STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265501	A. Building B. Wing	02/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Odessa Health Care Center	609 Golf Street Odessa, MO 64076

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation and interview the facility failed to ensure the kitchen equipment was kept clean for storage and cooking of food. This deficient practice potentially affected everyone who ate out of the kitchen. The facility census was 60 residents. 1. Observation on 1/28/226 at 8:59 A.M. of the kitchen showed:-The convection oven had grease build up on the inside windows and lip below the food racks.-The floor of the oven had raised burnt food debris at the base. -There was a greasy film on the outside of the oven.-The stove had a greasy film and debris on the knobs, front panel, oven handle and platform (on top of the stove).-Refrigerator #1 had a sticky, dried, orange spill on the floor of the refrigerator with food spillage and crumbs.-Refrigerator #3 had fruits and vegetables inside. The floor of the refrigerator had a white spillage and other food crumbs and debris.-The vents on the outside of the refrigerators had a buildup of grease and debris.-At the two-compartment sink, on the counter there was a silver pan with two packages of meat thawing in a pan of water. It was in the sink with cold water running over it to thaw. -In the dry storage room there was a large package of corn starch that was opened and there was white powdery spill on the floor beneath the package.During an interview on 1/28/26 at 9:16 A.M., [NAME] A said:-The night cook was supposed to take the meat out of the freezer and put it in the refrigerator so it would be thawed by the time he/she was to prepare it today, but no one had taken the meat out.-This morning, he/she took the meat out of the freezer and put it in the pan for it to thaw. -This was the only way to thaw the meat before preparing it for lunch. -It had been in the water since he/she came in and it was almost completely thawed but not quite. -He/She was going to begin cooking it after he/she completed cleaning the dishes and steam table.-Cook A left the meat in the pan of water and did not put it under cool running water to finish thawing.During an observation and interview on 1/28/26 at 9:24 A.M., the Dietary Manager looked at the two packages of meat that were still in a pan of water on top of the counter by the sink. The Dietary Manager said:-They should thaw frozen meat under running water until they were ready to use it. [NAME] A came over and said he/she initially was thawing the meat under water then he/she turned the water off and left it in the pan, when he/she went on break.-The convection oven was cleaned monthly he/she looked at the debris and said the night cook was also supposed to clean it at least weekly, so the ovens should be cleaned a couple times per month at least. -The staff could wipe down the greasy debris on the handles and knobs, and platform on the stove and oven. -When he/she looked inside refrigerators #1 and #3 and he/she saw the orange spill, he/she said and it was an orange beverage that was spilled and dried in the refrigerator. He/She had seen it there but forgot to clean it up. -There should not be any dried spills or debris in the inside of the refrigerators and they should be cleaned daily. -The grime and debris on the outside vents of the refrigerators should be cleaned daily. -The corn starch should be sealed and the spill cleaned up off the floor. -He/She would begin cleaning and correcting these areas immediately.

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure handwashing was completed to prevent cross contamination during tracheostomy (a surgical procedure that creates an opening, or stoma, through the neck into the trachea (windpipe) care and failed to use enhanced barrier precautions (EBP- an infection control intervention in nursing homes and skilled nursing facilities that mandate the use of gowns and gloves during high-contact resident care activities) when providing care for one sampled resident (Resident #4), out of 15 sampled residents; and the facility failed to provide and ensure accurate documentation of tuberculosis (TB a communicable disease that affects especially the lungs, that is characterized by fever, cough, difficulty in breathing, abnormal lung tissue and function) testing for two sampled residents (Resident #46 and #51) out of five residents sampled for immunizations. The facility census was 60 residents. Review of the facility's Infection Control policy and procedure dated 5/7/24, showed:-This facility has established and maintains an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections as per accepted national standards and guidelines.-All staff shall assume that all residents are potentially infected or colonized with an organism that could be transmitted while providing resident care services.-Hand hygiene shall be performed in accordance with our facility's established hand hygiene procedures. -All staff shall use personal protective equipment (PPE- refers to protective clothing, helmets, goggles, masks, or other gear designed to protect the wearer's body from injury, infection, or occupational hazards) according to established facility policy governing the use of PPE. Review of the facility Hand Hygiene policy and procedure dated 6/26/24, showed:-All staff will perform proper hand hygiene procedures to prevent the spread of infection to other personnel, residents and visitors.-The use of gloves does not replace hand hygiene. If your task requires gloves, perform hand hygiene prior to donning (to put on) gloves, and immediately after removing gloves.-Hand hygiene is to be performed between resident contacts, after handling contaminated objects, before performing invasive procedures, before applying and after removing personal protective equipment (PPE), including gloves, before and after handling clean or soiled dressings, linens, etc., before performing resident care procedures, after handling items potentially contaminated with blood, body fluids, secretions, or excretions, when, during resident care, moving from a contaminated body site to a clean body site, after assistance with personal body functions (e.g., elimination, hair grooming, smoking). Review of the facility's Tuberculosis Testing policy dated 6/29/23 showed:-The purpose of TB testing is to ensure each resident and employee of the facility is tested for TB after entering the facility to prevent the spread of infection.-Upon admission and readmission, each resident will receive a 2 step PPD (or Mantoux test) screens for latent tuberculosis by injecting a small amount of purified protein derivative under the forearm skin) skin test as ordered by the physician. Each resident will also have an annual 1 step TB test as ordered by the physician to ensure that any possible infections can be triggered proactively to prevent further spread. If the resident has not been hospitalized for the year, they will receive a signs and symptoms checklist to monitor for communicable diseases.-All TB tests and chest x-ray records will be kept on file in the according areas (employee files and resident records). 1. Review of Resident #4's Face Sheet showed the resident was admitted to the facility with (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	diagnoses that included:-Heart failure.-High blood pressure.-Traumatic brain injury (a disruption in normal brain function caused by an external mechanical force, such as a bump, blow, or jolt to the head, or a penetrating injury).-Respiratory failure. Review of the resident's Care Plan dated 10/31/25, showed the resident was at risk for impaired airway clearance and respiratory compromise related to recent tracheostomy decannulation (removal of the tubing). Interventions showed staff would: -Evaluate the resident for cough, shortness of breath, lung sounds and pulse oximetry (a test used to measure the percentage of oxygen saturation in the blood).-Monitor for changes in respiratory rate or shallow breathing. Review of the resident's Nursing Note dated 12/3/25, showed:-The resident had a diagnosis of Chronic Obstructive Pulmonary Disease (COPD a progressive disease that is characterized by shortness of breath and difficulty breathing) and required the use of an inhaler (a portable device for administering a drug which is to be breathed in) as needed and elevation of his/her head of bed to help prevent/alleviate episodes of shortness of air. -The resident continued to require cleansing of his/her tracheostomy site and placement of a dressing. Review of the resident's quarterly Minimum Data Set (MDS a federally mandated assessment tool to be completed by facility staff for care planning) dated 12/11/25, showed the resident:-Was alert and oriented without any cognitive incapacity.-Had behaviors of rejection of cares but had no delusional or hallucinatory behaviors.-Needed moderate assistance with bathing and dressing, needed supervision with eating, hygiene and transfers.-Mobilized in a wheelchair.-Received tracheostomy care. Review of the resident's Physician's Order Sheet (POS) dated January 2026, showed physician's orders for cleanse tracheostomy site with wound cleanser. Cover with border dressing or gauze with tape (ordered on 10/31/25). Observation on 2/2/26 at 9:50 A.M., showed:-The resident was in the common area outside of the nursing station. -Registered Nurse (RN) A was not wearing a dressing over his tracheostomy stoma. -RN A sanitized his/her hands then put on gloves. Without taking the resident to his/her room or to the shower room RN A began completing care on the resident. -RN A sprayed cleanser on a clean gauze then cleaned around the outside of the resident's stoma opening and inside the stoma. -Without degloving and washing or sanitizing his/her hands and re-gloving, RN A put a clean dressing over the stoma. The resident then self-propelled to his/her room. During an interview on 2/2/26 at 9:50 A.M. RN A said:-The resident's stoma was almost closed so all they did was clean it and put a clean dressing on it. -The resident's dressing was on the medication cart and was labeled.-He/She normally completed the resident's tracheostomy care in the resident's room.-The resident was on Enhanced Barrier Precautions and had personal protective equipment outside of his/her room.-They wore gloves when completing resident care, but they would only wear a gown if they were dealing with bodily fluids or if the resident had an infection that was contractable, they may even wear goggles/face shields in those cases.-He/She did not wear a gown when cleaning his stoma care because his/her stoma was dry, and the resident did not use it.-He/She would only wear a gown if there was risk of projectile of the resident's bodily fluids.-The resident could be finicky at times, so when the resident was agreeable to have care done, he/she would do the cares.-He/She could have taken him/her to the shower room or to his/her room.-He/She had not thought about that when he/she decided to complete his/her care.-When completing the care (on the resident's stoma) he/she should sanitize his/her hands before cleaning the resident's stoma and after the care has been completed.-He/She did not deglove and sanitize his/her hands after cleaning (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	the resident's stoma, before placing the clean dressing over it.-He/She sanitized her hands after completing the care. Observation and interview on 2/2/26 at 10:16 A.M. showed the resident was in his/her room in his/her bed watching television. The resident said:-The nursing staff usually completed his/her tracheostomy care daily in his/her room. -The nurse would normally put on gloves and gown prior to completing care. -He/She did not know why the nurse completed his/her care in the common area today. During an interview on 2/2/26 at 3:58 P.M. the Director of Nursing (DON) said:-Tracheostomy/stoma care should not be performed in the common area; it should be done in the resident's room to maintain the resident's privacy/dignity.-If the resident was on EBP, the expectation for the nursing staff providing care was for the nurse to wear a gown and gloves for cares to be provided in his/her room and have all of her supplies ready when he/she went in the room to provide care. -In this situation, the nurse should have taken the resident to his/her room to provide care because he/she was on EBP precautions.-Nursing staff should wash or sanitize their hands when providing care before they put on gloves, in-between glove changes, after care was completed, upon leaving the resident's room and when going from a dirty to a clean task. 2. Review of Resident #46's face sheet showed the resident admitted to the facility on [DATE]. Review of the resident's immunization and medical records showed:-Step 1 of a TB test was administered on 4/20/25.-There was no documentation of the resident's step 2 TB test read date or screening.-No was selected under the question of whether education was provided. 3. Review of Resident #51's face sheet showed the resident admitted to the facility on [DATE]. Review of the resident's immunization and medical records showed:-Step 1 of a TB test was administered on 5/15/25.-The status of the step 2 TB test was listed a pending immunization.-There was no documentation of the resident's step 2 read date or screening.-No was selected under the question of whether education was provided. 4. During an interview on 2/2/26 at 2:05 P.M., Registered Nurse (RN) A said:-All residents received two step TB testing upon admission.-He/She had not documented the administration or reading of any TB testing before, but would expect that a read date, time, education and appearance would be documented. -He/she was not able to find a read date, screening or education documentation in Resident #46's or Resident #51's medical record.-He/she was not sure who was responsible for making sure TB testing and documentation was done. During an interview on 2/2/26 at 12:55 P.M., the Director of Nursing (DON) said:-There was currently no medical records staff.-All residents received two step TB testing upon admission and annually.-TB testing should be read within 48-72 hours after administration; each step should be administered 1-3 weeks apart and documented in the resident's medical record.-All residents' TB tests should be documented in the medical record under immunizations section with the administered and read dates, resident education should have been received, date and signed.-Testing could be done annually or the RN could do an assessment. One or the other must be done.-He/she was not able to find a read date, screening or education documentation in Resident #46's or Resident #51's medical record.-He/She was currently responsible for making sure residents received TB testing, reading, education, and documentation of results.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on observation, interview and record review, the facility failed to ensure one sampled resident's dignity and privacy during resident care (Resident #4) by providing care in a common use area; and failed to ensure residents were treated with dignity during the lunch meal by failing to serve the lunch meal timely and failing to provide beverages to residents who were in the dining room waiting for their meals to be served. This failure potentially affected 22 residents who ate in the dining room. The facility sample was 15 residents. The facility census was 60 residents. 1. Review of Resident #4's Face Sheet showed he/she was admitted with diagnoses that included heart failure, high blood pressure, traumatic brain injury (a disruption in normal brain function caused by an external mechanical force, such as a bump, blow, or jolt to the head, or a penetrating injury), and respiratory failure.Review of the resident's quarterly Minimum Data Set (MDS-a federally mandated assessment tool to be completed by facility staff for care planning) dated 12/11/25, showed the resident:-Was alert and oriented without any cognitive incapacity.-Had behaviors of rejection of cares but had no delusional or hallucinatory behaviors.-Needed moderate assistance with bathing dressing, needed supervision with eating, hygiene and transfers and mobilized in a wheelchair.-Received tracheostomy (a surgical procedure that creates an opening, or stoma, through the neck into the trachea (windpipe) care.Observation on 2/2/26 at 9:50 A.M., showed:-The resident was in the common area outside of the nursing station. -The resident was not wearing a dressing over his tracheostomy site. -Registered Nurse (RN) A asked the resident if he/she was ready for his/her tracheostomy care and the resident said he/she was. -RN A sanitized his/her hands then put on gloves and without taking the resident to his/her room or to the shower room he/she began completing tracheostomy care on the resident. -After completing the resident's care, the resident self-propelled him/herself to his/her room. During an interview on 2/2/26 at 9:50 A.M. RN A said:-He/She normally completed the resident's tracheostomy care in his/her room.-The resident could be finicky at times, so when he/she was agreeable to have the tracheostomy care done, he/she would do it then.-He/She could have taken him/her to the shower room or to his/her room for privacy/dignity.-He/She had not thought about that when he/she decided to complete his/her tracheostomy care.Observation and interview on 2/2/26 at 10:16 A.M., showed the resident was in his/her room in his/her bed watching television. The resident said:-The nursing staff usually completed his/her tracheostomy care daily in his/her room. -He/She did not know why the nurse completed his/her care in the common area today. -He/she was not upset that RN A did it in the common area, but that was not normally where he/she preferred it to be done.During an interview on 2/2/26 at 3:58 P.M. the Director of Nursing (DON) said:-Tracheostomy/stoma care should not be performed in the common area; it should be done in the resident's room to maintain the resident's privacy/dignity.-In this situation, the nurse should have taken the resident to his/her room to provide care because he/she was on enhanced barrier precautions (EBP- an infection control intervention in nursing homes and skilled nursing facilities that mandate the use of gowns and gloves during high-contact resident care activities).2. Review of the facility mealtime showed the lunch meal was to start at 12:30 P.M.Observation on 1/28/26 at 12:23 P.M., showed:-The dietary staff were preparing to begin the lunch service, placing the food items on the steam tray, ensuring the food plates, bowls and trays were in place and residents meal tickets were accessible.-Cook A started making the meal trays at 12:30 P.M.-There were 3 nursing staff at the window ready to pass out trays and 10 residents were in the dining room.-The meal trays that were being made were placed on a rack and once the rack was full, dietary staff sent the rack out of the kitchen and nursing staff took that rack to the hall for room trays but did not pass out any of the meal trays to residents in the dining room. -At 12:47 PM there were 22 residents in the dining room.-Cook A continued to prepare meal trays that were placed on a rack that nursing staff then took to the hall to be passed out to residents in their rooms and none of the meal trays were passed out to (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	residents who were in the dining room.-Nursing staff took drinks to be served to residents receiving room trays but there were no beverages served to any of the residents in the dining room.-At 1:04 P.M. the first meal tray was served to residents in the main dining room. The nursing staff began taking requests for beverages and serving them to the residents. All meal trays were served at 1:13 P.M.During an interview on 1/28/26 at 1:15 P.M. [NAME] A said:-Since his/her employment, they had always made the meal trays for the residents who ate in their rooms first, put them on the cart, then nursing staff delivered them to residents on the halls, then they made the trays for the residents in the main dining room.