STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265534	A. Building B. Wing	09/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Heritage Care Center	4401 North Hanley Road Saint Louis, MO 63134

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 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations (including nights and weekends) and emergencies. Based on interview and record review, the facility failed to have a complete and thorough facility-wide assessment to determine what resources are necessary to care for the residents competently during both day-to-day operations and emergencies. In addition, the facility failed to have a facility assessment that addressed staffing ratios required per shift to meet the needs of residents, the need for a Registered Nurse (RN) for at least 8 consecutive hours a day, 7 days a week, designated an RN to serve as the Director of Nursing (DON), and followed their infection control prevention and control program by ensuring residents received required immunizations. There was no documentation of ratios of direct care staff, restorative therapy staff, Social Services staff, dietary staff, housekeeping and laundry staff necessary on each shift to ensure the needs of residents are met. The facility failed to provide information regarding staff competencies and skill sets that are necessary to provide the level and types of care needed for the resident population. The census was 105.Review of the facility's Registered Nurse (RN) policy, dated 4/30/24, showed:-Policy: The facility will utilize the services of a Registered Nurse for at least eight consecutive hours per day, seven days per week;-The facility will designate a Registered Nurse to serve as the Director of Nursing on a full time basis. Review of the facility's admission Agreement, received on 9/3/25, showed:-Facility is intended to serve residents in need of skilled nursing care and treatment, which are those services commonly performed by or under the supervision of a Registered Nurse for individuals requiring twenty-four (24) hours a day care. Facility may only accept residents for which it determines, in its sole discretion, it is able to provide appropriate services. No resident will be accepted without a valid physician order for care. In addition, should you become aware that you are no longer able to meet these criteria; you agree to immediately advise Facility. The following criteria outlines the level of cognitive and functional ability required for admission into Facility:-Medical status/symptoms of dementia: The resident has a diagnosis of Alzheimer's disease or related dementia and exhibits symptoms of dementia which necessitates any of the following: guidance and direction, a safe environment, cueing and task simplification, structured programming;-Communication: The resident maintains the ability to respond to other residents, staff, family, and the environment. The resident may exhibit difficulty or awkwardness in communicating and socializing;-Social Behavior: The resident has the ability to participate and relate in a group setting. The resident may exhibit intermittent disruptive or disabling behavior such as wandering, rummaging, uncooperativeness, verbal and/or physical abuse. The resident must not exhibit or suffer from any significant psychiatric or behavioral problems which may escalate anxiety and confusion among other residents and/or present a safety hazard to themselves or others;-Social History: The resident must not have past or current difficulty with substance abuse or addiction, and not have a primary psychiatric diagnosis;-Mobility and Transferring: The resident may be dependent upon a cane, walker or wheelchair. The resident may require minimum to total assistance with mobility and transferring;-Toileting: The resident may require verbal cues, hands on assistance or total assistance with toileting and incontinence care;-Personal Care: The resident requires assistance to perform some or all daily personal care tasks;-Nursing Services: The resident (continued on next page)

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

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

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 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	requires on-going supervision, medication administration and assistance. The resident may require intermediate or skilled nursing assistance for preventative, curative or therapy services;-Meals/Eating: The resident may require cues, reminders or hands on assistance during mealtime. The resident may have specialized dietary needs including altered consistencies, approved physician ordered diets, or dietary monitoring;-Facility is an intermediate and skilled care residence. Various services are available to meet a wide range of nursing and rehabilitative needs. Residents shall be assessed for admission to Facility based on the following criteria:-Medical Status: The resident has an acute or longstanding unpredictable medical condition which requires intermittent emergency nursing services;-Social Behavior: The resident does not exhibit or suffer from any significant psychiatric or behavioral problems which may put himself/herself or others at risk of physical or emotional harm;-Personal Care: The resident requires on-going daily assistance with some or all activities of daily living (ADLs): dressing, eating, bathing, transferring, grooming, continence care, etc.;-Nursing Services: The resident requires daily monitoring of a health and/or medical condition by professional staff;-Skilled Services: The resident requires skilled medical services including but not limited to: physical, occupational, speech, and/or intravenous therapy, wound care. Review of the facility's Matrix (form used to track resident conditions and care needs), received on 9/3/25, showed:-Residents with diagnoses of Alzheimer's/Dementia: 20;-Hospice: 3;-Dialysis: 1;-Intravenous therapy: 1;-Indwelling catheter;-Post Traumatic Stress Disorder (PTSD)/Trauma: 7;-Insulin: 13;-Anticoagulant: 4;-Antianxiety: 24;-Antipsychotic: 85;-Antidepressant: 46;-Hypnotic: 5. During the course of the survey process, problems were identified which included:-No full time Director of Nursing (DON);-No full time Social Worker or social service designee. During an interview on 9/9/25 at 12:31 P.M., the Administrator said she is responsible for ensuring the facility assessment is completed. She was supposed to do it but did not have maintenance or nursing information to add to the assessment. The only thing that was documented in the facility assessment was who they were supposed to call or when to use another facility, and contact information. She did not want to give a partial facility assessment. It was not a complete assessment.

