STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265605	A. Building B. Wing	11/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Forsyth Care Center	477 Coy Blvd Forsyth, MO 65653

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 failed to store, prepare and distribute and serve food in accordance with professional standards of practice and in a manner to prevent possible contamination when the facility failed to keep dented cans separated from other cans, when the facility staff failed to ensure all food items were properly labeled and sealed, failed to ensure expired foods were discarded, when the facility staff failed to ensure fans in food areas were free from dirt and debris, and when staff stacked dishes while still wet. This had the potential to affect all residents who consumed food from the facility kitchen. The facility census was 93 residents.1. Review of the 2022 Food and Drug Administration (FDA) Food Code showed the following information:-Depending on the circumstances, rusted, and pitted or dented cans may present a serious potential hazard;-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. Review of the facility policy titled, Food Storage (Dry, Refrigerated, and Frozen), undated, showed dented cans are to be set aside in a separate labeled area of the storeroom to avoid using them and discarded according to vending procedure.Observation on 08/25/25, at 10:20 A.M., of the canned food rack showed the following:-One seven pound and five ounce (oz) can of baked beans with a large dent on the bottom near the rim;-One six pound and 10 oz can of pineapple tidbits with a large dent on one entire side of the can;-One six pound and six oz can of sliced pears with a medium dent;-One six pound and six oz can of peaches with a medium dent near the bottom at the rim and a smaller dent on the bottom near the rim.Observation on 08/28/25, at 10:40 A.M., of the canned food rack showed the following:-One seven pound and five ounce (oz) can of baked beans with a large dent on the bottom near the rim;-One six pound and 10 oz can of pineapple tidbits with a large dent on one entire side of the can;-One six pound and six oz can of sliced pears with a medium dent;-One six pound and six oz can of peaches with a medium dent near the bottom at the rim and a smaller dent on the bottom near the rim;-One three pound and two oz can of cream of potato soup with small dent on top at the rim;-One three pound and two oz can of cream of mushroom soup with a small dent on the rim at the top.During an interview on 08/28/25, at 9:35 A.M., Dietary Aide (DA) L said the following:-Dented cans should not be on the rack with other cans;-He/she would remove a dented can from the rack and notify the Dietary Manager (DM);-He/she was unsure if there is a designated place to store dented cans;-He/she would not use food from a dented can unless he/she dropped it and cause the dent and used the food right away.During an interview on 08/28/25, at 9:51 A.M., DA M said the following:-Staff should not use food from a dented can;-He/she pulls dented cans and stores them in the designated area which is the DM's office.During an interview on 08/28/25, at 10:02 A.M., Dietary [NAME] (DC) N said the following:-Staff should never use food from a dented can;-Staff should pull dented cans from the rack and store in the DM's office.During an interview on 08/28/25, at 10:19 A.M., the DM said the following:-Staff should never use food from a dented can;-Staff should pull dented cans from the rack and store in her office;-She notified the food representative for credit.During an interview on 09/02/25, at 5:11 P.M. the Administrator said staff should not use dented cans and should store in a separate designated area.2. Review of the US Food (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	and Drug Administration policy, under the section of Food Labeling and Handling, updated 03/04/23, showed the following:-Facility staff must ensure their proper storage, keeping track of when to discard perishable foods, and covering, labeling, and dating all foods stored in the refrigerator or freezer as indicated;-Labeling, dating, and monitoring refrigerated food, including, but not limited to leftovers, so it is used by its use by date, or frozen (where applicable), or discarded.Review of the facility policy titled, Food Storage (Dry, Refrigerated, and Frozen), undated, showed the following:-All food items will be labeled. The label must include the name of the food and the date by which it should be consumed or discarded;-Discard food that has passed the expiration date, and discard food that has been prepared in the facility after send days of storing under proper refrigeration;-Leftover contents of cans and prepared food will be stored in covered, labeled and dated containers in refrigerators and/or freezers.Observation on 08/25/25, at 10:20 A.M., of the kitchen showed the following:-The following containers of seasonings with the lids open to air: rosemary leaves, garlic powder, parsley flakes, celery salt, two containers of onion powder, ground nutmeg, dill weed, lemon and pepper seasoning, salt, ground ginger, and mediterranean style oregano;-Two plastic squeeze bottles containing a substance resembling dressing with no label, and one medium sized jar of white liquid with no label in the standing refrigerator;-In the walk-in refrigerator was a plastic four-quart container of apple sauce with an unsealed lid, a gallon sized plastic bag with containing sausage patties with no label, a two-gallon plastic bag containing one hot dog labeled 08/06/25, and a gallon size plastic bag containing lunch meat labeled 08/18/25;-In the walk-in freezer was four crusts in a plastic bag open to air with no label, large plastic bag containing bread sticks with a hole in the bag open to air with no label, large plastic bag containing rolls open to air with no label, and a two-gallon plastic bag of some type of leftover meat with no label.Observation on 08/28/25, at 10:40 A.M., of the kitchen showed the following:-The following containers of seasonings with the lids open to air: rosemary leaves, garlic powder, parsley flakes, celery salt, two containers of onion powder, ground nutmeg, dill weed, lemon and pepper seasoning, salt, ground ginger, and mediterranean style oregano;-In the walk-in refrigerator was a two-gallon plastic bag containing sliced cheese unsealed and open to air, bag of cooked chicken labeled 8/23-8/26, and bag of hot dogs labeled 8/26, and a bag of salad labeled 8/27.Observation on 08/28/25, at 11:15 A.M., of the kitchen showed the following:-In the walk-in freezer was a blue bag containing green beans unsealed and open to air, a bag of beef patties inside a box unsealed and open to air, four crusts in a plastic bag open to air with no label, large plastic bag containing bread sticks with a hole in the bag open to air with no label, large plastic bag containing rolls open to air with no label, and a two-gallon plastic bag of some type of leftover meat with no label.During an interview on 08/28/25, at 9:35 A.M., DA L said the following:-Staff should store opened food in a sealed container labeled with the date opened and the use by date;-Leftover food items such as pudding, drinks, and soup should be used within three days.During an interview on 08/28/25, at 9:51 A.M., DA M said staff should store opened food in a sealed container labeled with the food name, date opened, and the use by date.During an interview on 08/28/25, at 10:02 A.M., DC N said the following:-All stored opened food should be sealed, labeled, and dated with the open date and use by date;-Leftovers should be used within three days;-Staff should discard all expired foods.During an interview on 08/28/25, at 10:19 A.M., the DM said the following:-All stored opened food should be sealed, labeled, and dated with the open date and use by date;-Leftovers should be used within three days;-Staff should dump all expired foods.During an interview on 09/02/25, at 5:11 P.M., the Administrator said opened food should be labeled, dated and sealed. Leftovers should be stored for three days and then discarded.3. Review of the 2022 Missouri Food Code showed food shall be protected from contamination by storing the food in a clean, dry location, and where it is not exposed to splash, dust, or other contamination.Review showed the facility did not provide a policy or cleaning schedule related to cleaning the fans in the walk-in refrigerator or freezer.Observation on 08/25/25, at 10:20 A.M., of the kitchen showed the following:-Fans inside the walk-in refrigerator had dirt and dust on them, and they were blowing (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	directly over food;-Fans inside the walk-in freezer had dirt and dust on them, and they were blowing directly over food.Observation on 08/28/25, at 10:40 A.M., of the kitchen showed fans inside the walk-in refrigerator had dirt and dust on them, and they were blowing directly over food.Observation on 08/28/25, at 11:15 A.M., of the kitchen showed fans inside the walk-in freezer had dirt and dust on them, and they were blowing directly over food.During an interview on 08/28/25, at 9:51 A.M., DA M said maintenance was responsible for cleaning the fans