-Sometimes the residents in the main dining room didn't get served until after 1:00 P.M. depending on how fast they could get the room trays delivered and assist those residents on the hall. -The dietary staff ensured the meal was prepared, plated the food, got and made substitutes, received and fulfilled requests during the meal service and the nursing staff passed out the meals and beverages to the residents in the halls and in the dining room.During an interview on 1/28/26 at 1:20 P.M. the Dietary Manager said: -They did not always serve the room trays first, but they were given instructions to serve the room trays first instead of serving the dining room so they could increase their efficiency. -Sometimes residents in the dining room had to wait until after 1:00 P.M. to get their meal, depending on what they were serving and how long it took the nursing staff to come back to the dining room.-If they could get the room trays started 30 minutes earlier (at 12:00 P.M.), they could have the room trays ready and serve the dining room at 12:30 P.M., but when they cooked meals from scratch, it took longer to get the room trays ready.-He/She thought that serving the dining room first, as residents enter, was always how the meal service was supposed to go to keep those residents from having to wait and to encourage the residents to come to the dining room to eat. -Resident's in the dining room had complained about having to wait for up to 45 minutes to receive their meal and residents who received room trays were encouraged to stay in their rooms because they got their meal first.-He/She was aware that the residents should not have to sit in the dining room and not receive their meal or beverage while they were in the dining room at the time of the meal service. -Even though he/she hired another dietary aide, the increase in dietary staff would not affect the way the service was run at meals.Observation on 1/29/26 at 12:42 P.M., showed the dietary staff was serving meals to the nursing staff who were taking meals to the halls and to residents in the dining room. There were 27 residents in the dining room at this time and 11 residents had their meals and 16 were still waiting to be served. During an interview on 1/29/26 at 12:47 P.M., the Activity Director was passing room trays and said:-Today they were not using the carts to deliver the room trays and were hand delivering meal trays. -Today they were instructed to hand deliver the room trays to see how the meal service would work. -They had hand delivered the meal trays to the rooms and served the dining room simultaneously before on holidays and it worked well. -Normally they were taking the room trays first on the carts, then dietary would prepare the meals for the residents in the dining room, and they would serve the dining room after all of the room trays were served.-There were several residents in the dining room that expressed they were not happy with that system because they would have to sit in the dining room and wait until after the room trays were served before they received their meal and that it was not fair to them. -This was a better system because the staff could serve the residents in the dining room and serve the room trays at the same time.During an interview on 1/29/26 at 12:54 P.M., Certified Nursing Assistant (CNA) A said:-They initially served the dining room first and then the room trays, but they started having complaints with the room trays having cold food so they began serving the room trays first, so they received their food hot. -Residents would still come into the dining room and wait for their meal to be served at 12:30 P.M. when the meal service started.-The change started about 2 months ago when they would serve the room trays before they served the dining room. -He/She never received a direct complaint from any resident about having to wait for their food but heard that residents who ate in the dining room were not happy because sometimes the residents in the dining room may not be served for a half hour or longer if they were still passing out room trays. -They had not been passing out beverages to (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	residents in the dining room until they began serving the dining room. -Today they were instructed to discontinue serving the room trays first and to serve the residents meals as they came from the kitchen whether the resident was in the dining room or received a room tray.-This seemed to be going better and residents in the dining room received their meals more timely.During an interview on 1/29/26 1:03 P.M., CNA E said:-They had been serving the room trays first at meals then they served the dining room. -The lunch meal service started at 12:30 P.M., If the meal trays were passed out before the dining service really got started, they could get the dining room served closer to the actual meal time at 12:30 P.M., but it depended on how long it took for nursing to pass out the room trays. -Residents still came into the dining room at the start of the lunch time and they usually had to wait until the room trays were passed before they could receive their meal because nursing passed all of the meal trays. -The residents in the dining room sometimes waited for more than 30 minutes for their meal because they were passing out the room trays.-Residents did complain about having to wait for so long when they saw the food going out to the rooms and they weren't getting served, but there was not much they could do about that. -Today they were trying a different way of passing out the meals and it seemed to be working much better. They were passing out the meal trays as they were served from the kitchen and so both the dining room and room trays were being served simultaneously. -This was working out much better and he/she had not heard any of the residents in the dining room complain about not being served timely.During an interview 2/2/26 at 3:58 P.M., the DON said:-Residents who come into the dining room at the designated mealtime were supposed to be served at the time of service.-It was not okay that residents in the dining room had to wait a half hour or longer until the room trays were served before they received their meal or beverages.-The hall trays were supposed to be sent out at the same time the dining room was being served.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, the facility failed to maintain the inside of the restroom ceiling vents in the following shared restrooms of the following pairs of resident rooms: 2 and 4; 1 and 3; 5 and 7; 10 and 12; 9 and 11; 13 and 15; 35 and 33; 36 and 34; 31 and 29; 32 and 30; 26 and 28; 27 and 25; 23 and 21; and room [ROOM NUMBER], a room without a shared restroom; failed to ensure that numerous pieces of paper debris was removed from the floor of Resident room [ROOM NUMBER] on 1/28/26 and 1/30/26; failed to maintain the tabletop fan free from a buildup of dust in Resident #49's room; and failed to maintain the ceiling fans in the Main Dining Room (MDR) free from a dust buildup on the blades of those fans. This practice potentially affected 56 residents who resided in those shared rooms. The facility census was 60 residents. 1.Observation on 1/28/26 with the Maintenance Director showed:-At 1:40 P.M. there was a heavy buildup of dust inside the ceiling vent of the shared restroom of resident rooms [ROOM NUMBERS],-At 1:43 P.M. there was a heavy buildup of dust inside the ceiling vents of the shared restroom of resident rooms [ROOM NUMBERS].-At 1:52 P.M. there was a heavy buildup of dust inside the ceiling vents of the shared restroom of resident rooms [ROOM NUMBERS].-At 2:03 P.M. there was a heavy buildup of dust inside the ceiling vents of the shared restroom of resident rooms [ROOM NUMBERS].-At 2:07 P.M. there was a heavy buildup of dust inside the ceiling vents of the shared restroom of resident rooms [ROOM NUMBERS].-At 2:16 P.M. there was a heavy buildup of dust inside the ceiling vent in the [NAME] Hall Shower room.-At 2:18 P.M. there was a heavy buildup of dust inside the ceiling vents of the shared restroom of resident rooms [ROOM NUMBERS].-At 3:03 P.M. there was a heavy buildup of dust inside the ceiling vents of the shared restroom of resident rooms [ROOM NUMBERS].-At 3:07 P.M. there was a heavy buildup of dust inside the ceiling vents of the shared restroom of resident rooms [ROOM NUMBERS].-At 3:11 P.M. there was a heavy buildup of dust inside the ceiling vents of the shared restroom of resident rooms [ROOM NUMBERS].- At 3:11 P.M. there was a heavy buildup of dust inside the ceiling vents of the shared restroom of resident rooms [ROOM NUMBERS].-At 3:23 P.M. there was a heavy buildup of dust inside the ceiling vents of the shared restroom of resident rooms [ROOM NUMBERS].-At 3:28 P.M. there was a heavy buildup of dust inside the ceiling vents of the shared restroom of resident rooms [ROOM NUMBERS].-At 3:30 P.M. there was a heavy buildup of dust inside the ceiling vent in the East Hall Shower room.-At 3:38 P.M. there was a heavy buildup of dust inside the ceiling vents of the shared restroom of resident rooms [ROOM NUMBERS]. -At 3:39 P.M. there was a heavy buildup of dust inside the ceiling vent of the restroom of resident room [ROOM NUMBER]. During an interview on 1/30/26 at 3:10 P.M. the Maintenance Director said he/she had not had a chance to check the ceiling vents for the three weeks he/she had been at the facility.2. Observation on 1/28/26 at 1:46 P.M. and on 1/30/26 at 2:40 P.M. showed numerous pieces of paper under the bed in resident room [ROOM NUMBER].During an interview on 1/30/26 at 2:43 P.M., Housekeeper A said:-On the previous day 1/29/26, the Housekeeper that day should have picked up the paper debris from the floor when the resident was not asleep.-He/she didn't pick up the paper debris earlier on 1/30/26 because he/she didn't want to bump into anything to awaken the resident.3. Observation on 1/28/26 at 3:17 P.M. with the Maintenance Director showed a heavy buildup of dust on the tabletop fan in Resident #49's room.During an interview on 1/28/26 at 3:19 P.M. Resident #49, a resident identified by the quarterly Minimum Data Set (MDS- a federally mandated assessment tool completed by the facility for care planning) dated 11/25/25, as cognitively intact, said facility staff cleaned his/her fan a couple of months ago.4. Observations on 1/28/26 at 12:39 P.M. and on 2/2/25 at 1:26 P.M., showed a buildup of dust on the blades of the fan in the MDR.During an interview on 2/2/26 at 1:28 P.M., Housekeeper B after he/she saw the dust on the fan blades, said he/she had never cleaned the ceiling fans.During an interview on 2/2/26 at 1:31 P.M. the Maintenance Director said he/she had not cleaned the fans in the three weeks since he/she started to work at the facility, and he/she needed to make a schedule.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265501	A. Building B. Wing	02/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Odessa Health Care Center	609 Golf Street Odessa, MO 64076

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure respiratory equipment such as nasal cannulas (a lightweight, flexible medical device used to deliver supplemental oxygen or increased airflow to a person in need of respiratory help), face masks (a medical device designed to deliver supplemental oxygen from a storage source (tank or concentrator) to a patient's nose and mouth to improve breathing and oxygen saturation) were kept covered to prevent cross contamination when not in use for three sampled residents (Resident #6, #1, and #50), who were at risk for respiratory infections, out of 15 sampled residents. The facility census was 60 residents. Review of the facility's Oxygen policy and procedure dated 5/18/24, showed:-Oxygen is administered under orders of a physician, except in the case of an emergency. In such case, oxygen is administered and orders for oxygen are obtained as soon as practicable when the situation is under control.-Personnel authorized to initiate oxygen therapy include physicians, Registered Nurse's (RNs), Licensed Practical Nurses (LPNs), and respiratory therapists.-Staff shall document the initial and ongoing assessment of the resident's condition warranting oxygen and the response to oxygen therapy.-The resident's care plan shall identify the interventions for oxygen therapy, based upon the resident's assessment and orders- Staff shall perform hand hygiene and don gloves when administering oxygen or when in contact with oxygen equipment. Other infection control measures include keeping delivery devices covered in plastic when not in use.1. Review of Resident #6's Face Sheet showed the resident was admitted with diagnoses that included: -Heart failure.-High blood pressure.-Diabetes (a chronic metabolic disease characterized by high blood sugar (hyperglycemia) resulting from the body's inability to produce enough insulin or effectively use the insulin it makes).-Asthma (a chronic (long-term) lung disease that inflames and narrows the airways, making it difficult to breathe).-Respiratory failure.-Chronic Obstructive Pulmonary Disease (COPD- a progressive disease that is characterized by shortness of breath and difficulty breathing).Review of the resident's Care Plan dated 2/17/25, showed the resident had oxygen therapy due to heart failure, COPD, and respiratory failure. Interventions showed:-The resident preferred to wear the nasal cannula in his/her mouth instead of in his/her nose.-Give medications as ordered by physician. Monitor/document side effects andeffectiveness.-Monitor for signs and symptoms of respiratory distress and report to the physician as needed.-Resident's oxygen settings were 3 liters per minute via nasal cannula continuously to keep saturation (the percentage of oxygen-saturated hemoglobin compared to total hemoglobin in the blood) above 90 percent.Review of the resident's Nursing Notes dated 12/3/25 showed:-The resident was sitting in his/her recliner in his/her room, alternating his/her nasal cannula from his/her nose to his/her mouth and back. The resident reported his/her breathing had not been too good lately. The resident was wearing oxygen at 3 liters per minute via nasal cannula and he/she checked his/her oxygen saturation which was 94 percent. The resident required the use of breathing treatments in conjunction with his/her oxygen, and elevation of his/her head of bed to help prevent/alleviate episodes of shortness of air/ exacerbation.Review of the resident's quarterly Minimum Data Set (MDS a federally mandated assessment tool to be completed by facility staff for care planning) dated 12/11/25, showed the resident:-Was alert and oriented without cognitive impairment.-Had one sided weakness in range of motion.-Needed moderate assistance with bathing and needed supervision with dressing, toileting, mobility and transfers. - Used oxygen. Review of the resident's Physician's Order Sheet (POS) dated January 2026, showed:-There were no physician's orders for oxygen.Observation and interview on 1/27/26 at 10:42 A.M., showed:-The resident was sitting in his/her recliner with his/her oxygen on at 3 liters per minute. -The nasal cannula was in his/her mouth. -His/Her wheelchair was in front of his/her bed with a portable oxygen tank on the back of it.-There was oxygen tubing and a nasal cannula that was wrapped around the handles of the wheelchair, uncovered. During an interview on 1/27/26 at 10:42 A.M. the resident said:-He/She placed (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	it there and stated his/her nose was stopped up at the time.-His/Her oxygen saturation was at 98 percent, and he/she was not having difficulty breathing. Observation on 1/27/26 at 2:05 P.M. showed:-The resident was in his/her bed with his/her nasal cannula in his/her nose while with his/her eyes closed and resting comfortably. -The resident showed no signs or symptoms of respiratory distress. -The resident's wheelchair was in front of the resident's bed with a portable oxygen tank on the back of it with the oxygen tubing and nasal cannula wrapped around the handles, uncovered. 2. Review of Resident #1's Face Sheet showed the resident was admitted with diagnoses including heart failure, high blood pressure, acid reflux (a common condition where stomach contents, including acid, flow backward into the esophagus, causing a burning sensation in the chest known as heartburn), pneumonia, and respiratory failure.Review of the resident's Nursing Notes showed:-On 11/12/25 the resident was being monitored while receiving antibiotics for an upper respiratory infection. There were no indications of any adverse reactions. On this day the resident was pleasant with increased lethargy this evening. Respirations even and non-labored oxygen saturation at 99 percent with oxygen therapy at 4 liters per minute via nasal cannula per baseline. Review of the resident's comprehensive MDS dated [DATE], showed the resident:-Was alert with some cognitive impairment.-Had lower impairment in range of motion and used a wheelchair for mobility.-Needed maximum assistance with bathing, toileting, dressing and grooming and moderate to extensive assistance with transferring.-Used oxygen. Review of the resident's Care Plan dated November 2025 showed the resident had COPD and shortness of breath. Interventions showed:-Give breathing treatments as ordered. Monitor/document any side effects andeffectiveness.-Identify and eliminate sources of respiratory irritation such as cigarette smoke,pollen, perfumes, etc.-Keep the head of the bed elevated to prevent shortness of air while lying flat related to COPD.-Monitor for difficulty breathing on exertion. Remind resident not to push beyond endurance.-Monitor for signs and symptoms of acute respiratory insufficiency (anxiety, confusion, restlessness, shortness of breath).-Monitor/document for anxiety. Offer support, encourage resident to vent frustrations, fears. Reassure. Give as needed medications for anxiety as ordered.-Monitor/document/report as needed any signs or symptoms of respiratory infection.Review of the resident's POS dated January 2026, showed physician's orders for:-Oxygen at 4 liters per minute via nasal cannula continuously to keep oxygen saturation above 90 percent every shift for respiratory failure (ordered 9/11/25).Observation on 1/27/26 at 11:43 A.M., showed:-The resident was not in his/her room. -There was oxygen tubing, and a nasal cannula coiled in his/her recliner, uncovered. -There was an oxygen concentrator (a medical device that provides purified, supplemental oxygen to patients with breathing difficulties by filtering nitrogen out of ambient air) beside his/her bed and it was turned off. -There was a continuous positive airway pressure (CPAP-a medical device that uses mild, steady air pressure to keep a person's upper airway passages open during sleep) machine that was behind his/her recliner with tubing and a face mask attached in a basket that was connected to the machine, and it was uncovered. During an interview on 1/27/26 at 12:52 P.M., LPN A said:-They did not use the CPAP machine during the day shift.-He/She thought the resident used the CPAP machine at night and the night shift staff assisted with administering it to the resident.-He/She would have to look at the resident's orders to know for sure what the frequency of use was.Observation on 1/29/26 at 1:34 P.M., showed:-The resident was sitting in the dining room dressed for the weather without odors with his/her oxygen on via nasal cannula. -After the resident was finished eating, nursing staff took the resident back to his/her room.-The resident's CPAP machine was still behind the resident's recliner and the face mask was in the basket that was attached to the CPAP machine, uncovered.Observation on 1/30/26 at 12:10 P.M., showed:-The resident was with nursing staff receiving assistance with toileting. -The resident was wearing oxygen via nasal cannula. -His/Her CPAP machine that was behind his/her recliner that was not on, but the facemask was sitting in a basket that was connected to the machine, and it was uncovered.During an interview on 1/30/26 at 12:16 P.M., the Director of Nursing (DON) said:-The resident refused to use his/her CPAP machine.-They (nursing staff) have (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	tried to get him/her to use it due to his/her diagnoses, but he/she refused it routinely.3. Review of Resident #50's Face Sheet showed the resident was admitted with diagnoses that included:-Iron deficiency.