STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265668	A. Building B. Wing	05/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Carrie Elligson Gietner Health Care Center	5000 South Broadway Saint Louis, MO 63111

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 0692 Level of Harm - Actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to identify and address nutritional needs and swallowing difficulties for one resident who was at risk for impaired nutrition and hydration. The resident experienced a significant weight loss of 20.52 % in three months (Resident # 2). The sample size was 20. The census was 97.Review of the facility's Nutritional Management policy, last revised on 5/18/24, showed:-Purpose: The facility provides care and services to each resident to ensure the resident maintains acceptable parameters of nutritional status in the context of his or her overall condition;-Definitions: Acceptable parameter of nutritional status is inadequate, relative to his/her overall condition and prognosis, such as weight, food and fluid intake, and pertinent lab values; Nutritional status includes both nutritional and hydration status;-Policy:--A systematic approach is used to optimize each resident's nutritional status:---Identifying and assessing each resident's nutritional status and risk factors;---Evaluation and analyzing the assessment information;---Developing and consistently implementing pertinent approaches;---Monitoring the effectiveness of interventions and revising them as necessary;-Identification and assessment: --Nursing staff shall obtain the resident's [NAME] and width upon admission, and subsequently in accordance with facility policy;-Monitoring:--Monitoring of the resident's condition and care plan interventions will occur on an ongoing basis; Examples of monitoring include:--Interview the resident and or resident representative to determine if their personal goals and preferences are being met;--Directly observing the resident;--Interviewing the direct care staff to gain information about the resident, the interventions currently in place, what their responsibilities are for reporting on these interventions, and possible suggestion for changes if necessary;--Evaluating the care plan to determine if current interventions are being implemented and are effective;--The resident will be monitored for complications associated with interventions;--The care plan will be updated as needed, such as when a resident's condition changes, goals are met per the resident changes his or her goals, interventions are determined to be ineffective, or as new causes of nutrition related problems are identified;-The physician will be notified of:--Significant changes in weight, intake, or nutritional status;--Lack of improvement toward goals;--Any complications associated with interventions;--Nutritional recommendations made by the dietician based on the resident's preference, goals, clinical condition or other factors and followed up with the physician or practitioner for orders per facility policy, if indicated;--Dietary orders may be written or modified by the qualified dietician or other clinically qualified nutrition professional if the resident's attending physician or practitioner delegates the task, dependent upon state law or policy;--The resident has the right to choose and decline interventions designed to improve or maintain nutritional or hydration status;--The facility shall discuss the risks and benefits associated with the resident and representative decision and off alternatives, as appropriate;--The comprehensive care plan should describe any interventions offered but declined by the resident or resident's representative. Review of the facility's Weight Monitoring policy, last revised 5/18/24, showed:-Purpose: Based on the resident's comprehensive assessment, the facility will ensure that all residents maintain acceptable parameters of nutritional status, such as usual body weight, or desirable body weights range and electrolyte balance, unless the residents' (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 0692 Level of Harm - Actual harm Residents Affected - Few	clinical condition demonstrates that this is not possible or resident preferences indicate otherwise;-Policy:-Monitoring weight:--Weight can be a useful indicator of nutritional status; Significant unintended changes in weight (loss or gain) or insidious weight loss (gradual unintended weight loss over a period of time) may indicated a nutritional problem:--The facility will utilize a systemic approach to optimize a resident's nutritional status; This process includes:---Identifying and assessing each resident's nutritional status and risk factors;---Evaluation and analyzing the assessment information;---Developing and consistently implementing pertinent approaches;---Monitoring the effectiveness of interventions and revising them as necessary;-A comprehensive nutritional assessment will be completed upon admission on residents to identify those at risk for unplanned weight loss or gain or compromised nutritional status; Assessments should include the following information:--General appearance (robust, thin, obese or cachectic (extreme weight loss and muscle wasting);--Height;--Weight;--Food and fluid intake; --Fluid loss or retention;--Laboratory or diagnostic testing;-Information gathered from the nutritional assessment and current dietary standards of practice are used to develop an individualized care plan to address the resident's specific nutritional concerns and preferences; The care plan should address the following, to the extent possible:--Identified causes of impaired nutritional status;--Reflect the resident's personal goals and preference;--Time frame and parameters for monitoring;--Updated as needed such as when the resident's condition changes, goals are met, interventions are determined to be ineffective or a new cause of nutritional related problems;--If nutritional goals are not achieved, care planned interventions will be reevaluated for effectiveness and modified as appropriate;--Interventions will be identified, implemented, monitored and modified as appropriate consistent with the residents' assessed needs, choices, preferences, goals and current professional standards to maintain acceptable parameters of nutritional status;-A weight monitoring schedule will be developed upon admission for all residents:--Weights should be recorded at the time obtained;--Residents with weight loss, monitor weekly weight;--If clinically indicated, monitor weight daily;--All others, monitor weight monthly;-Weight analysis:--The newly recorded width should be compared to the previous recorded weight; A significant change in width is defined as:---5% change in weight in one month;---7.5 % change in weight in three months;---10% change in weight in six months;-Documentation:--The physician should be informed of a significant change in weight and may order nutritional interventions;--The physician should be encouraged to document the diagnosis or clinical conditions that may be contributing to the weight loss;--Meal consumption information should be recorded and may be referenced by the interdisciplinary care team as needed;--If the interdisciplinary care team desires to explore specific meal consumption information for a resident, the Registered Dietician, Dietary Manager, or the nursing department may initiate the process;--The Registered Dietician (RD) or Dietary Manager should be consulted to assist with interventions; actions are recorded in the nutritional progress notes;--Observations pertinent to the resident's weigh status should be recorded in the medical record as appropriate;--The interdisciplinary plan of care communicates care instructions to staff. Review of Resident # 2's quarterly Minimum Data Set (MDS), a federally mandated assessment tool completed by facility staff, dated 2/11/26, showed:-Cognitively intact;-No rejection in care;-Required supervision or touch assistance with eating;-Swallowing disorder: none;-Diagnosis includes schizophrenia (a mental condition that distorts reality), infection of intravertebral disc (a part of the back), malnutrition (poor nutrition), and viral hepatitis (inflammation of the liver caused by a virus). Review of the resident's speech therapy evaluation and plan of treatment notes, dated 2/16/26, showed recommendations: thin liquids and upgrade to regular solid food. Review of the residents' weight summary report showed:-On 2/11/26: 143.8 pounds (lbs);-On 3/4/26: 155.0 lbs. Review of the resident's electronic medical record (EMR) showed:-Diagnosis that includes esophageal (a muscular tube that carries food from the mouth to the stomach) obstruction, gastritis (inflammation of the stomach), nausea with vomiting, and alcoholism. -The resident was on therapeutic leave from 3/4 through 3/26/26. Review of the residents' weight summary report (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	showed:-No weight was documented when the resident returned from his/her leave of absence from 3/4 through 3/26/26;-On 4/14/26: 141.0 lbs. Review of the resident's medication administration record (MAR), dated April 2026 and May 2026 showed:-An order, dated 7/12/25, for Boost (liquid nutrition) three times a day (TID); administer 8:00A.M. 11:00 A.M., and 4:00 P.M.;-The order did not provide instructions to document how much of supplement was consumed by the resident. Review of the resident physician progress note, showed on 4/14/26, The resident presents severe abdominal pain in the setting of know peptic ulcer disease (an open sore inside the stomach). The resident reports the pain has been severe for 3 days and persistent enough that the resident was unable to sleep. The resident states that Mylanta (medication to treat indigestion) provided some relief of pain and requested something for sleep. No other acute (short in duration) complaints reported. Vital signs (blood pressure, pulse, respirations and temperature) reviewed in EMR. Weight on 3/4/36: 155 lbs. Height 75 inches (6 foot 3 inches) Treatment: Continue Mylanta as needed for symptom relief. Start hydroxyzine (a medication used to treat anxiety) 25 milligrams (mgs). Encourage avoidance of irritant food and medications. Monitor for worsening symptoms such as bleeding and persistent severe pain. Nursing to report any changes. Preventative: Dietary and ulcer management counseling given. Follow up in four weeks. Review of the resident's RD progress notes, dated 4/29/26 at 4:45 P.M., showed:-Nutritional weight assessment: The resident's weights have been variable. The resident was receiving a regular diet with Boost TID; Weights: February 2026: 143.8 lbs., March 2026: 155 lbs., and April 2026: 141 lbs. Encourage intake of meals and supplements. Will monitor as needed.-The dietician did not make any new recommendations related to the resident's weight loss. Review of the residents' weight summary report showed, on 5/6/26: 128.7 lbs. Review of the resident physician progress notes, dated 5/15/26, showed:-The resident stated he/she was doing well. Denied nausea, vomiting, and diarrhea. Weight: 128.7 lbs. Continue with current care. Follow up in four weeks.-The physician did not address the residents' weight loss. Review of the resident's nursing progress notes, dated 3/1/26 through 5/17/26, showed: -No documentation that the resident's physician was notified about the resident's weight loss on 4/14/26 and 5/6/26.-No documentation of the resident's meal or nutritional supplement consumption as directed by the facility policy. Review of the resident's electronic physician order sheets (e-POS), dated 5/17/26, showed:-An order, dated 7/12/25 for Boost (liquid nutrition supplement) three times a day (TID);-An order, dated 2/17/26, regular diet, regular texture, thin liquids;-An order, dated 4/18/25, weights monthly and record;-An order, dated 9/24/25, dietician consult;-No order for weekly weights as directed by the facility policy. During an observation and interview on 5/17/26 at 10:10 A.M., the resident lay in bed. The resident appeared extremely gaunt (thin) and his/her clothing was extremely loose. The resident's face was sunken in. The resident sat up to the side of the bed and said he/she was weak and used a walker. There were three bottles of Boost on the floor. The resident said the bottles were empty. There were also three clear cups of undigested food and saliva. The resident said he/she was having difficulty swallowing. The resident said he/she had to chew his/her food cut chopped fine for it to go down. The resident said he/she frequently gagged on his/her own salvia and he/she had told everyone in the facility about his/her ongoing swallowing difficulties. The resident said he/she used to have a gastronomy tube (G-tube, a medical device inserted through the abdomen directly into the stomach). The resident raised his/her shirt and exposed his/her stomach, and no G-tube was present. The resident said he/she used to have a softer texture diet and believed he/she needed that type of diet again. The resident did not want another G-tube. The resident said he was aware that he/she lost a lot of weight and was concerned about it. Observation on 5/18/26 at approximately 8:00 A.M., showed the resident lay in bed with multiple cups of saliva and undigested food on the floor next to the resident's bed. Review of the resident's care plan, last updated 5/18/26, showed: -Problem: The resident has unplanned/unexpected weight loss related to esophageal obstruction and gastritis and duodenitis (inflammation of the colon);-Desired outcome: The resident will consume 75% two of three meals a day;-Interventions: Alert dietician if consumption is poor more than 48 hours. Give the resident (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	supplements as ordered and alert the nurse or dietician if not consuming on a routine basis. If weight decline persists, contact the physician and dietician immediately. Labs as ordered. Monitor and evaluate any weight loss. Determine percentage of weight lost and follow facility protocol for weight loss. Monitor and record food intake at each meal; -Problem: The resident is on a mechanical soft diet; -Desired outcome: The resident will maintain a mechanically soft diet with risk for aspiration;-Interventions: Monitor for cough or choking. Staff to educate resident on following his/her diet. Staff to monitor resident for any signs of aspiration (when food or liquids enter the lungs). --Further review showed the care plan was not updated to the upgraded diet order from 2/16/26. Review of the resident's RD progress notes, dated 5/19/26 at 12:52 P.M., showed Nutritional weight assessment: Weights: February 2026: 143.8 lbs, March 2026: 155 lbs., April 2026: 141 lbs., May 2026 128.7. The residents' weights have been variable, but a recent loss of 12.3 lbs. (8.7%) in the past month and weight is now below normal weight range. Recommend adding 2Cal Med Pass (a nutritional supplement), 90 milliliters (mls) four times a day. Encourage intake of meals and supplements. Will monitor and reassess as needed. Observation and interview on 5/19/26 at 5:30 P.M., showed the resident sat at the side of the bed. The resident's meal was regular texture and the resident took small bites of a hamburger with a bun and chewed it multiples times and then spit it into a soda bottle. The resident said he/she could not get the food down. Further observation showed most of the hamburger was chewed up and spit out into the soda bottle and no staff were there to assist the resident Review of the resident's nursing progress notes, dated March 2026 - May 2026, showed staff did not document the residents swallowing difficulties and hypersalivation (excessive saliva). Review of the residents' weight summary report showed:-On 5/20/26: 123.2 lbs;-The resident had a significant weight loss of 20.52 % in three months. During an interview on 5/20/26 at 1:55 P.M., Restorative Therapy (RT) Aide T said he/she was responsible for the monthly and weekly weights. RT Aide T said the resident frequently spit out his /her food and had been having difficulty swallowing. The resident was not on the weekly weight list. RT Aide T placed the weights in the EMR and gave a paper copy of all the weights to the DON and the Charge Nurse. Weekly weights required a physician order. The only weights RT Aide T had on the resident was documented in the EMR. The resident was not weighed when he/she returned from his/her leave in March and probably should have been. During an interview on 5/20/26 at 5:35 P.M., Licensed Practical Nurse (LPN) U said the resident had always had multiple stomach and swallowing issues and it was nothing new. LPN U said the resident always had cups of saliva and undigested food in his/her room. The resident had always looked thin. LPN U was not aware that the resident had a weight loss. The resident normally drank soda, ate candy and other junk food. LPN U didn't think the resident ate much of his/her meals that were served to him/her. He/She said any resident that had weight loss should be weighed weekly, but weekly weights required a physician order. The physician, the RD, and the Director of Nurses (DON) should have been notified of the resident's weight loss. Speech therapy also should have been notified so that they could give some recommendations related to the resident's diet and his/her swallowing difficulties. LPN U was not aware of any special monitoring or diet that the resident was on. During an interview on 5/20/26 at approximately 5:45 P.M., Certified Medicine Technician (CMT) V said the resident had always had swallowing difficulties and a lot of spitting up. CMT V noticed as recently with the last couple of med passes that the resident required his/her medications to be crushed because the resident could not swallow his/her mediations whole. CMT V notified the nurse regarding the resident's swallowing difficulties. During an interview on 5/21/26 at approximately 11:00A.M., Certified Nursing Assistant (CNA) L said the resident used to spit his/her food and saliva onto his/her plate in the dining room, so now the resident had to eat in his/her room. The resident used to have a basin because he/she would spit food and saliva out so often. CNA L said he/she told the nurses about it. The resident had always appeared thin. The resident ate about 25 % of his/her meals. The resident drank a lot of soda and snacks from the vending machine. CNA L was not aware of any special monitoring or diet the resident was on. During an interview on 5/20/26 at (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	approximately 11:00 A.M., the Dietary Manager said she wasn't familiar with the resident since the resident ate in his/her room. She did not know who had weight loss in the building. The RD was responsible for following those concerns. During an interview on 5/20/26 at 12:32 P.M., the RD said she documented the residents' weight loss on 5/19/26 and made recommendations based off of reviewing the resident's medical record. On the RD's 5/19/26 visit to the facility, the RD said she did not interview the resident or any direct staff caring for the resident related to the resident's eating habits or the resident's increased difficulty in swallowing. The RD did not make any observations of the resident eating or having difficulty swallowing. The RD said it was not a requirement for her to meet with the resident on every visit. The RD was not aware that there was no order for weekly weights. She would have expected the facility to follow their policy related to obtaining weights. The residents' weights often fluctuated in the past, so no new recommendations were made with the residents' weight loss on 4/14/26. She would have expected documentation of how much the resident consumed of the supplement. The expectation of the nursing staff was to call the physician first when residents experienced weight loss. During an interview on 5/20/26 at 5:13 P.M., the facility's Medical Director, who was also the resident's physician said he would have expected the nursing staff to notify him of the resident's weight loss. He would expect documentation on the consumption of meals and supplements. The Medical Director would have expected weekly weights per the facility policy. The resident had a history of alcoholism and was likely to have had a lot of muscle wasting. The resident should have been weighed when he/she returned from his/her leave. He would have expected speech therapy to be consulted by the nursing staff since the resident was having difficulty swallowing. The Medical Director would have expected the RD to make new recommendations and accommodate the residents request for a mechanically chopped diet and any food preferences the resident had. During an interview on 5/21/26 at 10:50 A.M., the Director of Rehab (DOR) said the resident was last seen by speech therapy on 2/16/26 and a regular diet and thin liquids were recommended. The speech therapy department was not aware of the residents' ongoing swallowing difficulties and weight loss. The DOR would have expected the nursing staff or the DON to notify the department so that they could complete another swallowing evaluation. Speech therapy normally evaluated residents every three months. The DOR said she usually got a list of residents experiencing weight loss. The DOR reviewed her list for April and May and the resident was not listed as experiencing weight loss. During an interview with on 5/21/26 at 2:22 P.M., the Assistant Director of Nursing (ADON), and DON said the resident had difficulty swallowing and recently had his/her G-Tube removed. The resident was at risk for weight loss. The DON and the ADON said the resident always looked thin but were not aware of the resident's recent significant weight loss. The RT Aide was responsible for reporting weights to the Charge Nurse and the DON. The DON and ADON would have expected the staff to notify physician, the RD and speech therapy about the residents' weight loss and swallowing difficulties. They would expected the RD to go and speak to the residents and observe them during mealtimes. During an interview on 5/21/26 at 2:30 P.M., the Regional Nurse Consultant (RNC) said she would have expected the RD to interview the resident and staff that provided direct care to the resident to get a better perspective on why the resident was losing weight. She would have expected more documentation on the meals and nutritional supplement consumption. She would have expected the staff to notify the RD, the physician and speech therapy regarding the resident's weight loss and swallowing difficulties and document in the resident's EMR. The DON was responsible for reviewing all of the residents' weights in the facility.

