STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265581	A. Building B. Wing	04/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Kingdom Care Senior Living	811 Center Street Fulton, MO 65251

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview and record review, the facility staff failed to store and serve food at temperatures adequate to prevent food-borne illness and in a manner to prevent contamination and outdated use. Facility staff also failed to allow mechanically washed dishes to air-dry prior to stacking in storage and use to prevent the growth of food-borne pathogens. These failures have the potential to affect all residents. The facility census was 27.1. Review of the facility's policy titled Record of Food Temperatures, undated, showed it is the policy of the facility to record food temperatures to ensure food is at the proper serving temperatures. Review showed potentially hazardous cold food temperatures will be kept at or below 41 degrees Fahrenheit (dF). Review showed the policy directed staff to measure and record temperatures for each food product and milk at all meals. Observation on 04/13/26 at 10:51 A.M., showed an unidentified Dietary Aide (DA) prepared the salad bar for the lunch meal. Observation showed the DA placed multiple food items in bowls which were placed on ice in the salad bar. Observation on 04/13/26 at 12:06 P.M., showed residents in the dining room consumed food items from the salad bar. Observation showed: -The temperature of the tuna salad on the salad bar measured 44 dF;-The temperature of the potato salad on the salad bar measured 49 dF;-The temperature of the ranch salad dressing on the salad bar measured 45 dF. During an interview on 04/13/26 at 12:40 P.M., [NAME] E said he/she is responsible to ensure food items in the salad bar are kept at a temperature below 40 d. The cook said he/she checks the salad bar temperatures sometimes, but he/she does not document the temperatures because he/she does not have a temperature log. The cook said he/she would normally wrap unused salad bar items and serve them again the following day. Observation on 04/14/26 at 12:05 P.M., showed residents in the dining room consumed food items from the salad bar. Observation showed: -The temperature of the tuna salad on the salad bar measured 48 dF;-The temperature of the boiled eggs on the salad bar measured 55 dF;-The temperature of the potato salad on the salad bar measured 49 degrees F. During an interview on 04/14/26 at 12:55 P.M., the dietary manager (DM) said he/she is responsible to ensure kitchen staff follow safe practices related to food temperatures and food items on the salad bar should maintain a temperature of 41 dF or below. The DM said the items on the salad bar are prepared on Mondays and any unused items are discarded on Thursdays. The DM said kitchen staff do not check the temperatures of the salad bar items during meal service and they do not keep logs of salad bar food temperatures. During an interview on 04/15/2026 at 11:34 A.M., the administrator said the cook and DM are responsible to maintain the temperature of food items on the salad bar at 40 dF or lower and staff should check and record the temperatures of the food items. The administrator said he/she did not know staff did not check the salad bar food temperatures and staff used the same food items on the salad bar over multiple days. 2. Review of the facility's policy titled Date Marking for Food Safety, undated, showed the policy directed staff to clearly mark ready-to-eat and time/temperature controlled foods to indicate the date or day by which the food shall be consumed or discarded. The head cook or designee shall be responsible for checking the refrigerator daily for food items that are expiring and shall discard accordingly. Prepared foods that are delivered to the nursing units shall be discarded within two hours if not consumed and not be refrigerated as (continued on next page)

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

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

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	the time/temperature controls cannot be verified. Observations on 4/12/26 at 9:29 A.M., showed the kitchen contained: -Two pieces of French toast wrapped in undated plastic wrap;-An undated container of peas;-Opened and undated beef patties wrapped in plastic wrap;-Opened and undated chicken patties wrapped in plastic wrap;-An opened and undated package of hotdogs wrapped in plastic wrap;-An undated container of prunes;-An undated container of mashed potatoes;-An opened and undated dry yeast package;-An undated container of cooked green beans. Observation on 4/12/26 at 10:21 A.M., showed the refrigerator in the dining room kitchenette contained: -An undated and unlabeled pitcher of yellow liquid;-An opened and undated 1/4 full jug of milk;-Two undated and unlabeled Styrofoam to-go containers of prepared food;-Two undated and unlabeled bowls of unidentifiable food;-An opened and undated container of cranberry juice;-An undated Styrofoam plate of vegetables and a potato;-Two undated red plates of vegetables and a potato. Observation on 04/13/26 at 10:19 A.M., showed the walk-in refrigerator contained a one-gallon container of lime juice