. Observations on 02/03/26, at approximately 10:50 A.M., of Memory Lane Hall/Unit, showed the following:-room [ROOM NUMBER] had a strong smell of urine;-There was wadded up trash on the floor, under the bed;-There were wads of paper that look like they had been wet and splattered, onto the floor. They were dried and hardened onto the floor.3. Observation on 01/30/26, beginning at approximately 10:35 A.M., of Prairie Lane Hall showed outside of room [ROOM NUMBER] a wadded-up piece of paper on the floor. Observation on 02/03/26, at approximately 11:25 A.M., outside of room [ROOM NUMBER] on Prairie Lane Hall showed, what appeared to be, the same wadded-up piece of paper. 4. Review of Resident #6's face sheet showed an admission date of 08/14/25.Review of the resident's quarterly Minimum Data Set (MDS - a federally mandated assessment tool completed by facility staff), dated 12/09/25, showed the resident was cognitively intact. Observation and interview on 02/04/26, at approximately 9:55 A.M., showed the following: -There was a strong odor of bowel upon entering the room;-The resident said he/she wanted to share that he/she usually cleaned the room by him/herself since it takes too long when waiting on staff to do it;-The housekeeping staff are good, but there are not enough, so it takes a long time for them to make it to all the rooms;-None of the other staff want to help with cleaning; -He/she pointed to a pile of bedding, laying on the floor, under the sink counter. He/she said they stink because they are soiled and that he/she removed them from his/her bed two days ago;-No one had been in the room for two days to notice the bedding;-He/she said it was embarrassing and if anyone were to come in, he/she would feel shame or be embarrassed.5. Review of Resident #2's face sheet showed an admission date of 01/02/26.Review of the resident's quarterly MDS, dated [DATE], showed the resident was cognitively intact.During an interview on 01/31/26, at approximately 10:55 A.M., the resident said the following:-Staff will empty trash, but it takes them a long time to come in and do it;-Weekdays are better because housekeeping comes to help clean rooms.6. During an interview on 02/03/26, at approximately 10:45 A.M., Certified Occupational Therapeutic Assistant (COTA) M said the following:-He/she had noticed the facility being somewhat in a disarray, at times;-He/she had recently cleaned up some gum wrappers from under a resident's bed because they had been there so long.During an interview on 02/03/26, at approximately 11:05 A.M., Certified Nurse Aide (CNA) A said the following:-He/she finds the facility to be dirty when he/she arrives to work;-The night shift is the worst about throwing trash around;-He/she always tries to keep the area clean, that they are working from;-He/she will empty trashcans when noticed;-They had a department head of housekeeping up until a few months ago, which was the Maintenance Director, but he/she quit, and they do not have anyone in that position at this (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	time;-Some of the residents are incontinent and if the aides are throwing anything with urine in the trash, it starts to smell;-They have a plumbing issue, as well, that makes the entire building have an odor;-Anytime they do showers, there is a sewer smell that comes up in several rooms throughout the facility.During an interview on 02/03/26, at approximately 11:25 A.M., CNA K said the following:-The facility is filthy when staff come in on Monday mornings;-It is the same after every weekend; -The weekend staff throw the trash down or leave it in residents' rooms, instead of taking it out and throwing it away.During an interview on 02/03/26, at approximately 12:40 P.M., Housekeeper L said the following:-It was normal to come in each day and find the facility a mess;-Typically, that included trash all over the floors;-The shower rooms would have clothes, bedding, and towels, all over, when they arrive in the mornings;-The trashcans in rooms or other areas were often overflowing.During an interview on 02/04/26, at approximately 1:20 P.M., CNA N said the following:-What housekeeping chores get done depend on who is working;-He/she always carried trash bags since someone's room is always dirty;-Housekeepers are supposed to clean every room, every day;-Once a month each room should be deep cleaned.During an interview on 02/04/26, at approximately 10:35 A.M., the Director of Nursing said the following:-There were three or four housekeeping staff;-She did not know if anyone from housekeeping was at the facility on weekends;-He/she believed there is a cleaning schedule that housekeeping was to follow;-Housekeeping should empty trashcans, sweep and wipe surfaces down daily. Aides can also do these tasks;-Generally, the aides change the linens, but anyone can and should sanitize the room.During an interview on 02/06/26, at approximately 4:00 P.M., the Administrator, said the following:-He/she expected all staff to pick up after any mess they make, regardless of the department they work in;-When staff notice an issue with cleanliness or odors, they try to clean right away.Complaint #2731470

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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 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to care plan and monitor a brain shunt (flexible tube surgically implanted to drain built-up fluid from the brain to another part of the body, helping relieve pressure in the brain), failed to ensure staff were aware of and trained in care of the shunt placement, failed to effectively address increased pain related to the resident's head, neck, and shoulder areas, and failed to notify the physician of increased head pain for one resident (Resident #1). The resident was sent to the hospital where the resident was taken to the operating room for shunt removal/replacement. The resident received a diagnosis of hydrocephalus (an abnormal buildup of cerebrospinal fluid (CSF) deep within the brain. This excess fluid causes the ventricles (cavities) within the brain to widen, putting harmful pressure on the brain's tissues). The facility also failed to address signs of a possible urinary tract infection, including reduced urine output and dark colored urine, in a timely fashion, and failed to complete ordered labs for elevated white counts in a timely fashion for one resident (Resident #1) with a history of kidney infections and sepsis. The resident was sent to the hospital and received diagnoses that included urosepsis (an extreme reaction to a urinary tract infection) and septic shock (a serious medical condition that can occur when an infection in your body causes extremely low blood pressure and organ failure due to sepsis) at the hospital. The resident (Resident #1) was intubated (use of a breathing tube) and sedated at the hospital. The facility census was 40. The administrator was notified on 02/05/26, at 4:49 P.M, of an Immediate Jeopardy (IJ) which began on 01/06/26. The IJ was removed on 02/07/26, as confirmed by surveyor onsite verification. Review of the facility policy titled, Pain Management, dated 05/01/25, showed the following information:-In order to help a resident attain or maintain his/her highest practicable level of physical, mental, and psychosocial well-being and to prevent or manage pain, the facility may recognize when the resident is experiencing pain and identify circumstances when the pain can be anticipated;-Evaluate the resident for pain and the causes upon admission, during ongoing scheduled assessments, and when a significant change of condition occurs;-Manage or prevent pain, consistent with the comprehensive assessment and plan of care, current professional standards of practice, and the resident's goals and preferences;-Facility staff may observe nonverbal indicators of pain which may include recurring restlessness, grimacing, decreased participation of usual physical or social events, loss of appetite, difficulty sleeping, and negative vocalizations such as groaning or crying;-The facility may use a