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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 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 implement an effective quality assurance (QA)/quality assurance performance improvement (QAPI) program when they failed to ensure they implemented appropriate interventions to correct on-going, systemic issues. This had the potential to affect all residents. The census was 105.Review of the facility's QAPI Plan, dated 5/14/21, showed:-This QAPI plan provides guidance for the facility overall quality improvement program. Quality assurance performance improvement principles will drive the decision making within the facility. Decisions will be made to promote excellence in quality of care, quality of life, resident choice, person directed care, and resident transitions;-Focus areas will include all systems that affect resident and family satisfaction, quality of care and services provided, and all areas that affect the quality of life for residents and staff;-On an annual basis, and as needed, a Facility Assessment will be conducted. Any chances in the facility assessment will be reflected, as necessary, in the QAPI Plan;-The QAPI Committee will review data for all areas of the facility to assure systems are being monitored and maintained to achieve the highest level quality. The following reports may be used by the QAPI committee; -Infection control log and infection prevention and control program; -Antibiotic utilization reports; -CMS Quality Measures, CASPER reports and any other data to measure the facility; -Medication administration audits; -Medication room audits;-Additionally, the Committee may use the following information: -Drug regimen review; -Family satisfaction; -Licensed nurse staff hours/resident day; -State survey results. Review of the annual Department of Health and Senior Services (DHSS) statement of deficiencies (SOD) for the past four years, showed the facility was cited for F880, a citation for infection control on July 2018, July 2019, and September 2023. The current SOD, dated 9/9/25, cited F880 for infection control. The facility failed to follow acceptable standards of practice for infection control when the facility failed to ensure an active Legionnaires (Legionella, bacteria in water that causes pneumonia) program was in place. In addition, staff did not pick up or replace oxygen or nebulizer tubing left on the bedroom floor for 3 of 3 residents sampled who received oxygen and breathing treatments. During an interview on 9/9/25 at 1032 A.M., the Maintenance Director said he worked at the facility since March 2025. Since he was employed, he had not conducted water testing. On 9/9/25, the Regional Maintenance Director brought two Legionnaires' test kits. The Maintenance Director said he completed one test. The results take 24 hours. Testing will be completed every 3 months. The facility did not have any water test kits prior to the regional staff delivering the kits on 9/9/25. The Maintenance Director could not locate any prior facility water testing. During an interview on 9/9/25 at 1:40 P.M., the Registered Nurse (RN) Supervisor said he/she expected the oxygen tubing to be picked up by staff, and even housekeeping would be able to pick up tubing to ensure it was not on the floor. He/She expected the oxygen tubing to be changed weekly. Tubing should not be allowed on the floor, the risk of infection increased. Review of the current SOD, dated 9/9/25, showed the facility was cited at F881 for failing to ensure an antibiotic stewardship program was in place and in use by failing to collect data regarding antibiotic treatment, reviewing and documenting the data to the antibiotic surveillance program. Five residents were identified as receiving antibiotics and issues were discovered with all five. During an interview on 9/9/25 at 3:02 P.M., the Administrator said the facility had no procedure in place to provide antibiotic stewardship or tracking of antibiotic use. All antibiotics should include an appropriate diagnosis. The care plan should reflect the antibiotic use. The antibiotic stewardship program is part of the infection control program (ICP). The facility did not have an active ICP staff and antibiotics were not monitored or data collected. During an interview on 9/9/25 at 1:40 P.M., the Administrator said the biggest issue that was found during the QAPI, was re-capping. When residents return from the hospital, pharmacy should be aware. The QAPI meetings have not been consistent. They were doing standup meeting, but it slacked and fell off. Sometimes she would meet with one nurse, at a different time, or during shift change.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to follow acceptable standards of practice for infection control when the facility failed to ensure an active Legionnaires' (Legionella, bacteria in water that causes pneumonia) program was in place. In addition, staff did not pick up or replace oxygen or nebulizer tubing left on the bedroom floor for 3 of 3 residents sampled who received oxygen and breathing treatments (Residents #54, #2 and #45). The sample was 43. The census was 105. Review of the infection prevention and control program, revised 5/7/24, showed:-Purpose: The 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;-Policy: -The designated infection preventionist is responsible for oversight of the program and serves as a consultant to our staff on infectious diseases, room placement, implementing isolation precautions, staff and resident exposures, surveillance, and epidemiologically investigations of exposures of infectious disease;-Isolation protocol (TBP, transmission-based precautions): -A resident with an infection of communicable disease shall be placed on TBP as recommended by current Centers for Disease Control (CDC) guidelines; -Residents on transmission-based precautions should be placed into a private/single room if available/appropriate, or are cohorted with residents with the same pathogen, or share a room with a roommate with limited risk factors, in accordance with national standards; -Residents will be placed on the least restrictive transmission-based precautions for the shortest duration possible under the circumstances; -When a resident on transmission based precautions must leave the resident care unit/area, the charge nurse on the unit/area shall communicate to all involved departments the nature of the isolation and shall prepare the resident for transport;-Supplies protocol: -Non-sterile supplies are stored and maintained as clean prior to use. Review of the Legionella surveillance policy, revised 6/26/24, showed:-Purpose: to establish primary and secondary strategies for the prevention and control of Legionella infections;-Policy: -Legionella surveillance is one component of the facility's water management plans for reducing the risk of Legionella and other opportunistic pathogens in the facility's water system; -In the absence of Legionella infections for a period of at least one year, the facility shall implement primary prevention strategies; -In the case of a definite or possible healthcare associated Legionnaire's disease within a 12-month period, the facility shall implement secondary prevention strategies in addition to primary prevention strategies until such time the water management team determines those strategies are no longer necessary, or as advised by local and/or state health department staff; -Principles of Legionella transmission: -To pose a health risk, Legionella has to grow in number and be aerosolized so people can breath in small, contaminated water droplets; -Legionella grows best in water temperatures of 77-108 degrees Fahrenheit (F), particularly in water that is not moving or that does not have enough disinfectant (pH 6.5-8.5) to kill germs; -Legionella can make people sick when the germs spread in droplets small enough for people to breath in. Medical devices, cooling towers, showers, hot tubs, and water fountains; -Although uncommon, Legionella may be contracted by aspiration of contaminated drinking water. Legionella is not usually spread from person to person; -The incubation period for Legionnaires' disease is generally 2-10 days; -Signs and symptoms of Legionnaires' disease are similar to pneumonia by other pathogens and include cough, fever, positive chest radiograph, sputum production, and new/changed lung examination abnormalities; -Primary prevention strategies: -Diagnostic testing: -The facility shall use the McGeer criteria (an infection surveillance tool) when diagnosing pneumonia; -Residents with healthcare associated pneumonia or who have failed antibiotic therapy for community-acquired pneumonia shall be tested for Legionella using both culture of lower respiratory secretions and the Legionella urinary antigen test; -Investigation for a facility source for Legionella, which may include culturing of facility water for (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Legionella: -The Infection Preventionist will investigate all cases of definite healthcare-associated Legionnaires' disease for the source of Legionella; -The Infection Preventionist will also investigate for the source of Legionella when two or more possible healthcare associated Legionnaires' diseases are identified; -Physical Controls: -Cooling towers and potable water systems shall be routinely maintained; -At risk medical equipment shall be cleaned and maintained in accordance with manufacturer recommendations; -Non-potable water systems shall be routinely cleaned and disinfected; -Nebulization devices shall be filed only with sterile fluid (sterile water or aerosol medication); -Temperature controls: -Cold water shall be stored and distributed below 68 degrees F. -Hot water shall be stored above 140 degrees F and circulated at a minimum return temperature of 124 degrees F;-Secondary prevention strategies: -A full scale environmental investigation to identify environmental sources: -All cases of Legionella shall be reported to local/state health officials, followed by an investigation; -Elements of an investigation may include: -Reviewing medical and microbiology records; -Actively identifying all new and recent residents with healthcare-associated pneumonia and testing them for Legionella using both culture of lower respiratory secretions and the Legionella urinary antigen test; -Developing a line list of cases; -Evaluating potential environmental exposures; -Performing an environmental assessment; -Performing environmental sampling, as indicated by the environmental assessment; -Subtyping and comparing clinical and environmental isolates;-Decontamination of identified environmental sources in accordance with current standards;-Heightened surveillance and environmental sampling, including increased suspicion for Legionella cases and increased frequency of testing above the facility's usual testing protocols. 1.During an interview on 9/9/25 at 10:32 A.M., the Maintenance Director said he worked at the facility since March 2025. Since he was employed, he had not conducted water testing. On 9/9/25, the Regional Maintenance Director brought two Legionnaires' test kits. The Maintenance Director said he completed one test. The results take 24 hours. Testing will be completed every 3 months. The facility did not have any water test kits prior to the regional staff delivering the kits on 9/9/25. The Maintenance Director could not locate any prior facility water testing. 2. Review of Resident #54's annual Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 8/21/25, showed: -Mild cognitive impairment; -Diagnoses include gastroesophageal reflux disease (GERD, acid reflux), hyperlipidemia, aphasia (a language disorder that affects a person's ability to communicate), hemiplegia, seizure disorder, depression, schizophrenia 9a disorder that affects a person's ability to think, feel, and behave clearly), asthma and cataracts; -Oxygen therapy: blank. Review of the Physician Order Sheet (POS), dated 9/2025, showed: -An order, dated 6/6/25 for oxygen at 2 liters continuous for shortness of breath (SOB), while in bed or sleeping; -No physician's orders noted to change the oxygen tubing. Review of the care plan, in use during survey, showed: -Problem: the resident is at risk for shortness of breath related to chronic obstructive pulmonary disease (COPD, lung disease);-Desired Outcome: the resident will have no complications related to shortness of breath; -Interventions: Head of bed elevated to prevent shortness of breath while lying flat; -Maintain a clear airway by encouraging resident to clear own secretions with effective coughing. If secretions cannot be cleared, suction as needed to clear secretions; -Monitor/document breathing patterns. Report abnormalities to physician; -Position resident with proper body alignment for optimal breathing pattern. Oxygen per orders. Observation on 9/3/25 at 11:36 A.M., 9/4/25 at 9:44 A.M., 9/8/25 at 10:13 A.M., and 9/8/25 at 2:09 P.M., showed the resident's oxygen tubing on the floor. Tape on the tubing showed a handwritten date of 7/15. The oxygen concentrator was turned on and set at 4 liters. 3. Review of Resident #2's quarterly MDS, dated [DATE], showed:-Cognitively intact;-Diagnoses included diabetes and COPD. Review of the care plan, undated and in use at the time of the survey, showed:-Focus: Oxygen therapy for COPD;-Goal: will have no signs and symptoms of poor oxygen absorption;-Interventions: provide extension tubing or portable oxygen apparatus, oxygen setting 02 using nasal cannula per orders. Review of the POS, dated 8/12/24, showed an order for a nebulizer (machine that turns liquid medicine into a mist that can be easily inhaled) (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	treatment every six hours as needed (PRN) for COPD. Observation and interview on 9/4/25 at 8:15 A.M., showed the resident resting in bed with a nebulizer machine, the tubing and mask laying on the floor at the head of the bed against the bed and wall. Observation showed dusty and dirty build up and what appeared to be animal scat on the floor along the wall. The resident said the nebulizer machine, tubing and mask lay on the floor because there is not enough room to place the machine anywhere else. The resident said the maintenance staff are aware his/her room has a mice problem, but the mice do not mess with the tubing or machine because the mice are just looking for food. Observation on 9/5/25 at 8:20 AM, and 9/9/25 at 9:30 A.M., showed the resident resting in bed with the nebulizer machine, tubing and mask laying on floor at the head of the bed against the bed and wall. Observation showed dusty and dirty build up and what appeared to be animal scat on the floor along the wall. 4. Review of Resident #45's medical record, showed:-Cognitively intact;-Diagnoses included COPD and acute respiratory failure with hypoxia (low oxygen). Review of the care plan, undated and in use at the time of the survey, showed:-Focus: Oxygen therapy for COPD with acute exacerbation and acute respiratory failure with hypoxia;-Goal: will display optimal breathing patterns daily through review date; -Interventions: monitor for difficulty breathing (dyspnea) on exertion, oxygen setting 02 using nasal cannula at four liters. Review of the POS, dated 7/25/25, showed an order for a nebulizer treatment every four hours PRN for shortness of breath. During observation and interview on 9/3/25 at 11:15 A.M., showed the resident resting in bed with the nebulizer machine placed on a large plastic bin that was on the floor at the head of bed. The plastic bin lid was covered with dust and a dried substance with the nebulizer tubing and mask laying on the floor. The floor had visible dirt build up around the head and foot of the bed. The resident said the nebulizer machine, tubing and the mask lay on floor because that is where the staff kept it. Observation on 9/4/25 at 7:05 AM, and 9/5/25 at 8:30 A.M., showed the resident resting in bed with a nebulizer machine placed on a large plastic bin that was on the floor at the head of bed. The plastic bin lid was covered with dust and a dried substance with the nebulizer tubing and mask laying on the floor. The floor had visible dirt build up around the head and foot of the bed. During an interview on 9/9/25 at 12:25 P.M., Assistant Director of Nursing (ADON) B said he/she expected the oxygen to be put on the resident. He/She never saw the resident without it, but the aides put it back on the resident. ADON B expected staff to ensure the resident was using the oxygen and checking oxygen saturations. The tubing was changed weekly. The night nurse is responsible for checking the oxygen sats and changing the tubing. If the resident took off the oxygen, he/she expected it to be care planned. During an interview on 9/9/25 at 1:40 P.M., the Registered Nurse (RN) Supervisor said he/she expected the oxygen tubing to be picked up by staff, and even housekeeping would be able to pick up the tubing to ensure it was not on the floor. He/She expected the oxygen tubing to be changed weekly. Tubing should not be allowed on the floor, as that would increase the risk of infection.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Implement a program that monitors antibiotic use. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure an antibiotic stewardship program was in place and in use by failing to collect data regarding antibiotic treatment, reviewing and documenting the data to the antibiotic surveillance program. Five residents were identified as receiving antibiotics and issues were discovered with all five (Residents #9, #34, #2, #72 and #64). The sample was 43. The census was 105.Review of the Infection prevention and control program, revised 5/7/24, showed:-Purpose: The 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;-Policy:-The designated infection preventionist (IP) is responsible for oversight of the program and serves as a consultant to staff on infectious diseases, room placement, implementing isolation procedures, staff and resident exposures, surveillance and epidemiological investigations of exposures of infectious diseases; -Antibiotic stewardship: -An antibiotic stewardship program will be implemented as part of the overall infection prevention and control program; -Antibiotic use protocols and a system to monitor antibiotic use will be implemented as part of the antibiotic stewardship program; -The IP, with oversight from the Director of Nursing (DON), serves as the leader of the antibiotic stewardship program; -The medical director, consultant pharmacist, and laboratory manager will serve as resources for the antibiotic stewardship program. 1.Review of Resident #9's medical record, showed:-An order, dated 9/3/25: Amoxicillin-Pot clavulanate (used to treat infection) 875/125 (combination medication) milligram (mg). Take one tablet by mouth twice daily for sinusitis for seven days. Review of the care plan, on 9/9/25, showed it did not reflect antibiotic use. 2. Review of Resident #34's medical record, showed an order, dated 9/3/25: Amoxicillin-Pot clavulanate (antibiotic) 875/125 mg. Take one tablet by mouth twice daily for sinusitis for seven days. Review of the care plan, on 9/9/25, showed it did not reflect antibiotic use. 4.Review of Resident #2's medical record, showed an order, dated 8/28/25: Doxycycline (antibiotic) 100 mg, take one tablet daily for seven days. No diagnoses included with the antibiotic order. Review of the care plan, on 9/9/25, showed it did not reflect antibiotic use. 5.Review of Resident #72's medical record, showed an order, dated 9/2/25: Clindamycin (antibiotic) 300 mg, take one capsule three times a day for prophylaxis related to other asthma. Review of the care plan, on 9/9/25, showed it did not reflect antibiotic use. 5. Review of Resident #64's admission MDS, dated [DATE], showed:-Diagnoses included traumatic spinal cord dysfunction, heart disease, high blood pressure, gastroesophageal reflux disease (GERD, acid reflux), neurogenic blader, hyperlipidemia, quadriplegia, malnutrition and depression;-Cognitively intact;-Was administered antibiotics in the last seven days. Review of the care plan, in use during survey, showed:-Problem: Resident has a indwelling suprapubic catheter due to neurogenic bladder. Noncompliance with keeping catheter bag in a privacy cover;-Desired Outcome: Enhanced Barrier Precautions (EBP) in place; -Monitor/document for pain/discomfort due to catheter; -Monitor/record/report to physician for signs and symptoms of urinary tract infection;-No documentation of long-term use of Amoxicillin (antibiotic). Review of the MAR, dated 8/2025, showed:-An order, dated 8/5/25, Amoxicillin oral tablet 500 mg, give one tablet by mouth three times a day for bacteria was administered on the following dates and times: -On 8/6/25 through 8/18/25 and 8/20/25 through 8/31/25 at 7:00 A.M.; -On 8/6/25 through 8/18/25 and 8/20/25 through 8/31/25 at 11:00 P.M.; -On 8/5/25 though 8/31/25 at 8:00 P.M. Review of the POS, dated 9/2025, showed an order, dated 8/5/25, Amoxicillin Oral Tablet 500 mg, give one tablet by mouth three times a day for bacteria. Review of the MAR, dated 9/2025, showed:-An order, dated 8/5/25, Amoxicillin Oral Tablet 500 mg, give one tablet by mouth three times a day for bacteria was administered on the following dates and times:-On 9/1/25 through 9/4/25 at 7:00 A.M.;-On 9/1/25 through 9/4/25 at 11:00 A.M.;-On 9/1/25 through 9/4/25 at 8:00 P.M. Review of the resident's Pharmacy Review note, dated 8/20/25, showed please add a stop date and a more appropriate (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	diagnosis (type of infection) to the amoxicillin order. During an interview on 9/9/25 at 12:41 P.M., the Registered Nurse (RN) Supervisor said the resident's Amoxicillin does not have a stop order per the physician. She expected it to be documented. The RN Supervisor expected all antibiotics to have a diagnosis attached with it. 6. During an interview on 9/9/25 at 3:02 P.M., the Administrator said the facility had no procedure in place to provide antibiotic stewardship or tracking of antibiotic use. All antibiotics should include an appropriate diagnosis. The care plan should reflect the antibiotic use. The antibiotic stewardship program is part of the infection control program. The facility did not have an active ICP staff and antibiotics were not monitored or data collected.

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F 0882 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Designate a qualified infection preventionist to be responsible for the infection prevent and control program in the nursing home. Based on interview and record review, the facility failed to designate one or more individuals with specialized training and certification in infection prevention and control as the Infection Control Preventionist (ICP) for the facility's infection prevention control program. The census was 105. Review of the Infection prevention and control program, revised 5/7/24, showed:-Purpose: The 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;-Policy:-The designated infection preventionist (IP) is responsible for oversight of the program and serves as a consultant to staff on infectious diseases, room placement, implementing isolation procedures, staff and resident exposures, surveillance and epidemiological investigations of exposures of infectious diseases. During an interview on 9/4/25 at 2:03 P.M., the Administrator said Assistant Director of Nursing (ADON) A is the IP for the facility. She had completed the IP training. During an interview on 9/9/25 at 3:02 P.M., the Administrator said ADON A had not completed the Center for Disease Control (CDC) IP training. The facility did not have a qualified staff member who was a certified ICP. The Administrator said a separate staff person, the transportation driver, had completed the non-medical infection control training, however, the training did not meet the needs of the facility residents, the infection control program or ICP qualifications.

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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. Based on observation, interview and record review, the facility failed to maintain a safe, clean, comfortable and homelike environment for resident areas throughout the building. The census was 105. 1. 1. Observation on 9/3/2025 at 11:00 A.M., 9/5/2025 at 1:15 P.M., and 9/9/2025 at 9:30 A.M., showed the following:-Room C1, behind the door, showed drywall mudding, measuring 30 inches () by 4 in length, unpainted;-Shared bathroom, located between C1 -C3, with missing cove base along the doorway of C1, exposing a large hole in the wall 8x4;-Shared bathroom, located between C1 -C3, with missing cove base along the doorway of C3 and behind the toilet;-Between room C1 and C3, in the hallway, a section measuring 4x4 of unpainted area, exposing four 1/2 holes;-Shared bathroom, located between C5 -C7, with cove base pulled away from wall along the doorway of C5, exposing crumbling drywall;-Room C7 bed 1, overhead bed light plastic cover laying on top of the fixture, exposing the light bulb;-Room C6 bed 1, approximate 14x4 unpainted section with two 1/2 circle holes;-Room C9 bed 1, 3x3 hole near the door approximately 6 from the floor and two additional circle areas measuring 2x2, exposing drywall;-Room C9, air conditioning unit (AC) with a 2 gap between the AC unit and the wall;-Shared bathroom, located between C10 -C12, with chipped and cracked paint along the length of the bottom of mirror with brown stains. The sink pulled away from wall with cracked paint and caulk;-Room C10, a hole measuring 2x2 behind the door;-Room C10, foot of bed 2, showed a hole in the corner of room measuring 1x1 with black hairy-like substance coming out of the hole with visible mice droppings;-Room C10, side of bed 2, showed a 1 x 1/2 hole in cove base that went through the wall exposing pieces of drywall. In front of the hole was a pest control bug glue trap;-Room C12 bed 1, 4 1/2 holes in wall. 2. Observation on 9/3/25 at 1:24 P.M., and on 9/5/25 at 2:47 P.M., of bedroom and bathroom A-10, showed the floor was dirty and sticky upon walking. In addition, in the bathroom, the baseboard was pulled out from the wall on the bottom left-hand side and the plaster was peeled away from the wall on the top right-side corner above the sink. 3. Observation on 9/3/25 at 1:46 P.M., and on 9/5/25 at 2:50 P.M., of room A-7, showed the floor was dirty and sticky upon walking. In the bathroom, the paint was peeled away from the wall behind the commode. 4. Observations on 9/3/25 at 2:17 P.M., and on 9/5/25 at 2:56 P.M., of room B-4, showed the floor was dirty and sticky upon walking. In in addition, the baseboard was pulled away from the wall behind the bedroom door. 5. Observation on 9/3/25 at 10:41 A.M., showed the floors of room D-3 were sticky upon walking and what appeared to be an opaque, dirty film on the tiles near the doorway. 6. Observation on 9/3/25 at 11:09 A.M., near the D-hall entrance, showed a broken ceiling tile above the doorway to the beautician's office, leaving an approximate 5 inch by 7 inch gap, exposing the electrical wires and space above the ceiling tiles. 7. During an interview on 9/8/25 at 9:30 A.M., the Maintenance Assistance (MA) said the staff fills out the facility's work order sheet when repairs are needed. Once the staff completes the form, the form is placed in the wall mounted box that is located at the entrance of each hall. The MA said every morning he gathers all the completed forms so the issues can be address. The MA said due to budget cuts, the supplies needed to make the repairs are slow.