dated 7/23/25. Observation showed the lime juice had a use by date of 01/28/26. Observation on 04/13/26 at 10:23 A.M., showed the refrigerator in the dining room kitchenette contained three undated pitchers of drinks and three wrapped and undated plates of meat and mixed vegetables. Observation showed the dining room kitchenette also contained undated plastic bins of crisped rice, cheerios and bran flakes cereal removed from their original containers, an undated loaf of bread opened to air, and an opened and undated bag of potato chips wrapped in plastic wrap. Observation showed the bag of potato chips had a manufacturer's use-by date of November 2025. Observation on 04/14/26 at 10:36 A.M., showed the refrigerator in the dining room kitchenette contained two undated and unlabeled bowls of a bread-like substance and three undated Styrofoam plates of meat, beets and a bowl of spiral pasta. Observation on 04/14/26 at 10:52 A.M., showed the walk-in freezer contained undated boxes of crescent and dinner rolls opened to the air. During an interview on 04/13/26 at 12:24 P.M., DA I said open food items should be dated by whomever wrapped or stored the items. The DA said he/she tries to check dates when he/she works but he/she did not realize there were items that were not dated or past their use-by dates. During an interview on 04/14/26 at 12:55 P.M., the DM said he/she is responsible to ensure kitchen staff follow safe practices related to food storage and the kitchen staff are expected to label and date all food items. The DM said all food items should also be stored covered or sealed, and items past their best by or use by dates should be discarded. The DM said he/she did not know about any food storage issues. During an interview on 04/15/2026 at 11:34 A.M., the administrator said the DM is responsible to ensure food is stored correctly. The administrator said the DM should ensure foods are labeled, dated, covered completely and discarded by their use by dates and he/she did not know about any issues with the food storage. 3. Review of the facility provided policies showed they did not contain a policy related to dish drying or storage. Observation on 04/13/26 at 10:15 A.M., showed five large metal food service pans stacked together wet on a kitchen shelf. Observation on 04/13/26 at 10:38 A.M., showed four stacks of clear plastic cups stacked together wet inside a cabinet in the dining room kitchenette. Observation also showed wet red plastic coffee cups stored inverted inside a cabinet directly on the surface of the cabinet which did not allow air flow beneath to dry them. During an interview on 04/13/26 at 12:40 P.M., [NAME] E said he/she washed the dishes this morning and he/she put away the dishes before they were completely dry because he/she was in a hurry and he/she knew dishes were to be air-dried before they are put away. During an interview on 04/14/26 at 12:55 P.M., the DM said he/she is responsible to ensure kitchen staff follow safe practices related to dish washing and storage, and staff should allow dishes to air-dry before they are put away. The DM said he/she did not know about any dish storage issues. During an interview on 04/15/26 at 11:34 A.M., the administrator said the DM and kitchen staff are responsible to ensure dishes are dry before they are put away and he/she did not know about any dish storage issues.

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F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations (including nights and weekends) and emergencies. Based on record review and interview, facility staff failed to document a thorough facility-wide assessment to include specific staffing needs for each resident unit in the facility and consider specific staffing needs for each shift, such as day, evening, night or include active involvement in the process from direct care staff, including but not limited to: Registered Nurses (RN), Licensed Practical Nurses (LPN), Nurse Aides (NA), and representatives of the direct care staff, if applicable, and/or solicit and consider input received from residents, resident representatives, and family members. The facility census was 27.1. Review of the facility's Facility Assessment policy, dated October 2018, showed the residents, representatives and family members may be asked to participate in the review of the care and services provided to meet the needs of our residents. The policy did not contain documentation or assessment of staffing needs of each unit or shift. Review of the Facility Assessment, dated 04/01/26, showed the workforce profile includes the following direct care staff type of RN's, LPNs, and Certified Nurse Aides (CNA). To ensure thoroughness, individuals involved in the facility assessment should include other individuals including direct care staff. Review of the assessment did not contain documentation on how the facility assessed or will staff each unit of the facility or shift and did not contain documentation a resident, resident representative, family member or direct care staff were involved in the assessment process. 