STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265573	A. Building B. Wing	01/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Big Spring Care Center for Rehab and Healthcare	202 East Mill Street Humansville, MO 65674

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41787 Based on observation, interview, and record review, the facility failed to ensure staff treated all residents with dignity and respect when they did not provide a dignity bag for one resident's (Resident #34) Foley catheter (sterile tube inserted into the bladder to drain urine) bag (bag that collects urine drained from a catheter inserted into the bladder) and when staff yelled in the dining room, and when the facility smoking scheduled was at the same time as lunch causing smoking residents to choose between smoke break and a hot meal. The facility census was 44. Review of facility policy titled Procedure for Ensuring Resident Rights, dated 2025, showed the following: -Residents are encouraged to participate in the Resident Council; -The facility will support and facilitate resident-led discussions on improving care; -No staff member may interfere with or retaliate against residents for voicing concerns. 1. Review showed facility did not provide a policy related to catheter. Review of Resident #34's face sheet (brief information sheet about the resident) showed the following: -admitted [DATE]; -Diagnoses included neuromuscular dysfunction of bladder (loss of bladder control, inability to empty bladder), urinary retention, and urinary incontinence. Review of the resident's care plan, dated last updated 10/08/24, showed the following: -The resident required an indwelling urinary catheter due to diagnosis of neurogenic bladder; -The resident will have catheter care managed appropriately as evidenced by not exhibiting signs of infection or urethral trauma; -Staff should provide catheter care per facility protocol or doctor's orders; (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Store collection bag inside a protective dignity pouch. Review of the resident's quarterly Minimum Data Set (MDS - a federally mandated assessment instrument completed by facility staff), dated 11/28/24, showed the following: -Cognitively intact; -Had an indwelling catheter (thin, hollow tube that's inserted into the bladder to drain urine). Review of the resident's physician's order sheet (POS), current as of 01/31/25, showed the following: -An order, dated 05/07/24, to check placement of Foley catheter securement device (anchor) and dignity bag (bag used to cover and hold the catheter collection bag so it is not visible) every shift; -An order, dated 10/01/24, to change Foley catheter bag monthly and as needed; -An order, dated 10/08/24, for Foley catheter care every shift and as needed; -An order, dated 10/18/24, to change Foley catheter monthly and as needed. Observation of the resident showed the following: -On 01/26/25, at 5:01 P.M., the resident was in bed with his/her eyes closed. A catheter bag was visible on left side of bed facing the open door with about 100 cubic centimeter (cc - a unit of volume used to measure liquids and medications) yellow urine visible. The catheter bag was not covered with a dignity cover; -On 01/27/25, at 3:29 P.M., the resident was in bed with eyes closed. The catheter bag was facing the door with yellow urine visible from hallway; -On 01/28/25, at 9:42 A.M., the resident was in bed with housekeeping in the room and nursing staff providing medications. The catheter bag was facing the door with about 200 cc yellow urine visible; -On 01/28/25, at 12:37 P.M., the resident was resting in bed with eyes closed. The catheter bag was facing the door with no dignity cover and had about 300 cc yellow urine visible from the hallway; -On 01/28/25, at 2:00 P.M., the resident was in bed on the telephone. The catheter bag was visible with over 300 cc urine visible from the hall. During an interview on 01/29/25, at 1:10 P.M., Certified Nurse Aide (CNA) C said that catheter bags should be in a dignity bag when resident is in a wheelchair or in the common areas. The catheter bag did not necessarily need to be in privacy bag when the resident was in their room unless the resident wanted that. He/she said that if the care plan had dignity bag us on it, then it should be done. During an interview on 01/29/25, at 1:25 P.M., CNA D said catheter bags should be in a dignity bag at all times so it was not visible to others. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 01/29/25, at 2:15 P.M., CNA E said residents should have catheter bags in dignity bag when out in public, but not necessarily in a dignity bag when in their room unless they want it. If it in their care plan to use one, then staff should follow care plan. During an interview on 01/29/25, at 2:24 P.M., Certified Medication Tech (CMT) F said catheter bags should be kept in dignity bags. During an interview on 01/29/25, at 3:00 P.M., Registered Nurse (RN) B said catheters should be covered if the resident wants it covered. Some residents do not care whether it is covered in their room or out of their room and just want to get to the activity. During an interview on 01/30/25, at 10:30 A.M., RN G said that catheter bags should be in a dignity bag at all times. Even in resident rooms the catheter bag should be in a cover because the resident might have a visitor. During an interview on 01/30/25, at 11:45 A.M., RN A said catheter bags should always be in a dignity bag, even in the resident room. During an interview on 01/30/25, at 3:00 P.M., the Director of Nursing (DON) said catheter bags should be in dignity covers. They should not be visible in common areas or in resident rooms. The bag should not be visible in resident rooms from the hallway. If a resident's care plan states a dignity bag should be used, there really should be a dignity bag. During an interview on 01/30/25, at 3:25 P.M., Administrator said staff should ensure that resident catheter bags were in dignity covers at all times. 2. Observation on 01/26/25, at 5:30 P.M., showed the Dietary Manager (DM) yelling does everyone have their food. Raise your hand if you do not. Observation on 01/29/25, at 1:09 P.M., showed the DM yelling, from behind the serving area to residents, who were sitting at their tables throughout the dining room, asking the residents if they wanted seconds. CNA C responded there is no need to yell. Observation on 01/31/25, at 12:42 P.M., showed Dietary Aide (DA) R behind the serving area yell through the dining room to Resident #19, do you want cheese. During an interview 01/31/25, at 8:50 A.M., Resident #41 said that staff often yell at meals, but they have to check who does not have food, they probably could be quieter. During an interview on 01/30/25, at 12:50 P.M., Resident #29 said mealtime in the dining room was very loud because of the staff yelling and some residents playing music. During an interview on 01/31/25, at 12:42 P.M., the DM said the he/she ensured that all residents had received their meals by checking all meal tickets and by screaming through the dining room asking the residents if they had received their food. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 01/31/25, at 10:57 A.M., the DON said a lot of yelling goes on during mealtime that is not necessary. The DON had spoken with the DM about the yelling during meal time. Facility staff members have complained about the DM yelling during meal time. Staff should be using their inside voice when in the building. The staff who are serving meals could ensure that all residents have received their meals so the DM would not have to yell. During an interview on 01/31/25, at 11:24 A.M., the Administrator said there was sufficient staff in the dining room to ensure that all residents received their meals. The kitchen staff should not be yelling through the dining room to the residents. 48534 3. Observation on 01/29/25, at 12:40 P.M., showed the following: -Resident #33 eating lunch when CNA D asked the resident if he/she was going to eat or go out and smoke. The resident stayed at the table and finished his/her food; -Resident #14 was eating lunch when CNA D asked the resident, do you want to smoke or eat. We'll put a cover over your food and you can eat when you come back. The resident took a bite of his/her ham and beans and left the dining room to smoke. CNA C put a food cover over the resident's food that was left on the table. Observation on 01/30/25, at 12:45 P.M., of the lunch serve out showed the following: -DA N prepared Resident #14's plate and sent to be served to the resident. Resident #14 was outside smoking. The plate was put to the side and left uncovered; -DA N prepared Resident #33's plate and sent to be served to the resident. Resident #33 was outside smoking. The plate was put to the side and left uncovered. During an interview on 01/30/25, at 12:50 P.M., Resident #29, who was in the smoking area, said the he/she was often made to choose between smoking or eating. Meals being served by kitchen staff are often not on time. He/she had to leave his/her food on the table, and go smoke during smoking time. He/she would return to the dining room to finish the meal, which was often cold by this time. During an observation on 01/30/25, at 12:50 P.M., of Resident #33, who was in the smoking area said, It's time to go eat my cold sandwich. During an interview 01/31/25, at 8:50 A.M., Resident #41 said sometimes he/she had to choose between the schedule cigarette break and having a hot lunch because the staff would not take the residents to smoke until the next scheduled smoke break at 3:30 P.M. During an interview on 01/30/25, at 12:51 P.M., Housekeeper (HK) Q, who was supervising residents smoking, said the following he/she was told residents had to smoke at designated smoking times or they would not be allowed to smoke until the next designated smoking time. There were no exceptions or altering of the designated smoking times. Lunch is often served late and residents often had to choose between smoking and eating a warm meal. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 01/31/25, at 10:57 A.M., the DON said meals were not always served on time. When meals were served late residents should be given the option to smoke when they are done eating. Residents should not be made to choose between eating a hot meal or smoking.

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F 0567 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to manage his or her financial affairs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34871 Based on observation, interview, and record review, the facility failed to act as a fiduciary and properly manage residents' funds when the facility failed to maintain access to a petty cash fund that ensured all resident could receive cash requests of less than $100.00 (or less then $50.00 if the resident received Medicaid) the same day for three residents (Resident #1, #26, and #44) out of a total sample of 17 residents. The facility census was 44. Review of the facility policy titled, Personal Needs Allowance (PNA), revised February 2019, showed the following: -All patients that the facility receives the original income checks in full are to be credited with $50.00 to their PNA account; -Petty cash in the amount of $750.00 is to be kept for small requests and should be replenished on a as needed basis; -All patients must sign their request and receipts acknowledging receipt of funds. (The policy did not address how quickly residents should be able to obtain their funds.) 1. Review of the resident council minutes, dated 12/30/24, showed the facility's banking hours were 10:30 A. M. to 3:00 P.M. 2. Review of Resident #1's face sheet (admission data) showed the resident admitted to the facility on [DATE] and readmitted on [DATE]. Review of the resident's significant change in status Minimum Data Set (MDS - a federally mandated assessment tool completed by facility staff), dated 12/24/24, showed the resident had intact cognitive skills. Review of the resident's authorization for patient account, dated 11/14/24, showed the resident signed to delegate the nursing facility to handle his/her financial transactions on his/her behalf. Review of the facility's maintained resident fund account showed as of 01/29/25 the resident with an ending balance of $38.76. During an interview on 01/28/25, at 10:15 A.M., during the group interview, the resident said he/she would like to have access to his/her funds available on the weekend. He/she had family visit this past weekend and wanted more money. 3. Review of Resident #26's face sheet showed the resident admitted to the facility on [DATE]. Review of the resident's quarterly MDS, dated [DATE], showed the resident had intact cognitive skills. (continued on next page)

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F 0567 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the resident's authorization for patient account, undated, showed the resident signed to delegate the nursing facility to handle his/her financial transactions on his/her behalf. Review of the facility's maintained resident fund account showed as of 01/29/25, the resident had a balance of $422.01. During an interview on 01/28/25, at 10:15 A.M., during the group interview, the resident said if he/she forgets to ask for his/her money during the week, he/she would like his/her personal funds on the weekends. 4. Review of Resident #44's face sheet showed the resident admitted to the facility on [DATE]. Review of the resident's quarterly MDS, dated [DATE], showed the resident's cognitive skills were moderately impaired. Review of the resident's authorization for patient account, undated, showed the resident signed to delegate the nursing facility to handle his/her financial transactions on his/her behalf. Review of the facility's maintained resident fund account showed as of 01/29/25, the resident had a balance of $637.00. During an interview on 01/28/25, at 12:50 P.M., the resident said he/she keeps in mind the time limits to access his/her money, but he/she plans ahead so it had not been an issue for him/her. There was a time when he/she wanted to buy a snack, but he/she did not have money to do so because it was outside the timeframe to obtain his/her money from the facility. He/she would like to have more access to his/her money. 5. Observations throughout the survey, 01/26/25 through 01/31/25, showed a laminated sign posted at the front office located near the facility entrance door which stated Resident trust banking Monday through Friday 10:30 A.M. until 3:00 P.M. 6. During an interview on 01/28/25, at 10:54 A.M., the Activity Director said the following: -The front office is open Monday through Friday from 10:30 A.M. to 3:00 P.M. if a resident wants cash; -The Business Office Manager (BOM) informs the resident how much money is available; -Residents sign a receipt book and the BOM writes it down on the log; -All the residents are pretty good about getting their money from 10:30 A.M. to 3:00 P.M. Monday through Friday; -Some residents occasionally say they want money after 3:00 P.M.; -He/she had heard residents say they have to wait till tomorrow to get money; -Residents did not have access to cash on the weekends. (continued on next page)

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F 0567 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 01/29/25, at 2:58 P.M., the BOM said the following: -He/she is responsible for the resident fund accounts; -Residents ask him/her for cash; -He/she writes the requested cash on a list and the resident signs a receipt; -Residents can access cash Monday through Friday from 8:00 A.M. to 4:30 P.M. The facility tries to have the banking hours from 10:30 A.M. to 3:00 P.M., but if a resident needs cash before then, staff can get the cash for them; -Residents come to the office to access cash and have it for the weekend; -Residents cannot get cash after hours or on the weekends. During an interview on 01/29/25 at 10:34 A.M., Registered Nurse (RN) A said residents cannot get money on the weekends because there is no one in the front office. During an interview on 01/29/25, at 11:29 A.M., the Director of Nursing (DON) said the following: -Residents go to the front office and ask the BOM for cash Monday through Friday during banking hours; -The resident are not able to get money on the weekends; -The residents know the office is closed on Saturday and Sundays. During an interview on 01/30/25, at 1:32 P.M., the Administrator said the following: -Residents access funds Monday through Friday from 10:00 A.M. to 3:00 P.M.; -Residents use the soda machine or the local store so staff get enough money for them to have until Monday.

