STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265514	A. Building B. Wing	04/24/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Claru Deville Nursing Center	105 Spruce Street Fredericktown, MO 63645

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a plan that describes the process for conducting QAPI and QAA activities. Based on interview and record review, the facility failed to demonstrate evidence of maintaining an ongoing effective, comprehensive, data-driven Quality Assurance Performance Improvement (QAPI) program that focuses on indicators of the outcomes of care and quality of life. This had the potential to affect all residents residing in the facility. The facility's census was 67. Review of the facility's policy titled, Quality Assessment and Assurance (QAA), reviewed 01/26/26, showed:- The facility is committed to ensuring high-quality care and continuous improvement in resident outcomes through a structured Quality Assessment and Assurance program. The Quality Measures (QM) committee will oversee and support quality improvement efforts by identifying, analyzing, and addressing concerns related to clinical care, resident safety, and regulatory compliance;- The QM committee is responsible for developing and implementing corrective plans of action, identifying deficiencies in care quality and regulatory compliance, creating and implementing corrective action plans to address identified issues, monitoring the effectiveness of corrective measures and making necessary adjustments, reviewing and analyzing quality data, regularly reviewing facility performance data, including metrics collected under the QAPI program, and analyzing data from drug regimen reviews to identify trends, errors, or adverse effects requiring intervention;- Members are responsible for upholding the standards of the QAPI program and fostering a culture of quality, accountability, and continuous improvement within the facility.Review of the facility's 2024 QAPI Plan showed:- The QAPI committee annually prioritizes activities, endorses or re-endorses policies and procedures, and continually monitors for improvement through the use of a QAPI self-assessment;- Physician oversight, direction, and involvement play an essential role in the QAPI process. The facility's Medical Director is the designated senior practitioner and advisor for all aspects of the QAPI program related to clinical care and safety. The Medical Director is accountable for providing leadership for, and is actively involved in the implementation of the QAPI program;- On a quarterly basis, data will be collected and reported to the QAPI Steering Committee from input from caregivers, residents, families, and others; adverse events; performance indicators; survey findings; and complaints;- The committee will consider and prioritize both external and internal elements affecting the long-term care industry and facility when selecting priorities of focus for the coming year;- A goal of reducing urinary tract infections (UTIs) by 20% by 12/31/25 with proper peri care and increased fluid intake;- No current QAPI Plan or goals.During an interview on 04/24/26 at 10:30 A.M., the Administrator said the regional nurse filled in as the Director of Nursing (DON) since she started in September. The regional nurse did not attend the QAPI meetings. The facility went without a DON for a while, and then they had an Assistant Director of Nursing (ADON) for a while. The current DON started on 12/01/25 and finished the Infection Preventionist training on 12/17/25. There was no IP before the current DON completed her training. She is just getting ready to start having meetings with the physician present. The current Medical Director took over on 08/01/25. She didn't update anything on the 2024 QAPI Plan because the Statement of Deficiencies from the last survey just said continue the plan, so that is what she did. She didn't update goals because she lacked a nurse. During an interview on 04/24/26 at 2:45 P.M., the Administrator said she would expect to have an ongoing QAPI program with an updated plan and goals and meetings to be held at least quarterly with the required members present.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0868 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have the Quality Assessment and Assurance group have the required members and meet at least quarterly Based on interview and record review, the facility failed to ensure the Quality Assurance and Performance Improvement (QAPI) program committee met at least quarterly with the required members present. This had the potential to affect all residents by limiting the facility's ability to identify and address quality of care and safety concerns. The facility's census was 67. Review of the facility's policy titled, Quality Assessment and Assurance (QAA), reviewed 01/26/26, showed:- This facility is committed to ensuring high-quality care and continuous improvement in resident outcomes through a structured QAA program. The QAA committee will oversee and support quality improvement efforts by identifying, analyzing, and addressing concerns related to clinical care, resident safety, and regulatory compliance;- The QAA committee shall include at a minimum, the Administrator, the Director of Nursing (DON) Services, the