2.Observation on 04/12/26 at 9:00 A.M., showed the facility with resident rooms on two separate halls in the facility. During an interview on 04/14/16 at 4:15 P.M., the Administrator said he/she is responsible for completion and review of the facility assessment. He/She said all staffing data should be a part of the assessment to include hours, days, and type of staff. The administrator said he/she does not include input from direct care staff or residents and/or resident representatives. He/She is new to the facility and did not include it during his/her initial review in January. During an interview on 04/15/26 at 10:58 A.M., LPN A said he/she does not participate or have input in the facility assessment. During an interview on 04/15/26 at 11:23 A.M., the Director of Nursing (DON) said he/she does not participate in the review of the facility assessment but is still new to the building. He/She said he/she is not familiar with the facility assessment. During an interview on 04/15/26 at 12:16 P.M., RN H said he/she does not participate or have input in the facility assessment review.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, facility staff failed to develop and implement a person-centered comprehensive care plan for four (Resident #1, # 9, #17, and #23) of twelve sampled residents. The facility census was 27.1. Review of the facility's Comprehensive Care Plan policy, dated March 2022, showed: -The care plan interventions are derived from a thorough analysis of information gathered as part of the comprehensive assessment;-The comprehensive, person-centered care plan:-Includes measurable objectives and timeframes;-Describes services to be furnished to attain or maintain the residents highest practicable physical, mental and psychosocial well-being;-Includes resident stated goals and outcomes;-Builds on resident strengths;-Reflects current recognized standards of practice for problem areas and conditions. 2. Review of Resident #1's Quarterly Minimum Data Set (MDS), a federally mandated assessment tool, dated 04/15/26, showed staff assessed the resident as cognitively intact. Review of the resident's care plan, dated 02/04/26, showed the care plan did not contain bed rail use. Observation 04/13/26 at 9:00A.M., showed the resident in bed with bed rails in the upright position on both sides of the bed. During interview on 04/13/26 at 9:00A.M., the resident said he/she uses the bed rails for bed mobility. 3. Review of Resident #9's Quarterly MDS, dated [DATE], showed staff assessed the resident as: -Cognitively intact;-Required set up and clean-up assistance for shower/tub hygiene and transfers.Review of the resident's care plan, dated 04/01/26, showed the resident required partial to moderate assistance from one staff with bathing. The care plan did not include shower preferences. During an interview on 04/13/26 at 10:32 A.M., the resident said he/she likes to receive a shower once a week on Tuesdays. 4. Review of Resident #17's Quarterly MDS, dated [DATE], showed staff assessed the resident as: -Cognitively Intact;-Required partial to moderate assistance of staff with toileting and showering/bathing;-Occasionally incontinent of urine; -Always continent of bowel. Review of the resident's care plan, dated 02/19/26, showed the care plan did not contain bed rail use. Observation 04/13/2026 9:00 A.M., showed the resident in bed with bed rails up on both sides. 5. Review of Resident #23's Significant Change in Status Assessment (SCSA), dated 02/12/26, showed staff assessed the resident as: -Cognitively impaired;-Felt it was very important to listen to music he/she enjoys;-Felt it was somewhat important to participate in group activities, favorite activities, go outside when the weather is nice, and religious activities. Review of the resident's care plan, dated 04/01/26, showed:-Likes one on one activities;-Enjoys spending time with daughter who comes to visit often;-Offer to participate in all activities;-The care plan does not indicate or give direction for residents' preference to go outside and/or religious activities. 6. During an interview on 04/15/26 at 12:16 P.M., the MDS Coordinator said he/she is responsible for the care plans with oversight of the corporate nurse and he/she is working to get all the care plans updated as they become due or as a change is reported to him/her. He/she said care plans should include all aspects of the residents' care based on the resident assessment and preferences. The MDS coordinator said he/she has only been in the role since February and is still learning the job. During an interview on 04/15/26 at 11:23 A.M., the Director of Nursing (DON) said the MDS nurse is responsible for the initial care plan and the care plan should reflect the residents' care, needs and preferences. The DON said he/she is new to the DON position and still learning about MDS assessments and care plans.