pain assessment tool, which is appropriate for the resident's cognitive status, to assist staff in consistent assessment of a resident's pain;-Based upon the evaluation, the facility in collaboration with the attending physician, other healthcare professionals, and the resident may develop, implement, monitor, and revise as necessary interventions to prevent or manage each individual resident's pain beginning at admission;-Facility staff may reassess resident's pain management at established intervals for effectiveness and or adverse consequences.Review of the facility policy titled, Catheter Care, dated 05/02/25, showed the following information:-Monitor output for changes in amount, color, clarity, or odor;-Monitor for signs of urinary tract infection (UTI);-Record output, and document abnormalities and report to physician immediately. Review of the facility policy titled, Medication Orders, dated 05/09/25, showed the following:-Verbal orders should be received only by licensed nurses and confirmed in writing by the provider. Review of the facility policy titled, Notification of Changes, dated 05/13/25, showed the following:-The facility must inform the resident, consult with the resident's physician and/or notify the resident's family member when there is a change requiring such notification.1. Review of Resident #1's face sheet (brief look at (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	resident information) showed the following information:-admission date 02/08/25;-Diagnoses included spina bifida (a congenital condition in which part of the spinal cord and int's meninges are exposed through a gap in the backbone, often causing paralysis of the lower limbs), paralysis, acute pyelonephritis (a serious kidney infection typically caused by bacteria that ascends from the bladder, with symptoms including fever, flank pain, chills, nausea, and vomiting), resistance to multiple antimicrobial drugs (occurs when germs evolve to defeat the drugs designed to kill them), neuromuscular dysfunction of bladder (disorders affecting the nerves controlling voluntary muscles and the muscled themselves), and history of UTIs and sepsis;-The face sheet did not include diagnoses of a brain shunt or use of urostomy (an opening in the abdomen that redirects urine outside the body). Review of the resident's quarterly Minimum Data Set (MDS- a federally mandated assessment tool filled out by facility staff), dated 01/07/26, showed the following information:-Intact cognition;-Impairment to both lower extremities;-Requires substantial to maximum assistance from staff for toileting, showering, dressing, and mobility;-Requires the use of indwelling catheter and ostomy;-UTI within the last 30 days prior to assessment;-Is not on a scheduled pain regimen, receives an as needed (PRN) pain regimen for occasional pain. Review of the resident's care plan, dated 04/11/25, showed the following information:-Requires assistance from staff for all activities of daily living (ADL- bathing, toileting, dressing) and mobility;-Obtain and monitor lab work as ordered, report results to the Medical Director (MD) and follow up as indicated;-Pain management as needed, evaluate the effectiveness of pain interventions every shift, and as needed;-Urostomy use; position drainage bag for urine and tubing below the level of the bladder, monitor and document intake and output as per facility policy, monitor for signs and symptoms of discomfort related to urostomy or kidney pain, monitor/record/report to MD any signs of kidney infection, sepsis, pain, blood tinged urine, cloudiness, no output, deepening of urine color, increased pulse, increased temp, foul smelling urine, fever, chills, altered mental status, and change in eating patterns;-The care plan did not indicate the resident had a brain shunt.Review of the resident's lab results, collected 12/01/25, showed the following:-White blood Cell (WBC- measurement of number of white cells in the blood, measures the body's immune cells used to fight infections, inflammations, and diseases) (normal range 3.8-10.04) count of 14.4.Review of the resident's January 2026 Physician Order Sheet (POS) showed the following:-An order, dated 02/08/25, pain assessment; Check and record every shift;-An order, dated 03/02/25, Tramadol (an opioid pain medication used to treat moderate to severe pain) 50 milligram (mg) tablet; give one tablet by mouth (po) every 4 hours prn for pain;-An order, dated 03/03/25, record urine output two times a day (BID);-An order, dated 09/22/25, Cephalexin (a first generation cephalosporin antibiotic used to treat bacterial infections) 250 mg capsule; Give one capsule by po BID related to acute pyelonephritis;-An order, dated 09/22/25, Acetaminophen (over the counter analgesic and antipyretic (fever reducing) medication used to treat mild to moderate pain) Extra Strength 500 mg; give two tablets (1000mg) po every 6 hours PRN for pain;-An order, dated 12/04/25, lab CBC (complete blood count) order dated for draw on 01/01/26;-The POS did not show an order for monitoring of the resident's brain shunt.Review of the resident's medication administration record (MAR), dated 01/01/26, showed the following;-Day and night shift documented a pain level of 0 out of 10; No PRN pain medication administered.-Day shift recorded a urine output of 1100 milliliters (ml);-Night shift recorded a urine output of 1100 ml.Review of the resident's MAR, dated 01/02/26, showed the following;-Day and night shift documented a pain level of 0 out of 10; No PRN pain medication administered.-Day shift recorded a urine output of 1000 ml;-Night shift recorded a urine output of 2000 ml.Review of the resident's MAR, dated 01/03/26, showed the following;-Day shift documented a pain level of 2 out of 10;-Night shift documented a (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	pain level of 4 out of 10; PRN Acetaminophen given for a pain scale of 6 out of 10 at 2:09 A.M.;-Day shift recorded a urine output of 1800 ml;-Night shift did not document a urine output.Review of the resident's MAR, dated 01/04/26, showed the following:-Day shift documented a pain level of 0 out of 10;-Night shift documented a pain level of 5 out of 10; No PRN pain medication administered;-Day shift recorded a urine output of 600 ml;-Night shift record a urine output of 1250 ml.Review of the resident's progress note, dated 01/04/26 at 1:27 P.M., showed the following:-Call placed to urology provider on-call to clarify cephalexin order from 09/22/25.Review of the resident's progress note, dated 01/04/25, at 1:57 P.M., showed the following:-On call Urologist returned call and said cephalexin should have been discontinued when the urinary stent was removed.Review of the resident's MAR, dated 01/05/26, showed the following;-Day documented a pain level of 5 out of 10; No PRN pain medication administered;-Night shift documented a pain level of 0 out of 10.