STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265610	A. Building B. Wing	01/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Life Care Center of St Louis	3520 Chouteau Ave Saint Louis, MO 63103

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 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 an infection prevention and control program when staff failed to change gloves, wash or sanitize hands and wear gowns during care for residents on enhanced barrier precautions (EBP, precautions for use during high-contact resident care activities for residents infected with a multidrug-resistant organism (MDRO, microorganisms that are resistant to one or more classes of antimicrobial agents) for four residents (Residents #101, #81, #9 and #56). The staff failed to change gloves and wash hands during perineal care (cleaning the genital and anal areas) for one resident observed during care (Resident #63). In addition, laundry staff failed to separate dirty linens from clean and washed linens. The sample was 23. The census was 90.Review of the facility's Hand Hygiene Policy, dated 10/28/25, showed:-Unless hands are visibly soiled, an alcohol-based hand rub is preferred over soap and waterin most clinical situations;-Associates perform hand hygiene (even if gloves are used) in the following situations, before performing a procedure such as an aseptic task (e.g. dressing care). Review of the facility's Droplet Precaution sign, undated showed:-Everyone must clean their hands, including before entering and leaving the room;-Make sure your eyes, nose and mouth are fully covered before room entry. Remove face protection before room exit. Review of the facility's Contact Precautions Policy, undated showed:-Everyone must clean their hands, including before entering and leaving the room;-Providers and staff must also put on gloves before room entry. Discard gloves before room exit;-Put on gown before room entry. Discard gown before room exit. Review of the facility's Activities of Daily Living (ADL) Policy, dated 9/4/25, showed after cleansing the perineum, perform hand hygiene, apply new gloves, apply a moisture-barrier skin protectant as needed to protect, and maintain intact skin or treat nonintact skin. Review of the facility's EBP sign, undated showed:-Everyone must cleanse their hands, including before entering and when leaving the room;-Providers and staff must also wear gloves and gowns for the following high contact resident care activities: dressing, transferring, providing hygiene, changing briefs or assisting with toileting;-Device care or use: wound care, any skin opening requiring a dressing. 1. Review of Resident #101's medical record, showed:-Alert and oriented times four (person, place, time, and situation);-admitted with right knee and sacral (the triangular region at the base of the spine) skin issues noted;-Diagnoses included sepsis (body's extreme reaction to infection) and high blood pressure. Review of the resident's physician order summary, dated 1/12/26, showed:-A physician order to cleanse the right knee with normal saline, apply xeroform (sterile, non-adherent wound dressing) and Allevyn (wound dressing) every day for treatment;-A physician order to cleanse sacral area, apply Duoderm (protective dressing) twice weekly on Wednesday and Saturday for treatment. Observation on 1/14/26 at 8:52 A.M., showed EBP signage on the resident's door, and the resident lay in bed. The Nurse Practitioner (NP) entered the room, performed hand hygiene and put gloves on. No gown was worn. The NP removed the dressing from the right knee, cleaned and measured the wound. Licensed Practical Nurse (LPN) F stood at the treatment cart. Once the NP instructed him/her on what was needed for the treatment, he/she entered the room, performed hand hygiene and put gloves on, no gown was worn. LPN F applied Triple Antibiotic Ointment (TAO) and a foam dressing. LPN removed his/her gloves and performed hand (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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	hygiene and went back to the cart. The resident was assisted to roll towards the door by the NP. The NP removed the sacral dressing, while wearing the same gloves used to remove the knee dressing, measured and cleaned the sacral area. LPN F entered the room, performed hand hygiene, put gloves on and applied a foam dressing, no gown was worn. The NP removed her gloves and performed hand hygiene. 