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, facility staff failed to review and revise the comprehensive care plan for five residents (Resident #2, #8, #13, #19, and #23) out of twelve sampled resident care plans. The facility census was 27.1. Review of the facility's Comprehensive, Care Plan policy, dated March 2022, showed: -The care plan interventions are derived from a thorough analysis of information gathered as part of the comprehensive assessment; -The comprehensive, person-centered care plan: -Includes measurable objectives and timeframes; -Describes services to be furnished to attain or maintain the residents highest practicable physical, mental and psychosocial well-being; -Includes resident stated goals and outcomes; -Builds on resident strengths; -Reflects current recognized standards of practice for problem areas and conditions. -Assessments are on-going and care plans are revised as information about the resident condition changes; -The Interdisciplinary team (IDT) revise and updates the care plan: -When the resident has a significant change in resident condition; -When a desired outcome is not met; -When readmitted from a hospital stay; -At least quarterly in conjunction with the quarterly assessment. 2. Review of Resident #2's Quarterly Minimum Data Set (MDS), a federally mandated assessment tool, dated 03/18/26, showed staff assessed resident as: -Cognitively intact; -Occasionally incontinent of urine; -Diagnosis of chronic kidney disease. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the resident's care plan, dated 04/01/26, did not address the resident's indwelling urinary catheter. Observation on 4/14/26 at 12:00 P.M., showed the resident had an indwelling urinary catheter. The resident said the nurse flushed his/her catheter twice a day. During an interview on 04/15/26 at 12:44 P.M., Licensed Practical Nurse (LPN) A said the catheter should be on the care plan, but the MDS Coordinator is new. 3. Review of Resident #8's Significant Change in Status (SCSA) MDS, a federally mandated assessment tool, dated 03/23/26, showed staff assessed the resident as: -Severely cognitively impaired; -Diagnoses of stroke and polyneuropathy (a malfunction of nerves throughout the body); -Received hospice care. Review of the resident's Physician Order Set (POS) showed an order dated 03/26/26 to admit to hospice. Review of the resident's care plan, dated 01/22/26, showed the care plan did not address hospice care. 4. Review of Resident #13's Quarterly MDS, dated [DATE], showed staff assessed the resident as: -Moderately cognitively impaired; -Did not have weight loss or require a specialized diet. Review of Dietary Notes, dated 12/18/25, showed a recommendation for a nutritional shake daily to help maintain weight. Review of the resident's care plan, dated 08/9/25, showed weight loss and nutritional needs were not addressed. During an interview on 04/15/26 at 9:00 A.M., the Director of Nursing (DON) said nutritional supplements and weight loss should be included on the care plan. 5. Review of Resident #19's Quarterly MDS, dated [DATE], showed staff assessed the resident as: -Cognitively intact; -Continent of bladder and bowel; -Required partial to moderate assistance from staff for toilet hygiene and transfers; -Diagnosis of renal insufficiency. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the resident's care plan, dated 04/01/26, showed the care plan did not contain direction or guidance for the residents toileting needs. During an interview on 04/12/26 at 10:27 A.M., the resident said he/she has occasional bowel incontinence and needs staff assistance for cleansing. 6. Review of Resident #23's SCSA MDS, dated [DATE], showed staff assessed the resident as: -Cognitively impaired; -Received hospice; -Had not fallen since admission/entry, re-entry or prior assessment; -Diagnosis of dementia. Review of the resident's nurse's notes dated 01/01/26 through 04/13/26 showed staff documented the resident had a fall from his/her wheelchair on 01/03/26. Review of the resident's census record showed the resident admitted to hospice services on 02/14/26. Review of the resident's care plan, dated 04/01/26, showed the care plan did not contain documentation of a fall review when the resident fell on [DATE] or election to hospice services. 7. During an interview on 04/15/26 at 12:16 P.M., the MDS Coordinator said he/she is responsible for the care plans with oversight of the corporate nurse. He/She said he/she is working on getting all the care plans updated as they become due or as a change is reported to him/her. Care plans should include all aspects of the residents' care based on the assessment of the resident and resident preferences. The coordinator said he/she has only been in the role since February and is a brand new MDS Coordinator still learning the job. During an interview on 04/15/26 at 11:23 A.M., the DON said the MDS nurse is responsible for the initial care plan and the care plan should reflect the residents' care, needs and preferences. He/She said he/she is new to the DON position and still learning MDS assessments and care plans. During an interview on 04/15/26 at 9:30 A.M., the Administrator said the MDS Coordinator and nurses are responsible for reviewing and revising care plans. Care plans are to include fall interventions, admission to hospice service, medications, treatments, bowel and bladder incontinence. He/She said nurses should be referring to the care plans to direct care.