-Coronary artery disease (a common heart condition characterized by the narrowing or blockage of the coronary arteries due to a buildup of plaque).-High blood pressure.-Stroke.-Anxiety (a feeling of fear, dread, or uneasiness, often a normal reaction to stress, but becomes a disorder when excessive and persistent, interfering with daily life).-Sleep apnea (a sleeping disorder in which the temporary cessation of breathing occurs more often than normal during sleep).Review of the resident's Care Plan dated 7/27/25, showed the resident has altered respiratory status related to sleep apnea. Interventions showed:-Assist resident/family/ caregiver in learning signs of respiratory compromise.-Keep CPAP setting at 10.0-17.0 pressure, nose mask with 2 liters of oxygen.-Encourage resident to wear CPAP at night. Review of the resident's quarterly MDS dated [DATE] showed the resident:-Was alert with minimal cognitive impairment.-Had lower extremity impairment and used a wheelchair for mobility.-Needed extensive assistance with bathing, dressing, toileting and moderate assistance with transfers.-Used oxygen.Review of the resident's Nursing Note showed: -On 11/7/25 the resident continued with antibiotic therapy for an upper respiratory infection. The resident had no indications of adverse reactions.-Utilized oxygen therapy while in bed per baseline. Review of the resident's POS dated January 2026, showed physician's orders for:-Oxygen at 2 liters per minute at night and as needed to keep oxygen saturation at or above 90 percent for obstructive sleep apnea.Observation on 1/27/26 at 11:49 A.M., showed:-The resident was not in his/her room. -There was an oxygen concentrator was beside his/her bed, with the oxygen tubing coiled and on the floor. It was attached to a breathing treatment machine and face mask that was wedged between the oxygen concentrator and his/her recliner, uncovered. -There was another oxygen tubing with a face mask attached that was in the seat of his/her recliner, uncovered.Observation on 1/30/26 at 12:03 P.M., showed:-The resident was not in his/her room. -His/Her oxygen concentrator was beside his/her bed with the oxygen tubing and nasal cannula draped over the armrest of his/her recliner, uncovered. -There was a breathing treatment machine in the seat of his/her recliner with the facemask sitting next to it in the recliner, uncovered. -There was a plastic bag beside it.4. During an interview on 2/2/26 at 12:01 P.M., Certified Medication Technician (CMT) A said:-When the resident's oxygen equipment such as nasal cannulas and facemasks were not in use, they were supposed to be placed in bags.-They usually had bags on the hall, but if not then they could get them from the kitchen.During an interview on 2/2/26 at 12:03 P.M., Certified Nursing Assistant (CNA) A said:-When nasal cannulas, face masks and other respiratory equipment was not in use, they were supposed to be stored in bags.-The night shift usually ensured the resident had bags available to store the oxygen equipment in and then the nursing staff was supposed to check as they passed in the halls during the day to ensure they were covered.-They usually did have bags available.During an interview on 2/2/26 at 12:06 P.M., RN A said:-Any nasal cannulas, tubing face masks that were not in use should be stored in plastic bags that were available to the nursing staff.-The expectation was that as the nursing staff made rounds or were in the resident rooms, they would check to ensure the oxygen equipment was covered in the bag.-If there was no bag, the nursing staff was supposed to obtain one for each device the resident had and store the oxygen equipment in it.- If the oxygen cannula or face mask was on the floor, he/she would expect staff to obtain a new one and discard the one that was on the floor.During an interview on 2/2/26 at 3:58 P.M., the DON said:-Oxygen nasal cannulas and tubing and face masks were supposed to be stored in a bag when not in use.-All nursing staff should monitor to ensure the oxygen equipment was in the bag as they went into the resident rooms to provide care or on rounds.-The nursing staff should replace the tubing, face mask or nasal cannula if it fell on the floor or was contaminated and place it in the bag otherwise.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to have sufficient staffing to meet the needs of two sampled residents (Resident #5 and #54) out of 15 sampled residents. The facility census was 60 residents. Review of the facility's Sufficient Staff Policy dated 5/18/24 showed:-It was the policy of this facility to provide sufficient staff with appropriate competencies and skill sets to assure resident safety and attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident. The facility's census, acuity and diagnosis of the resident population will be considered based on the facility assessment.--The facility will supply services by sufficient numbers of each of the following personnel types on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans.---Except when waived, licensed nurses; and other nursing personnel, including but not limited to nurse aides.--Except when waived, the facility must designate a licensed nurse to serve as a charged nurse on each tour of duty.--The facility was required to provide licensed nursing staff 24 hours a day, seven days a week.--The facility must ensure that licensed nurses have the specific competencies, and skill sets necessary to care for resident's needs as identified through resident assessments and described and the plan of care.--Providing care includes, but was not limited to, assessing, evaluating, planning and implementing resident care plans and responding to resident's needs.--The facility must ensure that nurse aides were able to demonstrate competency in skills and techniques necessary to care for resident's needs, as identified through resident assessments, and described and the plan of care.--The facility was responsible for submitting timely and accurate staffing data through the CMS Payroll-Based Journal (PBJ) system.--Except when waived, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, seven days a week.--The director of nursing may serve as a charged nurse only when the facility had an average daily occupancy of 60 or fewer residents.1. Review of the Resident Counsel Minutes dated 10/29/25 showed the resident's indicated the following:-There needs to be more workers.-Some Certified Nursing Assistants (CNA) were afraid to wipe/clean certain areas.-Bed linens do not get changed; staff had to be reminded to change the bed.-Had to remind staff to make the bed.-Staff took a long time to answer call lights.-There are lifts but not enough help.Review of the Resident Counsel Minutes dated 11/26/25 showed the resident's indicated the following: -Staff did not answer call lights fast enough.-Beds were not being made.-Staff were not giving showers twice a week.-Staff were not changing the sheets on the beds. --This was also mentioned in the October meeting.Review of the Resident Counsel Minutes dated 12/17/25 showed:-The beds were not being made.-Call lights were not being answered in a timely manner.-Staff were not giving showers twice a week.-Staff were not changing the sheets on the beds.--This was mentioned in the October and November meetings. 2. Review of Resident #5's Quarterly Minimum Data Set (MDS-a federally mandated assessment tool to be completed by facility staff for care planning) dated 1/19/26, showed the resident:-Was cognitively intact.-Required substantial/maximum assistance with bathing and dressing.During an interview on 1/27/26 at 11:41 A.M. the resident said: -Staff was slow to answer his/her call light.-It didn't matter if it was day or night. -He/She had only been receiving one bath a week when he/she was supposed to be getting two.3. Review of the Resident #54 Comprehensive MDS, dated [DATE], showed the resident:-Was moderately cognitively impaired. -Required substantial/maximum assistance with bathing.-Required supervision or touching assistance for dressing.During an interview on 1/27/26 at 11:45 A.M. the resident said:-Night shift staff was slow to answer his/her call light. -He/She had only been receiving one bath a week when he/she was supposed to be getting two.4. During an interview on 1/29/26 at 9:56 A.M., Certified Nursing Assistant (CNA) D said: -The residents did not get two showers a week because he/she was the only person designated for baths/showers. -He/She had residents tell (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	him/her that if he/she was not at the facility they did not get their baths/showers.-He/She knew some CNAs would try to give baths/showers. -He/She would get pulled to assist to feed the residents, pass trays, and help with transfers.-If a resident needed assistance, then he/she would assist them. -If a resident had an appointment like physical therapy, it was not always possible to get back to them before the end of the day to give them a bath/shower. -He/She was assigned 20 showers a day.-Gave between 15 and 18 baths/showers a day.-With there being 60 residents that was 120 baths a week.During an interview on 1/30/26 at 2:02 P.M. CNA C said:-There had been times when he/she was supposed to leave and knew there were residents who needed assistance. -They had been short because of scheduling.-He/She had to wait 15 minutes for another staff member to assist with a transfer with a mechanical lift. -He/She heard a few residents complain about not having enough help on night shift. -It had seemed like night shift had been short.-The bath aid was responsible for giving baths.-If a CNA had time they could assist with baths.-When the bath aid wasn't at the facility, the CNAs were supposed to give baths.-He/She was assigned as the bath aid for a day and was supposed to give 18 to 20 baths but was only able to do 14 baths.-He/She was pulled to the floor to help assist with residents and help with meals. -If a resident said to come back later for the bath it could be difficult to get back to them. -The residents were supposed to be offered a bath on another day if they did not get their bath on their assigned day. During an interview on 2/2/26 at 9:00 A.M. CNA A said:-He/She was not able to get his/her job done on time and would have to come in early or stay late. -The facility was short on staff.-Had residents and families complained all the time that there was not enough staff.-The bath aid was responsible for giving baths.-When the bath aid was not at the facility it was up to whoever was at the facility to give baths.-He/She had no idea how many baths he/she had given in a day.-If a resident did not get their baths on their assigned days, they could get them on Sundays which was the make-up day. During an interview on 2/2/26 at 10:24 A.M. Certified Medication Technician (CMT) A said:-The facility was short staffed.-When he/she worked the floor as a CNA sometimes he/she was unable to get the work done but would let another staff member know.-He/She heard of residents and family members complain about the facility being short staffed.-The bath aid was responsible for giving baths.-A CNA, who was on the floor, would fill in when the bath aid was not working.During an interview on 2/2/26 at 1:29 P.M., the Activity Director said: -He/She would get pulled to assist on the floor and it would put him/her behind on the scheduled activities. -He/She was called to the floor to assist with getting a resident ready to go to an appointment, but he/she was also supposed to do a scheduled activity at the same time. -Since he/she was on the floor he/she was not able to do the activity and was hoping to get it done before the afternoon activity. -He/She was pulled to the floor to assist with getting the residents up out of bed and this put him/her behind on the morning activity.-They were supposed to do coffee, news, and devotion readings and a scheduled activity and none of it was able to be done because of being pulled to the floor.-He/She was the only person doing the activities.During an interview on 2/2/26 at 1:54 P.M., CNA D said: -He/She was not able to get his/her job done on time and would have to stay late. -He/She had heard of residents and family members complain about the facility being short staffed on all shifts. -He/She was responsible for showers every week unless someone called in, then he/she would have to work the floor. -Usually, he/she would not take a lunch break because it would mean a resident would not get their bath on the assigned day. During an interview on 2/2/26 at 2:12 P.M. Registered Nurse (RN) A said:-The staff could come to him/her for assistance. -He/she had heard resident's ask if they were low on staff and saying there were not enough people to meet his/her needs. -The bath aide was responsible for giving baths.-If the bath aide was not at the facility, then a CNA would give the bath/shower.-He/She would comprise a list of the residents who did not receive their scheduled bath and let the night nurse know. -If a resident still did not receive their bath they would try the next day. -Baths were scheduled Monday through Saturday.-Sunday was the make-up shower day and a CNA would give the resident's their baths/showers. During an interview on 2/2/26 at 3:57 P.M. the Director of Nursing (DON) said:-If staff were unable to get their work done, they (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	should let the charge nurse know and he/she would assign someone. -Call lights were to be answered as quickly as possible, no longer than 10 minutes.-The CNAs were able to give baths when the bath aid was not in the building.-Baths could be given on the night shift and weekend.-There should not be any reason why a resident would not receive two baths a week. -The current floor staff or next shift staff would assist.-Bath sheets were monitored by the charge nurse and audited by him/her.-The charge nurse would reassign any baths. -Resident #5 and Resident #54 should have received two baths/showers a week.

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. Based on interview and record review, the facility failed to ensure that the Certified Nursing Assistants (CNAs) and licensed nursing staff had the appropriate competencies and skills check off training to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being was completed annually and as needed. This had the potential to affect any resident care provided by the nursing staff. The facility census was 60 residents. Review of the facility's Sufficient Staff Policy dated 5/18/24 showed:-It is the policy of this facility to provide sufficient staff with appropriate competencies and skills sets to assure resident safety and attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident. The facility's census, acuity and diagnoses of the resident population will be considered based on the facility assessment.-The facility must ensure that licensed nurses have the specific competencies, and skill sets necessary to care for resident's needs as identified through resident assessments and described in the plan of care.-The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments and described in the plan of care.Review of the Facility Assessment and Tool dated 6/29/23 showed the Facility Assessment must include the facility resident population including but not limited to:-The staff competencies that were necessary to provide the level and types of care needed for the resident population.-All Personnel, including managers, employees, employees who provided services under contract, volunteers, as well as their training and any competencies related to resident care.-Review if you have sufficient staff with appropriate skills and competencies to carry out functions of food and nutrition services.-Are there any training and education and/or competency needs based on residents and/or staff data or trends identified in the Facility Assessment?--Consider job competencies need to be updated.-Review the facility assessment requirements and guidance at F838 and be prepared to respond to surveyor for the following information:-How did facility determine what skills and competencies would be required by those providing care.1. Review of the employees' annual in-services and training records dated 1/1/25 to 1/30/26 showed the facility did not have documentation the staff had completed skills and competency check off records.During an interview on 2/2/26 at 12:43 P.M., the Administrator said:-They did not have skills and competencies check off record documentation.-They did not have a dedicated system for ensuring staff received their 12 hours of required training.-They were discussing setting up a skills training for the nursing staff and creating monthly in-services to ensure they receive their 12 hours of trainings but had not started implementing any training.-They are working with a local hospice company to create some of the trainings but had not started implementing any training. During an interview on 2/2/26 at 5:00 P.M., the Director of Nursing (DON) said:-He/She had been in this role since August 2025.-Staff was evaluated and assessed for competency through skill checkoffs, randomly, and when issues came up.-If staff had not signed an in-service sheet, they did not attend the in-service and had not received the education.-He/She was responsible for making sure all trainings and in-services were done.-There was no dedicated system to ensure staff received the required 12 hours of training.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. Based on observation, interview and record review, the facility failed to ensure a physician's response related to the pharmacist's Gradual Dose Reduction (GDR) recommendation and pharmacy monthly Medication/Drug Regimen Review(MRR or DRR) for as needed antipsychotic medication (used to manage psychosis symptoms, including hallucinations, delusions, paranoia, and severely disordered thinking) for one sampled resident (Resident #51) out of 15 sampled residents. Facility census was 60 residents. Review of the facility Pharmacy Services policy revised on 5/18/24 showed:-The facility will provide pharmaceutical services to include procedures that assure the accurate acquiring, receiving, dispensing, and administering of all routine and emergency drugs and biologicals to meet the needs of each resident, are consistent with state and federal requirements, and reflect current standards of practice.-The pharmacist, in collaboration with the facility and medical director, may include other aspects of pharmaceutical services such as:--Development of procedures and guidance in relation to medication issues and/or adverse effects.--Development of processes for receiving, transcribing or recapitulation of medication orders.--Recommendations of type(s) of medication delivery system(s) to standardize packaging, to minimize medication errors.1. Review of Resident #51's admission Record showed he/she was admitted with diagnoses that included:-Anxiety (is a persistent, excessive fear or worry that interferes with daily life).-Personality disorder (as the manifestation of extreme personality traits that interfere with everyday life and contribute to significant suffering, functional limitations, or both).-Hospice care (is a special kind of care that focuses on a person's quality of life and dignity as they near the end of their life) on 9/3/25 with diagnosis of severe protein-calorie malnutrition (s a life-threatening, often chronic, condition caused by extreme deficiencies in macronutrient intake such as protein, calories, and nutrients). Review of the resident's Physician Order Sheet (POS) dated December 2025 showed:-Lorazepam Oral Concentrated 2 milligrams (mg)/ milliliter (ML) give 0.25 ml by mouth every one hour as needed for agitation, was ordered on 9/10/25. -Olanzapine 10 mg give one tab for prophylaxis, was ordered on 5/9/25. -Quetiapine Fumarate give 50 mg by mouth one time a day for agitation/anxiety, was ordered on 5/9/25.-Quetiapine Fumarate give 100 mg by mouth every night at bedtime for agitation/anxiety, was ordered on 5/9/25.