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F 0740 Level of Harm - Actual harm Residents Affected - Few	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to identify, assess, monitor, and address behavioral health needs related to substance use disorder for residents with known history of substance abuse, including a thorough review of the referral information identifying recent substance use and positive toxicology results. The facility also failed to implement appropriate behavioral health interventions, monitoring, and services during a period in which social services staff were unavailable, resulting in missed opportunities to identify relapse risk, escalating warning signs, and ongoing substance use within the facility (Residents #104, #105, and #101). The resident sample was 20. The census was 97. The administrator was notified on [DATE], of the past non-compliance. The facility educated staff on incidents and accidents, screening resident's belongings, notifying physicians of resident changes in health, residents being in possession of illegal drugs, and the leave of absence policy. The facility also began monitoring and documenting behaviors associated with illegal substance use. The deficiency was corrected on [DATE].Review of the facility's Behavioral Health Service Policy, revised [DATE], showed:-Substance Use Disorder (SUD): Substance use disorder is defined as recurrent use of alcohol and/or drugs that causes clinically and functionally significant impairment, such as health problems, disability, and failure to meet major responsibilities at work, school, or home;-Policy: The facility will consider the acuity of the resident population. This includes residents with mental disorders, psychosocial disorders, or substance use disorders (SUDs), and those with a history of trauma and/or post-traumatic stress disorder (PTSD), as reflected in the facility assessment;-The facility will ensure that necessary behavioral health care services are person-centered and reflect the resident's goals for care, while maximizing the resident's dignity, autonomy, privacy, socialization, independence, choice, and safety;-Assessment/Care planning: The facility utilizes the comprehensive assessment process for identifying and assessing a resident's mental and psychosocial status and providing person-centered care. The assessment and care plan will include goals that are person-centered and individualized to reflect and maximize the resident's dignity, autonomy, privacy, socialization, independence, choice, and safety. Staff will:--Complete PASRR screening;--Obtain history from medical records, the resident, and as appropriate the resident's family and friends, regarding mental, psychosocial, and emotional health;--Monitor the resident closely for expressions or indications of distress;--Evaluate whether the resident's distress was attributable to their clinical condition and demonstrate that the change in behavior was unavoidable;--Utilize MDS and care area assessments;--Assess and develop a person-centered care plan for concerns identified in the resident's assessment;--Share concerns with the interdisciplinary team (IDT) to determine underlying causes of mood and behavior changes, including differential diagnosis;--Accurately document the changes, including the frequency of occurrence and potential triggers in the resident's record;--Ensure appropriate follow-up assessment, if needed;--Discuss potential modifications to the care plan;--Evaluate resident and care plan routinely to ensure the approaches are meeting the needs of the resident;-The resident, and as appropriate the resident's family, are included in the comprehensiveassessment process along with the interdisciplinary team and outside sources, as indicated. The care plan shall:--Provide for meaningful activities which promote engagement and positive,meaningful relationships. Residents living with mental health and SUDs may require different activities than other nursing home residents. The facility will ensure thatactivities are provided to meet the needs of these residents;--Address any other individualized needs the resident may have related to the mental disorder or the SUD;--Behavioral contact: If a behavioral contract is used, it will only be used with residents who have the capacity to understand it. A contract will only be used as a method of encouraging the resident to follow their plan of care, and not as a system of reward and punishment. The contract will not conflict with resident rights or other (continued on next page)

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F 0740 Level of Harm - Actual harm Residents Affected - Few	requirements of participation;--Resident refusal to accept, or non-adherence to the terms of a behavioral contract, will not be the sole basis for a denial of admission, transfer or discharge. Review of the facility's Residents- Possession and Use of Illegal Drugs, Marijuana and Alcohol and Drug Screen and Searches policy, revised [DATE], showed:-Purpose: To ensure that the Facility remains free from illegal drugs and substances as well as marijuana and alcohol. To define when and how a resident may be administered a drug screen or have their room searched;-Procedure: Illegal drugs or substances, marijuana and alcohol are not permitted;-The Facility is committed to maintaining a safe environment for every Resident. Part of this commitment is attempting to maintain an environment that is free of illegal drugs, dangerous items and other related contraband;-Use of illegal drugs creates a dangerous environment and may interfere with properly prescribed medications;-Marijuana (while legal) is not allowed in the Facility can interfere with properly prescribed medications.-The use, consumption, possession, transportation, sale or distribution of unlawful or unauthorized drugs (including marijuana), inhalants, alcohol, or the abuse of prescribed drugs or alcohol by any Resident while in the Facility or on Facility property is expressly prohibited and may result in an immediate discharge. Illegal or controlled substances (other than a valid prescription) will be confiscated, and the appropriate law enforcement agency(s) may be notified;-Contraband includes weapons of any kind, any items which could be used as a weapon, illegal or unauthorized drugs (including marijuana), drug paraphernalia, or alcohol. The possession or sale of any contraband while on Facility premises is expressly prohibited;-The Administrator and Director of Nursing shall educate staff and Residents (as appropriate) on the signs and symptoms of illegal drug use;-Process when suspicion of ingestion of illegal substance: If a Resident is suspected of taking an illegal drug or other substance (including marijuana), the Resident shall immediately be placed on one-on-one supervision and the Director of Nursing or charge nurse and Administrator notified;-If the Resident shows any signs of distress or there are other concerns, 911 shall be called immediately;-The nurse shall immediately evaluate the Resident and obtain a complete set of vital signs, including a neurology check and oxygen saturation level;-The Resident's primary care physician shall immediately be contacted for instructions;-If the Resident is not being sent to the hospital, the protocol below for drug screens and searches will apply;-Drug Screen: In the event the Administrator or Director of Nursing has reasonable suspicion that a Resident has ingested illegal or unauthorized drugs, a drug screen may be administered;-Search of Resident's room or property: In the event the Facility's Administrator or Director of Nursing has reasonable suspicion that contraband, illegal drugs or something that poses a safety risk to the Resident or others in the Facility is in a Resident's room, a search of the Resident's room may be considered;-The Facility should not act as an arm of law enforcement and may instead of a search (or if consent is not given for a search), the facility may make a referral will be made to local law enforcement;-If the Resident is his/her own person, the resident must consent to the search. If the Resident refuses the room or property search, the search will not be conducted, and the Management Company Regional Director will be notified;-If suspected illegal drugs are found, the local police and the Department of Health and Human Services will be notified. The Regional Director will also be notified;-Suspected Contraband or Illegal Drugs: If suspected contraband or illegal drugs (including marijuana) are found, those items will be given to the Administrator, Director of Nursing or Charge Nurse for inventory;-All items will be placed in a secure location for all Residents' safety;-Suspected illegal drugs will be turned over to law enforcement personnel for safe disposal;-Increased Oversight: To protect the health and safety of residents, the facility will provide additional monitoring and supervision, which includes denying access or providing supervised visitation to individuals who have a history of bringing illegal substances into the facility. 1. Review of Resident #104's hospital record, showed:-admitted [DATE]; -Assessment and Plan: Opioid withdrawal: Present on admission;-Sinus tachycardia (heartbeat over 100 beats per minute): Present on admission;-Fentanyl (potent, synthetic opioid drug) use disorder, severe: Present on admission;-Polysubstance use disorder: Present on admission;-Most likely etiology of discomfort at this time was relating to opiate withdrawal given (continued on next page)

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	265668	A. Building B. Wing	05/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Carrie Elligson Gietner Health Care Center	5000 South Broadway Saint Louis, MO 63111

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F 0740 Level of Harm - Actual harm Residents Affected - Few	his/her recent initiation of suboxone (used to treat opioid use disorder) and subjective history of mild improvement when using unspecified pill, presumed to be fentanyl (highly potent synthetic opioid) in an outpatient setting although unable to fully rule out component of known rheumatologic conditions;-Plan of care discussion: We reviewed his/her symptoms at the bedside and discussed that based on his/her story and the lab studies he/she performed, at this point that the most likely cause of his/her current pain was opiate withdrawal;-Physician progress note: He/She denied any issues with drug cravings. He/She was worried about managing his/her pain. The Buprenorphine (long-acting partial opioid agonist used to treat opioid use disorder) did not seem to be taking the edge off his/her pain. He/She would like to try methadone (long-acting synthetic opioid used to treat opioid use disorder). We discussed prolonged QT syndrome (a heart rhythm disorder) and strict federal regulations that both prohibit the use of methadone for him/her. He/She confirmed understanding and agreed with the plan to decrease buprenorphine to allow greater efficacy of the breakthrough pain meds;-The resident presented to hospital for chest pain on the initial workup for cardiac and musculoskeletal causes was unremarkable. Suspicion was raised for possible opiate withdrawal caused his/her pain. Review of the resident's face sheet, showed:-admitted [DATE];-Diagnoses of hemiplegia, hemiparesis, and cerebral infarction. Review of the resident's initial psychosocial history, dated [DATE], showed:-Substance Abuse;-Current stressors: blank;-Current diagnosis: blank;-Psychosocial assessment: Change in sleep and increased anxiety;-Past history: Suicidal ideations/attempts;-Self injurious behavior: non-suicidal;-Methods of self-injurious behavior: cutting;-Socialization and support system: Other: staff;-IDT signatures: blank. Review of the resident's care plan, dated 3/23 and revised [DATE], showed:-Problem: The resident was at risk for polysubstance abuse related to substance seeking behavior/safety risk;-Interventions: Administer Narcan per physician's order for signs/symptoms of narcotic overdose;-Monitor for signs of substance abuse/intoxication;-Monitor for signs of withdrawal;-Monitor items brought into the facility;-Offer emotional support during periods of agitation;-Notify physician of refusal or noncompliance;-Offer resident in the room alcoholic anonymous (AA)/ Narcotics anonymous (NA) program;-Problem: The resident is at risk for intentional or unintentional overdose due to history of depression, anxiety, confusion, access to medication substance misuse;-Interventions: Education provided on illegal drug use policy for the facility, Screens and search entering the building, resident possession and use of drug/alcohol policy, Adverse drug event policy, Narcan use policy, residents rights, abuse and neglect policy, and metal wand upon entering the building. Review of the resident's Physician Order Sheet (POS), dated [DATE] through [DATE], showed:-An order, dated [DATE], Hydromorphone (semi-synthetic opioid analgesic used to treat pain) HCl oral tablet 4 mg. Give one tablet by mouth every four hours as needed for pain;-An order, dated [DATE], Hydroxyzine (used to treat anxiety) HCl oral tablet 25 mg. Give 25 mg by mouth every six hours as needed for anxiety. Take one tablet by mouth four times daily as needed for anxiety;-An order, dated [DATE], Methocarbamol (muscle relaxer) Oral tablet 500 mg. Give 500 mg by mouth every six hours as needed for muscle spasms;-An order, dated [DATE], Narcan (lifesaving spray that reserves an opioid overdose) Nasal Liquid 4 mg / 0.1 milliliter (ml). Spray one spray into the nose as needed for overdose;-An order, dated [DATE], hydroxyzine HCl Oral Tablet 25 mg. Give 25 mg by mouth every six hours for anxiety;-An order, dated [DATE], Hydrocodone-Acetaminophen (used to treat pain) Oral Tablet 5-325 mg. Give one tablet by mouth three times a day for pain;-An order, dated [DATE], Trazodone (anti-depressant) HCl Oral Tablet 50 mg. Give one tablet by mouth at bedtime for insomnia;-An order, dated [DATE], hydroxyzine HCl oral tablet. Give 50 mg by mouth two times a day for anxiety;-An order, dated [DATE], hydroxyzine HCl oral tablet. Give 50 mg by mouth two times a day for anxiety until [DATE]. Review of the resident's progress notes, dated [DATE], showed:-Resident continued to exhibit erratic behavior and signs of withdrawal, though he/she denies experiencing any symptoms. Significant safety concerns are noted as the resident repeatedly slides out of his/her wheelchair and engages in self-picking, resulting in a sore on his/her face. Nursing attempted to perform a clinical evaluation and (continued on next page)