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on observation, interview and record review, facility staff failed to provide an environment free from accident hazards, when staff failed to lock medication carts when unattended and not in use and store chemicals when not in use. The facility census was 27.1. Review of the facility's Medication Storage policy, dated 2026, showed: -All drugs and biologicals will be stored in locked compartments (i.e., medication carts, cabinets, drawers, refrigerators, medication rooms) under proper temperature controls;-Only authorized personnel will have access to the keys to locked compartments;-During a medication pass, medications must be under the direct observation of the person administering medications or locked in the medication storage area/cart. 2.Observation on 04/12/26 at 9:15 A.M., showed one unlocked and unattended treatment cart and one unlocked unattended medication cart at the nurse's station. Observation showed residents and staff walked by carts. Observation on 04/12/26 at 7:38 A.M., showed an unlocked treatment cart at the nurse station. Registered Nurse (RN) C had his/her back to the cart. Residents and staff passed by the cart. The RN took the medication cart to the dining hallway and left the treatment cart unlocked and unattended. Housekeeping staff were in the area and residents passed the unattended, unlocked cart. Observation on 04/13/26 at 3:38 P.M., showed the medication cart by the nurse station, unlocked and unattended. During an interview on 04/12/26 at 8:06 A.M., RN C said he/she normally locks the cart and did not realize the treatment cart was left unlocked. He/She said residents, staff or visitors could get into the unlocked cart and take things that could hurt them. During an interview on 04/15/26 at 11:23 A.M., the Director of Nursing (DON) said the staff assigned the medication and treatment carts are responsible for ensuring the carts are locked when unattended and unsupervised to keep the contents secure from residents, staff and visitors so they don't get hurt. During an interview on 04/15/26 at 1:45 P.M., the Administrator said he/she is always reminding staff to keep the carts locked. The carts should be locked when unattended for safety. 3. Review of the facility's Environmental Services Safety Procedures policy, dated 2025, showed staff will ensure equipment (e.g., cords, ladders, or chemicals) is properly stored and not left unattended in areas that are accessible to residents. When not in use, equipment will be stored in a locking closet, cabinet or storage area for safety. 4.Observation on 04/12/26 at 10:21 A.M., showed an unlocked, unattended cabinet in the kitchenette area of the main dining room contained a bottle of a disinfectant cleaner and two bottles of multipurpose cleanser. Observation on 04/13/26 at 10:41 A.M., showed an unlocked unattended cabinet in the kitchenette area of the main dining room contained a bottle of a disinfectant cleaner and two bottles of multipurpose cleanser. Observation on 04/14/26 at 10:37 A.M., showed an unlocked unattended cabinet in the kitchenette area of the main dining room contained a bottle of a disinfectant cleaner and two bottles of multipurpose cleanser. During an interview on 04/14/26 at 12:55 P.M., the Dietary Manager (DM) said he/she is responsible for ensuring cleaning chemicals in the kitchenette are secure. The DM said the cleaning sprays should be locked up. The DM said he/she did not know the cleaning sprays were not locked up.

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. Based on record review and interview, facility staff failed to educate and offer Coronavirus disease 2019 (COVID-19), a respiratory disease that can cause severe illness, immunizations to residents as required for four residents (Residents #8, #13, #15, and #25) of five sampled residents. The facility census was 27.1. Review of the facility's policy COVID-19 Vaccination dated 2025, showed the facility will educate and offer the COVID-19 vaccine to residents, resident representatives and staff and maintain documentation of each. A copy of the Vaccine Information Statement will be given to staff, residents and resident representatives prior to administration. Review of Resident #8's medical record showed the record did not contain documentation of education, administration or refusal of the COVID-19 vaccination for the 2025-2026 season. Review of Resident #13's medical record showed the record did not contain documentation of education, administration or refusal of the COVID-19 vaccination for the 2025-2026 season.Review of Resident #15's medical record showed the record did not contain documentation of education, administration or refusal of the COVID-19 vaccination for the 2025-2026 season. Review of Resident #25's medical record showed the record did not contain documentation of education, administration or refusal of the COVID-19 vaccination for the 2025-2026 season. During an interview on 04/13/2026 at 10:00 A.M., the Infection Preventionist (IP) said he/she is new to the position, and the facility recently underwent a change of ownership. He/She said documentation may not have been uploaded into the computer system since the facility transitioned to a new electronic medical record on April 1st. The IP said he/she is responsible for the immunization program. During an interview on 04/15/26 at 9:30 A.M., the Administrator said he/she expects all residents be offered COVID-19 vaccination according to policy. He/She said the corporate transition and relocation of staff has made compliance challenging.