Medical Director or their designee, the Infection Preventionist (IP), and at least two other facility staff members;- The policy did not address the minimum frequency of meetings.Review of the facility's QAPI meeting documentation, provided by the Administrator, showed:- A QAPI meeting was held on 03/03/25, 04/07/25, and 05/05/25; - A Monthly QA Infection Control meeting was held on 10/29/25 with no documentation of the Medical Director, DON, or IP attending;- QAPI checklists for November 2025 completed with no documentation of the Medical Director, DON, or IP involvement;- QAPI checklists for December 2025 completed with no documentation of the Medical Director, DON, or IP involvement;- A QAPI meeting was held on 03/26/26 with no documentation of the Medical Director attending; - No documentation the QAPI program was implemented on a consistent and ongoing basis during this time period. During an interview on 04/24/26 at 10:30 A.M., the Administrator said she has the department heads fill out the QAPI checklists and they go over them. The regional nurse filled in as DON since she started in September, but the regional nurse did not attend the QAPI meetings. The facility went without a DON for a while. They had an Assistant Director of Nursing (ADON) for a while. The current DON started on 12/01/25 and finished IP training on 12/17/25. There was no IP before the current DON completed her training. She was just getting ready to start having meetings with the Medical Director present. The current Medical Director took over on 08/01/25.During an interview on 04/24/26 at 2:45 P.M., the Administrator said she would expect to have an ongoing QAPI program with an updated plan and meetings to be held at least quarterly with the required members present.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. Based on observation, interview, and record review, the facility failed to demonstrate measures used to minimize the risk of Legionella (a bacteria naturally found in freshwater that can cause serious lung infections, most common Legionnaires' disease, which is a severe form of pneumonia) and other opportunistic pathogens in the building water system, by not providing a documented water management program. This deficient practice had the potential to affect all residents, staff and visitors. The facility's census was 67. Review of the facility's policy titled, Guideline to Develop a Water Management Program to Reduce Legionella Growth, undated, showed:- Purpose of guideline is to aid the facility in creating a site-specific water management system to reduce Legionella growth in the facility;- The facility will create a Water Management Committee which will consist of at least the Administrator, Director of Nursing, and the Maintenance Director;- The facility will conduct a facility risk assessment on an annual basis to identify where Legionella and other opportunistic waterborne pathogens could grow and spread in the water system.Observation on 04/21/26 at 9:30 A.M., showed the hot water turned off on the 200 Hall.During an interview on 04/22/26 at 2:50 P.M., the Administrator said the hot water had been out in certain areas, specifically on the 100, 200 and 300 Halls, since 04/16/26, due to waiting on a thermostatic valve to come in. The hot water was turned off to prevent the potential of residents being burned. The facility did not have a policy on what preventative measures to take but had a policy on Legionella. She was unsure what the water temperature range should have been, but believed it had to be below 140 degrees Fahrenheit. She said maintenance usually took care of the temperature checks and he/she had just quit.During an interview on 04/23/26 at 8:45 A.M., the Maintenance staff said he/she just started last week but the hot water had been turned off on the 100, 200 and 300 Halls due to leaking. The laundry, kitchen, 400, 500 and 600 Halls still had hot water. He/She had checked those temperatures. They had moved people around so there weren't many rooms left empty. The Maintenance staff said he/she would be checking temperatures and flushing rooms that were empty today. During an interview on 04/24/26 at 2:45 P.M., the Administrator, Director of Nursing and Registered Nurse Quality Assurance Support said they would expect the facility to have a process in place to prevent Legionella.

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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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to inform residents and/or their representatives, in advance of the risks and benefits of proposed care, before beginning psychotropic medications (medications that affect the mind, emotions, and behavior) for four residents (Residents #4, #10, #27, and #46) out of 17 sampled residents. The facility's census was 67. Review of the facility's Management of Psychotropic Medications and Unnecessary Medications policy, dated 04/28/25, showed: - The use of psychotropic medications will be carefully monitored to prevent unnecessary usage and will be prescribed only when clinically indicated, with full consideration of the resident's preferences and rights; - Prior to initiating or increasing a psychotropic medication, the resident or their legal representative will be fully informed of the proposed treatment, including the potential risks, benefits, and alternatives; - The resident will have the right to participate in the decision-making process and to accept or refuse treatment; - Before any psychotropic medication is prescribed or increased, the resident will be informed of their rights regarding treatment, including the right to accept or decline medication; - The facility will ensure the residents are given appropriate information in a manner they can understand, considering cognitive and language differences, and have the opportunity to ask questions; - Documentation of informed consent will be maintained for all psychotropic medications prescribed. 