-Day shift recorded a urine output of 1200 ml;-Night shift record a urine output of 1250 ml.Review of the resident's progress note dated 01/05/26 at 11:06 A.M., showed the providing urologist was contacted and gave approval to discontinue cephalexin.Review of the resident's January 2026 POS showed cephalexin 250 mg tablet was discontinued on 01/05/26.Review of the resident's lab results, dated 01/06/26, showed a WBC count of 16.8.Review of the resident's progress notes, dated 01/06/26, did not show prompt notification to the resident's physician of the increasing WBC count.Review of the resident's MAR, dated 01/06/26, showed the following;-Day and night shift documented a pain level of 0 out of 10;-Day shift and night shift did not document a urine output.Review of the resident's physician progress note with a service date of 01/06/26, showed the following:-The resident was seen for management of chronic medical conditions;-Urostomy with clear yellow urine;-WBC of 14.4.Review of the resident's MAR, dated 01/07/26, showed:-Day and night shift documented a pain level of 0 out of 10;-Day shift did not document a urine output;-Night shift documented a urine output of 1200 ml;-PRN Tramadol was administered at 12:16 A.M., for a pain level of 5 out of 10. Review of the resident's progress note, dated 01/07/26 at 12:16 A.M., showed an administration of Tramadol. The progress note did not indicate any characteristics of the pain.Review of the resident's progress note, dated 01/07/26 at 3:17 A.M., showed the administration of Tramadol was effective with a follow-up pain scale of 0 out of 10.Review of the resident's MAR, dated 01/08/26, showed:-Day and night shift documented a pain level of 0 out of 10;-Day shift and night shift did not document a urine output.Review of the resident's MAR, dated 01/09/26, showed:-Day and night shift documented a pain level of 0 out of 10;-Day shift and night shift did not document a urine output.Review of the resident's MAR, dated 01/10/26, showed:-Day and night shift documented a pain level of 0 out of 10;-Day shift and night shift did not document a urine output.Review of the resident's MAR, dated 01/11/26, showed:-Day and night shift documented a pain level of 0 out of 10;-PRN Acetaminophen was administered at 3:35 P.M, for a pain level of 4 out of 10;-Day shift documented a urine output of 650 ml;-Night shift did not document a urine output.Review of the resident's progress note, dated 01/11/26 at 3:35 P.M., showed an administration of Acetaminophen two tablets. The progress note did not show any characteristics of the pain.Review of the resident's progress note, dated 01/11/26 at 7:19 P.M., showed the administration of Acetaminophen was effective with a follow up pain scale of 0 out of 10.Review of the resident's POS, dated 01/11/26, showed the following:-New order for Ajovy (a prescription medication for preventive treatment of migraines) subcutaneous auto-injector 225 mg/1.5ml; Inject 1.5 ml subcutaneously (under the skin) once a month, on the 13th of every month for migraines. Review of the resident's MAR, dated 01/12/26, showed the following;-Day shift documented a pain level of 4 out of 10; PRN Acetaminophen administered at 7:09 A.M.;-Night shift documented a pain level of 0 out of 10;-Day shift documented a urine output of 1000 (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	ml;-Night shift did not document a urine output.Review of the resident's progress note, dated 01/12/26 at 7:09 A.M., showed an administration of Acetaminophen two tablets. The progress note did not show any characteristics of the pain.Review of the resident's progress note, dated 01/12/26 at 7:10:43 A.M., showed the administration of Acetaminophen was effective with a follow up pain scale of 0 out of 10.Review of the resident's MAR, dated 01/13/26, showed:-Day and night shift documented a pain level of 0 out of 10;-Day shift did not document a urine output;-Night shift documented a urine output of 1600 ml.Review of the resident's MAR, dated 01/14/26, showed:-Day shift documented a pain level of 5 out of 10; PRN Tramadol administered at 12:22 A.M., for a pain level of 5;-Night shift documented a pain level of 0 out of 10;-Day shift and night shift did not document a urine output.Review of the resident's progress note dated 01/14/26 at 12:22 A.M., showed an administration of PRN Tramadol at 12:22 A.M., for generalized body aching, pain level not documented.Review of the resident's progress note, dated 01/14/26 at 9:11 A.M., showed the administration of PRN Tramadol was effective with a follow up pain scale of 1 out of 10. Review of the resident's MAR, dated 01/15/26, showed the following;-Day and night shift documented a pain level of 0 out of 10;-PRN Tramadol was administered at 1:50 AM., for a pain level of 5;-Day shift documented a urine output of 900 ml;-Night shift documented a urine output of 825 ml.Review of the resident's progress note, dated 01/15/26 at 1:50 A.M., showed an administration of PRN Tramadol at 1:50 A.M. The progress note did not show any characteristics of the pain.Review of the resident's progress note, dated 01/15/26 at 2:20 A.M., showed the administration of PRN Tramadol was effective with a follow up pain scale of 0 out of 10. Review of the resident's MAR, dated 01/16/26, showed:-Day shift documented a pain level of 0 out of 10;-Night shift documented a pain level of 3 out of 10;-Day shift and night shift did not document a urine output.Review of the resident's MAR, dated 01/17/26, showed:-Day and night shift documented a pain level of 0 out of 10;-PRN Acetaminophen was administered at 1:44 AM.;-PRN Tramadol was administered at 3:15 P.M., for a pain level of 5;-Day shift and night shift did not document a urine output.Review of the resident's progress note, dated 01/17/26, at 1:44 A.M., showed an administration of PRN Acetaminophen at 1:44 A.M. The progress note did not show any characteristics of the pain.Review of the resident's progress note, dated 01/17/26 at 5:35 A.M., showed the administration of PRN Acetaminophen was effective with a follow up pain scale of 0 out of 10. Review of the resident's progress note, dated 01/17/26 at 3:15 P.M., showed an administration of PRN Tramadol at 3:15 P.M for back pain. The progress note did not indicate the resident's level of pain.Review of the resident's progress note, dated 01/17/26 at 4:38 P.M., showed the administration of PRN Tramadol was effective with a follow up pain scale of 3 out of 10. Review of the resident's MAR, dated 01/18/26, showed the following;-Day and night shift documented a pain level of 0 out of 10;-PRN Tramadol was administered at 11:14 A.M., for a pain level of 6;-Day shift documented a urine output of 1200 ml.-Night shift documented a urine output of 1250 ml.Review of the resident's progress note, dated 01/18/26 at 11:14 A.M., showed the resident requested administration of PRN Tramadol at 11:14 A.M for a pain level of 6 out of 10. The progress note did not show the characteristics of the pain.Review of the resident's progress note, dated 01/18/26 at 1:25 P.M., showed the administration of PRN Tramadol was effective with a follow up pain scale of 1 out of 10. Review of the resident's MAR, dated 01/19/26, showed the following;-Day and night shift documented a pain level of 0 out of 10;-PRN Tramadol was administered at 5:52 P.M., for a pain level of 5;-Day shift did not document a urine output;-Night shift documented a urine output of 1200 ml.Review of the resident's progress note, dated 01/19/26, at 5:52 P.M., showed an administration of PRN Tramadol at 5:52 P.M. The progress note did not show the characteristics of the pain.Review of the resident's progress note, dated 01/19/26 at 11:46 P.M., showed the administration of (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Buffalo Prairie Center for Rehab and Healthcare		STREET ADDRESS, CITY, STATE, ZIP CODE 631 West Main Street Buffalo, MO 65622	

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	PRN Tramadol was effective with a follow up pain scale of 0 out of 10. Review of the resident's MAR, dated 01/20/26, showed the following;-Day and night shift documented a pain level of 0 out of 10;-PRN Tramadol was administered at 2:27 A.M., for a pain level of 7 and 8:09 P.M., for a pain level of 8;-Day shift documented a urine output of 750 ml;-Night shift documented a urine output of 1200 ml.Review of the resident's progress note, dated 01/20/26, at 2:27 A.M., showed an administration of PRN Tramadol at 2:27 A.M . The progress note did not show the characteristics of the pain.Review of the resident's progress note, dated 01/20/26 at 2:31 A.M., showed the administration of PRN Tramadol was effective with a follow up pain scale of 0 out of 10. Review of the resident's progress note, dated 01/20/26 at 8:09 P.M., showed an administration of PRN Tramadol at 8:09 P.M., The progress note did not show the characteristics of the pain.Review of the resident's progress note, dated 01/20/26 at 9:00 P.M., showed the administration of PRN Tramadol was effective with a follow up pain scale of 0 out of 10. Review of the resident's physician progress notes, for a service date of 01/20/26, showed the following information:-Urostomy with clear yellow urine;-Pain level 2 out of 10;-WBC count of 16.8;-Leukocytosis (a high