2. Review of Resident # 81's quarterly Minimum Data Set (MDS, a federally mandated assessment instrument completed by facility staff) dated 10/4/25, showed:-Cognitively intact;-Dependent on staff for toilet hygiene;-Partial/moderate assistance (helper does less than half the effort. Helper lifts, holds or supports trunk or limbs, but provides less than half the effort) for rolling left to right;-Frequently incontinent of urine and occasionally incontinent of bowel;-Diagnoses included hemiplegia or hemiparesis (paralysis and/or weakness to one side of the body), and left and right above knee amputation. Review of the resident's care plan in use at the time of survey, showed:-Focus: Stage 2 pressure ulcer injury (a partial thickness loss of dermis presenting as a shallow open ulcer with a red-pink wound bed, may also present as an intact or open/ruptured blister) and right stump surgical wounds, start date was 7/6/25;-Interventions included: EBP. Review of the resident's physician order summary dated 1/13/26, showed a physician order to cleanse the sacral area with normal saline/wound cleanser, pat dry, and apply Duoderm for protection every Wednesday and Saturday. Observation on 1/12/26 at 11:30 A.M., showed EBP signage on the resident's door and there was no PPE outside the resident's room. The resident lay in bed. Certified Nurse Aide (CNA) G entered the room, performed hand hygiene and put gloves on. No gown was worn. He/She performed perineal care and assisted the resident to get dressed; a mechanical lift sling was placed under the resident. When the resident was rolled onto his/her side, a Duoderm dressing was visible on the resident's sacrum. Registered Nurse (RN) H came into the room, performed hand hygiene and put gloves on. No gown was worn. The nurse told the CNA that the resident needed a full body lift. The lift sling was removed from under the resident. The nurse removed his/her gloves and left the room to look for a lift sling. Neither staff wore a gown. Observation on 1/14/26 at 9:03 A.M., showed EBP signage on the resident's door. LPN F entered the resident's room, performed hand hygiene and put on gloves. No gown was worn. LPN F assisted the resident to roll towards the window and removed the Duoderm dressing from the resident's sacrum. He/she cleansed the sacral area with wound cleanser, changed his/her gloves and applied a Duoderm dressing. LPN F said the resident did not have a wound. The Duoderm was used for protection. 3. Review of Resident #9's medical record, showed:-admitted with left thoracotomy (open surgical incision through the chest wall), with daily treatment orders;-An order dated 12/17/25, to cleanse left upper lateral chest wound with normal saline or wound cleanser, pat dry, apply wet to dry dressing using saline soaked Kerlix (gauze bandage), then apply calcium alginate (antimicrobial wound dressing), cover with ABD (absorbent dressing) and secure with tape;-Diagnoses included chronic respiratory failure, chronic obstructive pulmonary disease (COPD, lung disease), cognitive communication deficit, and dysphagia (difficulty swallowing). Review of the resident's care plan in use at the time of survey, showed:-Focus: resident has a left rib wound;-Goal: minimize risk of symptoms of infection;-Interventions included: EBP, treatment as ordered, weekly skin checks. Observation on 1/14/26 at 9:19 A.M., showed EBP signage on the resident's door. The NP and LPN F entered the room with gloves on and no gowns on. LPN F placed a clean plastic trash bag on the overbed table and lay clean wound treatment supplies on top. The NP removed the old wound dressings and placed them inside the plastic bag with clean supplies still on top. The NP removed the resident's soiled dressing and removed the gloves, but no hand hygiene was completed prior to applying clean gloves. He/She measured and cleaned the wound, then applied treatment and new dressing. The NP did not change gloves and performed hand hygiene after cleansing the wound and before applying wound treatment and new dressing. 4. Review of Resident #56's medical record, showed:-admitted with wounds to the buttocks;-An order dated 12/31/25, to cleanse both buttocks with normal saline or wound cleanse, pat dry, apply Flagyl (antibiotic medication) powder to wound bed, then apply Fibracol (sterile collagen and calcium alginate wound (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	dressing) to the middle and right wound bed, apply Xeroform (a sterile, fine-mesh gauze impregnated with petroleum) to left buttock, cover with ABD and secure with tape;-Diagnoses included cutaneous abscess of buttock, hidradenitis suppurativa (a chronic, painful skin condition causing recurring boil-like lumps, tunnels, and scarring), and squamous cell carcinoma (skin cancer). Review of the resident's care plan, in use at the time of survey, showed:-Focus: At risk for unavoidable pressure injury development or decline of skin integrity;-Goal: Maintain intact skin with no skin breaks;-Interventions included: treatment as ordered, weekly skin checks. Observation on 1/14/25 at 9:36 A.M., showed EBP signage on the resident's door. The NP and LPN F entered the room with no gowns on. LPN F placed a clean plastic trash bag on the overbed table and lay clean wound treatment supplies on top. The NP obtained several gloves from the PPE container hung by the door. He/She dropped a glove on the floor, picked it up and placed it with the other gloves and clean supplies on the overbed table. Both LPN F and the NP placed gloves on, removed the old wound dressing, then changed gloves with no hand hygiene prior to applying new gloves. The NP cleansed the wound area then applied the treatment without