1. Review of Resident #4's medical record showed: - admitted on [DATE]; - Diagnoses of schizoaffective disorder (chronic mental health condition characterized by a combination of schizophrenia symptoms, such as hallucinations or delusions, and major mood disorder symptoms, including mania or depression), generalized anxiety disorder (a mental health condition characterized by persistent, excessive, and uncontrollable worry about every day, routine situations), bipolar disorder (a chronic mental health condition characterized by intense, fluctuating mood shifts), and insomnia (difficulty sleeping). Review of the resident's quarterly Minimum Data Set (MDS - a mandatory assessment completed by the facility), dated 03/26/26, showed: - Severe cognitive impairment; - The resident received antipsychotic (medication used to treat mental health disorders), antianxiety, and antidepressant medication in the seven-day lookback period. (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the resident's physician order sheet (POS), dated 04/24/26, showed: - An order for lorazepam (anxiety medication), one milligram (mg) tablet three times a day for restlessness and agitation, dated 05/23/24; - An order for risperidone (an antipsychotic), two mg tablet daily for schizoaffective disorder, dated 05/23/24; - An order for trazodone (antidepressant), 150 mg tablet one time a day for insomnia, dated 05/23/24; - An order for haloperidol (an antipsychotic) five mg tablet two times a day for schizoaffective disorder, dated 03/17/26; - An order for Uzedy (an antipsychotic medication) 125 mg/0.35 milliliters (ml) subcutaneously (under the skin), every 24th of the month for schizoaffective disorder, dated 10/24/24. Review of the resident's progress notes showed: - On 03/17/26, a psychotropic consent for Haldol (haloperidol) decrease from 10 mg to five mg; - No psychotropic consents for lorazepam, risperidone, trazodone, or Uzedy. 2. Review of Resident #10's medical record showed: - admitted on [DATE]; - Diagnoses of dementia and other diseases classified elsewhere, unspecified severity with other behavioral disturbances (memory and thinking problems related to another disease process, along with behaviors such as agitation, aggression, wandering, or resistance to care), cerebral infarction, unspecified (a stroke caused by blocked blood flow to part of the brain; the exact type or location is not specified), mild cognitive impairment of uncertain or unknown etiology (mild problems with memory or thinking that are greater than normal aging, but not severe enough to be dementia; the cause is unknown), depression, unspecified (a mood disorder involving sadness, low motivation, or loss of interest, without a more specific type identified). Review of the resident's quarterly MDS, dated [DATE], showed: - Moderately impaired; - The resident received antipsychotic (medication used to treat mental health disorders), medication in the seven-day lookback period. Review of the resident's POS, dated 04/24/26, showed: - An order for Seroquel (an antipsychotic medication) 25 mg four times a day as needed related to restlessness and agitation, dated 12/21/25; - An order for quetiapine (an antipsychotic medication) 50 mg one tablet by mouth at bedtime related to dementia in other diseases classified elsewhere, unspecified severity, with other behavioral (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	disturbance, dated 12/21/25. Review of the resident's progress notes showed: - No documentation of consents or education of risks and benefits were provided to the resident and/or their representative for the Seroquel and quetiapine medications. During an interview on 04/23/26 at 10:35 A.M., Registered Nurse (RN) A said Resident #10 was put on Seroquel when he/she was in the hospital, so she did not do a psychotropic consent for it. RN A said he/she didn't know he/she needed to do them for those situations. RN A thought he/she just had to do them for the residents that were put on them once they arrived to the facility or if the dosage was adjusted. During an interview on 04/24/26 at 8:34 A.M., the Director of Nursing (DON) said when residents were admitted to the facility with a psychotropic medication, they were completing consents. They were only doing them if a resident was put on them while in the facility or if they had a medication change while in the facility. 