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. Based on interview and record review, the facility failed to provide a full time Director of Nursing (DON), who did not serve as a charge nurse, when the facility had a census over 60. The census was 105.Review of the facility's Registered Nurse (RN) policy, dated 4/30/24, showed:-Purpose: It is the intent of the facility to comply with Registered Nurse staffing requirements;-Full-time is defined as working 40 or more hours a week;-Charge Nurse is a licensed nurse with specific responsibilities designed by the facility that may include staff supervision, emergency coordinator, physician liaison, as well as direct resident care;-Policy: The facility will utilize the services of a Registered Nurse for at least eight consecutive hours per day, seven days per week;-The facility will designate a Registered Nurse to serve as the Director of Nursing on a full time basis;-The Director of Nursing may serve as charge nurse only when the facility has average daily occupancy of 60 or fewer residents;-The facility is responsible for submitting timely and accurate staffing data through the CMS Payroll-Based Jornal (PBJ) system. Review of the facility's census, showed 105 residents. Review of the facility's staffing roster, showed the facility had a DON. Review of the facility's handwritten RN coverage, received on 9/9/25, showed the RN Supervisor provided RN coverage on 9/3/25, 9/4/25, 9/5/25, 9/8/25, and 9/9/25. During an interview on 9/3/25 at 10:52 A.M., the Administrator confirmed the facility had a full time DON. During an interview on 9/9/25 at 12:25 P.M., Assistant Director of Nursing (ADON) B said the DON is on medical leave. He/She was unsure of when the DON would return. The RN Supervisor was the interim DON to his/her knowledge, but he/she was not sure if the RN provided RN coverage or the interim DON. During an interview on 9/9/25 at 12:41 P.M., the Administrator said the current DON was supposed to notify her of when he/she would return. The RN Supervisor is the interim DON and he/she started last week. On 9/8/25 and 9/9/25, he/she provided RN coverage. They did not have an interim DON on 9/8/25 and 9/9/25. RN staff from corporate also provide eight hours of coverage. Some provide coverage every other weekend. It was discussed during their Quality Assurance and Quality Improvement (QAPI) meeting. It was discussed if the DON would be able to complete some tasks from home. During an interview on 9/9/25 at 1:40 P.M., the RN supervisor confirmed he/she was the RN supervisor.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to implement the facility's policy and procedure for the monthly drug regimen review by failing to ensure the physician or designee responded to the pharmacy recommendation timely for nine residents (Residents #2, #7, #11, #72, #64, #13, #67, #35 and #85). The sample was 43. The census was 105.Review of the facility's Medication Regimen Review (MRR) policy, dated 6/26/24, showed: -Purpose: the drug regimen of each resident is reviewed at least once a month by a licensed pharmacist and includes a review of the medical chart;-Policy: -MRR or drug regimen review, is a thorough evaluation of the medication regimen of a resident, with the goal of promoting positive outcomes and minimizing adverse consequences and potential risks associated with medication. The MRR includes: -Review of the medical record in order to prevent, identify, report, and resolve medication related problems, medication errors, or other irregularities; -Collaboration with other members of the interdisciplinary team, including the resident, the family and/or the resident representative; -The requirements associated with the MR apply to all residents, whether short or long stay; -To facilitate the completion of the MRR, the facility shall provide the licensed pharmacist access to the following: -Residents and their medical records, including Medication Administration Record (MAR); -All portions of the electronic health record; -The pharmacy provider's resident medication profiles; -The facility's records of medication receipt and disposition; -Medication containers and storage areas; -Controlled substance records and supplies; -Answers to the previous month's pharmacy recommendations; -The pharmacist shall document electronically, that each medication regimen review has been completed; -The pharmacist shall document either that no irregularity was identified or the nature of any identified irregularities; -The pharmacist does not need to document a continuing irregularity in the report each month if the attending physician has documented a valid clinical rationale for rejecting the pharmacist's recommendation; -The pharmacist shall communicate any irregularities to the facility in the following ways: -Verbal communication to the attending physician, Director of Nursing (DON), and/or staff of any urgent needs; -Written communication to the attending physician, the Medical Director and the DON; -Written communications from the pharmacist shall become a permanent part of the medical record; -Timelines and responsibilities for MRR: -The consultant pharmacist shall schedule at least one monthly visit to the facility, and shall allow for sufficient time to complete to all required activities; -The pharmacist shall communicate any recommendations and identified irregularities via written communications within 10 working days of the review; -If the pharmacist should identify an irregularity that requires urgent action to protect a resident, the DON or designee is informed verbally; -The pharmacist will complete the MRR, and ensure this is documented into the electronic health record; -The facility shall act upon all recommendations according to procedures for addressing MRR irregularities;-Facility staff shall act upon all recommendations according to procedures for addressing the MRR irregularities. 1. Review of Resident #2's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 6/7/25, showed:-Cognitively intact;-Diagnoses included diabetes, chronic obstructive pulmonary disease (COPD, ongoing lung condition caused by damage to the lungs). Review of the resident's MRR, dated 6/20/25, 7/21/25 and 8/17/25, showed pharmacy recommendations to discontinue the multiple orders of Amlodipine (used to treat high blood pressure) and Tylenol. Review of the resident's active order summary, showed:-Continued duplicate orders of Amiodipine and Tylenol. Review of the resident's medical record, showed no documentation the physician or provider addressed the pharmacist's recommendation. 2. Review of Resident #7's annual MDS, dated [DATE], showed:-Cognitively intact;-Diagnoses included schizoaffective disorder (mental health condition that is marked by a mix of schizophrenia symptoms, such as hallucinations and delusions) delusional (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	disorder and allergies. Review of the Physician Order Sheet (POS), showed an order dated 6/3/25, for hydroxyzine (used to treat anxiety and allergies) oral tablet 50 milligrams (mg) by mouth (for anxiety) as needed (PRN) for 14 days. Review of the MRR, dated 6/26/25, 7/23/25 and 8/21/25, showed pharmacy recommendations to discontinue the order. Review of the medical record, showed discontinue order pending confirmation. 3. Review of Resident #11's medical record, showed his/her diagnoses included bipolar disorder, seizures, depression, liver disease, personality disorder and pain. Review of the pharmacy review note, dated 6/25/25, showed:-Patient has 2 orders for cholecalciferol (Vitamin D) 50000 (one to be given monthly and the other weekly). Duplicate therapy is generally not indicated, unless current clinical standards of practice and documented clinical rationale confirm the benefits of multiple medications from the same class or with similar therapeutic effects. Please discontinue one order to avoid med errors.-Patient has 2 orders for cyclobenzaprine (muscle relaxer) 10 mg daily. Duplicate therapy is generally not indicated, unless current clinical standards of practice and documented clinical rationale confirm the benefits of multiple medications from the same class or with similar therapeutic effects. Please discontinue one order to avoid med errors.-Patient has 2 orders for amlodipine 10 mg daily. Duplicate therapy is generally not indicated, unless current clinical standards of practice and documented clinical rationale confirm the benefits of multiple medications from the same class or with similar therapeutic effects. Please discontinue one order to avoid med errors.-This resident has active orders of Acetaminophen (either alone or in combination with other medications). Please add the following to each acetaminophen-containing order: Not to exceed 3 gm of APAP in 24 hours-Miralax (used to treat constipation) should be dissolved in 4-8oz of fluid before administration to patient. Please include with Miralax instructions for use. Review of the POS, during the survey, showed:-Duplicate orders for cholecalciferol 50,000;-Duplicate orders for cyclobenzaprine;-Duplicate orders for amlodipine 10 mg;-Acetaminophen without the recommended not to exceed 3 gm of APAP in 24 hrs;-Miralax order did not contain the recommended instructions for use. 4. Review of #72's medical record, showed his/her diagnoses included Sshizoaffective (a mental health disorder that combines symptoms of schizophrenia and mood disorder such as depression or bipolar disorder), seizures, asthma and vitamin D disorder. Review of the pharmacy review note, dated 6/25/25, showed:-This resident is currently receiving the following psychotropic (Non Antipsychotic) medication on a PRN basis: hydroxyzine. Per regulatory guidelines, the duration of treatment with such medications on a PRN basis should be limited to 14 days, however, a new order may be written to extend the duration beyond 14 days if the prescriber believes it is appropriate. Please evaluate the continued need for this medication. If it is to be extended, please document the rationale for the extended time period in the medical record and indicate a specific duration/end-date. Note, we can no longer have the unspecified duration of 'end of life care;-Please provide a diagnosis for the following medication(s): hydroxyzine. Medication is PRN and has no indication on when to give; -Miralax should be dissolved in 4-8oz of fluid before administration to patient. Please include with Miralax instructions for use;-This resident has active orders of Acetaminophen (either alone or in combination with other medications). Please add the following to each acetaminophen-containing order: Not to exceed 3 grams of APAP in 24 hours; Review of the pharmacy review note, dated 7/22/25, showed: please address pharmacy recommendations from the prior month. Review of the current POS, showed:-Acetaminophen did not contain the recommended not to exceed 3 gm of APAP in 24 hrs;-Miralax did not contain instructions for use;-Hydroxyzine remained as a PRN and no linked diagnoses. 5. Review of Resident #64's admission MDS, dated [DATE], showed:-Diagnoses included traumatic spinal cord dysfunction, coronary artery disease (CAD, heart disease), high blood pressure, gastroesophageal reflux disease (GERD, acid reflux), neurogenic blader, hyperlipidemia (high cholesterol), quadriplegia, malnutrition and depression;-Used an indwelling catheter;-Was administered antibiotics in the last seven days. Review of the resident's Pharmacy Review note, dated 8/20/25, showed:-This resident has active orders of Acetaminophen (either alone or in combination with other medications). Please add the following to each acetaminophen-containing (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	order: Not to exceed 3 grams of APAP in 24 hours;-Please add a stop date and a more appropriate diagnosis (type of infection) to the amoxicillin order;-Miralax should be dissolved in 4-8oz of fluid before administration to patient. Please include with Miralax instructions for use;-Please update the instructions on the Polyvinyl Alcohol Ophthalmic Solution order to say Instill 1 drop in both eyes three times a day;-Please adjust the instructions on the cyclosporine order to Give 1 capsule by mouth twice daily;-Tamsulosin is best taken with food. Please add Take with food Do not crush or chew. Review of the POS, dated 9/2025, in use during the survey, showed:-An order, dated 8/5/25, amoxicillin oral tablet 500 mg, give one tablet by mouth three times a day for bacteria;-An order, dated 8/5/25, acetaminophen tablet 325 mg, give two tablets by mouth every 6 hours as needed for pain;-An order, dated 8/5/25, hydrocodone-acetaminophen Oral Tablet 5-325 mg, give one tablet by mouth, two times a day for pain. Take one tablet by mouth every 12 hours;-An order, dated 8/5/25, polyethylene glycol powder 1450 (MiraLAX), give 17 gram by mouth, one time a day for constipation;-An order, dated 8/5/25, polyvinyl alcohol ophthalmic solution (Artificial tears), instill 1 mg in both eyes, three times a day for eye drops, 1 drop into both eyes, three times daily;-An order, 8/5/25, cyclosporine modified oral capsule (used to treat autoimmune conditions)100 mg, give 1 capsule enterally two times a day for eyes, one drop into both eyes two times a day;-An order, dated 8/5/25, tamsulosin (treats enlarged prostate) HCl oral capsule 0.4 mg, give 1 capsule by mouth at bedtime for enlarged prostate;-An order, dated 8/28/25, hydrocodone-acetaminophen oral tablet 5-325 mg, give one tablet by mouth two times a day for pain, take one tablet by mouth every 12 hours. 6. Review of Resident #13's medical record, showed his/her diagnoses including chronic kidney disease (CKD, a condition where the kidneys gradually lose their ability to filter waste products from the blood), depression, schizophrenia and unspecified muscle weakness. Review of the POS, in use during the survey, showed:-An order placed on 5/9/23 for Vitamin D (Ergocalciferol) 50,000 unit capsule to be given once daily. The order contained no end date;-An order placed on 10/11/24 for Vitamin D 1.2MG (50,000 units) capsule to be given once daily in the morning. The order contained no end date. Review of the resident's progress notes showed:-A note from 6/21/25 entered by the pharmacist indicating duplicate Vitamin D orders existed and needed clarification to ensure the resident was receiving the appropriate dose of Vitamin D daily;-A note from 7/23/25 entered by the pharmacist indicating pharmacy recommendations from June 2025 had not been responded to and clarification was still needed regarding Vitamin D orders;-No medication regimen review performed by a pharmacist was documented in August of 2025. During the survey period the facility was unable to provide physical copies of the consultant pharmacist's medication recommendations or physician responses to the pharmacist's recommendation. 7. Review of Resident #67's medical record, showed his/her diagnoses included major depressive disorder, schizophrenia, obsessive-compulsive disorder (a mental health condition characterized by intrusive, unwanted thoughts (obsessions) and repetitive behaviors or mental acts (compulsions that cause significant distress and impairment in daily functioning), post-traumatic stress disorder (PTSD, a disorder in which a person has difficulty recovering after experiencing or witnessing a terrifying event) and bipolar disorder. Review of the POS, in use during the survey, showed:-An order, placed on 7/11/25, for Haldol (Haloperidol, a first-generation or typical antipsychotic medication used to treat psychotic disorders) Injection solution 5 mg/mL (milligrams per milliliter) as needed every 8 hours for agitation/aggression. The order contained no stop date;-An order, placed on 9/7/25, for Haldol 5 mg tablet with instructions to give 2 tablets by mouth every 8 hours as needed for agitation/aggression for a total of 14 days. Review of the progress notes, showed:-7/22/25, the consulting pharmacist noted the resident's Haldol injection order contained, no stop date and antipsychotics should be restricted to 14 days if kept as a PRN order. An additional request to address the previous month's recommendations was made within the consultant review;-8/20/25, the consulting pharmacist noted the resident's Haldol injection still had not received a 14-day stop date and required one. During the survey, the facility was unable to provide physical copies of the consultant pharmacist's medication recommendations or physician responses to the (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	pharmacist's recommendation. 8. Review of Resident #35's medical record, showed his/her diagnoses included localized edema, high blood pressure, weight loss and kidney disease. Review of the pharmacy review note, dated 8/18/25, showed:-This resident is currently receiving the following: Furosemide (Lasix a diuretic treating blood pressure and water retention) without a proper diagnosis. Review of the pharmacy review note, dated 7/21/25, showed: please address pharmacy recommendations from the prior month. Please provide a more appropriate diagnosis for the following medication: Lasix Review of the POS, in use during the survey, showed:-Give Lasix (diuretic) tab 20 mg one tab daily for hyponatremia (low sodium). The facility did not address the pharmacy recommendations. 9. Review of Resident #85's medical record, showed his/her diagnoses included infection of the skin and the subcutaneous tissue, (bacteria in the skins layers), non-pressure ulcer of the left ankle limited breakdown of the skin (not related to pressure wound). Review of the pharmacy review note, dated 6/26/25, showed:-This resident is currently receiving the following provide a more appropriate diagnosis for the following medication(s) Aspirin (i.e. primary/ secondary prevention). Review of the pharmacy review note, dated 7/22/25, showed: please address pharmacy recommendations from the prior month. Review of the POS, in use during the survey, showed:-Aspirin 81 mg chewable one tablet by mouth daily for a supplement active since 2/16/23. -Aspirin 81 mg one tablet by mouth daily for a preventative discontinued since 8/17/21.-The pharmacy recommendations were not addressed. 10. During an interview on 9/9/25 at 1:11 P.M., the Administrator and acting Director of Nurses (DON) said after the consultant pharmacist reviews resident medication regimens, a packet is provided to the facility that contains recommendations for each resident. The DON and Assistant Directors of Nursing (ADONs) should act on those recommendations and notify the physician. The facility Medical Director (MD) usually answers right away. No singular staff member is responsible for ensuring recommendations are followed as any nurse should ensure this is done. Any action taken regarding medication regimen recommendations should be documented in the resident's medical record. Antipsychotic medications given on a PRN basis require a stop date no further than 14 days past the original order date.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to offer and vaccinate, as desired, eligible residents with the pneumococcal (pneumonia) and influenza (flu) vaccine for 5 out of 5 residents sampled for immunizations (Residents #85, #72, #67, #54 and #45). The sample was 43. The census was 105. Review of the influenza and pneumococcal immunization policy, revised 5/14/24, showed:-Purpose: to ensure that all residents residing in the facility are offered influenza and pneumococcal immunizations to prevent infection and the spread of communicable disease;-Procedure: -At admission, 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 immunizations; -The resident or their legal representative will be informed that the influenza immunization are provided yearly between October 1st and March 31, unless the immunization is medically contraindicated, the facility has evidence that the resident has already been immunized during this time, or the resident or the resident's legal representative has refused the immunization; -The resident or legal representative will be informed that the pneumococcal immunization will be offered upon admission per Centers for Disease Control (CDC) guidelines. The pneumococcal immunization will not be given if the immunization is medically contraindicated, the facility has evidence to support the resident received the immunization, or the resident/legal representative has refused the immunization; -The resident or the legal representative will be required to sign the revolving consent form. The resident or the legal representative will be told the form provides consent for annual influenza immunizations and for the pneumococcal immunization as needed unless those immunizations are medically contraindicated. The resident or legal representative will be told that they can revoke the revolving consent form at any time abut such revocation must be in writing;-Current residents: -Any resident who has not been offered a revolving consent form will have the revolving consent form offered to the resident or their legal representative following the procedure;-Annual consents: -If a resident or legal representative chooses to not sign a revolving consent form, an annual consent may be obtained; -The resident or legal representative will be provided education on the benefits and potential side effects of the immunizations; -On admission and yearly, the resident or their legal representative will sign a form showing the resident or the legal representative has been educated on and is aware of the benefits and potential side effects of receiving the immunizations; -Each resident will be offered the influenza immunization yearly between October 1st- March 31st unless medically contraindicated, the facility has evidence that the resident had already received the vaccine; -The pneumococcal immunization will be offered upon admission and a second pneumococcal immunization may be recommended after five years from the first immunization. The 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 has refused the immunization;-Consent Process: -The customer service consultant/designee or social services director/designee will provide educational information on the immunization and ensure the consent form is filled out, placed in the resident's chart and updated (if needed) before the immunization is given to the resident; -The consent/refusal form will include documentation to support that the resident or their legal representative is full informed and educated on the benefits and potential side effects of the immunizations; -Physician orders will be obtained for the immunizations unless medically contraindicated or the resident or their legal representative has refused the immunizations; -The resident's clinical record will document: -The resident of their legal representative was provided education regarding the benefits and potential side effects of influenza and pneumococcal immunizations; -The resident either received the influenza and pneumococcal immunizations or did not receive them due to medical contraindications or refusals. 1.Review of Resident #85's annual Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	dated 8/21/25, showed:-admitted : 2/16/23;-Cognitively intact;-Diagnoses included epilepsy (disorder in which nerve cell activity in the brain is disturbed, causing seizures), schizoaffective bipolar (irrational thoughts, including emotional highs and lows), anxiety, skin infection and vitamin deficiency;-Did the resident receive the influenza vaccine in this facility for this year's influenza season: No; -If influenza vaccine not received, state reason: offered and declined;-Is the resident's pneumococcal vaccination up to date? No; -If pneumococcal vaccination not received, state reason: not offered. Review of the resident's medical record, showed no documented offering or declination of the flu or pneumococcal vaccinations for the 2024 season. During an interview on 9/9/25 at 10:43 A.M., the resident said he/she had not been offered either vaccination while at the facility. He/She would consider the vaccinations. 2. Review of Resident #72's annual MDS, dated [DATE], showed:-admitted [DATE];-Cognitively intact;-Diagnoses included schizoaffective disorder (a mental health condition including schizophrenia and mood disorder symptoms), seizure disorder, and vitamin deficiency;-Did the resident receive the influenza vaccine in the facility for this year's influenza season: no; -If influenza vaccine not received, state reason: not offered;-Is the resident's pneumococcal vaccination up to date: no; -If pneumococcal vaccination not received, state reason: not offered. Review of the medical record, showed no documented offering or declination of the flu of pneumococcal vaccinations for the 2024 season. During an interview on 9/5/25 at 12:15 P.M., the resident said he/she had not been offered the flu or pneumococcal vaccinations. 3. Review of Resident #67's quarterly MDS, dated [DATE], showed:-admitted : 4/19/24;-Cognitively intact;-Diagnoses included schizoaffective disorder, bipolar disorder, epilepsy and anxiety;-Is the resident's pneumococcal vaccination up to date: no; -If pneumococcal vaccination not received, state reason: not offered. Review of the physician order sheet (POS), showed:-An order, dated 4/19/24: may have to pneumococcal vaccine every 5 years with written or verbal consent. Review of the medical record, showed no documented offer or declination of the pneumococcal vaccination. During an interview on 9/8/25 at 11:22 A.M., the resident said he/she had not been offered the pneumococcal vaccination. 4. Review of Resident #54's annual MDS, dated [DATE], showed:-admitted : 10/26/22;-Moderate cognitive impairment;-Diagnoses included stroke with paralysis, lung disease and Alzheimer's disease;-Did the resident receive the influenza vaccine in the facility for this year's influenza season: no; -If influenza vaccine not received, state reason: offered and declined;-Is the resident's pneumococcal vaccination up to date: no; -If pneumococcal vaccination not received, state reason: not offered. Review of the POS, showed:-An order, dated 10/6/22: -May have influenza vaccine yearly and pneumococcal vaccine every 5 years with written or verbal consent. Review of the medical record, showed no documented offer or declination of the influenza or pneumococcal vaccinations. 5. Review of Resident #45's quarterly MDS, dated [DATE], showed:-admitted : 2/4/25;-Moderate cognitive impairment;-Diagnoses included bipolar disorder, personality disorder, hepatitis C (liver infection, causing liver failure), heart failure, lung disease and anxiety;-Did the resident receive the influenza vaccine in the facility for this year's influenza season: no; -If influenza vaccine not received, state reason: resident not in the facility;-Is the resident's pneumococcal vaccination up to date: no; -If pneumococcal vaccination not received, state reason: not offered. Review of the POS, showed:-An order, dated 7/25/25: may have flu vaccine yearly and pneumococcal vaccine with written or verbal consent. Review of the medical record, showed no documented offer of declination of the influenza or pneumococcal vaccinations. 6. During an interview on 9/9/25 at 2:12 P.M., the Administrator said residents or the responsible party (RP) should be offered the influenza and pneumococcal vaccines, upon admission or re-admission if not previously offered or administered. The resident or RP should sign either the declination or acceptance form and the form should be placed into the resident record.