in the walk-in refrigerator and freezer.During an interview on 08/28/25, at 10:02 A.M., DC N said the following:-Maintenance was responsible for cleaning the fans in the walk-in refrigerator and freezer;-The fans in the walk-in refrigerator and freezer should not have dust or dirt particles on them.During an interview on 08/28/25, at 10:19 A.M., the DM said the following:-Maintenance was responsible for cleaning the fans in the walk-in refrigerator and freezer;-She was unsure of the schedule related to cleaning the fans in the walk-in refrigerator and freezer;-The fans in the walk-in refrigerator and freezer should not have dust or dirt particles on them.During an interview on 09/02/25, at 1:35 P.M, the Maintenance Director said the following:-He thought it was his responsibility to clean the fans in the walk-in refrigerator and freezer, but was unsure;-He had not cleaned them since he started his position in February of 2025, and no one informed him it was his responsibility;-The fans should not have dirt and debris on them.During an interview on 09/02/25, at 5:11 P.M., the Administrator said there should be no dirt or debris on fans over food. 4. Review of the Missouri Food Code, published 2022, showed dishes are required to be air dried before being stacked and stored. Review of the facility policy titled, Dish and Utensil Handling, undated, showed the following:-All silverware, dishes and glasses shall be handled to ensure sanitary conditions and infection control;-Dishes, cups, and glasses will be air-dried prior to storing;-Plates, soup bowls, salad bowls, and bread plates are stored on a rack covered.Observation on 08/28/25, at 10:40 AM., showed the following:-Plastic bowls stacked on a shelf under a table while still wet;-Plate covers stacked on the steam table while still wet.During an interview on 08/28/25, at 9:35 A.M., DA L said the following:-He/she washes dishes in the facility;-He/she stacked bowls upside down in the tub and does not allow for time for them to air dry;-He/she should not stack dishes with water, but the bowls drains since they are turned upside down;-He/she washes the insulated plate covers, dumps the water out, and stacks on the serving table to use for meal serve out with no drying process.During an interview on 08/28/25, at 9:51 A.M., DA M said all dishes should be air dried before stacking, and no dishes should be stacked wet.During an interview on 08/28/25, at 10:02 A.M., DC N said staff should air dry all dishes and bowls and insulated plate covers should not be stacked with water in them.During an interview on 08/28/25, at 10:19 A.M., the DM said staff should air dry all dishes before putting away for use, and no dishes should be stacked wet.During an interview on 09/02/25, at 5:11 P.M. the Administrator said dishes should be dried completely before stacking.

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, observation, and record review, the facility failed promote each resident's right to self-determination when the facility failed to provide services to maintain good grooming and personal hygiene in accordance with resident preferences for five residents (Resident #86, #77, #84, #82, and #64). The facility census was 93.Review showed the facility did not provide a policy related to showers. 1. Review of Resident #86's face sheet (a document that gives a resident's information at a quick glance) showed the following information:-admission date of 06/12/25;-Diagnoses included diabetes (a chronic condition in which the body cannot regulate blood sugar levels properly), chronic pain, high blood pressure, and chronic osteomyelitis (an autoimmune disease that causes bone inflammation). Review of the resident's admission Minimum Data Set (MDS - a federally mandated comprehensive assessment instrument completed by facility staff), dated 06/18/25, showed the following information:-Resident was cognitively intact;-Used wheelchair for mobility;-Dependent for showers, dressing, and toileting;-Required substantial staff assistance for bed mobility and transfers. Review of the resident's care plan, dated 08/06/25, showed staff did not care plan related to the resident's cares or need for assistance. Review of the resident's June 2025 shower sheets showed the resident received a shower on 06/25/25. Review of the resident's July 2025 shower sheets showed the resident received a shower on 07/10/25, 07/23/25, and 07/31/25. Review showed the facility did not provide resident shower sheets for the month of August 2025. Observation on 08/25/25, at 10:20 A.M., showed the resident sat in a wheelchair watching television. The resident's hair appeared to be greasy. During an interview on 08/27/25, at 3:15 P.M, the resident said he/she felt dirty with greasy hair and when he/she did not receive a shower. 2. Review of Resident #77's face sheet showed the following information:-admission date of 10/08/24;-Diagnoses included diabetes, high blood pressure, and congestive heart failure (CHF-chronic condition where the heart doesn't pump blood as well as it should). Review of the resident's quarterly MDS, dated [DATE], showed the following information:-Resident was cognitively intact;-Used wheelchair for mobility;-Supervision to partial assistance needed with showers, toileting, and mobility. Review of the resident's care plan, dated 04/28/25, showed the following:-Resident had a self-care deficit and required one staff assistance with activities of daily living (ADL-basic tasks that individuals perform to maintain their daily life);-At risk for falls. Review of the resident's June 2025 shower sheets for June 2025 showed the resident received a shower on 06/19/25 and (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	06/26/25.Review of the resident's July 2025 shower sheets showed the resident received a shower on 07/03/25, 07/11/25, 07/25/25, 07/31/25. Review of the resident's August 2025 shower sheets showed the resident received a shower on 08/15/25. During an interview on 08/26025, at 1:10 P.M., the resident the facility had been pulling the shower aide to the floor, and he/she usually gets one a week. He/she would like to have more showers. 3. Review of Resident #84's face sheet showed the following information:-admission date of 01/17/24;-Diagnoses included chronic obstructive pulmonary disease (COPD - a chronic lung disease typically causing breathing difficulty), chronic pain, communication deficit, muscle weakness, shortness of breath. Review of resident admission MDS, dated [DATE], showed the following information:-Resident was cognitively intact;-Used a wheelchair for mobility;-Partial / moderate assist for upper and lower body dressing;-Set up assistance for showers, toileting. Review of the resident's care plan, dated 04/15/25, showed the following:-Resident has an ADL performance deficit due to activity intolerance;-Staff will assist resident with shampoo and shower at least one time a week;-Resident needs one staff member to assist with transferring, toileting, bathing. Review of the resident's June 2025 shower sheets showed the resident received a shower on 06/26/25 and 06/30/25. Review of the resident's July 2025 shower sheets showed the resident received a shower on 07/21/25 and 07/28/25. Review of the resident's August 2025 shower sheets showed the resident received a shower on 08/12/25 and 08/26/25. During an interview on 08/25/25, at 1:30 P.M., the resident stated the following:-The facility was frequently short on staff;-The shower aides got pulled to the floor to help;-He/she did not believe residents were getting their showers like they are supposed to because of low staffing;-There was only one shower aide for the whole building;-He/she would like at least two showers a week and feels lucky to get one shower a week;-He/she feels frustrated because of the lack of showers. 4. Review of Resident #82's face sheet (basic resident profile information) showed the following:-admission date of 11/16/19;-Diagnoses included congestive heart failure (CHF-chronic condition in which the heart does not pump blood as well as it should), chronic obstructive pulmonary disease (COPD-group of diseases that block airflow and make it difficult to breathe), obstructive and reflux uropathy (urine flow is blocked in the urinary tract), chronic kidney disease, obsessive compulsive disorder (excessive thoughts that lead to repetitive behavior), peripheral vascular disease (condition in which narrowed blood vessels reduce blood flow to the limbs), repeated falls, and dementia. Review of the resident's quarterly MDS, dated [DATE], showed the following:-Cognitively intact;-Required partial to moderate assistance for bathing. Review of the resident's care plan, last revised on 05/08/25, showed the following:-Resident had a self-care deficit with ADLs, such as bathing, hygiene, dressing, and toileting related to CHF, COPD, and weakness;-Resident will be appropriately dressed and groomed through next review;-Provide (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	resident with clean and matching clothing daily and as needed;-Resident will be shampooed and showered at least one time weekly with fingernails and toenails cleaned and checked;-Resident required assistance of one staff for dressing, transferring, toileting, and