-NOTE: Did not have a documentation in nursing notes or physician progress noted showing had been reviewed by the resident's physician that he/she agreed or disagreed with pharmacy recommendation.Review of the resident's Pharmacy Review Note dated 12/18/25 at 4:13 P.M. showed GDR recommendation resident was receiving the following psychotropic medications (drugs that change brain chemical makeup to treat mental illnesses, emotional disorders, or behavioral issues) that were due for review:-Escitalopram (Lexapro, used for depression) give 20 milligrams (mg) one time a day.-Lorazepam (used to treat anxiety, agitation) 1 mg three times a day (TID) as needed (PRN).-Olanzapine (used to treat schizophrenia and bipolar I disorder)10 mg twice a day.-Quetiapine(an atypical antipsychotic medication used for schizophrenia, bipolar disorder, mania/depression) 50 mg in the morning and 100 mg at bedtime.-The following pharmacist recommendation was made:--Decrease the Lorazepam to 0.5mg TID (If as needed order then as needed x 14 days).-The form contained a blank line for a check mark or initial with the following comment:--An attempted GDR of listed medication is likely to result in destabilization, impairment of function or increased distressed behaviors.-The form contained a blank line for a check mark or initial with the following comment: --Target symptoms returned or worsened after the most recent attempt at a GDR within the facility and any additional attempted dose reduction at that time would be likely to impair the resident's function, exacerbate an underlying medical or psychiatric disorder or increased distressed behavior. Document supporting rationale. There was a blank line for the physician to document his/her response.-The form contained the following statement: The resident has specific, enduring, progressive, or terminal conditions (i.e. chronic depression, Parkinson's (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	psychosis) which affect brain activity indefinitely. Chronic condition.--There was an area left blank for the physician to document his/her response. -There was nothing indicated on the form as a response to any of the areas by the physician. -There was no documentation in the resident's nursing notes or physician progress notes that indicated the GDR form had been reviewed, agreed of disagreed with the pharmacist recommendations. Review of the resident's Quarterly Minimum Data Set (MDS a federally mandated assessment instrument completed by facility staff for care planning) dated 12/24/25, showed he/she:-Was moderately cognitively impaired. -Was able to understand others and make his/her needs known.Review of the resident's Pharmacy Review Note dated 1/21/26 at 6:06 A.M. showed: -The resident was recently started on the following PRN antipsychotic medication(s):-Lorazepam 1 mg given by mouth three times a day as needed with start date of 9/10/25).-Lorazepam (concentrated) 0.25 ml given by mouth every hour PRN for agitation was started on 9/10/25.--This was a second attempt to reduce the PRN medication. -The form contained the following statement: --As of 11/28/17 new CMS regulation 483.45(e)(5) states that as needed orders for all antipsychotic drugs have a maximum duration of 14 days and then be discontinued. There are no exceptions to this rule (including hospice) and any order for a as needed antipsychotic >14 days will result in an F tag from state surveyors. A new order may be written every 14 days after the prescriber meets the following and documents ongoing need for as needed antipsychotic. New regulations that these orders cannot be renewed unless the following conditions are met:1)Prescriber evaluates patient in person to assess for a new PRN order for the medication2)Prescriber documents in the residents chart the medical reason why the PRN is necessary.Please discontinue this residents' current antipsychotic as needed order and following the previously mentioned steps if the order is still medically necessary.-The form contained a blank line for a check mark or initial to DISCONTINUE the PRN medication. -The form contained a blank line for a check mark or initial with the following:--LORAZEPAM (X2). The form had a blank line for a check mark or initial with the following statement:-To comply with CMS Guidelines. If this medication is to be continued long term the afore mentioned steps are required each renewal. -There was no documentation in the resident's nursing notes or physician progress notes that indicated the GDR form had been reviewed, agreed of disagreed with the pharmacist recommendations. Review of the resident's Physician's monthly progress note dated 1/17/26 at 9:27 A.M. showed: -There was no documentation of any medication changes.-The resident's mood and behaviors were acceptable. -There was no documentation that indicated he/she reviewed the pharmacy recommendation or GDR. During an interview on 2/2/26 at 10:16 A.M., the Director of Nursing (DON) said:-He/She would be responsible for the facility audit of the resident's medical record for accuracy and any transcription errors. -He/She would be responsible for oversight of the pharmacy monthly review. -The resident's pharmacy monthly DRR that had pharmacy recommendations and the GDR recommendations had not been followed-up by nursing staff to ensure the recommendations had a physician's response.-The facility did not have a physician's response documented for the resident's GDR recommendations. -It was night shift's staff responsibility to ensure there was a physician's response related to any pharmacy recommendation. During an interview on 2/2/26 at 2:00 P.M. the Administrator said the facility received the DRR from the pharmacist monthly with his/her recommendations.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure safe and secure storage, with an ongoing monitoring system and accountability for narcotic medication (is technically known as opioids or opioid analgesics, are powerful, prescription-only drugs used to manage moderate-to-severe pain that is not relieved by other, safer pain medications) that included Morphine (used to treat pain severe enough to require daily, around-the-clock, long-term opioid treatment and when other pain medicines did not work well) and Lorazepam (Ativan antianxiety, involve more than occasional worry or fear) for three sampled residents (Resident #51, #10, and #35); failed to have accurate documentation of medication given on the Individual Resident Narcotic record form and on Treatment Administration (TAR) record for Morphine and Lorazepam for two sampled resident (Resident #51 and #10); and failed to label and date open bottles of Morphine and Lorazepam for one sampled resident (Resident #51) out of 15 sampled residents. The facility also failed to have a system in place to monitor over the counter medication (OTC) manufacture expiration dates from of one of two Certified Medication Technician (CMT) medication carts in the facility. The facility resident census of 60 Residents. Review of the facility policy titled Medication Storage revised on [DATE] showed: -It is the policy of this facility to ensure all medications housed on our premises will be stored in the medication rooms according to the manufacturer's recommendations and sufficient to ensure proper sanitation, temperature, light, ventilation, moisture control, segregation, and security.-All drugs and biologicals will be stored in locked compartments (i.e., medication carts, cabinets, drawers, refrigerators, medication rooms) under proper temperature controls.-Only authorized personnel will have access to the keys to locked compartments.-During a medication pass, medications must be under the direct observation of the person administering medications or locked in the medication storage area/cart.-Schedule II drugs and back-up stock of Schedule Ill, IV and V medications are stored under double-lock and key.-Schedule II controlled medications are to be stored within a separately locked permanently affixed compartment when other medications are stored in the same area, such as in a refrigerator.-Any discrepancies which cannot be resolved must be reported immediately as follows notify the Director of Nursing (DON), charge nurse, or designee and the pharmacy; complete an incident report detailing the discrepancy, steps taken to resolve it, and the names of all licensed staff working when the discrepancy was noted.-The DON, charge nurse, or designee must also report any loss of controlled substances where theft is suspected to the appropriate authorities such as local law enforcement, Drug Enforcement Agency, State Board of Nursing, State Board of Pharmacy, and possibly the State Licensure Board for Nursing Home Administrators. Staff may not leave the area until discrepancies are resolved or reported as unresolved discrepancies.Review of the facility's Controlled Substance Administration and Accountability Policy revised on [DATE] showed: -It is the policy of this facility to promote safe, high quality patient care, compliant with state and federal regulations regarding monitoring the use of controlled substances. The facility will have safeguards in place to prevent loss, diversion or accidental exposure.-In all cases, the dose noted on the usage form or entered into the automated dispensing system must match the dose recorded on the Medication Administration Record (MAR), Controlled Drug Record, or other facility specified form and placed in the patient's medical record.-The Controlled Drug Record (or other specified form) serves the dual purpose of recording both narcotic disposition and patient administration.-The Controlled Drug Record is a permanent medical record document and in conjunction with the MAR is the source for documenting any patient-specific narcotic dispensed from the pharmacy.-The charge nurse or other designee conducts a daily visual audit of the required documentation of controlled substances. Spot checks are performed to verify, controlled (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	substances that are destroyed are appropriately documented; and medications removed from either the automated dispensing system or medication cart/cabinet have a documented physician order.Review of the facility's Medication Administration policy revised on [DATE] showed: -Medications are administered by licensed nurses, or other staff who are legally authorized to do so in this state, as ordered by the physician and in accordance with professional standards of practice, in a manner to prevent contamination or infection. It is the policy of this facility to ensure the safe and effective administration of all medications by utilizing best practice guidelines.-Identify expiration date. If expired, notify nurse manager.-Remove medication from source, taking care not to touch medication with bare hand.-Administer medication as ordered in accordance with manufacturer specifications.-Sign MAR after administered. For those medications requiring vital signs, record the vital signs onto the MAR.-If medication is a controlled substance, sign narcotic book.-Report and document any adverse side effects or refusals.-Correct any discrepancies and report to nurse manager.1. Review of Resident #51's admission Record showed he/she was admitted with diagnoses of:-Personality disorder (as the manifestation of extreme personality traits that interfere with everyday life and contribute to significant suffering, functional limitations, or both).-Muscular Dystrophy (is a group of genetic diseases that cause progressive muscle weakness and loss of muscle mass).-The resident admitted to Hospice care (is a special kind of care that focuses on a person's quality of life and dignity as they near the end of their life) on [DATE] with diagnosis of severe protein-calorie malnutrition (a life-threatening, often chronic, condition caused by extreme deficiencies in macronutrient intake such as protein, calories, and nutrients). -Anxiety (is a persistent, excessive fear or worry that interferes with daily life)Review of the resident's Quarterly Minimum Data Set (MDS a federally mandated assessment instrument completed by facility staff for care planning) dated [DATE] showed he/she:-Was moderately cognitive impaired. -Was able to understand others and make his/her needs known.-Was on opioids (sometimes called narcotics, are a type of drug. They include strong prescription pain relievers) and anxiety (repeated episodes of sudden feelings of intense anxiety and fear or terror that reach a peak within minutes) medication during look back period.-Required assistance of staff for all cares. Review of the resident's Physician Order Sheet (POS) dated [DATE] showed:-Lorazepam Oral Concentrated 2 milligram (mg)/milliliter (ml) give 0.25 ml by mouth every one hour as needed for agitation, was ordered on [DATE]. -Morphine Sulfate (Concentrate) Oral Solution 20 mg/ml (Morphine Sulfate), nursing staff to give 0.5 ml by mouth every one hour, as needed to treat pain or Shortness of Air (SOA), was ordered on [DATE] at 2:45 P.M. Review of the resident's Treatment Administration Record (TAR) dated [DATE] showed: -This was the form the licensed nurses documented administration of narcotic medications.-A Physician order for Lorazepam Concentrate 2mg/ml give 0.25 ml by mouth every one hour as needed for agitation.-There was no documentation that indicated the Lorazepam was given on the following dates:--[DATE] at 10:45 P.M.---The Individual Resident Narcotic Record indicated the Lorazepam was signed out.--[DATE] at 1:33 A.M.---The Individual Resident Narcotic Record indicated the Lorazepam was signed out.--[DATE] at 3:00 A.M.---The Individual Resident Narcotic Record indicated the Lorazepam was signed out.--[DATE] at 7:00 A.M.---The Individual Resident Narcotic Record indicated the Lorazepam was signed out.----There was documentation that indicated the [DATE] dose at 7:00 A.M. was effective.-A Physician order for Morphine Sulfate (Concentrate) Oral Solution 20 mg/ml, nursing staff to give 0.5 ml by mouth every one hour, as needed to treat pain or SOA ordered on [DATE].-There was no documentation that indicated the Morphine was given on the following dates:--[DATE] at 1:00 A.M.---The Individual Resident Narcotic Record indicated the Morphine was signed out.--[DATE] at 6:00 A.M.---The Individual Resident Narcotic Record indicated the Morphine was signed out.--[DATE] at 3:00 P.M.---The Individual Resident Narcotic Record indicated the Morphine was signed out.--[DATE] at 1:00 A.M.---The Individual Resident Narcotic Record indicated the Morphine was signed out.--[DATE] at 6:00 A.M.---The Individual Resident Narcotic Record indicated the Morphine was signed out.--[DATE] at 10:00 P.M.---The Individual Resident Narcotic (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record indicated the Morphine was signed out.--[DATE] at 1:45 A.M. ---The Individual Resident Narcotic Record indicated the Morphine was signed out.--[DATE] at 6:40 P.M.---The Individual Resident Narcotic Record indicated the Morphine was signed out.--[DATE] at 12:50 A.M.---The Individual Resident Narcotic Record indicated the Morphine was signed out.--[DATE] at 3:00 P.M.---The Individual Resident Narcotic Record indicated the Morphine was signed out.--[DATE] at 6:00 A.M.---The Individual Resident Narcotic Record indicated the Morphine was signed out.--[DATE] at 12:00 A.M.---The Individual Resident Narcotic Record indicated the Morphine was signed out.--[DATE] at 1:12 A.M. ---The Individual Resident Narcotic Record indicated the Morphine was signed out.--[DATE] at 9:20 P.M.---The Individual Resident Narcotic Record indicated the Morphine was signed out.--[DATE] at 12:02 A.M.---The Individual Resident Narcotic Record indicated the Morphine was signed out.--[DATE] at 11:00 P.M.---The Individual Resident Narcotic Record indicated the Morphine was signed out.--[DATE] at 12:05 A.M.---The Individual Resident Narcotic Record indicated the Morphine was signed out.--[DATE] at 8:47 P.M.---The Individual Resident Narcotic Record indicated the Morphine was signed out.Review of the resident's Individual Resident Narcotic Record for Lorazepam, received on [DATE] that contained [DATE] showed:-Physician order for Lorazepam Concentrate 2mg/ml give 0.25 ml by mouth every one hour as needed for agitation.-The Lorazepam liquid was signed out on the following dates and times:--[DATE] at 10:45 P.M.---The TAR did not indicate the medication was given.--[DATE] at 11:40 P.M.--[DATE] at 1:33 A.M.---The TAR did not indicate the medication was given.--[DATE] at 3:30 A.M.---The TAR did not indicate the medication was given.--[DATE] at 7:00 A.M. ---The TAR did not indicate the medication was given.Review of the resident's Individual Resident Narcotic Record for Liquid Morphine, received on [DATE] that contained [DATE] to [DATE] showed: -Physician order for Morphine Sulfate (Concentrate) Oral Solution 20 mg/ml, nursing staff to give 0.25 ml by mouth every one hour, as needed to treat pain or SOA.-Handwritten on top of the narcotic record form was a note that indicated the medication dose was increased to Morphine 0.5 ml, every hour as needed dated [DATE]. --There was no indication of who had put the handwritten note on the top of the form. -The Morphine liquid was signed out on the following dates and times:--[DATE] at 1:00 A.M. ---The TAR did not indicate the medication was given.--[DATE] at 6:00 AM.---The TAR did not indicate the medication was given.--[DATE] at 9:00 A.M. ---The TAR did not indicate the medication was given.--[DATE] at 3:00 P.M.---The TAR did not indicate the medication was given.--[DATE] at 1:00 A.M. ---The TAR did not indicate the medication was given.--[DATE] at 6:00 AM.---The TAR did not indicate the medication was given.--[DATE] at 10:00 P.M.---The TAR did not indicate the medication was given.--[DATE] at 1:45 A.M.---The TAR did not indicate the medication was given.--[DATE] at 6:40 P.M.---The TAR did not indicate the medication was given.--[DATE] at 12:50 A.M.---The TAR did not indicate the medication was given.Review of the resident's Individual Resident Narcotic Record for Liquid Morphine received on [DATE] showed: -Physician order for Morphine Sulfate (Concentrate) Oral Solution 20 mg/ml, nursing staff to give 0.5 ml by mouth every one hour, as needed to treat pain or SOA.-Morphine 0.5 ml was signed out on the following dates and times:--[DATE] at 3:00 P.M.--[DATE] at 6:00 A.M.--[DATE] at 12:00 A.M.-NOTE: There was an alleged change in color of the Morphine on [DATE].Review of the resident's Individual Resident Narcotic Record for Liquid Morphine received on [DATE] showed: -Physician order for Morphine Sulfate (Concentrate) Oral Solution 20 mg/ml, nursing staff to give 0.5 ml by mouth every one hour, as needed to treat pain or SOA.-Morphine 0.5 ml was signed out on the following dates and times:--[DATE] at 1:12 A.M. --[DATE] at 9:20 P.M.--[DATE] at 12:00 A.M. --[DATE] at 11:00 P.M.--[DATE] at 12:00 A.M. --[DATE] at 8:47 P.M.-NOTE: There were many discrepancies between the documentation on the Individual Resident Narcotic Record and the TAR when the medication was signed out and given.Observation on [DATE] at 1:39 P.M. of the resident's medication pass showed:-Registered Nurse (RN) A had a key to the licensed nurse medication cart. -RN A did not have a key to get into the narcotic box in the licensed nurse medication cart.-The DON had a key to the controlled lock box inside the licensed nurse (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	medication cart.-The DON obtained and administered Morphine 0.5 ml (10mg) to the resident for pain and shortness of breath.2. Review of Resident #10's admission Record showed: -He/she was on Hospice services.-admitted with diagnoses of Chronic Obstructive Pulmonary Disease (COPD a progressive, incurable lung disease, that caused airflow blockage, breathing difficulty, and chronic cough) and Anxiety.Review of the resident's Quarterly MDS dated [DATE], showed he/she:-Was moderately cognitive impaired. -Was able to understand others and make his/her needs known.-Was on opioids and anxiety medication during look back period.