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. Based on observation, interview and record review, the facility failed to ensure a resident who experienced bilateral (both sides) finger amputations, had an accessible device to call for staff assistance (Resident #40). The sample was 43. The census was 105. Review of Resident #40's significant change Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 8/11/25, showed:-Cognitively intact;-Able to make needs and wants known;-Required physical assistance for eating; -Required brace for eating;-Required physical assistance for hygiene, eating, transfers and daily care;-Diagnoses included superficial frostbite of the left and right hand (a mild to moderate form of frostbite where ice crystals form in the top layers of the skin, making the skin appear pale, waxy, and feel stiff or hard), schizoaffective disorder (a chronic mental health condition characterized primarily by symptoms of schizophrenia, such as hallucinations or delusions, and symptoms of a mood disorder, such as mania and depression), bipolar type (hallucinations with high/low moods), polyneuropathy (peripheral nerve damage), drug induced subacute dyskinesia (involuntary movement disorder). Review of the care plan, in use during the survey, showed: -Problem: -The resident has a movement disorder of the upper extremities. Encourage the resident to use the bell to call for assistance; -The resident has an activities during daily living (ADL) self-care performance deficit related to external device. He/She lost all fingers on both hands to frostbite in March 2020 and needs adaptive devices to perform ADLs effectively. He/She often refuses to wear adaptive equipment, requires supervision for safety oversight;-Desired Outcome: The resident will demonstrate the appropriate use of adaptive devices(s) to increase ability in the ADLs;-Interventions:-The resident requires adaptive equipment of weighted utensils and divided plate, encourage the resident to use bell to call for assistance;-Monitor, document, report any changes, any potential for improvement, reasons for self-care deficit, expected course, declines in function; Observation and interview on 9/3/25 at 2:09 P.M., showed the resident sat in bed. No call light was noted next to the bed. The resident said his/her roommate used his/her own cell phone to call for assistance. The resident said the facility call light system was getting repaired. His/Her roommate had been supplied with a whistle. The resident was unable to use a whistle to call for assistance. The facility had not provided a different mechanism of communication. The resident said he/she relied on his/her roommate to call for help. During an interview on 9/10/25 at 1:45 P.M., the Administrator said during the call-light repair, each resident was to receive hourly checks. When the whistles were effective, residents would have 15-minute checks. Most of the residents did not effectively utilize the whistle system. The Administrator also said they tried a bell and did 15-minute checks. All residents should have accessibility to call for staff assistance. It is not appropriate for residents to rely on roommates to obtain staff assistance.

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F 0568 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Properly hold, secure, and manage each resident's personal money which is deposited with the nursing home. Based on interview and record review, the facility failed to maintain a system to ensure the resident trust fund account was managed in accordance with proper accounting principles by not maintaining an accurate accounting of all monies held in the resident trust fund account by not reconciling each month. The facility managed funds for 98 residents. The census was 105. Review of the facility's Resident Trust policy, dated 6/12/25, showed Resident Trust clerk must reconcile the cash left in the box with the receipts in the box by completing the Resident Trust Petty Cash Reconciliation Form. Attach all receipts in the petty cash box to the Resident Trust Petty Cash Reconciliation form. The administrator signs reconciliation form for approval.Review of the facility-maintained bank statements for the months 4/25 through 7/25, showed no documentation of reconciliations.Review of the facility-maintained attempted reconciliation forms, dated 4/25 through 7/25, showed the attempted reconciliations did not reconcile to the residents' current balance at the time of the attempted reconciliation.Observation and interview on 9/5/25 at 11:40 A.M., showed the Business Office Manager (BOM) counted the resident petty cash that was in the safe. The cash totaled $163.00. The BOM said he/she had been at the facility since July, 2016 and he/she did not know if the petty cash was accounted for on the reconciliation on the bank statement. The corporate office determines the set amount of petty cash that is withdrawn at the beginning of each month which is added to the existing petty cash. The BOM counts the resident petty cash every time he/she replenishes the cash. The BOM said the petty cash comes from the resident trust. There is running total on the petty cash sheet for tracking. The BOM said he/she has never had over $4,000.00 cash on hand and does not know why the bank reconciliation reports showed cash on hand in the amount of $6,626.00 in May 2025, $16,971.00 in June and $16,941.00 in July 2025.During an interview on 9/8/25 at 11:53 A.M., the Activity Director (AD) said every morning, he/she counts the petty cash envelope with the BOM, verifying the cash balances with the receipt book. The AD said each individual withdrawal with the resident signature is recorded in the receipt book. At the end of the day, the petty cash envelope cash is reconciled with the BOM and AD.During an interview on 9/5/25 at 11:45 A.M., the Corporate Business Office Manager (CBOM) said he/she expected the petty cash to be accounted for on the monthly reconciliation sheet and the actual cash itself is counted and documented to ensure accuracy. The petty cash is residents' money.During an interview on 9/9/25 at 9:45 A.M., the Administrator said she expected the facility to ensure the resident trust fund account is reconciled each month.