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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. 31464 Based on observation and interview, the facility failed to ensure residents had a safe, clean, comfortable and homelike environment when a handrail in a common area remained in an unsafe condition, chair cushions in a common area were in disrepair, and two walls of one resident's (Resident #16) room were damaged. A sample of 17 residents was reviewed; the facility census was 44. Review of a facility policy entitled Maintenance Service, revised December 2009, showed the following: -The Maintenance Department is responsible for maintaining the buildings, grounds, and equipment in a safe and operable manner at all times; -Functions of maintenance personnel include maintaining the building in good repair and free from hazards; -The Maintenance Director is responsible for maintaining work order requests. Review of the facility policy entitled Quality of Life - Homelike Environment, revised May 2017, showed the following: -Residents are provided with a safe, clean, comfortable and homelike environment; -Staff shall provide person-centered care that emphasizes the residents' comfort, independence and personal needs and preferences; -The facility staff and management shall maximize, to the extent possible, the characteristics of the facility that reflect a personalized, homelike setting. These characteristics include a clean, sanitary and orderly environment, inviting colors and decor, and personalize furniture and room arrangements. 1. Observation on 01/29/25, at 8:15 A.M., and on 01/30/25, at 8:20 A.M., of the 100 hall TV lounge area showed the following: -One rocking chair with a 4 to 6 inch tear in the right side of the cushion cover, exposing the foam interior and plastic piping with two rough/sharp ends, and a 3 to 4 inch tear on the left side exposing the plastic piping; -A second rocking chair with two 2 to 3 inch tears to the top of the cushion, revealing the inner foam. During an interview on 01/31/25, at 9:08 A.M., Certified Nurse Aide (CNA) L said he/she had not noticed the torn rocking chair cushions in the 100 hall TV lounge area. Several residents do like to sit there to watch TV. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 01/31/25, at 9:11 A.M., Certified Medication Tech (CMT) J said he/she was unaware of the torn rocking chair cushions. During an interview on 01/31/25, at 11:48 A.M., the Director of Nursing (DON) said he/she not aware of lounge rocking chair cushions that were torn with inner foam and piping exposed. Staff should have reported that to housekeeping. During an interview on 01/31/25, at 1:32 P.M., the Administrator said he/she was not aware of the torn rocking chair cushions. Staff should have told housekeeping or maintenance and those cushions should be thrown away and replaced. 2. Observations on 01/26/25, at 4:17 P.M., on 01/29/25, at 12:05 P.M., and on 01/30/25, at 12:05 P.M., of the hallway outside the dining room showed the handrail end cap was off and resting on top of the railing. The uncapped handrail end had two sharp connector edges, approximately 6 inches from the doorway into the dining room. The handrail was located directly under a hand sanitizer gel dispenser and adjacent sign board listing the meal service times. Review of the Maintenance Request Log located at the nurses' desk showed staff did not document repair needed to the hand rail outside the dining room. During an interview on 01/30/25, at 1:34 P.M., the Maintenance Director said nobody had told him/her about the broken hand rail. During an interview on 01/31/25, at 11:48 A.M., the DON said he/she was not aware of an issue regarding a hand rail that was in need of repair. 48534 3. Review of Resident #16's face sheet (gives basic profile information) showed an admitted facility on 06/13/23. Review of the resident's quarterly Minimum Data Set (MDS - a federally mandated assessment tool completed by facility staff), dated 11/27/24, showed the following information: -Severely impaired cognition; -Able to self propel wheelchair; -Required partial assistance for dressing, bathing, transfers, and toileting. Observations on 01/27/25, at 2:10 P.M., on 1/29/25 at 8:05 A.M., and on 1/31/25, at 9:25 A.M., of the resident's room showed the wall along bed had damage to an area at least 4 feet wide by 3 feet high. The area had multiple gouges of varying lengths, widths, and depths that penetrated through the paint, drywall paper, and drywall. Areas of orange coloring were visible in numerous spots where the paint and drywall paper was peeled/curled back. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation and interview on 01/31/25, at 1:16 P.M., in the resident's room showed the resident in his/her room, sitting in a wheelchair. The 4 to 6 inch wall to the left of the sink area was visibly damaged, with egg-sized pieces of the drywall and part of the vinyl baseboard missing. During the observation, the resident said the walls looked messy. He/she said it looked like they had been hit quite a few times with wheelchairs or something, and he/she would like it to be fixed. Review of the Maintenance Request Log located at the nurses' desk showed staff did not document repair needed to the resident's walls. During an interview on 01/31/25, at 9:14 A.M., the Maintenance Supervisor said he/she was not aware of the condition of the resident's walls and it was not on the list of rooms needing repairs. The condition of the resident's walls was unacceptable. During an interview on 01/31/25, at 11:24 P.M., the Administrator said he/she was not aware of the condition of the resident's walls. The resident's room was not on the list of rooms that needed repairs. The condition of the resident's walls was unacceptable. 4. During an interview on 01/31/25, at 9:08 A.M., CNA L said staff should report maintenance needs and repair requests to the Maintenance Director or put it on the Maintenance Log at the nurses' desk. During an interview on 01/31/25, at 9:11 A.M., CMT J said staff should log in maintenance requests/repairs needed on the book at the nurses' desk. The Maintenance Director checked the log daily. During an interview on 01/31/25, at 10:40 A.M., Registered Nurse (RN) A said staff should put maintenance requests on the log at the nurses' desk. During an interview on 01/31/25, at 9:14 A.M., the Maintenance Supervisor said staff were to log any request for repairs in the maintenance log book. He/she had a list of rooms that needed repairs. During an interview on 01/31/25, at 11:48 A.M., the DON said staff should report all maintenance issues to the Maintenance Director by putting it on the log at the nurses' desk. The Maintenance Director checked the log every morning. During interviews on 01/31/25, at 11:24 P.M. and 1:32 P.M., the Administrator said the staff should log all maintenance request in the maintenance log book or telling the Maintenance Supervisor directly if the repair is more urgent.