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident when there is a significant change in condition **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, facility staff failed to perform a significant change in status (SCSA) Minimum Data Set (MDS) assessment, a federally mandated assessment tool, for two (Resident #8 and #23) of three residents who elected hospice services and one (Resident #19) of four sampled residents who had a change in activities of daily living. The facility census was 27.1. Review of the facility's MDS 3.0 Completion policy, dated 2025, showed:-The facility conducts periodic comprehensive, accurate, and standardized assessment of each resident's functional capacity using the Resident Assessment Instrument (RAI) manual specified by the state;-A SCSA is a comprehensive assessment completed within 14 days of the identification of a status change that meets the requirements outlined in Chapter Two of the RAI manual;-A SCSA is a major decline or improvement in a resident's status that will not normally resolve itself without intervention by staff or by implementing standard disease-related clinical interventions, impacts more than one area of the resident's health status, and requires interdisciplinary (IDT) review and/or revision of the care plan;-A SCSA is required when a resident enrolls in a hospice program or changes hospice providers and remains in the facility, or a resident in the facility receiving hospice services discontinues those services and remains in the facility. 2. Review of Resident #8's Quarterly MDS, dated [DATE], showed staff assessed the resident as:-Cognitively impaired;-Received hospice services;-Diagnosis of dementia.Review of the census record showed the resident admitted to hospice services on 03/25/26.Review of the medical record showed the record did not contain a completed SCSA when the resident admitted to hospice services. During an interview on 04/15/26 at 12:16 P.M., the MDS Coordinator said he/she has only been in the role since February and is a new MDS Coordinator. He/She is still learning and was not aware a SCSA was not completed.3. Review of Resident #23's SCSA, dated 02/12/26, showed staff assessed the resident as follows:-Cognitively impaired;-Received hospice services;-Diagnosis of dementia.Review of the census record showed the resident admitted to hospice services on 02/14/26.During an interview on 04/15/26 at 12:16 P.M., the MDS Coordinator said he/she was not aware a SCSA was not completed.4. Review of Resident #19's Quarterly MDS, dated [DATE], showed staff assessed the resident as:-Cognitively intact;-Required supervision/touch assistance for toileting;-Independent transfers;-Occasionally incontinent of bowel.Review of the Quarterly MDS, dated [DATE], showed staff assessed the resident as:-Cognitively intact;-Required partial to moderate assistance from staff with toileting needs and transfers;-No incontinence.During an interview on 04/12/26 at 10:27 A.M., the resident said he/she had occasional bowel incontinence and needed assistance from staff to get cleaned up. He/She said he/she can transfer independently sometimes but needs help other times.5. During an interview on 04/15/26 at 12:16 P.M., the MDS Coordinator said residents newly admitted to hospice or discontinuing services should have a new MDS assessment completed. He/She said residents who have had a change of status should have a new MDS completed within 14 days of observing the change. He/She said he/she is responsible for ensuring the assessments are completed and the corporate nurse checks his/her work. During an interview on 04/15/26 at 11:23 A.M., the Director of Nursing (DON) said the MDS Coordinator is responsible to ensure MDS assessments are completed timely and include a change of status if necessary. The DON said he/she is not familiar with the MDS process, is a new DON, and is still learning.

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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** Based on observation, interview and record review, facility staff failed to obtain orders for an indwelling urinary catheter and catheter care for one resident (Resident #2) out of one sampled resident, failed to obtain an order for hospice for one (Resident #23) out of three sampled residents, and failed to notify the physician when one (Resident #17) of four sampled residents did not receive his/her medication as ordered. The facility census was 27.1. Review of the facility's Indwelling Catheter Care policy, undated, showed ff an indwelling catheter is in use, the facility will provide appropriate care for the catheter in accordance with current professional standards of practice and resident care policies and procedures that include but are not limited to insertion, ongoing care and catheter removal protocols that adhere to professional standards of professional and infection prevention and control procedures. 2. Review of Resident #2's Quarterly Minimum Data Set (MDS), a federally mandated assessment tool, dated 03/18/26, showed staff assessed the resident as: -Cognitively Intact; -Occasionally incontinent of urine; -Always continent of bowel. Review of the resident's Physician Order Summary (POS), dated March 2026, showed an order dated 03/18/26 to change the resident's urinary catheter every month on the 19th. The POS did not contain a catheter size, balloon size or orders for catheter care. Observation on 04/11/26 at 10:30 A.M., showed the resident his/her recliner in his/her room with a urinary catheter in place. During an interview on 04/11/26 at10:30 A.M., the resident said a nurse flushes his/her catheter twice a day. During an interview on 04/15/26 at 12:44 P.M., Licensed Practical Nurse (LPN) A said the nurses are responsible for changing the resident's indwelling urinary catheter. The LPN said he/she did not know the resident did not have orders for the indwelling catheter size/balloon size or catheter care. 3. Review of the facility's Hospice Program, dated July 2017, showed the program did not include direction or guidance for a physician order for such services. 