-Required assistance of staff for all cares. -Required Hospice Services.Review of the resident's Physician Orders dated [DATE] showed:-Lorazepam Oral Concentrated two ml/mg to give 0.25 ml by mouth every two hour as needed for agitation/anxiety part of hospice comfort measure, was ordered on [DATE]. -Morphine Sulfate (Concentrate) Oral Solution 100 MG/5ML (Morphine Sulfate), nursing staff to give 0.25 ml by mouth every two hour, as needed for pain/air hunger hospice comfort measure, was ordered on [DATE]. Review of the resident's TAR dated [DATE] showed: -Lorazepam Oral Concentrated 2 ml/mg to give 0.25 ml by mouth every two hour as needed for agitation/anxiety part of hospice comfort measure, was ordered on [DATE]. -Morphine Sulfate (Concentrate) Oral Solution 100 MG/5ML (Morphine Sulfate), nursing staff to give 0.25 ml by mouth every two hour, as needed for pain/air hunger hospice comfort measure, was ordered on [DATE]. -There was no documentation that indicated the Lorazepam was given from [DATE] to [DATE]. -There was no documentation that indicated the Morphine was given from [DATE] to [DATE]. Review of the resident's handwritten Individual Resident Narcotic Record for Lorazepam received on [DATE] showed Lorazepam was documented as signed out on the following dates and times:-On [DATE] at 9:30 P.M.--The TAR did not indicate the medication was given.-There was no legible signature to indicate who gave the medication. Review of the resident's handwritten Individual Resident Narcotic Record for Morphine received on [DATE] showed Morphine was documented as signed out on the following dates and times:-On [DATE] at 12:25 A.M.--The TAR did not indicate the medication was given. 3. Review of Resident #35's admission Record showed he/she had diagnoses of COPD and anxiety. Review of the resident's Quarterly MDS dated [DATE] showed he/she:-Was cognitively intact.-Was able to understand others and make his/her needs known.-Required assistance of staff for all cares. Review of the resident's Individual Resident Narcotic Record for liquid Morphine received on [DATE] showed:-Physician's order for Morphine Sulfate (Concentrate) Oral solution 20 mg/ml, nursing staff to give 0.25 ml by mouth every one hour as needed to treat pain or SOA. -There was no documentation the medications had been signed out. -The bottle had been opened. During an interview on [DATE] at 10:00 A.M. the DON said:-The facility had determined the resident's Morphine order was received on [DATE] and delivered as part of a hospice comfort kit.-The care team (the physician, nursing and hospice) determined the resident did not need the Morphine at that time. -There was no documentation that indicated the Morphine had been administered. -The bottle of Morphine was open. -The bottle of Morphine should not have been open until it was administered. 4. Observation on [DATE] at 12:05 P.M., of the locked medication storage room showed:-Resident #51 had one open box that had an open bottle of Lorazepam.-The open box had a pharmacy label that showed was received on [DATE].-The box and bottle of medication did not have date when was opened. -The open bottle of Lorazepam was not labeled with a resident name.-The black box E-kit for narcotic medication was locked and had two keys placed in zip lock bag taped to the top of boxDuring an interview on [DATE] at 12:05 P.M. LPN B and the DON said:-He/She would ensure the Lorazepam medication bottle went back in the box after administering the medication to the resident.-He/She had never lost the pharmacy prescription box; the box had the resident's name and prescription label on it. -For that bottle of medication, he/she had never mixed up the bottles of Lorazepam for the resident. Observation on [DATE] 12:15 P.M., of the [NAME] side nurse's medication cart showed:-Resident #51 had an open box and bottle of Morphine received on[DATE]. The bottle was not labeled with the resident's name; there was no date when the bottle had been opened.-Resident #10 had an open box and bottle of Morphine received on (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	[DATE], there was no date the box or bottle were opened, and the bottle was not labeled with the resident's name. During an interview on [DATE] at 12:15 P.M. LPN B said he/she counted and checked narcotics to ensure the documentation matched the amount of medication in the bottles at each shift change and when administered. Observation on [DATE] at 9:38 A.M., of the CMT Medication Cart showed:-Vitamin C 250 mg with a manufacture expiration date of [DATE], dated as opened on [DATE] and was still being used.-Allergy Relief 25 mg with a manufacture expiration date of [DATE], dated as opened on [DATE] and was still being used.-One a day Vitamin with a manufacture expiration date of [DATE], dated as opened on [DATE] and was still being used.During an interview on [DATE] at 9:38 A.M. CMT C said:-He/She normally checked manufacture expiration dates and labeled when the OTC medication was opened. -The three OTC medications were opened and used past their manufacture expiration dates.The three expired OTC medications should not be in the cart and should not be used.-The CMT's had access to the medication E-kit dispensing machine for approved non-narcotic medication. Only one staff was required to sign in.-If a CMT required a controlled substance, the E-kit dispensing machine required two nurses to access and sign in to get the narcotic medication. 5. During an interview on [DATE] at 9:51 A.M., CMT B said:-The licensed nurse was responsible to administer any liquid narcotic and as needed medication to include Morphine and Lorazepam. -CMT's and licensed nursing were to document any medication given or refused in the residents Medication Administration Record (MAR) or TAR and document on the resident's induvial narcotic record.-CMT's were not allowed to handle any PRN medication or liquid narcotics. -The CMT narcotic shift change was to be completed at begin and end of each shift and signed off by the CMT or nurses for each shift change.-CMT's were not allowed to leave if an error was noticed, or the count was off until the CMT and nurse figured out where and why the error occurred. During an interview on [DATE] at 9:59 A.M., CMT A said: -The licensed nurses were the only person who could give liquid narcotics and as needed narcotics including Morphine and Lorazepam.-Narcotics were to be documented in the resident's MAR/TAR and on the resident individual narcotic count sheet when given. During an interview on [DATE] at 10:25 A.M., RN A said -He/she was on probation and was not able to handle or access any narcotic/controlled substance medication. -The liquid Morphine and liquid Lorazepam were in the locked nurse's narcotic box. -He/she did not have a key to the medication room and to the nurse's medication cart locked narcotic box. -The resident's TAR and the resident's individual narcotic count record should match with dates and times of medication administration to the resident and by whom. During an interview on [DATE] at 10:16 A.M., the DON said:-He/she had recently noticed that Resident #51's Morphine was not signed off on the resident's TAR, but only on the resident's individual narcotic count record.-He/she would expect all nursing staff should ensure to document on TAR and on the resident individual narcotic record as given or refused. -He/she was not aware Resident #51's Lorazepam had not been documented as given on the resident TAR.During an interview [DATE] at 2:00 P.M., Administrator said: -All residents who had prescribed Morphine were getting the medication and was given medication as physician ordered. -The DON completed an audit of Resident #51's, Resident #10's, and Resident #10's TAR and resident individual narcotic record.-The DON found Resident #10's bottle of Morphine had been opened and there was no documentation the medication had been administered. -Resident #10's bottle of Morphine should not have been opened. -Resident #51's and Resident #10's bottles of Morphine did not have a date or time when they were opened. -Narcotics were secured by double lock on the nursing cart (the cart itself and the narcotic box on the cart) and did not require two staff to sign off as given. -CMT's did not have access to Morphine. -CMT's did not pass any liquid pain medications or any PRN narcotics. During an interview on [DATE] at 3:57 P.M., the DON said: -He/She was responsible for the audits of the resident's medical record for accuracy and any transcription errors. -CMT's were able to administer scheduled narcotics and control substance. -CMT's were not allowed to administer any PRN medications and no liquid narcotic medication. -When a controlled substance was administered, he/she would expect licensed nurses to document on the resident individual narcotic record form and (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	on the TAR.-When a controlled substance was administered, he/she would expect CMT's to document on the resident individual narcotic record form and on the MAR.-Resident #51's Morphine should be dated when they were initially opened.-He/she did not know how long Morphine was good once opened.-Resident #10's Morphine should not have been opened until it was administered.-Morphine should be stored in the nurse's medication cart in the lock box. -Only the charge nurse had access to the medication refrigerator and medication cart locked narcotic box. -All over the counter medication should not be given if expired.-The CMT's were responsible for monitoring the over-the-counter medication expiration dates.-All medication bottles / containers should be dated when they were opened. -There was no ongoing auditing system in place to ensure safe storage and administration of medications. 2707541

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures for flu and pneumonia vaccinations. Based on interview and record review, the facility failed to maintain an infection prevention and control program to help prevent the development and transmission of communicable diseases when the facility failed to provide a pneumococcal (pneumonia-lung inflammation caused by bacterial or viral infection) vaccine for one sampled resident (Resident #46) out of five residents sampled for immunizations. The facility census was 60 residents. Review of the facility's Influenza and Pneumococcal immunizations policy dated 5/14/24 showed:-As a part of the admission process , the resident and/or the resident's legal representative will be provided education on the benefits and potential side effects of both the Influenza and Pneumococcal Immunization.-The resident or their legal representative will be informed that the Pneumococcal immunization will be offered upon admission per CDC guidelines. The Pneumococcal immunization will not be given if the immunization is medically contraindicated, the facility has evidence to support the resident the resident received the immunization, or the resident or their legal representative has refused the immunization. -The resident or their legal representative will be required to sign the revolving consent form attached to this policy. The resident or their legal representative will be told this form provides consent for annual influenza immunization and for the Pneumococcal immunization as needed unless those immunizations are medically contraindicated.-The resident or their legal representative will be told that they can revoke the revolving consent form at any time, but such revocation must be in writing.--No revolving consent was provided.-The Pneumococcal immunization will be offered upon admission, and a second Pneumococcal immunization may be recommended after five years from the first immunization. The Pneumococcal immunization will be given unless the immunization is medically contraindicated, the facility has evidence the resident has already been immunized during this time period, or the resident or their legal representative had refused the immunization.-The resident's clinical record will document:--The resident or their legal representative was provided education regarding the benefits and potential benefits and side effects of influenza and pneumococcal immunizations or did not receive them due to medical contraindications or refusal.1. Review of Resident #46's face sheet showed he/she admitted with diagnoses that included:-Chronic Obstructive Pulmonary Disease (COPD - a disease process that decreases the ability of the lungs to perform ventilation).-Anemia (a condition where the blood lacks enough healthy red blood cells or hemoglobin, which are needed to carry oxygen from the lungs to the body's tissues and organs).Review of the resident's Physician's Order Sheet (POS) dated February 2026 showed the resident may have the pneumococcal vaccine.Review of the resident's annual immunization consent form dated 10/29/25 showed:-The resident had been educated on the risk vs benefits and potential side effects of receiving thePneumococcal Immunization.-The resident agreed to receive the Pneumococcal immunization as evidenced by the form being signed and dated on 10/29/25.Review of the resident's immunization record, generated from the Electronic Health Record (EHR) showed there was no documentation of the resident's pneumococcal vaccine status.During an interview on 2/2/26 at 2:05 PM., Registered Nurse (RN) A said:-He/She had never documented any vaccine information in the EHR personally, but would expect it would contain date, time, and education provided.-Residents were offered the Pneumococcal vaccine on admission.-He/She was unable to locate any documentation of the resident's Pneumococcal immunization in the immunizations, progress notes, or uploaded documents sections of the EHR.-He/She was not sure who was responsible for administering and documenting vaccine information.During an interview on 2/2/26 at 3:30 P.M., the Director of Nursing (DON) said:-Residents should be offered the Pneumococcal vaccine upon admission.-Residents who received education and signed a consent form for a vaccination should have received the vaccination.-He/She was unable to find any documentation of the administration of the Pneumococcal vaccine for the resident.- He/she was responsible for obtaining consent, education, administration, and documentation of all residents who are offered the Pneumococcal vaccine.

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to maintain an infection prevention and control program to help prevent the development and transmission of communicable diseases when the facility failed to ensure five sampled residents (Residents #2, #10, #35, #46, and #51) were offered and had documentation of refusal of COVID-19 (a new disease caused by a novel (new) coronavirus) education provided out of 5 residents sampled for immunization review. The facility census was 60 residents. Review of the facility's Infection Prevention and Control Program, dated 6/26/24 showed:-Residents will be offered the COVID-19 vaccine when vaccine supplies are available to the facility.-Education about the vaccine risks, benefits, and potential side effects will be given to residents or resident representatives and staff prior to offering the vaccine.-Residents or resident representatives will have the opportunity to accept or refuse a COVID-19 vaccination and change their decision based on current guidance.-Documentation will reflect the education provided and details regarding whether or not the resident received the vaccine.1. Review of Resident #2's admission Record showed he/she was admitted to the facility on [DATE].Review of the resident's medical record showed no documentation of the resident's COVID vaccine status or that the resident had received education for the risks and benefits of the vaccine since admission to the facility.2. Review of Resident #10's admission Record showed he/she was admitted to the facility on [DATE].Review of the resident's medical record showed no documentation of the resident's COVID vaccine status or that the resident had received education for the risks and benefits of the vaccine since admission to the facility.3. Review of Resident #35's admission Record showed he/she was admitted to the facility on [DATE].Review of the resident's medical record showed no documentation of the resident's COVID vaccine status or that the resident had received education for the risks and benefits of the vaccine since admission to the facility.4. Review of Resident #46's admission Record showed he/she was admitted to the facility on [DATE].Review of the resident's medical record showed no documentation of the resident's COVID vaccine status or that the resident had received education for the risks and benefits of the vaccine since admission to the facility.5. Review of Resident # 51's admission Record showed he/she was admitted to the facility on [DATE].Review of the resident's medical record showed no documentation of the resident's COVID vaccine status or that the resident had received education for the risks and benefits of the vaccine since admission to the facility.6. During an interview on 2/2/26 at 12:55 P.M., the Director of Nursing (DON) said:-He/She was also functioning as the facility's Infection Preventionist since starting in August of 2025.-COVID vaccines should be offered and education given to residents at the time of admission and annually.During an interview on 2/2/26 at 2:05 P.M., Registered Nurse (RN) A said:-He/She had never documented immunization information personally but knew it was kept under the immunization tab in the resident's chart and would expect for it to contain dates, times, and education.-He/She was unable to find any documentation of consents, education, or administration of the COVID vaccine for Residents #2; #10; #35; #46; or #51 in the progress notes, forms, or uploaded documents sections of the residents' medical records.-He/She was not sure who was responsible for ensuring COVID vaccine consents were obtained or who was responsible for administering the vaccines.During an interview on 2/2/26 at 3:30 P.M., the DON said:-Residents who were offered the COVID vaccine should receive an education/declination form to read and sign, there was no such form in use at the moment, but it was in the works. -He/She was working with the pharmacy to do in house vaccines going forward and was waiting for them to provide those forms.During an interview on 2/2/26 at 5:00 P.M., the DON said:-All residents should be offered and receive education on the risks and benefits of the COVID vaccine, and he/she was responsible for explaining and obtaining this information from the resident, filling out a (continued on next page)

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	consent/declination form and uploading it into the documents section of the resident's medical record.-He/She was unable to locate any documentation of education, administration, and declination for Residents #2; #10; #35; #46; and #51.-He/She was responsible for obtaining consent, education, administration, and documentation of all residents who were offered the COVID vaccine.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, the facility failed to ensure the commode safety rails (adjustable, sturdy, metal frames with handles that fit around or bolt onto a toilet to provide stable support for a person who was going from a siting to standing position or from a standing to sitting position) in the restrooms were sturdy in the shared restroom of resident rooms [ROOM NUMBERS], in the shared restroom of resident rooms [ROOM NUMBERS], in the shared restroom of resident rooms [ROOM NUMBERS], in the shared restrooms of resident rooms [ROOM NUMBERS], and resident room [ROOM NUMBER]. This potentially affected 15 residents who resided in those rooms. The facility census was 60 residents. 1. Observation pm 1/28/26 with the Maintenance Director showed:-At 1:43 P.M., the commode safety rails in the shared restroom of resident rooms [ROOM NUMBERS], were wobbly, when they were handled.-At 3:03 P.M., the commode safety rails in the shared restroom of resident rooms [ROOM NUMBERS], were wobbly, when they were handled.-At 3:07 P.M., the commode safety rails in the shared restroom of resident rooms [ROOM NUMBERS], were wobbly, when they were handled.-At 3:11 P.M., the commode safety rail in the shared restroom of resident rooms [ROOM NUMBERS], were wobbly when it was handled.-At 3:39 P.M., the commode safety rails in the restroom of resident room [ROOM NUMBER], were wobbly when they were handled.During an interview on 1/30/26 at 3:12 P.M., the Maintenance Director said:-He/she had only been at the facility for three weeks.-He/she had not had a chance to check the commode safety rails.-He/she did not have any idea how often the commode safety rails were checked.