3. Review of Resident #27's medical record showed: - admitted on [DATE]; - Diagnoses of bipolar (a chronic mental health condition characterized by intense, fluctuating mood shifts), and anxiety disorder (a mental health condition characterized by persistent, excessive, and uncontrollable worry about everyday, routine situations). Review of the resident's quarterly MDS, dated [DATE], showed: - Severe cognitive impairment; - The resident received an antipsychotic and an antidepressant medication in the seven-day lookback period. Review of the resident's POS, dated 04/24/26, showed: - An order for aripiprazole (antipsychotic medication), four mg once a day for bipolar disorder, dated 03/18/26; - An order for escitalopram oxalate (an antidepressant medication), five mg once a day for anxiety, dated 03/18/26. Review of the resident's progress notes showed: - No documentation of psychotropic consents and no documentation that the risks and benefits were provided to the resident and/or their representative for the use of aripiprazole and escitalopram. 4. Review of Resident #46's medical record showed: - admitted on [DATE]; (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Diagnoses of bipolar disorder, schizoaffective disorder, major depressive disorder (a serious mental health disorder characterized by persistent, severe sadness, low mood, or loss of interest in activities lasting at least two weeks), anxiety disorder, post-traumatic stress disorder (PTSD - a mental health condition triggered by experiencing or witnessing terrifying events), and borderline personality disorder (a serious mental health condition characterized by long-term instability in emotions, relationships, self-image and behavior). Review of the resident's quarterly MDS, dated [DATE], showed: - Moderately impaired; - The resident received antipsychotic, antianxiety, and antidepressant medications in the seven-day lookback period. Review of the resident's POS, dated 04/24/26, showed: - An order for depakote (a mood stabilizer) 750 mg, twice daily for schizoaffective disorder, dated 04/13/23; - An order for fluoxetine (an antidepressant) 60 mg, once daily for bipolar disorder, dated 04/13/23; - An order for haloperidol 10 mg, three times daily for schizoaffective disorder, dated 07/30/23; - An order for Seroquel 400 mg twice daily for schizoaffective disorder, dated 08/12/25. Review of the resident's progress notes showed: - No documentation of consents or education of risks and benefits were provided to the resident and/or their representative for Depakote, Seroquel or haloperidol. During an interview on 04/23/26 at 10:29 A.M., Registered Nurse (RN) A said he/she knew these consents were a new thing. He/She will complete them when there's a medication change, like if they go to the hospital and come back with a new order. Residents don't have consents done when they're admitted because the guardians knew they were already on those meds. During an interview on 04/24/26 at 2:45 P.M., the Administrator and DON said they would expect psychotropic medication consents to be completed for all residents who receive psychotropic medication. During an interview on 04/27/26 at 8:55 A.M., the DON said they were not completing the psychotropic medications consents on all residents with psychotropic medications but will be going forward.

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. Based on interview and record review, the facility failed to provide a Centers for Medicare and Medicaid Services (CMS) Skilled Nursing Facility Advance Beneficiary Notice (SNF ABN) to two residents (Residents #10 and #66) out of two sampled residents who were discharged from Medicare Part A services with benefit days remaining and remained in the facility. The facility's census was 67.Review of the Form Instructions: Advance Beneficiary Notice of Non-coverage, dated 2024, showed:- Medicare requires Skilled Nursing Facility to issue the SNF ABN to original Medicare patients prior to providing care that Medicare usually covers, but may not pay for in this instance because the care is not medically reasonable and necessary or considered custodial;- The SNF ABN provides information to the patient so that he/she can decide whether or not to get the care that may not be paid for by Medicare and assume financial responsibility.1. Review of Resident #10's medical record showed:- The resident discharged from Medicare Part A services on 01/05/26;- The resident remained in the facility;- The facility failed to issue a SNF ABN to the resident.2. Review of Resident #66's medical record showed:- The resident discharged from Medicare Part A services on 04/01/26;- The resident remained in the facility;- The facility failed to issue a SNF ABN to the resident. During an interview on 04/23/26 at 2:00 P.M., the Business Office Manager (BOM) said she just does a Notice of Medicare Non-Coverage (NOMNC) when residents discharge from a Medicare Part A stay. She hasn't been doing ABNs for anyone and asked what ABN stood for. During an interview on 04/24/26 at 2:45 P.M., the Administrator and BOM said they would expect a SNF ABN to be issued when a resident's Medicare Part A stay ended and the resident remained in the facility. The BOM said the facility has had so few Medicare Part A stays that she had to ask what an ABN was.