STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265670	A. Building B. Wing	03/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Stonebridge Owensville	1016 W Highway 28 Owensville, MO 65066

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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 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician. Based on interview and record review, the facility staff failed to designate a person to serve as the Director of Food and Nutrition Services with the appropriate qualifications, when the facility did not employ a qualified dietitian or other clinically qualified nutrition professional full-time. This failure has the potential to affect all residents. The facility census was 72.1. Review of the facility's policy titled Food Services Manager, updated 09/28/22, showed the Food Services Manager may serve as the Director of Food and Nutrition Services who must at a minimum meet one of the following qualifications:-A certified dietary manager (CDM), or;-A certified food service manager, or;-Has similar national certification for food service management and safety from a national certifying body, or;-Has an associates (or higher) degree in food service management or hospitality, if the course includes food service or restaurant management from an accredited institution, and;-Has two or more years of experience in the position of director of food and nutrition services in a nursing facility setting and has completed a course of study in food safety and management, by no later than October 1, 2023. Review of the dietary manager's (DM) Food Protection Manager on-line course enrollment showed the DM enrolled in the course on 02/02/26 and started the course on 02/20/26. Review showed, as of 03/24/26, the DM had not completed the course. During an interview on 03/24/26 at 1:52 P.M., the DM said he/she had worked as a cook in the facility for a little over two years and took over the DM position about a month ago. The DM said he/she had never been a DM before, was not certified, and did not have a degree in food service management or hospitality. The DM said the facility's registered dietician only worked for the facility part-time and the facility did not have any other clinically qualified nutrition staff who worked at the facility full-time. The DM said he/she was enrolled in a food manager certification course, but he/she had not had time to complete the course due to a staffing shortage and no one gave him/her a timeline to complete the course. During an interview on 03/26/26 at 2:01 P.M., the administrator said he/she knew the DM was not qualified for the position, but he/she promoted him/her to the position because he/she could not find a qualified DM to hire. The administrator said the facility did not have any clinically qualified nutrition staff employed at the facility full-time. The administrator said the DM was enrolled in an appropriate course for certification, but the kitchen had experienced a large amount of staff turnover so the DM had not been able to complete the course.

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview and record review, the facility staff failed to ensure the mechanical dishwasher operated according to manufacturer's instructions in a manner adequate to prevent cross-contamination of kitchen wares. This failure has the potential to affect all residents. The facility census was 72.1. Review of the facility's policy titled Dishwashing Machine Use, revised March 2010, showed: -The operator will check temperatures using the machine gauge with each dishwashing machine cycle, and will record the results in facility approved log;-The operator will monitor the gauge frequently during the dishwashing machine cycle. Inadequate temperatures will be reported to the supervisor and corrected immediately;-The supervisor will check the calibration of the gauge weekly by running a secondary thermometer through the machine or using commercial temperature test strips using manufacturer's instructions;-If hot water temperatures do not meet requirements, cease use of dishwashing machine immediately until temperatures are adjusted. Review of the manufacturer's specifications posted on the facility's mechanical heat-sanitizing dishwasher showed instruction for the wash temperature to measure a minimum of 155 degrees Fahrenheit (dF) and the rinse temperature to measure a minimum of 180 dF. Review of the facility's Dish Machine - High Temperature Sanitizing Log dated February 2026, showed: -Staff did not document dishwasher temperatures for the period of 02/01/26 through 02/19/26 an 02/25/26 through 02/28/26;-Staff documented morning and afternoon wash temperatures of 110 dF with a rinse temperature of 170 dF on 02/20/26;-Staff documented an afternoon wash temperature of 110 dF with a rinse temperature of 160 dF. Review of the facility's Dish Machine - High Temperature Sanitizing Log, dated 03/01/26 