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. Based on interview and record review, the facility failed to ensure one resident's right to be free from physical abuse was not violated when one resident was placed in a head lock by Floor Tech N (Resident #39). The sample was 43. The census was 105. Review of the facility's Abuse and Neglect Policy, dated 6/12/24, showed the following:-Purpose: -It is the policy of this facility ensure all allegations of abuse, neglect, exploitation or mistreatment, including injuries of unknown sources and misappropriation of resident property are reported immediately to the Administrator of the facility and to other appropriate agencies in accordance with current state and federal regulations within prescribed time frames;-Physical Abuse: -Purposefully beating, striking, wounding, or injuring any resident or any manner whatsoever mistreating or maltreating a resident in a brutal or inhumane manner. Physical abuse includes handling a resident with any more force than is reasonable for a resident's proper control, treatment or management. Physical abuse also includes, but is not limited to, hitting, slapping, punching, biting, and kicking. Physical abuse also includes corporal punishment, which is physical punishment used as a means to correct or control behavior;-Protection of Residents:-The Facility will take steps to prevent mistreatment while the investigation is underway; -Residents who allegedly mistreat another resident will be removed from contact with the resident during the course of the investigation. The accused resident's condition shall be immediately evaluated to determine the most suitable therapy, care approaches, and placement considering his or her safety, as well as the safety of other residents and employees in the facility. Review of the facility's restraint free environment policy, dated 4/30/24, showed:-Purpose: -It is the policy of this facility that each resident shall attain and maintain his/her highest practicable well-being in an environment that prohibits the use of restraints for discipline or convenience and limits restraint use to circumstances in which the resident has medical symptoms that warrant the use of restraints-Definitions: -Physical Restraints: Physical Restraint refers to any manual method or physical or mechanical device, material, or equipment attached or adjacent to the resident's body that the individual cannot remove easily which restricts freedom of movement or normal access to one's body. Physical restraints may include, but are not limited to: -Applying leg or arm restraints, hand mitts, soft ties, or vests that the resident cannot remove; -Holding down a resident in response to a behavioral symptom, or during the provision of care if the resident is resistive or refusing the care; -Discipline: Discipline means any action taken by the facility for the purpose of punishing or penalizing residents.-Policy: -The resident has the right to be treated with respect and dignity, including the right to be free from any physical or chemical restraint imposed for the purpose of discipline or staff convenience, and not required to treat the resident's medical symptoms. -Behavioral interventions should be used and exhausted prior to the application of a physical restraint; -How to assist the resident in attaining or maintaining his or her highest practicable level of physical and psychosocial well-being. Review of the facility's Crisis Prevention Institute (CPI) pamphlet/brochure overview, showed:-CPI Training Solutions for Human Services: De-escalation training solutions that improve staff safety and retention while lowering costs related to injuries, time off the floor, and workers' compensation claims.-Evidence-Based Training for Human Services Professionals: CPI teaches human services professionals the skills and techniques to identify, prevent, and de-escalate the complex situations they encounter in the workplace. With tiered levels of training, we offer customizable solutions that fit every role and risk level to foster facility-wide safety and well-being:-Experience the Benefits of a Tailored Training Solution -At CPI, we know that everyone plays a critical role in creating a safer workplace. So, we offer tailored training solutions for all staff, to help you create an organization-wide culture of safety. Our training provides your staff with relevant skills based on their role and the risks they encounter every day; -CPI training has helped human services facilities improve staff safety and retention, as well as lower costs related to staff (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	injuries, time off the floor, and workers' compensation claims. Our partners have also successfully reduced the need for restraints through our training's focus on prevention and proactive verbal intervention skills.-CPI NCITM with Advanced Physical Skills: -Learn Advanced Disengagement and Physical Intervention Techniques for Situations Involving Dangerous Behaviors CPI NCITM With Advanced Physical Skills; -High Risk Associated Behaviors: Destructive behavior. Causing harm to self or others. Physically aggressive; -Select Staff.-CPI Nonviolent Crisis Intervention: -Learn Intervention Skills and Techniques to Safely De-escalate Crisis Situations; -Mid-To-High Risk Associated Behaviors: Challenging behavior. Trauma-induced behavior. Using abusive language; -All staff.-CPI Verbal Intervention: -Learn Verbal De-escalation Skills to Avoid Restrictive Interventions; -Low Risk Associated Behaviors: Anxious behavior. Disruptive behavior. Verbally defensive; -All staff. Review of Resident #39's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 3/10/24, showed the following:-Intact cognition;-No behaviors;-Diagnoses of high blood pressure, high cholesterol, depression and schizophrenia (a chronic mental illness that affects a person's thoughts, feelings, and behaviors). Review of the resident's nurse's note, dated 8/10/25 at 2:57 P.M., showed a code green was called. The resident was physically fighting the staff. The resident was sent out to the area's local hospital for physical aggression and attacking staff. Staff called psych Nurse Practitioner (NP) for a PRN order for aggression. The Physician, NP, and Director of Nurses (DON) notified. Review of the resident's care plan, dated 9/1/24, showed the following:-Problem: On 8/10/25: Physical aggression against staff: The resident was coming in from his/her 1:1 smoke break with staff. While walking back into the building from the patio, he/she hit Certified Nurse Aide (CNA) O in the head and the face and pulled CNA O's hair. The resident also hit the Administrator in the right shoulder, neck area and in several regions of the head: top, back, left/right side of the head with a closed fist.-Desired Outcome: 8/10/25: The resident will not display physical aggression to staff through next review period; -Interventions: 8/10/25: A physical hold used to restrain resident from hitting others. Emergency Medical Services (EMS) was called and accompanied by police to assist. Administered as needed (PRN) intramuscular (IM), ordered 25 milliliter (ml) Thorazine (antipsychotic). The resident was sent to the hospital for evaluation and treatment with a medication evaluation. The resident was admitted . Review of the Statement for incident: Resident to Staff, dated 8/11/25, provided by the Administrator showed: On 8/10/25, the resident had a resident-to-resident altercation in the early afternoon about 1:00 P.M., He/She hit another resident while he/she was on the patio smoking. The resident said that the other resident was counting the number of flicks he/she made while smoking his/her cigarette. The residents were immediately separated. The resident was placed on 1:1. After the next smoke break, the resident was taken out when all the other residents were finished smoking. The resident's 1:1 was present. When the resident was walking with his/her 1:1, Floor Tech N, behind him/her, the resident ran up to CNA O and hit him/her and pulled his/her hair. Floor Tech N stopped the resident from hitting and pulling CNA O's hair. As Floor Tech N was walking the resident away from CNA O, he/she did not de-escalate the situation. Floor Tech N was asked by the Administrator to allow the resident to walk about the hall. At that time, the other residents were directed to go to their rooms for safety. The resident ran up on the Administrator and hit her in the head several times, the right shoulder, chest and thigh area. The resident walked to the dining area to await the EMS and the police. Review of the Floor Tech N's CPI Blue Card, showed:-Completion date: 6/2/25;-Expiration date: 6/3/26;-Completed seven Modules; -Thirteen hours completed. During an interview on 9/3/25 at 4:30 P.M., the resident said he/she has been at the facility for 10 years. There was an altercation. Floor Tech N choked him/her when Floor Tech N was trying to restrain him/her. Floor Tech N wouldn't let him/her go. Floor Tech N told the resident he/she was going to F- - k him/her up. The resident hit CNA O, Floor Tech N's family member, and then Floor Tech N hit the resident. No one else tried to restrain him/her. No one else hit the resident or had been rough with him/her that he/she knew of. The resident had not seen Floor Tech N since. During an interview on 9/9/25 at 10:40 A.M., (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Staffing Coordinator (SC) M said he/she worked at the facility for twenty-five years. He/She was familiar with the resident. He/she was aware of the incident involving the resident. He/she never slammed the resident against the wall. SC M may not have done the proper technique, but he/she never slammed the resident against the wall. The Administrator was down on the hall with him/her. Floor Tech N had the resident and was holding him/her. Staff told Floor Tech N to let the resident go. He/She let the resident go. He/she attacked the Administrator. Everyone was scared and running. The resident was just going through the hall just hitting people. Before the resident attacked the Administrator, he/she had punched Floor Tech N's family member, CNA O. SC M and the Administrator were not on the hall during that time. They had called code green. The resident had done this before. He/She would just snap out to where he/she would have to be sent out. He/She would not yell out; the resident would just start punching people. SC M did not know if Floor Tech N had the resident in a choke hold or head lock, but Floor Tech N wasn't doing the CPI technique right. The resident was punching the Administrator. SC M told the Administrator to run. SC M grabbed the resident's hand. She didn't know which hand. She was just trying to stop the resident from beating the Administrator to death. The other staff were supposed to help, but they didn't. They used to do a five man take down. He/She was just trying to get the resident off the Administrator. The resident had beat the Administrator within two seconds. The resident started punching the Administrator the first time. Floor Tech N then grabbed the resident. SC M didn't know how Floor Tech N grabbed the resident but just knew he/she grabbed the resident to get him/her off the Administrator. The resident was just punching, and everyone was too scared to do the CPI hold. The second time the resident punched the Administrator, he/she was punching her in her head. The resident even told SC M he/she didn't want to hurt her. The other staff left her. They were all scared and running. During an interview on 9/9/25 at 11:11 A.M., Floor Tech N said he/she had worked at the facility for about one and a half years, but he/she was no longer employed at the facility. He/she was familiar with the resident. Floor Tech N said it was true. He/She had placed the resident in a head lock. He/She said it was because at the time, it was just him/her right there. He/She had to restrain the resident. The resident had an altercation with another resident prior. After the altercation, the resident was placed on a 1 to 1 in which he/she was appointed the resident's 1 to 1. The resident couldn't smoke with the other residents on his/her hall so once everyone was done smoking, he/she smoked the resident. As they were walking back in, Floor Tech N's family member was working B Hall as the CNA. CNA O started to say something to Floor Tech N and before CNA O could get it out, the resident started punching CNA O in his/her face and head. Floor Tech N intervened as quickly as he/she could. He/She grabbed the resident from behind and that is when he/she proceeded to take the resident against the wall and that was when the headlock came in. At that point, the resident turned so it was a side-by-side head lock. Floor Tech N is trained in CPI. He/She just had his/her re-certification about two months prior to that incident. Floor Tech N was familiar with SC M. He/She did not see SC M slam the resident into the wall. He/She honestly did not see SC M lay a hand on the Resident. SC M arrived after he/she had got word of what was happening on the hall. After the situation with his/her family member, everyone told him/her to let the resident go. So, he/she let the resident go. It was at that time, the Administrator was walking up the hall and Floor Tech N and the resident were walking down the hall. As soon as he/she let the resident go, he/she attacked the Administrator. That's when Floor Tech N stepped in the middle of them. He/She didn't touch the resident. Floor Tech N just stepped between the resident and the Administrator and moved him/her away from the Administrator. They actually terminated him/her. Floor Tech N was originally sent home after the incident on that Sunday. On Monday, he/she called off work. He/She returned to work on that Tuesday, and they let him/her work his/her entire shift, 8:00 A.M. to 4:00 P.M. Later that night, around 11:00 P.M, he/she received a voice message from the Administrator saying he/she was suspended pending investigation, then he/she was officially terminated about one week later. Floor Tech N completed abuse and neglect in-services. They were passed around very often. He/She signed one probably a couple of weeks (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	prior to the incident. During interviews on 9/5/25 at 3:25 P.M., 9/9/25 at 9:52 A.M., and 9/10/25 at 12:50 P.M., the Administrator said the resident had a resident to resident earlier that day. He/She was placed on a1:1 as a result. The resident had been hearing voices and had gotten delusional, so had gone up and hit another resident. With his/her 1:1 status, it was already determined he/she wouldn't smoke with the other residents. His/her 1:1 staff, Floor Tech N, was behind him/her. The resident went up to CNA O, which happened to be Floor Tech N's family member, and had begun to hit him/her in his/her head and pulling his/her hair. Floor Tech N pulled the resident off CNA O. By that time, she heard some noise, maybe a code green call, so she went to the hall and staff were there. Floor Tech N was walking down the hall. She told staff to get residents into their rooms. Normally, they would have had a de-escalator. Floor Tech N was supposed to have deescalated the situation, which was include making sure everyone was safe, de-escalate, making sure the resident was safe, and making sure nothing was in the way. Floor Tech N was more focused on the resident getting off the unit and wasn't following her directive (to de-escalate). She told Floor Tech N to get his/her family member off the hall but deescalate and make sure all the residents were in their rooms. Floor Tech N finally followed the directive. By that time, she had told the staff to let the resident have the hall. She told one of the nurses to call the Physician to get an IM for the resident. At that point, Floor Tech N said he/she would do what was asked and that what was to escalate. The Administrator was the closet one to the resident. The resident started hitting her in the head. Mostly, the right side of her head and then when she leaned over to try to protect her face, he/she started hitting her on both sides of her head and other parts of her body. The Administrator was yelling out to get the residents to their rooms. Floor Tech N made sure his/her family member was off the unit and out the door. Then he/she grabbed the resident's arms (wrist area) to stop the resident from hitting her. After that, Floor Tech N tried to deescalate the resident, so he/she had the resident in a CPI hold by his/her wrists and walked him/her off the unit to the dining room area. Floor Tech N never had the resident in a head lock. She didn't think Floor Tech N did the CPI hold correctly. The hold was correct although it would have normally been two people to do the hold. Floor Tech N was terminated because he/she did not follow her directives regarding the de-escalation. It was her expectation for all the residents to be free from abuse and neglect. It is everyone's responsibility to ensure residents are free from abuse and neglect. This would include leaders, managers, supervisors, directors as well as front line staff.2606143