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F 0740 Level of Harm - Actual harm Residents Affected - Few	facilitated a telehealth visit with the physician; however, the resident refused both, stating he/she did not wish to speak with the physician again. The physician and Director of Nursing (DON) have been notified of the resident's behavior, his/her refusal of care, and his/her request regarding the physician. Staff will continue to monitor closely for safety and skin integrity.-Further review of the progress notes did not show staff spoke with the physician regarding the resident exhibiting signs of withdrawal of illegal substances. During an interview on [DATE] at 3:48 P.M., Licensed Practical Nurse (LPN) A confirmed he/she wrote the progress note on [DATE]. In his/her opinion, the resident was acting erratic. He/She was offered suboxone, but refused it. It helped with withdrawals. The resident started picking at him/herself and tried to act sane so LPN A would not suspect behaviors. The physician and psychiatrist were contacted. The psychiatrist saw the resident, but there was no way to redirect the resident. LPN A was asked to clarify why withdrawal was documented. LPN A said the resident was withdrawing from street drugs. He/She had an opioid abuse history before he/she was admitted . When the resident was first admitted , he/she was not exhibiting any behaviors, then he/she started to act erratic or self- medicate. Some behaviors included crying hysterically because of pain. They administered pain medication to him/her. One day, LPN A saw a lunch bag in the resident's room, and he/she never let anyone touch it. LPN A did not believe anyone searched his/her bag. Even during room search, an aide needed to search room, but the resident took the bag with him/her and held on to it. The resident was arrested at the facility for illegal substances on [DATE] and the bag was searched. He/She only had one visitor. When LPN A spoke to the physician, he/she mentioned the resident had withdrawals, but did not specify from what. The physician should have known the resident was coming off opioid abuse. [DATE] was the first time LPN A witnessed this behavior from the resident. Before, he/she cried about his/her arthritis. It felt like he/she was drug seeking. The resident would say I want to get out of here and he/she was better off on the streets. He/She was referred to pain management, but he/she did not go. Immediately the resident said he/she would rather go AMA (Against Medical Advice). As far as he/she knew, the resident was prescribed and never refused suboxone. Suboxene was found on him/her during the search. The pill was supposed to sit under the tongue, but LPN A believed the resident was taking it out when staff left the room after administering the medication. The resident took the other pills that were administered in front of staff, but placed the suboxone under the tongue and moved away. During an interview on [DATE] at 3:41 P.M., Certified Nurse Aide (CNA) J said Resident #104 was always in his/her room and he/she had only seen him/her come out about two or three times. He/She was in pain because the resident said he/she was coming off withdrawals from street drugs. CNA J was not sure what drugs, but the resident was on hard drugs. The resident would always sleep. He/She would sleep in his/her wheelchair leaned over the bed. CNA J was not sure if he/she was under the influence. During an interview on [DATE] at 12:19 P.M., the Assistant DON (ADON) said on [DATE], the behavior they were trying to identify was related to pain versus withdrawal. It was believed to be withdrawal because of the resident's substance abuse history. The resident could not identify where the pain was located, whether it was the hip, knee, or if it was arthritic pain. He/She started to get behaviors, and he/she could not identify what was hurting him/her. The resident declined to go to the hospital. They were juggling to see what was wrong. The physician was notified and said he/she would be in to see the resident. The physician would not approve any medication until he/she saw the resident and provided a signature. The resident did not want suboxone. The resident had a face to face with the physician and went against the medication. The ADON recalled he/she refused to take the suboxone. When asked about behaviors related to substance use or bringing illegal substances into the facility, the ADON said the resident only had one visitor. Per facility policy, if they found contraband, they called the authorities. The resident refused treatment. An aide reported at one point seeing the resident on the floor. The resident was abrasive at the time and a plastic bag was seen on the floor. The ADON said the aide no longer worked at the facility. During an interview on [DATE] at 12:56 P.M., Physician P said he/she remembered the resident, and (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility failed to ensure food storage, dishwasher sanitizing, and cleaning was in accordance with professional standards of practice, increasing the risk of cross-contamination and food-borne illness. In addition, there was no air gap between the ice machine and drain. This deficient practice had the potential to affect all residents who were served food from the kitchen. The census was 97. Review of dietary cleaning duties list, received 5/21/26, showed:-Morning Crew: Label and tag open food, microwave (inside, outside, under), toaster (inside, out, under after breakfast), freezers (tops, inside shelves, outside), meat slicer (inside, out, under), wipe down all stainless, wipe all mixer surfaces, plate warmer (inside, outside), window sills (kitchen, dining room), clean tables, dry milk cooler, hand washing sink, steam table, spice rack, fill all table condiments, clean and roll all silverware, sweep dining room, mop kitchen and dining room;-Evening Crew: Label and tag open food, microwave (inside, outside, under), toaster (inside, out, under after breakfast), freezers (tops, inside shelves, outside), meat slicer (inside, out, under), wipe down all stainless, wipe all mixer surfaces, plate warmer (inside, outside), window sills (kitchen, dining room), clean tables, dry milk cooler, hand washing sink, steam table, spice rack, fill all table condiments, clean and roll all silverware, sweep dining room, mop kitchen and dining room. Review of the Dietary - Equipment Operations, Infection Control, and Sanitation Policy, revised 2/2/24, showed:-Cleaning schedules: The Dietary Manager shall record all cleaning and sanitation tasks for the Dietary Department;-A cleaning schedule shall be posted with tasks designated to specific positions in the Department;-All tasks shall be addressed as to frequency of cleaning;-The procedures to be used are listed in this Policies and Procedures Manual.-General Daily and Weekly Cleaning schedules may be used or Cleaning Schedules by position may be used;-The Dietary Employee should complete the tasks assigned for the day and shift;-Employees should check off tasks as they are completed. If the employee doesn't accomplish a task, they need to communicate with the Dietary manager and place the task on the list for the following day;-Operation and Sanitation of Equipment: The Dietary Manager assembles and organizes manufacturers' directions for operating and cleaning all dietary equipment;-The U.S. Public Health Service Food Code states the following guidelines for sanitizing solutions:--Use chemical sanitizer in accordance with the manufacturers' use directions included in the labeling:--Serve Safe materials recommended contact times for each for the following sanitizers:---Chlorine: seven seconds at 50 ppm at temperature between 75 degrees Fahrenheit (F) and 115 degrees F;---Iodine: 30 seconds at 12.5 - 25.0 ppm at temperature between 75 degrees F and 120 degrees F;---Quats: 30 seconds at 200 ppm at temperature above 75 degrees F;-All surfaces and equipment shall be washed with a sanitizing solution;-Sanitation buckets must be established with appropriate sanitizing solution generally for bleach, 50-100 parts per million (ppm) or Quaternary (no rinse broad spectrum solution) solution, 200 ppm; however, follow manufacturer's recommended directions;-Sanitizing cloths shall be placed in the sanitizing buckets to be used in sanitizing all work surfaces and equipment;-Dietary shall change these buckets at least every three hours and test with the appropriate litmus strips each time the solution is changed to assure accurate levels of sanitizer;-Dish Machine: Before each use, prepare dish machine for use according to instructions. Allow dish machine to run for 10 minutes in order to bring water temperature up to proper level by sending several empty racks through the machine;-Read temperature gauge on top of machine while racks are in the machine;-Low temperature dish machine: Wash temperature: 120 degrees to 140 degrees F;-Rinse temperature: 120 degrees F to 150 degrees F;-Or follow manufacturer's directions, if different;-Any inaccurate temperatures must be brought to the attention of the Dietary Manager immediately;-The concentration of the sanitary solution during the rinse cycle is 200 ppm with quaternary ammonium. This is used on low temperature dish machines;-A potential of hydrogen (pH) test kit is used daily and may be obtained from the chemical (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Carrie Elligson Gietner Health Care Center	5000 South Broadway Saint Louis, MO 63111

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	supplier for the low temperature dish machines;-When the chemical sanitizing dispenser is broken or not working correctly on a cold temp machine, appropriate amount of sanitizer, per manufacturer directions, can be manually added to the dish machine at each rinse cycle. Check for correct amount of sanitizer at each rinse cycle with appropriate litmus paper;-Record ppm on low temperature machines three times daily;-Dishwashing procedure: Carefully place dishes in soaking sink as needed;-Air dry dishes by racking or putting on single trays lined with mesh;-Counters: Use a mild detergent and water. Rinse shelves with a clean rag and dry;-Frequency: weekly;-Floors: Dust mop or sweep the area;-Fill one mop bucket 2/3 full of clean warm water;-Add cleaning agent to water according to directions on the label of the container;-Place wet floor signs around the area to be mopped;-Dip the mop into the bucket with the cleaning agent;-Wring out the excess solution from the mop, but do not wring fully dry;-Start the mopping stroke approximately 2 feet straight out from the baseboard;-Make a long mopping stroke close to the baseboard;-Continue mopping in a figure-eight pattern;-After turning the mop over two or three times, dip into the bucket with the cleaning agent;-Mop an area 9 by 12 feet at a time;-Wring the mop out and rinse the floor previously mopped with the cleaning solution;-Allow the floor to dry. Then mop and rinse the other half or other areas that have not been mopped;-Change the cleaning solution water and rinse water as the water color turns brown;-Empty the mop buckets and rinse the buckets with clean warm water;-Rinse the mops in clean warm water and wring out as much water as possible;-Remove mop head and place in designated bucket. 1. Observation of the dining room on 5/17/26 at 8:54 A.M., 5/18/26 at 10:49 A.M., 5/19/26 at 1:55 P.M., and 5/20/26 at 11:47 A.M. and 2:30 P.M., showed a dead cockroach, on its back, and on the floor in the dining room approximately two feet from the door to the stairwell. 2. Observation of the refrigerators and freezer on 5/17/26 at 8:46 A.M., showed: -Sliced cheese open to air in the double refrigerator;-Sliced onions in a container with plastic pulled back in the double refrigerator;-Several large empty boxes in the hallway on the floor in between the kitchen prep and refrigerator area; -An open, uncovered seven-pound container of vanilla pudding; -Wrapped ground beef without date. 3. Observation of the kitchen on 5/18/26 at 10:49 A.M., showed:-Dirt and debris on the floor underneath the window, behind prep countertop;-One dead bug on the floor in front of prep table;-Several salt packets on the floor in the fridge/ freezer area. Observation of the kitchen on 5/19/26 at 1:55 P.M., showed:-Dust, debris and food crumbs under the three-sink sanitizer;-A large empty container of detergent with several dried, dirty rags inside;-Four stacked wet containers on the bottom shelf in the kitchen;-Box of salt and pepper packets in front of an open window during a rainstorm. Several packets inside the box were wet;-Food crumbs, dust and debris behind the prep table on the far end of the kitchen;-Uncovered pack of cheese slices in the refrigerator;-One unopened box of 2% milk with 5/11 written on the box. Manufacturer sticker on the box showed 5/18;-Light bulb in the refrigerator holding boxes of milk, showed water dripping from the bulb onto a box;-Ground beef wrapped and dated 5/15. Ground beef appeared darker in color on one side. Observation of the kitchen on 5/20/26 at 2:30 P.M., showed a bag of frozen, opened cauliflower tied in a knot without a date. 4. Observation of the storage room on 5/17/26 at 8:54 A.M., showed: -Approximately 12 empty boxes on the floor;-12 sugar packets on the floor;-Dust and debris around the perimeter of the floor, including underneath the shelves. Observation of the storage room on 5/18/26 at 10:49 A.M., showed: -Approximately 15 broken down boxes on the shelf between canned goods; -Dented 99 ounce (oz) can of pickle spears; -Plastic glove on the bottom shelf behind large plastic container of pickles; -Three empty boxes on the middle shelf near container of pickles; -Several sugar packets on the floor-Plastic glove on the floor at entrance to storage room-Storage room floor was sticky; -Food crumbs inside the steam table with dust and debris on the bottom shelf;-Five large empty boxes on the floor underneath an electronic box. A sign posted showed, area under fuse panel must stay clear. Observation of the storage room on 5/19/26 at 2:24 P.M., showed:-Approximately six boxes on the floor underneath an electronic box. A sign posted showed, area under fuse panel must stay clear; -Sticky floors;-A large can of six pound cheese dented at the top of the can;-A large three pound can of mushroom soup (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	dented at the top of the can;-A large can of pickle spears dented on the side of the can;-A 25-pound bag of seasoned fish breading not completely closed, open to air;-Approximately ten packets of sugar and salt on the floor. Observation of the storage room on 5/20/26 at 2:36 P.M., showed:-Approximately six empty boxes on floor below fuse box on wall, with sign that reads do not place anything below this fuse box;-A three pound can of mushroom soup dented at the top of the can;-A dented, six pound can of diced peaches;-A 25-pound bag of seasoned fish breading not completely closed, open to air;-Three salt and sugar packets on the floor;-Two visibly soiled towels with dark substance which were in an unused steam table with approximately 11 bags of unopened tortilla chips. 5. Observation and interview on 5/21/26 at 2:19 P.M., showed Dietary Aide F at the dish machine. There were several dishes in the dish machine sink that soaked in brown water. Dietary Aide F said he/she did not know how to test the dish machine. He/She made sure there was bleach and soap in the sink first and then he/she ran them through the dish machine. 6. During an observation and interview on 5/21/2026 at 2:23 P.M., Dietary Aide G said the three-sink sanitizer was tested daily. He/She was initially unable to find strips. At 2:25 P.M., Dietary Aide G found strips to test the sanitizer. He/She ran water and sanitizer into the sink and placed a testing strip inside the water. The strip did not change color. He/She matched the testing strip against the container that showed parts per minute (ppm) results with matching colors. Dietary Aide G said the strip appeared light purple; however, the strip did not change to light purple, which was 10 ppm on the container. He/She checked the sanitizer to ensure it was working properly. He/She used a new test strip and placed it inside the water. He/She was unsure of the color and confirmed the strip appeared darker due to it getting wet. Dietary Aide G said the sanitizer was installed earlier this year and they came by to check it but did not test it. The three-sink sanitizer was tested on ce a week. It was last tested this past weekend. 7. Observation on 5/17/26 through 5/21/26, on all days of survey, showed no air gap behind the ice machine in the kitchen. 8. During an interview on 5/21/26 at 2:36 P.M., the Dietary Manager said the three-sink sanitizer had soap, rinse, and sanitizer. They did not have a test book right now, but it was recently fixed. Dietary Manager was unable to say the amount of PPM the test strip needed but would find out. It was recently fixed on 4/4/26. They were unable to smell sanitizer and there were problems getting the solution to come out. The dish machine was tested with a strip to check the amount of sanitizer in the machine. It was both hot water and sanitizing dish machine. There was no test log and had not been used since she started March 2026. If cups and spoons needed to be soaked, they were placed in a prewash of sanitizer liquid and dish soap. It was the same liquid sanitizer used in the green and red buckets. Staff were in-serviced, and they talked about different procedures such as checking the hot water and if utensils came out spotty. Their spoons appeared spotty at one point. Staff was expected to test the dish machine and the three sanitizing sink every day. She would expect staff to report if sanitizer was not coming out. The dietary aides were responsible for cleaning the floors in the dining room, kitchen, and storage room. They did have cleaning duties that were listed for morning and evening. The cleaning list also included the storage room. Staff was expected to notify her if any cans were delivered dented. She would expect boxes to be broken down. Sometimes staff go too fast and grab things instead of taking their time. They did not take out of the boxes and did not have time to break them down. The Dietary Manager was not aware of the air gap, only to keep the area clean. The Dietary Manager and cooks were responsible for checking expiration dates on food. The Dietary Manager was not aware of a box of milk cartoons that had a best buy date of 5/18 written on it. She was not aware of milk thrown out. She would expect containers to be air dried completely before stacking on the shelf. At 2:56 P.M., the Dietary Manager confirmed there were no testing strips for the dish machine. She confirmed the sanitizing liquid used with dish soap to soak dishes was bleach. The Dietary Manager raised a container of brand name cleaner with bleach. The Dietary Manager said it was used for utensils but was not sure about dishes. They used the same cleaner to clean the table. 9. During an interview on 5/21/26 at 3:09 P.M., the Administrator said she would expect the dish machine and three sanitizer sink to be tested regularly. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	It was not appropriate to use brand bleach on dishes. They recently had the dish machine serviced. Corporate and maintenance would assist in the process. She would have expected the storage room to be cleaned, with non-food items off the shelves.