white blood cell count, most often caused by infections) WBC 16.8, will recheck CBC.Review of the resident's POS, dated January 2026, did not show any new lab orders.Review of the resident's progress notes, dated 01/20/26, did not show any documentation regarding the diagnoses of leukocytosis and/or follow up regarding new lab orders.Review of the resident's MAR, dated 01/21/26, showed the following;-Day and night shift documented a pain level of 0 out of 10;-PRN Tramadol was administered at 12:32 A.M. for a pain level of 9 and 8:29 P.M. for a pain level of 3;-Day shift documented a urine output of 700 ml;-Night shift documented a urine output of 2000 ml.Review of the resident's progress note, dated 01/21/26, at 12:32 A.M., showed an administration of PRN Tramadol at 12:32 A.M. The progress note did not show the characteristics of the pain.Review of the resident's progress note, dated 01/21/26 at 12:50 A.M., showed the administration of PRN Tramadol was effective with a follow up pain scale of 1 out of 10. Review of the resident's progress note, dated 01/21/26 at 8:29 P.M., showed an administration of PRN Tramadol at 8:29 P.M., per the resident's request. The progress note did not show the characteristics of the pain.Review of the resident's progress note, dated 01/21/26 at 9:44 P.M., showed the administration of PRN Tramadol was effective with a follow up pain scale of 0 out of 10.Review of the resident's MAR, dated 01/22/26, showed the following;-Day shift documented a pain level of 2 out of 10;-Night shift documented a pain level of 0 out of 10;-PRN Tramadol was administered at 1:43 P.M., for a pain level of 5 and 5:22 P.M., for a pain level of 5;-Day shift documented a urine output of 800 ml;-Night shift documented a urine output of 1100 ml.Review of the resident's progress note, dated 01/22/26 at 1:43 P.M., showed an administration of PRN Tramadol at 1:43 P.M., for neck and shoulder aching. The progress note did not show the level of pain.Review of the resident's progress note, dated 01/22/26 at 2:19 P.M., showed the administration of PRN Tramadol was effective with a follow up pain scale of 3 out of 10. Review of the resident's progress note, dated 01/22/26 at 5:22 P.M., showed an administration of PRN Tramadol P.M. The progress note did not show the characteristics of the pain.Review of the resident's progress note, dated 01/22/26 at 6:33 P.M., showed the administration of PRN Tramadol was effective with a follow up pain scale of 3 out of 10. Review of the resident's MAR, dated 01/23/26, showed the following;-Day shift did not document a pain level;-Night shift documented a pain level of 6 out of 10;-PRN Tramadol was administered at 12:33 A.M. for a pain level of 8 and 5:56 P.M. for a pain level of 9;-Day shift did not document a urine output;-Night shift documented a urine output of 1200 ml.Review of the resident's progress note, dated 01/23/26 at 12:33 A.M., showed an administration of PRN Tramadol at 12:33 A.M . The progress note did not show the characteristics of the pain.Review of the resident's (continued on next page)

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Buffalo Prairie Center for Rehab and Healthcare	631 West Main Street Buffalo, MO 65622

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	progress note, dated 01/23/26 at 1:34 A.M., showed the administration of PRN Tramadol was effective with a follow up pain scale of 0 out of 10. Review of the resident's progress note, dated 01/23/26 at 5:56 P.M., showed an administration of PRN Tramadol at 5:56 P.M. The progress note did not show the characteristics of the pain.Review of the resident's progress note, dated 01/23/26 at 7:25 P.M., showed the administration of PRN Tramadol was effective with a follow up pain scale of 0 out of 10.Review of the resident's MAR, dated 01/24/26, showed the following;-Day shift and night shift documented a pain level of 0 out of 10;-PRN Tramadol was administered at 2:25 A.M. for a pain level of 5 and 9:44 A.M. for a pain level of 3;-Day shift documented a urine output of 800;-Night shift did not document a urine output.Review of the resident's progress note, dated 01/24/26 at 2:25 A.M., showed an administration of PRN Tramadol at 2:25 A.M The progress note did not show the characteristics of the pain.Review of the resident's progress note, dated 01/24/26 at 2:26 A.M., showed the administration of PRN Tramadol was effective with a follow up pain scale of 0 out of 10. Review of the resident's progress note, dated 01/24/26 at 9:44A.M., showed an administration of PRN Tramadol at 9:44 A.M. The progress note did not show the characteristics of the pain.Review of the resident's progress note, dated 01/24/26 at 10:15 A.M., showed the administration of PRN Tramadol was effective with a follow up pain scale of 0 out of 10.Review of the resident's MAR, dated 01/25/26 showed the following;-Day shift documented a pain level of 0 out of 10;-Night shift documented a pain level of 8 out of 10;-PRN Tramadol was administered at 11:03 P.M. for a pain level of 8;-Day shift did not document a urine output;-Night shift documented a urine output of 2000 ml.Review of the resident's progress note, dated 01/25/26 at 11:03 P.M., showed an administration of PRN Tramadol at 11:03 P.M. The progress note did not show the characteristics of the pain.Review of the resident's progress note, dated 01/25/26 at 12:25 A.M., showed the administration of PRN Tramadol was not effective with a follow up pain scale of 5 out of 10. The note did not indicate the physician had been notified of the un-relieved pain.Review of the resident's MAR, dated 01/26/26, showed the following;-Day shift documented a pain level of 5 out of 10;-Night shift documented a pain level of 0 out of 10;-PRN Tramadol was administered at 6:16 P.M. for a pain level of 7 and 9:24 P.M. for a pain level of 8-Day shift documented a urine output of 500 ml;-Night shift documented a urine output of 1200 ml.Review of the resident's progress note, dated 01/26/26 at 6:16 P.M., showed an administration of PRN Tramadol at 6:16 P.M., The progress note did not show the characteristics of the pain.Review of the resident's progress note, dated 01/26/26 at 7:24 P.M., showed the administration of PRN Tramadol was not effective with a follow up pain scale of 5 out of 10. The note did not indicate the physician had been notified of the un-relieved pain.Review of the resident's progress note, dated 01/26/26 at 9:24 P.M., showed an administration of PRN Tramadol at 9:24 P.M., The progress note did not show the characteristics of the pain.Review of the resident's progress note, dated 01/26/26 at 11:25 P.M., showed the administration of PRN Tramadol was effective with a follow up pain scale of 0 out of 10. Review of the resident's physician progress notes, for a service date of 01/27/26, showed the following:-The resident was seen per request of the nursing staff for shoulder pain. The resident denied injury, but reports right shoulder pain for the last several weeks;-Urostomy with clear yellow urine;-Pain level of 7 out of 10;-Will order Zanaflex (muscle relaxant used to treat spasticity, muscle stiffness, spasms, and cramping) 4 mg po three times a day (TID) for 5 days for muscle spasms;-Will order Voltaren (an over-the-counter topical treatment used to relieve arthritis pain) gel BID, and Naproxen (a non-steroidal anti-inflammatory drug used to relieve stiffness, cramps, and muscle aches) 440mg po BID for 5 days then PRN;-Leukocytosis- WBC 16.8, will recheck CBC.Review of the resident's POS, dated 01/26/26, did not show continued orders to recheck CBC.Review of the resident's MAR, dated 01/27/26, showed the (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	following:-Day shift documented a pain level of 0 out of 10;-Night shift documented a pain level of 5 out of 10;-PRN Tramadol was administered at 4:48P.M. for a pain level of 5; PM dose of Naproxen administered for a pain level of 8;-Day shift documented a urine output of 400 ml;-Night shift documented a urine output of 1250 ml.Review of the resident's progress note, dated 01/27/26 at 4:48 P.M., showed