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	265534	A. Building B. Wing	09/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Heritage Care Center	4401 North Hanley Road Saint Louis, MO 63134

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, facility staff failed to prevent the misappropriation of one resident's patient trust funds, which was used without authorization of the resident. The funds were withdrawn from resident's patient trust account between the dates of 4/10 and 4/17/25, with total withdrawals of $7,877.01 (Resident #20). The census was 105. Review of the facility's policy titled, Abuse and Neglect, dated 6/12/24, showed:-Misappropriation of resident property is the deliberate misplacement, exploitation, or wrongful, temporary or permanent, use of resident's belongings or money without the resident's consent;-Theft of money from bank accounts;-Unauthorized or coerced purchases from resident's funds;-The Administrator will conduct all investigations. A formal investigation shall begin immediately and include interviews with all staff, interview facility residents and document that interviews were completed. Review of Resident #20's Mental Status Exam, dated 8/18/25, showed:-No cognitive impairment;-Diagnoses included schizophrenia (a disorder that affects a person's ability to think, feel, and behave clearly), anxiety disorder, depression and dementia. Review of the resident's Trust Statement, dated 6/30/25, showed: -On 4/10/25, a $500.00 cash withdrawal with description, money for shopping with family;-On 4/17/25, a $5,756.16 (invoice #81466) and $1,620.85 (invoice #82089) withdrawal with description, Resident Essentials Clothing. Review of the Resident Essentials Clothing invoice #81466, dated 4/17/25, showed:-Various sweatpants, shirts and other clothing items;-[NAME] two drawer nightstand for $550.00;-[NAME] five drawer chest for $1,260.00;-Home music system for $135.00;-Two twin bed sets for a total of $270.00;-Pep talk recliner for $945.00. Review of the Resident Essentials Clothing invoice #82089, dated 4/30/25, showed:-Various t-shirts, socks and other clothing items;-Two comforters for a total of $170.00. Observation on 9/8/25 at 3:30 P.M showed the resident sat on the edge of his/her bed with a large unopened box (24x18x24) marked Resident Essentials on the floor, in front of the closet and a blue roller walker. There were black tote boxes filled with various t-shirts, sweatpants and tops. There were numerous baseball hats laying around the room. The style and color of the resident's bedding, dresser and nightstand were seen throughout the facility. The Pep talk recliner, [NAME] nightstand, [NAME] dresser, twin bed sets, and comforters were not present. Observation on 9/9/25 at 9:04 A.M., showed the home music system in the unopened box in the resident's room and the Pep talk recliner were located in room A15. During an interview on 9/8/25 at 2:30 P.M., the resident said he/she did not give the facility permission to use his/her funds to make any purchases on his/her behalf. The resident said he/she received some clothes and a recliner but requested those items be returned because he/she only wears Adidas clothing and the recliner was a waste of money. The resident said he/she never received a new dresser, nightstand, twin bed sets and comforters. During an interview on 9/8/25 at 3:30 P.M., the Business Office Manager (BOM) said when the corporate office reports a resident is over resources (Medicaid eligibility maximum resource is $5,909.25), he/she will ask the Certified Nurse Aides (CNA) what the resident needs, then will make those purchases on the resident's behalf. The BOM said he/she remembers giving the resident $500 to go shopping with his/her family but forgot to have the resident sign the ledger receipt book. The BOM said she did not speak to the resident prior to making purchases and was unaware the resident did not want the items or requested for the items to be returned. During an interview on 9/9/25 at 9:30 A.M., the Administrator said she expected staff to follow the facility's patient withdrawal policy. The resident must sign the receipt for all withdrawals. The facility should not make purchases for a resident without first obtaining their permission and signature.

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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 or discharge to the hospital and the facility's bed hold policy at the time of transfer for three residents who were discharged to the hospital (Residents #119, #69 and #114) out of three residents sampled for bed hold notification. The census was 105.Review of the facility's undated admission agreement, showed facility offers a bed hold policy which assures you of re-occupation to your bed during a temporary absence from facility due to therapeutic leave or hospital admission. If you choose not to hold the bed during an absence from the facility, that bed shall be considered vacant and facility may place another resident in it for occupancy. If your personal belongings have not been removed and it becomes necessary to occupy that room with another resident, facility will package all personal items and place them in storage for a period not to exceed two (2) weeks. Upon your re-admission to facility, you will be placed in the first available appropriate bed. Paying to hold a bed is strictly voluntary. However, Facility cannot guarantee re-admission to the same specific bed from which you previously occupied, prior to the absence, unless the daily bed hold rate is paid. In the event you choose to hold the bed and pay the daily bed hold rate, but facility cannot re-admit you due to the determination that your resident level of care cannot be adequately provided, a refund will be issued for the bed hold days. However, if we can adequately provide care and you choose not to return to our facility for any reason, no refund will be made.1. Review of Resident #119's hospital discharge record, showed:-admitted on [DATE];-discharged on 12/9/24;-Diagnosis of suicidal thoughts.Resident #119's face sheet, showed the resident was admitted on [DATE]. Review of the resident's progress notes, dated 12/9/24, showed during rounds this nurse spoke with resident, who expressed that he/she was suicidal. I ask resident did he/she have a plan which he/she responded, yes. Resident stated he/she would not tell me his/her plan. Upon assessment resident has red marks on his/her left arm. I asked resident were those from today. Resident said no. I asked resident did he/she plan to cut him/herself today, which he/she responded yes. When asked did resident have any objects in the room that he/she could use to harm him/herself, he/she stated yes and he/she would not tell me where they were. Administrator and Director of Nursing (DON) notified. Social worker notified. One to one left with resident while this nurse reported and printed paperwork. This nurse waited with resident until Emergency Medical Services (EMS) and police arrived. Resident sent out to hospital via stretcher. Guardian contacted, message left. Resident's mother contacted, message left. Psych physician notified. Review of the resident's medical record, showed no bed hold notice. During an interview on 2/11/25 at 2:17 P.M., hospital Registered Nurse (RN) said the resident had been hospitalized since early December. In mid-January, the hospital received communication from the facility that the resident was being discharged for being out of the facility for an extended period of time. An appeal was made for the discharge. Department of Health and Senior Services (DHSS) upheld the appeal and the resident's discharge was waived and bed was held. 2. Review of Resident #69's face sheet, showed he/she was admitted on [DATE].Review of the resident's progress notes, dated 8/30/25, showed resident had mental status change. Family came to take him/her out for lunch but resident said he/she did not feel good and he/she did not want to go. Certified Nurse Aide (CNA) who works with this resident also said he/she was not his/her normal self. Vital signs were taken his/her blood pressure was 162/86 and his/her pulse was 78. At that time I did notice that he/she was acting a little sleepy and he/she was very weak. I called the doctor and reported what I saw. The doctor said send him/her out, he/she may be in a-fib or having a stroke because I did report left-sided weakness. Family made aware. I notified our corporate nurse, the Administrator and the DON. Family came and wanted resident taken to hospital. Niece said she had already called 911 before she got here. Ambulance came, report was called to hospital. Niece was (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	with the transport. Family said they would call back and talk about their concerns. Review of the resident's medical record, showed no bed hold notice. 3. Review of the Resident #114's medical record showed:-admitted to the facility on [DATE];-discharged to the hospital on 7/27/25. Review of the resident's progress notes showed:-On 5/24/25 at 12:16 A.M., the resident attacked staff. The resident became upset that his/her supervision was late and that he/she had to sit at the front with the nurse. The resident attempted to leave nurse supervision. The nurse attempted to stop him/her. The resident attacked the nurse. He/she scratched and swung at the nurse. The resident threw a pitcher of water at the nurse. He/she reached for a pill crusher and fell from a chair. 911 called. Two police officers and fire department EMS arrived. The resident was given her cell phone and was taken to the area's local hospital. Guardian notified. Management notified. Physician notified and psych notified.-On 6/3/25 at 12:15 A.M., the resident was refusing medication. The resident had been on 1:1. Staff bought it to writer attention that the resident was saying it would all be over soon while he/she held a shoestring. The nurse asked resident if he/she felt like he/she wanted to harm him/herself or others. The resident was unresponsive. The nurse asked if he/she could search the resident's person. The resident said no. The nurse called the Director DON and he spoke with the nurse practitioner (NP) psych who recommended that the resident be seen at the hospital. Before he/she left, the resident's bags were searched with the resident's consent, and the nurse found a screw in the pouch. The guardian and ADON were made aware. EMS transported the resident to the area's local hospital. The resident was alive and breathing when left the facility. Further review of the resident's medical record, showed no documentation of a transfer notice(s) was give 4. During an interview on 9/8/25 at 12:20 P.M., the Administrator said they will send the bed holds with the resident; however, a copy is sent to the hospital. She expected the resident to have a bed hold if they were transferred to the hospital. She was not in the facility at the time, so she was not aware of Resident #119's transfer. 1731660