bathing. Review of the resident's progress notes for July 2025 and August of 2025 showed staff did not document pertaining to showers/bathing. Review of the resident's July 2025 shower sheets showed the following information:-On 07/11/25, staff provided a shower and noted redness to skin;-On 07/21/25, staff documented the resident refused a shower, and the resident signed the sheet. Staff did not document further attempts;-On 07/25/25, staff provided a shower and noted redness to skin;-On 07/28/25, staff documented the resident refused a shower. The resident did not sign the sheet. Staff did not document of further attempts;-On 07/29/25, staff provided a shower and noted redness to the skin. Review of the resident's August 2025 shower sheets showed on 08/26/25, staff provided a shower and documented a patch on the skin. During interviews on 08/25/25, at 2:16 P.M., on 08/26/25, at 1:39 P.M., and on 08/27/25, at 2:34 P.M., the resident said the following:-It has been at least two weeks since he/she had a shower;-He/she would like to have two showers per week;-He/she felt dirty, and his hair felt greasy before he/she got a shower. During an interview on 08/29/25, at 3:10 P.M., Certified Nurse Aide (CAN) J said the resident had been complaining about not receiving showers. During an interview on 09/02/25, at 9:44 A.M., Licensed Practical Nurse (LPN) A said the resident preferred two showers per week, but sometimes only received one. During an interview on 09/02/25, at 2:49 P.M., Assistant Director of Nursing (ADON) said the resident will only accept showers from certain staff. 5. Review of Resident #64's face sheet showed the following:-admission date of 02/06/12;-Diagnoses included stroke (CVA), COPD, chronic ischemic heart disease (condition where the arteries that supply blood to the heart become narrowed or blocked over time), anxiety disorder, major depressive disorder, hereditary and idiopathic neuropathy (group of inherited disorders that affect the peripheral nervous system), hemiplegia affecting left nondominant side (condition that causes paralysis or weakness on one side of the body), repeated falls, seizure disorder, personal history of methicillin resistant staphylococcus aureus infection (past infection with this antibiotic resistant bacterium), and contracture of left wrist. Review of the resident's MDS, dated [DATE], showed the following:-Cognitively intact;-Required maximum assistance from staff for showers/bathing. Review of the resident's care plan, last revised 06/25/25, showed the following:-Resident had an ADL self-care performance deficit related to left side hemiplegia, prior CVA requiring removal of blood to relieve pressure;-Resident will maintain current level of function through the next review date;-Resident required maximum assistance from staff for dressing;-Resident required maximum assistance from staff for transfers. (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the resident's July 2025 and August of 2025 progress notes showed staff did not document pertaining to showers/bathing. Review of the resident's July 2025 shower sheets showed the following:-On 07/21/25, staff provided a shower and noted abnormal skin color on the left foot;-On 07/28/25, staff documented the resident wanted a shower on 07/29/25, after breakfast;-Staff did not document any other showers for the month of July of 2025. Review of the resident's August 2025 shower sheets showed the following:-On 08/26/25, staff documented the resident refused a shower, the resident did not sign the sheet;-On 08/27/25, staff provided a shower. During an interview on 08/25/25, at 2:58 P.M., the resident said the following:-He/she would like more showers;-He/she has not had a shower for at least a couple of weeks;-He/she received showers sometimes once a month and sometimes once every couple of weeks;-He/she did have his/her hair washed in the beauty shop last week. During interviews on 08/27/25, at 2:18 P.M. and 3:07 P.M., the resident said the following:-He/she received a shower before noon today and felt better;-He/she felt dirty and neglected before the shower because it had been at least two weeks since the last one;-He/she does not believe he/she has had two showers per week the entire stay in the facility;-He/she has expressed the preference for two showers per week to the ADON and Director of Nursing (DON). During an interview on 08/29/2025, at 3:10 P.M., CNA J said the resident has been complaining about not receiving showers. During an interview on 09/02/25, at 9:44 A.M., LPN A said the resident preferred two showers per week, and he/she did not realize the shower last week was the first for the month. During an interview on 09/02/25, at 2:49 P.M., the ADON said the resident will only accept showers from certain staff and takes 45-minute showers. During an interview on 09/02/25, at 4:09 P.M. the Director of Nursing (DON) said the resident can be difficult about when and who he/she allows to give a shower. 6. During an interview on 08/27/25, at 9:28 A.M., CNA E said he/she was the shower aide. Showers are scheduled once a week, but he/she gets pulled from showers to work the floor a lot. He/she is behind with showers at times. Shower sheets are completed are if a resident receives a shower. The resident will sign a shower sheet if he/she refuses a shower. The nurse will sign the shower sheet for residents that are unable to do so. During an interview on 08/29/25, at 2:50 P.M., CNA I said the following:-He/she does not usually give showers unless they carry over from the day shift or a resident prefers evenings;-Facility policy is residents should receive one shower per week;-If a resident prefers two showers per week, staff will try to squeeze them in for a second one. During an interview on 08/29/25, at 3:10 P.M . CNA J said the following:-The facility has an assigned shower aide during the week;-He/she gives showers when they are behind because of pulling the shower aide to the floor;-Residents should get at least one shower per week;-Staff document resident refusals on the shower sheet, have resident sign, and turn into the nurse. (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 08/28/25, at 12:39 P.M., LPN K said showers should be given three times a week. Residents are not getting showers three times a week due to staffing. Residents have complained to him/her about not getting showers. During an interview on 09/02/25, at 9:44 A.M., LPN A said the following;-Residents should receive two showers per week;-Staff should document refusals on the shower sheet and turn into the ADON;-Residents are not receiving two showers per week due to short staffing and the shower aide being pulled to the floor;-He/she doubts residents have been receiving even one shower during some weeks. During an interview on 09/02/25, at 10:49 A.M. LPN F said the following:-Residents should receive two showers per week;-The facility is short staffed, and the shower aide gets pulled to the floor;-Residents have complained about not receiving showers. During an interview on 09/02/2025, at 2:01 P.M., the MDS Coordinator said best practice would be for staff to include resident shower preferences for frequency, day, time in the care plan. During an interview on 09/02/25, at 2:49 P.M. the ADON said the following:-Facility policy is for residents to receive two showers per week, and this is not happening;-The facility is having a difficult time finding staff, and the shower aide gets pulled to the floor;-Residents are receiving an average of one shower per week;-Residents have complained about not receiving showers;-Staff document refusals on the shower sheet and have the resident sign the sheet. During an interview on 09/02/25, at 4:09 P.M. the DON said the following:-Residents should have a minimum of one shower per week;-The facility is having staffing issues, and the shower aides are pulled to the floor;-There have probably been weeks where residents did not receive one shower per week;-They have received approval to bring in agency staff, but they call in often. During an interview on 09/02/25, at 5:11 P.M. the Administrator said the following:-Residents should receive at last two showers per week;-It is the DON's responsibility to ensure showers are done;-Shower aides are being pulled to the floor;-He was not aware residents have not been receiving two showers per week. Complaint 1711133, 2585798

