| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 265473 | A. Building<br>B. Wing | 12/10/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Glendale Gardens Nursing & Rehab | 3535 East Cherokee<br>Springfield, MO 65809 |

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 0561<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to promote and facilitate each resident's right of self-determination in support of resident choice when staff failed to honor resident preferences for shower frequency for four residents (Resident #6, #11, #23, and #33). The facility census was 91.Review of the facility procedure for Bath/Shower, undated, the purpose of a shower is to maintain the resident's skin integrity, comfort, and cleanliness.1.Review of Resident #6's face sheet showed the following:-admission date of 02/23/14;-readmission date of 02/23/23;-Diagnoses included cerebral palsy (a group of conditions that affect movement and posture), spastic hemiplegia (a neuromuscular condition that results in the muscles on one side of the body being contracted) affecting his/her right side, anxiety, major recurrent depression, open wounds to his/her right thigh and lower back, and reduced mobility.Review of the resident's quarterly Minimum Data Set (MDS - a federally mandated assessment tool completed by facility staff), dated 09/04/25, showed the following:-Moderate cognitive impairment;-No rejection of care;-Functional limitation in range of motion to one side of his/her upper and one side of his/her lower body;-Motorized wheelchair for mobility;-Dependent on staff assistance for toileting hygiene, transfers, and showering;-Required substantial/maximal staff assistance with upper and lower body dressing and personal hygiene;-Always incontinent of bowel and bladder;-Risk of pressure ulcer development and presence of one pressure ulcer.Review of the resident's current care plan showed the following:-Required extensive assistance for all his/her activities of daily living (ADLs - dressing, toileting, showering, grooming, etc.) related to mobility issues, weakness, and disease process;-Resident will be offered two baths per week and have the right to refuse or request additional baths. Please encourage the resident if needed;-Two staff to assist the resident with positioning and Hoyer (a mechanical transfer lift) for transfers.Review of the July 2025 Shower Schedule showed the following: -The resident received a shower on 07/03/25, 07/10/25, and 07/22/25;-Staff did not document any resident refusals.Review of the August 2025 Shower Schedule showed the following: -The resident received a shower on 08/08/25 and 08/12/25;-Staff did not document any resident refusals.Review of the resident's electronic medical record, dated 09/01/25 to 09/09/25, showed staff did not document any showers received by the resident.Observation and interview on 09/10/25, at 11:20 A.M., showed the following:-The resident said he/she would like to have a shower three times per week, but he/she was lucky to get one shower per week;-The resident said it makes him/her feel yucky when he/she does not receive a shower;-The resident said his/her head gets, itchy when he/she does not get assistance with shampooing his/her hair;-Observation showed the resident's hair appeared greasy;-The resident said he/she had not received a shower so far this week.2. Review of Resident #11's face sheet showed the following:-admission date of 07/20/22;-re-admission date of 08/03/24;-Diagnoses included of congestive heart failure, diabetes, anxiety, and major recurrent depression.Review of the resident's quarterly MDS, dated [DATE], showed the following:-Cognitively intact;-No rejection of care;-Utilized walker or wheelchair for mobility;-Partial/moderate staff assistance for toileting hygiene and showering;-Required substantial/maximal staff assistance with<br>(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 0561<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | lower body dressing;-At risk of pressure ulcer development and presence of moisture associated skin damage (MASD, skin breakdown from prolonged exposure to moisture).Review of the resident's current care plan showed;-Required assistance of one to two staff for all his/her ADLs related to weakness and rhabdomyolysis (a condition in which the skeletal muscles break down quickly);-Resident will be offered two baths per week and have the right to refuse or request additional baths. Please encourage the resident if needed. Review of the resident's July 2025 Shower Schedule showed the following:-On 07/08/25, the resident refused a shower;-On 07/17/25 and 07/30/25, the resident received a shower. Review of the resident's August 2025 Shower Schedule showed the following: -The resident received a shower on 08/19/25;-Staff did not document any resident refusals.Observation and interview on 09/03/25, at 11:25 A.M., showed the following:-Resident sat up in his/her recliner with his/her walker nearby;-The resident said his/her main concern was showers because staff have not assisted him/her with a shower for a few weeks;-The resident said staff came in earlier that morning on 09/03/25 and said he/she would get a shower tomorrow on 09/04/25;-The resident said his/her head was itching and hair was greasy because of no shower or shampoo.Review of the resident's electronic medical record, dated 09/01/25 to 09/09/25, showed the resident received a shower on 09/04/25.3. Review of Resident #23's face sheet showed the following:-admission date of 12/05/23;-Diagnoses included stroke, diabetes, general anxiety disorder, and depression.Review of the resident's quarterly MDS, dated [DATE], showed the following:-Moderate cognitive impairment;-No rejection of care;-Utilized walker or wheelchair for mobility;-Supervision/touching assistance of staff for toileting hygiene, transfers, and showering;-Occasionally incontinent of bladder;-At risk of pressure ulcer development.Review of the resident's current care plan showed the following:-Required supervision or assistance of one staff for all his/her ADLs related to weakness and disease process;-Resident will be offered two baths per week and have the right to refuse or request additional baths. Please encourage the resident if needed.Review of the July 2025 Shower Schedule showed the resident received one shower for the month on 07/08/25. Staff did not document any resident refusals.Review of the August 2025 Shower Schedule showed the resident received one shower for the month on 08/04/25. Staff documented two refusals on 08/20/25 and 08/22/25.Review of the resident's electronic medical record, dated 09/01/25 to 09/09/25, showed staff did not document any showers received by the resident.During an interview on 09/03/25, at 1:50 P.M., the resident said he/she has not had assistance with a shower for 2 weeks.Observation on 09/10/25, showed the resident participating in activities. The resident's hair was visibly oily and stringy.4. Review of Resident #33's face sheet showed the following:-admission date of 05/13/24;-re-admission date of 03/11/25;-Diagnoses included of chronic respiratory failure and generalized anxiety disorder. Review of the resident's quarterly MDS, dated [DATE], showed the following:-Cognitively intact;-No rejection of care;-Utilized wheelchair for mobility;-Substantial/maximal staff assistance for toileting hygiene, transfers, showering, and upper and lower body dressing;-Occasionally incontinent of bladder;-At risk of pressure ulcer development.Review of the resident's care plan showed the following:-Required assistance of one staff for all his/her ADLs related to weakness, and disease process (respiratory failure); -Resident will be offered two baths per week and has the right to refuse or request additional baths. Please encourage the resident if needed.Review of the July 2025 Shower Schedule showed the following: -The resident received showers on 07/04/25, 07/09/25, 07/16/25, 07/23/25, and 07/30/25;-Staff did not document any resident refusals.Review of the August 2025 Shower Schedule showed the following: -The resident received showers on 08/06/25, 08/13/25, 08/20/25, and 08/27/25;-Staff did not document any refusals.Observation and interview of Resident #33 on 09/03/25 at 9:38 A.M., showed:-Staff propelled the resident to his/her room in his/her wheelchair;-The resident stated he/she just came from a shower, but the facility had an issue with not providing residents with enough showers at times;-He/she felt dirty when he/she did not get a shower.Review of the resident's electronic medical record, dated 09/01/25 to 09/09/25, showed the resident received one<br>(continued on next page) |

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| F 0561<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | shower on 09/03/25.During an interview on 09/10/25 11:05 A.M., the resident said the following:-During the summer, he/she wanted two showers per week, but only received one shower per week at times, because the facility pulled the shower aides to work the floor;-When at home, he/she took a shower every morning;-In the summer, he/she would sweat and liked a shower twice per week.5. During an interview on 09/08/25, at 1:49 P.M., Restorative Aide G said the following:-He/she worked at the facility for approximately the last six years-The facility was having a rough time completing all resident showers;-The facility used to have four shower aides;-One of the shower aides quit working at the facility and another stepped into a different role;-The two remaining shower aides each work part-time at the facility and the facility did not have anyone on evening helping to complete showers;-Staff are not able to assist some of the residents with showers weekly;-He/she was unsure how the facility was keeping track of showers, but he/she did not think the shower aides had a clear idea of when residents were last showered. During an interview on 09/09/25, at 11:26 A.M., Certified Nurse Assistant (CNA) F said the following:-He/she worked at the facility as a shower aide for approximately three years;-He/she worked Monday through Friday, 8:00 A.M. to 1:00 P.M.;-The other shower aide worked as needed;-The facility did not have anyone else helping with resident showers;-He/she showered four to six residents per day on average;-A few residents were independent with showering but not a lot of them were;-It was possible that residents were going over a week without showers;-The Director of Nursing (DON) or Assistant Director of Nursing (ADON0 gave him/her a list of showers for the day, The list usually had 6 to 8 residents each day;-He/she tried to complete as many showers as he/she could each day;-He/she gave a list of completed showers and showers that were not completed to the DON each day;-He/she completed an estimated 25 resident showers per week;-He/she did not realize that some of the residents were having to wait longer than a week for showers.During an interview on 09/10/25 at 10:14 A.M., Licensed Practical Nurse (LPN) D said the following:-He/she thought the DON or ADON made out the resident shower lists for the shower aide each day;-He/she was unsure if staff were completing all resident showers or not;-Some of the residents and families had complained about the staff not completing resident showers;-The shower aides do not report to the nurse which showers were not completed;-If a shower aide came to the nurse and said the resident was refusing his/her shower, the nurse would try to convince the resident to shower;-Staff was supposed to assist residents with two showers per week.During an interview on 09/09/25, at 1:00 P.M., Registered Nurse (RN) C said the following:-He/she was unsure if the showers aides were completing all the resident showers or not;-The DON made a list of residents for the shower aide;-He/she thought the shower aide would inform the DON if a resident refused a shower.During an interview on 09/10/25, at 2:30 P.M., the Long-Term Care (LTC) Case Manager said the following:-He/she was not aware of any issues with staff not completing resident showers, but the DON and former ADON were tracking the showers;-The shower aides should try to offer the resident a shower three times and if the resident refused, the aide should notify the nurse, and the nurse would try to convince the resident.-If the nurse could not get the resident to take a shower, the nurse should contact the resident's family or responsible person and document in the resident's progress notes. During an interview on 09/09/25, at 2:13 P.M., the DON said the following:-The facility currently had two shower aides working and each worked five hours per day and typically completed four to five showers per day;-The DON gave the shower aides a list of which residents to shower each day;-The DON tracked the shower on a monthly schedule and would mark an X on the days staff gave each resident a shower;-Based on the showers completed and a list of resident preferred shower days, he/she made the list for the following day;-There are residents going longer than a week without with showers due to not enough shower aides;-The facility goal is to provide each resident with two showers per week;-He/she did not have anyone asking for more than two showers per week and the residents were care planned for showers based on their preference.During an interview on 09/10/25, at 5:42 P.M., the Administrator said facility staff should provide residents with showers assistance per each resident's preference and per each resident's care plan. |