4. Review of Resident #23's Significant Change in Status Assessment (SCSA) MDS, dated [DATE], showed staff assessed the resident as cognitively impaired, received hospice services, and had a diagnosis of dementia. Review of the resident's POS, dated April 2026, showed the POS did not contain an order for hospice. During an interview on 04/14/26 at 10:58 A.M., LPN A said residents should have a hospice order in the medical record when a resident elects hospice services. LPN A said he/she did not know the resident did not have an order. It is the nurse's responsibility to ensure the orders are obtained and documented. During an interview on 04/14/26 at 11:23 A.M., the Director of Nursing (DON) said the nurses should obtain an order from the physician when the resident and/or family elects hospice services. He/She was not aware there was not an order. 5. Review of the facility's Medication Orders policy, dated 2025, showed if using electronic medication records, input the medication order according to the electronic health record (EHR) instructions. Transcribe the newly prescribed medications on the Medication Administration Record (MAR) in the electronic record. Review of the facility's Notification of Changes policy, dated 2025, showed the facility must consult with the physician when there is a change requiring such notification. The policy did not contain direction or guidance regarding omission of medications. Review of the facility's Charting and Documentation policy, dated July 2017, showed documentation of procedures and treatments will include care-specific details including notification of family, physician or other staff, if indicated. 6. Review of Resident #17's Quarterly MDS, dated [DATE], showed staff assessed the resident as cognitively intact. Review of the resident's POS, dated March 2026, showed the physician ordered Tirzepatide (a weight reduction medication) 2.5 milligrams (mg)/0.5 milliliters (ml) on 02/08/26, Inject once a week on Mondays. The order was discontinued on 03/16/26 and reordered on 03/23/26. Review of the nurse notes, dated 01/14/26 through 04/14/26 showed: -On 2/23/26 - trizepatide, prior authorization needed;-On 03/02/26 - trizepatide, did not contain documentation why the medication was not administered;-On 03/09/26 - trizepatide, prior authorization needed;-03/23/26 - trizepatide, prior authorization needed;-03/30/26 - trizepatide, omission;-04/06/26 - trizepatide, prior (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	authorization awaiting;-04/13/26 - trizepatide, omission. Review of the resident's MAR, dated March 2026, showed staff documented showed staff documented for the trizepatide:-03/02/26 a code of 11 (the MAR did not contain a key to indicate what 11 meant) on the MAR;-03/09/26, 03/23, and 3/30/26 a code of nine (the MAR did not contain a key to indicate what nine meant) on the MAR;-03/16/26 did not contain an entry. Review of the MAR, dated April 2026, showed staff documented on 04/06/26 and 04/13/26 a code of OT (other, see progress note) for the resident's trizepatide. Review of the residents progress notes did not contain documentation staff notified the physician the medication had not been administered or a follow up had been conducted for prior authorization. During an interview on 04/14/26 at 8:58 A.M., a family member said the resident needs to lose weight so he/she can have hip surgery. When the resident switched insurances the trizepatide has not been given. He/She is concerned the resident will not lose the needed weight to get his/her hip surgery. During an interview on 04/14/26 at 9:58 A.M., the pharmacy said a denial was sent to the facility on [DATE] for a Trizepatide order received on 03/13/26. He/She said the resident transferred to this pharmacy in February. He/She said the order received on 03/13/26 required prior authorization before the pharmacy could send it to the facility. When prior authorization is needed, the form is sent to the facility and the physician's office for follow-up. The pharmacy reviews the prior authorization folder every one to two weeks for follow-up. During an interview on 04/14/26 at 10:20 A.M., the Primary Care Physician's office said he/she would expect the facility to notify him/her if medication is unavailable so a modification can be made to the treatment plan. He/She was not notified about the medication omission and would expect to if the resident's goal is to lose weight for surgery. During an interview on 04/14/26 at 10:58 A.M., LPN A said since the resident's payor source changed the facility has had an issue obtaining prior authorization for the medication. He/She said he/she did not receive a denial until today for the trizepatide. He/She said he/she had been in contact with the physician a while back about this, he/she had not recently reached out. He/She said when a resident is out of a medication or unable to obtain a medication, the physician should be notified. He/She was recently given additional duties and did not follow up on the trizepatide. During an interview on 04/14/26 at 11:23 A.M., the DON said he/she was not aware of any issues with the resident's medications. He/She said if a resident is out of a medication or cannot obtain it, staff should notify the physician and the DON. He/She said it's the nurses responsibility to ensure prior authorizations are obtained timely.