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed document identification and use of possible alternatives prior to use of side rails; failed to document assessing risk versus benefits of side rail use; failed to obtain informed consent for the use of side rails prior to installation; failed to care plan side rails; and failed to complete ongoing assessments to ensure the side rails are appropriate for use for eight residents (Resident #1, Resident #2, Resident #12, Resident #19, Resident #47, Resident #86, Resident #77, and Resident #100). The facility census was 93.Review of the facility's policy titled Bed Rails, dated December 2024, showed the following:-Prior to the installation of bed rails, attempts to provide the residents with alternative measures to meet their need for positions, mobility, or transfer ability while in bed will be made;-When alternatives are deemed ineffective or not adequate to meet the resident's needs, the resident will be assessed for the use of bed rails, including the risk of entrapment. In addition, informed consent is obtained from the resident or resident's representative;-Bed rails (which can also be referred to as safety rails) are defined as adjustable metal or rigid plastic bars that attach to the bed. The rails are available in a variety of types, shapes, and sizes ranging from full to one-half, one-quarter, or one eighths length;-Bed rails may not be designed as part of the bed by the manufacturer and may be installed on or used along the side of the bed;-Bed rails may include, but are not limited to bed rails, safety rails, U-bars, halo bars, grab bars, assist bars. 1. Review of Resident #1's face sheet (basic resident profile information) showed the following:-admission date of 08/01/25;-Diagnoses included vascular dementia (brain damage caused by multiple strokes), generalized anxiety disorder and type two diabetes mellitus (long term condition in which the body has trouble controlling blood sugar and using it for energy). Review of the resident's comprehensive Minimum Data Set (MDS-federally mandated assessment tool administered by staff), dated 08/11/25, showed the following:-Severe cognitive impairment;-Resident required substantial/maximum assistance from staff with activities of daily living (ADLs). Observation on 08/26/25, at 3:55 P.M., showed a metal quarter side rail on right side of the resident's bed in raised position and extremely loose. The side rail was not raised straight in the air. It was at an angle due to being loose. Observation on 08/27/25, at 1:28 P.M., showed the side rail remained in raised position and loose at an angle. Observation on 08/28/25, at 8:58 A.M., showed the side rail remained in raised position and loose at an angle. Observation on 08/28/25 , at 1:03 P.M., showed the side rail remained in raised position and loose at an angle. Observation on 09/02/25, at 9:33 A.M., showed the side rail remained in raised position and loose at an angle. Review of the resident's care plan, dated 08/08/25, showed staff did not care plan regarding the resident's use of a side rail. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the resident's record showed staff did not document completion of a side rail assessment or any measurements for the risk of entrapment. Review of the resident's record showed staff did not document review of the risks and benefits of side rails with the resident's representative and did not obtain a signed consent for side rail usage. During an interview on 09/02/25, at 9:44 A.M., Licensed Practical Nurse (LPN) A said the following:-The resident slept in his/her bed;-The resident required assistance with transferring in and out of bed, but did use the side rail for positioning while in bed;-He/she does not check side rails for safety daily, and did not notice the resident's side rail was loose. During an interview on 09/02/25, at 1:35 P.M., the Maintenance Director said the following:-He tightened the resident's side rail today and will be checking that daily as the resident pulls on it quite a bit;-He had never checked the resident's side rail before today. During an interview on 09/02/25, at 2:49 P.M., the Assistant Director of Nursing (ADON) said the following: -She was unsure if the resident had side rails on his/her bed upon admission;-The resident was cognitively able to side rails for repositioning. During an interview 09/02/25, at 4:09 P.M., the Director of Nursing (DON) said the following:-The resident had a rental bed for hospice with the rails on and had not had an assessment;-The resident kicks and shakes the bed and might be making the side rails loose. 2. Review of Resident #2's face sheet showed the following: -admission date of 01/31/25;-Diagnoses included dementia, and muscle weakness. Observations on 08/26/25, at 9:06 A.M., showed the resident in his/her room in in a wheelchair. The resident's bed had quarter side rails on each side of the bed in the up position. Observations on 08/27/25, at 2:14 P.M., showed the resident in his/her bed, with a fall mat on floor and side rails on both sides of the bed in the up position. Observations on 08/29/25, at 9:14 A.M., showed the resident in his/her bed, with a fall mat on floor and side rails on both sides of the bed in the up position. Review of the resident's quarterly MDS, dated [DATE], showed the following:-Resident had significant memory loss and severe cognitive decline;-Resident required substantial assistance for rolling left or right in bed. Review of the resident's care plan, dated 04/02/25, showed staff did not care plan related to the resident side rail use. Review of the resident's August 2025 POS showed staff did not have an order for side rail use. Review of the resident's medical record showed the following: -Staff did not document a side rail assessment/evaluation;-Staff did not document side rail safety check form and completion of a regular inspection of bed frames and side rails;-Staff did not document resident's side rail/grab bar informed consent and release. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. Review of Resident #12's face sheet showed the following information:-admission date of 04/14/23;-Diagnoses included dementia, insomnia (difficulty sleeping), and post traumatic stress disorder (anxiety disorder due to prior traumatic exposure). Review of the resident's MDS, dated [DATE], showed the following information:-Cognitively impaired;-Memory impairment. During an interview on 08/27/25, at 1:32 P.M., in the residents' room, the resident said he/she didn't know why the rails were on his/her bed. The resident said she did not use them. Observation on 08/28/25, at 9:09 A.M., showed the resident lying in bed with side rails up on both sides of the bed. Review of resident's side rail measurements showed the last measurements completed by staff on 07/19/23. Review of the resident's care plan, dated 08/18/25, showed staff did not care plan related to the side rail use. Review of residents' record showed staff did not document completion of a side rail safety assessment. 4. Review of Resident #19 face sheet showed the following information:-admission date of 11/13/23;-Diagnoses included schizophrenia(disorder that affects a person's ability to think, feel, and behave clearly), history of falls, and depression. Review of the resident's MDS, dated [DATE], showed the following information:-Cognitively intact;-Mild memory impairment;-Set up assist for functional abilities. Observations and interview on 08/25/25, at 10:21 A.M., showed the resident lying in bed with side rails up on right side of the bed. The resident said he/she used the side rails to pull herself/himself up in bed. Observation on 08/28/25, at 9:06 A.M., showed the resident lying in bed with side rails on up on right side of the bed. Review of residents' side rail measurements showed staff last completed measurements on 12/11/23. Review of the resident's care plan, dated 03/03/25, showed staff did not care plan related to the resident's side rails. Review of resident's record showed staff did not document completion of the side rail safety assessment. 5. Review of Resident #47's face sheet showed the following: -admission date of 08/26/24;-Diagnoses included muscle weakness and depression. Observations on 08/25/25, at 1:42 P.M., showed the resident in his/her wheelchair in his/her room. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The resident's bed had quarter side rails on each side of the bed in the up position. Observations on 08/29/25. at 9:20 A.M., showed the resident in bed with lights off and blanket pulled over him/herself. Side rails on both sides of bed were in the up position. Observations made on 09/02/25, at 9:26 A.M., showed the resident in bed with lights off and blanket pulled over him/herself. Side rails on both sides of bed were in the up position. Review of the resident's quarterly MDS, dated [DATE], showed the following:-Resident had some memory loss and significant cognitive decline;-Required minimal assistance for rolling left or right in bed. Review of the resident's care plan, dated 6/20/25, showed staff did not care plan related to the resident's use of side rails. Review of the resident's August 2025 POS showed staff did not have physician's order for side rail use. Review of the resident's medical record showed staff did not document side rail assessment/evaluation; did not document side rail safety check form and completion of a regular inspection of bed frames and side rails; and did not document resident's side rail/grab bar informed consent and release. 