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| F 0628<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies.<br><br>Based on record review and interview, the facility failed to ensure that staff notified the resident and/or the resident's representative in writing of a transfer at the time of transfer for two residents (Residents #8 and 104). The facility census was 91.Review of the facility's policy titled Discharge/Transfer of Resident, undated, showed the following:-Explain transfer and reason to the resident and/or representative and give copy of signed transfer or discharge notice to the resident and/or representative or person responsible for care.-If emergency transfer, transfer or discharge notice form may be completed later, but as soon as possible.1. Review of Resident #41's face sheet (gives basic profile information at a glance) showed an admission date of 09/08/23.Review of the resident's nurse progress notes, dated 08/03/25, showed the following:-An aide informed a nurse that the resident was unresponsive;-The nurse tried to arouse the resident with no response;-The nurse called for two nurses to help;-Resident was placed on the floor for chest compressions to be administered;-Staff contacted 911 and emergency medical services (EMS) arrived;-Staff provided report and medical records;-Staff notified Director of Nursing (DON), physician, and next of kin (NOK).Review of the resident's medical records showed staff did not have documentation regarding a written transfer notice given and/or mailed to the resident and/or resident's representative pertaining to a hospital transfer on 08/03/25.2. Review of Resident #104's face sheet showed an admission date of 04/05/24.Review of the resident's nurses' progress notes, dated 07/10/25, showed the following:-Registered Nurse (RN) assessed resident after report and vital stats taken;-Resident grunting and not responding to nurse when talking to him/her;-Breath sounds were diminished;-Contacted Nurse Practitioner (NP) with condition update, labs and stats;-Order received to send resident to the emergency room (ER) for evaluation and treatment;-NP will contact NOK, physician, and ER;-Staff gathered paperwork gathered and contacted emergency medical services;-EMS arrived and report given. Review of the resident's medical records showed staff did not have documentation regarding a written transfer notice given and/or mailed to the resident and/or resident's representative pertaining to a hospital transfer on 07/10/25.3. During an interview on 09/09/25, at 1:07 P.M., Licensed Practical Nurse (LPN) D said the following:-Nurses notify the resident's family as soon as possible if a resident is transferred or discharged ;-LPN D does not issue a letter to family regarding the discharge.During an interview on 09/09/25, at 1:09 P.M., Social Services (SS) said the following:-Nurses notify family and put note in record if a resident is transferred to the hospital;-SS will occasionally contact the family regarding the transfer if the nurse requests;-Nurses send paperwork including the face sheet and physician's orders with resident to hospital;-SS does not send written notification to family or the resident explaining the transfer;-SS does not believe the facility provides written notification of transfer. During an interview on 09/09/25, at 1:24 P.M., the Business Office Manager (BM), said the following:-When a resident is transferred to the hospital, the nurses enter a note in the resident's chart documenting where the resident was transferred to and who was notified of the transfer; -No written notification is issued to the resident or their family. During an interview on 09/09/25, at 1:42 P.M., Long-Term Care Case Manager (LTC CM) said the following:-Nurses will notify a resident's family when they are transferred out of the facility;-LTC CM does not know if written notification of the transfer is provided to the resident or their family. During an interview on 09/10/25, at 12:31 P.M., the Director of Nursing (DON) said the following:-The charge nurse is responsible for notifying the resident's family when a resident is transferred to the hospital;-No written notification is provided to the resident or their family. During an interview on 09/10/25, at 12:33 P.M, the Administrator said the following:-The nurse will verbally notify the resident's family when a resident transfers out to a hospital;-No written notification is provided to the family or resident. |

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| F 0678<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident?s advance directives.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to maintain a system an effective system to make code status (whether or not the resident wished to receive cardiopulmonary resuscitation (CPR - an emergency procedure used during cardiac or respiratory arrest)) of each resident available to staff at all times when staff failed to maintain accurate, current, and accessible code status information for nine resident (Resident #2, #10, #27, #30, #7, #8, #42, #33, and #68). The facility had a census of 91.Review of the facility policy titled, Advanced Directives, undated, showed Information about whether or not the resident has executed an advance directive shall be displayed prominently in the medical record under the advance directive tab.<br><br>1. Review of Resident #2's face sheet (brief look at resident information) showed the following information:-admission date of [DATE];-Code status of do not resuscitate (DNR – does not wish to receive CPR).<br><br>Review of the resident's current physician order sheet showed an order, dated [DATE], for code status of DNR.<br><br>Review of the resident's care plan, dated [DATE], showed code status of DNR.<br><br>Review of the facility's Resident Face Sheet book, on [DATE], showed the resident as a full code (to receive CPR).<br><br>Review of the facility's Certified Nursing Assistant (CNA) quick reference book, on [DATE], showed the resident's information absent from the book.<br><br>2. Review of Resident #10's face sheet showed the following information:-Current admission date of [DATE];-Code status of DNR.<br><br>Review of the resident's current physician order sheet showed an order, dated [DATE], for code status of DNR.<br><br>Review of the resident's care plan, dated [DATE], showed code status of DNR.<br><br>Review of the facility's Resident Face Sheet book, on [DATE], showed the resident's face sheet and code preference absent from the book.<br><br>Review of the facility's CNA quick reference book, on [DATE], showed the resident's information absent from the book.<br><br>3. Review of Resident #27's face sheet showed the following information:-admission date of [DATE];-Code status of DNR.<br><br>Review of the resident's current physician order sheet showed an order, dated [DATE], for code status of DNR.<br><br>Review of the resident's care plan, dated [DATE], showed code status of DNR.<br>(continued on next page) |

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| F 0678<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Review of the facility's Resident Face Sheet book, on [DATE], showed the resident's face sheet and code preference absent from the book.<br><br>Review of the facility's CNA quick reference book, on [DATE], showed the resident's information absent from the book.<br><br>4. Review of Resident #30's face sheet showed the following information:-admission date of [DATE];-Code status of DNR.<br><br>Review of the resident's current physician order sheet showed an order, dated [DATE], for code status of DNR.<br><br>Review of the resident's care plan, last reviewed/revised [DATE], showed code status of DNR.<br><br>Review of the facility's Resident Face Sheet book, on [DATE], showed the resident's face sheet and code preference absent from the book.<br><br>Review of the facility's CNA quick reference book, on [DATE], showed the resident's information absent from the book.<br><br>5. Review of Resident #7's face sheet showed the following information:-readmission date of [DATE];-Code status of DNR.<br><br>Review of the resident's Physician Order Sheet (POS), current as of [DATE], showed an order, dated [DATE], for resident to be a DNR.<br><br>Review of resident's care plan, dated [DATE], showed the resident was a DNR.<br><br>Review of the facility's Resident Face Sheet book, on [DATE], showed the resident's face sheet and code preference absent from the book.<br><br>Review of the facility's CNA quick reference book, on [DATE], showed the resident's information absent from the book.<br><br>6. Review of Resident #8's face sheet showed the following information:-readmission date of [DATE];-Code status of full code (wished to receive CPR).<br><br>Review of the resident's POS, current as of [DATE], showed an order, dated [DATE], for full code.<br><br>Review of resident's care plan, dated [DATE], showed the resident to be full code.<br><br>Review of the facility's Resident Face Sheet book, on [DATE], showed the resident's face sheet and code preference absent from the book.<br><br>Review of the facility's CNA quick reference book, on [DATE], showed the resident's information absent from the book.<br><br>7. Review of Resident #42's face sheet showed the following information:-admission date [DATE];-Code status of DNR.<br>(continued on next page) |

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| F 0678<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Review of the resident's POS, current as of [DATE], showed an order, dated [DATE], for resident to be a DNR.<br><br>Review of resident's care plan, dated [DATE], showed the resident was a DNR.<br><br>Review of the facility's Resident Face Sheet book, on [DATE], showed the resident's face sheet and code preference absent from the book.<br><br>Review of the facility's CNA quick reference book, on [DATE], showed the resident's information absent from the book.<br><br>8. Review of Resident #33's face sheet showed:-admission date of [DATE];-Code status of DNR.<br><br>Review of the resident's current physician order sheet showed an order, dated [DATE], for code status of DNR.<br><br>Review of the resident's care plan, dated [DATE], showed code status of DNR.<br><br>Review of the D hall binder titled, Resident Face Sheet, on [DATE] at 12:06 P.M., showed it contained the face sheets and code status information for several residents, but did not contain a face sheet or any information for Resident #33.<br><br>9. Review of Resident #68's face sheet showed:-admission date of [DATE];-Code status of full code.<br><br>Review of the resident's current physician order sheet showed code status of full code. -Full code.<br><br>Review of the resident's care plan, dated [DATE], showed code status of DNR.<br><br>Review of the D hall binder titled, :Resident Face Sheet, on [DATE] at 12:06 P.M., showed it contained the face sheets and code status information for several residents, but did not contain a face sheet or any information for Resident #68.<br><br>10. During an interview on [DATE], at 9:21 A.M., Registered Nurse (RN) C said the following:-Resident code status can be located in the Face Sheet book located at the nurses' stations;-The Face Sheet book is updated periodically or when code status changes.<br><br>During an interview on [DATE], at 10:14 A.M., Licensed Practical Nurse (LPN) D said the following:-He/she would look for a resident's advanced directives on his/her face sheet in the electronic medical record or check for the DNR in the document section in the electronic medical record;-One of the evening nurses also placed a list of resident code status for C and D hall residents in the C/D medication room.<br><br>During an interview on [DATE], at 1:43 PM, the Skilled Case Manager (CM) said the following:-Upon admission, he/she will obtain the resident's code status preference;-He/she will place the form in the physician folder to obtain a signature;-Code status is entered into the computer, but he/she is unsure who enters the information;-He/she would ask medical records if he/she needed to know a resident's code status.<br><br>During an interview on [DATE], at 12:06 P.M., the Long-Term Care (LTC) Case Manager/ MDS<br>(continued on next page) |

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| F 0678<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Coordinator said the following:-If he/she needed to check a resident code status, he/she would look in the electronic health record (EHR) system on the resident's face sheet or the physician orders;-If a staff member could not access the electric health record, he/she should look in the face sheet binder for that hall located at the nurse desk;-He/she thought the Director of Nursing (DON) or Medical Records person was in charge of keeping the binder up to date, but was unsure when they completed updates;-He/she updated each resident's code status in the electronic medical record when he/she completed a care plan for that resident;-If a resident's code status changed, the nurse should update the code status in the EHR and pass the change on to the next shift nurse in report;-As far as he/she knew, the face sheet book was up to date with current resident code statuses.<br><br>During an interview on [DATE], at 12:48 P.M., the LTC Social Service Director (SSD) said the following:-He/she completed admission paperwork with LTC admissions at the facility;-He/she goes over the admission packet which included a DNR form;-He/she educated residents and families about the DNR form and the resident or his/her responsible parties had an option to sign the form.-If the resident decided to sign the form, he/she notified the nurse on duty and the nurse would contact the resident's physician for a DNR order and place the order in electronic medical record;-He/she then placed the paper copy of the signed DNR form into the physician's box located at the nurse desk for signature or fax the physician for signature;-If he/she obtained a physician signature for the DNR, he/she then gave the form to the DON;-The DON ensured the order the nurse updated the order in electronic medical record and then the DON gave the form to Medical Records;-When Medical Records person was not at work, he/she was unsure if the nurses would have access to the original DNR order form or not;-If the nurse asked the SSD a resident's code status, he/she would run to a computer and look in the electronic medical record;-He/she thought each resident was supposed to have a code status sheet inside each closet with all that information. He/she remembered discussion about that one day in the morning meeting.<br><br>During an interview on [DATE], at 12:16 P.M., Medical Records said the following: -When admitting a new resident, he/she scanned in the resident's hospital records and hospital discharge orders into electronic medical records;-He/she checked the Medical Records mailbox located at each nurses' station and if there was a resident DNR order form in the box, he/she delivered the form to the DON and the DON updated the resident's physician order for code status in the electronic medical record;-He/she kept the original DNR forms in a file cabinet in his/her office;-He/she locked the office when he/she left work;-He/she did not think the nurses had access or a key to the office in the evenings or on weekends; -Each resident's code status is in the electronic medical record. It should either read full code or DNR, but he/she was unaware the nurses needed to have a hard copy of each resident's code status;-He/she was unsure if anyone in the facility had access to resident code status information in the event of an emergency.<br><br>During an interview on [DATE], at 2:50 P.M., the DON said the following:-If staff were unable to access code status from the computer, it could be obtained by accessing the offline electronic medication administration record (eMAR);-To access the offline eMAR, staff would contact the DON and he/she could give staff instructions to print off the eMAR.<br><br>During an interview on [DATE], at 5:43 P.M., the Administrator said the following:-The computers should not be affected as they have generator power;-There is an offline eMAR available that nurses should be able to access;-If staff cannot access the eMAR, they should contact the DON or Administrator. |

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| | 265473 | A. Building<br>B. Wing | 12/10/2025 |