changing gloves prior to obtaining the treatments or medications. LPN F assisted the NP in applying Xeroform, dressing and tape. 5. Review of Resident #63's admission MDS, dated [DATE], showed:-Severe cognitive impairment;-Dependent on staff for toilet hygiene and rolling left to right;-Always incontinent of bowel and bladder;-Diagnoses included heart failure, high blood pressure, Alzheimer's disease, and hemiplegia or hemiparesis. Review of the resident's care plan in use at time of survey, showed:-Focus: resident had an ADL self-care performance deficit related to Alzheimer's, impaired balance, limited mobility, and trauma;-Interventions included: toilet use: dependent on staff for toileting needs. Observation on 1/14/26 at 9:30 A.M., showed the resident lay in bed. Certified Nurse Aide (CNA) I entered the residents room, performed hand hygiene and put gloves on. CNA I unfastened the resident's brief, provided perineal care, rolled the resident onto his/her side removed the brief and cleansed the resident's buttocks. He/She then tucked a new brief halfway under the resident and rolled the resident onto his/her back, pulled the brief up between the resident's legs and fastened the brief. CNA I did not change his/her gloves after touching soiled areas and before touching clean areas. 6. Review of the facility's Laundry Service Policy, dated 7/5/25, showed facility staff should handle all used laundry as potentially contaminated and use standard precautions with appropriate personal protective equipment. Observation on 1/14/26 at 7:10 A.M., showed Laundry Aide K removed the clean laundry from the washer and put it in a gray cart lined with linen. A sheet and pillowcase fell on the floor. The laundry aide picked up the pillowcase and threw it to the side and said he/she discards pillowcases with stains on them. He/She picked up the sheet and tossed it on top of the clean linens. Laundry Aide J pushed the grey cart to the dryer; there was a sheet dragging on the floor. All linens were tossed into the dryer. 7. During an interview on 1/15/26 at 2:51 P., the Infection Control Preventionist (ICP) said residents were placed in EBP rooms if they had gastrostomy tubes (device used to provide nutrition to people who cannot obtain nutrition by mouth), colostomies (opening in the abdomen to the large intestine), intravenous lines (IV), wounds, and urinary catheters. EBP signage was hung on the residents' doors. Staff should apply gowns and gloves when providing care. Eyewear can be worn as needed. When providing care involving high contact with residents, including personal care and wound care, personal protective equipment (PPE) should be worn. The ICP expected staff to change gloves from dirty to clean contact and perform hand hygiene in between glove changing. The ICP also expected to maintain infection control in the laundry area. Linen should not be dragged on the floor. If washed or clean linens were dragged and dropped on the floor, they were considered dirty and should be re-washed. 8. During an interview on 1/16/25 at 1:01 P.M., RN P said EBP rooms have signage on the door and instructions on what PPEs are to be used. Gowns and gloves should be worn when providing care to the residents on EBP. Hand hygiene should be performed before and after changing gloves. 9. During an interview on 1/16/26 at 1:36 P.M., the Regional Nurse Consultant (RNC) said staff were expected to follow the infection control policies.

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F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. Based on interview and record review, the facility failed to ensure five out of 10 randomly selected Certified Nurse Aide (CNA)/Certified Medication Technicians (CMT), employed by the facility for over 12 months received their annual 12 hours of in-service training. The census was 90.Review of the facility's CNA 12 Hours of Inservice Training policy, dated 12/17/25, showed the Staff Development Coordinator (SDC) will develop, implement, and maintain an effective in-service program for all nurse aides to ensure they have received the necessary in-services and education to meet the federal requirement. CNAs have a requirement of at least 12 hours of continuing competency every 12 months and must include dementia management training and resident abuse training. Review of the facility's Personal In-Service Records, dated in-service year 2025, and reviewed on 1/12/26, showed:-CMT R, date of hire 6/20/22, with 2.0 hours of in-service training;-CMT S, date of hire 10/30/18, with 3.25 hours of in-service training;-CNA T, date of hire 7/25/18, with 2.0 hours of in-service training;-CNA U, date of hire 7/7/98, with 2.0 hours of in-service training;-CNA V, date of hire 11/30/21, with 2.5 hours of in-service training. During an interview on 1/13/26 at 3:30 P.M., Registered Nurse N said the facility did not have any more in-service training hours. During an interview on 1/16/26 at 1:36 P.M., the Regional [NAME] President said she would expect for CNAs/CMTs to have 12 hours of education completed and documented annually.