through the morning of 03/24/26, showed staff recorded morning and afternoon wash and rinse temperatures each day. Review showed staff documented the morning and afternoon wash temperatures below 155 dF each day. Review also showed staff last documented the rinse temperature of the dishwasher at or above 180 dF in the morning on 03/06/26 and in the afternoon on 03/11/26. Observation on 03/23/26 at 10:29 A.M., showed Dietary Aide BB ran a load of kitchen wares through the dishwasher. Observation showed the wash temperature measured 110 dF and the rinse temperature measured 166 dF. Observation on 03/24/26 at 11:08 A.M., showed an unidentified staff member ran a load of kitchen wares through the dishwasher. Observation showed the wash temperature measured 108 dF and the rinse temperature measured 176 dF. Observation on 03/24/26 at 1:58 P.M., showed the dietary manager (DM) ran an empty dish rack through the dishwasher and the wash temperature measured 110 dF. During an interview on 03/24/26 at 1:58 P.M., the DM said the wash temperature of the dishwasher should be at least 155 dF and the rinse temperature should be at least 180 dF. The DM said he/she became the DM about one month ago and was not very familiar with the dishwasher, but when he/she thought the dishwasher was not reaching the correct wash temperature for at least one week, he/she notified the maintenance director. The DM said the maintenance came and checked the dishwasher and told him/her it was working okay. The DM said the maintenance director and assistant told him/her if the end temperature reached 180 dF, it should be fine. The DM said he/she had not reviewed what staff documented on the Dish Machine - High Temperature Sanitizing Logs and did not know there was an issue with the dishwasher temperatures. During an interview on 03/26/26 at 12:32 P.M., the maintenance director said he/she is responsible for the maintenance of the dishwasher. The maintenance director said he/she believed the dishwasher temperatures issues were caused by a water softener that broke down about one month ago. The maintenance director said he/she replaced the water softener but the dishwasher still did not reach the correct wash cycle temperature, but he/she thought the rinse cycle temperatures were adequate. The maintenance director said he/she replaced the booster heater yesterday, but the dishwasher still did not reach the correct operating temperatures. During an interview on 03/26/26 at 2:01 P.M., the administrator said he/she would expect the DM to follow facility policy related to (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	operation of the dishwasher and dietary staff should report any equipment issues to the DM and/or maintenance staff. The administrator said he/she did not know about any issues with the dishwasher until yesterday.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, facility staff failed to properly clean and maintain wheelchairs for three residents (Resident #41, #45 and #37) of a sampled of 20 residents. The facility census was 72. 1. Review of the Facility's policy titled, Wheelchair Cleaning Procedure, undated, showed staff are to make sure no visible dirt, foot, etc. on any part of the wheelchair. Provides wheelchair cleaning schedule to cover all wheelchairs in the facility to be cleaned once a week. 2. Review of the Facility's policy titled, Creating a New Work Order in Technology Efficiency Life Safety and Services (TELS), undated, showed staff are directed how to place a work order for maintenance, when staff observe items needing to be repaired. 3. Review of Resident #41's Quarterly Minimum Data Set (MDS), a federally mandated assessment, dated 03/23/26, showed staff assessed the resident as follows:-Severe cognitive impairment;-Maximal assistance from staff member with eating;-Dependent on staff member for transfers;-Wheelchair.Observation on 03/23/2026 at 3:06 P.M., showed the resident in his/her wheelchair, both armrest on the resident's wheelchair cracked and missing vinyl, and exposed yellow foam. Observation on 03/24/26 at 11:35 A.M., showed the resident in his/her wheelchair with dried food debris on the frame of the wheelchair, and both armrest cracked and missing vinyl. Observation on 03/25/26 at 1:21 P.M., showed the resident in his/her wheelchair. The resident's wheelchair had dried food debris built up on both foot pedals, and both arm rest had cracked and torn vinyl, with exposed yellow foam. 4. Review of Resident #45's Quarterly MDS, dated [DATE], showed staff assessed the resident as follows: -Severe cognitive impairment;-Moderate assistance from staff member with eating;-Dependent on staff member for transfers;-Wheelchair. Observation on 03/23/26 at 3:50 P.M., showed the resident in his/her wheelchair. The wheelchair's left armrest vinyl cracked. The wheelchairs wheels and tires had dried food debris on them. Observation on 03/24/26 at 11:35 A.M., showed resident in his/her wheelchair. The wheelchair wheels had dried food debris on them. The left armrest vinyl cracked and damaged. Observation on 03/25/26 at 8:00 A.M., showed resident in his/her wheelchair, in the dining room for breakfast. Observation showed his/her wheelchair with dried food debris and splatter on the wheels and tires. Observation showed the left armrest cracked and peeled vinyl. 