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| F 0695<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide safe and appropriate respiratory care for a resident when needed.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to provide care respiratory care per standards of practice when staff failed to administer oxygen per physician orders for one resident (Resident #110) and failed to obtain complete oxygen administration orders for three residents (Resident #2, #30, and #8). The facility census was 91. Review of the facility's policy titled Oxygen Administration, undated, showed the following:-The purpose is to administer oxygen to the resident when insufficient oxygen is being carried by the blood to the tissues;-Check physician's order for liter flow and method of administration;-For oxygen per nasal cannula, connect the tubing to the humidifier outlet and adjust the flow as ordered;-Place prongs of cannula into the resident's nares;-Adjust elastic loosely around head above the ears;-If cannula does not have elastic adjustment, loop the plastic around the ears and under the chin;-Adjust the plastic slide to hold cannula in place;-Constant flow of oxygen can cause drying and thickening of normal secretions resulting in laryngeal ulceration.<br><br>1. Review of Resident #110's face sheet (brief look at resident information) showed the following information:-admission date of 10/21/24;-Diagnoses included chronic obstructive pulmonary disease (COPD-a lung disease that causes airflow obstruction and breathing problems, anxiety (mental health condition that causes excessive worry, fear, and nervousness), and dementia (progressive decline in memory, thinking, reasoning, and judgment).<br><br>Review of the resident's quarterly Minimum Data Set (MDS – a federally mandated assessment tool completed by facility staff), dated 05/13/25, showed the following:-Resident was cognitively intact;-No indication of oxygen administration;-Health conditions include shortness of breath or trouble breathing with exertion (e.g. walking, bathing, transferring) and shortness of breath or trouble breathing when lying.<br><br>Review of the resident's care plan, revised 09/10/25, showed the following:-Monitor for respiratory difficulties and intervene as needed;-Apply oxygen as ordered for comfort and assess for signs and symptoms of activity intolerance as evidenced by fatigue, pain. and/or shortness of breath;-Resident required oxygen therapy per orders and oxygen stats;-Administer oxygen as ordered 2 liters per minute via nasal cannula, change tubing per protocol, ensure oxygen supply is available at all times, monitor for changes in symptoms that may indicate worsening respiratory status, and report to physician.<br><br>Review of the resident's current Physician's Orders Sheet (POS) showed an order, dated 09/05/25, for oxygen 2 liters per minute per nasal cannula continuous, every shift- day, evening, and night.<br><br>Review of the resident's Treatment Administration Record (TAR), dated 09/01/25 to 09/10/25, showed an order, dated 09/05/25, for oxygen at two liters per minute per nasal cannula continuous every shift.<br><br>Observation on 09/8/25, at 10:27 A.M., showed the resident lying in bed with eyes closed. The oxygen tubing was lying on his/her stomach and not in his/her nose. The oxygen concentrator was set on three liters per minute.<br><br>During an interview and observation on 09/08/25, at 11:21 A.M., the resident stated, he/she was not on oxygen prior to coming to the facility. He/she was supposed to be on two liters of oxygen all the time. He/she does not do any adjustments on the oxygen concentrator, he/she lets staff do that.<br>(continued on next page) |

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| F 0695<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | He/she puts on and takes off his or her own oxygen tubing. The oxygen concentrator was set on three liters per minute per nasal cannula.<br><br>Observation on 09/09/25, at 12:07 P.M., showed the resident in the dining room with a portable oxygen tank on the back of his/her wheelchair. The oxygen concentrator was set at three liters per minute. Certified Nurse Aide (CNA) M came to attend to the resident, and he/she confirmed that the resident's oxygen concentrator was set on three liters per minute. The resident asked the CNA to turn his/her oxygen off while she ate lunch. The CNA turned the resident's oxygen concentrator off per the resident's request.<br><br>During an interview on 09/09/25, at 10:31 A.M., CNA M said the resident had oxygen set at three liters per minute. He/she checked the CNA quick reference book and stated that he/she did not see any information regarding oxygen or the prescribed amount, but he/she just knew his/her residents on the hall.<br><br>During an interview on 09/09/25, at 10:51 A.M., CNA N said the resident was put on oxygen at the hospital approximately a week ago and he/she was still on it. The resident was supposed to wear oxygen all the time, but sometimes the resident took it off. He/she thought the resident should be on two liters of oxygen per minute.<br><br>2. Review of the Resident # 2's face sheet showed the following information:-admission date of 03/20/23;-Diagnoses included COPD and congestive heart failure (CHF - condition where the heart muscle becomes weak and cannot pump blood effectively).<br><br>Review of the resident's quarterly MDS, dated [DATE], showed the following:-No indication of oxygen administration;-Health conditions included shortness of breath or trouble breathing when lying flat.<br><br>Review of the resident's care plan, dated 07/29/25, showed staff should monitor for respiratory difficulties, intervene as needed, and apply oxygen as ordered for comfort.<br><br>Review of the resident's Medication Administration Record (MAR) and TAR, dated 06/01/25 to 09/09/25, showed staff did not document orders for oxygen usage.<br><br>Review of the resident's nurse's note on 08/11/25, at 12:49 A.M., showed the resident reported he/she could not breathe, so staff obtained an oxygen concentrator and placed the resident on oxygen per nasal cannula at 2.5 liters per minute.<br><br>Review of the resident's nurses note on 08/21/25, at 3:20 P.M., showed the resident was lethargic and on two liters of oxygen due to the resident breathing heavily.<br><br>Review of the resident's nurses note on 08/23/25, at 3:22 P.M., showed oxygen was placed after the resident received a shower.<br><br>Review of the resident's nurses note on 08/24/25, at 1:10 A.M., showed staff placed oxygen per nasal cannula for comfort.<br><br>During an interview on 09/09/25, at 10:31 A.M., CNA M said the resident was not on oxygen that he/she was aware of.<br>(continued on next page) |

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| F 0695<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During an interview on 09/09/25, at 10:51 A.M., CNA N said the resident was only on oxygen as needed for anxiety, but he/she did not know how much oxygen was ordered for the resident. He/she did not need it all the time. The oxygen made him/her feel better.<br><br>During an interview on 09/09/25, at 2:06 P.M., LPN D said he/she looked in the electronic health record for the resident and did not see an order for the resident to have oxygen. The resident did wear oxygen, but he/she thought the resident only wore it as needed. He/she puts two liters of oxygen on the resident when the resident complained of anxiety or shortness of breath. The resident wore his/her oxygen off and on.<br><br>During an interview on 09/09/25, at 1:42 P.M, the Long-Term Care (LTC) Case Manager (LTC-CM) looked in the electronic health record for the resident and said he/she did not find an order for him/her to receive oxygen.<br><br>During an interview on 09/10/25, at 4:56 P.M., the Director of Nursing (DON) said the resident had an oxygen tank in his/her room from Hospice. He/she was not sure if the resident has an order for oxygen.<br><br>3. Review of the Resident #30's face sheet (brief look at resident information) showed the following information:-admission date of 12/05/15;-Diagnoses included anxiety (mental health condition that causes excessive worry, fear, and nervousness).<br><br>Review of the resident's quarterly MDS, dated [DATE], showed the following:-Severe cognitive impairment;-No indication of oxygen administration;-Health conditions include dyspnea (shortness of breath).<br><br>Review of the resident's progress notes, dated 06/01/25 through 09/09/25, showed staff did not document the resident use of oxygen.<br><br>Review of the resident's physician order report, dated 06/01/25 through 09/09/25, did not include an order for oxygen administration.<br><br>Review of the resident's care plan, revised 06/24/25, showed short apneic periods may occur during or immediately following generalized seizure activity. Staff should provide oxygen as necessary to maintain saturations greater than 90 percent.<br><br>Observation on 09/03/25, at10:42 A.M., showed the resident in bed covered up with blanket, awake, and in no distress. Oxygen tubing near the resident's mouth. Oxygen concentrator set on three liters per nasal cannula.<br><br>Observation on 09/03/25, at 11:22 A.M., showed the resident's oxygen tubing was below his/her nose, near his/her mouth.<br><br>Observation on 09/04/25, at 11:27 A.M., showed CNA N and CNA O assisted the resident from the bed into a wheelchair with the use of a Hoyer lift (mechanical lift). CNA O removed the resident's oxygen and left it off once the resident was in the wheelchair.<br><br>Observation on 09/08/25, 11:37 A.M., showed the resident lying in bed asleep with oxygen on at three liters per nasal cannula.<br>(continued on next page) |

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| F 0695<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During an interview on 09/09/25, at 10:31 A.M., CNA M said the resident was on oxygen, but he/she did not know how many liters. He/she looked in the CNA quick reference book, located at the nurses' station and did not find any information regarding the resident being on oxygen or the number of liters per minute ordered.<br><br>During an interview on 09/09/25, at 10:51 A.M., CNA N said the resident was on two liters of oxygen the last time he/she checked. The resident was not on oxygen all the time and usually only when he/she was in bed. He/she does not usually need oxygen while he/she was up in a chair.<br><br>Observation on 09/09/25, at 11:25 A.M., showed the resident lying in bed with his/her eyes closed. No oxygen on and the tubing was rolled up inside a clear bag on top of the oxygen concentrator.<br><br>During an interview on 09/09/25, at 1:42 P.M, the LTC-CM looked in the electronic health record for the resident and said he/she did not find an order for him/her to receive oxygen.<br><br>During an interview on 09/09/25, at 2:06 P.M., Licensed Practical Nurse (LPN) D said the resident had oxygen on and off quite a bit. The resident has an order for pulse ox checks every shift, but he/she did not find an order in the chart for oxygen. The resident wore his/her oxygen more in bed, not when he/she is up in his/her wheelchair. The resident received anywhere between two to three liters of oxygen per minute.<br><br>During an interview on 09/10/25, at 4:56 P.M., the said he/she was not sure if the resident hac an order for oxygen. He/she did not always wear oxygen, but he/she should have an as needed order.<br><br>4. Review of Resident #8's face sheet showed the following information:-readmission date of 08/21/22;-Diagnoses included atrial fibrillation (irregular heartbeat) and anxiety.<br><br>Review of the resident's POS, current as of 09/09/25, showed an order, dated 05/20/25, for oxygen saturation (SPO2 - a measure of how much oxygen is in your blood) every shift to keep stats above 90% for shortness of breath. (The record did not reflect a liter amount of oxygen.)<br><br>Review of the resident's quarterly MDS, dated [DATE], showed the following:-Resident was cognitively intact;-No indication of oxygen administration.<br><br>Review of resident's care plan, dated 07/07/25, showed staff did not document regarding the resident receiving oxygen.<br><br>Observation on 09/04/25, at 1:30 P.M., showed the resident lying in bed with oxygen canula on. Oxygen was set at 3 liters.<br><br>Observation and interview on 09/09/25, at 10:39 A.M., showed the following:-Resident lying in bed with oxygen canula on;-Oxygen set at 3.5 liters;-He/she wore his/her oxygen all the time.<br><br>During an interview on 09/09/25, at 1:42 P.M., LTC CM said the following:-The resident's order only stated to check pulse ox;-No orders for oxygen were present;<br><br>During an interview on 09/10/25, at 8:56 A.M., Registered Nurse (RN) B said the following:-An oxygen order for Resident #8 was entered on 09/09/25;-No tube changing order is listed in the resident's orders.<br>(continued on next page) |