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F 0567 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to manage his or her financial affairs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to obtain written authorization from the guardian of two sampled residents (Resident #21 and #9) to allow the facility to make withdrawals from their Resident Trust accounts for specific HealthCare (clinics which were funded through supplemental insurance paid by residents and are established on-site and treatment is provided using advanced equipment specifically selected for residents of senior care communities in the areas of optometry, podiatry, dental and audiology services) out of four residents sampled for resident funds review. The facility census was 60 residents. Review of the Facility's Policy titled Resident Trust, revised on 9/21/25, showed:-Personal funds of the resident shall be used exclusively for the resident, which must be authorized in writing. -The individuals who can authorize such transactions may be the resident, his/her legal guardian, or a legal representative (who may not be an employee at the facility, including the Administrator). -The facility is allowed to purchase a burial plan for the resident when written authorization is obtained.1. Review of Resident #21's Face Sheet showed the following diagnoses:-Schizoaffective Disorder of the Bipolar type (a chronic mental health condition that combines symptoms of schizophrenia (psychosis) and a mood disorder, such as mania or depression).-Intellectual disabilities (a neurodevelopmental condition characterized by significant limitations in both intellectual and adaptive functioning).-Primary insomnia (a common sleep disorder characterized by difficulty falling asleep, staying asleep, or experiencing poor quality sleep).-Essential hypertension (high blood pressure).Review of the resident's medical record showed the resident had a guardian since July 2011.Review of the resident's Resident Trust Transaction History dated 10/1/25 through 12/31/25 showed:-On 11/19/25 a withdrawal of $564.00 was made for a payment to a specific HealthCare.-On 12/3/25 a withdrawal of $282.00 was made for a payment to a specific HealthCare.Review of the resident's authorizations showed the absence of a signed document by the resident's guardian which would authorize the facility to make withdrawals from the resident's account.During a phone interview on 2/6/26 at 8:27 A.M., the resident's legal guardian said:-He/She was not informed about his/her ward signing up for a specific HealthCare.-He/She did not know what the specific HealthCare was and would have wanted to explore more about it.-The facility had not asked him/her about signing the resident up for the specific HealthCare.2. Review of Resident #9's Face sheet showed diagnoses which included:-Parkinsons' Disease (a movement disorder of the nervous system that worsens over time).-Lewy Bodies neurocognitive disorder (abnormal clumps of the protein alpha-synuclein that build up inside brain cells, damaging them and leading to neurodegenerative diseases like Parkinson's disease).-Restless legs syndrome.Review of the Resident's quarterly MDS dated [DATE] showed the resident had severe cognitive impairment. Review of the resident's Resident Trust Transaction Summary dated 10/3/25 through 12/31/25, showed: -On 10/3/26, a withdrawal of $283.00 was made for a payment to a specific HealthCare.-On 11/19/26, a withdrawal of $282.00 was made for a payment to a specific HealthCare.-On 12/3/25, a withdrawal of $282.00 was made for a payment to a specific HealthCare.During an interview on 2/2/26 at 10:34 A.M., the Business Office Manager (BOM) said the resident already had the specific HealthCare program when he/she started at the facility as the BOM in 2025. During a phone interview on 2/6/26 at 12:49 P.M., the resident's relative said:-There were times when the resident was confused.-He/she spoke with someone over the phone about a specific HealthCare.-He/she did not sign any paperwork or forms to allow money to be withdrawn from the resident's Resident Trust Account.3. During an interview on 2/2/25 at 2:41 P.M. the Social Service Designee (SSD) said:-He/she started his/her tenure at the facility, three months ago.-He/she had asked the residents if they wanted to sign up for specific HealthCare.-He/she had asked the residents since he/she started for consents to allow withdrawals to be made from their trust accounts to specific HealthCare.-He/she was unaware that Residents #21 and Resident #9 were part of specific HealthCare, because those residents signed up before he/she started at the facility.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. Based on observation, interview, and record review, the facility failed to ensure the mood and behaviors section of the care plan was up to date for one sampled resident (Resident #43) out of 15 sampled residents. The facility census was 60 residents. Review of the facility's policy Comprehensive Care Plans dated 10/31/24 showed:-It was the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and time frames to meet a resident's medical, nursing, and mental and psychosocial needs that were identified in the resident's comprehensive assessment. -The comprehensive care plan would be reviewed and revised by the interdisciplinary team after each comprehensive and quarterly MDS assessment.-The comprehensive care plan would include measurable objectives and time frames to meet the residents needs as identified in the resident's comprehensive assessment.-The objectives would be utilized to monitor the resident's progress. Alternative interventions would be documented as needed.1. Review of Resident #43's admission Record showed the resident was admitted with the following diagnoses of:-Paraplegia (the partial or complete loss of motor and sensory function in the lower half of the body) unspecified.-Bipolar disorder, current episode manic without psychotic feature, severe (characterized by extreme, disruptive mood highs without hallucinations or delusions. It represents intense, persistent mania causing major impairment in daily functioning, work, or social life, typically requiring immediate treatment or hospitalization to manage high-risk behaviors, such as risky spending or reckless action.)-Essential (Primary) Hypertension (HTN- high blood pressure).Review of the resident's Care Plan dated January 2026, showed:-The resident had a mood problem.-GOAL: The resident would have improved mood state (SPECIFY: happier, calmer appearance, no signs or symptoms of depression, anxiety or sadness) through the review date. --There were no specifics noted in the care plan. -The resident had depression.-The resident would exhibit indicators of depression, anxiety or sad mood less than daily by review date. --There were no specifics of what the resident's indicators were.Review of the resident's quarterly Minimum Data Set (MDS-a federally mandated assessment tool to be completed by facility staff for care planning) dated 1/1/26 showed the resident:-Was cognitively intact.-Had hypertension.-Had paraplegia.-Had Bipolar Disorder. Observation on 1/27/26 at 9:30 A.M. showed the resident was talking loudly at the television about religion and laughing; that's right man. During an interview on 1/27/26 at 10:35 A.M. the resident said:-He/She was in the middle of his/her bible study and pointed to the television where there where bible verses on the screen but said he/she had time for a couple of questions.-The medical facilities don't know what they were doing, and they were all frauds. -Doctors and pharmacist were all liars and greedy and just wanted to push pills. -They kept him/her alive and play God when he/she should be dead. -Now he/she can't walk and had no use of the lower half of his/her body; that was no life. -Believed his/her roommate was not a Christian. -That his/her beliefs were just opinions they were not opinions he/she doesn't have to listen to anyone. -The church people that come in here don't know what they were talking about. -Staff tell him/her not to talk so loudly and he/she replied that they talk loud on their phones all the time, so what was the difference. Observation on 1/27/26 at 11:30 A.M. showed the resident continued speaking loudly doing his/her bible studies and agreeing with his/her bible study on the television. Observation on 1/30/26 at 10:00 A.M. showed the resident was talking at the housekeeper about religion and how the medical staff didn't know what they were doing. During an interview on 1/30/26 at 12:18 P.M. Housekeeper A said:-This was his/her third week working here.-The resident could be loud and talkative.-He/She just went in and out of rooms and did his/her job.During an interview on 1/30/26 at 2:02 P.M., Certified Nursing Assistant (CNA) C said: -The resident didn't voice his/her concerns very often.-Last week it was constant, and he/she was mainly yelling about religion. During an interview on 2/2/26 at 9:00 A.M. CNA A said:-The resident would voice his/her (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	concerns daily.-Did not know if it was in his/her care plan.-Thought the care plan should have something about his/her behaviors and how to work with him/her. During an interview on 2/2/26 at 10:24 A.M. Certified Medication Technician (CMT) A said:-The resident would voice his/her concerns all the time.-There should be something in his/her care plan about his/her behaviors.-He/She refused his/her medications a lot. During an interview on 2/2/26 at 1:54 P.M. CNA D said:-The resident would voice his/her concerns at least once a day mainly about religion. -Last week it was every day. -There should be something in his/her care plan about his/her behaviors and how to help him/her. Observation on 2/2/26 at 2:00 P.M. showed:-The resident was in his/her motorized wheelchair talking loudly.-The resident had a somewhat angry sarcastic tone saying that the place was charging him/her $20,000 for what and saying the medical staff were quacks. -They were stealing his/her money. During an interview on 2/2/26 at 2:12 P.M. Registered Nurse (RN) A said:-He/She would not call the resident's actions a behavior, but he/she would call it a strong personality. -Last week the resident was speaking loudly/yelling about religion or how medical personal were liars and quacks daily. -It was recognized the resident was loud/yelling more when he/she was in his/her motorized wheelchair, he/she would be very opinionated and thought he/she was right. -The resident's care plan should have something about the individual's personality and what would be the best way to work with the resident. -He/she thought administration oversaw care plans. During an interview on 2/2/26 at 3:45 P.M. the Administrator said:-If a resident was having a behavior, the behavior should be in the care plan.-Since the outburst were so recent they hadn't had a chance to evaluate why he/she was having them. -The resident was doing fine when he/she was first admitted . During an interview on 2/22/26 at 3:57 P.M. the Director of Nursing (DON) said:-There should be something in the resident's care plan about his/her outbursts/yelling behaviors.-He/She was responsible for making sure the care plans were up to date.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure bathing was completed twice weekly by nursing staff in addition to bathing that was completed by hospice (end of life) staff for one sampled resident (Resident #10) out of 15 sampled residents. This deficient practice potentially affected all residents on hospice services. The facility census was 60 residents. Review of the facility undated Shower Expectations procedure showed:-Residents on Hospice must be offered 2 showers a week from the facility for a total of 4 showers a week.-Bed Baths must be approved by the charge nurse and only ONE shower per week can be a bed bath unless otherwise arranged/care planned by the Director of Nursing (DON).-All shower declines must immediately be told to the charge nurse so they can follow up.-If the resident continues to decline, the DON or Administrator must be notified immediately.-Do not wait until the end of the day to tell the charge nurse about shower declines.-If a resident continues to decline, you must get their signature on the declined shower sheet.-ALL shower sheets MUST be signed by the resident, after the shower is completed. If the resident is unable to sign, it must be signed by a staff who witnessed some part of the showering process (in, out, during, etc.) and the shower aide.-Only the charge nurse, DON, or Administrator can fill out a refusal shower sheet.-Showers must be done even if there is not a shower aide.-Saturday showers must be completed.-Every resident must be offered at least 2 showers a week.-If a resident requests a shower on a random day, they are to get a shower that day.-Nurses must sign all shower sheets & address any issues on the shower sheet.-All Hospice showers must have a shower sheet turned in by the hospice aide.1.Review of Resident #10's Face Sheet showed the resident was admitted on [DATE], with diagnoses including heart failure, high blood pressure, diabetes, high cholesterol, heartburn, arthritis, stroke, traumatic brain injury (a disruption in normal brain function caused by an external physical force, such as a bump, blow, jolt, or piercing object) anxiety and depression.1. Review of the resident's comprehensive Minimum Data Set (MDS a federally mandated assessment tool to be completed by facility staff for care planning) dated 1/8/26 showed the resident:-Was alert with minimal cognitive incapacity.-Had lower extremity impairment on both sides and used a wheelchair for mobility.-Needed maximum assistance with bathing, dressing, toileting, hygiene and transfers.-Received Hospice care.Review of the resident's Care Plan updated on 11/17/25 showed the resident had limited physical mobility related to neuropathy (a condition resulting from damage to the nerves outside the brain and spinal cord that can cause numbness, tingling, burning pain, and muscle weakness, commonly starting in the hands or feet) and pain. Interventions showed:-Dressing: The resident relied on staff for dressing his/her lower body. The resident was able to assist with upper body dressing with extensive assist.-Oral Care: The resident required one person to assist with oral cares.-Toileting: The resident required assist with toileting by two staff and wore an adult incontinence product. -Transfer: The resident transferred with a full body mechanical lift and assisted by two staff persons. -NOTE: The care plan did not show the resident's capability for bathing or amount of assistance needed. It did not show that the resident resisted bathing or resident cares.Review of the resident's bath sheets dated November 2025 showed:-On 11/20/25 the resident refused the bath-On 11/27/25 there was nothing that indicated the bath was offered or given (no signatures were on the form).Review of the resident's bath sheets dated December 2025 showed:-On 12/11/25 the resident refused the bath. -On 12/12/25, 12/19/25, 12/22/25, 12/23/25, 12/27/25, 12/29/25, 12/31/25 Hospice gave the resident baths.-The facility staff did not provide their required baths to the resident.Review of the resident's Hospice Note dated 12/31/25, showed:-The resident was now bedbound and required at least 40 percent of activity of daily living assistance (bathing, dressing, eating, toileting, transfers and mobility) needed.-The resident no longer got out of bed, used a full body mechanical lift for transfers, had increased confusion, poor appetite but drank very well, -The resident also used oxygen at 2-4 liters per (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	minute.-Notes showed the bath aide visited daily to complete care/bathing and feeding/drinking assistance.Review of the resident's bath sheets dated January 2026 showed:-On 1/2/26, 1/9/26, 1/12/26, 1/16/26, 1/20/26, 1/23/26, and 1/30/26 baths were completed by the Hospice aide. -There was no documentation showing the facility nursing staff or bath aide gave any resident baths. -The resident did not receive the minimum number of baths during the month.Observation on 1/28/26 at 8:46 A.M., showed the resident was lying in bed with his/her eyes closed and he/she was resting comfortably. His/Her oxygen was on and running and there were no signs or symptoms of distress. The resident was not odorous.Observation on 1/30/26 at 12:07 P.M., showed the resident was lying in a low bed with positioning pillows and Prafo boots (a custom-fitted, adjustable medical device designed to suspend the heel) on. The resident was dressed for the weather without odors. His/her oxygen was on and running the resident's eyes were closed and he/she was resting comfortably.During an interview on 2/2/26 at 3:05 P.M., the Bath Aide said:-He/She was supposed to give baths to all residents including those who were on Hospice.-He/She was supposed to give baths twice weekly to the residents.-He/She worked five days weekly and was responsible for giving 120 baths every week.-The resident's Hospice staff also gave baths to the resident at least twice weekly.-The Hospice staff did not know they were supposed to use their bath sheets, so they were using the facility bath sheets to document their baths, and they documented Hospice on the bath sheets.-He/She focused on giving showers to those residents who were not on Hospice first to try to get at least one bath weekly to every resident.-He/She had not been able to get to the residents who were on Hospice services because he/she had so many residents to give showers to and was not able to do so without some help.-The baths he/she was supposed to give to residents on Hospice were not getting done.During an interview on 2/2/26 at 3:10 P.M., Certified Nursing Assistant (CNA) A said: -Residents on Hospice were to receive four baths weekly.-When the Bath Aide was not there or was unable to complete resident baths, the CNAs were supposed to assist with giving resident baths.-Nursing staff did help give baths if they had three CNA staff working-one would be designated to provide bathing.-They did not often have enough nursing staff daily to assist with giving baths.-Other times they would try to give baths on Sundays.-They would always document the baths they gave on the resident bath sheets.-The Bath Aide was not able to get all the resident baths completed because there were too many residents to give baths to.-He/She did not think that the residents on Hospice received four baths weekly, but they did receive the baths that Hospice came in to give.During an interview on 2/2/26 at 3:58 P.M., the Director of Nursing (DON) said:-Hospice aides bathe their residents twice weekly and the facility bath aide was supposed to give two baths to every resident weekly for a total of four baths for those residents receiving Hospice services.2702915