6. Review of Resident #86's face sheet showed the following information:-admission date of 06/12/25;-Diagnoses included chronic pain and chronic osteomyelitis (an autoimmune disease that causes bone inflammation). Review of the resident's admission MDS, dated [DATE], showed the following information:-Resident was cognitively intact;-Required substantial staff assistance for bed mobility and transfers. Observations on 08/25/25, at 10:20 A.M., on 08/26/25 at 2:51 P.M., and on 08/27/25 at 3:15 P.M., showed the resident sitting in his/her wheelchair in his/her room with both side rails up. Observations on 08/27/25, at 9:41 A.M., showed resident resting in bed with both side rails up next to head of the bed. Review of the resident's care plan, last revised 08/06/25, showed staff did not care plan related to the resident's side rail use. Review of the resident's current POS showed staff did not document an order for the use of side rails. Review showed the facility did not provide any evaluation, consent, or measurements for resident's side rails. Review of the resident's current medical record showed staff did not document identification and use of possible alternatives prior to use of side rails, assessing risk versus benefits of side rail use, or ongoing assessments to ensure the side rails were appropriate for use. 7. Review of Resident #77's face sheet showed the following information:-admission date of (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	10/08/24;-Diagnoses included congestive heart failure (CHF-chronic condition where the heart doesn't pump blood as well as it should). Review of the resident's quarterly MDS, dated [DATE], showed the following information:-Resident was cognitively intact;-Used wheelchair for mobility;-Supervision to partial assistance needed with showers, toileting, and mobility. Observation and interview on 08/25/25, at 11:00 A.M., showed the resident sat up in a wheelchair in his/her room with a grab bar on the bed in the up position. The resident reported the half side rail on the right side of the bed was used for mobility, Observation on 08/26/25, at 11:14 A.M., showed the resident resting in bed with the right half side rail up. Review of the resident's care plan, dated 04/28/25, showed staff did not care plan related to the resident's side rail use. Review of the resident's current POS showed staff did not document an order for side rail use. Review showed the facility did not provide any evaluation, consent, or measurements for resident's side rails. Review of the resident's current medical record showed staff did not document identification and use of possible alternatives prior to use of side rails, assessing risk versus benefits of side rail use, or assessments to ensure the side rails were appropriate for use. 8. Review of Resident #100's face showed the following information:-admission date of 08/14/25;-Diagnoses included fracture of the humerus (upper arm bone) on right arm. Observation and interview on 08/26/25, at 3:03 P.M., showed the resident was resting in bed with both half side rails in the up position at the head of the bed. The resident reported he/she uses the left side rail to pull up in bed, but he/she was unable to use the right side due to wearing a cast. Observations on 08/25/25, at 10:25 A.M., and on 08/27/25, at 3:07 P.M., showed the resident was resting in bed with both half side rails up next to head of the bed. Review of the resident's care plan, dated 08/25/25, showed staff did not care plan related to the resident's side rail use. Review of the resident's current POS showed staff did not document an order for side rail use. Review showed the facility did not provide any evaluation, consent, or measurements for resident's side rails. Review of the resident's current medical record showed staff did not document identification and use of possible alternatives prior to use of side rails, assessing risk versus benefits of side rail use, or ongoing assessments to ensure the side rails were appropriate for use. 9. During an interview on 08/29/25, at 2:50 P.M., Certified Nurse Assistant (CNA) I said the following:-He/she notifies the nurse if he/she believes a resident could benefit from a side rail, and (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the nurse will discuss with it the Assistant Director of Nursing (ADON) and the Director of Nursing (DON);-He/she raises and lowers side rails to ensure they are functioning every night when he/she lays a resident down for the night. During an interview on 08/29/25, at 3:10 P.M., CNA J said the following:-He/she will let the DON and ADON know if a resident requests or may need side rails;-He/she checks the side rails when putting them in the raised position at night, so the resident doesn't fall out of bed;-He/she would report loose side rails. During an interview on 09/02/25, at 9:44 A.M., LPN A said the following:-The facility has a process to ensure side rails are safe;-The ADON and DON get maintenance involved for measuring for safety and should be care planned;-Residents use side rails for bed repositioning and transferring in and out of bed;-Side rails should never be used to keep a resident from rolling out of bed and would be considered a restraint. During an interview on 09/02/25, at 10:49 A.M. LPN F said the ADON and DON complete side rail evaluations and maintenance does the measurements. Staff will usually catch an issue if loose just by moving side rails up and down throughout the day. During an interview on 08/28/25, at 9:10 A.M., LPN H said the following:-Residents should have a diagnosis that would call for the use of side rails or grab bars;-Side rails are for mobility or as a safety feature for the resident;-The DON or the ADON are responsible for measuring the side rails;-Side rails are not on the bed prior to the resident arrival to the facility;-The resident will usually request side rails, and he/she will put a request into the DON or ADON;-The DON and the ADON will conduct a side rail assessment;-He/she did not know if the resident needed to sign anything prior to obtaining side rails;-He/she did not know who installed the side rails;-Side rails should be included in the care plan. During an interview on 08/28/25, at 12:39 P.M., LPN K said the facility only used half side rails. Side rails required an assessment and a consent. He/she had never seen a consent for side rails at the facility. Side rails should be used to assist a resident with mobility. Side rails should be assessed regularly and included in the care plan. During an interview on 08/28/25, at 12:00 P.M., Registered Nurse (RN) G said the following:-The residents decide if they want side rails;-Side rails are used for positioning in bed;-Side rails need to be assessed because they can be an entrapment risk;-He/she did not know who was responsible for assessing side rails. During an interview on 09/02/25, at 1:35 P.M., the Maintenance Director said the following:-He had never completed a side rail assessment, but was his responsibility as of today;-He will be completing measurements and regular periodic safety checks along with the housekeeping supervisor. During an 09/02/25, at 2:01 P.M., the MDS Coordinator said side rails should be included in the care plan. During an 09/02/25, at 2:49 P.M., the ADON said the following: -Side rail consents should be completed by nurse on admission, and the ADON, DON, and maintenance complete the rest of the process including measurements;-The process does not include any type of interventions prior to unless they are on the unit first and then therapy says they need them;-Staff should complete periodic checks for safety, aides should always be checking. There are no quarterly or regular documented safety checks or assessments. During an interview on 09/02/25, at 4:09 P.M. the DON said the following:-Residents request side rails upon admission and sign a consent;-The ADON and DON did complete measurements, but the new (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	ownership wants maintenance to complete the measurements;-Measurements will be completed annually or if there is a mattress change or any other changes;-Safety checks were previously completed quarterly at care plan meetings. During an interview on 09/02/25, at 5:11 P.M., the Administrator said the following;-Side rails should include an order, assessment, measurement, and consent with risks and benefits;-Interventions should be attempted first when possible;-Side rails should be care planed;-Staff should complete monthly safety checks;-Side rails should never be used as a restraint.