an administration of PRN Tramadol at 4:48 P.M., for neck and shoulder. The progress note did not show the level of the pain.Review of the resident's progress note, dated 01/27/26 at 7:24 P.M., showed the administration of PRN Tramadol was not effective with a follow up pain scale of 7 out of 10. The note did not indicate the physician had been notified of the un-relieved pain.Review of the resident's progress note, dated 01/28/26 at 10:21 A.M., showed:-The resident's family member was at the facility and asked to speak to the Director of Nursing (DON), Social Services Director (SSD), and the nurse, regarding health concerns of the resident for the last week;-The family member reported the resident had not been eating regularly;-The family member reporter the resident had tea colored urine, and was concerned the resident was becoming septic;-The DON and charge nurse assessed the resident and discussed going to the hospital with the resident.Review of the resident's progress note, dated 01/28/26 at 1:59 P.M., showed the following:-The resident was sent to the hospital after assessment which showed the resident was confused, hypotensive (low blood pressure), and had dark colored urine;-The family was present at the time of transfer;-Physician and DON aware. Review of the resident's hospital document titled General Surgery Consult, dated 01/28/26, showed the following:-admitted to hospital on [DATE] for altered mental status;-The resident was in the operating room [ROOM NUMBER]/27/26 for External Ventricular Drain (EVD- a neurosurgical procedure to temporarily drain CSF and monitor pressure by inserting a catheter through the skill into the brain's ventricles) replacement by neurosurgery;-The resident is currently intubated and sedated in the intensive care unit;-The resident is being treated for septic shock due to urosepsis. Urostomy in place draining dark cloudy urine;-White blood cell count on 01/28/26 at 4:35 P.M., is 43.7.During an interview on 02/03/26, at 10:13 A.M., Resident #5 said the following;-He/she was Resident #1's roommate;-The resident seemed okay, until about a month ago. At that time, he/she started having a lot of pain. The staff would bring him/her medication, but it didn't relieve the pain;-The resident began getting confused about three days prior to the resident being sent to the hospital;-The resident's head appeared swollen prior to being sent to the hospital.During an interview on 02/03/26, at approximately 11:25 A.M., Certified Nurse Aide (CNA) K, said the following:-He/she has worked with Resident #1, in the past;-Had known the resident to complain about headaches daily;-The resident would say his/her head is blowing up or exploding;-The resident cried a lot from being in so much pain. It was reported to the charge nurse, who would say, okay, and that they would check the resident;-CNA K said he/she was glad when the resident was sent out and hopes he/she is being taken care of.During an interview on 02/03/26, at 1:15 P.M., CNA A said the following:-CNAs are responsible for draining resident's urinary bags and reporting the output for the nurses to document;-If he/she was to notice urine that is anything but pale yellow, he/she would report it to the nurse;-If he/she was to become aware of decreased urine output, he/she would report it to the nurse;-If a resident had continuous complaints of pain, he/she would report it to the nurse;-There is typically one nurse for the whole building, so things slip their mind. He/she likes to follow back up with the resident on any complaints;-The resident was generally alert and oriented;-He/she noticed the resident's urine output had been decreasing. Typically, he/she had to empty the resident's urinary bag several times a shift; that decreased to sometimes just once a day;-The resident complained of headaches a lot. The resident would just have to sit in a dark room;-The medication given to the resident was for migraines and did not relieve the (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	resident's pain; this was ongoing for a little over a month. The resident has a brain shunt and he/she believes that something was possibly malfunctioning as the resident would report the pain directly where the shunt was located;-He/she reported the urine output decrease, the resident's unrelieved pain, and complaints of pain at the brain shunt site to the nurse a few days prior to the resident being hospitalized ;-He/she was off work for a few days, and when he/she returned on 01/28/26, the resident was slurring his/her words, hallucinating (seeing things that were not there), and had only 300 ml of burnt orange colored urine. He/she reported this immediately to the charge nurse and questioned the nurse about obtaining a urinary analysis. The nurse told him/her no, the resident just needed a new drainage bag; -The resident was sent out to the hospital approximately 2 hours later;-The CNA said management did not want to send the resident to the hospital. He/she overheard them saying, the confusion could just be from the new medication the resident started. They wanted to treat him/her in-house;-The CNA observed the resident's face was puffy, and his/her abdomen looked distended (abnormal swelling or enlargement of the abdomen);-He/she obtained vital signs on the resident and reported the resident had extremely low blood pressure;-The CNA reported the findings to Licensed Practical Nurse (LPN) C. During an interview on 02/03/26, at 2:50 P.M., LPN C said the following:-CNAs are responsible for emptying and recording urinary output. They will report to the nurses who are responsible for that documentation;-The CNAs reported the resident's urine was dark in color to him/her. He/she did not instruct the aides to obtain a urinary analysis but instead sent the resident to the hospital a couple hours later;-He/she only noticed the resident was in pain when he/she and other staff members would attempt to roll or reposition the resident. The resident complained of headaches/migraines and was on medication for that. He/she expected information regarding the pain to be documented; -There we

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. Based on observation, interview, and record review, the facility failed to ensure residents with pressure ulcers (localized damage to the skin and/or underlying soft tissue usually over a bony prominence or related to a medical or other device) received necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection, and prevent new ulcers from developing when the facility failed to timely assess and monitor, failed to obtain and document treatment orders, and failed to update the care plan regarding a facility acquired pressure ulcer that required surgical intervention for one resident (Resident #1). The facility census was 40. Review of the facility policy titled, Wound Treatment and Management, dated 05/15/25, showed the following information:-Wound treatments will be provided in accordance with physician orders, including the cleansing method, type of dressing, and frequency of dressing change;-In the absence of treatment orders, the licensed nurse will notify the physician to obtain treatment orders. This may be the treatment nurse, or the assigned licensed nurse in the absence of the treatment nurse;-Treatment decisions will be based on the etiology of the wound, characteristics of the wound, location of the wound, and goals and preferences of the resident;-Treatments will be documented in the Treatment Administration Record (TAR) for providing wound care;-The effectiveness of treatments will be monitored through ongoing assessment of the wound. Considerations for needed modifications include lack of progression towards healing, changes in the characteristics of the wound, and changes in the resident's goals and preferences, such as end of life care.1. Review of Resident #1's face sheet (brief look at resident information), showed the following information:-admission date of 02/08/25;-Diagnoses included spina bifida (a congenital condition in which part of the spinal cord and int's meninges