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. Based on observation, interview and record review, the facility failed to create an environment that supported and respected the right of a resident to make choices about significant aspects of daily life. The failure affected one resident (Resident #66) who requested to get out of bed for meals. Resident #66 required extensive assistance with activities of daily living (ADLs) due to left-side paralysis and required staff assistance for transfers out of bed. The facility utilized a get-up list to determine which residents would be assisted out of bed in the morning. This process did not consider or honor the resident stated preference to be out of bed for all meals. The facility census was 90. Review of the facility's Policy for Resident Rights, dated 6/8/2020, showed:-The resident has the right to be informed of, and participate in, his or her treatment, including the right to be fully informed in language that he or she can understand of his or her total health status, including but not limited to, his or her medical condition; the right to participate in the development and implementation of his or her person centered plan of care; -The resident has the right to make choices about aspects of his or her life in the facility that are significant to the resident. Review of the resident's annual Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 10/14/25, showed the following:-Diagnoses included hemiplegia (paralysis of one side of the body) following cerebral infarction (stroke) affecting the left non-dominant side; dysphasia (disorder that affects the ability to speak) following cerebral infarction; and abnormal posture; -Moderately impaired cognition.Review of the resident's care plan, last reviewed/revised on 11/12/25, showed the following: -Focus: ADL self-care performance deficit related to hemiplegia, impaired balance, and stroke;-Goal: Maintain current level of function through the review date;-Interventions: Require moderate assist by one staff to turn and reposition in bed and as necessary, need assistance by one staff to dress. The resident required set up assistance with bed mobility and transfers;-The resident's care plan did not include his/her preference for wake-up time. Observation and Interview on 1/12/25, showed the following:-At 11:37 A.M., the resident lay in his/her bed at an angle with his/her dominant right-side against the right quarter bedrail and mattress, raised at a 90-degree angle. The resident's dominant right arm was tucked under resident's upper body and the call light was tied to the bottom of the right bottom quarter bedrail, inaccessible for the resident to reach. The resident had crumbs of eggs on his/her chest. The resident said he/she was unable to get to his/her call light with his/her left hand due to a stroke that affected the left side of his/her body. The resident said he/she did not like eating in his/her room but when he/she requests to get up, he/she is told to wait until after breakfast.-At 12:15 P.M., Certified Nurse Aide (CNA) I entered the room with another CNA and said we are going to get up for lunch. The resident told CNA I he/she should have already been up. -At 12:20 P.M., CNA I said he/she knows the resident does not like being in bed and tries to make sure the resident is up after breakfast. Normally the night shift gets the resident up for breakfast but sometimes they run short. Today he/she was just running behind. Observation and Interview on 1/13/25, showed the following:-At 10:24 A.M., the resident lay in bed and watched television. The resident said he/she requested assistance to get up for breakfast; however, the CNA did not return. The resident said he/she preferred to be out of bed for meals and that eating in bed was difficult due to his/her history of stroke. He/She slid down in bed or leaned to one side while eating. The bedside table contacted the quarter side rails, and his/her positioning makes digestion difficult.-At 10:40 A.M., the resident lay in bed and watched television.-At 11:50 A.M., two CNAs entered the resident's room, pushing a mechanical lift and told the resident they were there to get him/her up. Observation and Interview on 1/14/25, showed the following:-At 8:16 A.M., the resident ate breakfast in bed, with the bed positioned at a 45-degree angle with the resident's legs pointing to the bottom left side of the bed and right shoulder closer to the right side of the bed. The resident's upper body rested on the quarter side rail. The center section of the resident's chest rested in the crease of the mattress bend. The (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	bedside table had several puddles of spilled coffee.-At 11:15 A.M., Occupational Therapist Registered (OTR) K said the resident has extensor tone pattern (muscles that straighten or stiffen the limb are dominating or difficult to relax) from his/her stroke which causes the resident to slide in bed. OTR K preferred to have all residents eating in the dining room for safety reasons, but residents have the right to decide to eat in their room or in the dining room and their choice should be honored. -At 1:40 P.M., CNA J said the resident does not like being in bed so if night shift was not able to get resident up before breakfast, he/she would make sure the resident got up after breakfast. -At 1:50 P.M., Registered Nurse (RN) H, said the resident always requested to get up because the resident does not like being in bed. RN H was not sure why the resident was not up for breakfast. The nurses generated a get-up list for nights and was not sure why the resident was not on the list. Observation and Interview on 1/15/25, showed the following:-At 8:10 A.M., the resident ate breakfast in bed, with the bed positioned at a 45-degree angle. The resident said he/she did not like eating in bed, and he/she ate better when out of bed. -At 9:38 A.M., CNA G said the facility has a get up list for nights to determine which residents are up before breakfast. The resident is not on the get up list, but nights sometimes will get the resident up. CNA G was unaware the resident did not like eating in bed but knew the resident did not like being in bed. -At 10:15 A.M., CNA G assisted the resident into the main dining room. During an interview on 1/16/26 at 2:30 P.M., the Operation Specialist said resident rights should be honored regarding when a resident gets up in the morning.