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to maintain a complete and effective infection prevention and control program when the facility failed to ensure staff were educated on enhanced barrier precautions (EBP - infection control interventions designed to reduce transmission of resistant organisms that employs targeted gown and glove use during high contact resident care activities); failed to ensure staff wore appropriate protective personal equipment (PPE) when providing catheter care for two residents (Resident #1 and #66) with a catheter (flexible tubing that is used to drain urine from the bladder) and when accessing a peripherally inserted venous catheter (PICC - a tube inserted into a large vein near the heart got long term IV access) for one resident (Resident #101); when the facility failed to ensure EBP was care planned for two residents (Resident #1 and #66) with a catheter and one resident (Resident #101) with a PICC; and when the facility failed to post clear signage on the doors or walls outside of three resident rooms (Resident #1, Resident #64, and Resident #101) indicating the type of precautions and required PPE. The facility census was 93.Review of the Centers for Disease Control's (CDC) Implementation of Personal Protective Equipment Use in Nursing Homes to Prevent Spread of Multidrug-Resistant Organisms, dated 07/12/22, showed the following:-Multidrug-Resistant Organisms (MDRO - microorganisms that are resistant to one or more classes of antimicrobial agents) transmission is common in skilled nursing facilities, contributing to substantial resident morbidity and mortality and increased healthcare costs;-EBP are infection control interventions designed to reduce transmission of resistant organisms that employs targeted gown and glove use during high contact resident care activities;-EBP may be indicated (when contact precautions do not otherwise apply) for residents with any of the following: wounds or indwelling medical devices, regardless of MDRO colonization status, and infection or colonization with an MDRO;-Effective implementation of EBP requires staff training on the proper use of PPE and the availability of PPE and hand hygiene supplies at the point of care;-EBP use of PPE refers to the use of gown and gloves during high-contact resident care activities that provide opportunities for transfer of MDROs to staff hands and clothing;-Examples of high-contact resident care activities requiring gown and glove use for EBP includes dressing, bathing/showering, transferring, providing hygiene, changing linens, changing briefs or assisting with toileting, device care or use such as central line, urinary catheter, feeding tube, and tracheostomy/ventilator, and wound care on any skin opening requiring a dressing;-Post clear signage on the door or wall outside of the resident room indicating the type of precautions and required PPE; -Make PPE, including gowns and gloves, available immediately outside of the resident room. Review of the facility policy titled, Infection Prevention and Control Manual-Enhanced Barrier Precautions, undated, showed the following:-Enhanced Barrier Precautions (EBP) are an infection control intervention designed to reduce transmission of multidrug-resistant organisms (MRDOs) in nursing homes;-EBP involves gown and glove use during high-contact resident care activities for residents known to be colonized or infected with a MRDO as well as those at increased risk for MDRO acquisition (residents with wounds or indwelling medical devices). This is because devices and wounds are risk factors placing residents at higher risk for carrying or acquiring a MRDO;-If splashed and sprays are anticipated during the high contact activity, face protection should be used in addition to the gown and gloves;-EBPs are recommended for residents with an infection or colonization (living inside the body without causing active illnesses) with a MRDO or a wound or indwelling medical device, even if the resident is not known to be infected or colonized with a MRDO. Indwelling medical devices include central venous catheters, urinary catheters, feeding tubes, tracheostomies/ventilators;-High-contact resident care activities include bathing/showering, transferring positions of residents, providing hygiene, changing bed linens, changing briefs or assisted (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	toileting, caring for or using an indwelling medical device, and performing would care;-Methicillin-resistant Staphylococcus aureus (MRSA-an infection caused by bacteria commonly found on the skin or in the nose genetically distinct from other strains of staph infections) is an example of an epidemiologically (identifying the where, when, and who of diseases)important MRDO targeted by the Center for Diseases Control (CDC). 1. Review of Resident #1's face sheet (basic resident profile information) showed the following:-admission date of 08/01/25;-Diagnoses pneumonia due to klebsiella pneumoniae (unknown bacteria) and acute kidney failure with tubular necrosis (damage to the kidney tubules impairing the ability to filter blood leading to a buildup of wastes). Review of the resident's comprehensive Minimum Data Set (MDS-federally mandated assessment tool administered by staff), dated 08/11/25, showed the following:-Severe cognitive impairment;-Resident required substantial/maximum assistance from staff with activities of daily living (ADLs);-Resident has indwelling catheter. Review of the facility's current list of residents on EBP did not include the resident. Review of the resident's progress notes showed the following:-On 08/01/25, at 3:32 P.M., resident admitted to facility this morning around 9:45 A.M., via ambulance with foley (catheter) intact. Resident incontinent of bowel;-On 08/23/25, at 1:15 P.M., foley catheter in place and with clear yellow urine noted;-On 08/24/25, at 1:36 P.M., foley catheter in place with clear yellow urine noted;-On 08/30/25, at 1:46 P.M., foley catheter in place with clear urine noted;-On 08/31/25, at 1:22 P.M., foley catheter in place with clear urine noted;-On 08/31/25, at 7:28 P.M., foley catheter with a closed draining system, amber color urine present and draining well, good urine output this evening. Review of the resident's care plan, dated 08/08/25, showed staff did not care plan related to the resident being on EBP or having a catheter. Review of the resident's current physician order sheet showed an order, revised on 08/26/25, with a start date of 09/05/25, to change foley catheter one time every month starting on the 28th for 28 days, change every 28 days. Observation on 08/26/25, at 3:55 P.M. showed no EBP sign on the resident's door. Observation on 08/27/2025, at 1:28 P.M. showed no EBP sign on the resident's door. Observation on 08/28/25, at 8:58 A.M., showed no EBP sign on door. Observation on 08/28/25, at 1:03 P.M., showed no EBP sign on the resident's door. Observation on 08/29/25, at 11:04 A.M., showed the following:-No EBP sign on the resident's door;-Certified Nurse Assistant (CNA) D and CNA E provided catheter care to the resident and donned only gloves and no other PPE;-CNA D and CNA E gathered trash, washed hands, and exited room. Observation on 09/02/25, at 9:33 A.M., showed no EBP sign on door. During an interview on 08/29/25, at 11:25 A.M., CNA D said the following:-EBP means staff should wear gown and gloves;-Not all residents with a foley catheter are on EBP;-The resident is not on EBP (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	because there is no sign on the door. During an interview on 08/29/25, at 11:36 A.M., CNA E said the following:-Staff know if a resident is on EBP because there are signs on the door;-Not all residents with foley are on EBP. During an interview on 09/02/25, at 9:44 A.M., Licensed Practical Nurse (LPN) A said the following:-The resident is not on EBP;-The resident does have a catheter, but did not know residents with catheters should be on EBP;-Staff should include EBP in the care plan. During an interview on 08/29/25, at 2:50 P.M., CNA I said staff have to don both gown and gloves to provide catheter care to a resident due to EBP. During an interview on 09/02/25, at 10:49 A.M., LPN F said the following:-Residents are on EBP due to having catheters, continuous infections, and antibiotic-resistant infections;-The resident has a catheter and should be EBP;-He/she is unsure if staff should include EBP in the care plan. During an interview on 09/02/25, at 2:49 P.M. the Assistant Director of Nursing (ADON) said the resident should be on EBP, have an EBP sign on the door, and staff should include EBP in the care plan. During an interview on 09/02/25, at 4:09 P.M. the Director of Nursing (DON) said the resident should be on EBP, have an EBP sign on the door, and staff should include the EBP in the care plan. During an interview on 09/02/25, at 5:11 P.M., the Administrator said staff should be donning gloves and gowns when providing cares for a resident with a catheter, and an EBP sign should be on the door to alert staff when entering the room. 2. Review of Resident #66's face showed the following:-admission date of 10/03/24;-Diagnoses included benign prostatic hyperplasia (BPH – age associated prostate gland enlargement that can cause urination difficulty). Review of the resident's quarterly MDS, dated [DATE]. showed the following:-Cognitively intact;-Required one staff assistance with showers, toileting, mobility, and transfers;-Used a wheelchair for mobility;-Resident had an indwelling catheter. Review of the resident's care plan, dated 04/29/25, showed the following:-Resident had a urinary catheter;-The resident will show no signs or symptoms of a urinary infection;-Catheter care every shift and as needed;-Monitor, record, and/or report to the physician for signs and symptoms of a urinary tract infection (UTI).