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. Based on observation, interview, and record review, the facility failed to ensure resident rooms (Resident #2), resident common area meeting spaces, and resident belongings were kept in a clean, safe, and homelike manner. Concerns were noted with shower rooms on the 300, 500 and 100 hall, resident phone rooms, and with the sunrooms at the ends of resident halls. The sample size was 20. The census was 97.Review of the facility's Safe and Homelike Environment policy, revised 6/5/24, showed:-In accordance with the residence rights, the facility will provide a safe, clean, comfortable, and home like environment, allowing the resident to use his or her personal belongings to the extent possible. This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk;-A homelike environment is one that D emphasizes the institutional character of the setting, to the extent possible, and allows the resident to use those personal belongings that support a home like environment. A determination of homelike should include the residence opinion of the living environment;-The facility will create and maintain, to the extent possible, a homelike environment that deemphasizes the institutional character of the setting;-Housekeeping and maintenance services will be provided as necessary to maintain a sanitary and comfortable environment;-The facility will provide and maintain bed and bath linens that are clean and in good condition. Review of the facility's Housekeeping - Deep Cleaning Policy, revised 6/29/23-All areas should be monitored on a daily basis and all resident living areas and non living areas should be clean and odor free;-Daily cleaning: Pick up all trash and put into trash can and empty, dust mop or sweep floor, and clean shower rooms inside the shower, around the shower, and the baseboards in the room;-Bathroom floors will be swept and mopped and any dirt, grime, or stains will be hand scrubbed with stiff brush or other equipment suitable for removing surface dirt from entire floor. If the stain is not removable then housekeeper will notify maintenance department with a maintenance request form. 1. Review of Resident # 2's quarterly Minimum Data Set (MDS), a federally mandated assessment tool completed by facility staff, dated 2/11/26, showed:-Cognitively intact;-No rejection in care;-Requires partial to moderate assistance with personal hygiene and bathing;-Diagnosis include, schizophrenia (a mental condition that distorts reality), infection of intravertebral disc (a part of the back), malnutrition (poor nutrition), and viral hepatitis (inflammation of the liver caused by a virus). Observation on 5/17/26 at 10:10 A.M., 5/18/26 at 9:05 A.M., and 5/19/26 at 8:45 A.M., showed the resident lay in bed. The white fitted bed sheet had stains and dark discoloration. Multiple bottles of empty soda bottles, crumbs of food, food wrappers, and cups of undigested food in clear cups were on the resident's floor next to his/her bed. Multiple personal items were in the residents' room and closet. During an interview on 5/18/26 at 9:05 A.M., the resident said he/she wasn't sure if his/her room was cleaned every day. The resident said he/she was messy and tried to pick things up him/herself but really couldn't, due to pain. The resident said he/she was having difficulty swallowing and that was why he/she spit food and saliva in the cups 2. Observation on 5/17/26 at 8:43 A.M. of the 300 hall Tub Washroom, showed two large industrial trash cans filled with waste lined up next to the tub. Broken baseboard pieces and broken tiles were observed behind the washroom's toilet. Observation on 5/17/26 at 9:07 A.M. of the shower room on the 500 hall, showed three large industrial trash cans blocking access to the sink and cabinets. A soiled blue sock was observed in the bathtub. Observation on 5/18/26 at 9:27 A.M. of the shower room on the 500 hall, showed three large industrial trash cans blocking access to the sink and cabinets. A soiled blue sock was observed in the bathtub. Observation of the 100 hallway shower room, showed:-On Observation on 5/19/26 at 9:02 A.M., the room had a mildew-like smell. Dirty towels were on the ground under the bench and on top of the shower bench. A wet towel was on the ground. Hair was on the ground and on the shower wall. A used white washcloth was on the ground in the right corner of the room; -On 5/20/26 at 6:59 A.M., the room had a mildew-like smell. Hair was on (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the floor and the shower wall. A used washcloth was on ground in the right corner of room; -On 5/21/26 at 6:43 A.M., wet towels were on the ground in front of the shower bench. Hair was on the ground and on the shower bench. A used white washcloth was on the floor in the right corner of the room. During an interview on 5/17/26 at 10:10 A.M., Resident #2 said he/she didn't take showers because the shower room was so filthy. The facility did not provide any type of shoes to wear in the shower, and he/she did not want to put his/her bare feet directly on the shower floor. 3. Observation 5/17/26 9:28 A.M. of the 300 hall resident Phone Room, showed a small room with a sitting table and chairs with a phone available for residents to use. The room's floor had a dark, sticky stain in the center of the room and pieces of plastic trash were observed in the corner of the room near the doorway.Observation 5/18/26 9:16 A.M. of the 300 hall resident Phone Room, showed a small room with a sitting table and chairs with a phone available for residents to use. The room's floor had a dark, sticky stain in the center of the room and pieces of plastic trash were observed in the corner of the room near the doorway. 4. Observation on 5/17/26 at 8:42 A.M. of the sunroom at the end of the 300 East resident's hall, showed an empty wood pallet propped up against the [NAME] wall of the sunroom. Observation on 5/19/26 at 9:00 A.M., of the 100 hallway sun room, showed:-A large dead cockroach was on ground in the corner of the room;-Trash debris was on ground in various areas;-Grey cigarette ash was on the ground behind the desk;-Food wrappers were on the desk. The desk was visibly dusty. Observation on 5/21/26 at 6:45 A.M., showed:-Food wrappers were on the desk. The desk was visibly dusty. 5. During an interview on 5/17/26 at approximately 9:00 A.M., Housekeeper H said the hall shower rooms, common areas, and resident rooms were cleaned daily and as needed. During an interview on 5/21/26 at 11:20 A.M., Certified Nursing Assistant (CNA) L said the nursing staff changed sheets daily and as needed and the housekeeping staff cleaned the resident rooms and swept the floors once daily. During an interview on 5/21/26 at 8:54 A.M., Licensed Practical Nurse (LPN) A said Certified Nursing Assistants (CNA) were responsible for ensuring dirty linen was taken out of the shower rooms. He/She said housekeeping was responsible for cleaning the shower rooms. He/She said the shower rooms were cleaned once a day and as needed. During an interview on 5/21/26 at approximately 10:00A.M., the Housekeeping Supervisor said resident rooms and the shower rooms on resident halls were expected to be cleaned daily and as needed. During an interview on 5/21/26 at 2:22P.M., the Administrator, Director of Nursing, Assistant Director of Nursing, and Regional Nurse Consultant said she would expect all shower rooms and resident rooms to be cleaned daily and as needed. The Administrator said she would expect facility staff to complete the inventory list on admission and when new items were brought in for a resident. She would expect all rooms to be cleaned daily and sheets to be changed when visibly soiled.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. Based on interview and record review the facility failed to send a copy of the transfer and discharge notices to a representative of the Office of the State Long-Term Care Ombudsman (resident advocate) for January, February, March, and April 2026. The census was 97. Review of the facility's Resident Transfer, Discharge, Immediate Discharge, and Therapeutic Leave policy, last revised 4/28/25, showed:-Purpose: Establish policy and procedure regarding the transfer/discharge of residents; To ensure no inappropriate discharges are made and that no discharges are made in an unsafe manor;-Notice of discharge or transfer: -Who must receive notice; -Notifying the representative for the Office of the State Long-Term Ombudsman; -A copy of the discharge transfer notice shall be sent to the Ombudsman at least 30 days in advance of the discharge or as soon as possible; -In the case of an emergency or immediate discharge, copies shall be sent to the Ombudsman; This notice shall be sent when practicable and a monthly list is acceptable and should include if the resident's return is expected. Review of the facility's admission and Discharge Report, dated 6/27/24 through 5/17/26, showed:-January 2026: Eight residents discharged ;-February 2026: Six residents discharged ;-March 2026: Eight residents discharged ;-April 2026 : Eight residents discharged . During an interview on 5/14/26 at 8:04 A.M., the Ombudsman said their office has not received the transfer discharge notifications consistently from the facility starting from January 2026. During an interview on 5/18/26 at 2:50 P.M., the Social Service Director (SSD) said he had only been at the facility for two weeks and has not sent any documentation of the facility's transfers and discharges to the Ombudsman's office and is unsure what the previous SSD sent. During an interview on 5/21/26 at 2:22 P.M., the Administrator said she expected the SSD to send the required documentation for discharges and transfers to the Ombudsman's office. The facility has not been sending the transfer discharge documentation timely and consistently to the Ombudsman's office. The facility has not had a dependable SSD in the facility for several months.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 residents received appropriate activities of daily living (ADL, daily care) care to meet the needs of residents by not assisting three residents with their showers (Resident # 35, Resident #25 and Resident #2) and provide foot care for one resident (Resident #25). The facility also failed to assist one resident during mealtimes (Resident #55). The sample size was 20. The census was 97. Review of the facility's ADL policy, dated 5/18/24, showed:-Purpose: The facility will, based on the resident's comprehensive assessment and consistent with the resident's needs and choices, ensure a resident's abilities in ADLs do not deteriorate unless deterioration is unavoidable;-Cares and services will be provided for the following ADLs;-Bathing, dressing, grooming and oral care;-Transfer and ambulation;-Toileting;-Eating to include meals and snacks; and systems;-Policy: The facility will provide a maintenance and restorative program to assist the residents in achieving and maintaining the highest practicable outcome base on the comprehensive assessment.-A resident who is unable to carry out activities of daily living will receive the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. Review of the facility's Podiatry Services policy, last revised on 5/14/24, showed:-Purpose: It is the policy of this facility to ensure residents receive proper treatment and care within professional standards of practice and state scope of practice, as applicable, to maintain mobility and good foot health;-Policy:-Foot care that is provided in the facility, such as toenail clipping for residents without complicating disease processes, should be provided by staff who have received education and training to provide this service;-Residents requiring foot care who have complicating disease processes will be referred to qualified professionals such as a podiatrist (foot doctor). 1. Review of Resident #35's annual Minimum Data Set (MDS, a federally mandated assessment instrument completed by facility staff) dated 2/10/26, showed:-Diagnoses included cerebrovascular accident (CVA, stroke), paraplegia, malnutrition, depression, schizophrenia, and asthma;-Cognitively intact;-Impairment on both sides to upper and lower extremity;-Uses wheelchair;-Substantial/maximal assistance for eating;-Dependent with oral hygiene, toileting, shower/bathe self, upper and lower body dressing, and personal hygiene. Review of the resident's care plan, in use during survey, showed:-Problem: Resident has an Activity of Daily Living (ADL) self-care performance and mobility deficit related to spinal injury paraplegia, poor coordination, obesity, weakness, and neurological impairment requiring maximum assistance with ADLs;-Interventions:--Monitor for fatigue and poor coordination;--Provide max assist with ADLs, transfers, mobility, and hygiene;--Two staff members for ADL care;--Bathing/showering: Resident is totally dependent on 1-2 staff to complete this task;--Bed mobility: The resident is totally dependent on staff for repositioning and turning in bed;--Personal hygiene/oral care: The resident is totally dependent on one staff for personal hygiene and oral care;--Encourage the resident to discuss feelings about self-care deficit;--Encourage the resident to use bell to call for assistance;--Monitor/document/report as needed (PRN) any changes, any potential for improvement, reasons for self-care, deficit, expected course, decline in function; -Problem: Resident's family member came into facility to discuss resident's care;-Interventions:--Staff will offer daily get ups to resident;--Showers will continue to be offered 2x a week. Review of the resident's shower sheets, May 2026, showed:-On 5/2/26, a bed bath and signed by Certified Nursing Aide (CNA) and charge nurse;-On 5/6/26, a shower was documented and signed by CNA and charge nurse;-On 5/9/26, a bed bath or shower was not documented. It was signed by CNA and charge nurse;-On 5/13/26, a bed bath or shower was not documented. It was signed by the charge nurse;-On 5/16/26, no staff signature or other written documentation. During an observation and interview on 5/20/26 at 2:38 P.M., the resident said showers were not frequent, it was whenever staff wanted to take him/her there. Cleanliness was a part of nursing too. He/She asked for a shower in the past and was told no due to (continued on next page)

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	265668	A. Building B. Wing	05/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Carrie Elligson Gietner Health Care Center	5000 South Broadway Saint Louis, MO 63111