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F 0567 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to manage his or her financial affairs. Based on observation, interview and record review, the facility failed to ensure residents or the resident's Durable Power of Attorney - Healthcare (DPOA-Healthcare) were invited to participate in all aspects of person-centered care planning for one resident (Resident #67) who was not notified in spending down the resident's resources on medical requirement in the amount of $2,725.80 and did not authorize the funds to be spent. The sample was 23. The census was 90.Review of the facility's Policy for Resident Rights, dated 6/8/20, showed:-The resident has the right to be informed of, and participate in, his or her treatment, including the right to be fully informed in language that he or she can understand of his or her total health status, including but not limited to, his or her medical condition; the right to participate in the development and implementation of his or her person centered plan of care;-The resident has the right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care;-The resident has the right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care;-The resident has the right to be informed, in advance, of changes to the plan of care. Review of the facility's Policy for Resident Trust Fund, dated 5/6/25, showed:-For the purposes of these resident trust procedures, a representative may act on behalf of the resident only when a legal document is on file detailing the representative's power of attorney, guardianship, conservatorship, or other relationship granting the representative the authority to act on behalf of the resident;-The facility will provide written notification to the resident and/or authorized resident representative when the resident's trust account is within $200.00 of the resource limit for Medicaid eligibility for that state. In the same written notification, the resident will be advised that reaching the state's resource limit in the account could jeopardize the resident's Medicaid and/or Supplemental Security Income (SSI) eligibility;-Withdrawals from the Resident Trust - all withdrawals from a resident's trust account must meet two requirements to be paid: a) The withdrawal must be authorized by signature of the resident or of the resident's authorized representative. b) The withdrawal must be of benefit to the resident.-Documentation for both requirements shall be maintained in the resident's financial files. When a resident is unable to approve a purchase and an authorized representative is unavailable, the receipt may be signed by a facility representative. This signature shall be accompanied by witness signatures of not less than two (2) other facility associates from a nonbusiness office department.-A disbursement of cash to a resident should be documented with a signed receipt in triplicate. One copy of the signed receipt shall be provided to the resident. Review of Resident #57's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 8/10/25, showed: -Diagnoses included diabetic, stroke, difficulty with speech and swallowing; -Severe cognitive impairment;-No behaviors and/or depression. Review of the resident's care plan, in use during survey, showed: -Focus: Resident has impaired cognitive ability;--Goal: Resident will be able to communicate basic needs through the review date;--Intervention: Ask yes/no questions in order to determine his needs;-Focus: Resident has difficulty performing activities of daily living;--Goal: Maintain current level of function through the review date;--Intervention: requires substantial assist of one for wheelchair mobility. Review of the resident's quarterly resident fund statement, dated 10/1/25 through 12/31/25, showed the following:-On 10/1/25, beginning balance of $2,618.26;-On 10/7/25, a withdraw with a description Medical equipment in the amount of $2,725.80;-On 12/31/25, an ending balance of $101.60. Observation on 1/15/26 at 11:20 A.M., showed the Business Manager Assistant (MBA) and the Activity Director (AD) asked the resident to sign the top page of a packet that read Trust Fund Disbursement Authorization Form. The form was visibly incomplete with only the resident's name, amount ($2,725.80) and the payable to sections completed. The resident said he/she was having problems holding the pen to sign. Observation on 1/15/26 at (continued on next page)

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F 0567 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	11:21 A.M., showed the packet presented to the resident contained the following documents:-Trust Fund Disbursement authorization form with the sections: Date, Resident/Authorized Signer, (2) Facility Witness were blank. Sections that were written in black ink reflected the resident's name, $2,725.80 and payable to a medical equipment company.-The medical equipment company invoice-dated 9/11/2025, included the resident's name at the top, itemization of wheelchair parts including amounts and invoice total of $2,725.80. -A copy of the facility's Petty Cash Account check #2050, dated 10/7/25 in the amount of $2,725.80. Wheelchair written at the bottom left side of check.-A withdrawal Record dated 10/6/25, showed created by Business Manager Assistant (BMA) with BMA authorized signature, reflecting the medical equipment withdraw from the resident's patient trust account.-A copy of the resident's quarterly resident fund statement, dated 10/1/25 through 12/31/25, with a written X at the top of the statement, no other signatures or markings. During an interview on 1/15/26 at 11:21 A.M., the BMA said the Business Manager (BM) gave direction to have the resident sign a new Trust Fund Disbursement Authorization Form because the original form that was completed back in October of 2025 was misplaced. During an interview on 1/15/26 at 11:24 A.M., the resident said he/she was not sure what he/she was asked to sign, if the wheelchair was new or if he/she had purchased the wheelchair. During an interview on 1/15/26 at 12:10 P.M., the Operations Specialist said she was the administrator at the time the resident's wheelchair was purchased and recalled talking to the family and said the facility did not communicate prior to the purchase, to discuss the needs of the resident. The Operations Specialist was not aware the resident was missing the Trust Fund Disbursement Authorization form. Having a resident sign for a back-dated purchase is not acceptable practice. During an interview on 1/15/26 at 4:20 P.M., the resident's Durable Power of Attorney (DPOA) said the facility made him/her aware of the purchase of the wheelchair, after the fact. He/she would have liked to have a discussion prior to the purchase, since the resident has no burial arrangements and still needs funds to purchase cremation. During an interview 1/16/26 at 2:30 P.M., the Operational Specialist said it is expected that staff follow the facility's patient trust policy and procedures.