are exposed through a gap in the backbone, often causing paralysis of the lower limbs), paralysis, acute pyelonephritis (a serious kidney infection typically caused by bacteria that ascends from the bladder, with symptoms including fever, flank pain, chills, nausea, and vomiting), resistance to multiple antimicrobial drugs (occurs when germs evolve to defeat the drugs designed to kill them), neuromuscular dysfunction of bladder (disorders affecting the nerves controlling voluntary muscles and the muscled themselves), and history of urinary tract infections and sepsis.Review of the resident's quarterly Minimum Data Set (MDS- a federally mandated assessment tool filled out by facility staff), dated 01/07/26, showed the following information:-Intact cognition;-Required substantial to maximum assistance from staff for toileting, showering ,dressing, and mobility; -Did not have pressure ulcers;-At risk for pressure ulcers;-Required pressure reducing devices for chair and bed.Review of the resident's care plan, dated 04/11/25, showed the following information:-Required assistance from staff for all activities of daily living (ADL - bathing, toileting, dressing) and mobility;-Assess/record/monitor wound healing as ordered;-Measure wound length, width, and depth when possible;-Assess and document status of wound perimeter, wound bed, and healing process;-Report improvements and declines to the Medical Director (MD);-Follow facility policies and protocols for the prevention and treatment of skin breakdown.Review of the resident's weekly skin assessment, dated 01/03/26, showed the following:-No open areas on the skin;-No pressure reducing devices;-Skin discoloration related to thick, dry, scaling skin on left buttocks.Review of the resident's Braden Scale (assessment tool staff use for predicting pressure ulcers) assessment, dated 01/08/26, showed the resident was at risk for skin breakdown. Review of the resident's progress note, dated 01/09/26, showed the Director of Nursing (DON) documented she was called into the resident's room related to the resident's coccyx (tailbone - a small triangular bone at the very bottom of the spine) area being open. The DON applied Optiform Gentle EX (a 5-layer bordered silicone adhesive foam dressing designed for managing moderate to high drainage in (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	partial and full thickness wounds). The resident tolerated well. The resident was educated on not wearing underwear so his/her coccyx could breathe. The resident verbalized understanding. (Staff did not document a full description of the area including measurement and description and did not document notification of the MD of the new area.)Review of the resident's January 2026 Physician Order Sheet (POS) showed staff did not document orders for pressure reducing devices for chair and bed or new orders for the new area identified on the resident's coccyx. Review of the resident's electronic medical record (EMR) showed staff did not complete a new skin assessment after 01/03/26.Review of the resident's care plan showed staff did not update the care plan to reflect the new area on the coccyx. Review of the resident's progress notes, dated 01/10/26 through 01/16/26, showed staff did not document an assessment or documentation related to the resident's open area on the coccyx.Review of the resident's progress note, dated 01/17/26, showed the following:-Nurse received a report the resident's coccyx and buttocks were open and bleeding. Upon exam bilateral (both) buttocks, coccyx, and sacrum (triangular bone located at the base of the lumbar spine) were open, red, irritated, and weeping (exuding) serous (a thin, watery, clear to pale yellow fluid) drainage;-Staff notified MD and new orders received for wound care of cleanse with wound cleanser, pat dry, and apply border foam dressing change every other day and as needed (PRN);-Staff applied ordered treatment.(Staff did not document an assessment to include wound measurement or detailed description of the wound.) Review of the resident's January POS showed staff did not document the new wound order received on 01/17/26 to the POS. Review of the resident's physician's progress note, dated 01/20/26, showed the following information:-The resident was seen for evaluation of seating and pressure relief needs. The staff reported the resident had ulcerations to the coccyx, sacrum, and bilateral buttocks;-The resident reported prolonged sitting in his/her power chair;-The resident required a wheelchair cushion to provide adequate pressure reduction.Review of the resident's January 2026 POS showed an order, dated 01/20/26, to cleanse bilateral buttocks with wound cleanser, pat dry, apply hydroferra blue (antibacterial foam dressing containing methylene blue and gentian violet used for managing wounds), and cover with protective dressing every day and PRN. (Staff did not document an order for a pressure reducing cushion to chair.)Review showed the resident's wound assessment documentation, dated 01/27/26, showed the following information:-Location of the wound was coccyx;-Left buttock with two open areas measuring 3.5 centimeters (cm) by 1.1 cm and 14 cm by 10 cm with a depth of 0.2 cm;-Right buttock with one open area measuring 5 cm by 1.5 cm;-Dressing changes are daily.(Staff did not document a detailed description of the areas.) Review of the resident's progress note, dated 01/28/26, showed the resident was sent to the hospital for other medical conditions. Review of the resident's electronic medical record (EMR) showed a surgery consult, dated 01/29/26, from the resident's hospitalization on 01/28/26. The consult showed the following:-The skin of the sacral area and around the anus were excoriated (red);-The area around the left side of the anus appears necrotic (dead, non-viable tissue resulting from irreversible cell death caused by lack of blood flow, infection, trauma, or toxins);-Foul-smelling, purulent (pus filled) fluid was seen to be draining from the vaginal area;-Surgical intervention required once resident's other medical concerns stabilize.During an interview on 02/03/26, at 1:51 P.M., Certified Nursing Assistant (CNA) A said the following:-If he/she noticed a resident's wounds were worsening, he/she would report it to the nurse;-Nurses were responsible for providing wound care, performing assessments, and documenting wound care, characteristics, and measurements;-He/she would describe the resident's wound as looking like hamburger meat on both buttocks and bleeding;-There was an odor to the wounds and it sometimes had areas that looked like dried blood.During an interview on 02/03/26, at 2:33 P.M., Registered Nurse (RN) B said the following:-Nurses were responsible (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	for doing wound care;-The facility used to have an Assistant Director of Nursing (ADON) and that was who completed weekly wound assessments to include measurements and documentation;-When he/she finds a new open areas on the resident's, he/she will go ahead and grab measurements and that time, and document the findings;-Anytime a new area of concern is found, it should be assessed, documented, and the MD should be notified for treatment orders;-He/she was aware of the resident's wounds on his/her bilateral buttocks. It appeared to be holes everywhere resembling Swiss cheese. He/she did not note any areas that were necrotic, but the resident did have very fragile skin. During an interview on 02/03/26, at 2:50 P.M., Licensed Practical Nurse (LPN) C said the following:-The resident's buttocks were open;-The floor nurses typically don't do the weekly wound assessments, but he/she happened to on 01/27/26;-He/she documented on paper and should have entered the measurements in a skin assessment form within the resident's EMR;-He/she was not sure of how regularly wounds should be monitored, measured, or documented on.During an interview on 02/04/26, at 12:22 P.M., Certified Medication Technician (CMT) D said the following:-The resident had wounds across his/her bilateral buttocks;-He/she was not sure