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to obtain and transcribe a physician order for the use of a Low Air Loss Mattress (LAL mattress a specialized medical mattress technology designed for pressure ulcer prevention and treatment) with soft side bolsters (create a gentle raised edge that gives resident sensory awareness when near the mattress edge) to include the required settings and monitoring of the LAL mattress for proper inflation and function for one sampled resident (Resident #51) who was at risk for skin changes; and failed to ensure the smoking assessment accurately reflected the current safety status of one sampled resident (Resident #4) who required supervision when smoking due to adverse smoking behaviors, and failed to monitor the smoking behaviors out of 15 sampled residents. The facility census 60 residents. Review of the facility's Bed Maintenance and Inspections Policy revised on 5/14/25 showed:-It is the policy of this facility to conduct regular inspections of all bed frames, mattresses, if any, as part of a regular maintenance program to identify and avoid areas of possible entrapment.-The Maintenance Director, or designee, is responsible for keeping records of bed inspections and maintenance.-A list of bed frames, mattresses, will be maintained, including the manufacturer for each. Review of the facility's Transcription of Orders/Following Physician's Orders Policy revised on 5/18/25 showed:-The purpose of this policy is to outline procedures in accurately transcribing physician's orders and to ensure that all physicians' orders are followed. To ensure a process is in place to monitor nurses in accurately transcribing and following physician's orders.-Upon receiving a physician's order via telephone, fax, written order, verbal order, transcribed order or other, it will be documented in residents' electronic medical records in orders section. Review of the facility Smoking policy and procedure dated 5/18/24, showed -The purpose of this policy is to define what the facility classifies as smoking contraband and to provide safety and protective oversite to the residents and employees by monitoring the smoking contraband in the facility. It is the goal of the facility to provide a safe environment for all.-Under the quality of care regulation, each resident must receive and the facility must provide the necessary care and services to allow a resident to attain or maintain the highest practicable physical, mental and psychosocial well-being, in accordance with the resident's comprehensive plan of care. To achieve this, the facility must, among other requirements, ensure that The resident environment remains as free of accident hazards as is possible, that each resident receives adequate supervision and assistance devices to prevent accidents and to mitigate risks of smoking.-Residents will not be allowed to carry or keep any smoking contraband on their person or in their possession on the unit or in their rooms.-Residents will be assessed for independent smoking upon admission/re-admission, quarterly and PRN. The resident must be approved per Legal Guardian and by the interdisciplinary care plan team to smoke unsupervised. This is determined by assessment of the resident's history and current plan of care.-Residents who have been assessed to be safe to smoke unsupervised and have purchased their own smoking contraband will be allowed to sign out their personal smoking contraband from the staff to utilize when they wish to smoke. 1. Review of Resident #51 admission Record showed he/she was admitted with diagnoses that included:-Personality disorder (as the manifestation of extreme personality traits that interfere with everyday life and contribute to significant suffering, functional limitations, or both.) -Muscular Dystrophy (is a group of genetic diseases that cause progressive muscle weakness and loss of muscle mass).-Chronic Obstructive Pulmonary Disease (COPD an ongoing lung condition caused by (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	damage to the lungs).-Hospice care (is a special kind of care that focuses on a person's quality of life and dignity as they near the end of their life) on 9/3/25 with diagnosis of server protein-calorie malnutrition (s a life-threatening, often chronic, condition caused by extreme deficiencies in macronutrient intake such as protein, calories, and nutrients). -Anxiety (is a persistent, excessive fear or worry that interferes with daily life). Review of the resident's Care Plan revised on 8/1/25 showed he/she did not have a care plan for the use and the monitoring of the function of his/her LAL mattress. Review of the resident's Quarterly Minimum Data Set (MDS a federally mandated assessment instrument completed by facility staff for care planning) dated 12/24/25, showed he/she:-Was moderately cognitive impaired. -Was able to understand others and make his/her needs known.-Required assistance of staff for all cares. Review of the resident's Physician Order Sheet (POS) dated January 2026 showed:-Staff were to elevate the head of the bed due to shortness of air and COPD while in bed, every day and night shift for monitoring related to COPD ordered on 5/13/25.-There was no physician's order for the resident's use of a LAL mattress that included the mattress settings, and the monitoring to ensure the power box system was working and the mattress was inflated properly every shift. Review of the resident's Treatment Administration Record (TAR) dated January 2026 showed:-There was no physician's order for the resident's LAL mattress that included the settings, and the monitoring to ensure the LAL mattress was functioning properly. Observation on 1/27/26 at 10:29 A.M., of the resident in bed showed:-He/she was on a LAL mattress with soft sided bolsters.-The LAL mattress power box was not turned on and the mattress was deflating. Observation on 1/27/26 showed:-At 10:42 A.M. an unknown Certified Nursing Assistant (CNA) entered the resident's room and provided the resident personal care. -At 10:50 A.M., the unknown CNA exited the resident room. The resident's LAL mattress was partially deflated, and the power box was not turned on.-At 11:52 AM the resident's LAL mattress power box was turned on and the bed was inflated.-NOTE: The resident laid on a deflated LAL mattress for over one hour. During an interview on 1/30/26 at 2:38 P.M., CNA B said:-The resident's LAL mattress would be working properly when the green and red light on. -The resident recently received a new LAL mattress that was provided by Hospice.-He/she would notify the charge nurse of any concerns found with the LAL mattress. -The licensed nurse would be responsible for any documentation of the monitoring the function of the LAL mattress every shift in the TAR. During an interview on 2/2/26 at 9:51 A.M., Certified Medication Technician (CMT) B said:-The resident's LAL mattress settings and the function of the bed, that included the bed being inflated, should be checked every shift.-The resident should have a physician's order for the LAL mattress.-The resident's LAL mattress order should be on the TAR. During an interview on 2/2/26 at 9:59 A.M., CMT A said:-He/She was not aware of the facility policy regarding monitoring the function of a LAL mattress or who was responsible for checking and documenting the monitoring of the function of the LAL mattress. During an interview on 2/2/2026 at 10:25 A.M., Registered Nurse (RN) A said:-He/She was unsure of the facility protocol for use and monitoring of LAL mattresses.-He/She was not sure if a LAL mattress required a physician's order for use.-The resident was on hospice care and medical equipment was provided by hospice. During an interview on 02/02/26 at 3:57 P.M., the Director of Nursing (DON) said: -He/She was not made aware the resident's LAL mattress was (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	not turned on the morning of 1/27/26. -He/She would expect a physician's order on the resident's POS for his/her LAL mattress to include the mattress settings and the monitoring of the function by licensed staff every shift.-The licensed staff was responsible for documenting of the LAL mattress monitoring on the resident's TAR every shift. -All care staff were responsible for observing the residents LAL mattress and power box to ensure the power to the bed was turned on.-The resident's LAL mattress was ordered and provided by hospice. He/she would expect the hospice order to be on the resident's POS. -He/She would be responsible for auditing medical records for accuracy and to ensure there were no transcription errors. 2. Review of Resident #4's Face Sheet showed the resident was admitted to the facility with diagnoses that included:-Heart failure.-High blood pressure.-Traumatic brain injury (a disruption in normal brain function caused by an external mechanical force, such as a bump, blow, or jolt to the head, or a penetrating injury).-Respiratory failure. Review of the resident's Care Plan dated 10/31/25, showed the resident had noncompliance with the facility's smoking policy related to nicotine dependence and impaired judgment, as evidenced by hoarding cigarettes and lighters and attempting to leave the building to smoke outside of designated smoking times and areas. Interventions showed:-The resident will comply with facility smoking rules and designated smoking times/areas.-The resident will refrain from hoarding cigarettes, lighters, or matches.-The resident will remain safely within the building except during approved outings.-The risk of fire, elopement, and injury related to smoking would be reduced.-The resident would verbalize understanding of smoking rules and safety concerns. Review of the resident's Smoking and Safety assessment dated [DATE], showed:-Smoking status: Resident used tobacco products.-Resident followed the facility's policy on location and time of smoking.-Resident did not have poor vision or blindness, balance problems while sitting or standing, had limited or no range of motion in arms or hands, had insufficient fine motor skills needed to securely hold tobacco, marijuana, or vape products, was not lethargic/falls asleep easily during tasks or activities, did not drop ashes on self.-Resident was not unable to light tobacco safely, hold tobacco or vape products safely, to extinguish tobacco safely, or use the ashtray to extinguish tobacco products.-There were no concerns documented regarding the resident's behaviors regarding smoking and any interventions to ensure compliance with the facility smoking policy and procedure. -There was no documentation showing the resident needed to be supervised due to his/her behaviors while on the smoking patio.-This assessment did not show the resident was safe to smoke. Review of the resident's quarterly Minimum Data Set (MDS a federally mandated assessment tool to be completed by facility staff for care planning) dated 12/11/25, showed the resident:-Was alert and oriented without any cognitive incapacity.-Had behaviors of rejection of cares but had no delusional or hallucinatory behaviors.-Needed moderate assistance with bathing dressing, needed supervision with eating, hygiene and transfers and mobilized in a wheelchair.-Received tracheostomy care. Review of the resident's Nursing Note dated 1/8/26 showed:-The resident was outside on the patio smoking. He/She said he/she got a cigarette from the ashtray and was smoking it. The resident had been known to do that but had also been observed pocketing cigarettes during smoke break and refused to give them back to staff. He/She had also refused to give staff the lighter he/she had and denied having one. Staff reminded the resident at that time that residents could not be outside smoking without staff present. Resident shrugged his/her shoulders and rolled away. The staff informed the Director of Nursing (DON). (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the resident's medical record dated 1/9/26 to 1/26/26 showed there was no documentation showing the facility reassessed the resident's ability to smoke safely or unsupervised due to his/her behaviors while on the smoking patio. There was no documentation of the resident having reoccurring behaviors regarding smoking (picking up butts off the ground or out of the receptacle, hoarding lighters/cigarettes) that were being monitored by the nursing staff. There was no documentation showing the facility re-educated the resident on the smoking policy and procedure or any interventions implemented after the resident continued to have behaviors around smoking. Observation on 1/28/26 at 1:30 P.M., showed:-Staff took the residents out on the smoking patio to smoke and supervised them. -Staff passed out cigarettes and used a lighter to light the cigarettes for the residents on the smoking patio. -The resident was dressed for the weather and received assistance to light his/her cigarette but was able to smoke without assistance and smoked safely without burning himself/herself. -While smoking, he/she flicked ashes onto the ground instead of into a smoking receptacle. -When he/she was finished, he/she came back into the facility. Observation on 2/2/26 at 9:34 A.M., showed:-Housekeeper A was on the smoking patio with residents who were already smoking. -The resident was sitting in his/her wheelchair dressed for the weather and was smoking a cigarette on the patio with peers. -Housekeeper A continued passing out cigarettes and lighting them for residents who came onto the smoking patio. -The resident was smoking without assistance and was smoking appropriately. During an interview on 2/2/26 at 9:37 A.M., Housekeeper A said: -Facility staff took turns supervising smoking on the smoking patio.-The residents had designated smoke periods. -The resident often smoked at most of the smoke times. -The resident used to have behaviors of picking up cigarette butts off of the ground and dumping the cigarette receptacle out and looking for butts to smoke. -They used to give the residents two cigarettes at each smoke period and allowed them to use the lighter so they could light their own cigarette, but they noticed the resident would hoard cigarettes and the lighters, so they started keeping the lighters and giving one cigarette per resident at a time and lighting the cigarette for the residents. -The nursing staff educated the resident on not getting butts from the receptacle and the ground to smoke. -Since this re-education occurred, the resident had been compliant with the smoking policy and procedures. -To his/her knowledge, it had been about two to three weeks since this change occurred. During an interview on 2/2/26 at 12:27 P.M. Registered Nurse (RN) A said:-The resident had a behavior of getting cigarette butts out of the receptacle outside and trying to smoke them, hoarding lighters and they had to watch him/her very closely when he/she was on the smoking patio.-The resident had recently stopped doing that since it had been cold.-They had to educate the resident on these behaviors and on the smoking protocol and then they also changed how they supervised the smoking. -They no longer allowed the residents to light their own cigarettes and they only gave one cigarette at a time. When it was time to smoke they supervised the residents during the entire smoke period. -The resident was able to smoke safely as far as his/her ability to handle the cigarette and put it out, but he/she absolutely needed to be supervised while smoking because of his/her behaviors while on the smoking patio.-If they deemed the resident able to smoke safely, it may had been prior to observing his/her behaviors, but another assessment should have been completed after the behaviors began because the resident should not be left to smoke independently and did need supervision due to his/her behavior. During an interview on 2/2/26 at 3:58 P.M., the DON said:-Residents with behaviors during smoking should be documented as part of the smoking assessment.-Residents should be reassessed if the (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	resident exhibited behaviors that would change the initial assessment.-Since August the staff were supposed to handle all lighters and light the cigarettes for the residents and they could only have one cigarette at a time. When they finished smoking it, they could have another one, but the resident did not get to keep the cigarettes unsmoked.-The resident had past behaviors of dumping the smoking receptacle and smoking cigarette butts, and hoarding lighters and cigarettes.-The nursing staff had to watch him/her all of the time because of these behaviors, and he/she somehow always had a lighter.-In warmer weather he/she would go outside to hang out-get fresh air and at those times he/she would go into the receptacle to get cigarette butts.-They educated him/her daily on the policy and procedures for smoking and he/she voiced understanding.-Over the past month, he/she had not had many issues with smoking due to the cold weather. He/She did not stay outside for long so he/she would smoke and come back into the facility.-They had not documented as much as they should have regarding his/her behaviors around smoking.-Once they noticed the resident's behaviors, they should have re-assessed his/her smoking assessment to show that he/she needed to be supervised when smoking due to his/her behaviors.-The smoking assessments were completed quarterly but if there was a change in behavior they would reassess the smoking safety of any resident.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to obtain and transcribe a physician's order for use of an Indwelling Catheter (is a flexible, indwelling tube inserted through the urethra into the bladder to drain urine, held in place by a small, water-filled balloon) to include the type of catheter used, the French size of the tube (Fr, a measure of the outer diameter of a catheter) and tip, [NAME] size and daily monitoring and care of the catheter; failed to prevent cross contamination during catheter care by not using enhanced barrier precautions (EBP- an infection control intervention in nursing homes and skilled nursing facilities that mandate the use of gowns and gloves during high-contact resident care activities) when providing care for one sampled resident (Resident #35) who was at risk for bladder infections, out of 15 sampled residents. The facility census was 60 residents. Review of the facility's Transcription of Orders/Following Physician's Orders Policy revised on 5/18/24 showed:-The purpose of this policy is to outline procedures in accurately transcribing physician's orders and to ensure that all physicians' orders are followed. To ensure a process is in place to monitor nurses in accurately transcribing and following physician's orders.-Upon receiving a physician's order via telephone, fax, written order, verbal order, transcribed order or other, it will be documented in residents' electronic medical records in orders section.Review of the facility's Infection Control policy and procedure dated 5/7/24, showed:-This facility has established and maintains an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections as per accepted national standards and guidelines.-All staff shall assume that all residents are potentially infected or colonized with an organism that could be transmitted while providing resident care services.-Hand hygiene shall be performed in accordance with our facility's established hand hygiene procedures. -All staff shall use personal protective equipment (PPE- refers to protective clothing, helmets, goggles, masks, or other gear designed to protect the wearer's body from injury, infection, or occupational hazards) according to established facility policy governing the use of PPE.Review of the facility's Catheter Care policy revised 6/26/24 showed: -Don (put on) gloves and gown per Enhanced Barrier Precautions (EBP) in nursing homes are targeted infection control measures designed to reduce the spread of multidrug-resistant organisms (MDROs) -Document care and report any concerns noted to the nurse on duty. 1. Review of Resident #35's admission Record showed: -He/she admitted to Hospice services (is a special kind of care that focuses on a person's quality of life and dignity as they near the end of their life) on 12/11/25.-Diagnosis of Chronic Kidney Disease (when the kidneys have become damaged over time).Review of the resident's Quarterly Minimum Data Set (MDS a federally mandated assessment tool completed by facility staff for care planning) dated 11/6/25, showed he/she:-Was cognitively intact. -Was able to understand others and make his/her needs known.-Required assistance of staff for all caresReview of the resident's Physician Order Sheet (POS) dated January 2026 showed: -May change catheter every night shift every 1 month(s) starting on the 11th for 1 day(s) for catheter care and as needed ordered on 12/12/25 and to start date of 1/11/26. -Did not have a detailed catheter order that included the type of catheter, size of catheter using Fr tip and [NAME] size; and how often catheter care was to be provided and by whom. Review of the resident's Treatment Administration Record (TAR) dated January 2026 showed:-He/she did not have a detailed physician order for the catheter.-May change foley catheter every night shifts every 1 month(s) starting on the 11th for 1 day(s) for catheter care and as needed ordered on 12/12/25 and to start date of 1/11/26. Observation on 1/29/26 at 10:51 A.M., of the resident showed:-He/She was in bed.-He/She had his/her catheter drainage bag hooked on to the bed frame. -His/Her urine was covered by the privacy flap on the drainage bag. During interview on 1/29/26 at 11:00 A.M. Certified Nursing Assistant (CNA) A (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	said:-He/She only emptied the resident's catheter bag. -The licensed nursing staff were responsible for the resident's catheter care. Observation on 1/29/26 at 11:07 A.M., of the resident's catheter care showed:-The resident did not have EBP signage posted on his/her door and there was no isolation cart with personal protective equipment (PPE) of gown, gloves and mask.