(Staff did not care plan related to EBP due to catheter). Review of the resident's current POS showed the following:-An order, dated 02/10/25, for a urinary catheter 18 French (F - size) and 10 milliliter (ml) balloon, change as needed for occlusion (blockage);-An order, dated 02/10/25, for urinary catheter care every shift. During an observation on 08/26/25, at 11:16 A.M., the resident placed his/her call light on due to a complaint of the urinary catheter not secured correctly in the stat lock (a skin adhesive device designed to secure a urinary catheter in place). CNA B entered the resident's room, sanitized his/her hands, and applied gloves. The CNA did not apply a gown. CNA B then unclamped the catheter tubing from the stat lock and adjusted it. CNA B then wiped the catheter tubing with cleansing wipes and (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	placed the tubing back into stat lock and clamped it shut. CNA B then removed gloves and sanitized his/her hands. The resident had an EBP sign on the outside of his/her room door indicating what precautions should be used. 3. Review of Resident #101's face showed the following information:-admission date of on 08/19/25;-Diagnoses included endocarditis (an infection of the heart's inner lining, usually involving the heart valves), sepsis (a condition where the body responds improperly to an infection), and congestive heart failure (CHF-chronic condition where the heart doesn't pump blood as well as it should), Review of the resident's current POS showed the following:-An order, dated 08/19/25, to flush PICC line with10 ml normal saline every shift;-An order, dated 08/20/25, for ceftriaxone (an antibiotic) sodium solution 2 grams, administer 2 grams intravenously once a day;-An order, dated 08/20/25, to flush PICC line before and after IV antibiotic every day for 6 weeks. Review of the resident's care plan, dated 08/21/25, showed the following:-Resident required staff assistance with transfers and toileting;-Had an intravenous line (IV – a tube inserted in the vein to deliver medications or fluids) access right peripherally inserted venous catheter (PICC-a tube inserted into a large vein near the heart got long term IV access) line;-Resident on antibiotics due to endocarditis;-Resident will have not have any complications related to IV access; -Staff should check the IV site daily for redness, swelling, or drainage and report any findings to the nurse;-Staff should monitor, document, and/or report to the physician and signs or symptoms of infection at IV site.(Staff did not care plan related to EBP.) Observation on 08/28/25, at 9:50 A.M. showed LPN H sanitize his/her hands and entered the resident's room to provide IV antibiotics via a PICC line. LPN H placed supplies on the resident's bedside table and explained the procedure to the resident. LPN H applied gloves, but did not apply a gown and placed and prepared the IV medication to administer to the resident. LPN H cleansed the PICC line in the resident's right arm with an alcohol wipe and flushed the line with 10 ml of normal saline. The LPN then opened the IV line and started to administer the medication to the resident. LPN H then removed gloves and washed his/her hands and left the room. There was no sign indicating resident was on EBP prior to entering room. During an interview on 08/28/25, at 12:39 P.M., LPN K said EBP are for a resident with a tracheostomy, a wound, feeding tube, or IV. EBP is used for a resident with any indwelling tube. Staff should wear a gown and gloves to provide any direct care to a resident. 4. Review of Resident #64's face sheet showed the following:-admission date of 02/06/12;-Diagnoses included personal history of methicillin resistant staphylococcus aureus infection (past infection with this antibiotic resistant bacterium. Review of the facility's current list of residents on EBP included the resident. Review of the resident's MDS, dated [DATE], showed the following:-Cognitively intact;-Required substantial/maximum assistance from staff for toileting hygiene, dressing lower body, taking on/off footwear, and showers/bathing. Review of the resident's care plan, last revised 06/25/25, showed the following:-Resident is on EBP due to personal history of methicillin resistant staphylococcus aureus infection;-Resident will be free (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	of active infections while on enhanced barrier precautions;-Staff should wear gown and gloves when performing high-contact resident care activities. Observation on 08/27/25, at 2:18 P.M., showed no EBP sign on the resident's door. Observation on 08/09/25, at 2:17 P.M., showed no EBP sign on the resident's door. Observation o 09/02/25, at 9:35 A.M., showed no EBP sign on the resident's door. Observation on 09/02/25, at 2:20 P.M., showed no EBP sign on the resident's door. During an interview on 08/29/25, at 3:10 P.M., CNA J said the resident is not on EBP. During an interview on 09/02/25, at 9:44 A.M., LPN A said the resident was on EBP due to white blood cell count, and staff should don gown and gloves to provide personal cares. During an interview on 08/29/25, at 2:50 P.M., CNA I said the following:-Residents on EBP should have a sign on their door, and there should be information in the resident record;-Staff should wash hands and don gown and gloves to provide personal cares for residents on EBP. During an interview on 08/29/25, at 3:10 P.M., CNA J said staff should don gown and gloves every time care is performed in the room of a resident on EBP. During an interview on 9/02/25, at 9:44 A.M., LPN A said the following:-Staff know if a resident is on EBP because a sign should be on the door;-Staff discuss new residents on EBP during monthly meetings;-Staff should include EBP in the care plan;-Staff should also know what residents are on EBP through communication. During an interview on 09/02/25, at 2:01 P.M., the MDS Coordinator said staff should include EBP in the care plan. During an interview on 09/02/25, at 2:49 P.M., the ADON said the following:-She completes audits on EBP and checks upon admission;-Staff know a resident is on EBP because of the sign on the door and banners in the electronic record;-Staff should include EBP in the care plan. 5. During an interview on 09/02/25, at 4:09 P.M., the DON said the following:-Residents on EBP should have a sign on their door;-Residents on EBP have a red stop sign in their electronic record;-Staff should include EBP in the care plan. During an interview on 09/02/25, at 5:11 P.M., the Administrator said the following:-Staff should be donning gloves and gowns for cares on residents on EBP;-Residents on EBP should have signs on their doors and other education.

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. Based on interview and record review, the facility failed to provide a Skilled Nursing Facility Advance Beneficiary Notice (SNFABN - form CMS-10055) or the Notice of Medicare Provider Non-Coverage (NOMNC - form CMS-10123) at the initiation, reduction, or termination of Medicare Part A benefits for two sampled residents (Resident #16 and Resident #107) who remained in the facility upon discharge from Medicare Part A services. The facility census was 93.Review of the Centers for Medicare and Medicaid Services Survey and Certification memo (S&C -09-20), dated 01/09/09, showed the following information:-The Notice of Medicare Provider Non-Coverage (NOMNC - form CMS-10123) is issued when all covered Medicare services end for coverage reasons;-If the skilled nursing facility (SNF) believes on admission or during a resident's stay that Medicare will not pay for skilled nursing or specialized rehabilitative services and the provider believes that an otherwise covered item or service may be denied as not reasonable or necessary, the facility must inform the resident or his/her legal representative in writing why these specific services may not be covered and the beneficiary's potential liability for payment for the non-covered services. The SNF's responsibility to provide notice to the resident can be fulfilled by use of SNFABN (form CMS-10055);-The SNFABN provides an estimated cost of items or services in case the beneficiary has to pay for them his/herself or through other insurance they may have;-If the SNF provides the beneficiary with the SNFABN at the initiation, reduction, or termination of Medicare Part A benefits, the provider has met its obligation to inform the beneficiary of his/her potential liability for payment and related standard claim appeal rights. Issuing the NOMNC to a beneficiary only conveys notice to the beneficiary of his/her right to an expedited review of a service termination.Review showed the facility did not provide a policy related to giving the residents or resident representative the NOMNC form CMS-10123 or the SNFABN form CMS-10055.1. Review of Resident #16's SNF Beneficiary Protection Notification Review showed the following information:-On 05/01/25, Medicare Part A skilled services started;-Staff noted 06/20/25 as the last covered day of Medicare Part A service.(Facility staff did not document providing the resident, or his/her legal representative, the required SNFABN form CMS-10055 or the NOMNC form CMS-10123.)2. Review of Resident #107's SNF Beneficiary Protection Notification Review showed the following information:-On 04/07/25, Medicare Part A skilled services started;-Staff noted 05/14/25 as the last covered day of Medicare Part A service. (Facility staff did not document providing the resident or his/her legal representative the required SNFABN form CMS-10055 or the NOMNC form CMS-10123)3. During an interview on 09/02/25, at 3:15 P.M., the Business Office Manager confirmed the facility failed to provide Resident #16 and Resident #107 the required SNFABN form CMS-10055 or the NOMNC form CMS-10123. She said she did not know why the forms had not been given to the residents.During an interview on 09/02/25, at 3:30 P.M., the Administrator said he did not know the facility failed to provide Resident #16 and Resident #107 the required SNFABN form CMS-10055 or the NOMNC form CMS-10123. He said he did not know why the forms had not been given to the residents, and was not sure which staff were responsible for the two forms.