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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 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41787 Based on observation, interview, and record review, the facility failed to assess the use of a seat belt, failed to obtain written consent for use of the seat belt, failed to document what less restrictive options were attempted, failed to document risk versus benefit review related to the seat belt use, failed to obtain a physician's order for use of the seat belt, and failed to care plan the use of the seat belt for one resident (Resident #11) who was unable to effectively and consistently remove the seat belt without staff assistance. The facility census was 44. Review of the facility provided policy titled Use of Restraints, dated December 2007, showed the following: -Restraints should only be used for the safety and well-being of the resident and only after alternatives have been tried unsuccessfully; -Restraints shall only be used to treat the resident's medical symptoms and never for discipline or staff convenience, or for the prevention of falls; -Physical Restraints are defined as 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 restricts normal access to one's body; -The definition of a restraint is based on the functional status of the resident and not the device. If the resident cannot remove a device in the same manner in which the staff applied it given that resident's physical condition (i.e., side rails are put back down, rather than climbed over), and this restricts his/her typical ability to change position or place, that device is considered a restraint; -Restraints may only be used if/when the resident has a specific medical symptom that cannot be addressed by another less restrictive intervention and a restraint is required to treat the medical symptom, to protect the resident's safety, and to help the resident attain the highest level of his/her physical or psychological well-being; -Prior to placing a resident in restraints, there shall be a pre-restraining assessment and review to determine the need for restraints. The assessment shall be used to determine possible underlying causes of the problematic medical symptom and to determine if there are less restrictive interventions (programs, devices, referrals, etc.) that may improve the symptoms; - Restraints shall only be used upon the written order of a physician and after obtaining consent from the resident and/or representative (sponsor); -The order shall include the specific reason for the restraint (as it relates to the resident's medical symptom), how the restraint will be used to benefit the resident's medical symptom, and the type of restraint, and period of time for the use of the restraint.; (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Orders for restraints will not be enforced for longer than twelve hours, unless the resident's condition requires continued treatment; -Reorders are issued only after a review of the resident's condition by his or her physician; -Restraints shall be used in such a way as not to cause physical injury to the resident and to insure the least possible discomfort to the resident; -Physical restraints shall be applied in such a manner that they can be speedily removed in case of fire or other emergency; -Restraints with locking devices shall not be used; -A resident placed in a restraint will be observed at least every thirty minutes by nursing personnel and an account of the resident's condition shall be recorded in the resident's medical record; -The opportunity for motion and exercise is provided for a period of not less than ten minutes during each two hours in which restraints are employed; -Restrained residents must be repositioned at least every two hours on all shifts; -Residents and/or surrogate/sponsor shall be informed about the potential risks and benefits of all options under consideration, including the use of restraints, not using restraints, and the alternatives to restraint use; -Restrained individuals shall be reviewed regularly (at least quarterly) to determine whether they are candidates for restraint reduction, less restrictive methods of restraints, or total restraint elimination; -Care plans for residents in restraints will reflect interventions that address not only the immediate medical symptoms, but the underlying problems that may be causing the symptoms; -Care plans shall also include the measures taken to systematically reduce or eliminate the need for restraint use. 1. Review of Resident #11's face sheet (brief information sheet about the resident), showed the following: -admitted [DATE]; -Diagnoses included quadriplegia (partial or complete paralysis of both the arms and legs especially as a result of spinal cord injury or disease in the region of the neck), degenerative disorders of nervous system (group of conditions that affect the nervous system, causing progressive deterioration and loss of function over time), inclusion body myositis (a rare, chronic, and progressive muscle disease characterized by inflammation and muscle weakness), post traumatic stress disorder (PTSD - disorder in which a person has difficulty recovering after experiencing or witnessing a terrifying even). (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation and interview on 01/27/25, at 3:36 P.M., showed the following: -Certified Nurse Aide (CNA) H and CNA I entered the resident room with the Hoyer lift (mechanical lift used for non-weight bearing transfers); -Resident was seated in the electric wheelchair, covered with a blanket; -Staff removed the resident's blanket, the resident had a seatbelt across his/her lab; -CNA H unbuckled and removed the seatbelt; -The staff transferred the resident to the bed; -The staff completed resident personal cares; -The staff transferred the resident back to the wheelchair with the Hoyer lift; -The resident requested CNA H re-applied the seatbelt. CNA buckled the belt across the resident's lap area. Review of the resident's significant change in condition Minimum Data Set (MDS - a federally mandated comprehensive assessment instrument completed by facility staff), dated 12/30/24, showed the following: -Cognitively intact; -Restraints not used in chair or bed; -Required use of motorized wheelchair. Review of the resident's care plan, last updated on 01/06/25, showed the following: -Resident was admitted with specialized high back wheelchair with arms that hold his/her phone and tablet for ease of use; -Staff should Instruct his/her in the use of the wheelchair as needed; -Resident's wheelchair was his/her main mode of transportation; -Staff should assist the resident with mobility as necessary; -Resident was at risk for falling related to inability to ambulate; -Staff should encourage resident to use environmental devices such as hand grips or handrails. (Staff did not care plan related to resident's use of the seat belt.) (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the resident's Physician's Order Sheet (POS), current as of 01/30/25, showed no orders for use of a seatbelt or restraint. During an interview on 01/27/25, at 4:27 P.M., the resident said he/she had a seatbelt on wheelchair. He/she was not able to take it off. He/she was aware the seatbelt was considered a restraint, but he/she had enough motion in his/her upper torso that he/she would adjust too much or have a muscle spasm was afraid of falling out of the wheelchair. The resident said he/she was of sound mind and wanted to have the seatbelt and he/she had signed consent. During an interview on 01/30/25, at 10:30 AM., Registered Nurse (RN) G said the resident had a seatbelt in his/her wheelchair and thought that most staff knew that. He/she said would think it was on the care plan, but did not know. He/she was aware of the seatbelt just from working with resident and in report. During an interview on 01/30/25, at 11:45 A.M., RN A said he/she was not sure if the resident had a seatbelt for his/her wheelchair, but if he/she did then he/she should be able to unbuckle him/herself, or it would be considered a restraint. He/she did not know the facility policy about restraints. He/she said there should be a physician's order, it should be in the care plan, and it would require close monitoring if used. During an interview on 01/29/25, at 2:15 P.M., CNA E said the resident had a seatbelt on his/her wheelchair that he/she requested. It should be in the care plan. The resident was repositioned in the wheelchair throughout the day and staff lay him/her down throughout the day for personal cares and to give him/her a break from the wheelchair. During an interview on 01/29/25, at 2:30 P.M., the Director of Nursing (DON) said the resident had a seatbelt in his/her wheelchair and that should be in the care plan. He/she did not know if there was signed consent for the seatbelt or a physician's order, but that should have been completed prior to using the seatbelt. During an interview on 01/29/25, at 2:45 P.M., the Administrator said she was not aware that the aides were putting the seatbelt on for the resident. The resident was not supposed to have a seatbelt. She had discussed with the resident in the past that it was a restraint, and the facility did not allow restraints. The resident had a fear of falling due to past trauma. His/her wheelchair was able to incline and decline. There was not any paperwork completed for consent or risks because the facility did not allow restraints.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34871 Based on interview and record review, the facility failed to ensure all residents received care per professional standards of practice when staff failed to obtain ordered blood tests in a timely fashion for one resident (Resident #8) out of a total sample of 17 residents. The facility census was 44. Review of the facility's policy titled, Laboratory Services For Nursing Staff, dated 2025, showed the following: -The facility shall provide or arrange for laboratory services to meet residents' medical needs; -The nursing staff is responsible for coordinating, collecting, and documenting laboratory specimens in accordance with state and federal regulations; -All laboratory results must be reviewed, documented, and communicated to the provider in a timely manner. 1. Review of Resident #8's face sheet (gives basic profile information) showed the following information: -admitted [DATE]; -Diagnoses included atrial fibrillation (abnormal heartbeat), hyperlipidemia (high cholesterol), chronic kidney disease, and edema (swelling). Review of the resident's care plan, updated 10/01/24, showed the following: -The resident has urinary incontinence problems as evidenced by need for dependent on staff for assistance to use the bedpan for toileting; -The resident is at risk for increased probability of infections. Review of the resident's quarterly Minimum Data Set (MDS - a federally mandated assessment tool completed by facility staff), dated 12/03/24, showed the resident was cognitively intact. Review of the resident's progress note dated 11/29/24, at 1:02 A.M., showed a licensed practical nurse (LPN) documented the aides reported the resident had bleeding vaginally the past few days. The nurse reported that is why the Foley catheter (a tube that is inserted into the bladder, allowing urine to drain freely.) was discontinued. The aides reported the bleeding is heavier tonight. The nurse notified the physician of the resident's condition and orders received to get complete blood count (CBC) in the morning and he will follow up after the CBC results. Review of the resident's Physician Order Sheet showed an order, dated 11/29/24, for CBC sent to the lab company one time only related to urinary tract infection. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the resident's progress note dated 12/01/24, at 12:51 A.M., showed a nurse documented the resident stated he/she is still bleeding vaginally. The CBC has yet to be drawn. The nurse added the resident to the physician's list for him/her to assess the resident and follow up on order for the CBC. Review of the resident's medical record, on 01/29/25, showed staff had not obtained the CBC ordered 11/29/24. During an interview on 01/29/25 at 10:34 A.M., Registered Nurse (RN) A said the following: -When a nurse receives an order from physician, he/she gives the lab order to the Director of Nursing (DON) who enters the order into the computer; -Staff order lab orders for a change in condition, need for urinalysis, or edema issues; -Staff text or call the physician for needed labwork; -The DON is the only one who has access to enter lab requests; -The DON prints the lab results and gives it to staff; -Staff notify the physician and update him on the lab results; -The physician reviews the lab results and gives new orders based on the results; -He/she did not see the resident's CBC results ordered 11/29/24. During interviews on 01/29/25, at 11:29 A.M., and on 01/30/25, at 8:50 A.M., the DON said the following: -Nurses get a lab order and she enters the lab orders in the new lab company computer which started 01/01/25; -She checks the lab portal every day for lab results; -Nurses have a lab binder that has a log to enter information of the lab; -She prints lab results and puts them in the physician folder for him to review; -Staff call the physician with critical lab results; -The physician comes to the facility on Monday and Wednesdays and reviews the lab results and he/she writes orders if needed and the nurse documents it in the computer system; -Staff order labs for a change in condition, all new admissions, or a follow up lab; -With the old lab company, the nurse called the physician or texted to request a lab; (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Staff wrote on the lab order requisition form and then staff progressed to enter the lab order in the computer and print out the requisition order, place it in the lab book at the desk under the date it needed drawn; -The old lab came Tuesday and Thursdays and emailed the facility the lab results, prior to emails the lab company faxed the results; -Staff checked the fax machine throughout the day for lab results; -She checked the computer daily until the facility received a result and would email the lab if no results;. -Staff wanted a CBC for the resident due to vaginally bleeding, but did not know for sure the reason; -The resident has improved with the bleeding; -She did not find the CBC results for the resident. During an interview on 01/30/25, at 01:32 P.M., the Administrator said if a resident had an order for labs to be drawn, they should be drawn as ordered.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51882 Based on observation, interview, and record review, the facility failed to provide care for residents on oxygen per professional standards of practice when staff failed to administer oxygen per physician orders for two residents (Resident #5 and Resident #7). The facility census was 44. Review of the facility's policy titled Monitoring Oxygen Use and Oxygen Saturation, undated, showed the following: -Purpose to ensure the safe and effective use of oxygen therapy and comply with regulatory requirements; -Applies to all residents receiving oxygen therapy and the nursing staff responsible for their care; -Oxygen therapy must be prescribed by a physician, including flow rate (liters per minute - lpm) and oxygen saturation range; -Only licensed nurses may adjust oxygen flow rates based on the physician's order; -Record oxygen flow rate, delivery method, and saturation levels in the resident's medical record; -Document any changes, incidents, or interventions related to oxygen therapy; -Review incidents related to oxygen use as part of the facility's quality improvement program. 1. Review of Resident #5's face sheet (a brief resident profile) showed the following: -admitted [DATE]; -Diagnoses included chronic obstructive pulmonary disease (COPD- a group of lung diseases that block airflow and make it difficult to breath), dependence on supplemental oxygen, pleural effusion (a buildup of fluid between the tissues that line the lungs and chest), pyothorax (a condition where pus collects in the space between the lungs and chest wall), and chronic respiratory failure with hypoxia (a condition where the body is not able to adequately exchange oxygen and carbon dioxide over a prolonged period). Review of the resident's January 2025 Physician Order Sheet (POS) showed an order, dated 09/30/24, for oxygen at 2 lpm by nasal cannula continuous while in bed to maintain oxygen level (saO2) greater than 91% every morning and at bedtime for shortness of breath related to COPD. Review of the resident's annual Minimum Data Set (MDS - federally mandated assessment tool completed by facility staff), dated 01/03/25, showed the following: -Moderately impaired cognition; (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Received oxygen therapy. Review of the resident's care plan, last reviewed 01/03/25, showed a risk for signs and symptoms of COPD/chronic respiratory failure and may receive continuous oxygen at two lpm for shortness of breath. Review of the resident's January 2025 Medication Administration Record (MAR) showed the following: -An active order for oxygen at two lpm per nasal cannula, continuous while in bed to maintain saturation level greater than 91% every morning and at bedtime for shortness of breath related to COPD. -Staff did not document verification of number of oxygen liters provided to the resident. Review of the resident's nurses' notes, dated 01/26/25, showed the resident's oxygen set on three liters of oxygen per nasal cannula with an oxygen saturation of 94% at 5:24 P.M. and 97% at 5:58 P.M. Observation on 01/28/25, at 11:56 A.M., showed the following: -The oxygen concentrator sat in the resident's room and set on two and a half liters of oxygen per minute; -The oxygen tubing sat on top of the concentrator. Observation on 01/28/25, at 12:55 P.M., showed the following: -Resident sat in the wheelchair in his/her room; -The resident had oxygen on at two and a half liters per minute per nasal cannula. Observation on 01/29/25, at 11:17 A.M., showed the following: -Resident rested in bed with his/her eyes closed; -Resident had oxygen on per nasal cannula; -Oxygen concentrator was set at two and a half liters per minute. During an interview on 01/29/25, at 11:35 A.M., Certified Nursing Assistant (CNA) E said as far as he/she knew, the resident's oxygen setting should be on two liters of oxygen. During an interview on 1/29/25, at 11:43 A.M., Registed Nurse (RN) A said the following: -The resident's oxygen saturation level is checked two times per day; -The resident should be on two liters of oxygen per physician orders; -The resident takes his/her oxygen off on occasion or it gets misplaced, so staff replaces it for him/her as needed. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation and interview on 01/29/25, at 12:00 P.M., showed the following: -The resident sat in the dining room waiting for lunch; -RN A checked the resident's oxygen concentrator and said his/her oxygen was set on two and a half lpm; -RN A checked the resident's oxygen saturation level and it was 99%; -RN A asked Certified Nurse Aide (CNA) E to turn the resident's oxygen down to two liters, while he/she was present; -CNA E changed the resident's oxygen to two lpm as instructed; -RN A confirmed the resident's oxygen was set on two liters of oxygen per nasal cannula before leaving the dining room. During an interview on 01/31/25, at 9:40 A.M., Licensed Practical Nurse (LPN) K said the following: -He/she checked the resident's oxygen saturation level daily and documents it in his/her electronic record. He/she believed the resident's oxygen saturation level was 94% when he/she checked it yesterday; -He/she looked at the resident's liters of oxygen every day and he/she has not noticed any problems or concerns with the resident's liters of oxygen. During an interview on 1/29/25, at 12:20 P.M., the Director of Nursing (DON) said if the resident's order was for two liters of oxygen, he/she should be on two liters. 2. Review of Resident #7's face sheet (a brief resident profile) showed the following: -admitted [DATE]; -Diagnoses included chronic diastolic (where the heart relaxes and fills with blood) congestive heart failure (CHF - a condition where the heart does not pump blood as well as it should) and COPD. Review of the resident's care plan, last reviewed 07/01/24, showed a risk for signs and symptoms of CHF/COPD and he/she received oxygen at three lpm continuously for shortness of breath. Review of the resident's quarterly MDS, dated [DATE], showed the following: -Moderately impaired cognition; -Received oxygen therapy. Review of the resident's January 2025 POS showed an order, dated 09/30/24, for oxygen at three liters per nasal cannula, continuous to maintain saturation level of greater than 91% every morning and at bedtime for shortness of breath related to COPD. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the resident's January 2025 MAR showed the following: -A current order for oxygen at three liters per nasal cannula, continuous to maintain saturation level greater than 91% every morning and at bedtime for shortness of breath related to COPD. - Staff did not document verification of number of oxygen liters provided to the resident. Observation on 01/27/25, at 3:42 P.M., showed the following: -The resident sat in a wheelchair in his/her room; -The resident had oxygen on at two liters per minute per nasal cannula. Observation on 01/28/25, at 9:37 A.M., showed the following: -The resident sat in a wheelchair in his/her room and read a book; -The resident had oxygen on at two liters per minute per nasal cannula. Observation on 01/28/25, at 11:15 A.M., showed the following: -The resident sat in a wheelchair in his/her room completing a nebulizer treatment; -The resident had oxygen on at two liters per minute per nasal cannula. Observation on 01/28/25, at 12:01 P.M., showed the following: -The resident sat in a wheelchair in the restorative dining room, sleeping on and off while waiting for lunch; -The resident did not have on any oxygen. Observation and interview on 1/28/25, at 12:50 P.M., showed the following: -The resident sat in a wheelchair in his/her room; -The resident said he/she does not always wear his/her oxygen in the dining room, but he/she is okay with that. He/she wears oxygen when staff tells him/her to; -The resident had oxygen on at two liters per minute per nasal cannula. During an interview on 01/29/25, at 11:35 A.M., CNA E said he/she believed the resident's oxygen setting should be on three liters of oxygen. During an interview on 01/29/25, at 11:43 A.M., RN A said the following: -He/she checked the resident's oxygen saturation level two times per day; (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The resident took his/her oxygen off sometimes, but he/she does not adjust his/her oxygen liters on the concentrator; -The resident had a physician's order for three liters of oxygen; -The resident keeps his/her oxygen on while eating. Observation and interview on 01/29/25, at 11:54 A.M. showed the following: -RN A checked the residents oxygen titration setting and said that his/her oxygen concentrator was set on two lpm; -RN A said he/she did not know how many liters of oxygen were ordered for the resident; -RN A checked the MAR and said the resident's lpm were a little off because his/her oxygen concentrator was set at two liters, but his/her order showed the resident should receive three liters of oxygen per minute. During an interview on 01/31/25, at 9:40 A.M., LPN K said the following: -He/she does not complete oxygen saturation level checks on the resident; -He/she puts the resident's oxygen back on him/her when he/she notices the resident does not have the oxygen on; -He/she looks at the resident's oxygen concentrator to make sure his/her liters of oxygen are correct when he/she places oxygen on him/her. During an interview on 01/29/25, at 12:20 P.M., the DON said if the resident's order is for three lpm of oxygen, then he/she should be on three liters. 3. During an interview on 01/29/25, at 11:35 A.M., CNA E said the following: -He/she talks to the nurse during their daily huddle if he/she needs to know which residents have oxygen and how many liters of oxygen they are on; -The nurse is responsible for making sure the residents are on the correct liters of oxygen and changing the oxygen settings; -If there is an issue or he/she notices that a resident's oxygen is not on the correct setting, he/she lets the nurse know immediately; -The resident's oxygen saturation level is checked as needed and one time every day on his/her shift. He/she does not document the resident's oxygen saturation level results, he/she reports the results to the nurse; -If a resident's oxygen saturation level is low, he/she automatically gets the nurse. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 01/31/25, at 9:40 A.M., LPN K said the following: -He/she monitors oxygen liters for each resident; -Generally, the residents are on two liters of oxygen, but some may have orders for a different number of liters; -If he/she notices a resident's oxygen is not in place, he/she replaces it. Some residents take their oxygen off or it gets removed for other reasons; -If a resident's pulse ox is low, he/she would review the electronic record to double check their oxygen order; -If he/she noticed a resident's liters of oxygen was not correct, he/she would verify the orders in their chart and change it to the correct number of liters. During an interview on 01/29/25, at 11:43 A.M., RN A said the following: -He/she knows which residents have oxygen because he/she does all the admissions; -He/she looks in the physician orders to know how many liters of oxygen the resident should be on and current oxygen settings for each resident on oxygen is communicated between staff during the shift change report; -CNA's do not have the authority to change or adjust a resident's oxygen setting; -The resident's oxygen saturation level is checked as needed; -Oxygen saturation level readings and liters of oxygen are documented in the resident's chart per physician orders; -If a resident's oxygen saturation level reading is low or abnormal and there is an order to put oxygen on the resident, they place oxygen on the resident, assess them and order a chest x-ray. Then they continue to monitor the resident; -If a resident does not want to wear his/her oxygen; then, staff documents his/her refusal in their chart; During an interview on 01/29/25, at 12:20 P.M., the DON said the following: -The facility has oxygen orders for residents in the electronic health record system; -Staff should review physician orders with a change in condition or if improvements are made; -He/she would expect staff to know how many liters of oxygen a resident is on from their orders in the chart; (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-If the CNA has a question about a resident's oxygen or the number of liters they are on, the CNA will first contact the nurse working with the resident; -Staff do walk rounds and shift reports between oncoming and outgoing staff. When a resident is on oxygen, the outgoing nurse provides a report to the oncoming nurse any change in condition; -Each resident's oxygen saturation level is checked depending on the individual resident. If the resident is on oxygen their oxygen saturation level is usually checked every shift; -The order for oxygen saturation level checks (pulse ox checks) and oxygen are on the resident's MAR; -If a resident's pulse ox is low the staff should immediately report to the nurse. The nurse should call the physician and put the resident on oxygen if ordered. During an interview on 01/29/25, at 1:00 P.M., the Administrator said the following: -Oxygen orders are in the resident's electronic record; -He/she would expect the resident's liters of oxygen to be accurate with what is ordered; -He/she would expect nursing staff and CNA's to know how many liters of oxygen a resident has ordered; -He/she would expect staff to communicate any changes in oxygen levels or liters of oxygen at shift change and as needed. MO00245504