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. Based on observation and interview, the facility failed to provide a homelike environment by failing to ensure the building was free from odors and adequate reusable dinnerware was available for the residents, which resulted in the use of disposable foam dishware. This affected one resident (Resident #53) out of 17 sampled residents and one resident (Resident #44) outside the sample. This had the potential to affect all residents. The facility's census was 67. The facility did not provide a policy regarding odors or the use of disposable dinnerware. 1. Observations on 04/21/26 at 12:14 P.M., 04/23/26 at 2:50 P.M., and 04/24/26 at 1:04 P.M., of the 600 Hall showed a strong odor of urine. 2. Observation of the test tray on 04/21/26 at 12:00 P.M., showed the tray included a foam bowl containing black-eyed peas. 3. Observation of the noon meal preparation on 04/24/26 at 10:00 A.M., showed a dietary aide placed desserts onto foam plates for the resident meal service. During an interview on 04/24/26 at 10:15 A.M., the Dietary Manager (DM) said the facility used foam plates, bowls, and other disposable dishware because there were not enough reusable supplies available. The facility previously had adequate dinnerware, but over time silverware, plates, cups, and other dinnerware had gone missing. She reported the concern to the Administrator and requested replacement supplies but had not been approved to order additional dishware. Staff had checked the resident rooms for missing items, but supplies had not been recovered. In the meantime, the facility continued using foam to supplement the meal services. During an interview on 04/24/26 at 10:35 A.M., Resident #53 said he/she sometimes received meals on foam plates. The foam plates could break when he/she ate salads, and that caused difficulty during meals. He/She would prefer regular plates and bowls. 4. Observation on 04/24/26 at 1:00 P.M., of the noon meal service in the dining room showed some residents were served their meal on reusable dinnerware, while others were served on foam dinnerware. During an interview on 04/24/26 at 1:00 P.M., Resident #44 said he/she would prefer to eat on regular dinnerware and not foam. During an interview on 04/24/26 at 2:45 P.M., the Administrator said she would expect proper dinnerware to be available to all residents for each meal service and would expect the building to be free from odors.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to notify the resident and/or the resident's representative in writing of a transfer to the hospital and failed to provide a copy of the bed hold policy upon transfer to the hospital for four residents (Residents #3, #10, #27, and #55) out of 17 sampled residents. The facility also failed to notify the ombudsman (a trained advocate who investigates and resolves complaints made by or on behalf of residents in nursing homes, assisted living, and other residential care facilities) of the transfers. The facility's census was 67.The facility did not provide a policy. 1. Review of Resident #3's medical record showed: - The resident transferred to the hospital on [DATE], and returned to the facility on [DATE]; - No documentation the resident's representative was informed in writing, of the daily bed hold rate; - No documentation that a notification of transfer was provided to the ombudsman. 2. Review of Resident #10's medical record showed: - The resident transferred to the hospital on [DATE], and returned to the facility on [DATE]; - The resident transferred to the hospital on [DATE], and returned to the facility on the same day; - The resident transferred to the hospital on [DATE], and returned to the facility on [DATE]; - No documentation the resident's representative was informed in writing of the daily bed hold rate; - No documentation that a notification of transfer was provided to the ombudsman. 3. Review of Resident #27's medical record showed: - The resident transferred to the hospital on [DATE], and as of 04/24/26, had not returned; - A signed bed hold, dated 04/22/26; - No documentation the resident's representative was informed in writing of the daily bed hold rate. - No documentation that a notification of transfer was provided to the ombudsman. 4. Review of Resident #55's medical record showed: - Resident transferred to the hospital on [DATE] and returned to the facility 06/29/25; - No documentation that written notification of the transfer or a copy of the bed hold policy, including daily rate, was provided to the resident and/or the resident's representative at the time of the transfer; (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- No documentation that a notification of transfer was provided to the ombudsman. During an interview on 04/13/26 at 2:20 P.M., the Ombudsman said the facility had not been submitting their discharge and transfer notices through the new system, but they had received them prior. He/She received notice that they have a new social services person recently. During an interview on 04/24/26 at 12:50 P.M., the Administrator said she has no proof they have sent anything to the ombudsman because the previous social worker got fired for not doing it. They have not begun submitting them with the new process that started at the end of January. During an interview on 04/24/26 at 2:45 P.M., the Administrator said she would expect bed holds to have the bed hold rate included and would expect transfer notices and bed holds to be completed at the time of transfer and submitted to the ombudsman.