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	reasons such as staffing or broken or no shower bed. Staff changed his/her brief, but that is it. When he/she received a bed bath, it was not sufficient because they used wipes on his/her back. He/She asked staff not to do that. They called it a bed bath, but it was only a wet wipe without any water. If he/she received a shower, staff did not moisturize his/her skin. His/her shower days were Wednesday and Saturday and confirmed today was his/her shower day. His/Her scalp was very itchy, and his/her hair had not been washed. He/She did not remember the last shower, but it was the end of last month. His/her scratched his/her scalp a lot. The resident never refused a shower. Staff documented he/she refused, but no one talked to him/her about refusal. The resident said when he/she was at a former facility, he/she signed the shower sheet if they refused. The resident believed staff should do the same here. The resident's hair appeared matted, covered with a large amount of dandruff, presenting as whitish flakes throughout his/her hair. During an interview on 5/20/26 at 3:38 P.M., Licensed Practical Nurse (LPN) I said sometimes the resident refused to get out of bed. For example, he/she told staff he/she would not get out of bed if certain people were out there or in the hall. He/She was not known to refuse showers. During an interview on 5/20/26 at 3:41 P.M., CNA J said the resident did not have any refusals for showers or getting out of bed. Sometimes, in a sarcastic way, he/she would say, I did not know I could get out of bed. During an interview on 5/21/26 at 9:52 A.M., the Administrator said the resident had not received a shower since 5/6/26. She was uncertain if the resident wanted it and did not hinder the shower. She would inform nursing so the resident could receive a shower. During an interview on 5/21/26 at 10:30 A.M., CNA K said he/she used two gray buckets for bed baths. One bucket has hot water and the other was for the soap. They used soap and wash cloths, depending on the part of the body. If a resident requested wipes, he/she would use them. Otherwise, he/she used a washcloth. 2. Review of Resident #25's, quarterly MDS, dated [DATE], showed:-Moderate cognitive impairment;-No rejection of care;-Uses a walker and wheelchair;-Partial to moderate assistance with personal hygiene, bathing, toilet hygiene, putting on and taking off footwear;-Requires supervision or touching assistance from staff for lower body dressing;-Diagnosis includes chronic (long term) lung disease, high blood pressure, heart failure, morbid obesity and difficulty walking. Review of the resident's care plan, in use during the time of the investigation, did not address the resident's ADL needs. Review of the resident's shower sheets, dated 4/1, 4/6, 4/9, 4/13, 4/20, 4/23, 4/24, 4/30, 5/4, 5/7, 5/11, 5/14, 5/16, and 5/18/26 showed:-Signed by the CNA and Charge Nurse;-No description of type of bathing or showering;-No skin issues listed;-Does the resident need his or her toenails cut? Blank. Review of the podiatrist list provided by the facility, dated 4/9/26, showed the resident was not listed.During an observation and interview on 5/17/ 26 at 8:47 A.M. and 5/19/26 at 8:55 A.M., the resident sat in his/her wheelchair. The resident exposed his/her lower legs and feet by lifting his/her pant legs. The resident's legs and feet were extremely dry with a dark skin discoloration to the calf area of the legs. The resident's hair was oily. The resident said he/she required assistance getting in the shower room because there was a lip when you entered the shower and he/she was afraid he/she was going to trip and fall because of it. The resident said he took a bird bath and washed his/her hair at the sink located in his/her room. He/She had not received assistance from staff for his/her showers. The resident's toenails were approximately one half an inch long and were jagged. The resident said no staff member had ever provided any type of toenail trimming or foot care since he/she had been admitted . Observation on 5/17/26 at 10:00 A.M., 5/18/26 at 9:00 A.M., and 5/19/26 at 1:05 P.M., showed the shower room had an uneven bump located directly before the shower stall. During an interview on 5/21/26 at 10:50 A.M., CNA L said the resident required assistance with his/her showers and he used his/her walker to get into the showers. The facility nail clippers were so flimsy that they were not useful in cutting the resident toenails. If staff could not cut resident's toenails, then the resident should be referred to the podiatrist. If a resident required a bed bath, then it should be written on the shower sheet as a bed bath. Foot care should be provided on their shower days and as needed. All skin issues including dry skin should be on the resident's shower sheets. 3. Review of Resident # 2's quarterly MDS, dated (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	[DATE], showed:-Cognitively intact;-No rejection in care;-Requires partial to moderate assistance with personal hygiene and bathing;-Requires supervision or touch assist putting on and takin off footwear;-Diagnoses included, schizophrenia (a mental condition that distorts reality), infection of intravertebral disc (a part of the back), malnutrition (poor nutrition), and viral hepatitis (inflammation of the liver caused by a virus). Review of the resident's care plan, in use at the time of survey, showed:-Problem: The resident is at risk for ADL self-care performance deficit due to deconditioning;-Interventions: Encourage the resident to participate to the fullest extent with each interaction. Monitor and document any changes, any potential for improvement, reason for self-care deficit, expected course or declines in function. Praise all efforts of self-care. Review of the resident's shower sheets, dated 4/2, 4/9, 4/13, 4/16, 4/20, 4/24, 4/27, 4/30,5/4, 5/7, 5/11, 5/14, and 5/18/26 showed:-Signed by the CNA and Charge Nurse;-No description of type of bathing or showering. Observation on 5/17/ 26 at 10:10 A.M., 5/18/26 at 9:05 A.M. and 5/19/26 at 8:45 A.M., showed the resident lay in bed. The white fitted bed sheet had stains and dark discoloration. The resident wore white socks and the bottom of the socks were stained black. The resident's hair was messy and had white particles in it. During an interview on 5/17/26 at 10:10 A.M., the resident said he/she didn't take showers any longer because the shower room on the 200 hall was so filthy. The facility did not provide any type of shoes to wear in the shower, and he/she did not want to put his/her bare feet directly on the shower floor. The resident said he required assistance with his/her showers because he/she was unsteady on his/her feet. The resident could not remember the last shower he/she took at the facility. Observation on 5/17/26 at 10:00 A.M., 5/18/26 at 9:00 A.M., and 5/19/26 at 1:05 P.M., showed the shower room on 200 hall had multiple used wet towels and had a moldy odor. There was mold on the tile grout on the wall of the shower. During an interview on 5/21/26 at 10:50 A.M., CNA L said the resident refused his/her showers and always had an excuse. The CNAs should document refusals of resident showers on the shower sheets. The facility did not supply any type of shower shoes. The resident should be encouraged to change his/her soiled socks, but the resident had a tendency to refuse care. 4. During an interview on 5/21/26 at 2:22 P.M., the Regional Nurse Consultant (RNC) and the Director of Nursing (DON) said the residents were expected to get showers two to three times a week. They would expect staff to complete accurate documentation of the showers to include what type of bathing activity occurred and any skin or foot issues. Foot care could be provided by staff and included toenail trimming and moisturization of the feet. It was expected that staff helped the residents with showers when the resident's needed assistance. The facility did not provide any type of shower shoes for the residents to wear. 5. Review of Resident #55's quarterly MDS, dated [DATE], showed:-Diagnoses included hypertension (high blood pressure), depression and anxiety;-Cognitively intact. Review of the resident's care plan, in use at the time of the survey, showed:-Problem: Resident has an activities of daily living(ADL) self-care performance deficit;-Desired outcome: Resident will maintain current level of function by the review date;-Interventions: Eating: Resident requires supervision or touching assistance from staff to perform this task. Review on 5/17/26 at 11:14 A.M., of the resident's POS, dated 5/2026, showed an order, dated 9/30/24 for regular diet, regular food texture, thin/regular drink consistency. Observation on 5/20/26, of the resident in the main dining room, showed:-At 7:59 A.M., the resident was in the dining room for breakfast. The resident had a carton of milk, bowl of cereal, plate of scrambled eggs, a piece of toast, and a sausage patty;-At 8:02 A.M., the resident was struggling to open the milk carton. The resident, who was seated at the table with him/her, opened the milk carton for him/her. CNA B was in the dining room speaking with other residents;-At 8:16 A.M., the resident started to eat the hot breakfast portion. He/She struggled to use his/her fork with his/her hand visably shaking. He/She started to shovel the scrambled eggs onto the fork with his/her hands;-At 8:17 A.M., the resident pushed the remainder of the scrambled eggs onto the piece to toast. The resident brought his/her head down to the piece of toast to take a bite and appeared to struggle with lifting the piece of toast all the way to his/her mouth. During an interview on 5/20/26 at 12:24 P.M., the Registered (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Dietician (RD) said she was unaware the resident was not on hospice and must have been documented that in error. She said she came to the facility on 5/19/26 but did not actually lay eyes on the resident. She said she was unaware the resident was struggled to open his/her milk carton and with lifting silverware up to his/her mouth. She would have expected staff oversight in the dining room. She would expect staff to assist the resident and refer the resident to occupational therapy if they had concerns. During an interview on 5/21/26 at 6:47 A.M., the resident said he/she struggled to open juice cartons and milk cartons. He/She said the residents who sat at his/her table in the dining room helped him/her. He/She said he/she did have weight loss but tried to eat as much as possible. Observation on 5/21/26 at 7:45 A.M., showed the resident in the main dining room for breakfast. The resident held his/her milk carton and attempted to open it. A resident from the table next to his/her got up and opened the milk carton for the resident. CNA B was in the dining room talking with dietary staff. During an interview on 5/21/26 at 9:46 A.M., CNA B said the resident required one staff touch assistance and supervision during meals. He/She said the resident should be eating finger food because he/she ate with his/her hands. He/She said he/she did not help the resident because the resident wanted to be independent. During an interview on 5/21/26 at 2:46 P.M., the Administrator and DON said staff should assist residents during meals with opening packages. If any staff saw residents struggling to feed themselves, they should have reported this to the resident's nurse. Nursing staff should have assist the residents and if they were having a hard time eating, staff should have notified therapy for possible occupational therapy evaluations. 1611324 2784565

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide an ongoing activity program that supports resident's interests and their choices of activities for three residents (Residents #7, Resident #25, and Resident #8). In addition, the facility failed to provide one to one (1:1) activities to one resident who was identified as having the potential to benefit from them (Residents #35). The sample size was 20. The census was 97. Review of the facility's Activities policy, last revised on 7/19/23, showed:Purpose: The purpose of this policy is to ensure that all residents in the facility are provided an ongoing program of activities designed to meet, in accordance with comprehensive assessment, their interests and their physical, mental and psychosocial well-being;-Procedure:--The Life Enhancement Director coordinates from the comprehensive assessment and ensures that activities are designed to promote and enhance emotional health, self-esteem, pleasure, comfort, education, creativity, success and independence for all residents based on interview and assessing the resident's likes and dislikes;--If the resident requires more intensive interventions for activities, programming that is relevant to the resident' specific needs, interests, culture, and history/background, than an individualized activities plan of care will be developed to enhance their psychosocial well-being;--The activities calendar will be posted on each unit and will include activities that are appropriate for general therapeutic social setting of the population that meets the specific needs, cognitive impairments, interests and supports the quality of life while enhancing self-esteem and dignity. Review of the facility's activity calendar, dated 5/17 through 5/27/26, showed:-On 5/18/26 at 10:00A.M., dancing; 10:30 A.M., coffee and conversation; 2:00 P.M., bingo;-On 5/19/26 at 10:00 A.M., chair exercises; 10:30 A.M., What song is this?; 2:00 P.M., Men's club; 3:30 P.M., Narcotics Anonymous meeting;-On 5/20/26 at 10:00 A.M., dancing; 10:30 A.M., washers and cornhole; 2:00 P.M., arts and crafts;-On 5/21/26 at 10:00 A.M., dancing; 10:30 A.M., sharing jokes; 2:00 P.M., women's club;-On 5/22/26 at 10:00 A.M., dancing; 10:30 A.M., washers and cornhole; 2:00 P.M., bingo;-On 5/23/26 at 10: 00 A.M., chair exercises, 10:30 A.M., cards and games; 2:00 P.M., music sensory.-On 5/27/26 at 10:00 A.M., prayers in the chapel, 10:45 A.M., washers and cornholes; 2:00P.M., Fun facts and trivia;-The facility did not offer any activity in the evening hours. 1. Review of Resident #7's quarterly Activities Assessment, dated 1/14/2026, showed:-Describe the resident's favorite activities: being with friends. No additional comments;-Described the resident's activity preferences and attendance levels: the resident attends quite a few activities but notes she feels it's hard to attend sometimes. No additional comments;-Describe changes to activity focuses (strengths, problems, preferences): none;-Progress towards activity goals marked as met by the resident;-Summary note: The resident attends quite a few activities but notes she feels it's hard to attend sometimes. The resident likes being with friends. Review of the resident's quarterly MDS (Minimum Data Set, a federally mandated resident assessment tool completed by facility staff), dated 2/3/26, showed:-The resident is cognitively intact;-Medical diagnoses including hypertension, obstructive uropathy (a chronic condition in which urine is blocked in the urinary tract due to intrinsic issues in the tract or processes pressing on the ureters), Type II Diabetes, depression, and schizophrenia (a chronic and severe brain disorder characterized by disruptions in thought processes, perceptions, and emotional responsiveness, often leading to hallucinations, delusions, and disorganized thinking). Review of the resident's care plan, in use during the time of the survey, did not address the resident's current dissatisfaction with the lack of activities. During an observation and interview on 5/17/26 at 9:04 A.M., the resident sat pleasantly near the nurse's station on the 500 hall and watched television. The resident said he/she often sat there as it was one of the best ways to pass the time. During an observation and interview on 5/19/26 at 1:31 P.M., the resident sat pleasantly at the nurse's station on the 500 hall. When asked about activities in the facility the resident said there were no activities after dinner and indicated the only activity in the afternoons and (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	evenings were the smoke times for residents who smoked. The resident did not smoke and would have liked to have something to do in the afternoons or evenings throughout the week. The resident said he/she liked dogs and would have enjoyed any kind of visit from a dog. During an interview on 5/21/26 at 10:11, A.M. Certified Nursing Assistant (CNA) M said activities in the afternoons and evenings included coffee socials or residents would go outside in the yard to do activities. CNA M had never saw Resident #7 attend an activity and had never seen anyone attempt to encourage him/her to attend any activities. 2. Review of Resident # 25's, quarterly MDS, dated [DATE], showed:-Moderate cognitive impairment;-No rejection of care;-Uses a walker and wheelchair;-Diagnosis includes chronic (long term) lung disease, high blood pressure, heart failure, morbid obesity and difficulty walking. Review of the resident's care plan in use at the time of survey showed:-Problem: The resident has little to no involvement with activities;-Interventions: Explain to the resident the importance of social interaction, and leisure time; Encourage the resident's participation by: blank; Remind the resident that he/she can leave the activity at any time. Review of the residents Engagement Insights, dated 4/1/26 through 5/1/26 showed the resident participated in one program, bingo for 120 minutes. During an interview on 5/19/26 at 8:55 A.M., the resident said he/she would really enjoy some evening activities. If you did not smoke, there was nothing to do. The resident would have enjoyed a non-alcoholic Happy Hour. None of the activities really interested the resident and the same activities were repeated so much. 3. Review of Resident #8's annual MDS, dated [DATE], showed:-Diagnosis included schizoaffective disorder (mental health condition that includes features of both schizophrenia and a mood disorder), anxiety, and depression;-Moderately impaired cognition. Review of the resident's care plan, in use at the time of the survey, showed:-Problem: The resident has a potential for decline in activity participation;-Desired outcome: The resident will remain active in participating in activities of choice through next review;-Interventions: Activities will provide 1:1 activities on request. Activities will remind/escort the resident as needed to activities of choice. Encourage socialization with others as tolerated. The resident enjoys music and TV in his/her room. He/She joins group smoking and some activities in the main dining room. During an interview on 5/17/26 at 8:36 A.M., the resident said there were not enough activities provided. He/She would have liked to see more activities of different varieties. He/She said he/she attended activities he/she was interested in but other than that sat around and waited for smoke breaks. Observation on 5/19/26 at 8:56 A.M., showed the resident in the hallway waiting for the smoke break at 9:30 A.M. No morning activities were provided on the 100 hallway. During an interview on 5/21/26 at 12:33 P.M., the Activity Director said the resident participated in activities such as bingo and music. She said the resident would benefit from more activities. 