5. Review of Resident #37's Quarterly MDS, dated [DATE], showed staff assessed the resident as follows:-Severe cognitive impairment;-Supervision, or touching assistance from staff member with eating;-Dependent on staff members for all transfers. Observation on 03/23/26 at 4:02 P.M., showed the resident in his/her mechanical chair, with dried food debris and splatter on the chair's armrest, wheels and seat. Observation on 03/24/26 at 9:52 A.M., the resident in his/her mechanical chair in the community day room. Observation showed the armrest and wheels of the mechanical chair with dried, and splattered food debris on them. Observation on 03/25/26 at 7:57 A.M., showed the resident in mechanical chair in dining room. Observation showed the armrest and wheels of the mechanical chair with dried, and splattered food debris on them. 6. During an interview on 03/26/26 at 1:23 P.M., Certified Nurse Aide (CNA) G said CNAs are supposed to clean food off resident's wheelchairs after meals, and the wheelchairs should be cleaned at least once a week by the overnight CNAs. The CNA said there is a schedule to clean the resident's wheelchairs at the nurse's station. The CNA said the resident's wheelchairs are not getting cleaned. The CNA said cracked armrest on wheelchairs are a safety issue, and staff should put a work order in the TELS system immediately for maintenance to fix, but nothing changes. During an interview on 03/26/26 at 1:38 P.M., Licensed Practical Nurse (LPN) H said nightshift CNAs clean wheelchairs, but he/she tells the aides on his/her shift, to clean food off chairs, if the aides see it when transferring the residents. The LPN said he/she doesn't know why the wheelchairs are not getting cleaned, because he/she knows the aides have a schedule they are supposed to go by. The LPN said the nightshift charge nurse is responsible to ensure the nightshift (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	aides are doing those duties. The LPN said cracked armrest are supposed to be put in the TELS system. The LPN said the cracked vinyl on armrest can cause skin tears. The LPN said bacteria lives inside the cracked areas of armrest, and if the armrest is cracked, it can't be cleaned appropriately. During an interview on 03/26/26 at 2:46 P.M., the Maintenance Director said he/she is responsible for maintaining wheelchairs. The Maintenance Director said staff are supposed to put in TELS, when the resident's armrest are cracked and peeling. The Maintenance Director said cracked armrest could cause abrasions on the resident's arms. The Maintenance Director said he/she is not sure why the staff have not reported the cracked armrest to him/her. During an interview on 03/26/26 at 3:23 P.M., the Director of Nursing (DON) said CNAs are responsible for cleaning wheelchairs per schedule, on nights. The DON said the nurses and himself/herself are supposed to make the sure the aides are cleaning the wheelchair per schedule. The DON said he/she had a complete turnover in staffing for the night shift recently, and himself/herself and the Assistant Director of Nursing (ADON) had been covering the night shift. The DON said if there is dried food debris on the wheelchairs, he/she expects staff to clean it immediately. The DON said staff are supposed to report cracked arm rest in the TELS system, so maintenance can follow up on it. The DON said residents can get wounds, infections and skin tears from cracked vinyl on the arm rest. The DON said he/she does not know why staff are not reporting the cracked armrest. During an interview 03/26/26 at 4:41 P.M., the administrator said night shift CNAs have cleaning wheelchairs on their task list. The administrator said the ADON, DON and charge nurses are supposed to monitor the aides, to make sure they complete the task list. The administrator said he/she does not know why the wheelchairs are not getting cleaned, the night shift probably needs someone in there to train them correctly on a routine. The administrator said he/she would expect the aides to do a visual scan of residents and their wheelchairs after meals, to make sure there is not food debris on them, before staff take the residents out of the dining room. The administrator said he/she would expect staff to put vinyl tares on armrest of wheelchairs in the TELS system. The administrator said staff have a bad habit of telling the Maintenance Director about things in passing and he/she can't remember everything. The administrator said torn vinyl on the armrest can affect residents skin integrity.