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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 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34871 Based on observation, interview, and record review, the facility failed to provide dialysis (the cleaning of the blood with a machine due to the kidneys not working) services per professional standards of practice when the facility failed to document routine assessment and monitoring of the dialysis site and failed to document ongoing communication with the dialysis center for one resident (Resident #2) who received dialysis. The facility census was 44. Review of the facility's policy titled Dialysis Policy, dated 2025, showed the following: -Purpose to establish guidelines for nursing staff to manage and support residents undergoing dialysis, ensuring safety, infection control, and continuity of care; -Confirm dialysis treatment orders, including type of dialysis (in-center, home, bedside), frequency and duration of treatments and access site type (arteriovenous-an abnormal connection between an artery and a vein (AV)) fistula, graft, catheter); -Obtain contact information for the dialysis center or provider; -Document baseline vital signs, lab results, and current medications; -Share clinical updates, recent lab results, and medication changes with dialysis center; -Obtain the dialysis treatment schedule; -Pre-dialysis care included assess vital signs, inspect dialysis access site for signs of infection, bleeding or hematoma (bruising) and patency bruit (an audible vascular sound associated with blood flow) or thrill (indicates the fistula is working) in AV fistulas); -Post-dialysis care included monitor residents for complications including hypotension (low blood pressure), dizziness, fainting, bleeding at the access site, and fatigue or cramps; -Maintain detailed records of pre and post dialysis assessments, communication with the dialysis center, and resident's condition and any complications. 1. Review of Resident #2's face sheet (admission data) showed the following: -admitted [DATE]; -Diagnoses included end stage renal disease (ESRD - a condition in which the kidneys lose the ability to remove waste and balance fluids). Review of the resident's care plan, initiated 09/27/24, showed the following: (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The resident was at risk for infection related to receiving hemodialysis (a machine filters wastes, salts and fluid from the blood when the kidneys are no longer healthy enough to do this work adequately) three times weekly on Monday, Wednesday and Friday for treatment of chronic renal disease; -The resident had a dialysis fistula (a connection) is in his/her right upper arm; -Provide ongoing monitoring and care of the resident's vascular access and complications for hemodialysis; -Charge nurse to complete the dialysis communication form and send with the resident to the dialysis clinic to aide in communication between clinic and this facility; -Communicate any information including the resident's status with the dialysis clinic prior to and post dialysis; -Provide dialysis site care as ordered. Provide direct visual monitoring of his/her site before and after dialysis for signs of infection. Review of the resident's Minimum Data Set (MDS - a federally mandated assessment tool completed by facility staff), dated 12/24/24, showed the following information: -Moderate cognitive impairment; -Resident received dialysis; -No skin conditions or treatments. Review of the resident's January 2025 Physician Order Sheet (POS) showed an order, dated 09/30/24, for dialysis every Monday, Wednesday and Friday at 7:00 A.M. (Staff did not have an order regarding assessment of the resident's dialysis site.) Review of the resident's medical record showed staff did not have documentation of dialysis communication forms between the facility and the dialysis center. The nurses did not document follow-up contact with the dialysis center after each dialysis visit. The nurses did not document related to assessment of dialysis site. During interviews on 01/28/25, at 4:45 P.M., and on 01/29/25, at 10:34 A.M., Registered Nurse (RN) A said the following: -Nurses did not send communication forms for the resident's dialysis appointments on Monday, Wednesday and Friday; -The resident did not return from his/her dialysis appointment with a communication form; -The resident is at his/her appointment by the time he/she starts shift at 6:00 A.M.; -The dialysis center calls the facility with any abnormal problems with the appointment; (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The dialysis center sends a form back to the facility on ly when they complete labs; -He/she checked the resident's fistula for bruit/thrill unofficially and did not document; -There is no order for dialysis site assessment; -Nurses should check the resident's dialysis site to ensure everything is functioning correctly; -Staff should check the resident's dialysis site for bruit, thrills and make sure is not bleeding or infected. During an interview on 01/29/25, at approximately 1:00 P.M., the physician said he/she expected staff to check a resident's fistula if they receive dialysis. During an interview on 01/29/25, at 11:29 A.M., the Director of Nursing (DON) said the following: -Nurses assess the resident's dialysis site every shift to make sure that it is working and document on the medication administration record or treatment administration record; -Nurses should check the resident's dialysis site upon return from the appointment for bleeding; -There should be an order from physician for dialysis site assessment; -There was no order for staff to check the resident's dialysis site; -The facility had dialysis communication forms but the dialysis center never sent them back to the facility; -Staff communicate with the dialysis center via telephone. During an interview on 01/29/25, at 12:50 P.M., the Administrator said he/she expected staff to send communication forms for dialysis to and from the dialysis center. She expected staff to check the resident's fistula and document on the TAR.

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31464 Based on observation, interview, and record review, the facility failed to acknowledge, assess, provide supportive services, and to develop a care plan that showed interventions the facility staff would take to try to protect the resident and prevent trauma from recurring for one resident (Resident #1), out of 17 sampled residents, who informed staff of past trauma. The facility census was 44 residents. Review of the facility's policy entitled Trauma-Informed Care, dated 2025, showed the following: -The facility will provide trauma-informed care (TIC) that recognizes, assesses, and responds to the effects of trauma on residents; -Staff will be trained in trauma-informed care principles, focusing on psychological safety, trust, and individualized care; -The facility will integrate evidence-based interventions and coordinate with behavioral health providers when necessary; -Person-centered approaches will be used to reduce re-traumatization and support residents in their recovery; -Upon admission screen all residents for history of trauma (physical, emotional, medical, or war-related PTSD (post-traumatic stress disorder), abuse, neglect, etc.); document any signs of trauma-related distress (anxiety, aggression, withdrawal, nightmares, etc.); identify triggers or care preferences that may help avoid re-traumatization; and obtain resident and family input (when appropriate) to develop a trauma-sensitive care plan; -Ongoing monitoring included staff to observe for emotional distress, PTSD symptoms, or behavioral outbursts and document concerns in the medical record and social services and nursing will conduct quarterly assessments and update care plans accordingly; -Develop individualized care plans that incorporate resident's history and identified triggers, preferred coping strategies, staff communication preferences, and special accommodations; review care plans and update regularly based on the resident's progress and feedback; -Resident have the right to trauma-informed care that supports dignity, respect, and autonomy. 1. Review of Resident #1's face sheet (gives brief profile information) showed the following information: -admitted [DATE]; -Diagnoses included bipolar disorder (mood swings), borderline personality disorder (characterized by unstable moods, behavior, and relationships), schizophrenia (affects a person's ability to think, feel, and behave clearly), depression, anxiety, and insomnia. (continued on next page)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the resident's electronic medical record showed a hospital emergency department note, dated 11/13/24, with an indication of victim of emotional abuse and sexual abuse. Review of the resident's Social Service History & Initial Assessment, dated 11/15/24, showed the following information: -admitted from living in a hotel and homeless; -Close with parents and two siblings until both siblings sexually assaulted him/her. He/she was told it was his/her fault because he/she didn't tell them no; however he/she did not ask for it either. Review of the resident's reentry Trauma Informed Care Assessment, dated 12/17/24, showed the following information, per the resident's responses: -Experienced something unusually or especially frightening, horrible, or traumatic, but no specific triggers; -Tried hard not to think about the event(s) or went out of the way to avoid situations that reminded him/her of the event(s); -Been constantly on guard, watchful, or easily startled; -Felt numb or detached from people, activities, or surroundings; -Felt guilty or unable to stop blaming self or others for the event(s) or any problems the event(s) may have caused. Review on 01/28/25 of the resident's care plan, last updated on 01/02/25, showed the following: -Diagnoses of serious mental illness including schizophrenia, schizoaffective disorder bipolar type, generalized anxiety disorder, major depression disorder, and bipolar 1 disorder; -Address emotional issues, monitor and give medications as ordered; -History of suicidal ideations; monitor for signs/symptoms; -At risk for mood problems - allow control over situations if possible. (Staff did not document information pertaining to past identified trauma.) During an interview on 01/27/25, at 4:00 P.M., the resident said he/she had been sexually abused by his/her siblings growing up. The resident said he/she was sometimes uncomfortable with the thought of personal care being provided by a male caregiver. There was one male staff on night shift that could assist another aide with care and repositioning. During an interview on 01/31/25, at 9:08 A.M., Certified Nurse Aide (CNA) L said the resident always seemed nervous and anxious. The CNA was not aware of previous trauma or triggers for the resident. (continued on next page)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 01/31/25, at 10:59 A.M., Certified Medication Technician (CMT) J said he/she was not aware of trauma or any specific triggers for the resident. During an interview on 01/31/25, at 8:40 A.M. Registered Nurse (RN) A said he/she just found out the day before about the resident's trauma history. The RN was not sure if the trauma would go on the MDS report, but it should be put on the resident's care plan by the MDS/Care Plan Coordinator. During an interview on 01/31/25, at 9:14 A.M., the Director of Physical Therapy (PT) said he/she was not aware of resident's trauma or specific triggers. Their department is usually given that type of information. The resident does have anxiety and psychological issues, but did not know any specific diagnoses. During an interview on 01/29/25, at 6:00 P.M., the Social Services Director (SSD) said the resident told him/her during the admission process about being sexually abused by both of his/her siblings growing up. The resident said his/her family said it was his/her fault for not saying no. The SSD was unaware of any triggers for the resident related to the trauma. The SSD said he/she informs the MDS/Care Plan Coordinator if the trauma should be added to any resident's MDS report and/or care plan. During an interview on 01/31/25, at 8:50 A.M., the MDS/Care Plan Coordinator said there should be an admission assessment for trauma. The SSD would tell him/her if trauma was indicated and MDS would see that on the assessment score. The MDS/Care Plan Coordinator said the resident's addition to MDS and the Care Plan was put in process the day before. During and interview on 01/29/25, beginning at 6:00 P.M., the Director of Nursing (DON) said he/she was unaware of the resident's report of sexual abuse or of any triggers. The DON was unaware of the resident's concern regarding personal care provided by male aide. During an interview on 01/31/25, at 1:32 P.M., the Administrator said the admission process should include a PTSD/Trauma-Informed Care assessment completed by the SSD. Information pertaining to PTSD and/or triggers should be passed on to the MDS/Care Plan Coordinator for inclusion. Other staff should be told in generality regarding a resident's history of sexual abuse or trauma and triggers, if known.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 41787 Based on observation, interview, and record review, the facility failed to have a system or records that showed provided an accurate reconciliation of controlled medications when facility's licensed staff failed to ensure the Emergency Kit (E-Kit) and the form titled BNDD (Bureau of Narcotics and Dangerous Drugs) Kit Administration Record matched the current narcotic count, when a random count of the narcotics in the E-Kit with the nurse did not match. The facility census was 44. Review of the facility provided policy titled BNDD Kit Policy, dated March 2019, showed the following: -The BNDD kit is owned, managed, and controlled by the long-term care facility; -The BNDD kit will be used when extenuating circumstances exist; -When accessing/opening the BNDD kit the nurse will contact the physician to obtain an order to access the BNDD kit and an order to administer the medication; -The nurse opening the BNDD kit will fill out the form titled Missouri Emergency Kit Order/Audit Form with a witness nurse; -A physical count will be performed on each medication each time the BNDD kit is opened. The quantity on hand shall be documented for each medication listed on the Order/Audit Form; -If a medication is removed from the BNDD kit for administration to a resident that quantity shall be documented in the column QTY ORDERED. This is the quantity that the nurse is requesting that the pharmacy replenish; -If a medication is added to the BNDD kit that quantity shall be documented in the QTY REFILLED. This is the quantity the pharmacy sent as a replacement for what needs to be replaced; -Two nurses shall initial the counts on the Order/Audit form each time the BNDD kit is opened; -The tag numbers shall be documented on the bottom of the Order/Audit form; -The Order/Audit form shall be faxed to the pharmacy upon completion so that the pharmacy knows to replenish the desired medication; -When removing a dose from the BNDD kit the nurse shall document the utilization on the BNDD kit administration record; -A daily shift audit will be performed on the tag numbers and documented on the Tag Log Audit Form; -The DON and/or consultant pharmacist will perform a periodic audit of BNDD kit utilization and records; (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-An annual physical inventory will be taken on the BNDD kit; -A list of the contents of the BNDD kit shall be displayed on the outside of the container; -A soonest to expire date shall be displayed on the outside of the container. 1. During observation, record review, and interview on 01/29/25, at 2:12 P.M., Registered Nurse (RN) A said the following: -The E-Kit was currently located in the locked black medication cart near the medication room. The cart had a key for the outside of cart and a key for the locked narcotic box on the inside. They did not use lock/tag numbers. The charge nurse was the only one that had the keys to the cart. The nursing staff did not count this cart at shift change. The medications were only counted when the nurse entered to sign out a medication. There was not a two person count of this cart. When signing out a medication, the staff person counted the pills and then sign out the needed medication on the log. The count should match the previous logged out dose. The current count of the Hydrocodone (controlled medication used to treat pain) 5/325 milligrams (mg) showed 6 tablets in cart and 5 tablets on the log. The nurse stated that it should be 6 tablets on the log and he/she would make the correction in the log. He/she said someone just documented incorrectly; -Review of the record, titled BNDD Kit Administration Record, showed the following: -The three-ring binder showed seven pages for the month of January; -On 01/10/25, staff signed out one dose of Hydrocodone 5/325 mg and showed 10 on hand, 1 used, and 9 remaining; -On 01/11/25, staff signed out one dose of un-named medication, dosage 5/325 mg and showed 8 on hand, 1 used, and 7 remaining; -On 01/12/25, staff signed out one dose of Hydrocodone 5/325 mg and showed 7 on hand, 1 used, and 8 crossed out to show 6 on hand; -On 01/13/25, staff signed out one dose of Hydrocodone 5/325 mg and showed 6 on hand, 1 used, and 5 remaining; -On 01/13/25, staff signed out one dose of Hydrocodone 5/325 mg and showed 6 on hand, 1 used, with 5 remaining; -On 01/23/25, staff signed out one dose of Hydrocodone 5/325 mg and showed 9 on hand, 1 used and 8 remaining; -On 01/23/25, staff signed out one dose of Hydrocodone 5/325 mg and showed 8 on hand, 1 used and 7 remaining; -On 01/24/25, staff signed out one dose of Hydrocodone 5/325 mg and showed 7 on hand, 1 used and 6 remaining; (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-On 01/25/25, staff signed out one dose of Hydrocodone 5/325 mg and showed 6 on hand, 1 used and 5 remaining; -On 01/29/25, observation showed Hydrocodone 5/325 mg with 6 tablets in the cart and 5 tablets on the log. During an interview on 01/30/25, at 10:30 A.M., RN G said the nurses were not counting the E-Kit each shift. The nurse counted the medication at the time of need. When pulling a medication, the nurse had to look back on the log and find the last time someone used the specific medication they were checking out and then add this to the log on the next open line. During an interview on 01/30/25, at 11:45 A.M., RN A said that the Director of Nursing (DON) stocks the E-Kit cart when the medications arrived from the pharmacy. The pharmacy does not enter the E-Kit or write on the log. When the nurse opened the cart he/she wrote the amount of the specific medication he/she was checking out. There was not a full count done with two nurses at each shift or when checking out medications. The log and amount available should match. He/she fixed the log from the inaccuracy on 01/29/25. During an interview on 01/30/25, at 12:00 P.M., the DON said that the current E-Kit was temporary, and they had used this set up for less than two months. The E-Kit was the black and red medication cart located near the medication room. The narcotics were double locked in the cart. The pharmacy delivered the medications and the nurses put all the non-narcotics in the E-Kit and the DON stocked the narcotics. She did not make any note that medications were added into the log. The pharmacy told the DON to put the medications into the cart and then circle on the packing sheet if anything was missing and return the packing sheet to the pharmacy. The nursing staff did not count the E-Kit narcotics every shift, they only count the specific medication needed by themselves when checking out a narcotic. The DON reviewed the log and noted areas where the staff only wrote the strength and did not write the medication name. She said that she had asked the nurses to write the name and strength of the medication in the QTY Ordered line. She audited the E-Kit on Mondays. During an interview on 01/30/25, at 12:15 P.M., the Administrator said she was not aware of the E-Kit process but was aware that it was rocky at the time. She said the facility was in the process of transitioning. She thought they had been using the current system since December.