4. Review of Resident #35's annual MDS, dated [DATE], showed:-Diagnoses included cerebrovascular accident (CVA, stroke), paraplegia, malnutrition, depression, schizophrenia, and asthma;-Cognitively intact;-Impairment on both sides to upper and lower extremity;-Uses wheelchair;-Activity preferences: Somewhat important to do your favorite activities, go outside to get fresh air when the weather is good, participate in religious services and practices, do favorite activities, to be around animals such as pets, and listen to music. Review of the resident's care plan, in use during survey, showed:-Problem: Discharge plan: Resident admitted to facility for long term care;-Interventions: Encourage resident to become engaged in facility life through group activities, meals in dining room, and therapeutic groups if applicable to needs;-Problem: Resident refused care from staff;-Interventions: Staff to offer daily if patient would like to get up;-If resident refuses, multiple attempts will be made by aid then nurse. Document if indicated;-Resident's right to refuse will be respected; -Resident will be educated on the benefits of services offered, such as increased quality of life, dignity, and increased socialization; -Resident will be educated on the increased risk of not receiving the services he/she is offered such as immunity, impaired skin integrity, psychosocial mood disturbance. Review of the resident's quarterly activities assessment, dated 3/23/26, showed:-Attendance and participation summary: Does not really come to activities, but says he/she would like to do more things;-Describe resident's favorite activities: Live music, (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	going outside to get fresh air;-Activity plan review: Activity related focus remains appropriate/current as per current care plan;-Describe changes to activity focuses: He/She wants therapy equipment he/she can use and books to read;-Describe changes to goals: He/She wants to do more when it comes to activities. During an interview on 5/20/26 at 2:38 P.M., the resident said he/she did not get out of bed. He/She was not asked daily if he/she wanted to get out of bed and staff would refuse. They gave excuses such as staffing or would tell him/her there were emergencies. They would also ask, are you sure. The resident liked getting fresh air. The residents who smoked or were able to walk were able to go outside. He/She was out of bed last week, but it was only for four hours. The resident preferred longer, but the aide was leaving and did not know who would relieve them. Activities did not go to resident rooms or walk around. The resident said the only interaction was when mail was delivered. It would be helpful to go outside. He/She felt isolated, and it was depressing. During an interview on 5/20/26 at 3:38 P.M., Licensed Practical Nurse (LPN) I said sometimes the resident refused to get out of bed. For example, he/she told staff he/she would not get out of bed if certain people were out there or in the hall. During an interview on 5/20/26 at 3:41 P.M., Certified Nurse Aide (CNA) J said the resident did not have any refusals regarding getting out of bed. Sometimes, in a sarcastic way, he/she would say, I did not know I could get out of bed. During an interview on 5/21/26 at 12:22 P.M., the Activity Director said the resident preferred to keep to him/herself. He/She tried to engage with the resident when he/she delivered the mail. The resident was not talkative or willing to engage. He/She asked if there were books or crossword puzzles, he/she wanted. The Activity Director was not sure if the resident had a rapport with other residents, but if he/she did, they would have to go to his/her room. 5. Observation on 5/19/26 at 10:05 A.M., showed music played in the main dining room. Five residents sat in the main dining room and no residents were exercising. Activities Assistant (AA) N sat at a dining room table and spoke with another staff member. 6. Observation on 5/20/26 at 2:10 P.M., showed three residents worked on a paper craft. Activities Aide (AA) N stood in the main dining room and did not assist or engage with the residents who participated in the arts and crafts activity. 7. During the resident council meeting on 5/20/26 at 2:00 P.M. nine residents said there was a lack of variation in activities, specifically activities that happened in the evening. Residents indicated they had a desire for various activities and said the Activity's Director told them to suggest activities that they would like to do, but residents had trouble remembering activity ideas to relay to the Activities Director. Recently a washer's board and two corn-hole boards were purchased, but residents were unable to use them in the dining room or indoors. Very few activities were held in the afternoons after 2:30 P.M., and one of them was the monthly Resident Council Meeting. Activities were often held on the second-floor dining room, the largest space in the facility, but the room could not be used in the afternoons because dietary staff needed to turn it over for dinner service. 8. During an interview on 5/19/26 at 1:30 P.M., AA N said the Activities Department was responsible for all the smoke breaks. There were no evening activities except smoking. 9. During an interview on 5/21/26 at 8:54 A.M., LPN A said the facility needed more activities. He/She said the activity department was short staffed. He/She said a lot of the time residents just sat around doing nothing. 10. During an interview on 5/21/26 at 12:21 P.M., the Activities Director (AD) said her current calendar of events was based off what the previous AD did before. She tried to provide interesting activities by looking online and collecting input from the residents. She had a budget to maintain, and it didn't cover all the costs of the activities. The AD paid for some of the supplies for the activities out of her own pocket. The Activities Department was responsible for all the smoke breaks and that sometimes cut into the activity times. She would have expected staff to engage with the residents while providing the activities and encourage resident to come out of their rooms to participate. The AD did not have a 1:1 list. She would normally go into the resident rooms that did not come out for activities and speak with them for about five minutes. The AD did not consider five minutes of speaking with the resident a 1:1 activity. There were no evening activities because of lack of staff, family conflicts and being unable to work evenings. She would (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	have liked the nursing staff to have provided some evening activities. 11. During an interview on 5/21/26 at 2:22 P.M. the Administrator expected all departments to take turns providing smoke breaks for the residents. It should not have just been the Activities Department doing the smoke breaks. The Administrator would have expected a variety of activities that interested the residents. She would have expected evening activities and staff to engage with the residents during the activity. She did not consider Narcotics Anonymous and Resident Council meetings an activity. The Administrator would have expected the AD to have had a 1:1 list and provided activities to those residents as well. 2784565

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure smoking assessments were completed for three residents (Residents #91, #2, and #31) and failed to ensure lighters and cigarettes were not taken in two residents' rooms (Residents #91 and #2). The sample was 20. The census was 97. Review of the facility's Smoking Safety Regulations Policy, dated 6/29/23, showed: -The facility will provide direct supervision for smoking by patients classified as not responsible; -The policy did not address the frequency of smoking assessments; -The policy did not address the storage locations of smoking materials. 1. Review of Resident # 91's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 3/28/26, showed: -Diagnoses included cancer, chronic (long term) lung disease, seizures, and stroke; -Moderately impaired cognition; -admission date 10/31/25. Review of the resident's care plan, in use at the time of the survey, showed: -The care plan did not address that the resident smoked. Review of the resident's smoking and safety evaluation, dated 10/31/25, showed: -Uses tobacco; -Smoking safety evaluation: Blank; -Care planning: Blank; -Smoking cessations care planning: Blank; -Clinical suggestions: Blank. -No further smoking assessments were available for review. Observation on 5/19/26 at 1:30 P.M., showed the resident walked out to the smoking area using a rollator (a type of walker). Activities Assistant (AA) N gave the resident one cigarette and a lighter. The resident sat on his/her rollator and lit the cigarette and began to smoke. Once the resident finished smoking his/her cigarette, the resident extinguished and disposed of the cigarette on the ground. At 2:00 P.M., the resident walked into the building passing Certified Nursing Assistant (CNA) O and AA N that were holding the door open for the resident. The resident kept the lighter in his/her hand as he/she propelled the rollator into the building. The resident got into the elevator and took it to (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the 200 hall. The resident got off the elevator with the cigarette lighter in his/her hand and walked to his/her room and set the lighter on the bedside table. CNA O and AA N did not remove the cigarette lighter from the resident before he/she entered the building. 2. Review of Resident # 2's quarterly MDS, dated [DATE], showed: -Diagnoses included schizophrenia (a mental condition that distorts reality), infection of intravertebral disc (a part of the back), malnutrition (poor nutrition), and viral hepatitis (inflammation of the liver caused by a virus); -Cognitively intact; -Uses a walker; -admission date 4/18/25. Review of the resident's care plan in use at the time of survey, showed: -Problem: The resident is smoker; -Interventions: Instruct resident about smoking risks, smoking hazards, and smoking cessation aids that are available; -Instruct resident about the facility smoking policy on smoking : Locations, times, safety concerns; -Notify charge nurse immediately if it is suspected the resident has violated facility smoking policy. Review of the resident's smoking and safety evaluation, dated 4/18/25, showed: -Uses tobacco; -Balance problems sitting or standing. -Care planning: Blank; -Smoking cessations care planning: Blank; -Clinical suggestions: Blank. Review of the resident's smoking and safety evaluation, dated 1/8/26, showed: -Uses tobacco: -Follows the facility's policy on location and time of smoking; -Care planning: Blank; -Smoking cessations care planning: Blank; (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Clinical suggestions: Blank. Review of the resident's record showed no further smoking and safety evaluations available for review. Observation and interview on 5/17/26 at 10:10 A.M., showed the resident lay in bed. Next to the resident on the bed was half of a smoked cigarette and a lighter. The resident said he/she just came back in from smoking. 3. During an interview 5/19/26 at 1:40 P.M., CNA O and AA N said the residents are not to have cigarettes in their room. Residents are allowed to light their own cigarettes with the lighters that are provided to them. All lighters are then taken back before the resident goes back into the building. During an interview on 5/21/26 at 11:20 A.M., CNA L said that no residents should have lighters or cigarettes in their room. Staff should immediately remove the cigarettes and lighter when found. During an interview on 5/21/26 at 12:21 P.M., the Activities Director said she would expect staff to ensure that the residents do not go into the building with cigarettes or lighters in their possession after smoking. 4. Review of Resident #31's quarterly MDS, dated [DATE], showed: -Diagnosis included chronic obstructive pulmonary disease (COPD, lung disease), diabetes, and mild intellectual disabilities; -Moderately impaired cognition; -admission date 10/24/22. Review of the resident's care plan, in use at the time of the survey, showed: -Problem: Resident is a smoker; -Desired outcome: Resident will not smoke without supervision through the review date; -Interventions: Instruct resident about smoking risks and hazards and about smoking. Instruct resident about the facility policy on smoking: locations, times, safety concerns. Notify charge nurse immediately if it is suspected resident has violated smoking policy. Review of the resident's smoking and safety evaluation, dated 7/11/25, showed: -Uses tobacco; -Smoking and safety: Blank; -Care planning: Blank; (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Smoking cessations care planning: Blank; -Clinical suggestions: Blank. Observation on 5/20/26 at 9:39 A.M., showed the resident walking back into the building from the 100 hallway smoking patio after smoking. Staff supervised the smoke break. 5. During an interview on 5/21/26 at 8:54 A.M., Licensed Practical Nurse (LPN) A said upon admission to the facility, the nurse was responsible for completing the initial smoking assessment. The smoking assessments should be completed upon admission and quarterly. The smoking assessments should be completely filled out. The care plan should indicate if the resident is a smoker. 6. During an interview on 5/21/26 at 2:22 P.M., the Administrator and the Regional Nurse Consultant (RNC) said the residents are not allowed to have cigarettes or lighters in the room. The staff are expected to remove the items when discovered. The RNC said she would expect the staff to light the residents cigarettes and not give them the lighter to ensure the resident do not have them in their possession. They would expect the resident's tobacco use to be addressed on the care plan. They would expect the smoking assessments to be accurate and fully completed on admission and quarterly.

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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. Based on interview and record review, the facility failed to ensure employee two-step tuberculin skin tests were completed in accordance with State guidelines for nine of 10 sampled employees. The census was 97. Review of the facility's tuberculosis (TB) testing policy, dated 6/29/23, showed:-Purpose: To ensure each resident and employee of the facility is tested for TB after entering the facility to prevent the spread of infection;-Procedure: Upon hire a new employee will receive a two step purified protein derivative (PPD) skin test. Each employee will also have an annual one step TB test to ensure that any possible infections can be triggered proactively to prevent further spread. 1. Review of Employee AA's personnel file, showed:-Hire date of 5/28/25;-No documentation of first step TB test being administered;-No documentation of second step TB test being administered. 2. Review of Employee BB's personnel file, showed:-Hire date of 5/4/26;-A first step TB test administered on 4/27/26 and read on 4/29/26 with a negative result;-No documentation of second step TB test being administered. 3. Review of Employee CC's personnel file, showed:-Hire date of 5/4/26;-A first step TB test administered on 4/28/26 and read on 4/30/26 with a negative result;-No documentation of second step TB test being administered. 4. Review of Employee DD's personnel file, showed:-Hire date of 5/4/26;-A first step TB test administered on 4/28/26. No documentation of results;-No documentation of second step TB test being administered. 5. Review of Employee EE's personnel file, showed:-Hire date of 4/24/26;-A first step TB test administered on 4/17/26 and read on 4/19/26 with a negative result;-No documentation of second step TB test being administered. 6. Review of Employee FF's personnel file, showed:-A first step TB test administered on 4/27/26 and read on 4/29/26 with a negative result;-No documentation of second step TB test being administered. 7. Review of Employee GG's personnel file, showed:-Hire date of 6/11/25;-No documentation of first step TB test being administered;-No documentation of a second step TB test being administered. 8. Review of Employee HH's personnel file, showed:-Hire date of 7/30/25;-No documentation of first step TB test being administered; -No documentation of second step TB test being administered. 9. Review of Employee II's personnel file, showed:-Hire date of 4/24/26;-No documentation of step one TB test being administered;-No documentation of second step TB test being administered. During an interview on 5/21/26 at 2:59 P.M., the Regional Nurse Consultant and Administrator said employees should receive their first step TB test prior to their first day on site at the facility. They would expect staff to also receive a second step TB test within the required timeline. Nursing staff was responsible for administering the TB test to the newly hired employees.