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	265610	A. Building B. Wing	01/16/2026

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F 0577 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to easily view the nursing home's survey results and communicate with advocate agencies. Based on observation and interview, the facility failed to post in a place readily accessible to residents, family members and legal representatives of residents, the results of the most recent survey and complaint investigations of the facility in a location where they would not be required to ask staff for assistance. The census was 90.Observations on 1/12/26 through 1/15/26, showed no survey results maintained at the entrance of the building, in the lobby of the building or at the desk with the receptionist. No signs were posted for the location of the survey results and/or availability of the last survey or complaint investigations. During a group interview on 1/13/26 at 10:00 A.M., six residents, who the facility identified as alert and oriented, attended the group meeting. All six residents said they were unaware of where the state survey results were located. Observation on 1/15/26 at 11:48 A.M., showed a dresser diagonal from the receptionist's area, No signs or posting sat on top of the dresser, or anywhere in the area surrounding the dresser. Upon opening the dresser, the most recent survey and complaint investigations were in a binder, inside of the dresser. During an interview on 1/15/26 at 11:49 A.M., the Receptionist said the survey binder was in the dresser and was always kept there. There was no sign indicating the survey results were available. The binder was not accessible to residents, families or visitors. During an interview on 1/16/26 at 1:36 P.M., the Regional Nurse, Regional [NAME] President and Operations Specialist said the survey binder should have been available and accessible for residents, families and visitors. The binder was not accessible prior to 1/16/26.

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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 interview and record review, the facility failed to ensure services provided meet professional standards when one resident's physician order was not transcribed onto the physician order sheet timely (Resident #91). The sample was 23. The census was 90.Review of Resident #91's admission Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 10/30/25, showed:-Moderately impaired cognition;-No rejection of care;-Resident had an indwelling catheter (a sterile tube inserted into the bladder to drain urine);-Diagnoses included renal (kidney) insufficiency, renal failure or end stage renal disease (ESRD, chronic irreversible kidney failure) and obstructive uropathy (disorder of the urinary tract that occurs due to obstructed urinary flow). Review of the resident's care plan, in use at the time of survey, showed:-Focus: had a left nephrostomy (a flexible tube inserted through the back into the kidney to drain urine when the normal urinary tract is blocked) related to obstructive uropathy;-Goal: will have no complications related to nephrostomy use;-Interventions included catheter care every shift, check tubing for kinks each shift, educate resident and/or family regarding indwelling catheter and care, observe for and report to medical doctor for signs and symptoms urinary tract infection: pain, burning, blood tinged urine, cloudiness, no output, deepening of urine color, increased pulse, increased temp, frequency, foul smelling urine, fever, chills, altered mental status, change in behavior, change in eating patterns. Review of the resident's Transfer Orders for Receiving Facility, admission date 10/21/25 and expected discharge date [DATE], showed:-Your discharge diagnosis was kidney stone;-General instructions: left nephrostomy tube dressing to be changed every 1-2 days and when soiled. Keep nephrostomy tube clamped. Call if patient has increased flank/back pain with tube clamped;-After a Percutaneous Nephrolithotomy (PCNL, procedure to remove kidney stone), a left nephrostomy tube remained in place, please keep this tube clamped. Change dressing every 24-48 hours and when soiled. If pain worsens on the left back/flank, please contact Genitourinary (GU, medical term for urinary specialist) for further instructions. Review of the resident's physician order summary, in use at the time of survey, showed:-A physician order for nephrostomy tube output every shift, start date 10/23/25;-A physician order to keep nephrostomy tube clamped, per urology every shift, start date was 11/10/25;-There was no order for a dressing change and no order prior to 11/10/25 to clamp the nephrostomy tube. Review of the resident's progress notes dated 10/23/25 through 10/31/25, showed:-On 10/23/25 at 5:39 P.M., resident arrived from hospital. All orders verified with medical doctor;-On 10/24/25 at 1:40 P.M., physician note, left nephrostomy tube to remain in place at discharge. Keep Percutaneous Nephrostomy (PCN, a medical procedure used to drain urine directly from the kidney when the normal flow is blocked) clamped. Change dressing every 24-48 hours and when soiled;-On 10/27/25 at 12:56 P.M., physician note, seen today. Urinary catheter and nephrostomy tube in place. Assessment/plan: left nephrostomy to remain in place until follow up with urologist. Review of the residents