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure two residents received an accurate assessment, reflective of the residents' status at the time of assessment, by failing to identify the residents' hospice admission (Residents #10 and #36). The facility identified three residents receiving hospice services, two were sampled. The census was 105. 1. Review of Resident #10's face sheet, showed his/her diagnoses included malignant neoplasm (cancerous tumors) of cecum (pouch that forms the first part of the large intestine), secondary malignant neoplasm of liver and intrahepatic bile duct, and secondary malignant neoplasm of left lung.Review of the resident's Physician's Orders Sheet (POS), showed an order, dated 5/20/25, okay for hospice to evaluate and treat. Review of the resident's care plan, in use during survey, showed:-Problem: Resident receiving chemotherapy related to cancer that has metastasized (mets, spread to other parts of the body) to several areas of his/her body;-Desired Outcome: The resident will remain free of complications related to chemotherapy side effects;-Interventions: Give medications and treatments as ordered. Monitor/document for side effects and effectiveness;-Problem: The resident has a terminal prognosis related to cancer that has mets to multiple sites. June 3rd, resident was admitted under the care of hospice services due to cancer diagnosis;-Desired Outcome: The resident will be free of depression and anxiety;-Interventions: Adjust provision of activities of daily living (ADLs) to compensate for resident's changing abilities. Encourage participation to the extent the resident wishes to participate; -Assess resident coping strategies and respect resident wishes; -Consult with physician and Social Services to have Hospice care for resident in the facility; -Encourage resident to express feelings, listen with non-judgmental acceptance, compassion; -Encourage support system of family and friends; -Observe resident closely for signs of pain, administer pain medications as ordered, and notify physician immediately if there is breakthrough pain; -Refer for Psychiatric/Psychogeriatric consult if indicated; -Review resident's living will and ensure it is followed. Involve family in discussion; -Work cooperatively with hospice team to ensure the resident's spiritual, emotional, intellectual, physical and social needs are met; -Work with nursing staff to provide maximum comfort for the resident. Review of the resident's hospice agreement, showed it was signed on 6/2/25. Review of the resident's significant change Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 6/16/25, showed:-Does the resident have a condition or chronic disease that may result in a life expectancy of less than six months: No. 2. Review of Resident #36's face sheet, showed his/her diagnoses included heart failure, pulmonary hypertension (high blood pressure) and chronic kidney disease.Review of the resident's quarterly MDS, dated [DATE], showed:-Does the resident have a condition or chronic disease that may result in a life expectancy of less than six months: No. Review of the resident's POS, dated 9/25/25, showed an order, dated 12/3/24, admit to hospice. Review of the resident's hospice agreement, showed:-Signed on 11/20/24;-Diagnosis of left middle cerebral artery (MCA) stroke. Review of the resident's care plan, in use during survey, showed:-Problem: Resident is on hospice;-Desired Outcome: The resident's comfort will be maintained;-Interventions: Adjust provision of ADLs to compensate for resident's changing abilities. Encourage participation to the extent the resident wishes to participate; -Assess resident coping strategies and respect resident wishes; -Encourage resident to express feelings, listen with non-judgmental acceptance, compassion; -Encourage support system of family and friends; -Keep the environment quiet and calm. Keep linens clean, dry and wrinkle free. Keep lighting low and familiar objects near; -Refer for Psychiatric/Psychogeriatric consult if indicated; -Work cooperatively with hospice team to ensure the resident's spiritual, emotional, intellectual, physical and social needs are met; -Work with nursing staff to provide maximum comfort for the resident. 3. During an interview on 9/9/25 at 12:25 P.M., the Administrator said corporate completes the MDS. The calendar is sent, and they work on it together as a group with the care plans. She expected the MDS to be accurate and completed timely.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure a resident who re-admitted to the facility on [DATE] with a recommended hospice evaluation received the ordered hospice evaluation. The resident's physician assessed the resident on 7/18/25 and documented the resident received hospice services. On 7/30/25, the resident experienced a change in condition. Staff discovered the resident had not been enrolled into hospice services and did not notify the physician of the discovery. The resident expired at the facility approximately three hours after the change in condition (Resident #118). The census was 105. Review of the notifying clinician's policy, revised 6/26/24, showed:-Purpose: to ensure clinicians are properly notified of a resident's change in condition and overall, health and mental status;-Policy: -Process for notification: -Before calling the physician, the nurse must ensure they have all pertinent/situational information on the resident readily available; -The clinician shall be notified of changes in condition, emergent situations and concerns of the resident's overall health status; -Examples include falls, out of range vital signs, altered mental status, poor intake, changes in behaviors, and anything regarding a change in the resident's baseline or condition; -The nurse will implement 911 (emergency services) for immediate transfer for physician evaluation when a significant change or deterioration in the resident's physical, mental or psychosocial status (life threatening condition or clinical complication); -The nurse will initiate verbal communication with the clinician when a condition or incident arises with a resident which would warrant and immediate implementation of a change in plan of care to include physician advisement or initiation of physician orders to avoid a delay in treatment that may cause worsening in condition. Review of Resident #118's medical record, showed:-re-admitted : 7/13/25;-Diagnoses included chronic obstructive pulmonary disease (COPD, scarring to lung tissues), kidney disease, depression, heart failure, lung cancer, protein malnutrition and dementia. Review of the post hospital after visit summary, dated 7/13/25, showed:-discharged : 7/13/25;-Discharge diagnosis: hospice care;-Start taking the following medications:-Lorazepam (Ativan, for anxiety); -Morphine (used to treat severe pain);-Stop taking the following medication: -Atorvastatin (used to lower cholesterol); -Vitamin B-12; -Colace (stool softener); -Aricept (used for dementia); -Lexapro (used for depression); -Iron tablet; -Norco (narcotic used for moderate pain); -Midodrine (used for high blood pressure); -Remeron (used as an appetite stimulant and treat depression); -Prednisone (used for inflammation);-Outpatient referrals: referral to hospice. Review of the care plan, dated 7/15/25, showed:-Problem: the resident has a terminal diagnoses related to lung mass and has elected hospice services;-Outcome: comfort will be maintained;-Interventions: observe the resident closely for pain and work cooperatively with hospice to ensure needs are met. Review of the facility re-admission Physician Order Sheet (POS), showed:-An order, dated 7/13/25: Hyoscyamine sulfate (used for spasms) 0.125 milligram (mg) tablet. Give one tablet as needed (PRN) every four hours. Noted as not given 7/13/25 through 7/30/25;-An order, dated 7/13/25: Lorazepam concentrate. Give 0.25 milliliter (ml) every four hours, PRN. Noted as not administered from 7/13/25 through 7/30/25;-An order, dated 7/13/25: Morphine solution. Give 0.25 ml every four hours, PRN. Noted as not administered from 7/13/25 through 7/30/25. -No hospice orders were documented in the re-admission orders. Review of the progress notes, showed:-On 7/13/25 at 4:28 P.M., a nursing admission note: resident readmitted from hospital, oxygen in place. Skin is fair condition and multiple pinpoint bruising to both arms. The resident physician was notified and verified orders and hospice team contacted regarding admission to hospice services;-On 7/14/25 at 2:49 P.M., a plan of care note: a do not resuscitate order, signed by the resident;-On 7/15/25 at 11:22 A.M., a dietary note: the resident readmitted to the facility on hospice services, provide food preferences. Review of the care plan, initiated 7/15/25, showed:-Problem: the resident has a terminal prognosis related to a lung mass and elected hospice services;-Desired outcome: the resident's comfort will be maintained;-Interventions: observed the resident for signs of pain or discomfort. Work (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	cooperatively with the hospice providers to ensure needs are met. Review of the physician visit note, dated 7/18/25, showed:-History of present illness: COPD with exacerbation, dementia and now on hospice care;-Assessment and plan: COPD end state, on hospice. Review of the significant change Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 7/19/25, showed:-Rarely understood;-Memory problem;-Moderate cognitive impairment;-Used wheelchair for mobility;-Staff assistance for hygiene, eating and transfers:-Diagnoses included lung cancer, dementia, heart disease and severe protein malnutrition;-Does the resident have a life expectancy of 6 months or less: No Review of the progress notes, showed:-On 7/24/25 at 8:07 A.M., a social service note: the hospice team was contacted regarding the hospice referral. The hospice team said the referral had been closed, and a new referral would be sent to a different hospice provider;-On 7/25/25 at 7:05 A.M.,: a nurse note: the resident found lying next to the bed and he/she said he/she rolled out of the bed. No injuries noted and bed in lowest position. Message left with physician;-On 7/25/25 at 1:41 P.M., a nurse note: fall mat ordered for the resident due to decline in mental and physical status. Physician aware;-On 7/30/25 at 3:04 P.M., a nurse note: attempted to contact next of kin to notify of the resident's declining status. Unable to reach next of kin. The physician was notified;-On 7/30/25 at 5:32 P.M., a nurse note: vital signs ceased at 4:39 P.M. The family was called and unable to be reached. The physician was at the facility, and cause of death as COPD. Funeral home notified;-No further progress notes were noted to ensure the resident was admitted into hospice services. During an interview on 9/4/25 at 12:43 P.M., Licensed Practical Nurse (LPN) G said on 7/30/25 he/she started work at 7:00 A.M., and he/she received report from the night shift nurse. The night shift nurse said the resident was not doing well, was on hospice and he/she attempted to reach the next of kin. LPN G said he/she assessed the resident, and he/she appeared very ill. The resident had low blood pressure, irregular breathing and a low oxygen saturation. LPN G attempted to call the next of kin and was unable to speak to family. He/She contacted the physician regarding the change in condition, and did not recall what the physician said, except to keep the resident comfortable. LPN G reviewed the record for the hospice provider and when researched, LPN G discovered the resident had not been enrolled in hospice care. LPN G made the discovery around noon and he/she expired several hours later. LPN G did not call the physician back and notify him the resident was not on hospice services. LPN G wrote down the assessment and vital signs on a piece of paper and forgot to document the findings in the medical record. During an interview on 9/4/25 at 12:23 P.M., the resident's physician said he assessed the resident on 7/18/25 and assumed the resident had been admitted into hospice services per review of the hospital discharge orders on 7/14/25. He did not recall if he had been contacted regarding the resident's change in condition on 7/30/25 and expected the nursing assessment and vital signs to be documented in the medical record. If the staff discovered the resident had not received hospice services, he should have been notified. He would have sent the resident to the hospital for evaluation and treatment. The resident had a history of refusal of care, if he/she refused hospice services, it should have been documented in the medical record. During an interview on 9/4/25 at 1:23 P.M., the Administrator and Assistant Director of Nursing (ADON) B said the resident's hospital discharge orders included hospice assessment orders. The resident had not been admitted to hospice services related to obtaining signatures from the next of kin. The resident was not enrolled in hospice services at the time of his/her death. When staff became aware the resident was not enrolled in hospice, the nurse should have notified the physician. The physician may have elected to send the resident to the hospital. All assessments and vital signs should be in the medical records. 2591480