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F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician. 48534 Based on interview and record review, the facility failed to employ a qualified dietary manager for food and nutrition services with accredited education in food service management. The facility census was 44. Review of the facility's policy titled, Director of Food and Nutrition Services, undated, showed the following: -The Director of Food and Nutrition Services (DFNS) will be responsible for all aspects of the food and nutrition services department including, but not limited to food safety, staff safety, cost management, and meeting nutritional needs of patients/residents served; -The DFNS will be hired by corporate staff, the Administrator, or by the immediate supervisor of the position as deemed appropriate by the facility; -The DFNS will be qualified according to the position's job description and guidelines put forth by the agency that regulates the facility. A facility that does not have a full time dietitian (registered dietitian nutritionist or RDN) or clinically qualified nutrition professional must designate a person to serve as DFNS. According to the Centers for Medicare and Medicaid (CMS) services State Operations Manual for nursing homes F tag 801, the DFNS hired prior to 11/28/16 must meet the following requirement no later than five years after 11/28/16, or no later than one year after 11/12/16, for those hired or designated to that position after 11/28/16: -The DFNS must be a certified dietary manager (CDM); certified food service manager; have a similar national certification for food service management and safety from a national certifying body; or have an associate's or higher degree in food service management or in hospitality, if the course study includes food service or restaurant management from an accredited institution of higher learning; and in states that have established standards for food service managers or dietary managers, must meet state requirements for food service managers or dietary managers. During an interview on 01/31/25, at 8:59 A.M., the Dietary Manager said the following: -She started the DM position in December 2024; -She had been the DM assistant for a year; -She had two years of study and received a certificate in culinary arts from Le Cordon Bleu; -She was not a CDM and not enrolled in a training/certification course; -She was not a Certified Food Services Manager and did not have an associate's degree or higher in food service management or hospitality; -She did not have regular contact with a registered dietitian. (continued on next page)

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F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of the DM's personnel file showed the facility did not provide documentation of certification, training, or experience that met the requirements for a DFNS in a long-term care setting. During an interview on 01/31/25, at 10:44 A.M the Registered Dietician (RD) said the DM should have the serv safe certification. She did not know what the corporate policy was or how soon after hiring for the DM was to have the certification. There was a correspondence course to go through to become knowledgeable which would prepare the DM to take the certified dietary manager exam. During an interview on 01/31/25, at 11:24 A.M., the Administrator said the following: -The DM is the Director of Food Services; -The DM had a degree in culinary arts; however the facility did not have a copy of it; -The DM was taking the safe serve class and test that day; -The Administrator thought the DM had the required qualifications.

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service. 48534 Based on observation, interview, and record review, facility staff failed to ensure dietary staff had the appropriate competencies and skills to safely and effectively carry out the functions of food and nutrition services. The facility census was 44. Review showed the facility did not provide a policy regarding new employee training. 1. Review showed the facility did not provide completed training documents or skills test for the current kitchen staff. During an interview on 01/29/25, at 2:25 P.M., Dietary Aide (DA) P said the following: -DA P started in the kitchen on 01/24/25; -DA P was still in training and the Dietary Manager (DM) had not gone over any kitchen policies with him/her; -DA P did not feel that he/she had enough training to be serving lunch to residents ,but was told to do so. During an interview on 01/29/25, at 3:00 P.M., [NAME] O said the following: -Cook O started in the kitchen on 12/12/24; -The DM had not gone over facility policy with him/her; -The DM had not trained [NAME] O on facility policy and procedures; -The DM had not provided training to [NAME] O on the puree process. During an interview on 01/29/25, at 3:27 P.M., the DM said the following: -He/she started in the kitchen on 08/30/23; -None of the kitchen staff were safe serve certified including the DM; -New employees had one week of training before working on their own; -The DM had no orientation or training checklist for new kitchen staff; -The DM had no skills competency checks for kitchen staff; -The DM had no document showing staff had been trained; (continued on next page)