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| F 0695<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During an interview on 09/10/25, at 4:56 P.M., the DON said he/she is unsure of the resident's order for oxygen.<br><br>5. During an interview on 09/09/25, at 10:31 A.M., CNA M said the nurses let him/her know which residents were on oxygen or he/she looked at the resident's care plan in the physical record located at the nurses' station. He/she was not sure where to find that information in the electronic health record. The nurses were responsible for monitoring and adjusting the oxygen concentrators. The CNA's do not make any adjustments with oxygen. He/she would get a nurse to adjust the oxygen, if needed. The nurses get the oxygen order from the DON or Assistant Director of Nursing (ADON).<br><br>During an interview on 09/09/25, at 10:51 A.M., CNA N said he/she just knows the residents and how much oxygen they should be on. If he/she cares for a new resident, he/she can look at the computer profile for the resident or look in the physical binder located at the nurses' station to see how much oxygen a resident is on, but it is easier to look at the computer for that information. The nurses were responsible for monitoring and adjusting the oxygen concentrators. He/she would only adjust the oxygen concentration if the nurse was in the room and told him/her to adjust it. If he/she was in the room alone and noticed that the oxygen needed to be adjusted, he/she would get a nurse to adjust the oxygen. There should be an order for oxygen, but he/she does not know what the order should include. The nurses get the oxygen order from the physician.<br><br>During an interview on 09/09/25, at 2:06 P.M., LPN D said nurses can give oxygen as needed without a physician's order, but they should let the physician know. If a resident is on continuous oxygen there would be an order.<br><br>During an interview on 09/09/25, at 1:42 P.M., LTC-CM said the following:-Residents who require oxygen should have a physician's order;-Oxygen orders should indicate if it is continuous or PRN (as needed), how many liters, and the oxygen saturation level.<br><br>During an interview on 09/10/25, at 8:56 A.M., Registered Nurse (RN) B said the following:-Residents requiring oxygen should have a physician's order;-Oxygen orders should indicate how many liters to be administered.<br><br>During an interview on 09/10/25, at 4:56 P.M., the DON said the following:-Residents receiving oxygen should have a physician's order;-Continuous orders should state how many liters to administer;-PRN orders should state oxygen levels to be greater than 90%, and staff would assess how many liters are needed;- Oxygen orders are documented in the care plan.<br><br>During an interview on 09/10/25, at 5:43 P.M., the Administrator said resident's receiving oxygen should have an order for the amount (liters) and for scheduled tube changing. |

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| F 0755<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.<br><br>Based on observations, interview, and record review, the facility failed to provide pharmaceutical services that provided a consistent system of reconciliation for all controlled substances, when staff failed to consistently sign the controlled medication count sheets at change of shift for two of seven medication/treatment carts in the facility. The facility census was 91. Review of the facility policy titled, Narcotic Count, undate, showed the following:-Purpose to complete a physical inventory of narcotics at each shift change to identify discrepancies;-The narcotic supply is to be kept under two locks at all times. The lock on the medication cart and the lock on the narcotics. These two locks and the medication room are to be locked at all times; -One registered nurse (RN), licensed practical nurse (LPN) or certified medication technician (CMT) going off duty and one RN, LPN, or CMT coming on duty must count and justify accuracy of narcotics supply for each individual resident at the change of each shift;-Narcotics records are reconciled by a physical count of the remaining narcotic supply at each shift change by the incoming and outgoing licensed nurse. Records are to be retained for a least one year. Emergency kits containing narcotics will be checked at the same time to be sure the seal has not been broken or will be reconciled if the seal is broken;-One prescription for a controlled substance is entered on one individual narcotic sheet;-After the supply is counted and justified, the nurse/CMT records the date and his/her signature, verifying that the count is correct.1. Review of the August 2025 A/B Nurse Controlled Drugs-Count Record showed staff failed to sign a reconciliation count completed on the following dates and times:-On 08/02/25, 3-11 shift, the oncoming and off going nurses failed to sign;-On 08/04/25, 7-3 shift, the oncoming nurse failed to sign, and 3-11 shift, the oncoming and off going nurses failed to sign;-On 08/05/25, 3-11 shift, the oncoming and off going nurse failed to sign;-On 08/06/25, 3-11 shift, the oncoming and off going nurse failed to sign;-On 08/07/25, 11-7 shift, the oncoming nurse failed to sign;-On 08/08/25, 11-7 shift, the off going nurse failed to sign;-On 08/12/25, 3-11 shift, the oncoming and off going nurse failed to sign;-On 08/17/25, 7-3 shift, the oncoming nurse failed to sign;-On 08/19/25,1 1-7 shift, the oncoming nurse failed to sign;-On 08/20/25; 11-7 shift, the off going nurse failed to sign;-On 08/25/25, 3-11 shift, the oncoming and off going nurses failed to sign and 11-7 shift, the oncoming nurse failed to sign;-On 08/26/25, 11-7 shift, the off going nurse failed to sign and 7-3 shift, the oncoming nurse and off going failed to sign, and 3-11 shift, the oncoming and off going nurses failed to sign;-On 08/27/25, 7-3 shift, the oncoming nurse and off going failed to sign, and 3-11 shift, the oncoming and off going nurses failed to sign;-On 08/28/25, 7-3 shift, the oncoming nurse and off going failed to sign, and 3-11 shift, the oncoming and off going nurses failed to sign;-On 08/29/25, 7-3 shift, the oncoming nurse and off going failed to sign, and 3-11 shift, the oncoming and off going nurses failed to sign;-On 08/30/25, 7-3 shift, the oncoming nurse and off going failed to sign, and 3-11 shift, the oncoming and off going nurses failed to sign;-On 08/31/25, 7-3 shift, the oncoming nurse and off going failed to sign.Review of the September 2025 A/B Nurse Controlled Drugs-Count Record showed staff failed to sign a reconciliation count completed on the following dates and times:-On 09/01/25, 7-3 shift, the oncoming nurse and off going failed to sign, and 3-11 shift, the oncoming and off going nurses failed to sign;-On 09/02/25, 7-3 shift, the oncoming nurse and off going failed to sign, 3-11 shift, the oncoming and off going nurses failed to sign, and 11-7 shift, the oncoming nurse failed to sign;-On 09/03/25, 11-7 shift, the off going nurse failed to sign, 7-3 shift, the oncoming nurse and off going failed to sign, and 3-11 shift, the oncoming and off going nurses failed to sign;-On 09/04/25, 7-3 shift, the oncoming nurse and off going failed to sign, and 3-11 shift, the oncoming and off going nurses failed to sign;-On 09/05/25, 7-3 shift, the oncoming nurse and off going failed to sign, and 3-11 shift, the oncoming and off going nurses failed to sign;-On 09/06/25, 7-3 shift, the oncoming nurse and off going failed to sign, and 3-11 shift, the oncoming and off going nurses failed to sign;-On 09/07/25, 7-3 shift, the oncoming nurse and off going failed to sign, and 3-11 shift, the oncoming and off going nurses failed to<br>(continued on next page) |

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| F 0755<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | sign;-09/08/25, 7-3 shift, the oncoming nurse and off going failed to sign, and 3-11 shift, the oncoming and off going nurses failed to sign;-On 09/09/25, 7-3 shift, the oncoming nurse and off going failed to sign, 3-11 shift, the oncoming and off going nurses failed to sign; and 11-7 shift, the oncoming nurse failed to sign.During interviews on 09/10/25, at 9:50 A.M. and at 10:50 A.M., RN C said the following:-At the beginning and end of each shift the oncoming and off going nurse or CMT should count all the controlled medications and both should sign the count sheet;-Some of the nurses were not signing the controlled medication count sheets at the change of shift.Observation on 09/10/25, at 9:50 A.M., of the A/B hall nurse cart narcotic book showed RN C showed the surveyor the A/B hall-controlled medication book which contained several blank spaces where nurses had failed to sign in September 2025 at the change of shift count.2.Review of the August 2025 C/D Nurse Controlled Drugs-Count Record showed staff failed to sign a reconciliation count completed on the following dates and times:-On 08/01/25, 11-7 shift, the off going nurse failed to sign, 3-11 shift, the oncoming and off going nurse failed to sign;-On 08/02/25, 3-11 shift, the oncoming and off going nurse failed to sign;-On 08/03/25, 3-11 shift, the oncoming and off going nurse failed to sign;-On 08/08/25, 3-11 shift, the oncoming and off going nurse failed to sign;-On 08/09/25, 3-11 shift, the oncoming and off going nurse failed to sign;-On 08/10/25, 3-11 shift, the oncoming and off going nurse failed to sign;-On 08/12/25, 3-11 shift, the oncoming and off going nurse failed to sign and the 11-7 oncoming nurse failed to sign;-On 08/13/25, 11-7 shift, the off going nurse failed to sign, 3-11 shift, the oncoming and off going nurse failed to sign and the 11-7 oncoming nurse failed to sign;-On 08/14/25, 11-7 shift, the off going nurse failed to sign, 3-11 shift, the oncoming and off going nurse failed to sign;-On 08/15/25, 3-11 shift, the oncoming and off going nurse failed to sign and the 11-7 oncoming nurse failed to sign;-On 08/16/25, 11-7 shift, the off going nurse failed to sign, 3-11 shift, the oncoming and off going nurse failed to sign;-On 08/17/25, 3-11 shift, the oncoming and off going nurse failed to sign;-On 08/18/25, 3-11 shift, the oncoming and off going nurse failed to sign and the 11-7 oncoming nurse failed to sign;-On 08/19/25, 11-7 shift, the off going nurse failed to sign, 3-11 shift, the oncoming and off going nurse failed to sign and the 11-7 oncoming nurse failed to sign;-On 08/20/25, 11-7 shift, the off going nurse failed to sign, 3-11 shift, the oncoming and off going nurse failed to sign and the 11-7 oncoming nurse failed to sign;-On 08/21/25, 11-7 shift, the off going nurse failed to sign, 3-11 shift, the oncoming and off going nurse failed to sign and the 11-7 oncoming nurse failed to sign;-On 08/22/25, 11-7 shift, the off going nurse failed to sign, 3-11 shift, the oncoming and off going nurse failed to sign and the 11-7 oncoming nurse failed to sign;-On 08/23/25, 11-7 shift, the off going nurse failed to sign, 3-11 shift, the oncoming and off going nurse failed to sign;-On 08/26/25, 7-3 shift, the oncoming and off going nurse failed to sign;-On 08/27/25, 7-3 shift, the oncoming and off going nurse failed to sign;-On 08/28/25, 7-3 shift, the oncoming and off going nurse failed to sign, and 3-11 shift, the oncoming and off going nurse failed to sign;-On 08/29/25, 3-11 shift, the oncoming and off going nurse failed to sign, and the 11-7 oncoming nurse failed to sign;-On 08/30/25, 11-7 shift, the off going nurse failed to sign, 3-11 shift, the oncoming and off going nurse failed to sign and the 11-7 oncoming nurse failed to sign;-On 08/31/25, 11-7 shift, the off going nurse failed to sign, 3-11 shift, the oncoming and off going nurse failed to sign.Review of the September 2025 C/D Nurse Controlled Drugs-Count Record showed staff failed to sign a reconciliation count completed on the following dates and times:-On 09/04/25, 11-7 shift, the off going nurse failed to sign, 3-11 shift, the oncoming and off going nurse failed to sign;-On 09/05/25, 3-11 shift, the off going nurse failed to sign, and the 11-7 oncoming nurse failed to sign;-On 09/06/25, 11-7 shift, the off going nurse, 3-11 shift, the oncoming and off going nurse failed to sign, and the 11-7 oncoming nurse failed to sign;-On 09/07/25, no nurses signed the count;-On 09/08/25, 11-7 shift, the off going nurse, 7-3 shift, the oncoming and off going nurse failed to sign, 3-11 shift, the oncoming and off going nurse failed to sign, and the 11-7 oncoming nurse failed to sign;-On 09/09/25, 3-11 shift, the oncoming and off going nurse failed to sign.During an interview on 09/10/25, at 10:00 A.M., LPN D said not all nurses were signing the C/D hall nurse cart narcotic book.Observation on 09/10/25, at 9:50 A.M., of the C/D hall nurse cart<br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 265473 | A. Building<br>B. Wing | 12/10/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Glendale Gardens Nursing & Rehab | 3535 East Cherokee<br>Springfield, MO 65809 |