Medication and Treatment Administration Records (MAR and TAR) dated 10/23/25 through 10/31/25, showed a physician order for nephrostomy tube output every shift. Documentation showed: On day shift: five out of eight opportunities an output was documented; on evening shift: six out of eight opportunities an output was documented; on night shift: five out of nine opportunities an output was documented. Review of the resident's progress notes dated 11/1/25 through 11/10/25, showed:-On 11/3/25 at 3:01 P.M., indwelling catheter and nephrostomy tube patent and intact, both draining via gravity;-On 11/5/25 at 11:45 A.M., resident returned from doctor's appointment, no new orders, no paperwork sent with resident;-On 11/5/25 at 10:40 P.M., resident had an indwelling catheter and a nephrostomy tube, both draining to gravity;-On 11/7/25 at 4:02 P.M., has an indwelling and nephrostomy tube, both draining to gravity;-On 11/8/25 at 2:48 P.M., has an indwelling and nephrostomy tube, both draining to gravity;-On 11/9/25 at 11:52 A.M., has indwelling and nephrostomy tube, both draining to gravity;-On 11/10/25 at 11:10 A.M., physician note, seen (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	today, indwelling and nephrostomy tube in place. Followed up with urology on Wednesday-failed trail void. Per urologist plan clamp nephrostomy tube. Nurse given orders today, not sent with resident last week. Review of the resident's MAR dated 11/1/25 through 11/10/25, showed:-A physician order for nephrostomy output every shift. Documentation showed on day, evening and night shift, eight out of nine opportunities, output was documented;-A physician order to keep the nephrostomy tube clamped every shift. The start date 11/10/25. During an interview on 1/15/26 at 1:43 P.M. Licensed Practical Nurse (LPN) E said when a resident is admitted to the facility, the nurse on the floor was responsible for entering the orders into the computer and completing the assessments. The hospital discharge orders are verified with the doctor or the nurse practitioner (NP). If a change was made during the reconciliation process, he/she would note it on the hospital discharge paperwork. When the doctor or NP made rounds at the facility, they make a note in the computer. They also enter their own orders into the computer. The nurse had to confirm the order to activate it. LPN E did not review the doctors or NP notes unless they said something like there were new orders. If a resident went out for an appointment and came back with no paperwork, he/she would call the provider to obtain the records and document it. When the resident admitted to the facility, he/she had an indwelling catheter and a nephrostomy tube, the nurse could not remember if the nephrostomy tube was clamped or not. During an interview on 1/15/26 at 2:28 P.M., the Nurse Manager said the nurse on the floor was responsible for admitting the residents. The after-visit summary is what they used for orders. The orders are verified with the doctor. The next day, admissions are audited by nurse management. When a provider visits the facility, they make notes in the progress notes. The Nurse Managers reviews their progress notes. Providers enter their own orders into the computer and the nurse is responsible for confirming the orders. Any nurse can confirm an order. If a resident went out to see a provider and returned with no paperwork, the nurse would call the office and document it in the progress notes. During an interview on 1/15/26 at 3:49 P.M. Registered Nurse (RN) N said the facility used the after-visit summary for the discharge orders. The nurse should read the whole document for orders. RN N said the nephrostomy tube should have been clamped, and the dressing should be changed every 24-48 hours, unless the orders changed when they were verified. If the tube was clamped there would be no output from the tube. During an interview on 1/16/26 at 11:01 A.M., the NP said the general instructions and care of sites should be verified when the resident is admitted . The NP looked at the progress notes and said the doctor verified the orders with the nurse on 10/23/25 and she saw the resident on 10/24/25 and wrote a note. The order for the tube to be clamped and the dressing changed should have been placed. If the tube was clamped there would be no output from the tube. During an interview on 1/16/26 at 9:09 A.M., RN Q said the resident had a nephrostomy tube because he/she had an obstruction. The tube was clamped to see if the resident could void more on their own. If the tube was clamped there would be no output from the tube. Sometimes there may be a small amount of drainage from around the tube but that would not be measurable. The dressing around the tube was to help keep the area clean and dry. During an interview on 1/16/25 at 1:36 P.M., the Director of Nursing said the resident's orders were verified with the physician on admission. 2713882