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. Based on interview and record review, the facility failed to carry out and document a physician order timely for a discontinued medication and failed to implement monitoring of fluid intake for one resident (Resident #77). The facility census was 93. Review showed the facility did not provide a policy regarding physician orders.1. Review of Resident #77's face sheet (a document that gives a resident's information at a quick glance) showed the following information:-admission date of 10/08/24;-Diagnoses included diabetes (metabolic disorder characterized by high blood sugar levels), high blood pressure, and congestive heart failure (CHF-chronic condition where the heart doesn't pump blood as well as it should).Review of the resident's quarterly Minimum Data Set (MDS - a federally mandated assessment completed by facility staff), dated 04/18/25, showed the resident was cognitively intact.Review of the resident's care plan, dated 04/28/25, showed the following:-Resident had a self-care deficit and required one staff assistance with activities of daily living (ADL-basic tasks that individuals perform to maintain their daily life);-The resident was on diuretic therapy related to edema (swelling).Review of the resident's Physician P progress note, dated 07/10/25, showed an implementation of 1.5-liter fluid restriction. Resident should limit fluids to 1.5 liters (about 6 cups) per day, weigh every day, and report any sudden weight change (more than two pounds daily).Review of the resident's care plan, dated 04/28/25, showed staff did not update the care plan with the new orders for routine weights and fluid intake limit. Review of the resident's physicians' orders showed staff did not update the care plan with the new orders for routine weights and fluid intake limit.Review of the resident's Physician P progress note, dated 07/17/25, showed the following:-Resident should maintain 1.5-liter daily fluid restriction;-Nursing staff to monitor for signs of fluid overload;-Continue daily weight monitoring.Review of the resident's care plan, dated 04/28/25, showed staff did not update the care plan with the new orders for routine weights and fluid intake limit. Review of the resident's physician progress note, dated 08/15/25, showed a fluid restriction continued of 1.5-liter limit, though patient finds this challenging to maintain.Review of the resident's care plan, dated 04/28/25, showed staff did not update the care plan with the new orders for routine weights and fluid intake limit. Review of the resident's physicians' orders showed staff did not update the care plan with the new orders for routine weights and fluid intake limit.Review of the resident's physician progress note, dated 08/24/25, showed the following:-Interim Events: Mid-July: Lasix (diuretic) reduced from 40 milligrams (mg) daily to 30 mg daily, then increased back to 40 mg with 1.5L fluid restriction;- Discontinued Tradjenta (used to treat blood sugar levels) 5 mg daily due to inappropriate with heart failure;- Plan to maintain fluid restriction of 1.5L daily with discontinued Tradjenta 5 mg, ensure adequate and hydration within fluid restriction parameters;-Medications reviewed and reconciled with Tradjenta discontinued due to contraindication with heart failure.Review of resident's current Physician Order Sheet (POS), dated 08/28/25, showed an order, dated 01/31/25, for Tradjenta 5 mg tablet, give one tablet once daily and no order for 1.5-liter fluid restriction or fluid intake monitoring.Review of the resident's care plan, dated 04/28/25, showed staff did not update the care plan with the new orders. Review of the resident's physicians' orders showed staff did not update the care plan with the new orders for routine weights and fluid intake limit.During an interview on 08/28/25, at 9:10 A.M, Licensed Practical Nurse (LPN) H said the physician's orders are received via fax or verbally. The nurse enters all new orders into the electronic charting system. He/she does not check progress notes for new orders. He/she was unaware of any orders placed in the progress notes. A resident should have an order for fluid restriction, and it should be included in the care plan. During an interview on 08/28/25, at 12:39 P.M., Licensed Practical Nurse (LPN) K said physician orders could be written or verbal. The resident's physician was at the facility on Sunday and gave written orders for some residents. He/she can also call the physician for orders if needed. He/she had never had an issue with obtaining orders. Some physicians place orders in the progress notes. He/she reviews the progress notes for the last 30 days to ensure no orders were missed. Every now (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and then physician orders are missed. The resident had a note in the communication book today indicating he/she had a new order for 1.5-liter fluid restriction. Care plans guide staff to provide the best care to the residents. During an interview on 08/28/25, at 1:12 P.M., the Dietary Manager (DM) said the nurse notifies dietary of new orders by submitting a dietary slip. Residents on fluid restriction should have an order indicating how much fluids they are allowed. The amount of fluid allowed per the order is included on the resident's meal ticket. He/she advised the cooks and dietary assistants of any resident on fluid restriction. He/she received a new order for fluid restriction for the resident yesterday. The resident had never been on fluid restriction before.During an interview on 08/28/25, at 11:20 A.M., the Director of Nursing (DON) said the resident's two physicians are new to the facility and do not write orders like the other physicians do. The new physicians are writing orders in the progress notes in the electronic charting system and do not notify the nurse. The resident's order for Trajenta was discontinued on 08/24/25 in the physician note, but was not communicated to the nurses. During an interview on 08/28/25, at 11:53 A.M., the resident's Physician O said the nurse should carry out the orders listed in the progress note.

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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. Based on observation, interview, and record review, the facility failed to ensure staff provided respiratory care per standards of practice when staff failed to have a process in place to ensure routine cleaning of a continuous positive airway pressure (CPAP - a mask that uses air pressure to keep the airway open during sleep) device, failed to obtain orders for the use of the CPAP, and failed to include the use of a CPAP on the care plan for one resident (Resident #100). The facility census was 93.1. Review of Resident #100's face showed the following information:-admission date of 08/14/25;-Diagnoses included fracture of the humerus (upper arm bone) on right arm and anemia (deficiency of red blood cells).Review of the resident's discharge instructions from the hospital, dated 08/14/25, showed the resident used a CPAP at bedtime.Observation and interview on 08/26/25, at 2:51 P.M., showed a CPAP sitting on the resident's bedside table. The resident reported he/she was unable to use the CPAP without assistance due to a broken arm, but staff were putting it on him/her.During an interview on 08/27/25, at 3:07 P.M., the resident reported the staff put water in the CPAP and put it on him/her most nights. He/she wore the CPAP every night and had someone help care for it when at home. Staff told her they were aware on how to use the CPAP when he/she was admitted to the facility.Review of the resident's care plan, dated 08/25/25, showed staff did not care plan regarding resident using a CPAP.Review of the resident's current Physician Order Sheet (POS) showed no order for cleaning or use of a CPAP.During an interview on 08/27/25, at 9:28 A.M., Certified Nursing Assistant (CNA) E said CNA's were responsible for applying, removing, and cleaning CPAPs. He/she had never observed a CPAP for the resident. During an interview on 08/28/25, at 9:10 A.M., Licensed Practical Nurse (LPN) H said the following:-Residents that utilize a CPAP should have physician orders;-The CPAP's are cleaned weekly on night shift;-The resident had a CPAP;-The resident did not have any orders for the use of a CPAP; -The use of a CPAP should be included in the care plan. During an interview on 08/28/25, at 12:39 P.M., LPN K said a resident with a CPAP needed to have orders. The resident had a CPAP that he/she brought from home. LPN K assumed he/she had orders for the CPAP. Staff would not know that a resident needed to use a CPAP without orders. CPAP's should have an order to clean them to ensure that it is done routinely. CPAP's should be included on the care plan.