about wound assessment and documentation, but knew the nurses were to provide treatment. During an interview on 02/04/26, at 3:05 P.M., Housekeeper (HK) L said he/she could smell an odor from the resident's wounds when he/she would be near the resident.During an interview on 02/04/26, at 4:54 P.M., LPN H said the following:-He/she saw the resident's wounds a few days prior to the resident being sent to the hospital. The open areas appeared to be red, and the peri-wound (surrounding skin) was sloughing (shedding) off;-Nurses were responsible for doing wound care;-The facility used to have an ADON and that was who completed weekly wound assessments to include measurements and documentation;-He/she believed staff nurses now collected wound measurements and should be documenting those weekly;-If he/she were to note that a wound was getting worse and/or a new area was opened, he/she would obtain measurements and document that and his/her assessment in the progress notes;-Routinely staff nurses don't measure wounds unless there is a change in the wound.During an interview on 02/05/26, at 12:05 P.M., CNA J said the following:-He/she saw the resident's wounds prior to the resident going to the hospital and described the wounds as appearing as hamburger meat and oozing;-The wounds did have a blackened appearance in several areas;-Nurses were responsible for wound treatment, assessment, and documentation.During an interview on 02/05/26, at 12:46 P.M., the MDS/Medical Records Nurse said the following:-Care plans should be individualized;-Care plans should include wounds and wound treatment and should be updated with any changes.During an interview on 02/06/26, at 10:36 A.M., the DON said the following:-She expected the nurses to assess any new open areas, notify the MD, get treatment orders, perform a skin assessment, and document that skin assessment;-Skin assessments should be completed weekly;-Wound assessments along with measurements should also be completed weekly;-The ADON was previously responsible for wound reports, but that is something she will have to address now;-She did not observe the resident's wounds, but the resident had a history of wounds and had fragile skin;-If the wounds were worsening, she would hope someone would have reported that;-She did not think she was aware of the wounds opening until nursing had brought it to her attention around 01/17/26.During an interview on 02/06/26, at 2:51 P.M., the Administrator said the following:-She expected wounds and skin to be assessed, monitored, measured, and documented on;-She expected care plans to be individualized.Complaint #2731470

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. Based on observation, interview, and record review, the facility failed to ensure residents who were incontinent of bladder received appropriate treatment and service care to prevent possible urinary tract infections when staff failed to provide catheter (tube placed in the body to drain and collect urine from the bladder) care per standards of practice, failed to obtain an order for catheter care, and failed to complete catheter care per the care plan for one resident (Resident #2). The facility census was 40.Review of the facility policy titled Catheter Care, dated 05/02/25, showed the following information:-Catheter care will be performed every shift and as needed;-Gently grasp penis and draw foreskin back if applicable;-Using a circular motion, cleanse the meatus (opening) with a clean cloth moistened with water and soap;-With a new moistened cloth, starting at the urinary meatus, moving downward, cleanse the shaft of the penis;-With a new moistened cloth, starting at the urinary meatus, moving outward, and wipe the catheter making sure to hold the catheter in place to not pull it;-Dry area with a towel.1. Review of Resident #2's face sheet (brief look at resident information) showed the following information:-admission date of 01/02/26;-Diagnoses included neuromuscular dysfunction of bladder (occurs when nerve damage disrupts signals between the brain and bladder, causing overactive or under active symptoms). Review of the resident's admission Minimum Data Set (MDS- a federally mandated assessment tool filled out by facility staff), dated 01/02/26, showed the following information:-Cognitively intact;-Dependent on staff assistance for toileting;-Indwelling catheter used.Review of the resident's care plan, dated 01/02/26, showed the following:-Monitor and document intake and output;-Monitor and report to nurse any kinks in catheter tubing;-Monitor and document any pain/discomfort due to the catheter;-Monitor/record/report to Medical Director signs and symptoms of urinary tract infections.(The care plan did not address catheter care.) Review of the resident's February 2026 Physician Order Sheet (POS) showed staff did not obtain orders related to catheter care. Observation on 02/05/26, at 10:45 A.M., showed the following:-Certified Nursing Assistant (CNA) I and CNA O entered the resident's room to perform catheter care; -Both CNAs performed hand hygiene and applied personal protective equipment (PPE);-The resident laid in his/her bed, with CNA O on his/her right side and CNA I on his/her left side;-CNA O took off the resident's brief, and CNA I began cleansing the resident's inner thighs with a wet washcloth;-After cleansing the inner thighs, CNA I did not obtain a new washcloth, but folded the washcloth over after swipes. CNA I did not discard soiled gloves, perform hand hygiene, or apply new gloves;-CNA I did not draw back the resident's foreskin and began cleansing the distal (furthest from resident) end of the catheter tubing and working his/her way up to the proximal (closest to the resident) end of the catheter, where it entered the meatus;-The resident rolled toward CNA O and CNA I provided care to the resident's backside, as the resident had been incontinent of bowel;-CNA I did not perform hand hygiene or perform a glove change prior to obtaining a clean brief and placing it under the resident;-The resident was rolled back onto his/her back. CNA I adjusted the resident's urinary catheter, and hung the resident's catheter bag on the side of his/her bed;-CNA I obtained a graduate (a disposable or reusable plastic container used in healthcare to accurately measure urine output) and drained the resident's catheter bag of urine. During an interview on 02/05/26, at 11:14 A.M., CNA I said the general process for catheter care was to perform hand hygiene, apply gloves, obtain the proximal end to the resident's catheter tubing, and clean away from the resident's body, so nothing is contaminated during the process.During an interview on 02/05/26, at 12:05 P.M., CNA J said catheter tubing should be cleansed in a manner away from the body to prevent infections.During an interview on 02/06/26, at 10:30 P.M., the Director of Nursing said she (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	expected catheter tubing to be cleansed away from the body to prevent infections.During an interview on 02/06/26, at 2:51 P.M., the Administrator said she expected catheter tubing to be cleansed away from the body to prevent infections.Complaint #2731470