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Claru Deville Nursing Center	105 Spruce Street Fredericktown, MO 63645

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to implement care plans with specific interventions to meet individual needs for two residents (Residents #12 and #21) out of 17 sampled residents. The facility's census was 67.Review of the facility's policy, dated 10/01/15, showed it is the policy of the facility to use the most current Center for Medicare and Medicaid Services (CMS) Minimum Data Set (MDS-a standardized comprehensive assessment completed by facility staff) Resident Assessment Instrument (RAI) Manual, any published interim RAI manual errata documents, and applicable federal guidelines as the authoritative guide for completion of MDS, Care Area Assessment (CAAs-investigations triggered by the MDS), and resident care planning. 1. Review of Resident #12's medical record showed: - admission date of 09/01/25; - Diagnosis of post-traumatic stress disorder (PTSD - a disorder in which a person has difficulty recovering after experiencing or witnessing a terrifying event and triggers may bring back memories, intense emotions and physical reactions). Review of the resident's care plan, revised 02/13/26, showed: - PTSD only mentioned as a diagnosis related to behaviors; - Did not address triggers or interventions on how to care for the resident. 2. Review of Resident #21's medical record showed: - admitted on [DATE]; - Diagnoses of PTSD, bipolar disorder (a mental health condition characterized by intense, fluctuating mood shifts ranging from manic highs to depressive lows), and anxiety. Review of the resident's care plan, revised 03/24/26, showed: - Resident had experienced trauma and had diagnoses of PTSD; - Resident may have fear, terror, dread, or helplessness due to traumatic event; - Did not address specific triggers or interventions on how to care for the resident. During an interview on 04/24/26 at 11:00 A.M., CNA B said he/she did not know what triggers or why Resident #21 has PTSD. He/She knows Resident #21 had a car accident because of what a family member said, when visiting. If Resident #21 has to wait for coffee, he/she gets upset but that's about it. He/She did not know any specifics related to the car accident Resident #21 had. During an interview on 04/24/26 at 11:20 A.M., CNA B said he/she thinks Resident #12 maybe had PTSD from when his/her family member pushed him/her and he/she hit his/her head on concrete. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	CNA B did not know for sure if that was why, but Resident #12 would talk about that at times. CNA B did not know if Resident #12 had any specific triggers. During an interview on 04/24/26 at 2:45 P.M., the Administrator and Director of Nursing said they would expect resident care plans to address triggers, interventions, and how to care for residents that are diagnosed with PTSD.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. Based on observation, interview, and record review, the facility failed to obtain physician's orders for two residents (Residents #1 and #75) out of 17 sampled residents. The facility's census was 67.Review of the facility's policy titled, Physician's Orders, undated, showed:- Each resident must be under the care of a licensed physician authorized to practice medicine in this state and must be seen by the physician at least every sixty days;- Physician's orders must be signed by the physician and dated when such order was signed;- Physician orders must be reviewed and renewed. 1. Review of Resident #1's medical record showed:- admission date of 12/27/23;- Diagnoses of chronic pain, tremor (involuntary movement), and fracture of left acetabulum (deep cup shaped socket where the upper part of the hip sits for the ball and socket hip joint).Review of the resident's physician order sheet (POS), dated 04/23/26, showed no order for restorative therapy.Review of the resident's restorative nursing report showed:- Restorative therapy services provided seven times for the month of March 2026 on 03/04, 03/11, 03/16, 03/18, 03/23, 03/27 and 03/30;- Restorative therapy services provided once for the month of April 2026 on 04/08.Review of the resident's care plan, last reviewed 02/03/26, showed restorative care plan as follows: 3x/week restorative nursing program (RNP) to maintain gait and bilateral lower extremity (lower legs) strength.During an interview on 04/24/26 at 10:40 A.M., Resident #1 said he/she exercises and walks with staff sometimes.During an interview on 04/24/26 at 1:13 P.M., the restorative aide said he/she works with Resident # 1 two times a week, usually on Tuesdays and Thursdays. The therapist puts restorative therapy orders into the system. He/She said sometimes orders will fall off of the e-MAR (electronic medication administration record) and he/she thinks it might have to do with the time frames.2. Review of Resident #75's medical record showed:- admission date of 03/06/26;- Diagnoses of morbid obesity (excess of body fat that severely impairs physical function and increases risk for life-threatening conditions), chronic pain, muscle spasm, and acquired absence of the right leg below the knee.Review of the resident's POS, dated 04/21/26, showed no orders for the use of a continuous positive airway pressure (CPAP - a medical device that uses air pressure through a mask to keep the airways open while sleeping) or the cleaning of a CPAP or use of a trapeze (a medical mobility device consisting of a triangular handle hanging from an overhead metal frame, attached to a bed or freestanding) bar for bed mobility and transfers.Review of the resident's care plan, last reviewed 04/16/26, showed:- The resident uses a CPAP during hours of sleep, and to assist the resident with the CPAP as needed;- Trapeze bar above the bed for bed mobility and transfers.Observations of the resident showed:- On 04/21/26 at 11:45 A.M., the resident lay in bed with his/her CPAP on and a trapeze bar overhead attached to his/her bed;- On 04/23/26 at 1:00 P.M., the resident lay in bed with his/her CPAP on and a trapeze bar overhead attached to his/her bed.During an interview on 04/23/26 at 3:10 P.M., Resident #75 said he/she uses his/her CPAP when he/she sleeps. He/She has a company come in and clean the machine, but today staff messed with it, and it started smoking and is now giving an error code. The facility is getting a rental CPAP until it can be repaired or replaced.During an interview on 04/24/26 at 10:20 A.M., Resident #75 said he/she uses the trapeze bar multiple times a day every day to help reposition himself/herself and to get out of bed. He/She said it was brought from home and attached to his/her bed by staff.During an interview on 04/24/26 at 10:00 A.M., Registered Nurse (RN) G said the nurses should put orders in on admission for residents with trapeze bars and CPAPS. There should be an order for CPAP use, an order to clean the mask daily, an order to replace the tubing, and an order for settings. Therapy puts orders in for restorative nursing and the restorative aide documents the minutes.During an interview on 04/24/26 at 2:45 P.M., the Administrator and the Director of Nursing (DON) said they would expect a resident that receives restorative nursing, a resident with a CPAP, and a resident that has a trapeze to have orders for each.