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-The DM was not aware of any kitchen policies and procedures that the facility had; -The DM was not familiar with Centers for Medicaid and Medicare Services (CMS) dietary regulations; -DA P did not have enough training before being told to serve lunch; -DA N did not have enough training to puree food items without supervision; -Cook O had previous knowledge and experience and had adequate training; -The DM had provided sporadic in-services with kitchen staff. During an interview on 01/31/25, at 11:24 A.M., the Administrator said the following: -The kitchen staff have not had adequate training; -The DM is responsible for training the kitchen staff; -The DM should complete skills testing with all kitchen staff; -The DM should have gone over kitchen policy and procedures with new staff; -The Administrator did not review kitchen staff training, observe meal prep, or observe a meal serve out.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48534 Based on observation, interview, and record review, the facility failed store, prepare, distribute, and serve food in accordance with professional standards when staff failed to use effective hair restraints; failed to remove dented cans from use; failed to consistently label and date food; failed to ensure the dishwasher machine sanitation was at the appropriate level; failed to keep trash covered when not in use; failed to wash hands and equipment appropriately during food prep and service; and when staff failed to ensure non-food contact surfaces were clean and maintained in good repair. The facility census was 44. 1. Review of the Food and Drug Administration (FDA) 2022 Food Code showed food employees shall wear hair restraints such as hats, hair coverings or nets, beard restraints, and clothing that covers body hair, that are designed and worn to effectively keep their hair from contacting exposed food; clean equipment, utensils, and linens; and unwrapped single-service and single-use articles. Review of the facility's policy titled, Food Safety and Sanitation, not dated, showed the following: -Employees are required to have their hair styled so that it does not touch the collar; -Hair restraints are required and should cover all hair on the head; -Beard nets are required when facial hair is visible. Observations on [DATE], at 3:15 P.M., and on [DATE], at 3:03 P.M., of the kitchen staff showed [NAME] O had facial hair and did not wear a beard restraint. Observation on [DATE], at 10:21 A.M., of the kitchen staff showed [NAME] M had facial hair and was not wearing a beard restraint. Observation on [DATE], at 10:25 A.M., and on [DATE], at 11:53 A.M., showed Dietary Aide (DA) N had facial hair and was not wearing a beard restraint. During an interview on [DATE] at 2:25 P.M., DA P said the following: -All kitchen staff were responsible for putting food in the refrigerator and freezer; -Food was to be labeled with what it was and the date it was put in the refrigerator or freezer; -DA P did not know how long left over items can be stored in the refrigerator; -DA P said serving food out of dented cans could make the residents sick; -Resident food is stored in the facility walk in refrigerator and should be labeled and dated; (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-A hair/beard net must be worn anytime staff were in the kitchen or around food. During an interview on [DATE], at 3:00 P.M., [NAME] O said a hair and beard net should be worn at all times while in the kitchen or serving food. During an interview on [DATE], at 2:10 P.M., DA N said hair and beard nets were to be worn while preparing and serving meals. During an interview on [DATE], at 10:44 A.M., the Registered Dietician (RD) said staff should wear a beard guard if they have a beard. If staff did not have a beard guard, staff can wear a hair net over the beard. During an interview on [DATE], at 3:27 P.M., the DM said hair nets and beard nets were to be worn when in the kitchen. During an interview on [DATE], at 11:24 A.M., the Administrator said kitchen staff were required to wear hair nets and beard nets at all times while in the kitchen and serving food. 2. Review of the FDA 2022 Food Codes showed the following: -Damaged or incorrectly applied packaging may allow the entry of bacteria or other contaminants into the contained food; -If the integrity of the packaging has been compromised contaminants may find their way into the food. -Close inspection of cans for imperfections or damage may reveal punctures or seam defects; -Suspect cans must be returned. Review of the facility's policy titled, Food Safety and Sanitation, not dated, showed bulging or leaking cans, cans with severe dents on the seams, or broken containers of food will not be used. Observations on [DATE], at 3:15 P.M., [DATE], at 3:03 P.M., and on [DATE], at 10:20 A.M. of the of the dry food storage area showed the following: -One dented 6 pound (lb) can of diced peaches; -One dented 6 lb can of sausage gravy; -One dented 6 lb can of kidney beans; -One dented 7 lb can of pork and beans; -One dented 6 lb can of mandarin oranges. During an interview on [DATE], at 2:25 P.M., DA P said serving food out of dented cans could make the residents sick. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on [DATE], at 11:24 A.M., the Administrator said dented cans should not be used and were to be returned to the distributor. 3. Review of the facility's policy titled, Food Safety and Sanitation, not dated, showed the following: -All time and temperature control for safety (TCS) foods (including leftovers) should be labeled, covered, and dated when stored; -When a food package is opened, the food item should be marked to indicate the open date. This date is used to determine when to discard the food; -Leftovers are used within 72 hours (or discarded); -Perishable foods with expiration dates are used prior to the use by date on the package. Observations on [DATE], at 3:52 P.M., of the walk-in refrigerator showed the following: -One food tray containing 12 uncovered condiment containers with a red substance in them. A piece of tape on the food tray read, ,d+[DATE], Italian, Ranch, French; -One 3-quart deep clear food pan that contained lettuce, covered with aluminum foil that had a dried yellow/orange substance on it, with no date or label; -One 2-gallon plastic bag that contained approximately 25 baked potatoes with cheese that was not dated or labeled; -One ,d+[DATE] gallon of whole milk with a best by date of [DATE], labeled activities and dated [DATE]; -One large pizza box containing four slices of pizza, not dated; -Two sandwich size plastic bags containing cubed cheese, not dated or labeled; -Two clear condiment containers with a white substance in them not dated or labeled. Observation on [DATE], at 3:03 P.M., of the walk-in refrigerator showed the following: -One gallon size plastic bag containing 3 pieces of pizza with a residents name on it and no date; -Two sandwich size plastic bags containing cubed cheese not dated or labeled; -Two clear condiment containers with a white substance in them not dated or labeled. Observation on [DATE], at 10:25 A.M., of the walk-in refrigerator showed the following: -One gallon size plastic bag containing 3 pieces of pizza with a resident's name on it and no date; (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-One sandwich size plastic bag containing cubed cheese not dated or labeled; -Two clear condiment containers with a white substance in them not dated or labeled;. During an interview on [DATE], at 2:25 P.M., DA P said the following: -All kitchen staff were responsible for putting food in the refrigerator and freezer; -Food was to be labeled with what it was and the date it was put in the refrigerator or freezer; -DA P did not know how long left over items can be stored in the refrigerator; -Resident food is stored in the facility walk-in refrigerator and should be labeled and dated. During an interview on [DATE], at 2:10 P.M., DA N said the following: -Kitchen staff are responsible for putting food in the refrigerator, labeling it and dating it; -Leftovers can stay in the fridge for two days after being made. During an interview on [DATE], at 3:00 P.M., [NAME] O said the following: -Kitchen staff were responsible for putting food in refrigerator, including resident food; -Items were to be labeled and dated before being put in refrigerator; -Leftovers could stay in the refrigerator for up to three days; -Resident food is also stored in the walk-in refrigerator and should be dated and labeled. During an interview on [DATE], at 10:44 A.M., the Registered Dietician (RD) said staff should label and date foods with date of delivery otherwise they cannot do the first in and first out. Staff should date the date food in the cold storage and date marked for seven days out. During an interview on [DATE] at 3:27 P.M., the DM said the following: -All kitchen staff are responsible for putting food in the refrigerator; -All items should be labeled with what it is and dated with the day it goes into the refrigerator; -Resident food is kept in the facility refrigerator and should be labeled with residents name and dated; -The activities director also stored food in the refrigerator and those items need to be dated and labeled; -The DM checked the refrigerator daily for items not dated/labeled and expired items. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on [DATE], at 11:24 A.M., the Administrator said all items in the refrigerator and freezer should be labeled with what it is and dated. Resident food were to be labeled and dated prior to going into the refrigerator. Staff should pull items out of the refrigerator that had passed their used by date. 4. Review of the FDA 2022 Food Code showed the presence of adequate detergents and sanitizers is necessary to effect clean and sanitized utensils and equipment. Review of the facility's policy titled, Resource: Sanitation of Dishes/Dish Machine, not dated, showed the final sanitization for low temperature dishwasher, spray type dish machines using chemicals to sanitize should test at 50 parts per million (ppm) hypochlorite (a strong chlorine solution used for disinfecting and sanitizing). Review of the facility's policy titled, Cleaning Dishes/Dish Machine, not dated, showed the following: -All flatware, serving dishes, and cookware will be cleaned, rinsed, and sanitized after each use. The dish machines will be checked prior to meals to assure proper functioning and appropriate temperatures for cleaning and sanitizing. Observations on [DATE], at 3:16 P.M., on [DATE], at 3:04 P.M., and on [DATE], at 10:21 A.M., of the kitchen showed several 12 ounce plastic, shatterproof, stackable, drinking cups drying on a dish rack and stacked on serving cart with white powdery residue on the outside and inside. The white powdery residue could be scratched off with a butter knife. Observations [DATE], at 5:06 P.M., on [DATE], at 1:15 P.M., and on [DATE], at 1:45 P.M., showed a table in the dining room that had pitchers of flavored drinks and a pot of coffee along with three trays that held 12, 8-ounce brown coffee mugs each. The coffee mugs had a white powdery residue on the inside of them and a buildup of white powdery residue on the bottom of the cups. This residue could be scratched off using an eating utensil. Observations on [DATE] ,at 3:06 P.M., on [DATE], at 10:38 A.M., and on [DATE], at 11:04 A.M., of the kitchen showed one blue plastic basket containing adaptive eating utensils sitting on a wire rack next to the dishwasher that contained three black handle knives with debris on the blades and one gray handle knife with debris on handle. During an interview on [DATE], at 2:25 P.M., DA P said the drinking cups were ran through the dishwasher 3 or 4 times and still have a residue on them. He/she did not know what caused the white powdery residue on the drinking cups. During an interview on [DATE], at 2:10 P.M., DA N said he/she did not know what caused the white powdery residue on the drinking cups. During an interview on [DATE], at 3:27 P.M., the DM said the following: -All kitchen staff were responsible for washing dishes; (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-Staff should check all items that came out of dishwasher to ensure the items are clean and free of debris; -The white powdery residue on the drinking cups was from hard water and not harmful to the residents. During an interview on [DATE], at 9:22 A.M., [NAME] M and DA N said the following: -Cook M and DA N did not know how to test the sanitizer in the dishwasher; -Cook M and DA N did not know who was responsible for testing them; -Cook M used a PH test strip to test the sanitizer in the dishwasher; -The PH test strip turned yellow in color when placed in the dishwasher water; -When the test strip was compared to the reference chart on the bottle of test stripes the color yellow read 0; -Cook M and DA N did not know what the reading meant. During an interview on [DATE], at 1:52 P.M., [NAME] O said the following: -Cook O did not know how to test the sanitizer in the dishwasher; -Cook O did not know who was responsible for testing the sanitizer; -Cook O used a PH test strip to test the sanitizer in the dishwasher; -The PH test strip turned yellow in color when placed in the dishwasher water; -When the test strip was compared to the reference chart on the bottle of test stripes the color yellow read zero (0); -Cook O did not know what the reading meant. During an interview on [DATE], at 1:56 P.M., the DM said the following: -The DM checked the chemicals on the dishwasher every morning; -The DM used a chlorine test strip to test the sanitizer on the low temperature dishwasher; -The chlorine test strip of the sanitizer on the low temperature dishwasher showed 200 PPM; -The DM did not know the manufactures recommendation for the strength of the sanitizer; -The DM did not keep a log of the test; (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-The cooks had been trained on how to test the chemicals in the dishwasher; -The cooks should be testing the chemicals on the dishwasher when the DM is not available. During an interview on [DATE], at 10:44 A.M., the RD said the sanitization is not correct if dishes have a white film. The low temperature sanitization dish machine sanitation should be 50 to 100 ppm. Staff should contact the company who services the machine and they need to turn it down. During an interview on [DATE], at 11:24 A.M., the Administrator said the following: -The white powdery residue on the drinking cups and coffee cups was from hard water and did not believe it was harmful to the residents; -The sanitizer strength on the dishwasher should meet the manufactures recommendation. 5. Observation on [DATE], at 3:06 P.M., on [DATE], at 10:38 A.M., and on [DATE], at 11:04 A.M., of the kitchen showed the following: -One 32-gallon gray trash can containing trash uncovered; -One black two-shelf bussing cart with an attached trash bin that contained trash, sitting next to dishwasher in kitchen not covered; -One white, round trash can with step on pedal that contained trash sitting open next to stove; -The trash cans were not in use. During an interview on [DATE], at 10:44 A.M., the RD said she expected the trash cans covered when not in use. 6. Review of the FDA 2022 Food Code showed food employees shall keep their hands and exposed portions of their arms clean. Review of the facility's policy titled, Hand Washing, not dated, showed the following: -Employees will wash hands as frequently as needed throughout the day using proper hand washing procedures; -Hands and exposed portions of arms should be washed immediately before engaging in food preparation; -Wash hands when entering the kitchen at the start of shift, after touching bare human body parts other than clean hands and clean, exposed portions of arms, during food preparation, as often as necessary to remove soil or contamination and to prevent cross contamination when changing tasks, when switching between working with raw food and working with ready to eat food, before donning disposable gloves for working with food and after gloves are removed, and after engaging in other activities that contaminate the hands. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of the facility's policy titled, Employee Sanitary Practices, not dated, showed the following: -All food and nutrition services employees will practice good personal hygiene and safe food handling procedures; -Wash hands before handling food; -Gloves must be worn if raw food is handled; -Clean and sanitize equipment and work areas after use; -Use clean hands, pick flatware ad cups up by their handles, pick dishes up by their [NAME], and pick glasses up by their base. Observation on [DATE], at 10:26 A.M., of [NAME] M showed the following: -Cook M went outside to get food item out of walk-in freezer; -Cook M re-entered the kitchen and did not wash his/her hands; -Cook M used the sprayer at the dishwasher and filled a pot with water; -Cook M placed the pot of water on the stove and put a smaller empty pot in the pot of water; -Cook M with ungloved hands put his hand in the second pot touching the bottom of the pot; -Cook M used the can opener to open four cans of tomato soup; -Cook M used his/her right hand to open the trash can next to the stove and left trash can open; -Cook M donned one glove on his/her right hand and poured the four cans of tomato soup in the empty pot on the stove; -Cook M doffed the glove on his/her right hand and put in open trash can; -Cook M went outside to get a food item out of the walk-in refrigerator and re-entered the kitchen and did not wash his/her hands. Observation on [DATE], at 10:41 A.M., of the DM showed the following: -The DM went outside to get a food item out of the walk-in refrigerator, re-entered the kitchen and did not wash his/her hands or don gloves; -The DM opened a stick of butter, put the butter in a bowl to be melted and set it next to microwave; -The DM did not wash his/her hands or don gloves during this process. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Observation on [DATE], at 11:34 A.M., of the puree process showed the following: -DA N gathered the blender bowl, blade, lid and serving spoon to puree food items; -DA N did not wash his/her hands; -DA N placed sweet potatoes in blender bowl, pureed potatoes then poured into metal pan; -DA N removed blender bowl, blade, and lid and sprayed them with hot water to remove food debris, then attached the pieces to the blender. The cook did not use soap or sanitize the equipment; -DA N did not wash his/her hands or don gloves; -DA N took the pan of pureed potatoes out of the kitchen to the serving area, placed on steam table, covered with lid, returned to the kitchen, cook did not wash his/her hands; -DA N went outside to get ham out of walk-in freezer, re-entered the kitchen and did not wash his/her hands; -DA N donned oven mitts to pour beans from pot to metal pan. [NAME] doffed the oven mitts and did not wash his/her hands; -DA N poured diced ham in to pan of beans; -DA N took pan of ham and beans to the serving area and placed on the steam table; -DA N re-entered the kitchen doffed his/her gloves and did not wash his/her hands; -DA N placed ham and beans in the wet blender bowl, pureed ham and beans then poured into metal pan; -DA N removed blender bowl, blade, and lid and sprayed them with hot water to remove food debris, then attached the pieces to the blender. The cook did not use soap or sanitize the equipment; -DA N obtained a large black handled knife from the blue plastic basket containing adaptive eating utensils. The knife had food debris on the blade and was not clean; -DA N donned gloves, picked up the knife and started to make a cut in the pan of cornbread; -DA N took the knife and two other knives from the basket to the dishwasher; -DA N used his/her gloved hands to place three pieces of cornbread, into the wet blender bowl, pureed cornbread then poured into metal pan; -DA N doffed gloves and did not wash hands. Observation on [DATE], at 11:30 A.M., of the puree process showed the following: (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-Cook M donned gloves, sprayed a metal pan with nonstick spray, used his/her gloved hands to pick up three chicken patties, ground chicken to mechanical soft then poured in metal pan; -Cook M removed blender bowl, blade, and lid and sprayed them with hot water to remove food debris, then attached the pieces to the blender. The cook did not use soap or sanitize the equipment; -Cook M put hot water from the coffee maker in the blender bowl, used his/her gloved hands to pick up four chicken patties and place in the blender bowl; -During the puree process cook M opened the blender, used his/her gloved hands to pull out three chicken patties and tear into smaller pieces and placed back in blender, pureed chicken then poured in metal pan; -Cook M performed this task while wearing the same gloves that he/she donned at the beginning of the task. Observation on [DATE] at 12:09 P.M., of lunch preparation showed the following: -Cook M donned gloves, went out of the kitchen to the steamtable, picked up two tomatoes, held them in the air while walking back into the kitchen, placed them on a plate, unwrapped plastic used to cover sliced cheese, took out two slices of cheese placed them on a plate, then opened container of jelly and a container of peanut butter; -Cook M obtained another knife, using one knife to spread jelly on a piece of bread, then using a separate knife to spread peanut butter on a piece of bread; -Cook M then doffed his/her gloves. Observation on [DATE], at 12:22 P.M., of the lunch serve out showed the following: -DA N washed hands and donned gloves; -DA N went from serving food with serving utensils, opened a bag of hamburger buns, using his/her hands retrieved one hamburger bun, and placed it on plate, then used tongs and placed chicken patty on bun; -DA N picked up resident menu card, then sent menu card along with plate to be served to resident; -DA N did not remove his/her gloves or wash his/her hands. -DA N returned to serving food with serving utensils; -DA N using his/her hands retrieved one hamburger bun, and placed it on plate, then used tongs and placed chicken patty on bun; -DA N retrieved a package of sliced cheese from the kitchen, unwrapped the cheese, using his/her hands retrieved one slice of cheese and placed it on a chicken patty; (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-DA N picked up resident menu card, then sent menu card along with plate to be served to resident; -DA N did not remove his/her gloves or wash his/her hands. -DA N repeated this process four times; -Cook N did not doff his/her gloves during the lunch serve out process. During an interview on [DATE], at 2:25 P.M., with DA P said the following: -The staff were to wash hands before and after touching food, doing dishes, before and after serving food, entering the kitchen, and putting on a hair net; -DA P said gloves should be worn when food is being touched. During an interview on [DATE], at 2:10 P.M., DA N said the following: -Hands were to be washed after touching any surface; -DA N looked over items coming out of the dishwasher to ensure they were clean; -Dishes are sanitized when they are run through the dishwasher; -The blender bowl, blade and lid should be run thru the dishwasher between each item and dried before next use During an interview on [DATE], at 3:00 P.M., [NAME] O said the following: -Staff should wash hands as often as possible, after touching doorknobs, when entering the kitchen, and when handling food or trash; -When using the blender bowl to puree food items it should be ran through the dishwasher between each use and set out to air dry; -Cook O has had to dry the blender bowl with a towel during meals if the blender bowl was needed. During an interview on [DATE], at 10:44 A.M., the RD said the following: -Staff should wash hands before starting a meal service and if staff stay on the serving line only touch the scoops. Staff should wash hands when change gloves and if they leave the serving line or go to the storage room, staff should wash hands before they come back to serve a meals; -She expects dietary staff to know policies for hand hygiene and sanitation. During an interview on [DATE], at 3:27 P.M., the DM said the following: -Hand hygiene should be performed every time staff enter the kitchen, touch any food item, trash cans, doors, and tables; (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-All kitchen staff were responsible for washing dishes; -The blender bowl, blade, and lid should be run through the dishwasher after each use to be cleaned and sanitized; -The blender bowl, blade, and lid should be air dried between each use. During an interview on [DATE], at 11:24 A.M., the Administrator said the following: -Kitchen staff were to wash hands every time staff entered the kitchen, when hands were soiled, before food preparation, before and after glove use and after touching contaminated surfaces; -Kitchen staff were to run the blender bowl through the dishwasher to be cleaned, sanitized and air dried between each use; -Food should not be put in a wet blender bowl; -Kitchen staff were to check all items coming out of the dishwasher for cleanliness and to ensure the items are free of debris. 7. Review of the facility's Daily Cleaning Schedule,, dated 2004, showed the following: -Clean outside and inside of microwave - dietary aide; -Clean food processor after each use and under the unit - day and evening cook; -Clean trash cans - evening aide. Review of the facility's Weekly Cleaning Schedule, dated 2004, showed staff were to clean inside of walk-ins, including fans and racks. Review of the facility's Monthly Cleaning Schedule, dated 2004, showed staff were to clean overhead pipes. Review of the facility's Deep Cleaning the Kitchen, to be done every March, June, September and December, undated, showed the following: -Wipe down all ceilings; -Clean all light fixtures, vent covers, and fan covers; -Clean all appliance and containers inside and out, even the appliances not used and cover with a fresh bag; -Clean all trash cans inside and out; -Check all dishes for cracks, scratches, or blemishes and report to the administrator the findings. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Observations on [DATE], at 3:16 P.M., on [DATE], at 3:04 P.M., and on [DATE], at 10:21 A.M., of the kitchen showed the following: -A 6-inch area of peeling paint on the ceiling around the round vent above the food preparation table: -A 4-inch area of peeling paint on the ceiling around the round vent above the 5-shelf rack at the end of the prep table; -A round vent on the ceiling to the left of the range hood that was partially hanging off the ceiling and the area around the vent was yellow in color; -A square, white, steel vent cover partially hanging off the ceiling above the commercial coffee and tea maker; -The microwave in the kitchen had a two-inch area on the top, a 3-inch area on the bottom around the edge where the door seals and a 2-inch area under the turn table ring where paint had peeled off. Under the peeled paint in the microwave the surface was brown and orange in color and appeared to be rust. Observations on [DATE], at 3:52 P.M., on [DATE], at 3:03 P.M., and on [DATE], at 10:25 A.M., of the walk-in refrigerator showed dust and dirt build up on the white PVC pipes and the black cables coming from the cooler fans. The PVC pipe was directly over an opened box containing individual cartons of [NAME] Ready Care chocolate shakes. During an interview on [DATE], at 2:25 P.M., DA P said he/she was not aware of any cleaning list/schedule. DA P had been cleaning what the DM told him/her to clean. During an interview on [DATE], at 2:10 P.M., DA N said he/she was not aware of a cleaning schedule. He/she cleaned what the DM tells him/her to clean. During an interview on [DATE], at 3:00 P.M., [NAME] O said the DM tells him/her what he/she is responsible for cleaning. The DA's have a cleaning schedule. He/she was not aware of any cleaning list/schedule for the cooks. During an interview on [DATE], at 3:27 P.M., the DM said the following: -Kitchen staff had daily, weekly, monthly, and quarterly cleaning schedules; -The DM assigns cleaning jobs to staff weekly. During an interview on [DATE], at 11:24 P.M., the Administrator said the following: -There should not be peeling paint on the ceiling in the kitchen; -The vents should not be hanging off the ceiling in the kitchen; (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-The fans and pipe in the walk-in refrigerator and freezer should be cleaned on a regular basis and be free from dust and debris; -The microwave in the kitchen was to be free of peeling paint and rust; -Peeling paint, rust, debris, and dust could contaminate food which, when served to residents could cause residents to become ill; -Kitchen staff were to be following the daily, weekly, monthly and quarterly cleaning list for the kitchen; -All repairs should be logged in the maintenance book so maintenance staff were aware of the issue and can make necessary repairs. 34871