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| F 0755<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | narcotic book showed RN C showed the surveyor the C/D hall-controlled medication book which contained several blank spaces where nurses had failed to sign in September 2025 at the change of shift count.3. During an interview on 09/10/25, at 4:38 P.M., LPN A said he/she sometimes forgot to sign the control count sheet at the beginning and end of each shift, but he/she did count the controlled medications.During an interview on 09/10/25, at 2:30 P.M., the Long-Term Care (LTC) Case Manager, a RN, said the off going and oncoming nurse or CMT should count all narcotics/controlled medications, and both staff should sign the narcotic count record.During an interview 09/10/25, at 10:10 A.M., the Director of Nursing (DON) said the following: -The oncoming and off going nurses should count and sign the controlled medication sheet and the change of each shift;-He/she thought the nurses were counting but were just forgetting to sign the sheet.During an interview on 09/10/25, at 5:42 P.M., the Administrator said the off going and oncoming nurses and/or CMTs should count all the controlled medications at the beginning and end of each shift, and both should sign the narcotic count record. |

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| F 0761<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.<br><br>Based on observation, interview, and record review, the facility failed to ensure all resident medications were secure, when a staff member failed to lock 1 of 7 carts containing resident medications while out of his/her line of sight. The facility census was 91.Review of the facility policy titled, Storage of Medication, undated showed the following:-All medications for residents must be stored at or near the nurses' station in a locked cabinet, a locked medicine room, or one or more locked mobile medication carts;-All mobile medication carts must be under visual control of the staff at all times when not stored safely and securely. Carts must be either in a locked room of otherwise made immobile;-All controlled substances must be stored under double lock and key;-An unattended medication cart must remain locked at all times. In the event the nurse is distracted from the task of passing medications by some unforeseen occurrence, the cart must be locked before leaving it or secured in a locked medication room.1. Observation on 09/05/25, at 9:04 A.M., of Certified Medication Technician (CMT) K showed the following:-CMT K stood at a medication cart preparing medications. The medication cart was located on the B resident hall, midway down the hall;-CMT K prepared a resident's medications while standing at the B hall medication cart;-The CMT placed the medications in a medicine cup-The CMT pressed in slightly on the medication cart lock. The lock was protruding approximately one inch from the front of the cart with a visible red dot on the side of the lock;-The CMT walked away from the cart, down the hall, and into a resident's room, out of sight line of the cart;-When the CMT returned to the medication cart, he/she pulled the lock out with his/her fingers, without the use of a key, and opened the cart drawers to prepare another resident's medications;-After preparing the medications and placing in a medication cup the CMT again pressed in slightly on the medication cart lock. The lock was protruding approximately one inch from the front of the cart with a visible red dot on the side of the lock;-The CMT walked away from the cart, down the hall, and into the resident's room, out of line of sight of the cart;-The CMT checked the resident's blood pressure and administered the resident medications and offered the resident a drink of water;-When the CMT returned to the cart, he/she pulled the lock with his/her fingers, without the use of a key and opened the cart drawers.During an interview on 09/05/25, at 9:15 A.M., CMT K said the following:-The B hall medication cart did not lock properly;-He/she did not compress the lock entirely, because sometimes the lock would stick and when that occurred, he/she was unable to access the resident medications;-He/she was able to access the medications without the use of a key, by pulling on the lock;-When he/she started working for the facility other CMTs told him/her not to lock the B hall medication cart due to the cart lock sticking.During an interview on 09/05/25, at 9:25 A.M., CMT L said the following:-If the B hall cart drawers were not lined up correctly, he/she was unable to push the cart lock in all the way;-He/she had not spoken to anyone about the issue;-He/she had a similar problem with the C Hall medication cart as it was hard for him/her to get the medication cart drawers shut and he/she had to ensure all the drawers were lined up in order to lock the car;-He/she did not leave the unlocked cart unattended.During an interview on 09/10/25, at 2:30 P.M., the Long-Term Care (LTC) Case Manager, a Registered Nurse (RN), said the nurse and/or CMT should keep the medication carts locked when not in use or if the cart was not in the staff member's direct line of sight.During an interview on 09/09/25, at 2:13 P.M., the Director of Nursing said the following:-He/she was not aware staff were leaving B hall medication cart unlocked or that the lock would stick;-If staff were going out of line of sight of the medication cart, then the cart needed to be fully locked where it required a key to access, and the narcotic drawer should be locked as well.During an interview on 09/10/25, at 5:42 P.M., the Administrator said nurses/CMTs should keep their medication cart locked if not in line of their sight. |

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| | 265473 | A. Building<br>B. Wing | 12/10/2025 |

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| Glendale Gardens Nursing & Rehab | 3535 East Cherokee<br>Springfield, MO 65809 |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.<br><br>Based on observation, interview, and record review, the facility failed to ensure food was stored in a manner to protect the food from possible contamination when staff failed to store food in sealed containers and failed to dispose of expired food items. The facility had a census of 91 residents.Review of the facility's policy titled, Safe Food Handling, dated April 2011, showed the following:-Food items are to be labeled and dated when removed from the freezer to be thawed;-No potentially hazardous food should be refrigerated over three days or per state regulation;-All food, including bulk items, should be tightly sealed with an identifying label and date. Review of the facility's policy titled, Receiving and Storage of Food, dated April 2011, showed the following:-The Dining Services Manager (DM) is responsible for receiving and storing food and nonfood items;-Follow the rule of First in, First Out.Review of the Missouri Food Code, published 2013, regarding refrigerator food storage, showed the following:-Refrigerated, ready-to-eat, potentially hazardous food, prepared and held in a food establishment for more than 24 hours shall be clearly marked to indicate the date or day by which the food shall be consumed on the premises, sold, or discarded when held at a temperature of forty-one degrees Fahrenheit (41F) or less for a maximum of seven days or when held at a temperature of forty-five degrees Fahrenheit (45 F) or less for a maximum of four days.-Refrigerated, ready-to-eat, potentially hazardous food, prepared and packaged by a food processing plant shall be clearly marked, at the time the original container is opened in a food establishment and if the food is held for more than 24 hours, to indicate the date or day by which the food shall be consumed on the premises, sold, or discarded, based on the temperature and time combinations specified:-The day the original container is opened in the food establishment shall be counted as day 1;-The day or date marked by the food establishment may not exceed a manufacturer's use-by-date if the manufacturer determined the use-by date based on food safety;-Food shall be protected from cross contamination by storing the food in packages, covered containers, or wrappings.1. Observation on 09/03/25, at 9:38 A.M., of the walk-in refrigerator in the kitchen showed the following:-Three slices of bread in a bag, twisted, and folded over with best by date 08/07/25;-An icing package, thawed, with directions that read to store at 0 degrees and thaw overnight in fridge. The package had no date noted;-Orange sauce in a reusable container, covered in saran wrap, with no label or date;-Chopped tomato and onion in a metal bowl covered with saran wrap with no date;-Ham in a metal pan, wrapped in saran wrap, dated 08/28 and use by 08/31.Observation on 09/05/25, at 12:00 P.M., of the double-door refrigerator in the kitchen showed the following:-Two open cartons of prune juice marked 06/17/25;-Four open cartons of grape juice, marked 08/12/25;-One cup of macaroni salad, covered in saran wrap, at back of fridge tilted over with no date. Observation on 09/05/25, at 12:09 A.M., of the walk-in refrigerator in the kitchen showed the following:-A brown liquid in a reusable container, covered in saran wrap, with no label or date;-Two plastic bins with raw chicken in plastic bags, on the bottom shelf, with no date;-Sliced cheese wrapped in saran wrap, dated 08/25, and use by 08/28;-Sliced cheese wrapped in saran wrap, dated 08/28 and use by 08/31;-Two 1 quart jugs of half and half creamer with expiration date 09/02/25.Observation on 09/09/25, at 10:44 A.M., of the activities area refrigerator showed the following:-On the outside of the refrigerator, signage indicated all items must be covered and labeled with name and date;-An open bottle of apple juice with no open date;-An open bottle of sparkling cider with no open date;-Ten individual servings of salad dressing with no label or open date;-An open bottle of mustard with expiration date of 01/01/25;-An open bag of flour, folded open, with no date;-An open large bottle of flavored creamer with no date.Observation on 09/10/25, at 1:00 P.M., of the double-door refrigerator in the kitchen showed the following:-An open container of cottage cheese with no open date;-Two open cartons of prune juice marked 06/17/25;-Three open cartons of grape juice, marked 08/12/25;-Two pitchers of an unknown liquid with no date;-One pitcher of lemonade<br>(continued on next page) |

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|---|---|---|---|
| | 265473 | A. Building<br>B. Wing | 12/10/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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|---|---|
| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | with no date;-Three pitchers of orange juice with no date;-Three pitchers of tea with no date;-An open carton of orange juice concentrate with no open date;-An open carton of cranberry juice marked 08/12/25.During an interview on 09/09/25, at 11:36 A.M., the Activities Director (AD) said the following:-The activity staff checked the refrigerator periodically for expired items;-Staff use the manufacturer expiration date on the item to determine which items need to be disposed of, not the date the item is opened;-The DM also checked the refrigerator and records the temperatures;-Only items used for resident use were stored in the refrigerator.During an interview on 09/10/25, at 1:09 P.M., the Dietary Aide (DA) H said the following:-Opened items need to be labeled with the date the item is opened and the dispose date;-Open items can be kept for five days;-Cooks check the refrigerators daily for expired items;-He/she was unsure who recorded refrigerator temperatures.During an interview on 09/10/25, at 1:14 P.M., Dietary Aide (DA) said the following:-Opened items are dated with the day open, and the dispose date which is three days out;-The DA's check the refrigerators in the kitchen daily for expired items, and the cooks oversee;-Any expired item is thrown out;-The refrigerators in the kitchen are temped daily;-DA I believed activity staff temps the refrigerator in the activities room. During an interview on 09/10/25, at 1:19 P.M., DA J said the following:-All open items are dated, and kept for three days;-The cooks clean out the refrigerator daily and throw out all expired items;-The refrigerators are checked daily;-Activity staff are responsible for cleaning out the refrigerator in the activity room, but the DM temps the refrigerator daily.During an interview on 09/10/25, at 1:30 P.M., the DM said the following:-All items placed in the refrigerators should be covered securely and dated;-Items should be marked with the open date, and a dispose date which is three days after the open date;-Dry goods should be dated;-The DM pulls expired items from the refrigerators in the kitchen on Monday, Tuesday, and Friday;-All open juices should be disposed of after three days;-Coffee and tea is made fresh every shift;-Items placed in the refrigerator to thaw are used within the week;-Activity staff is responsible for the refrigerator in the activity room;-Activity staff should be labeling all items, disposing of expired items and temping the refrigerator and logging the temp daily. During an interview on 09/10/25, at 5:43 P.M., the Administrator said the following:-The DM was responsible for overseeing food storage and disposal of expired food items;-The rules that applied to the refrigerators in the kitchen, should also apply to the refrigerator in the activity room;-The DM iwas responsible for checking the activity room refrigerator and temping it as required. |

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| | 265473 | A. Building<br>B. Wing | 12/10/2025 |