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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 complete smoking assessments for two residents, to evaluate their smoking behavior risks. Both residents were smoking in their rooms. In addition, the facility failed to develop and implement appropriate safety interventions (Residents #7 and #108). The census was 105.Review of the facility's policy entitled, Smoking Safety Regulations, dated 6/23, showed:-Policy: to ensure staff and residents are following the safety regulations for smoking as outlined by the Life Safety Code of the National Fire Protections Association (NFPA).-Facility will provide direct supervision for smoking by patients classified as not responsible.Review of the facility's undated admission agreement, showed:-Section M, entitled Smoking: smoking is allowed only in designated smoking areas and times set forth by the facility. Residents shall only be permitted to smoke in accordance with the resident assessment and plan of care. Review of Resident #7's annual Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 4/16/25, showed:-Intact cognition;-Diagnoses included schizoaffective disorder (a mental health condition that is marked by a mix of schizophrenia symptoms, such as hallucinations and delusions, and mood disorder symptoms, such as depression, mania and a milder form of mania called hypomania) and delusional disorder. Review of the resident's care plan, in use during the survey, showed:-Focus: Resident is a supervised smoker;-Goal: Resident will not smoke without supervision through the review date;-Interventions: Instruct resident about smoking locations, times, safety concern. Notify charge nurse immediately if it is suspected resident has violated facility smoking policy. Resident requires supervision while smoking. Review of the resident's Smoking and Safety Evaluation, dated 4/25/25, showed the assessment was incomplete with one question answered:-The resident uses tobacco. Review of the resident's Smoking and Safety Evaluation, dated 6/12/25, showed the assessment was blank. Review of Resident #108's annual MDS, dated [DATE], showed:-Intact cognition;-Diagnoses included schizoaffective disorder, unspecified disorder of psychological development, anxiety, personality disorder and drug induced subacute dyskinesia (involuntary, erratic, writhing movements of the face, arms, legs or trunk). Review of the resident's care plan, in use during the survey, showed:-Focus: Resident is a supervised smoker;-Goal: Resident will not smoke without supervision through the review date;-Interventions: Instruct resident about smoking locations, times, safety concern. Notify charge nurse immediately if it is suspected resident has violated facility smoking policy. Resident requires supervision while smoking. Review of the resident's Smoking and Safety Evaluation, dated 3/12/25, showed the assessment was incomplete with one of three sections completed. The section completed showed the following:-The resident uses tobacco.-Resident follows the facility's policy on location and time of smoking-Smoking Safety Notes: Staff lights all tobacco products. Review of the resident's Smoking and Safety Evaluation, dated 6/12/25, showed the assessment was blank. Observation on 9/3/25 at 11:15 A.M., showed Resident #7 and Resident #108 resting in bed. The floor had dirt around the perimeter of the room. The windowsill showed ash-like substance over more than half of the window ledge. The window was opened approximately six inches with 13 cigarette butts and cigarette ash in the window tracking. Ash-like substance was observed on the floor in front of the window. Observation on 9/3/25 at 1:10 P.M., showed Certified Nurse Aide (CNA) H and Assistant Director of Nursing (ADON) A in the resident's room, standing in the doorway, then said to both residents, This room smells like cigarette smoke. Is anyone smoking in here? Resident #108 denied anyone was smoking. Both staff members left the area without further investigation. Observation on 9/3/25 at 1:15 P.M., showed the residents' window remained open with 13 cigarette butts and cigarette ash in the window tracking. At 2:05 P.M., the residents' window remained open with cigarette ash in the window tracking. The cigarette butts were no longer present. During an interview on 9/5/25 at 1:04 (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	P.M., CNA I said he/she was not aware of any resident smoking in their room and any issues would be immediately reported to the charge nurse. During an interview on 9/9/25 at 10:15 A.M., Resident #108 said no one had been smoking in the room and did not know where all the cigarette butts came from that were in the window. Resident #108 said the housekeeper removed the cigarettes from the window but didn't know which housekeeper or when that occurred. During an interview on 9/9/25 at 2:30 P.M., the Administrator said she expected staff to follow the facility's smoking policy and report any concerns immediately to the charge nurse. The Administrator expected all residents who smoke to have a smoking assessment completed annually and quarterly.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. Based on observation, interview and record review, the facility failed to implement an effective pain management regime for one sampled resident (Resident #90). Staff failed to ensure Resident #90, who experienced pain related to chronic osteomyelitis with drainage sinus, right tibia and fibula involvement (a long-standing bone infection affecting the shinbone) and chronic pain most severe on the right knee, received physician prescribed Percocet (narcotic which treats moderate to moderately severe pain). The sample was 21. The census was 105.Review of the facility's Pain Management Policy, revised 6/26/24, included:-Recognized when the resident is experiencing pain and identify circumstances when the pain can be anticipated;-Evaluate the resident for the pain and the cause(s) upon admission, during ongoing scheduled assessments, and when significant change of condition or status occurs (after fall, change in behavior or mental statues, new pain or exacerbation of pain);-Manage or prevent, consistent with the comprehensive assessment and plan of care, current professional standards, and the resident's goal and preference;-Facility staff observe for nonverbal indicators which indicate the presence of pain. These indicators include but are not limited to: change in ambulation (limping), rubbing the site, guarding the site, skin color, blood pressure, loss of function or inability to perform activities of daily living, restlessness, facial appearances (crying, grimacing, frowning, etc.) behaviors;-Facility will performs pain assessment ask the patient to rate intensity of his/her pain using a numerical scale, a verbal or visual descriptor that is appropriate and preferred by the resident;-Review the resident's current medical conditions (e.g. pressure injuries, diabetes with neuropathic pain, immobility, infections, amputations, oral health conditions, post CVA (stroke), venous and arterial ulcers, and multiple sclerosis);-Physical and psychosocial issues that might be causing or exacerbating the pain. Review of the Ordering and Receiving Controlled Medication Policy, dated 5/14/24, showed:-The pharmacy maintains the supply of controlled substance in automated dispensing system;-For patient care area which do not utilize automated dispensing system, daily orders for stocked narcotic out by the charge nurse according to the following procedure: The designated order form is completed and sent to the appropriate pharmacy making sure it contains the following: -Unit/wing ordering the medications -Signature of the person making the request; -Date; -Medication and quantities required. Review of Resident #90's medical record, showed diagnoses included chronic osteomyelitis with drainage sinus, right tibia and fibula (skin bones) involvement, pain due to trauma, muscle weakness and difficulty walking. Review of the resident's current care plan, showed:-Problem: The resident has an abscess to right knee-Interventions: The resident will have no signs and symptoms of infection through the review date Initiated: 3/9/25;-Give meds as ordered for pain. Date Initiated: 3/9/25;-Monitor, document, report as needed for signs and symptoms of infection: green drainage, foul odor, redness and swelling, red lines coming from the wound, excessive pain, fever date Initiated: 3/9/25-Treatment per physician's orders, document location of wound, amt of drainage, peri-wound area, pain, edema, and circumference measurements. Review of the resident's pain assessment, dated 8/20/25, document pain every shift, showed:-8/20/25 at 8:08 P.M., Tylenol 650 milligrams (mg) received: pain level was 0/10;-8/26/25 at 3:50 P.M., Tylenol 650 mg received: pain was 6/10. Review of the progress notes, dated 8/26/25 at 3:50 P.M., showed an orders/administration note. Tylenol oral tablet 325 mg. Give 650 mg by mouth every 6 hours, as needed for pain, fever. Review of the resident's pain assessment, dated 8/20/25, document pain every shift, showed:-8/26/25 at 9:24 P.M., Tylenol 650 mg received pain was charted at a 6/10;-8/27/25 at 4:50 P.M., Tylenol 650 mg received: pain was charted at a 4/10;-8/27/25 A.M./P.M., 0/10 pain. Review of the progress notes, dated 8/27/25 at 4:05 P.M., showed patient received new order per doctor for Percocet 10/325 for right knee pain three times daily (TID) for two weeks. As needed (PRN) order has been placed in PCC script faxed to pharmacy. Review of the physician's progress notes, showed:- -8/27/25, order for Percocet 10 milligram (mg), give 1 tablet every 8 hours as needed for right knee pain. - Review of the resident's pain assessment, dated 8/20/25, document (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	pain every shift, showed:-8/28/25 A.M./P.M., pain zero;-8/29/25 A.M./P.M., pain zero;-8/30/25 A.M./P.M., pain zero;-8/31/25 A.M./P.M., pain zero;-9/1/25 A.M./P.M., pain zero;-9/2/25 A.M/P.M., pain zero;-9/3/25 A.M/P.M., pain zero. During observation and interview on 9/3/25 at 2:23 P.M., the resident said he/she doesn't feel staff are properly caring for the right knee wound. He/She said the dressing was last changed yesterday. Observation showed no date, initials or time marked on the adhesive dressing. The adhesive bandage was coming off and discoloration on the left side with purulent (yellow) drainage, and some serosanguinous (red and serum fluid) drainage. Erythema (redness) was present around the wound and yellow drainage with slough inside the wound. Review of the resident's pain assessment, dated 8/20/25, document pain every shift, showed:-9/4/25 A.M/P.M., pain zero. During an interview on 9/4/25 at 1:43 P.M., Pharmacy Representative M said no order was received from the facility regarding the resident's Percocet 10-325 mg. Review of the resident's pain assessment, dated 8/20/25, document pain every shift, showed:-9/5/25 A.M/P.M., pain zero. During an interview on 9/5/25 at 11:34 A.M., the resident said he/she was upset due to the staff not providing him/her any pain medications. He/She informed the nursing staff of his /her pain being high, at a level 10. Review of the resident's pain assessment, dated 8/20/25 document pain every shift, showed:-9/6/25 A.M/P.M., pain zero;-9/7/25 A.M/P.M., pain zero;-9/8/25 Tylenol 650 mg received by mouth every 6 hours: pain was charted at a 6. During an interview on 9/8/25 at 8:05 A.M., the resident said he/she received the morning medications; however, there was no pain medication. He/She stopped asking staff for pain medication because staff only give him/her Tylenol or Ibuprofen which does not assist with the pain. At 11:10 A.M., the resident said he/she spoke to Licensed Practical Nurse (LPN) B, who said there was no pain medication. He/She informed LPN B his/her pain level was 9/10. Review of the resident's Medication Administration Record (MAR), showed no Percocet had been administered. During an interview on 9/9/25 at 8:27 A.M., LPN A said staff call narcotic orders straight to the pharmacy. He/She has asked for the facility to show him/her how to electronically send orders via the electronic medical records system. LPN A would make sure to tell oncoming staff of any new medications a resident is starting. LPN A is unaware if he/she worked on 8/28/25, however he/she recalls an order written for the resident, for Percocet. During an interview on 9/8/25 at 11:35 A.M., LPN B said the resident did not have any narcotics, but he/she provided the resident Tylenol and ibuprofen, which he/she confirmed the Ibuprofen could not be found on the MAR. LPN B said the resident was in pain. All controlled substances must be faxed to the facility's contracted pharmacy, per the facility's policy. LPN B then retracted his/her initial statement of the resident being in pain. LPN B said all medications are received by the facility within 24-hours of them notifying the pharmacy. Someone in management pulls a 24-hour report to see the new orders and checks them against the medications received from the pharmacy. LPN B is unaware if this process was followed during the time the narcotics order was placed. LPN B was aware of a prescription for a controlled substance for the resident, due to the fact he/she was working on the day the physician wrote the order. LPN B said he/she was not the nurse assigned to the resident but knew about the medication order. LPN B found the order for Percocet dated 8/27/25 and refaxed it today. LPN B said the pharmacy never received the fax due to another resident's prescription being faxed twice. During an interview on 9/9/25 at approximately 1:45 P.M., the RN Supervisor said narcotics orders are supposed to be verified with the provider. Each controlled substance order should be placed into the medical records and faxed to the pharmacy, then double check the pharmacy received the order. The RN Supervisor said a nurse or supervisor oversees following up with new orders. He/She expected nursing staff to notify their superior if a medication did not arrive to the facility. The RN Supervisor said 12 days of not addressing someone's pain was excessive. He/She expected a nurse to double check the chart, and the medical record should have triggered staff to do a pain assessment. He/She said the facility did an investigation, and it showed two scripts were faxed to the pharmacy, however, those two scripts were for a different resident in the facility.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. Based on observation, interview and record review, the facility failed to ensure residents are free from significant medication errors. Staff attempted incorrect administration technique for one resident, when he/she did not prime the insulin Flex pen in accordance with facility policy (Resident #2). The census was 105.Review of the facility's medication administration of insulin policy, revised May 2024, showed:-Prepare an insulin dose, before administering insulin, perform two nurse verifications of the correct resident, dose calculations, and correct route of administration.-Insulin pens will be primed prior to each use to avoid collection of air in the insulin reservoir,-Dial 2 units (U) by turning the dose selector clockwise,-With the needle pointed up, push the plunger and watch to see that at least one drop (gtt) appears. Review of Resident #2's medical record, showed his/her diagnoses included diabetes, morbidly obese (severe), chronic obstructive pulmonary disease (COPD, lung disease that causes difficulty breathing), metabolic encephalopathy (altered brain function) and kidney failure. Review of the resident's current care plan, showed:-Problem: At risk for elevated/low blood sugars levels related to diabetes;-Interventions: Diabetes medication as ordered by provider, monitor and document side effects. Review of the resident's Physician Order Sheet (POS), showed an order, dated 03/25/25, for Aspart Flex pen Insulin (insulin, short-acting insulin), three units a day (TID). Observation on 9/5/25 at 8:10 A.M., showed Licensed Practical Nurse (LPN) G checked the resident's blood sugar level. The results read 149. LPN G verified the resident's order to receive 10 U of Aspart insulin. LPN G went to the medication cart and took out the Aspart pen. LPN G verified the resident's name on the insulin pen and dialed the pen to 10 U without priming the Flex pen 2 U. LPN G nearly administered 10 U of insulin to the resident but was stopped due to the Flex pen showing 50 U of air and leaking. LPN G was asked to call the Assistant Director of Nursing (ADON), before administration continued. LPN G left the resident's room. LPN G returned with ADON A, ADON B and the Registered Nurse Supervisor. During an interview on 9/5/25 at 8:10 A.M., LPN G said, This is how we do things all the time. During an interview on 9/5/25 at 8:19 A.M., ADON A said she expected insulin to be primed at 2 U per the policy. ADON A said the resident may not have gotten the full dose or any insulin due to the air inside the Flex pen. ADON A said they need to pull a new pen. Nurses could be pulling insulin straight from the pen with a syringe that led to the 50 U of air. An infection could stem from using this pen due to the pen having significant air and was leaking when touched. ADON A said no air should be present in Flex pens, and that is why staff should prime. During an interview on 9/05/25 at 8:19 A.M., ADON B said this Flex pen was not calibrated correctly due to the amount of air in the reservoir.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 maintain controlled substances in a restricted area until appropriate medical staff could destroy them. The Registered Nurse (RN) and Licensed Practical Nurse (LPN) medication cart assigned to the B and D halls held two discharged residents' narcotics for several weeks (Residents #114 and #117). The census was 105. Review of the facility's Narcotic Destruction Policy, revision date 6/24, showed:-All controlled substances shall be retained in a securely locked area with restricted access until authorized nursing personnel destroy them;-Any medication that is to be destroyed is to be locked in a separate cabinet and labeled to be destroyed. No other items, medications or treatments are allowed to be stores in the to be destroyed cabinet;-Medications should not be placed in the pocket or in an unsecured medication drawer to be handled at a later time. It must immediately be in the to be destroyed cabinet;-Destruction shall be completed as soon as practicable;-When the items are places in the to be destroyed cabinet they shall be placed there by a minimum of the two employees licensed medication and shall consist of one Registered Nurse (RN)/Licensed Practical Nurse (LPN) or Certified Medication Technician (CMT), or two nurses (excluding the Director of Nursing (DON). When the medication is placed in the cabinet, both the narcotic dispending record and signed medication to be destroyed record must be attached. The Medication to be Destroyed Record must be fully completed with the date, medication name and dosage, resident name and both authorized signatures.-Medications should be destroyed weekly if possible but a minimum of monthly.-Medications that cannot be returned to the pharmacy and are to be destroyed by the facility. This included medications that is expired or medications for residents who are permanently discharged .-The two health care providers handling the destruction include one designated to destroy and one designated as the witness for the destruction/disposal of medications. These two health care providers must reconcile the medications to be destroyed record with the specific narcotic dispending record, and the actual narcotic medications to be destroyed prior to the medication destruction. If a discrepancy is noted the DON will be notified immediately and will begin an investigation.-II Missing Narcotics:-In the event there is a discrepancy in the narcotics dispensing record, the manual narcotic count, and slash or the pharmacy medication destruction records, their nurse must notify the DON immediately, and the DON will initiate an investigation. The investigation must be completed for any discrepancies not involved prior to shift change. Count variants of less than 5 for oral narcotics solutions can be corrected without a completion open investigation. For all other discrepancies not immediately resolved, and slash or drugs are missing, and slash or drugs diversion is suspected, the DON will notify the administrator immediately. The administrator will contact the RCMC or the RCMC chief nursing officer if regional director not available). The DON will notify the RCMC facility nurse advisor. The RCMC regional director will notify the RCMC chief nursing officer, and the RCMC chief compliance officer;-Once the investigation has been completed, the DON, in consultation with the RCMC chief nursing officer is responsible for ensuring the following report required are followed; -Theft of controlled substance is a crime in Missouri and should be reported to law enforcement. See also elderly elder Justice Act policy; -Department of Health and Human Senior Services should be notified of their misappropriation. -The abuse hotline should be notified if the misappropriation amounts to abuse. Example of neglect related to misappropriations of medication. A facility employee takes a residents' pain medication for his/herself and falsifies the Medication Administration Record (MAR) to show the medication was administered. The resident experiences pain as a result of the misappropriation. See Residents Right Policy. 1.Review of Resident #114's electronic medical record (EMR), showed:-discharged [DATE];-Diagnoses included bipolar, anxiety, (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	post-traumatic stress disorder (PTSD, persistent mental and emotional stress), personality disorder and schizophrenia (disorder that affects a person's ability to think, feel, and behave clearly). Observation of the B and D hall medication cart on 9/4/25 at 8:58 A.M., showed the resident's name on two cards of acetaminophen with codeine tablets. Counted and documented were 20 tablets remaining in the blister pack. The actual count was 19 tablets with one missing from #17, and #7 had a break in the seal. 2. Review of Resident #117's EMR, showed:-discharged [DATE].-Diagnoses included difficulty walking, lower back pain, anxiety, muscle weakness, Parkinsons's Disease (disorder that affects movement, balance, and coordination). Observation of the B and D hall medication cart on 9/4/25 at 8:58 A.M., showed the resident's name on one card of oxycodone tablets (semi-synthetic opioid). Counted and documented were 37 tablets remaining in the blister pack. The actual count was 35 tablets, with one missing from #21 and #32. 3. During an interview on 9/4/25 at 10:01 A.M., Assistant Director of Nursing (ADON) A he/she would not expect the narcotics to be on the cart. During an interview on 9/9/25 at 8:14 A.M., CMT D said CMTs, LPNs and RNs are all responsible for cleaning out their carts. This would include expired medications and medications from expired or discharged residents. CMT D said if he/she came across narcotics for a discharged resident, he/she would pull the controlled substance and deliver the narcotics to the charge nurse. The receiving staff member would be responsible for the narcotics. CMT is unaware of the facility's policy and is unaware of when the facility trained on the specifics of these policies. During an interview on 9/9/25 at 1:45 P.M., the RN Supervisor said he/she expected employees to follow policies and procedures at the facility. The RN Supervisor and ADONs are ultimately responsible for pulling narcotics from the medication carts. The RN Supervisor would anticipate any resident departing the facility and not returning all their medications would be pulled within 24-hour period. He/She said the facility does not have a destroy cabinet. The RN Supervisor could not explain why Resident #114's medications remained on the cart, and why Resident #117's narcotics were left in circulation. Staff count narcotics every shift and they should have been caught during the process. The RN Supervisor said he/she does not believe failure to follow facility's Destruction Policy would lead to misappropriation. These medications could have easily been popped out and lay in the bottom of the bin. Since the medication was not destroyed, it is difficult to say what occurred.