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Administer the facility in a manner that enables it to use its resources effectively and efficiently. 34871 Based on observation, interview, and record review, the facility failed to ensure the home was administered in an effective and efficient manner to ensure the highest practical well-being of all residents when the facility failed pay their bills in a timely manner. The facility census was 44. 1. Review of the facility's laboratory service invoices showed the following: -An invoice, dated 07/08/24, showed an amount owed of $2664.31. The invoice showed a note of terms of net 30 days; -An invoice, dated 08/08/24, showed an amount owed of $241.41. The invoice showed a note of terms of net 30 days; -An invoice, dated 09/05/24, showed an amount owed of $3466.70. The invoice showed a note of terms of net 30 days; -An invoice, dated 10/28/24, showed an amount owed of $2880.47. The invoice showed a note of terms of net 30 days. Review of the laboratory's accounts receivable (A/R) aging detail spreadsheet which listed the invoices showed the following: -An invoice, dated 07/08/24 with a due date of 08/07/24. The invoice total and open balance due were $2664. 31; -An invoice, dated 08/08/24 with a due date of 10/07/24. The invoice total and open balance due were $241. 41; -An invoice, dated 09/05/24 with a due date of 10/05/24. The invoice total and open balance due were $3466. 70. Review of the facility check dated 11/25/24, paid to the laboratory showed an amount of $10,918.42. Review of the laboratory's accounts receivable (A/R) aging detail spreadsheet which listed the invoices showed an invoice, dated 10/28/24 with a due date of 11/27/24. The invoice total and open balance due were $2880.47. During an interview on 01/29/25 at 2:58 P.M., the Business Office Manager (BOM) said he/she had received invoices from the company that had not been paid. The company provides laundry soap and kitchen and housekeeping chemicals. He/she and corporate staff received invoices from the providers usually through email. He/she reviewed the invoices to make sure they were correct and emailed them to the billing system which are approved by the regional manager to be paid. He/she did not know the process from there. (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 01/30/25, at 2:03 P.M., the Director of Fiscal Services said the facility paid the bill on 11/25/24. She did not know why it was late. The company provided chemicals for the dishwasher and laundry. During an interview on 01/31/25, at 10:09 A.M., the Laboratory Company Representative said his/her company provided the dishwashing detergent and sanitizers for the kitchen dishwasher and laundry and housekeeping chemicals to the facility. The facility did not show the bill paid up and had not paid the bill since July 2024. During an interview on 01/30/25, at 1:32 P.M., and 01/31/25, at 1:33 P.M., the Administrator said she did not know of the laboratory bill being late. The BOM is responsible to submit the bills to the corporate staff. She expected the facility bills to be paid. MO00246960

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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** 41787 Based on observation, interview, and record review, the facility failed to use appropriate infection control procedures to prevent the spread of bacteria or other infectious causing contaminants when staff failed to use appropriate hand hygiene after personal cares for two residents (Residents #11 and #8), during and after wound care for one resident (Resident #34), and during and after feeding tube care for one resident (Resident #149). Staff also failed to follow Enhanced Barrier Precautions (EBP) for one resident (Resident #44) who had an indwelling catheter and failed to follow their Legionella (severe form of pneumonia) Water Management Program. The facility census was 44. Review of the facility policy titled Hand Hygiene Policy and Procedure, dated 2025, showed the following: -Purpose to establish clear and standardized hand hygiene practices for all staff to prevent the spread of infections, maintain a safe environment. This policy includes specific hand hygiene practices related to peri-care to minimize the risk of urinary tract infections (UTI - bacterial infection in the urinary tract), and other infections; -This policy applies to all facility staff, including nurses, CNAs, therapists, dietary staff, housekeeping, and any personnel with direct or indirect resident contact; -All staff must perform hand hygiene correctly and consistently before, during, and after resident care activities, including peri-care, to prevent the transmission of infections; -Staff must perform hand hygiene before and after direct contact with a resident; before performing an aseptic task (e.g., wound care, catheter care); after contact with blood, body fluids, secretions, excretions, or contaminated surfaces; before and after wearing gloves; after using the restroom; before and after eating or handling food; after coughing, sneezing, or touching the face; after contact with a resident's environment (bed rails, bedside tables, medical equipment); and before and after performing peri-care; -Use alcohol-based hand rub (ABHR) with at least 60% alcohol when hands are not visibly soiled; -Use soap and water when hands are visibly soiled (e.g., dirt, blood, body fluids), after using the restroom, after caring for a resident with Clostridium difficile (C. diff - a bacteria that can cause inflammation of the colon) or Norovirus (highly contagious virus that causes gastroenteritis, or inflammation of the stomach and intestines); -Peri-care is a high-risk procedure requiring strict adherence to hand hygiene to prevent urinary tract infections (UTI's) and infections; -Before peri-care perform hand hygiene and put on gloves before providing care; -After peri-care remove gloves without touching contaminated surfaces and perform hand hygiene immediately after glove removal; (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-Gloves do not replace hand hygiene; -Perform hand hygiene before putting on gloves and immediately after removing them; -Change gloves when moving from a dirty to a clean task, when gloves become damaged or visibly contaminated, and when switching between different body areas (e.g., from peri-care to face washing). 1. Review of the facility policy titled Perineal Care, dated October 2010, showed the following: -The purpose of the procedure was to provide cleanliness and comfort to the resident, to prevent infections and skin irritation, and to observe the resident's skin condition; -Assemble the equipment and supplies as needed; -Place the equipment on the bedside stand and arrange the supplies so they can be easily reached; -Wash and dry your hands thoroughly; -Put on gloves; -Wash perineal area, wiping from front to back; -Gently rinse and dry the area; -Continue to wash the perineum moving from inside outward to and including thighs, alternating from side to side, and using downward strokes; -Do not reuse the same washcloth or water; -Rinse perineum thoroughly in same direction, using fresh water and a clean washcloth; -Gently dry perineum; -Assist the resident to turn on his/her side; -Wash the rectal area thoroughly; -Do not reuse the same washcloth or water; -Rinse thoroughly; -Dry area thoroughly; -Discard disposable items into designated containers; -Remove gloves and discard into designated container; -Wash and dry your hands thoroughly; (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-Reposition the bed covers; -Make the resident comfortable; -Place the call light within easy reach of the resident; -Clean the bedside stand; -Wash and dry hands thoroughly. 2. Review of Resident #11's face sheet (brief information sheet about the resident) showed the following: -admitted [DATE]; -Diagnoses included quadriplegia (partial or complete paralysis of both the arms and legs especially as a result of spinal cord injury or disease in the region of the neck), degenerative disorders of nervous system (group of conditions that affect the nervous system, causing progressive deterioration and loss of function over time), and inclusion body myositis (a rare, chronic, and progressive muscle disease characterized by inflammation and muscle weakness). Review of the resident's significant change in condition Minimum Data Set (MDS - a federally mandated assessment instrument completed by facility staff), dated 12/30/24, showed the following: -Cognitively intact; -Required use of motorized wheelchair; -Impairment on both sides of upper extremity and lower extremity; -Dependent on staff for oral hygiene, toileting hygiene, shower, dressing, and personal hygiene; -Dependent on staff for mobility and transfers. Review of the resident's care plan, last updated on 01/06/25, showed the following: -Resident had activities of daily living functional problems as evidenced by need for dependence on staff assistance due to diagnosis; -Resident required staff assistance for oral hygiene, toileting hygiene, shower, upper and lower body dressing, personal hygiene, chair to bed transfers, shower transfers and wheelchair mobility; -Resident had an indwelling catheter related to diagnosis; -Staff should complete catheter care appropriately; -Staff should provide catheter care per facility protocol and physician's orders; (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-Resident was at risk for increased probability of Infections; -Staff should clean hands before entering room, before donning gloves, between tasks as appropriate, and when leaving the room; -Staff should wear glove for high-contact care and wound care. Observations on 01/27/25, at 3:36 P.M., showed the following: -Certified Nurse Aide (CNA) H and CNA I used hand sanitizer and applied gown, gloves, and masks before entering the resident's room; -The staff entered the resident's room with the Hoyer lift (medical device that helps caregivers move patients who have limited mobility); -The resident was seated in his/her motorized wheelchair; -CNA H removed the resident's blanket and the seatbelt; -CNA H pulled the resident's upper body forward; -CNA I put the Hoyer lift pad behind residents back; -The staff hooked the lift pad to the lift and transferred the resident to the bed; -CNA H pulled the residents pants down; -CNA I went to the cabinet and picked up a clean brief; -CNA H removed the tape and opened the brief; -CNA I handed the container of wet wipes to CNA H; -CNA H used two wet wipes and cleaned peri-area and catheter (a tube that is inserted into the bladder, allowing your urine to drain freely) tubing; -Without removing gloves or using hand sanitizer, the aide rolled the resident to his/her left side; -The staff used a wet wipe and cleaned soiled buttock; -The staff pulled the soiled brief out and put in the trash; -The staff continued wiping the buttocks; - Without removing gloves or using hand sanitizer, the staff applied the clean brief; -The staff rolled the resident to his/her right side; (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Big Spring Care Center for Rehab and Healthcare	202 East Mill Street Humansville, MO 65674