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|---|---|
| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide and implement an infection prevention and control program.<br><br>Based on record review and interview, the facility failed to implement a complaint infection prevention and control program when the home failed to have processes in place to ensure each resident was screened annually for tuberculosis when staff failed to screen four residents (Residents #1, #42, #22, and #30) and when the facility failed to review and update their infection prevention and control program policies and procedures manual annually as required. The facility census was 91. 1. Record review of the facility Infection Prevention and Control Policy (IPCP) manual showed the policy dates in the manual included 04/23/20, 08/11/20, 05/15/23, and 05/18/23. There was no documentation included in the manual showing staff reviewed and revised the manual on an annual basis.<br><br>During an interview on 09/10/25, at 10:45 A.M., the Registered Nurse/Quality Assurance Consultant said he/she was not aware of the infection control policies and procedures or the manual being reviewed or updated annually. He/she is not doing an annual review<br><br>During an interview on 09/10/25, at 10:40 A.M, the Director of Nursing (DON) said he/she does not do an annual review of the IPCP policies and procedures, but the Administrator may review it.<br><br>During an interview on 09/10/25, at 10:43 A.M, the Administrator said he/she does not do an annual review of the infection prevention and control policies and procedures.<br><br>2. Review of the facility's policy entitled Tuberculosis Control, undated, showed the following:-Annual skin tests for residents with documented results under 10 millimeters (mm) are not required, nor are annual chest x-rays for resident with documented skin test results greater than 10 mm;-Staff person must be constantly vigilant for signs and symptoms of TB in residents, and obtain a chest x-ray and sputum specimens should such signs and symptoms appear;-In addition, residents are to be evaluated, at least annually, to assure absence of signs and symptoms for TB disease.<br><br>3. Review of Resident #22's face sheet (gives basic profile information at a glance) showed the following:-admission date of 02/24/22;-Diagnoses included chronic obstructive pulmonary disease (COPD-a lung disease that causes airflow obstruction and breathing problems).<br><br>Review of the resident's preventative health records showed the following:-Annual TB screening form completed on 02/18/24 indicating no TB symptoms, no current/recent respiratory infection;-No annual TB screening form completed or documented for 2025.<br><br>During an interview on 09/10/25, at 4:56 P.M., the DON said the resident did not have documentation in his/her records regarding the annual TB screening form being completed in 2025.<br><br>4. Review of Resident #30's face sheet showed an admission date of 12/05/15.<br><br>Review of the resident's Physician's Order Sheet (POS), current as of 9/10/25, showed an order, dated 08/07/17, for permission to administer 2 step PPD upon admission and then TB screen annually.<br><br>Review of the resident's preventative care records showed the following:-TB screening form completed on 05/01/24, indicating no TB symptoms, no current/recent respiratory infection, no further action needed at this time;-No annual TB screening form completed or documented for 2025.<br>(continued on next page) |

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| | 265473 | A. Building<br>B. Wing | 12/10/2025 |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During an interview on 09/10/25, at 4:56 P.M., the DON said the resident did not have documentation in his/her records regarding the annual TB screening form being completed in 2025.<br><br>5. Review of Resident #1's face sheet showed an admission date of 06/12/22.<br><br>Review of the resident's POS, current as of 09/10/25, showed an order, dated 06/11/22, for permission to administer 2 step PPD (purified protein derivative, a substance used in a skin test to determine if a person has been infected with Mycobacterium tuberculosis, the bacteria that causes TB or resident to be screened annually for tuberculosis) upon admission and then TB screen annually.<br><br>Review of the resident's preventative health records showed staff did not document information pertaining to TB annual screening for 2023, 2024, and 2025.<br><br>During an interview on 09/11/25, at 4:56 P.M., the DON said the resident did not have documentation in his/her records regarding annual TB screenings being administered.<br><br>6. Review of Resident #42's face sheet showed admission date of 06/13/22.-Diagnoses included Huntington's disease, protein-calorie malnutrition, and anxiety.<br><br>Review of the resident's POS, current as of 9/10/25, showed an order, dated 06/13/22,<br><br>Review of the resident's preventative care records showed the following:-An annual screening was complete on 06/18/23;-Staff did not document information pertaining to TB annual screening for 2024 and 2025.<br><br>During an interview on 09/11/25, at 4:56 P.M., DON said the resident did not have documentation in his/her records regarding annual TB screenings being administered in 2024 or 2025.<br><br>7. During an interview on 09/10/25, at 4:38 P.M., Licensed Practical Nurse (LPN) A said the registered nurses (RN) complete the annual TB screening.<br><br>During an interview on 09/10/25, at 4:41 P.M., RN B said the following:-The RN on the floor completed the annual TB screening;-The Treatment Administration Record (TAR) alerts the RN that a screening is due.<br><br>During an interview on 09/10/25, at 4:56 P.M., the DON said the following:-All residents should have a physician's order for an annual TB screening;-Resident TB screenings are completed by an RN;-The TAR triggers nurses to conduct the screening. During an interview on 09/10/25, at 5:43, the Administrator said RN's are responsible for completing annual resident TB screenings. |

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| | 265473 | A. Building<br>B. Wing | 12/10/2025 |

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| F 0909<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Regularly inspect all bed frames, mattresses, and bed rails (if any) for safety; and all bed rails and mattresses must attach safely to the bed frame.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to have a process in place for periodic bed rail safety checks, to include measurements of the bed frame and bed rails for risk of entrapment, for seven residents (Residents #22, #30, #91, #1, #5, #8, and #21) out of a sample of 24 residents. The facility census was 91.Review of the facility policy, Bed Rails, undated, showed the following information:-Prior to use of bed rails the facility should complete the Bed Rail Observation including the following observation detail, clinical assessment, alternatives attempted prior to bed rail implementation, bed rail details, assessment of potential entrapment zones, review the risk and benefits with resident and resident representative, obtain informed consent with resident and/or resident representative signature, and obtain physician order for medical symptom assessed requiring bed rail use;-Develop a care plan that outlines the medical factors necessitating bed rails and an explanation of how the use of a bed rail is intended to treat the specific resident's condition;-Staff will conduct regular inspections of all bedframes, mattresses, and bed rails, to identify areas of possible entrapment.<br><br>Review of the Owner's Operator and Maintenance Manual for the IVC bed series, dated 2007, showed the following:-A process that requires ongoing patient evaluation and monitoring will result in optimizing bed safety;-Reassess the need for using bed rails on a frequent, regular basis.<br><br>1. Review of Resident #22's face sheet (gives basic profile information at a glance) showed the following:-admission date of 02/24/22;-Diagnoses included chronic obstructive pulmonary disease (COPD-a lung disease that causes airflow obstruction and breathing problems), chronic kidney disease (condition where the kidneys lose their ability to filter waste products from the blood), anxiety (mental health condition that causes excessive worry, fear, and nervousness), and depression (mental health condition that causes persistent feelings of sadness, loss of interest, and other symptoms that can significantly impact daily life).<br><br>Review showed a bed rail assessment and consent signed by the resident on 04/22/22.<br><br>Review of the resident's Physician Order Sheet (POS), current as of 09/10/25, showed an order, dated 11/11/22, for bilateral half side rails for repositioning and transfers.<br><br>Review of the resident's comprehensive Minimum Data Set (MDS - a federally mandated assessment instrument completed by facility staff), dated 06/05/25, showed the following:-Moderate cognitive impairment;-Substantial/maximal assistance for shower/bathing, lower body dressing, putting on and taking off footwear, rolling left and right, lying to sitting on side of bed, sit to stand, chair/bed-to-chair transfer, toilet transfer, and tub/shower transfer;-Partial/moderate assistance for upper body dressing, personal hygiene, and sit to lying.<br><br>Review of the resident's care plan, revised 06/23/25, showed the following:-Required one person assist for all activities of daily living (ADL – dressing, toileting, grooming, etc.) due to weakness and disease process;-Bilateral half side rails for repositioning and transfers.<br><br>Review of the resident and facility records showed staff did not provide documentation of periodic assessment and measurements of the rails to ensure they placed appropriately and were not loose.<br>(continued on next page) |

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| | 265473 | A. Building<br>B. Wing | 12/10/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Glendale Gardens Nursing & Rehab | 3535 East Cherokee<br>Springfield, MO 65809 |

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| F 0909<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Observation on 09/03/25, at 11:00 A.M., showed the following;-Bilateral half size side rails in the upright position on the resident's bed;-Right bed rail was loose to touch and wiggled from top to bottom with twice as much movement at the bottom of the rail near the middle of the bed compared to the movement at the top of the rail near the head of the bed.<br><br>Observation on 09/08/25, at 11:40 A.M., showed the right siderail loose. It moved top to bottom with it moving twice as much at the bottom of the rail near the middle of the bed compared to the movement at the top of the rail near the head of the bed. It also pushed all the way in to touch the mattress on the bed.<br><br>Observation on 09/09/25, at 11:22 A.M., showed the following:-Resident resting in bed awake;-Right side rail with a two to three inch gap moving away from mattress when touched;-Right side rail also with an approximate six inch back and forth, up and down play from the top of the rail (head of the bed) to the bottom of the rail (middle of the bed).<br><br>During an interview on 09/10/25, at 4:56 P.M., the Director of Nursing (DON) said the resident used the side rails to set on the side of the bed.<br><br>2. Review of Resident #30's face sheet showed the following:-admission date of 12/05/15;-Diagnoses included Down Syndrome (a genetic disorder that causes physical, ability to think and understand, and developmental disabilities), chronic kidney disease, anxiety, depression, and epilepsy (seizures).<br><br>Review showed a bed rail assessment and verbal consent was provided by the resident's power of attorney on 08/03/21 via telephone due to COVID-19.<br><br>Review of the resident's POS, current as of 09/10/25, showed an order, dated 11/11/22, for half side rails for purpose of assisting with repositioning/transferring.<br><br>Review of the resident's comprehensive MDS, dated [DATE], showed the following:-Severe cognitive impairment;-Substantial/maximal assistance for toileting hygiene, upper body dressing, personal hygiene, sit to lying, and lying to sitting on side of bed;-Dependent for lower body dressing, putting on and taking off footwear, chair/bed-to-chair transfer, tub/shower transfer;-Partial/moderate assistance for rolling left and right.<br><br>Review of the resident's care plan, revised 06/24/25, showed the following:-Required one or two persons assist for all ADLs due to weakness and disease process;-Half side rails for purpose of assisting with repositioning and transfers;-During seizure activity, ensure that the head is protected to prevent injury and do not attempt to restrain the resident;-If the seizure occurs in bed remove all pillows and ensure the side rails are raised bilaterally.<br><br>Review of the resident and facility records showed staff did not provide documentation of periodic assessment and measurements of the rails to ensure they placed appropriately and were not loose.<br><br>Observation on 09/08/25, at 10:14 A.M., showed staff provided peri care to the resident. The resident unable to assist staff with rolling in bed.<br><br>Observation on 09/09/25, at 11:16 A.M., showed the resident's left bed rail had an approximate four-inch gap at the bottom side of the rail (middle of the bed) that moved back and forth from the rail to the mattress. The left bed rail also moved approximately two to three inches up and down<br>(continued on next page) |

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| F 0909<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | lengthwise to the bed.<br><br>During an interview on 09/09/25, at 10:51 A.M., Certified Nurse Aide (CAN) N said the following:-The resident was not able to use his/her side rails;-The resident was moving a lot a few years back, but he/she cannot pull himself/herself to his/her side by himself/herself anymore;-He/she thought the facility kept the bed rails on the resident's bed for the safety of rolling the resident during care.<br><br>During an interview on 09/09/25, at 1:42 P.M., the Long-Term Care Case Manager (LTC CM) said he/she thought the resident had his/her bed rails for comfort and repositioning in bed when being changed. During an interview on 09/10/25, at 4:56 P.M., the Director of Nursing (DON) said the resident used the bed rails to hold on to when staff changed him/her. He/she thought the resident could move his/her arms and hands and hold on to the rail.<br><br>3. Review of Resident #91's face sheet showed the following:-admission date of 05/24/21;-Diagnoses included Alzheimer's disease (progressive brain disorder that causes memory loss, confusion, and cognitive decline) and anxiety.<br><br>Review showed a bed rail assessment and consent signed by the resident on 08/06/21.<br><br>Review of the resident's (POS, current as of 09/10/25, showed an order, dated 11/11/22, for half side rails bilaterally for purpose of assisting with repositioning/transferring.<br><br>Review of the resident's comprehensive MDS, dated [DATE], showed the following:-Moderate cognitive impairment;-Substantial/maximal assistance for toileting hygiene, shower/bathing, lower body dressing, putting on and taking off footwear, going from sit to stand, chair/bed-to/chair transfer, tub/shower transfer, and toilet transfer;-Partial/moderated assistance for upper body dressing, personal hygiene, sit to lying, and lying to sitting on the side of the bed;-Supervision or touching assistance for rolling left and right.<br><br>Review of the resident's care plan, dated 08/02/21, showed the following:-Required one to two persons assist for all ADLs due to weakness and disease process;-Half side rails bilaterally for turning, repositioning, and transferring.<br><br>Review of the resident and facility records showed staff did not provide documentation of periodic assessment and measurements of the rails to ensure they placed appropriately and were not loose.<br><br>During an observation and interview on 09/03/25, at 10:00 A.M., the resident said the right bed rail was loose and had been loose for three to four months. He/she told staff the bed rail is loose. He/she did not feel like the bed rail is safe for him/her to use. Observations showed the right bed rail wiggled up and down from the top of the rail (head of the bed) to the bottom of the rail (middle of the bed).<br><br>During an interview and observation on 09/9/25, at 11:22 A.M., the resident said the following:-His/her right bed rail fell to the floor yesterday and he/she was glad his/her hand was not in it because he/she felt like he/she would have been injured;-The resident's right bed rail had approximately a five-inch movement back and forth from the top of the rail (at the head of the bed) to the bottom of the rail (at the middle of the bed).<br><br>During an interview on 09/10/25, at 10:51 A.M., CNA N said the resident used his/her bed rails for rolling.<br>(continued on next page) |