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to identify, assess, and provide supportive interventions for three residents (Residents #12, #21, and #46) with a diagnosis of post-traumatic stress disorder (PTSD - a mental health condition triggered by a terrifying event - either experiencing it or witnessing it; symptoms may include flashbacks, nightmares and severe anxiety, as well as uncontrollable thoughts about the event) out of three sampled residents. The facility's census was 67. The facility did not provide a policy. 1. Review of Resident #12's medical record showed: - admitted on [DATE]; - Diagnoses of PTSD and major depressive disorder (persistent low mood, loss of interest in pleasurable activities, and fatigue, lasting at least two weeks); - No trauma informed care assessment. Review of the resident's physician order sheet (POS), dated 04/24/26, showed: - An order for prazosin (medication to treat high blood and off-label for PTSD - related nightmares and sleep disturbances) 2 milligrams (mg) by mouth at bedtime for PTSD, dated 08/25/25. Review of the resident's care plan, revised 02/13/26, showed: - PTSD only mentioned as a diagnosis related to behaviors; - No triggers listed or interventions regarding how to care for the resident's trauma. 2. Review of Resident #21's medical record showed: - admitted on [DATE]; - Diagnoses of PTSD, bipolar disorder (a mental health condition characterized by intense, fluctuating mood shifts ranging from manic highs to depressive lows), and anxiety. - No trauma informed care assessment. Review of the resident's POS, dated 04/24/26, showed an order for Prazosin 3 mg daily for PTSD, dated 03/20/26. Review of the resident's care plan, revised 03/24/26, showed: - Resident had experienced trauma and diagnosed with PTSD; - No triggers listed or specific interventions regarding how to care for the resident's trauma. 3. Review of Resident #46's medical record showed: (continued on next page)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- admitted on [DATE]; - Diagnoses of bipolar disorder, schizoaffective (a mental health condition with symptoms of both schizophrenia and mood disorders) disorder, major depressive disorder, anxiety disorder, PTSD, and borderline personality disorder (a serious mental health condition characterized by long-term instability in emotions, relationships, self-image and behavior); - No trauma informed care assessment. Review of the resident's POS, dated 04/24/26, showed: - An order for depakote (a mood stabilizer) 750 mg twice daily for schizoaffective disorder, dated 04/13/23; - An order for fluoxetine (an antidepressant) 60 mg once daily for bipolar disorder, dated 04/13/23; - An order for haloperidol (an antipsychotic) 10 mg three times daily for schizoaffective disorder, dated 07/30/23; - An order for Seroquel (an antipsychotic) 400 mg twice daily for schizoaffective disorder, dated 08/12/25. Review of the resident's care plan, revised 01/29/26, showed: - Resident had experienced trauma related to sexual trauma during childhood; - Interventions included listening, determine readiness to discuss events, provide realistic feedback when resident attempts to use learned strategies to manage anxiety. During an interview on 04/23/26 at 10:40 A.M., the Administrator said the assessments for PTSD had been missed. During an interview on 04/24/26 at 11:45 P.M., Certified Nurse Aide (CNA) B said he/she did not know Resident #21 had PTSD or what the triggers were. He/She said a family member had said the resident had been in a car accident. If Resident #21 had to wait for coffee, he/she got upset, but that was about it. He/She did not know any specifics related to the car accident. During an interview on 04/24/26 at 12:00 P.M., CNA C said he/she thinks Resident #12 had PTSD from when his/her family member had pushed him/her, which caused him/her to hit head on concrete, but did not know if that was reason for PTSD. CNA C did not know if Resident #12 had any specific triggers.