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to establish and follow an effective infection control program when staff failed to perform proper hand hygiene and prevent cross-contamination while performing peri-care for one resident (Resident #2) and when providing wound care to one resident (Resident #4). The facility census was 40. Review of the facility policy titled Standard Precautions Infection Control, dated 04/18/25, showed the following:-All staff are to assume that all residents are potentially infected or colonized with an organism that could be transmitted during providing resident care services. Therefore, all staff shall adhere to standard precautions to prevent the spread of infection;-Hand hygiene is a general term for cleaning hands by handwashing with soap and water or the use of antiseptic hand rub, also known as alcohol-based hand rub (ABHR) and should be performed during the delivery of resident care services. Avoid unnecessary touching of surfaces in close proximity to the resident to prevent contamination of clean hands from environmental services and transmission of pathogens from contaminated hands to surfaces;-Personal protective equipment (PPE) refers to protective items or garments worn to protect the body or clothing from hazards that can cause injury and to protect residents from cross-contamination. All staff who have contact with the residents and/or their environments must wear personal protective equipment as appropriate during resident care and/or with exposure to blood, body fluids, or potentially infectious materials1.Review of Resident #2's face sheet (brief look at resident information) showed the following information:-admission date of 01/02/26;-Diagnoses included multiple sclerosis (a chronic autoimmune disease of the central nervous system where the immune system attacks the protective myelin sheath covering nerve fibers, disrupting brain to body communication), neuromuscular dysfunction of bladder (occurs when nerve damage disrupts signals between the brain and bladder, causing overactive or under active symptoms), and quadriplegia (paralysis affecting all four limbs and the torso). Review of the resident's admission Minimum Data Set (MDS - a federally mandated assessment tool filled out by facility staff), dated 01/02/26, showed the following information:-Cognitively intact;-Dependent on staff assistance for dressing, toileting, and mobility;-Indwelling catheter (a flexible tube inserted into the bladder to drain urine continuously into a bag, held in place by a small, inflated balloon) use.Review of the resident's care plan, dated 01/02/26, showed the following:-Monitor and document intake and output;-Monitor and report to nurse any kinks in catheter tubing;-Monitor and document any pain/discomfort due to the catheter;-Monitor/record/report to Medical Director for signs and symptoms of urinary tract infections.Observation on 02/05/26, at 10:45 A.M., showed the following: -Certified Nursing Assistant (CNA) I and CNA O entered the resident's room to perform catheter care;-Both CNAs performed hand hygiene and applied PPE;-The resident laid in his/her bed, with CNA O on his/her right side and CNA I on his/her left side;-CNA O took off the resident's brief and CNA I provided catheter care;-The resident rolled toward CNA O and CNA I provided care to the resident's backside. The resident had been incontinent of bowel;-CNA I obtained a clean brief and placed it under the resident without performing hand hygiene and changing gloves;-The CNAs rolled the resident back onto his/her back. CNA I adjusted the resident's urinary catheter, and hung the resident's catheter bag on the side of his/her bed without performing hand hygiene or changing gloves;-CNA I obtained a graduate (a disposable or reusable plastic container used in healthcare to accurately measure urine output) and drained the residents catheter bag of urine. CNA I emptied the graduate into the residents toilet, flushed the toilet, touched the resident's sink, and turned on the water to rinse the graduate in the sink;-CNA I removed his/her gloves and performed hand hygiene;-CNA I did not sanitize any of the areas in the room he/she touched with soiled (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	gloves. During an interview on 02/05/26, at 11:14 A.M., CNA I said hand hygiene and glove changes should be performed anytime a staff member was going from a dirty surface to a clean surface to prevent cross-contamination.During an interview on 02/05/26, at 12:05 P.M., CNA J said hand hygiene and glove changes should be performed anytime a staff member goes from a dirty surface to a clean surface to prevent cross-contamination.During an interview on 02/06/26, at 10:30 P.M., the Director of Nursing (DON) said she expected staff to perform hand hygiene and glove changes anytime they move from a dirty surface to a clean surface.During an interview on 02/06/26, at 2:51 P.M., the Administrator said she expected staff to perform hand hygiene and glove changes anytime they go from a dirty surface to a clean surface.2. Review of Resident #4's face sheet showed the following information:-admission date of 05/12/25;-Diagnoses included cellulitis (bacterial skin infection) of left lower limb, non-pressure chronic ulcer (painful sore) of right lower and left lower leg, and pain in right lower and left lower leg.Review of the resident's quarterly MDS, dated [DATE], showed the following information:-Moderate cognitive impairment;-Required substantial to maximum assistance from staff for lower body dressing, and supervision for mobility;-Open lesions on the foot. Review of the resident's care plan, dated 05/21/24, showed the following:-Complete weekly skin assessments;-Notify doctor of any new skin impairments and implement treatment orders.Observation on 02/05/26, at 10:14 A.M., showed the following:-Licensed Practical Nurse (LPN) C entered the resident's room to perform wound care;-An odor was detected from the wound and flies were seen around the resident's left leg. The left leg had gauze wrap that had brownish-yellow drainage coming through the wrap. There was a bed pad under the resident's leg with brownish-yellow drainage;-The LPN placed dressing supplies including gauze roll, bag of gauze, wound cleanser, and tape onto a clean barrier on the resident's bedside table;-The resident laid on his/her back with his/her left leg facing the LPN;-The LPN applied gloves without performing hand hygiene;-The LPN removed the resident's shoe and sock, obtained scissors from his/her pocket, and cut off the soiled dressing. Once the dressing was removed, he/she threw it into the trash can;-The LPN placed the soiled scissors onto the designated clean barrier on the resident's bedside table, beside the clean supplies;-The LPN removed his/her gloves, did not perform hand hygiene, applied clean gloves, and began cleansing the resident's wounds;-The LPN used one gauze pad and discarded it into the trash, obtained an additional gauze pad from the bag of gauze and grabbed the wound cleanser. The LPN did not perform hand hygiene or change his/her gloves before reaching into the bulk gauze bag and/or obtaining clean supplies;-The LPN continued with this process, then placed the wound cleanser bottle back onto the designated clean barrier and obtained the clean gauze roll from the designated clean barrier; -The LPN then said, I'm sorry, I don't remember all the steps, put the gauze roll back onto the designated clean barrier, removed his/her gloves, performed hand hygiene, applied clean gloves, and obtained the previously touched gauze roll;-The LPN began wrapping the resident's wound and put on the resident's sock;-The LPN left the resident's side and went to his/her medication cart, and opened three drawers looking for a biohazard bag;-The LPN returned to the resident's side, put on his/her shoe, and placed the resident's leg back onto the soiled bed pad, then exited the room;-The LPN removed his/her gloves and used hand sanitizer;-The contaminated bulk bag of gauze, scissors, and wound cleanser was placed on top the treatment cart.During an interview on 02/05/26, at 11:14 A.M., CNA I said any item used for multiple residents and/or taken in and out of resident rooms should be sanitized before and after use.During an interview on 02/05/26, at 12:05 P.M., CNA J said any item used for multiple residents and/or taken in and out of resident rooms should be sanitized before and after use.During an interview on 02/06/26, at 10:30 P.M., the DON said the following:-She expected staff to sanitize any item that was used for multiple residents before and (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	after use;-Soiled hands should not be placed into bulk supplies.During an interview on 02/06/26, at 2:51 P.M., the Administrator said the following:-She expected staff to sanitize any item that were used for multiple residents before and after use;-Soiled hands should not be placed into bulk supplies.Complaint #2731470