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F 0840 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Employ or obtain outside professional resources to provide services in the nursing home when the facility does not employ a qualified professional to furnish a required service. Based on observation, interviews and record review, facility staff failed to ensure arrangements were made for nephrology (services that provide care for kidney related conditions) services outside of the facility for one resident (Resident #35) of one sampled resident with kidney disease. The facility census was 27.1. Review of the facility's admission Agreement, undated, showed if a resident chose a physician who does not have privileges at the facility, the resident must travel, at their own expense, to the healthcare provider to receive services from that provider. The agreement did not contain direction or guidance on assistance to set up transportation for ordered services or assistance in set up for the appointments. Review of Resident #35's Annual Minimum Data Set (MDS), a federally mandated assessment tool, dated 01/01/26, showed staff assessed the resident as: -Cognitively intact;-Always incontinent of bladder;-Diagnosis of impaired kidney function. Review of the resident's nurse's notes, dated 01/01/26 through 03/31/26, showed staff documented: -02/08/26: Order received for a nephrology appointment;-02/09/26: Called and left voicemail for family concerning order for nephrology consult, awaiting a call back;-02/09/26: Spoke with family, would like to have an update on appointment date/time so they can go with the residents;-03/23/26: Spoke with family concerning appointment for nephrology to be scheduled, family states these appointments must be scheduled out 30 days due to needing to request off from work;-The notes did not contain documentation to show staff attempted to schedule the nephrology appointment, as ordered, from the date of the original order on 02/08/26 to when the resident discharged from the facility on 03/30/26. Review of the Physician Progress Notes showed: -02/10/26, nephrology consult requested;-02/19/26, nephrology appointment requested;-03/23/26, nephrology appointment requested. Review of the Physician Order Set (POS), dated February 2026 through March 2026, showed the physician ordered a nephrology consult on 02/08/26. Review of an email attached to the medical record, dated 02/20/26, showed the physician requested staff to schedule a nephrology appointment. During an interview on 03/25/26 at 8:00 A.M., a family member of the resident said he/she reminded staff a nephrology appointment was ordered in February and still had not been set-up. He/She said blood work completed 02/08/26 showed the resident was in Stage Four Kidney failure. The facility originally had a urology appointment set up for the resident but the family was told by staff to cancel it and just have the resident see the nephrologist. Review of the Resident Roster, dated 04/12/26, did not show the resident as admitted to the facility. During an interview on 04/15/26 at 10:58 A.M., Licensed Practical Nurse (LPN) A said he/she is responsible for scheduling appointments but during that time another staff member was assigned to set up appointments. He/She said the employee responsible does not work at the facility any longer. He/She said the employee told the family to cancel the urology appointment and just go to the nephrologist. The LPN is not sure why the appointment was not set up timely for the resident but would expect the appointment set up even if it was for a future date and attempts documented. He/She said he/she believes the appointment was set up prior to the residents discharge to another facility but could not confirm it. During an interview 04/15/26 at 11:36 A.M., the Director of Nursing (DON) he/she did not work for the facility during the timeframe but would expect the nursing staff to set up appointments within a day or two of getting the order and communicating that to the families. He/She said attempts to set up appointments, dates of appointments, any transportation needs, and family contact should be documented in the resident record. #2961796

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F 0584 Level of Harm - Potential for minimal harm Residents Affected - Many	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. Based on observation, interview and record review, the facility staff failed to provide a clean, comfortable and homelike environment for residents, when staff failed to maintain one of one shower rooms free of an excessive buildup of foreign material. This failure has the potential to affect all residents. The facility census was 27.F1. Review of the facility's policy titled Safe and Homelike Environment, dated 2025, showed housekeeping and maintenance services will be provided as necessary to maintain a sanitary, orderly and comfortable environment. Review showed the policy did not contain specific guidance related to the resident shower room. Observation on 04/14/26 during the Life Safety Code tour showed the facility equipped with one shower room for use by all residents. Observation showed the spa tub contained a large amount of brown discoloration that extended from the faucet all the way down the tub to the drain area. Observation showed all three walls of the shower, the shower grab bar, and the shower caddy contained a large amount of a thick white substance. Observation also showed the outer edges of the shower floor contained a large buildup of white and off-white substances. During an interview on 04/14/26 at 12:10 P.M., Housekeeper H said staff clean the shower daily. The housekeeper said the thick white substance, which had been in the shower for quite some time, was limescale buildup and he/she thought maintenance staff had some kind of chemical to remove it. During an interview on 04/15/26 at 8:30 A.M., the housekeeping supervisor said nursing staff are responsible to clean the tub and shower after each use. The supervisor said housekeeping staff tried to clean the shower and tub a few months ago but they could not remove all of the buildup. The supervisor said he/she thought if the tub and shower were deep cleaned more regularly the buildup would not be so bad, but he/she never discussed this with the nursing or maintenance staff. The supervisor said he/she would expect the tub and shower to be clean and free of excessive limescale. During an interview on 04/15/26 at 10:09 A.M., the maintenance director said nursing staff are responsible to clean the tub and shower daily and housekeeping staff also deep clean the shower and tub but he/she did not know how often. The maintenance director said he/she is responsible to remove the scale buildup on the tub and shower. The maintenance director said he/she has known the tub and shower needed the limescale removed for about two or three months, but he/she got busy with other things and had not addressed it. During an interview on 04/15/26 at 11:34 A.M., the administrator said housekeeping is responsible to keep the tub and shower clean and free of limescale buildup. The administrator said he/she just found out about the issues and the shower room should not be in that condition.