-CNA B entered the resident's room and sanitized his/her hands prior to placing gloves on hands. -CNA B obtained a barrier and graduate and proceeded with drainage of the urine.-He/she did not use a gown or mask to empty the resident catheter drainage bag. -With gloved hands, CNA B cleaned the tip of the drainage spout and proceeded to empty the drainage bag of clear yellow urine into a graduate. -He/she cleaned the tip of the drainage spout with an alcohol wipe before closing the spout. -CNA B then emptied the graduate and rinsed the graduate out with water. -CNA B removed the soiled gloves and left the resident's room. Observation on 1/30/26 at 1:30 P.M., of the resident showed: -He/she had refused to allow the surveyor to watch full catheter care by CNA B. -CNA B entered the resident's room without EBP on. During an interview on 2/2/26 at 9:51 A.M. Certified Medication Technician (CMT) B said:-He/she was not aware the resident should have been on EBP. -He/she was not familiar with the facility protocol for residents on EBP. During an interview on 2/2/2026 at 10:25 A.M., Registered Nurse (RN) A said:-He/she would expect the resident to have a detailed physician order for the catheter.-The order should include the type of catheter, the size and size of balloon, and frequency of care every shift.-He/she would document the resident's catheter care and monitoring in the resident's TAR.-The resident should have had EBP signage posted on the door due to having a catheter. -For all residents on EBP, all care staff should wear PPE of gown and gloves when providing direct contact care.-There should have been an isolation cart with PPE outside the resident's room with EBP signage on door.During an interview on 2/2/26 at 3:58 P.M. the Director of Nursing (DON) said:-He/she would be responsible for auditing medical records for accuracy and any transcription of physician orders. -He/she would expect nursing staff to obtain a detailed physician order for the residents with a catheter to include the type of catheter, size and frequency when to provide catheter care.-He/she would expect licensed nursing staff to ensure the physician's order was transcribed to the TAR and document catheter care and monitoring in the resident TAR,-The resident's on EBP, he/she would expectation CNA and nursing staff who providing any catheter care to wear PPE of gloves. gown and mask for potential of splatter. -He/she would expect the resident to be on EBP due to his/her catheter and EBP signage posted on the resident's door.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. Based on observation, interview, and record review, the facility failed to ensure a resident's meal intake was being monitored when one sampled (Resident #12) was having gradual weight loss out of 15 sampled residents. The census was 60 residents. Review of the facility policy titled Weight Monitoring Policy revised dated 5/7/2024 showed: -Based on the resident's comprehensive assessment, the facility would ensure that all residents maintain acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the residents clinical condition demonstrates that this was not possible or resident preferences indicate otherwise.-A weight monitoring schedule would be developed upon admission for all residents:--Weights should be recorded at the time obtained. --Newly admitted residents monitor weight weekly for 4 weeks.--Residents with weight loss monitor weight weekly.--If a clinically indicated-monitor weight daily. --All others-monitor weight monthly. -Meal consumption information should be recorded a may be referenced by the interdisciplinary care team as needed.1. Review of Resident #12's face sheet showed he/she admitted with the following diagnoses:-Type two Diabetes Mellitus without complications (a complex disorder of carbohydrate, fat, and protein metabolism that was primarily a result of a deficiency or complete lack of insulin secretion in the pancreas or resistance to insulin).-Needed assistance with personnel care.-Iron deficiency anemia (a shortage of healthy red blood cells or a low concentration of hemoglobin, reducing the blood's capacity to transport sufficient oxygen to tissues).-Acquired absence of right leg below knee. Review of the resident's annual Minimum Data Set (MDS - a federally mandated assessment tool completed by the facility for care planning) dated 9/22/25 showed the resident: -Was moderately cognitively impaired.-Was dependent on staff for self-care.-Used a wheelchair. -Needed supervision or touching assistance with eating. -Was able to mobilize self in wheelchair.-Was unable to walk. Review of the resident's current physician orders dated January 2026 showed:-Regular diet with, thin regular consistency, magic cup with every meal related to type two Diabetes Mellitus without complications. Review of the resident's care plan dated January 2026 showed the resident:-Was on a regular diet, regular texture, thin liquids.-Would continue with regular diet through next review date. -Would have no negative outcomes from current dietary status.-Would have the dietary department monitor his/her diet monthly to ensure proper dietary recommendations.-Would have the Dietician review his/her chart quarterly to ensure regular diet was still proper diet for resident. Review of the resident's weight summary on 1/27/26, showed:-On 11/7/25 the resident was weighed in his/her wheelchair at 118.1 lbs.-On 12/1/25 the resident was weighed in his/her wheelchair at 110.4 lbs.-On 1/1/26 the resident was weighed in his/her wheelchair at 108.0 lbs.-There was a 3% weight loss in one month from December to January.-There was an 8% weight loss in two months from November to January.Observation on 1/28/26 at 1:14 P.M. showed the resident: -Was served a salad, biscuit, beef stew, bread pudding, and a magic cup. -Was able to feed himself/herself without assistance and ate all the salad, biscuit, and beef stew.-Did not eat the bread pudding.-Did not remove the magic cup lid; and staff did not remove the lid. Observation on 1/29/26 at 12:54 P.M. showed the resident: -Was served baked chicken with onion gravy, rice pilaf, carrots, pear spiced upside-down cake, and a magic cup. -Was able to feed himself/herself without assistance and ate all the chicken and cooked vegetables.-The magic cup lid was removed, and the resident took two bites which was maybe a 1/4 of the container.Observation on 1/30/26 at 12:39 P.M. showed the resident: -Was served seasoned baked fish, parmesan pasta, sauteed squash, fruit cobbler, and a magic cup.-Was able to feed himself/herself without assistance and ate all the fish and pasta.-Removed the lid from the magic cup and ate two bites which was maybe a 1/4 of the container.During an interview on 2/2/26 at 9:00 A.M. Certified Nursing Assistant (CNA) A said:-He/She had not heard that anyone needed to be monitored for weight loss. -He/She had not heard anything about the resident's weight loss.During an interview on 2/2/26 at 10:24 A.M. Certified Medication Technician (CMT) A said:-He/She had not heard that (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	anyone needed to be monitored for weight loss. -He/She had not heard anything about the resident's weight loss. -Did not know if anyone monitored the resident's meal intakes. -At one time someone did monitor meal intakes, but he/she didn't do it, and he/she did not have time.During an interview on 2/2/26 at 11:34 A.M. the Dietary Manager said:-The resident was on a regular diet with a magic cup.-The resident was very petite and did not eat all his/her food.-The CNAs monitored the meal intake. -The resident had lost a couple pounds.During an interview on 2/2/26 at 1:54 P.M. CNA D said:-No one had ever told him/her to monitor resident meal intakes.-He/She just knew who got mechanical soft and puree diets. During an interview on 2/2/26 at 2:12 P.M. Registered Nurse (RN) A said:-If a resident was experiencing weight loss, he/she would notify the administration, the physician, and dietary.-He/She would get orders for blood work to be done.-He/She would see what supplements to put the residents on.-The Magic Cups were used as a supplement.-He/She would monitor the resident's weights if they were losing weight. -The resident should be weighed weekly. -The CNAs should be monitoring meal intakes. -The CNAs were supposed to document the percentage of each meal for all residents.-There used to be a book to keep track of meal intakes, but the book had not been used because of a privacy violation.-The CNAs were supposed to document the resident's meal intake in the computer. -He/She had noticed the resident was eating smaller amounts than when he/she first arrived. During an interview on 2/22/26 at 3:57 P.M. the Director of Nursing (DON) said:-If a resident was losing weight, he/she should be notified by the staff.-He/She would look at any trends and interview the resident, if possible, to see what was going on.-He/She would notify the physician and see about a supplement.-He/She would monitor the weight of the resident. -Currently there was not a meal intake process. -The CNAs were supposed to notify the charge nurse if a resident did not eat. -The CNA's used to have a book to document resident meal intakes, the book is no longer used. -As of now they were just monitoring the resident's weight to see what was working.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. Based on observation, interview, and record review, the facility failed to ensure there was a thermometer in the refrigerator and the temperature was monitored and logged for one sampled resident (Resident #26) out of 15 sampled residents. The census was 60 residents Review of the facility policy titled Resident Food: Storage and Sharing revised dated 9/16/24 showed:The purpose of this policy was to ensure that residents food storage was safe with sanitary storage, handling and consumption.-Resident personal refrigerators and facility snack refrigerators would be monitored on a daily basis by facility staff.-Refrigerators would be kept clean and within the regulation temperature guidelines of 32-40 degrees. If the temperature falls beyond the regulated guidelines the food would be discarded. -Each refrigerator we'll have a thermometer and the freezer and refrigerated compartments.-Each refrigerator would have a temperature log and would be documented daily.-Food items would be dated after opening.-Prepared foods that were dated 3 days after it was placed in the refrigerator would be discarded.1. Review of Resident #26's quarterly Minimum Data Set (MDS a federally mandated assessment tool completed by the facility staff for care planning), dated 10/1/25, showed the resident was cognitively intact.During an interview on 1/29/26 at 9:16 A. M., the resident said:-Staff came in to assist with roommate at 4:00 A.M. or 5:00 A.M. and somebody was standing by his/her refrigerator. -When he/she got up around 7:00 A.M., he/she went to the refrigerator to grab a bottle of grape juice he/she saw that his/her refrigerator had been moved and was unplugged. -There had never been a thermometer or temperature log since he/she got it in December 2025. -There was sherbet in the freezer, meat and cheese in the refrigerator that was melted and warm.-He/She told the charge nurse that morning and was told the sherbet could be refrozen. -The fact that someone unplugged the refrigerator pissed me off.Observation on 1/29/26 at 9:16 A.M. showed:-There was no thermometer or temperature log with the refrigerator. Observation on 1/30/26 at 9:16 A.M. showed:-There was no thermometer or temperature log with the refrigerator. Observation on 1/30/26 at 12:06 P.M. showed:-There was no thermometer or temperature log with the refrigerator. During an interview on 1/30/26 at 2:02 P.M., Certified Nursing Assistant (CNA) C said: -He/She would never unplug a resident's refrigerator without telling them. Observation on 2/2/26 at 8:45 A.M. showed:-There was no thermometer or temperature log with the refrigerator. During an interview on 2/2/26 at 9:00 A.M., CNA A said: -He/She had never had to unplug a resident's refrigerator.-Had no idea why someone would unplug it.-He/She knew every resident refrigerator was supposed to have a thermometer.-He/She thought maintenance, or the Activity Director was supposed to monitor them. During an interview on 2/2/26 at 10:24 A.M., Certified Medication Technician (CMT) A said: -He/She had never had to unplug a resident's refrigerator.-He/She thought maybe to defrost it or the temperature wasn't right. -Didn't know who was responsible for refrigerator maintenance.-He/She knew every resident refrigerator was supposed to have had a thermometer.-He/She thought housekeeping kept track of the temperature logs. During an interview on 2/2/26 at 10:43 A.M., Housekeeper A said: -He/She had no idea about the resident's refrigerators. During an interview on 2/2/26 at 10:52 A.M., the Maintenance Director said: -As of now he/she had not seen or had been told anything about monitoring temperatures.-He/She had no idea about the resident's refrigerators. During an interview on 2/2/26 at 12:34 P.M., the Activity Director said: -The residents' refrigerators should have had thermometers in them. -He/She thought housekeeping kept track of the temperature logs. During an interview on 2/2/26 at 1:54 P.M., CNA D said: -He/She had never had to unplug a resident's refrigerator.-Would only do it if he/she was told to do so.-All resident refrigerators should have had thermometers, should have been checked, and the temperatures wrote down every day. During an interview on 2/2/26 at 2:12 P.M. Registered Nurse (RN) A said:-One of the lifts had a rechargeable battery and it had an eight-foot-long cord so if the battery was dead, staff could plug it in and use it to move the resident. -He/She would never unplug a resident's refrigerator.-He/She knew every resident refrigerator was supposed to have a thermometer and they were supposed to be monitored.-He/She (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	thought dietary, or nursing was supposed to monitor the temperatures but didn't know for sure. During an interview on 2/2/26 at 3:57 P.M. the Director of Nursing (DON) said:-Residents who had a refrigerator in their room should have had a thermometer.-The temperatures should have had been checked and wrote down daily. -He/She did not know who was supposed to keep track of the temperatures.-He/She had told the resident they would replace the food.

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure communication was established and completed between the facility and the hospice nursing staff; and failed to ensure change of condition hospice orders were in place for one sampled resident (Resident #59) out of 15 sampled residents. The facility census was 60 residents. Review of the Coordination of Hospice Services Policy, revised dated [DATE] showed: -When a resident chooses to receive hospice care and services, the facility would coordinate and provide care and cooperation with hospice staff in order to promote the residents highest practicable physical, mental, and psychosocial well-being.--The facility maintains written agreements with hospice providers that specify the care and services to be provided and the process for hospice and nursing home communication of necessary information regarding the resident's care.--The facility and hospice provider would coordinate a plan of care and would implement Interventions in accordance with the resident's needs, goals, and recognized standards of practice in consultation with the resident's attending physician/practitioner and resident representative, to the extent possible.--The plan of care would identify the care and services that each entity would provide in order to meet the needs of the resident and his/her expressed desire for hospice care.---The hospice provider retains primary responsibility for the provision of hospice care and services that were necessary for the care of the resident's terminal illness and related conditions.---The facility retains primary responsibility for implementing those aspects of care that were not related to the duties of the hospice.--The facility would communicate with hospice and identify, communicate, follow and document all interventions put into place by hospice and the facility.--The facility would monitor and evaluate the resident's response to the hospice care plans.--The facility would maintain communication with hospice as it relates to the resident's plan of care and services to ensure each entity was aware of their responsibilities.--The plan of care would include directives for managing pain and other uncomfortable symptoms and would be revised and updated as necessary.--The facility would monitor for medications and medical supplies to ensure they were provided by hospice as indicated in the plan of care for palliation and management of terminal illness.--All residents receiving hospice would continue to receive the same facility services as residents who have not elected hospice. This includes, but was not limited to the following:---Ongoing comprehensive and quarterly assessments,---Personal care/ support with activities of daily living,---Medication administration,---Physician visits,---Medication regimen review,---Social services and activities programming,---Nutritional support and services,---Ongoing monitoring of residents' conditions.--The facility would immediately contact and communicate with hospice staff, attending physician/practitioner and the family resident representative regarding any significant changes in the resident status, clinical complications or emergent situations.1. Review of Resident #59 Face Sheet showed the resident admitted with diagnoses that included: -Chronic Obstructive Pulmonary Disease (COPD unspecified (refers to a progressive, incurable lung disease).-Acute respiratory failure with hypoxia (where the lungs cannot adequately transfer oxygen to the blood).-Unspecified cirrhosis of liver (advanced scarring (fibrosis) where the underlying cause was not determined, leading to irreversible damage and potential liver failure). -Dehydration.-Muscle weakness.-Need for assistance with personnel care. -Hyperlipidemia, unspecified (high levels of lipids in the blood). Review of the resident's Minimum Data Set (MDS a federally mandated assessment tool completed by the facility staff for care planning) dated [DATE] showed the resident:-Was moderately cognitively impaired.-Was on hospice. -Was on oxygen. -Needed a wheelchair. -Needed assistance with activities of daily living. Review of the resident's physician orders dated [DATE] showed:-Hospice to evaluate and treat as indicated.-No notes showing the resident changed from a Full Code to a Do Not Resuscitate (DNR a legally binding medical document, written by a physician, (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265501	A. Building B. Wing	02/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Odessa Health Care Center	609 Golf Street Odessa, MO 64076

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	that instructs healthcare providers not to perform cardiopulmonary resuscitation (CPR) or other life-saving measures if a patient's breathing or heart stopped) after admitting to hospice. Review of the resident's DNR form showed:-The resident signed it on [DATE].-The attending physician signed it on [DATE].Review of the resident's hospice communication book on [DATE] showed:-Another name was on the STOP page at the start of the book.-There was no code status sheet.-In the Interdisciplinary Group meeting notes dated [DATE] indicated the resident was a DNR.-There were no summary notes from the hospice staff from their daily visits. During an interview on [DATE] at 2:12 P.M. Registered Nurse (RN) A said:-Residents should have an order for hospice and an order for their code status of DNR or full code. -The orders should be in the resident's medical record for staff to see.-Hospice personnel took care of the hospice books.-Hospice personnel would tell the nurse if there were any new orders or changes.-He/She did not do anything with the hospice books. During an interview on [DATE] at 3:57 P.M. the Director of Nursing (DON) said:-There should be orders for a resident who was on hospice and had a DNR.-Social Services was supposed to audit the hospice books. -The nurses were to make sure the orders were placed in the resident's medical record. -They did not have a monitoring system in place to make sure the hospice books were up to date and accurate. -He/She was responsible for auditing the resident's medical record for accuracy or orders.