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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 ensure a Notice of Medicare Non-Coverage (NOMNC) was given to three of three sampled residents who remained in the facility upon discharge from Medicare Part A services (Residents #9, #21, and #75). The census was 97. Review of the facility's Advanced Beneficiary Notice policy, dated 11/5/24, showed:-Purpose: To ensure the facility provides timely notices regarding Medicare eligibility and coverage;-Policy: A Notice of Medicare Non-Coverage (NOMNC), Form CMS-10123, shall be issued to the resident/representative when Medicare covered service(s) are ending, no matter if resident is leaving the facility or remaining in the facility. This informs the resident on how to request an appeal or expedited determination from their quality improvement organization (QIO).-To ensure that the resident, or representative, has enough time to make a decision whether or not to receive the services in question and assume financial responsibility, the notice shall be provided at least two days before the end of a Medicare covered Part A stay or when all of Part B therapies are ending. The notices must not be provided while the resident/representative is under duress or in an emergency situation;-The Social Service Director or designee, is responsible for issuing such notices. 1. Review of Resident #9's medical record, showed: -Medicare Part A skilled services start date of 4/23/26 and end date of 4/29/26;-Stayed in facility;-No NOMNC form given to resident. 2. Review of Resident #21's medical record, showed:-Medicare Part A skilled services start date of 3/4/26 and end date of 3/10/26;-Stayed in facility;-No NOMNC form given to resident. 3. Review of Resident #75's medical record, showed:-Medicare Part A skilled services start date of 11/6/25 and end date of 12/18/25;-Stayed in facility;-No NOMNC form given to resident. During an interview on 5/21/26 at 3:05 P.M., the Administrator said NOMNCs should have been given to the residents at least two days before Medicare covered services ended. She said the Social Service Director was responsible for this, but the facility was without a social worker for at least four months.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide necessary care and services for two residents (Resident #101 and #104) by failing to assess, monitor, and respond to signs and symptoms associated with substance use and overdose. The facility failed to ensure ongoing medical monitoring following an overdose that required Narcan (life-saving medication used to rapidly reverse opioid overdoses) administration (Resident #101). The facility failed to assess, evaluate, and implement interventions following observed behavioral changes and signs consistent with substance use or withdrawal, resulting in missed opportunities to identify and address ongoing substance related risks (Resident #104). The sample size was 20. The census was 97. Review of the facility's Residents-Possession and Use of Illegal Drugs, Marijuana and Alcohol and Drug Screen and Searches policy, revised 4/30/24, showed:-Purpose: To ensure that the Facility remains free from illegal drugs and substances as well as marijuana and alcohol. To define when and how a resident may be administered a drug screen or have their room searched;-Procedure: Illegal drugs or substances, marijuana and alcohol are not permitted;-The Facility is committed to maintaining a safe environment for every Resident. Part of this commitment is attempting to maintain an environment that is free of illegal drugs, dangerous items and other related contraband;-Use of illegal drugs creates a dangerous environment and may interfere with properly prescribed medications;-Marijuana (while legal) is not allowed in the Facility and can interfere with properly prescribed medications;-The use, consumption, possession, transportation, sale or distribution of unlawful or unauthorized drugs (including marijuana), inhalants, alcohol, or the abuse of prescribed drugs or alcohol by any Resident while in the Facility or on Facility property is expressly prohibited and may result in an immediate discharge. Illegal or controlled substances (other than a valid prescription) will be confiscated and the appropriate law enforcement agency(s) may be notified;-Contraband includes weapons of any kind, any items which could be used as a weapon, illegal or unauthorized drugs (including marijuana), drug paraphernalia, or alcohol. The possession or sale of any contraband while on Facility premises is expressly prohibited;-The Administrator and Director of Nursing (DON) shall educate staff and Residents (as appropriate) on the signs and symptoms of illegal drug use;-Process when suspicion of ingestion of illegal substance: If a Resident is suspected of taking an illegal drug or other substance (including marijuana), the Resident shall immediately be placed on one-on-one supervision and the Director of Nursing or charge nurse and Administrator notified;-If the Resident shows any signs of distress or there are other concerns, 911 shall be called immediately;-The nurse shall immediately evaluate the Resident and obtain a complete set of vital signs, including a neurology check and oxygen saturation level;-The Resident's primary care physician shall immediately be contacted for instructions;-If the Resident is not being sent to the hospital, the protocol below for drug screens and searches will apply;-Drug Screen: In the event the Administrator or DON has reasonable suspicion that a Resident has ingested illegal or unauthorized drugs, a drug screen may be administered;-Search of Resident's room or property: In the event the Facility's Administrator or DON has reasonable suspicion that contraband, illegal drugs or something that poses a safety risk to the Resident or others in the Facility is in a Resident's room, a search of the Resident's room may be considered;-The Facility should not act as an arm of law enforcement and may instead of a search (or if consent is not given for a search), the facility may make a referral will be made to local law enforcement;-If the Resident is his/her own person, the resident must consent to the search. If the Resident refuses the room or property search, the search will not be conducted and the Management Company Regional Director will be notified;-If suspected illegal drugs are found, the local police and the Department of Health and Human Services will be notified. The RCMC Regional Director will also be notified;-Suspected Contraband or illegal Drugs: If suspected contraband or illegal drugs (including marijuana) are found, those items will be given to the Administrator, Director of Nursing or Charge (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Nurse for inventory;-All items will be placed in a secure location for all Residents' safety;-Suspected illegal drugs will be turned over to law enforcement personnel for safe disposal;-Increased Oversight: To protect the health and safety of residents, the facility will provide additional monitoring and supervision, which includes denying access or providing supervised visitation to individuals who have a history of bringing illegal substances into the facility. Review of the facility's Intensive Monitoring policy, revised 4/30/24, showed:-Residents who require more intensive monitoring due to crisis, behavioral/psychiatric symptoms will be monitored by the facility staff;-Intensive Monitoring is defined as periodic (hourly, every two hours, or every shift) check by a facility staff member;-One to One monitoring a designated employee assigned by a Facility Supervisor. Residents who require intensive monitoring of one to one will have a dedicated staff member within eyesight;-Intensive Monitoring: Intensive monitoring is provided as periodic (e.g. hourly, every two hours, or every shift) check by a facility staff member;-Residents may require more intensive monitoring based on their crisis, behavioral, psychiatric issues. The level of Intensive Monitoring shall be identified by the specific situation or resident assessment;-Residents who are showing poor impulse control including crisis, behavioral, psychiatric issues, such as, verbal/physical aggression, elopement ideations, suicidal/homicidal ideations, and decompensation mentally or crisis may be placed on intensive monitoring or one-to-one or two-to-one (within eyesight of staff) monitoring at the discretion of the administrative staff or facility supervisor;-Based on the assessment of the resident at the discretion of the administrative staff of Facility Supervisor, either intensive monitoring, one to one or two to one;-Residents who require intensive monitoring of one to one will have an assigned employee within eyesight until resident has stabilized or returned to prior level of function. Educated on the reasoning for the intensive monitoring, including triggers and interventions for that specific resident. The employee will interact with the resident throughout to receive therapeutic interventions;-The facility's Interdisciplinary Team will address the residents' behavioral concerns and ensure interventions are in place to address the residents' needs (psychiatry follow up, counseling, medical needs, etc.);-Once the resident has stabilized and/or returned to prior level of function, the facility's Interdisciplinary Team will meet to discuss determination of discontinuation of Intensive Monitoring;-The facility staff will document the intensive monitoring in the residents' Electric Medical Record;-Documentation: Documentation of intensive monitoring will be done in the electronic medical record under the task. 1. Review of Resident #101's care plan, dated 3/26/26, showed:-Problem: Resident is at risk for polysubstance abuse r/t substance-seeking behavior/safety risk/opioid abuse;-Desired outcome: Resident will verbalize risks associated with substance abuse;-Interventions: Monitor for signs of substance abuse/intoxication Monitor for signs of withdrawal. Monitor items brought into facility. Offer emotional support during periods of agitation Notify physician of refusal or noncompliance. Offer resident in the room alcohol anonymous (AA)/narcotics anonymous (NA) program. Review of the resident's admission Minimum Data Set (MDS, a federally mandated assessment instrument completed by facility staff) dated 4/1/26, showed:-Diagnosis included opioid abuse, acute kidney failure, and chronic obstructive pulmonary disease (COPD, lung disease);-Cognitively intact. Review of the resident's physician's orders summary (POS), dated 4/20/26, showed an order, dated 4/20/26, for a urine analysis (UA) for drug screening. Review on 5/21/26 at 11:50 A.M., of the resident's UA results, showed:-The resident's urine was collected on 4/21/26 at 3:15 P.M.;-The resident's urine tested positive for methamphetamine (meth, a highly addictive synthetic stimulant). Review on 5/21/26 at 11:50 A.M., of the resident's progress notes, showed:-A note, dated 4/28/26 at 9:01 P.M., Resident left the facility to go the store. Upon return, he/she took his/her night medication and then went to his/her room. The Certified Medication Technician (CMT) heard a loud gasp outside his/her room. The CMT called this writer to his/her room. Writer observed resident sitting upright in his/her wheelchair snoring loudly. After approximately two minutes of sternum rub, the resident was transferred to the bed. Narcan was given and he/she let out numerous gasps. Writer observed the resident's chest rise and fall. Writer left room to inform administration and the doctor. The resident is (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	back in his/her wheelchair eating a sandwich. The resident was counseled about the dangers of using street drugs;-A note, dated 4/28/26, Order received for UA and Urine drug screen. Spoke with resident about receiving counseling. He/She agreed to do so;-A note, dated 4/29/26 written by the Administrator, the resident came to the Administrator as he/she was doing rounds. The resident freely admitted he/she had taken something while out on 4/28/26 and the results had scared him/her. He/She spoke of his/her life being more important than what he/she had done and we discussed the possibility of mixing unknow substances with his/her prescribed medication. He/She advised he/she was willing to start and continue a program. I offered open door for any follow up or if he/she wished to talk at any given time. He/She does not want to leave the facility and will follow appropriate guidelines;-No documentation on 4/29/26 of monitoring after the resident's overdose. During an interview on 5/20/26 at 6:37 A.M., Certified Nursing Assistant (CNA) Q said no interventions were put in place prior to the resident's drug overdose other than checking the resident's room. After the resident's overdose, no further monitoring was put in place. During an interview on 5/20/26 at 11:37 A.M., the DON and Assistant Director of Nursing (ADON) said on 4/28/26 the resident was administered Narcan when the resident was observed to being having symptoms of a drug overdose. They said the resident was not sent to the hospital because he/she was in the early stages of a drug overdose and was not in respiratory distress. They said the resident's physician was notified and gave an order for the resident to be monitored and for a UA to be obtained. During an interview on 5/20/26 at 12:56 P.M., Physician P said the facility contacted him/her on 4/28/26 and reported that the resident had a drug overdose. He/She ordered monitoring of the resident, a UA, and a consultation for psychiatric services. He/She said he/she told the facility not to send the resident to the hospital to avoid unnecessary emergency room visits. He/She would have expected the facility to conduct neurological (a brief physical examination to evaluate brain and nervous system functions) checks on the resident for 24 hours and obtain the resident's vitals. He/She would have expected the facility to document their monitoring in the resident's medical record. He/She said documenting that the resident is in his/her wheelchair eating a sandwich was not appropriate monitoring. During an interview on 5/20/26 at 1:05 P.M., Licensed Practical Nurse (LPN) A said he/she was aware of the resident's overdose. He/She said if a resident had a drug overdose, staff was supposed to call emergency services and inform the DON and ADON of the overdose. He/She said she would have called 911 regardless of what the physician said if a resident had symptoms of an overdose and narcan was administered. He/She said documenting the resident was eating a sandwich was not appropriate monitoring. He/She would have expected proper monitoring to be conducted. During an interview on 5/21/26 at 3:06 P.M., the Administrator, DON, and Regional Nurse Consultant said the physician's order was given after the resident overdosed to monitor for change of condition, obtain a drug screen, and consult with psychiatric services to see the resident. They said the physician never mentioned neurological checks. They said they did not know if the resident actually had a drug overdose. They said monitoring of the resident should have been documented in the resident's medical record. They said they should have documented vitals and the resident's cognitive status. 