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| F 0909<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During an interview on 09/10/25, at 4:56 P.M., the DON said the resident can hold on to the rail and position himself/herself in bed.<br><br>4. Review of Resident #1's face sheet showed the following:-admission date of 06/12/22;-Diagnoses included senile degeneration of the brain and anxiety.<br><br>Review showed a bed rail assessment and consent signed by the resident on 06/22/22.<br><br>Review of the resident's POS, current as of 09/10/25, showed an order, dated 11/14/22, for bilateral half side rails for transfers and repositioning.<br><br>Review of the resident's comprehensive MDS, dated [DATE], showed the following:-Cognitively impaired;-Substantial/maximal assistance with toileting;-Substantial/maximal assistance with personal hygiene;-Substantial/maximal assistance with lying to sitting;-Dependent with bed to chair transfer.<br><br>Review of the resident's care plan, dated 07/07/25, showed the following:-Required one person assist for all ADLs due to weakness and disease process;-Half bilateral side rails for transfers and repositioning.<br><br>Review of the resident and facility records showed staff did not provide documentation of periodic assessment and measurements of the rails to ensure they placed appropriately and were not loose.<br><br>Observation on 09/05/25, at 10:36 A.M. showed the following;-Bilateral half size side rails in the upright position;-Resident in bed with hand gripped on rail and rail leaning over at approximately 120 degrees.<br><br>Observation on 09/09/25, at 10:18 A.M., showed the following:-Resident rested in bed with eyes closed;-Both side rails loose to the touch.<br><br>During an interview on 09/10/25, at 4:56 P.M., the DON said the resident had used to use the rail to assist with getting up.<br><br>5. Review of Resident #5's face sheet, showed the following:-readmit date of 12/31/24;-Diagnoses included dementia without behavioral disturbance, major depressive disorder, and anxiety disorder.<br><br>Review showed a bed rail assessment and consent signed by the resident on 10/27/23.<br><br>Review of the resident's POS, current as of 09/10/25, showed and order, dated 01/26/24, for half side rails bilaterally for assistance with bed mobility and transfers.<br><br>Review of the resident's quarterly MDS, dated [DATE], shows the following:-Cognitively impaired;-Dependent with toileting;- Substantial/maximal assistance with personal hygiene;- Dependent with lying to sitting;-Dependent with bed to chair transfer.<br><br>Review of the resident's care plan, dated 06/23/25, showed the following:-Resident required assist of one to two staff for all ADLs due to weakness and lack of mobility;-Resident would like half side rails bilaterally for purpose of assistance with bed mobility and transfers.<br>(continued on next page) |

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| F 0909<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Review of the resident and facility records showed staff did not provide documentation of periodic assessment and measurements of the rails to ensure they placed appropriately and were not loose.<br><br>6. Review of Resident #8's face sheet showed the following information:-readmission date of 08/21/22;-Diagnoses included coagulation defect (impairment to body's ability to form blood clots), major depression disorder, and anxiety.<br><br>Review showed a bed rail assessment and consent completed on 11/07/23 and signed by the resident on 12/24/24.<br><br>Review of the resident's POS, current as of 09/10/25, showed and order, dated 11/07/23, for half side rails right and left for purpose of bed mobility per resident request.<br><br>Review of the resident's quarterly MDS, dated [DATE], showed the following:- Cognitively intact;-Substantial/maximal assistance with toileting;- Partial/moderate assistance with personal hygiene;-Partial/moderate assistance with lying to sitting;-Dependent with bed to chair transfer.<br><br>Review of the resident's care plan, dated 08/07/25, showed the following:-Resident required assist of one to two staff for all ADL due to weakness and disease process;-Resident required bilateral half rails for purpose of assistance with bed mobility.<br><br>Review of the resident and facility records showed staff did not provide documentation of periodic assessment and measurements of the rails to ensure they placed appropriately and were not loose.<br><br>Observation and interview with resident on 09/09/25, at 10:19 A.M., showed the following:-Both side rails loose to the touch;-Resident used the rails to assist with positioning.<br><br>7. Record review of Resident #21's face sheet showed the following information:-readmit date of 11/26/24;-Diagnoses include cerebral infarction due to occlusion or stenosis of small artery (a stroke caused by a blockage or narrowing of a small blood vessel in the brain), amputation, hemiplegia (paralysis to one side of the body), and seizures.<br><br>Review showed a bed rail assessment and consent completed on 08/27/21 and signed by the resident representative on 08/30/21.<br><br>Review of the resident's POS, current as of 09/10/25, showed and order, dated 04/02/25, for half side rails bilaterally for assistance with bed mobility and transfers.<br><br>Review of the resident's care plan, dated 07/30/25, showed the following:-Resident has potential for seizure activity;-If the seizure occurred in bed remove all pillows and ensure the side rails are raised bilaterally.<br><br>Review of the resident's comprehensive MDS, dated [DATE], showed the following:-Cognitively impaired;-Dependent with toileting;-Dependent with personal hygiene;-Dependent with lying to sitting;-Dependent with bed to chair transfer.<br><br>Review of the resident and facility records showed staff did not provide documentation of periodic assessment and measurements of the rails to ensure they placed appropriately and were not loose.<br>(continued on next page) |

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| F 0909<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Observation on 09/09/25, at 10:16 A.M., showed the following:-Resident resting in bed;-Both rails secure to the touch.<br><br>During an interview on 9/09/25, at 10:16 A.M., Nursing Assistant (NA) E said the resident did not use the bed rails for positioning, as they are in place for safety if the resident has seizure.<br><br>During an interview on 09/09/25, at 1:42 P.M., LTC CM said he/she believed the resident had bed rails to prevent the resident from falling out of bed while being changed.<br><br>During an interview on 09/10/25, at 4:56 P.M., the DON said the resident can use his/her rail with his/her one arm.<br><br>8. During an interview on 09/09/25. at 10:31 A.M., CNA M said the following:-He/she was not aware of any bed rails being loose;-If he/she was aware of a loose bed rail he/she would verbally notify the charge nurse and the maintenance staff;-If the maintenance department determined that a bed rail needed to be replaced, they would fill out a form and provide it to the nurse for notification that the bed rail was looked at. The nurse gives the notification to the DON or Assistant Director of Nursing (ADON), so they will know to order a new bed rail;-Bed rail assessments are completed one time per week, but he/she did not know who was responsible for completing them;-The older black bed rails like to come loose;-The main maintenance staff who does the work inside the facility does the maintenance on the bed rails;-He/she was unsure what the facility policy or process is for checking bed rails was since maintenance staff was responsible for that;-When bed rails are loose, it scares the residents.<br><br>During an interview on 09/09/25, at 10:51 A.M., CNA N said the following:-He/she was not aware of any bed rails being loose;-If he/she was aware of a loose bed rail, he/she would notify the maintenance staff or the housekeeping supervisor;-The nurses and therapy department check bed rails, but he/she was not sure how often. They check for loose and broken rails and to see if they move up and down;-He/she was unsure what the facility policy or process is for checking bed rails since maintenance staff is responsible for that.<br><br>During an interview on 09/10/25, at 8:56 A.M., Registered Nurse (RN) C said the following:-He/she was not aware of any loose bed rails;-Staff can notify the charge nurse or maintenance if they observe a loose bed rail;-He/she was unsure if a protocol is in place to regularly check the bed rails for safety issues.<br><br>During an interview on 09/09/25, at 1:42 P.M., LTC CM said the following: -He/she reviewed the bed rail assessment with the resident and the family;-Maintenance provided the measurement numbers to LTC CM to enter into the form;-LTC CM obtained the order from the physician and added the information to the care plan;-LTC CM is not aware of any procedures in place to regularly check the rails.<br><br>During an interview on 09/09/25, at 1:56 P.M., the Maintenance Worker (MW) said the following:-The LTC CM notified him/her which residents need a bed rail;-Measurements are obtained during installation, and he/she provided the measurements to the LTC CM;-Staff will verbally notify MW if a resident has a loose rail;-MW regularly tightens bed rails as they often come loose from residents pulling on the rails;-MW does not document which rails he/she tightens;-There is no regular assessment or maintenance schedule.<br>(continued on next page) |