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-CNA I pulled the clean brief through and rolled resident to back side; -CNA H applied fungal powder to the private area and taped brief; -With the same gloved hands, the staff rolled the resident to left side and pull up pants, then rolled to the right side and pulled pants; -The staff rolled the resident to his/her back and attached the lift pad to the Hoyer lift and transferred the resident back to wheelchair; -Without changing gloves or cleaning hands CNA H pulled the resident's upper body forward for CNA I to remove lift pad; -CNA H re-attached the resident's seatbelt and covered the resident with the blanket; -The staff picked up trash and soil linens, removed gown and gloves and washed hands at sink and left the room. 3. Review of Resident #8's face sheet (gives basic profile information) showed the following information: -admitted [DATE]; -Diagnoses included atrial fibrillation (abnormal heartbeat), hyperlipidemia (high cholesterol), chronic kidney disease, and edema (swelling). Review of the resident's care plan, dated 10/01/24, showed the resident was at risk for increased probability of infections. Review of the resident's quarterly MDS, dated [DATE], showed the following: -Cognitively intact; -Dependent on staff for toileting hygiene, personal hygiene, dressing, shower, bed mobility. Observation on 01/28/25, at 1:35 P.M., showed the following: -CNA H and CNA I used hand sanitizer at door, applied gown, mask, and gloves and entered the resident's room; -The staff pulled the covers back from resident; -Rolled the resident to his/her left side and put the bed pan with brief under the resident; -Rolled the resident to his/her back and pulled the covers over the resident; -Pulled the residents privacy curtain and waited on the opposite of room; (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-While waiting CNA H pushed down soiled gowns in red bag container and noted he/she would remove the box when completed with cares; -He/she did not change gloves or use hand sanitizer; -The resident notified he/she was ready for staff to clean up; -Staff returned to resident's bed side and pulled down resident covers; -CNA H took a wet wipe and cleaned the front private area; -When putting wipe in the trash, he/she saw some bowel movement (BM) smear on his/her glove on the right hand; -He/she picked up another wet wipe with left gloved hand and wiped front area with his/her right hand; -He/she pushed the wet wipes and brief between the resident legs; -Using the interior side of his/her right glove hand touching the resident's outer thigh (with BM on opposite side of glove) and using his/her gloved left hand assisted the resident to roll to left side; -He/she then folded the soiled brief together and pulled from under resident and put into the trash bag; -He/she took the bag of soiled brief and wipes to the red bag trash on opposite side of the room;; -He/she removed soiled gloves into red bags; -CNA H returned to the resident and applied clean gloves without completing hand hygiene; -He/she picked up the bed pan and took to the resident's bathroom and put into a bag; -He/she returned to the resident's bed and assisted the resident to roll to left side, removed soiled sheet and applied a clean sheet; -CNA I assisted the resident to roll to his/her right side and pulled the clean sheet through; -CNA I assisted the resident to back side; -CNA H put pillow under the resident's right side of lower back; -CNA I put the pillow wedge under the resident's left leg; -CNA I picked up the oxygen tubing and CNA H pulled the covers over the resident; -CNA H then took the oxygen tubing and put on the resident's nose; (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-CNA H moved the bedside table to the resident; -CNA I ensured the resident had his/her call light and bed controls in his/her hand; -CNA H removed trash cups and papers from the resident's bedside table and picked up a pear from the resident table and the resident said he/she wanted to keep that pear; -CNA H put the pear back down on to the table; -CNA H put the trash in the red bag trash box in the room; -CNA H picked up the resident's cup from bedside table and took off the lid, poured water out of the cup into the sink and poured the contents of a new foam cup of water and ice from resident's bedside table into the resident's cup. He/she pushed the lid with straw back on the cup and put on the bedside table; -CNA I removed gown and gloves and washed hands at room and left the room to get more red bag trash boxes; -CNA H remained in room waiting for new red bag trash box to be brought to the room; -After putting boxes together and preparing soiled boxes he/she removed gown and gloves in the room and washed hands at sink and left the room. 4. Review of Resident #34's face sheet, showed the following: -admitted [DATE]; -Diagnosis included cellulitis (common and potentially serious bacterial skin infection) of buttock, chronic osteomyelitis (bone infection that occurs when bacteria invade and infect the bone tissue), pressure ulcer of sacral region stage 4 (severe pressure sore located on the sacrum (the bony area at the base of the spine) where the skin damage extends completely through all tissue layers), and urinary tract infection. Review of the resident's care plan, last updated 10/08/24, showed the following: -The resident was admitted with impaired skin integrity as evidenced by my being admitted with reoccurring chronic Stage 4 coccyx and right buttocks pressure ulcers; -Resident was dependent on staff for assistance with bed mobility; -Resident at risk for increased probability of infections; -Staff should clean hands before entering room before putting on gloves, between tasks as appropriate, and when leaving the room. Review of the resident's quarterly MDS, dated [DATE], showed the following: (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-Cognitively intact; -Impairment on both sides of upper and lower body; -Dependent on staff for toileting hygiene, shower, and bed mobility; -Indwelling catheter. Observation on 01/29/25, at 9:00 A.M., showed the following: -RN B prepared wound care supplies at the treatment cart in the hallway for the resident; -He/she sprayed wound cleanser on gauze and put into a clean cup; -The nurse entered the resident room with supplies, placed supplies on a clean towel and a box of gloves on the bed; -The nurse applied a gown and gloves in room without using hand sanitizer or washing hands, the nurse said he/she had cleaned hands before preparing supplies; -The nurse moved the resident's bedside table and assisted the resident to roll to right side; -The nurse removed the soiled dressing and put it on resident's bed sheet; -The nurse wiped resident's buttock and back of upper thighs with wound cleanser on the gauze; -He/she picked up soiled gauze and dressing and took to trash can on the opposite of the bed; -He/she removed gloves and disposed in trash can; -He/she applied new gloves without using any hand sanitizer or washing hands; -Returned to the opposite side of the bed and applied a collagen pad to an area on the right buttock; -He/she then applied calcium alginate (a water-insoluble, cream-colored substance used in wound dressings) to the area on the coccyx; -He/she removed gloves and disposed to trash; -He/she put on new gloves without using any hand hygiene; -The nurse applied a protective outer dressing pad with tape and date; -He/she removed supplies from the bed, removed gloves and disposed of into the trash; -He/she applied new gloves without using hand sanitizer or washing hands; (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-Assisted the resident to roll to back side; -The nurse handed the resident bed controls and call light; -Then moved the bedside table to resident's bedside; -The nurse removed gloves and gown disposed to trash; -The nurse left the resident room and returned to treatment cart; -He/she had not completed hand hygiene; -He/she put on a glove and opened disinfecting wipe and briefly wiped the top of the treatment cart; -The nurse visited with a resident in the hallway and then gave the resident a fist bump; -The nurse turned to the treatment cart and used hand sanitizer and pushed cart down to nurse station. 31464 5. Review of the facility's policy entitled Feeding Tubes, undated, showed the following: -Purpose was to establish guidelines for the safe and effective management of feeding tubes in residents requiring enteral nutrition in long-term care facilities, ensuring compliance with clinical standards and regulatory requirements; -Feeding tube care will be managed to promote resident comfort, minimize complications, and ensure nutritional needs are met, in accordance with clinical guidelines and resident-specific care plans; -Inspect the tube site daily for signs of infection, leakage, or irritation and clean the site with antiseptic solution as per facility guidelines. Review of Resident #149's face sheet showed the following: -admitted [DATE]; -Diagnoses included stroke, right dominant side weakness, fluid buildup in the brain, dysphagia (swallowing disorder), feeding tube malfunction, generalized muscle weakness, and acid reflux. Review of the resident's discharge (return anticipated) MDS assessment, dated 12/21/24, showed the following: -Total dependence on others for all activities of daily living (ADLs); -Received intake via tube feeding. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of the resident's care plan, last updated on 01/02/25, showed the following: -Feeding tube required related to dysphagia following a stroke; -Check PEG (percutaneous endoscopic gastrostomy; surgically placed feeding tube into the stomach) placement previous to flushes, medications, and feedings; -Cleanse PEG tube site and apply new drainage gauze every day shift. Review of the resident's current Physician Orders Sheet (POS) showed an order dated 12/23/24, to cleanse PEG tube site and apply new drainage gauze every day shift. Observation on 01/29/25, at 8:50 A.M., showed Registered Nurse (RN) B sanitized his/her hands, donned a surgical gown and gloves, and entered the resident's room. RN B removed the gown and gloves, exited the room, and returned to the treatment cart in the hallway. The RN retrieved spray wound cleanser from the drawer and sprayed it onto gauze he/she placed into a plastic cup, returning the cleanser to the drawer. Without performing hand hygiene, RN B donned a new gown and gloves and re-entered the resident's room. The RN spoke to the resident, raised the resident's nightgown, and cleansed the stoma site. Using the same gloves, the RN dried the site with gauze. Without performing hand hygiene, RN B changed gloves and placed and taped a clean dressing to the site. Without performing hand hygiene, the RN changed gloves, removed the protective boot from the resident's right foot to view the heel status, replaced the boot, then removed the gloves and washed his/her hands before exiting the room. 6. During an interview on 01/31/25, at 10:55 A.M., CNA H said that staff should completed hand hygiene before and after any resident care. He/she usually completed hand hygiene between glove changes. He/she said it was not appropriate to touch soiled trash or items and then touch the resident. During an interview on 01/31/25, at 9:25 A.M., Certified Medication Tech (CMT) J said staff should complete hand hygiene during every resident care, between dirty and clean, and between glove changes. Staff should clean their hands all the time. During an interview on 01/31/25, at 9:45 A.M., Licensed Practical Nurse (LPN) K said staff should complete hand washing or using hand sanitizer when doing wound care and with any resident care. Staff should clean hands before cares, when changing gloves, before putting on new gloves, and after cares. Staff should clean hands with all dirty to clean process. He/she said he/she took extra gloves and hand sanitizer into the room with wound care. During an interview on 01/29/25, at 3:00 P.M., RN B said that staff should clean hands with soap and water or hand sanitizer when entering a resident room. Staff should apply gloves, remove soiled items, and re-glove and keep re-gloving any time touch something different. He/she said sometimes he/she used hand sanitizer between glove changes. Staff should clean their hands between removing soiled peg tube dressing and applying clean gauze dressing. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 01/30/25, at 10:30 A.M., RN G said that all staff should wash hands before and after all resident cares, including wound care, catheter care, and peg tube care. Hands should be cleaned after removing soiled gauze and before putting on clean gauze. Staff should clean hands between glove changes and between any dirty and clean process. Staff should not touch dirty trash, laundry, or anything possibly soiled and then touch the resident for cares without cleaning hands and changing gloves. During an interview on 01/30/25, at 11:45 A.M., RN A said staff should wash hands or use hand sanitizer before and after every resident care. Staff should clean hands with every glove change. Staff should not touch any soiled items with gloved hands and then touch the resident without cleaning hands and changing gloves. Staff should clean hands between dirty and clean process of wound care, catheter care, and peg tube care. During an interview on 01/30/25, at 3:00 P.M., the Director of Nursing (DON) said staff should complete hand hygiene between every task, upon entering the resident room, when leaving the resident room, between meal tray pass, after personal breaks, and any time touch anything soiled. Staff should clean hands during catheter care or toileting care. Staff should change gloves and clean hands between dirty to clean process. The same with wound care, clean hands and change gloves dirty to clean process. During an interview on 01/30/25, at 3:25 P.M., the Administrator said that all staff are trained and in-serviced on appropriate hand hygiene. Staff should clean hands all the time, after any resident cares, any touch of any contaminated items, and between dirty and clean process. Staff should not have gloves on and push down the red bag trash or any other trash and then touch the resident without changing gloves or cleaning hands. 7. Review of the facility's policy entitled Enhanced Barrier Precautions (last reviewed 3/2024) showed the following: -Enhanced Barrier Precautions (EBP) refer to an infection control intervention designed to reduce transmission of multidrug-resistant organisms (MDRO) that employs targeted gown and gloves use during high contact resident care activities; -All staff receive training on EBP upon hire and at least annually and are expected to comply with all designated precautions; -All staff receive training on high-risk activities and common organisms that require EBP; -The facility will have the discretion on how to communicate to staff which residents require the use of EBP, as long as staff are aware of which residents require the use of EBP prior to providing high-contact care activities; -An order for EBP will be obtained for residents with wounds and/or indwelling medical devices such as urinary catheters and feeding tubes, even if the resident is not know to be infected or colonized with a MDRO; (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34871 Based on observation, interview, and record review, the facility failed to maintain a functional environment for all residents, when staff failed to maintain a bariatric Hoyer weight scale when staff were unable to take a weight on one resident (Resident #8), out of a total sample of 17 residents, for six months for one resident. The facility census was 44. Review of the facility's policy titled Weight Assessment and Intervention, revised September 2008, showed the following: -The multidisciplinary team will strive to prevent, monitor, and intervene for undesirable weight loss for our residents; -The dietician will review the unit weight record monthly to follow individual weight trends over time. Negative trends will be evaluated by the treatment team whether or not the criteria for significant weight changes has been met. 1. Review of Resident #8's face sheet (gives basic profile information) showed the following information: -admitted [DATE]; -Diagnoses included atrial fibrillation (abnormal heartbeat), hyperlipidemia (high cholesterol), chronic kidney disease, and edema (swelling). Review of the resident's current physician orders showed an order, dated 03/03/24, for monthly weights one time a day starting on the 3rd and ending on the 3rd of every month for monthly monitoring. Review of the resident's vital signs, dated 07/03/24, showed the resident weighed 438.8 pounds. Review of the resident's care plan, dated 08/14/24, showed the following: -The resident has nutritional problems as evidenced by his/her weight being above the recommended BMI (body mass index) and diagnosis of morbid obesity; -The resident has a desired weight loss of eight pounds with increase of his/her Lasix (a diuretic medication); -Staff to monitor/record weight; -Staff to notify the physician and family of significant weight changes; -Monitor the resident's weight at least monthly. Notify the resident's physician and dietician per facility weight protocol. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265573	A. Building B. Wing	01/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Big Spring Care Center for Rehab and Healthcare	202 East Mill Street Humansville, MO 65674

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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 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility's rental agreement for patient lift electric bariatric up to 600 pounds showed the following: -On 10/21/24, from 9:00 A.M. to 5:00 P.M., showed the company delivered lift to the facility. Documentation at the top of the document showed rented 10/21/24 and delivered broken; -On 10/22/24, at 12:46 P.M., showed the company picked the patient lift electric bariatric up to 600 pounds/ Documentation at the top of the document showed returned next day because it was received broken; -On 10/22/24, from 9:00 A.M. to 5:00 P.M., service order reason for service was repair for the patient lift electric bariatric up to 600 lbs; -On 10/22/24, at 12:46 P.M., the company delivery order showed patient lift electric bariatric up to 600 pounds. Documentation at the top of the sheet showed rented new because other was received broken; -On 11/27/24, at 9:00 A.M. to 5:00 P.M., for patient lift electric bariatric up to 600 pounds reason for pickup was equipment not needed. Staff wrote at top of document, Returned broken and purchased new. The Hoyer broke while transferring patient and bolt holding sling fell out. Review of the resident's quarterly Minimum Data Set (MDS - a federally mandated assessment tool completed by facility staff), dated 12/03/24, showed the following: -Cognitively intact; -Weight of 439 pounds. Review of the facility's durable medical equipment invoice dated 12/05/24, at 9:42 A.M., showed an invoice for lift patient bariatric electric 600 pounds with total of $1398.00. Review of the resident's vital signs, dated 01/16/25, showed the resident weighed 398.8 pounds. During an interview on 01/30/25, at 8:43 A.M., Certified Nurse Aide (CNA) E said the following: -He/she did not know the resident had a weight loss; -Staff weigh residents on the scale monthly; -The nurses give the aides a list of residents to weight monthly; -Staff report the weight to the nurse and the nurse documents the weight in the computer. During an observation and interview on 01/30/25, at 11:15 A.M., the resident lay in his/her bed. The resident said staff weigh him/her one time per month with a Hoyer weight scale. He/she had tried to eat better and less. He/she wants to lose weight. (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 01/31/25, at 8:57 A.M., CNA L said it was several months the durable medical equipment company brought a Hoyer scale and it was sent back, brought back another one the next day and for a short period, the company had trouble getting a Hoyer lift with a scale on it. The facility scale was not wide enough for the resident's wheelchair. During an interview on 01/31/25, at 9:08 A.M., CNA H said the following: -The facility had a Hoyer scale then did not have it and he/she did not know why; -Staff did not weigh the resident from July 2024 to January 2025 because the scale was broken; -The Administrator and Director of Nursing (DON) said they were working on it when staff reported the broken scale. During an interview on 01/30/25, at 12:01 P.M., Registered Nurse (RN) A said staff did not have a a way to weigh the resident from 07/03/24 to 01/16/25. During an interview on 01/31/25, at 9:55 A.M., the MDS/Care Plan Coordinator said she asked for the resident's monthly weights between the months of July 2024 through January 2025. The facility had two or three broken weight scales. During an interview on 01/31/25, at 8:59 A.M., the Director of Rehab said he attends the weekly risk meeting and staff discuss weights. He/she did not know the scale did not work for the resident. During an interview on 01/30/25, at 12:11 P.M., the DON said the following: -The facility had trouble with the Hoyer scale. The facility rented a scale that did not work and finally the facility purchased a hoyer weight scale; -Staff did not weigh the resident from 07/03/24 through 01/16/25 due to the facility did not have a Hoyer weight scale for the resident; -She did not know how much weight the resident had lost. Staff did not document the weight loss on 01/16/25. During interviews on 01/30/25, at 1:32 P.M., on 01/31/25, at 1:33 P.M., the Administrator said the following: -The facility's Hoyer lift for the resident was broken and she did not know staff did not weigh the resident from 07/03/24 to 01/16/25; -She did not know how long the Hoyer lift scale was broken; -Right before Christmas, she requested a weight and staff said the Hoyer scale was broken; -She purchased a new Hoyer lift scale December 2024; -She instructed staff to weigh residents who had not been weighed. (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-She expected staff inform her if equipment is broken; -She expected staff to document and notify the physician if staff did not get a monthly weight for longer than four months. MO00246960