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure a resident who required assistance with activities of daily living (ADL) received showers and personal care in accordance with their personal needs, for one of 23 sampled residents (Resident #56). The census was 90. Review of the facility's Activities of Daily Living (ADLs) policy, reviewed 9/10/24, showed:-Policy: The resident will receive assistance as needed to complete ADLs. Any change in the ability to perform ADLs will be reported to the nurse;-A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. Review of Resident #56's medical record, showed diagnoses included hidradenitis suppurative (HS, a chronic painful skin condition causing recurring boils, blackheads, and painful lumps that form deep in hair follicles, often in skin folds leading to pus drainage, tunnels and inflammation. Common areas affected are buttocks and around the anus), muscle weakness and cancer. Review of the resident's admission minimum data set (MDS), a federally mandated assessment instrument completed by facility staff, dated 12/24/25, showed:-Mild cognitive impairment;-No behaviors;-Required partial/moderate assistance with showering/bathing;-Required supervision or touching assistance with personal hygiene;-Diagnoses included cancer. Review of the resident's care plan, revised 12/29/25, and in use during the time of the investigation, showed:-Focus: The resident has an ADL self-care performance deficit related to impaired balance, limited mobility and pain;-Goal: The resident will improve current level of function through the review date;-Interventions: The resident requires moderate assistance for bathing at least twice a week and as necessary. The resident requires personal assistance for personal hygiene. Review of the resident's shower calendar, showed the resident was admitted [DATE]. Showers and/or bed baths were documented as provided on 12/25/25, 1/5/26, 1/8/26, 1/10/26 and 1/14/26. During observation and interview on 1/12/26 at approximately 11:30 A.M., the resident lay in bed on his/her stomach. The resident's hair was approximately eight inches long and appeared matted and unkempt. An odor of bowel movement was present throughout the resident's room. The resident said he/she was admitted to the facility about three weeks ago. He/she had pain due to boils on his/her buttocks. The boils leaked and caused an odor, pain and discomfort. He/she had not had a shower since being admitted to the facility. Observation on 1/12/26 at 5:43 P.M., showed the resident lay in bed on his/her stomach. An odor was present in the resident's room. He/She said he/she was not offered a shower or bed bath today. Observation on 1/13/26 at 2:33 P.M., showed the resident lay on his/her stomach in bed and said he/she just received the treatment to his/her wounds. The wound nurse cleansed the area surrounding the wound. The resident said he/she was not offered a bed bath or shower. Observation on 1/14/26 at 3:11 P.M., showed the resident lay in bed on his/her stomach asleep. The resident's hair appeared matted and unkempt. During an observation and interview on 1/15/26 at 10:39 A.M. and 3:51 P.M., the resident lay in bed on his/her stomach. The resident's hair was matted and unkempt. The resident said no staff had offered to wash his/her hair since he/she was admitted to the facility. He/She was able to walk to the bathroom and attempted to wash him/herself but could not reach behind him/herself to clean or could not wash his/her own hair. Staff had observed the resident at the sink washing him/herself, but no one had offered to assist. The resident wanted a shower or bed bath and wanted his/her hair washed. During an observation and interview on 1/16/26 at 9:46 A.M., the resident was observed in bed on his/her stomach. The smell of bowel movement was present in the resident's room. His/her hair appeared matted and unkempt. The resident said last night, he/she was offered a bed bath, but when they attempted to provide it, there were issues with the water temperature. He/she was moved to another room for the bed bath, but there was a mix up with another resident in the room. He/she asked to be moved back to his/her room and never received the bed bath. The resident said this upset him/her and he/she expected (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	more but did not want to get anyone in trouble. During an interview on 1/16/26 at 9:43 A.M., Certified Nursing Assistant (CNA) O said he/she was familiar with the resident and he/she was able to stand on his/her own. The resident needed some assistance with showers or bed baths. The resident needed his/her hair washed and treated. Staff was expected to offer the resident two showers per week. The resident did not refuse care. During an interview on 1/16/26 at 9:59 A.M. and 12:36 P.M., CNA I said he/she was assigned to the resident and was familiar with the resident. The residents received two showers per week. CNA I checked the resident's shower schedule and said, the resident is not due for a shower today. The resident received showers on Mondays and Thursdays on evening shifts. When asked about the resident's hair, CNA I said he/she has an afro. What do you expect? If the resident wanted his/her hair washed, he/she would wash the resident's hair. During an interview on 1/16/26 at 10:13 A.M., Registered Nurse (RN) P said the resident needed assistance with showers and personal care. The resident was to receive at least two showers per week. Hair care was part of receiving a shower or bed bath. RN P was not sure what staff was doing about the resident's hair. During an interview on 1/16/26 at 1:36 P.M., the Regional Nurse, Regional [NAME] President and Operations Specialist said the resident should have received at least two showers per week, including washing the resident's hair, if he/she requested it. 2713882