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| F 0909<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During an interview on 09/10/25, at 4:56 P.M., the DON said the following:-The side rail assessment was only completed once;-The LTC CM completed the side rail assessment with the resident and/or family;-Maintenance took measurements and installed the side rails;-Staff should try to tighten loose side rails or notify maintenance;-Maintenance checks side rails weekly.<br><br>During an interview on 09/10/25, at 5:43 P.M., the Administrator said the following:-He/she was not aware of any additional assessments after the initial assessment is complete;-Maintenance checks the rails once a week;-He/she was unsure if the maintenance checks are documented;-Staff notify maintenance if a side rail is loose. |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate treatment and care according to orders, resident?s preferences and goals.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide care per standards of practice and care plan when staff failed to complete accurate and timely skin assessment for two residents (Resident #27 and #23) with identified skin concerns and skin treatments in place. The facility census was 91. Review of facility policy titled, Wound Care and Treatment, undated, showed the following:-It is the purpose of the facility to prevent and treat all wounds;-On-going skin assessment with weekly documentation of status.<br><br>Review showed the facility did not provide a policy regarding skin assessments.<br><br>1. Review of Resident #27's face sheet (give basic profile information at a glance) showed the following information:-admission date of 03/25/25;-Diagnoses included dementia (progressive decline in memory, thinking, reasoning, and judgment), spondylolisthesis (a condition where one bone in the spine slips forward over the bone below it) anxiety (mental health condition that causes excessive worry, fear, and nervousness), type 2 diabetes mellitus (the body does not use insulin effectively or does not produce enough insulin to regulate blood sugar levels), hypertension (high blood pressure), heart failure, chronic kidney disease, and cellulitis, unspecified (a bacterial skin infection that affects the deeper layers of the skin).<br><br>Review of the resident's care plan, dated 03/31/25, showed the following:-Skin will remain intact;-Assess for presence of risk factors and treat, reduce, eliminate risk factors to extent possible;-Report any signs of skin breakdown (sore, tender, read, or broken areas).<br><br>Review of the resident's quarterly Minimum Data Set (MDS - a federally mandated assessment instrument completed by facility staff), dated 07/01/25, showed the following information:-Resident was cognitively intact;-Application of ointments/medications other than to feet.<br><br>Review of the resident's progress note, dated 07/01/25, showed the following:-Resident bilateral (both sides) lower extremities weeping (with drainage) slightly, showered self in personal shower and re-wrapped bilateral lower extremities and placed tubi-grips (compression bandage) on;-Staff notified provider of weeping;-No new orders at this time.<br><br>Review of the resident's progress note, dated 07/02/25, showed the following:-A few scratches on outer right forearm;-Tubi-grip change on right lower leg due to weeping clear fluid;-Encouraged to get legs elevated.<br><br>Review of the resident's progress note, dated 07/03/25, showed the following:-New order for tubi-grips to remain on in A.M. and off in P.M.;-May have gauze to bilateral lower extremities as needed if has weeping edema (swelling).<br><br>Review of the resident's Physician Order Sheet (POS), current as of 09/10/25, showed an order, dated 07/03/25, for may have gauze to bilateral lower extremities as needed if resident has weeping edema.<br><br>Review of resident's July 2025 Weekly Skin Assessments showed a skin assessment, dated 07/04/25, showed staff noted skin intact (excluding feet), with no interventions or treatments. (Staff did not document regarding the bilateral lower extremity weeping or dressing ordered.)<br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Review of resident's July 2025 Weekly Skin Assessments, dated 07/11/25, showed staff noted skin intact (excluding feet), with no interventions and treatments in place. (Staff did not document regarding the bilateral lower extremity weeping or dressing ordered.)<br><br>Review of the resident's progress note's, dated 07/13/25, showed the following:-Observed resident's bilateral lower extremities which are swollen and red;-The left leg is weeping yellow fluid;-The left leg also has an open area where resident scraped on something in his/her room. It is on the anterior (front) shin, raw, and larger than a quarter;-Resident was using soaker pads to wrap the left leg every two hours and he/she has filled a white large trash sack half full of soaker pads used during this night;-Resident is on torsemide (a medication used to remove excess water and salt from the body) 3 time a week for a week and then daily, 10 milligrams (mg);-Resident has some clear liquid weeping from right upper leg and left lower leg;-Placed absorbent bandage and wrapped in kerlix (stretch, self-adhesive bandage);-Resident has bed pad wrapped around his/her leg;-Kerlix has held up this shift;-Resident continuously weeping to bilateral lower extremities;-Staff called nurse practitioner to update.<br><br>Review of the resident's Physician Order Sheet (POS), current as of 09/10/25, showed, showed the following: -An order, dated 07/15/25, to check resident room for extra wound supply and check resident for putting his/her own dressing on twice daily for safety measures;-An order, dated 07/15/25, for treatment order for left inner thigh, to cover with band aid and piece of gauze two times per day and as needed for weeping;-An order, dated 07/15/25, for treatment order for right ankle band aid and piece of gauze two times per day and as needed;-Order, dated 07/15/25, for treatment order for left shin apply two ABD pads (highly absorbent wound dressing) ace wrap lightly.<br><br>Review of the resident's July 2025 Weekly Skin Assessments showed an assessment, dated 07/18/25. Staff noted skin intact (excluding feet), no interventions and treatments. (Staff did not document regarding the bilateral lower extremity weeping or dressing ordered.)<br><br>Review of the resident's progress notes, dated 07/21/25 and 07/23/25, showed the resident continued antibiotic for legs with no adverse effects.<br><br>Review of the resident's progress note, dated 07/24/25, showed the following:-No adverse reaction from antibiotic/lower legs;-Leg is wrapped and resident refused to let nurse do anything with it.<br><br>Review of the resident's progress note, dated 07/26/25, showed the following:-Treatments completed;-Resident did have blister on right lower inner calf;-Area on left shin open;-Excess treatment supplies removed from room.<br><br>Review of the resident's POS, current as of 09/10/25, showed a new order, dated 07/26/25, for treatment order for left inner thigh, to cover with band aid and piece of gauze two times per day and as needed for weeping.<br><br>Review of the resident's progress note, dated 07/29/25, showed the following:-Resident alerted this nurse to having what he/she described as a blister to his/her inner right calf/ankle area;-Resident stated that he/she had already cleansed and bandaged the area;-Area noted to be wrapped with washcloth and tape securing with writing on tape describing wound;-This nurse removed resident's bandage and observed an area that was approximately the size of a half dollar with no skin intact and scant sanguineous (containing blood) drainage noted;-New order placed for daily treatment;-Healthcare provider registered nurse (RN) in facility and will be updated.<br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 265473 | A. Building<br>B. Wing | 12/10/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Glendale Gardens Nursing & Rehab | 3535 East Cherokee<br>Springfield, MO 65809 |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Review of the resident's POS, current as of 09/10/25, showed, showed an order, dated 07/29/25, to cleanse area to right inner ankle/calf with wound cleanser, pat dry, apply xeroform (specialized dressing) and cover with gauze, wrap with ace wrap daily, and as needed until resolved.<br><br>Review of the resident's July 2025 Weekly Skin Assessments showed staff did not document complete skin assessment completed between 07/19/25 and 07/31/25.<br><br>Review of the resident's August 2025 Weekly Skin Assessments showed the following:-On 08/01/25, staff completed a skin assessment. Staff noted skin intact (excluding feet), with no interventions and no treatments. (Staff did not address the current identified areas and current ordered treatments.);-On 08/08/25, staff completed a skin assessment. Staff noted skin intact (excluding feet), with no interventions and not. (Staff did not address the current identified areas and current ordered treatments.);On 08/15/25, staff completed a skin assessment. Staff noted skin intact (excluding feet) with no interventions and no treatments. (Staff did not address the current identified areas and current ordered treatments.) Review of the resident's progress note, dated 08/19/25, showed the following:-Resident approached this nurse this A.M. requesting that her wraps be cut off to shower;-Bilateral lower extremities noted to be wrapped tightly with kerlix and wrapped with paper tape;-This nurse noted edema proximal and distal to wraps. Resident stated, yea, that's my fault indicating that she wrapped her legs. Tubi-grips noted to be off at that time too;-Education provided as to not be doing the treatment him/herself and to allow nursing staff to do treatments;-Asked where supplies were coming from, resident acknowledged and shrugged his/her shoulders;-This nurse informed resident of needing to perform bilateral lower extremity treatment.<br><br>Review of weekly skin assessments for August 2025 showed the following:-On 08/22/25, staff completed a skin assessment. Staff noted skin intact (excluding feet), with no interventions and no treatments. (Staff did not address the current identified areas and current ordered treatments.);-On 08/29/25, staff completed a skin assessment. Staff noted skin intact (excluding feet), with no interventions and no treatments. (Staff did not address the current identified areas and current ordered treatments.)<br><br>Review of the resident's September 2025 Weekly Skin Assessments for September 2025 showed the skin assessment dated [DATE] was still pending on 09/10/25.<br><br>Review of the resident's progress note, dated 09/09/25, showed the following:-Completed daily dressing change to bilateral lower extremities;-On the left lower leg noted three to four areas that are seeping with clear liquid, about 0.1centimeter (cm) x 0.1 cm size and on the right three areas about 0.1 cm x 0.1 cm with one of them noted brown color scab over no drainage;-Tolerated procedure well and was very cooperative during procedure.<br><br>During an interview on 09/09/25, at 2:52 P.M., the resident said the following:-He/she has had fluid leaking from both lower extremities since March 2025;-The leaking is not any better or worse;-The black scabbed area was a new because it was not there during the dressing change on 09/08/25.<br><br>During an interview on 09/09/25, at 10:11 A.M., Licensed Practical Nurse (LPN) D said the following:-The resident came to the facility with his/her leg wounds;-The resident had an order to make sure no dressing supplies were left in his/her room. He/she was not sure who was bring the dressing supplies to the resident;-The resident had taken off some of the dressing that staff apply.<br><br>During an interview on 09/09/25, at 2:52 P.M., LPN P said the following:-The resident's left lower (continued on next page) |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | extremity oozed more than the right lower extremity;-The oozing was on and off. 2. Review of Resident #23's face sheet showed the following information:-readmission date of 11/26/24;-Diagnoses include cerebral infarction due to occlusion or stenosis of small artery (a stroke caused by a blockage or narrowing of a small blood vessel in the brain), amputation, hemiplegia (paralysis to one side of the body), type II diabetes, and seizures.<br><br>Review of the resident's care plan, dated 06/12/25, showed the following:-Resident at risk for alteration in skin integrity due to decreased mobility and incontinence issues;-Report any signs of skin breakdown (sore, tender, read, or broken areas).<br><br>Review of the resident's quarterly MDS, dated [DATE], showed the following information:-At risk of developing pressure ulcers;-Applications of ointments/medications other than to feet.<br><br>Review of the resident's POS, current as of 09/10/25, showed, showed an order, dated 08/15/25, to cleanse area to right shoulder with wound cleanser, pat try, cover with TAO (antibacterial ointment) and telfa (non-stick bandage), secure with tape QOD (every other day).<br><br>Review of the resident's progress notes, dated 08/23/25, showed the following:-While performing treatment order to cleanse resident's right shoulder, purulent drainage (a thick, cloudy, and often foul-smelling fluid that can exude from an infected wound) noted with some redness around wound;-Slightly warm to touch;-Physician contacted and new orders received<br><br>Review of the resident's POS, current as of 09/10/25, showed the following:-An order, dated 08/23/25, for amoxicillin (antibiotic), 1 tablet, 500 milligrams, for diagnosis rash and other nonspecific skin eruption;-An order, dated 08/24/25, to cleanse area to right shoulder with would cleanser, pat dry cover with Bactroban (topical antibiotic) and telfa, secure with tape, daily.<br><br>Review of the resident's medical record showed staff did not document routine skin assessments for the resident for August 2025.<br><br>Review of the resident's progress notes, dated 09/02/25, showed the following:-Right shoulder had wound measuring 1.2cm x 1.5cm with serous drainage (a clear, watery fluid) noted with some erythema (reddening of the skin) around wound;-Completed amoxicillin for possible wound infection;-Continue treatment order daily.<br><br>Review of the resident's POS, current as of 09/10/25, showed an order, dated 09/09/25, to cleanse area to right shoulder with wound cleanser, pat dry, cover with Bactroban and cover with a band-aid daily.<br><br>Review of the resident's medical record showed staff did not document routine skin assessments for the resident the week of 09/01/25 to 09/07/25.<br><br>2. During an interview on 09/09/25, at 11:13 A.M., Nursing Assistant (NA) E said the following:-Nurses conduct weekly skin assessments;-NA E was unsure where the skin assessment is documented.<br><br>During an interview on 09/09/25, at 11:19 A.M., Certified Nursing Assistant (CNA) F said the following:-CNA F believed nurses conducted resident skin assessments;-He/she did not know the frequency of the assessments.<br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an interview on 09/10/25. at 10:14 A.M., Licensed Practical Nurse (LPN) D said the following:-When he/she was the only nurse assigned to the C/D side, he/she had to oversee approximately 58 residents and was not always able to complete the assigned skin assessments;-The facility had a skin assessment form;-He/she told the Director of Nursing (DON) in the past, when he/she was not able to complete all the assigned resident skin assessments.<br><br>During an interview on 09/10/25, at 8:56 A.M., Registered Nurse (RN) C said the following;-Nurses conduct weekly skin assessments on all residents;-The skin assessments should be documented in the electronic record.<br><br>During an interview on 09/09/25, at 1:42 P.M., the Long-Term Care Case Manager (LTC CM) said the following:-Hall nurses conduct weekly skin assessments of residents;-The computer notifies the nurses when to conduct the weekly assessments.<br><br>During an interview on 09/09/25 at 2:13 P.M., the Director of Nursing (DON) said the following:-Nurses were doing the resident weekly skin assessment and the wound treatments;-The nurses should initial completion of each resident's weekly skin assessments form on the treatment administration record (TAR);-At times, the nurse on duty might get busy and miss a week of completing resident skin assessments.<br><br>During an interview on 09/10/25, at 4:56 P.M., the DON said the following:-Nurses should be completing skin assessments weekly;-The TAR should prompt the nurses to complete the assessment;-A skin assessment form in the electronic chart should be completed;-Skin assessments might not be complete on busier days;-An audit of skin assessments has not been complete in two months.<br><br>During an interview on 09/10/25, at 5:43 P.M., the Administrator said nurses should be conducting weekly skin assessments on all residents and documenting their findings. |