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observe each nurse aide's job performance and give regular training. Based on interview and record review, the facility failed to ensure three out of three sampled Certified Nurse Aides (CNAs) received an annual performance review. The facility's census was 67.The facility did not provide a policy regarding CNA annual performance reviews.1. Review of CNA D's personnel file showed:- Hire date of 04/01/25;- No documentation of an annual performance review.2. Review of CNA E's personnel file showed:- Hire date of 04/07/25;- No documentation of an annual performance review.3. Review of CNA F's personnel file showed:- Hire date of 03/21/25;- No documentation of an annual performance review.During an interview on 04/24/26 at 12:30 P.M., the Director of Nursing (DON) said performance reviews have not been getting done, but they are going to start doing them. She said she was unsure of how often they will be done, maybe yearly.During an interview on 04/24/26 at 2:45 P.M., the Administrator and DON said they would expect performance reviews to be completed at least yearly and to provide regular in-service education based on the outcome of the review.

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F 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Regularly inspect all bed frames, mattresses, and bed rails (if any) for safety; and all bed rails and mattresses must attach safely to the bed frame. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to conduct a safety and maintenance assessment for the use of a trapeze bar (a medical mobility device consisting of a triangular handle hanging from an overhead metal frame, attached to a bed or freestanding) for one resident (Resident #75) out of one sampled resident. The facility's census was 67.The facility did not provide a policy regarding the use and maintenance of a trapeze bar.1. Review of Resident #75's medical record showed:- admitted on [DATE];- Diagnoses of morbid obesity (excess of body fat that severely impairs physical function and increases risk for life-threatening conditions), chronic pain, muscle spasm, and acquired absence of the right leg below the knee;- Care plan, last reviewed on 03/24/26, showed a trapeze bar above the bed for bed mobility and transfers;- No documentation of a trapeze bar safety assessment or maintenance assessment.Observations of the resident showed:- On 04/21/26 at 11:45 A.M., the resident lay in bed with a trapeze bar overhead and attached to his/her bed;- On 04/23/26 at 1:00 P.M., the resident lay in bed with a trapeze bar overhead and attached to his/her bed.During an interview on 04/24/26 at 10:20 A.M., Resident #75 said he/she uses the trapeze bar multiple times every day to help reposition himself/herself and to get out of bed. He/She said it was brought from home and attached to his/her bed by staff.During an interview on 04/24/26 at 9:30 A.M., the Administrator said she has talked to the Director of Operations, and they do not have a safety assessment or maintenance assessment for trapeze use.During an interview on 04/24/26 at 10:30 A.M., the Maintenance Director said he/she has only worked here for a short time and just recently moved to the maintenance department. He/She did not attach the trapeze bar to Resident #75's bed, but thinks it was probably put on by the previous maintenance director. The Maintenance Director said he/she has not done a maintenance assessment and didn't know that it was required.During an interview on 04/24/26 at 2:45 P.M., the Administrator and Director of Nursing (DON) said they would expect a safety assessment and maintenance assessment to be completed for the use of a trapeze bar.

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F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. Based on interview and record review, the facility failed to provide at least twelve hours of nurse aide in-service education per year to include dementia care (care of a resident with an impaired ability to remember, think or make decisions), care of cognitively impaired residents and/or abuse/neglect training for three of the three sampled Certified Nurse Aides (CNAs). The facility's census was 67.The facility did not provide a policy regarding CNA in-service requirements.1. Review of CNA D's in-service record showed:- A hire date of 04/01/25;- A total of nine in-services, dated 12/10/25; no length of time provided for each in-service;- No documented abuse/neglect, dementia care or the care of cognitively impaired residents training.2. Review of CNA E's in-service record showed:- A hire date of 04/07/25;- A total of nine in-services, dated 12/10/25; no length of time provided for each in-service;- No documented abuse/neglect, dementia care or the care of cognitively impaired residents training.3. Review of CNA F's in-service record showed:- A hire date of 03/21/25;- A total of nine in-services, dated 12/10/25, no length of time provided for each in-service;- No documented dementia care or the care of cognitively impaired residents training.During an interview on 04/24/26 at 12:30 P.M., the Director of Nursing (DON) said she, the Assistant Director of Nursing (ADON) or the Administrator provide in-services. She believes CNAs should have 12-15 hours of annual in-services to include resident rights, abuse and neglect, infection control, and all the basics. In-services should include who is attending, the topic, the date and the length of time of the in-service. She believes each of the in-services provided was around 15 minutes.During an interview on 04/24/26 at 2:45 P.M., the Administrator and DON said they would expect CNAs to have at least 12 hours of in-services per year to include dementia care, abuse/neglect prevention and the care of the cognitively impaired resident.