2. Review of Resident 104's hospital record, showed:-admitted [DATE]; -Assessment and Plan: Opioid withdrawal: Present on admission-Sinus tachycardia (heartbeat over 100 beats per minute): Present on admission; -Fentanyl (potent, synthetic opioid drug) use disorder, severe: Present on admission; -Polysubstance use disorder: Present on admission;-Most likely etiology of discomfort at this time is relating to opiate withdrawal given his /her recent initiation of suboxone (used to treat opioid use disorder) and subjective history of mild improvement when using unspecified pill, presumed to be fentanyl in an outpatient setting although unable to fully rule out component of known rheumatologic conditions;-Plan of care discussion: We reviewed his/her symptoms at the bedside and discussed that based on his/ her story and the lab studies he/she performed at this point that the most likely cause of his/her current pains was opiate withdrawal;-Physician progress note: He/She denies any issues with drug cravings. He/She is (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	worried about managing his/her pain. The Buprenorphine (long-acting partial opioid agonist used to treat opioid use disorder) does not seem to be taking the edge off his/her pain. He/She would like to try methadone (long-acting synthetic opioid used to treat opioid use disorder). We discussed prolonged QT syndrome (a heart rhythm disorder) and strict federal regulations that both prohibit the use of methadone for him/her. He/She confirmed understanding and agreed with the plan to decrease buprenorphine to allow greater efficacy of the breakthrough pain meds;-Resident presented to hospital for chest pain on the initial workup for cardiac and musculoskeletal causes was unremarkable. Suspicion was raised for possible opiate withdrawal cause his/her pain. Review of the resident's hospital discharge record, showed:-admitted [DATE];-discharged [DATE];-Discharge diagnosis: Opioid withdrawal. Review of the resident's initial psychosocial history, dated 3/23/26, showed:-Substance Abuse;-Current stressors: blank;-Current diagnosis: blank;-Psychosocial assessment: Change in sleep and increased anxiety;-Past history: Suicidal ideations/ attempts;-Self injurious behavior: non-suicidal;-Methods of self injurious behavior: cutting;-Socialization and support system: Other: staff;-Interdisciplinary Team (IDT) signatures: blank. Review of the resident's care plan, dated 3/23/26 and revised 4/21/26, showed:-Problem: Resident is at risk for polysubstance abuse related to substance seeking behavior/safety risk;-Interventions: Administer Narcan per physician's order for signs/symptoms of narcotic overdose. Monitor for signs of substance abuse/intoxication. Monitor for signs of withdrawal, monitor items brought into the facility. Offer emotional support during periods of agitation. Notify physician of refusal or non-compliance. Offer resident in the room Alcohol Anonymous/Narcotics Anonymous (AA)/ NA) program;-Problem: The resident is at risk for intentional or unintentional overdose due to history of depression anxiety confusion access to medication substance misuse;-Interventions: Education provided on illegal drug use policy for the facility, screens and search entering the building, resident possession and use of drug/alcohol policy, adverse drug event policy, Narcan use policy, resident's rights, abuse and neglect policy, and metal wand upon entering the building. Review of the resident's admission MDS, dated [DATE], showed:-Diagnoses include cerebrovascular accident (CVA, stroke), hemiplegia or hemiparesis,-Cognitively intact;-Feeling down, depressed, or hopeless: No response;-No verbal or physical behaviors;-Impairment on one side to upper and lower extremity;-Uses a walker;-No presence of pain the last five days;-Administered antipsychotic and antidepressant in the past seven days. Review of the resident's POS, dated 3/23/26 through 4/20/26, showed:-An order, dated 3/23/26, Hydromorphone (semi-synthetic opioid analgesic used to treat pain) HCl oral tablet 4 milligrams (mg). Give one tablet by mouth every four hours as needed for pain;-An order, dated 3/23/26, Hydralazine (used to treat high blood pressure) HCl (hydrochloride) 25 mg. Give 1 tablet by mouth every six hours as needed (PRN) for anxiety;-An order, dated 3/23/26, Hydroxyzine (used to treat anxiety) HCl oral tablet 25 mg. Give 25 mg by mouth every six hours as needed for anxiety. Take one tablet by mouth four times daily as needed for anxiety;-An order, dated 3/23/26, Methocarbamol (muscle relaxer) Oral tablet 500 mg. Give 500 mg by mouth every six hours as needed for muscle spasms;-An order, dated 3/23/26, Narcan Nasal Liquid 4 mg / 0.1 milliliter (ml). Spray one spray into the nose as needed for overdose;-An order, dated 3/23/26, Sennosides (laxative) Oral Tablet 8.6 mg. Give 8.6 tablet by mouth one time a day for constipation;-An order, dated 3/23/26, Melatonin (sleep supplement) oral tablet 3 mg. Give 3 mg by mouth at bedtime for sleep.-An order, dated 3/23/26, Acetaminophen Oral tablet 325 mg. Give two tablets by mouth every six hours PRN for pain;-An order, dated 3/23/26, Aspirin oral capsule 81 mg. Give 81 mg by mouth one time a day to prevent heart attacks;-An order, dated 3/23/26, Butalbital-ASA-Caffeine Oral Capsule 50-325-40 mg (Butalbital-Aspirin-Caffeine, combination medication used to treat headaches), give one capsule by mouth every four hours PRN for headaches or migraine;-An order, dated 3/29/26, Butalbital-ASA-Caffeine Oral Capsule 50-325-40 mg, give one capsule by mouth as needed for headaches or migraine;-An order, dated 3/30/26, Excedrin Extra Strength Oral Tablet 250-250-65 mg (Aspirin-Acetaminophen-Caffeine), [NAME] (dispense as written). Give two tablets by mouth every six hours PRN for migraine;-An order, dated 3/26/26, (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	hydroxyzine HCl Oral Tablet 25 mg. Give 25 mg by mouth every six hours for anxiety.;-An order, dated 3/27/26, Fioricet Oral Capsule 50-300-40 MG (Butalbital- Acetaminophen-Caffeine, pain reliever). Give one tablet by mouth every 24 hours as needed for headaches or migraine;-An order, dated 3/30/26, Hydrocodone-Acetaminophen (used to treat pain) Oral Tablet 5-325 mg. Give one tablet by mouth three times a day for pain;-An order, dated 4/2/26, Trazodone (anti-depressant) HCl Oral Tablet 50 mg. Give one tablet by mouth at bedtime for insomnia;-An order, dated 4/2/26, hydroxyzine HCl oral tablet. Give 50 mg by mouth two times a day for anxiety;-An order, dated 4/10/26, hydroxyzine HCl oral tablet. Give 50 mg by mouth two times a day for anxiety until 4/16/26;-An order, dated 4/11/26, Furosemide (used to treat fluid retention) oral tablet 20 mg. Give 20 mg by mouth one time a day for excessive fluid retention;-An order, dated 4/12/26, Cephalexin Oral Capsule (used to treat bacterial infections) 500 mg. Give 500 mg by mouth two times a day for leg infection for seven days. Review of the resident's progress notes, dated 4/12/26, showed resident continue to exhibit erratic behavior and signs of withdrawal, though he/she denies experiencing any symptoms. Significant safety concerns are noted as the resident repeatedly slides out of his/her wheelchair and engages in self-picking, resulting in a sore on his/her face. Nursing attempted to perform a clinical evaluation and facilitated a telehealth visit with the physician; however, the resident refused both, stating he/she does not wish to speak with the physician again. The physician and DON have been notified of the resident's behavior, his/her refusal of care, and his/her request regarding the physician. Staff will continue to monitor closely for safety and skin integrity. During an interview on 5/19/26 at 12:19 P.M., the Administrator said the resident went through a confession that he/she was clean and wanted to stay clean. He/She had a Brief Interview Mental Status (BIMS) of 15 (cognitively intact). When he/she first arrived, he/she did not leave a lot. He/She was isolated in his/her room but came out in the evening. They went over the drug policies and the resident reassured staff it was not the life he/she wanted. The resident received treatment and got clean. He/She was in the hospital for two months working on his/her sobriety. During an interview on 5/19/26 at 12:19 P.M., the ADON said on 4/12/26, the behavior they were trying to identify was related to pain versus withdrawal. It was believed to be withdrawal because of the resident's substance abuse history. The resident could not identify where the pain was located, whether it was the hip, knee, or if it was arthritic pain. He/She started to get behaviors, and he/she could not identify what was hurting him/her. The resident declined to go to the hospital. They were ?juggling to see what was wrong. The physician was notified and said he/she would be in to see the resident. He/She would not approve any medication until he/she saw him/her and provided a signature. While the resident was at the facility, he/she had issues with medications. There were several combinations of medications he/she wanted to put together. Physician did not see evidence that would suffice for those medications. He/She tried Norco for seven days, then Butram (synthetic opioid used to manage pain) order would be approved. He/She did not want to prescribe Suboxone medication. The resident had a face to face with the physician and went against the medication. The ADON recalled he/she refused to take the medication. The resident only had one visitor. Per facility policy, if they found contraband, they called the authorities. An aide reported seeing the resident on the floor. The resident was abrasive at the time and only a plastic bag was seen on the floor. The ADON said the aid no longer worked at the facility. During an interview on 5/20/26 at 3:48 P.M., LPN A confirmed he/she wrote the progress note on 4/12/26. In his/her opinion, the resident was acting erratic. He/She was offered the suboxone but refused it. It helped with withdrawals. The resident picked at him/herself and tried to act sane so LPN A would not suspect behaviors. He/She was off for two days, but there were sores that appeared on the resident. He/She had not interacted with anyone else, so it was self-induced picking. The resident was brought out in the hall and did the same thing. The physician and psychiatrist were contacted. Psych saw the resident, but there was no way to redirect the resident. LPN A was asked to clarify why withdrawal was documented. LPN A said the resident was withdrawing from street drugs. He/She had an opioid abuse history before he/she was admitted . When he/she was first admitted he/she was not doing (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	any of the behaviors, then he/she started to do it or self- medicate. Some behaviors included crying hysterically because of pain. They administered pain medication to him/her. LPN A saw a lunch bag in the resident's room, and he/she would never let anyone touch it. LPN A did not believe anyone searched his/her bag. Even during room search, an aide needed to search room, but the resident took the bag with him/her and held on to it. On the day the resident was arrested, the bag was searched. He/She only had one visitor. When LPN A spoke to the physician, he/she mentioned the resident had withdrawals, but did not specify from what. The physician knew the resident was coming off opioid abuse. On 4/12/26 was the first time LPN A witnessed this behavior from the resident. Before, he/she cried about his/her arthritis. It felt like he/she was drug seeking. The resident would say I want to get out of here and he/she was better off on the streets. He/She was referred to pain management, but he/she did not go. Immediately he/she said he/she would rather have gone AMA (Against Medical Advice). The resident never refused Suboxone. It was found on him/her during the search. The pill was supposed to sit under the tongue, but LPN A believed the resident was taking it out. The resident took the other pills that were administered in front of staff but placed the Suboxone under the tongue and moved away.Review of the resident's progress notes, showed no further assessment or documentation regarding the residents' withdrawal symptoms. During an interview on 5/20/26 at 12:56 P.M., Physician P said he/she remembered the resident, and he/she was one of the hard ones. The resident used to ask for narcotics, and they referred him/her to the pain clinic. He/she refused medications at times, even the Suboxone. He/She also threw tantrums. Staff reported the resident's refusals, but there was also a psych component as well. On 4/12, he/she was aware of the resident's erratic things, odd behaviors in attempt to get his/her way. Physician P did not hear them say withdrawal. It was not physical; it was more psychological. The resident did things to get things. Physician P would expect to be informed. If the resident was believed to have withdrawal symptoms, he/she would have sent the resident to the hospital, did a drug screen, and continued to monitor and document. During an interview on 5/20/26 at 3:41 P.M., CNA J said Resident #104 was always in his/her room and only had seen him/her come out about two or three times. He/She was in pain because the resident said he/she was coming off withdrawals from street drugs. CNA J was not sure what drug, but the resident was on hard drugs. The resident always slept. He/She slept in his/her wheelchair but leaned over the bed. The resident said he/she was comfortable. CNA J was not sure if he/she was under the influence. Review of the resident's progress notes, showed:-On 4/20/26 at 2:46 P.M., call placed to Physician P for a teledoc / or in-house visit related to patient behaviors, suspected drug use, and possession of illegal substance. Resident refused room sweep which was conducted due to suspected substance abuse. Patient became irate, demanding to sign AMA form. Resident became aggressive, screaming and resistant, and crises prevention intervention (CPI) became in progress by CPI certified staff. Patient screamed that he/she would have rather been homeless on the street than in pain and would have liked the regimen that he/she had while in the hospital. He/She admitted being clean for a few months and has used recently Fentanyl and [NAME] Meth. He/She is requesting physician to review pain regime; -On 4/20/26 at 4:30 P.M., resident consented to having his/her purse searched by the DON, with RDO as witness. During the search there were multiple opened capsules, which appeared to be empty, and multiple capsules which appeared to be intact. There was also a baggie in the resident's purse which contained a crystallized substance which appeared to be clear in color, and white powder in the bottom of the baggie. The resident stated the substances found in his/her purse were Fentanyl and Methamphetamine. The resident was asked if he/she had given any residents any of the narcotics and he/she stated he/she had not. Police Department was notified of the suspected narcotics found on the resident and summoned to the facility. The narcotics were transferred to officers' possession. Officer then conducts another search of the resident's room and found an additional capsule. Officer interviewed the resident. The resident admitted to the officer that last evening, he/she sent money to the supplier of the narcotics and asked another resident to sign out and retrieve the narcotics for him/her. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, the facility failed to ensure expired medications and biologicals were removed from medication carts and medication rooms in the facility. Concerns were noted with two of two medication rooms and one of four medication carts reviewed for the survey. The resident sample was 20. The census was 97.Review of the facility's Medication Storage Policy revised 5/18/24, showed:-All drugs and biologicals will be stored in locked compartments under proper temperature controls;-Only authorized personnel will have access to the keys to locked compartments;-The pharmacy and all medication rooms are routinely inspected by the consultant pharmacist for discontinued, outdated, defective, or deteriorated medications with worn, illegible, or missing labels. These medications are destroyed in accordance with the medication destruction policy. 1.Observation on 5/18/26 at 12:31 P.M. of the fifth-floor medication storage room showed a bottle of MedLine Drug Buster (a chemical agent that uses activated charcoal to quickly neutralize the active ingredients in pills, liquids, controlled substances and transdermal patches), expired as of 3/31/25. Observation on 5/18/26 at 12:41 of the fourth-floor medication room showed: -Seven bottles of Nutren 1.5 (a calorically dense, complete liquid nutrition formula designed for tube feeding or oral supplementation) 250mL (milliliters), expired as of 2/13/26; -One bottle of Geri-Care Bisacodyl Laxative, expired as of 12/2025; -One bottle of Nature's Blend Vitamin C 250mg (milligram) tablets, expired as of 1/2026; -One bottle of Acamprosate (an FDA-approved prescription medication used alongside counseling and social support to help people with alcohol use disorder ([NAME]) maintain abstinence) 333mg, expired as of 5/15/26; -One bottle of Atorvastatin (a prescription statin medication used to lower bad cholesterol (LDL) and triglycerides in the blood) 40mg, expired as of January 2026. Observation on 5/18/26 of the third-floor treatment cart, showed:-One bottle of Geri-Care Daily Multivitamins, expired as of April 2026; -One box of Mucinex-DM (an over-the-counter medication that combines an expectorant and a cough suppressant to relieve chest congestion and quiet both wet and dry coughs) 12 Hour Relief, expired January 2026. 2. During an interview on 5/19/26 at 9:21 A.M., Certified Medication Technician (CMT) E said no one member of the nursing staff or administration was responsible for auditing carts and rooms, but nursing staff took it as a collective responsibility. CMT E noted not all staff accept this responsibility, often causing CMTs or nurses passing medications to travel multiple floors to retrieve stocked medications that were not replaced on the cart. CMT E would expect all expired medications to be removed from the facility medication rooms and carts. 3. During an interview on 5/21/26 at 9:48 AM, Licensed Practical Nurse (LPN) D said he/she was not sure how often the pharmacy partner came in to remove expired medications or perform necessary medication wasting services. Not one individual on the nursing staff or administration was responsible for the auditing of medication rooms and medication carts, but nursing staff took it as a collective responsibility to restock medication carts or remove expired medications when noted. LPN D would expect all expired medications to be removed from treatment carts or medication rooms in the facility. 4. During an interview on 5/21/26 at 2:41 PM, the facility Administrator, Director of Nursing (DON), Assistant Director of Nursing (ADON), and the Regional Nurse Consultant said they would expect all expired medications and biologicals to be removed from medication rooms and carts within the facility. No current process placed sole responsibility on any member of the nursing administration to review or audit medication rooms for expired medications. The facility pharmacy partner came once per month to audit and remove expired medications identified by the facility. The Administrator, DON, ADON, and Regional Nurse Consultant would expect all medications in medication rooms or on medication carts to be within the date of expiration and should be removed by staff when noted as expired.