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures to prevent abuse, neglect, and theft. Based on interview and record review, facility staff failed to screen eight employees (Registered Nurse (RN) AA, Laundry Aide Z, Laundry Aide X, Dietary Aide Y, Certified Nurse Aide (CNA) S, [NAME] V, Nurse Aide (NA) T and Licensed Practical Nurse (LPN) U) out of ten new employees prior to employment to determine if the employees had indicators on the CNA Registry, Family Care Safety Registry (FCSR), Criminal Background Check (CBC) and/or Employee Disqualification List (EDL). The facility census was 72. 1. Review of the Facility's policy titled, Background Screening Investigations, dated March of 2019, showed the facility conducts employment background screening checks, reference checks and criminal conviction investigation checks on all applicants. For purposes of this policy direct access employee means any individual who has access to a resident or patient of a long-term care (LTC) facility or provider through employment or through a and has duties that involve (or may involve) one-on-one contact with a patient or resident of the facility or provider, as determined by the state for purposes of the national background check program. The director of personnel, or designee, conducts background checks, reference checks and criminal conviction checks on all employees. Background and criminal checks are initiated within two days of an offer of employment or agreement and completed prior to employment. Should the background investigation disclose any misrepresentation on the application form or information indicating that the individual has been convicted of abuse, neglect, mistreatment of individuals, and/or misappropriation of property, the applicant is not eligible for employment. 2. Review of RN AA's personnel record showed:-Hire date of 06/02/25;-FCSR check on 06/13/25;-EDL check on 06/03/25:-CNA Registry check without a date. 3. Review of Laundry Aide Z's personnel record showed:-Hire date of 06/30/25;-CBC on 07/29/25;-EDL check on 03/25/26;-CNA Registry check on 07/09/25. 4. Review of Laundry Aide X's personnel record showed:-Hired date of 08/06/25;-FCSR checked on 08/13/25; -CNA Registry check without a date. 5. Review of Dietary Aide Y's personnel record showed:-Hire date of 10/27/25;-CBC and EDL check dated 11/04/25;-CNA Registry check without a date. 6. Review of CNA S's personnel record showed:-Hire date of 12/17/25;-FCSR checked on 12/30/25;-CNA Registry check without a date. 7. Review of [NAME] V's personnel record showed:-Hire date of 12/31/25;-CBC dated 01/08/26;-EDL check dated 01/29/26;-CNA Registry check without a date. 8. Review of NA T's personnel record showed:-Hire date of 02/11/26;-CBC and EDL check dated 03/25/26;-CNA Registry check without a date. 9. Review of LPN U's personnel record showed:-Hire date of 02/18/26;-CBC and EDL check dated 03/25/26;-FCSR dated 03/24/26;-CNA Registry check without a date.10. During an interview on 03/26/26 at 9:56 A.M., the Business Office Manager (BOM) said he/she is responsible to complete the pre-employment screening for staff. The BOM said the employee's pre-employment screenings were not completed prior to them starting, because the Director of Nursing (DON) and Assistant Director of Nursing (ADON) needed the staff bad on overnights and were having to cover those shifts. The BOM said the kitchen staff were started before checks, because there was only one cook, and he/she was in dire need of help. The BOM said he/she is aware he/she is supposed to check the FCSR, EDL, CBC and CNA Registry before the staff start working in the facility. The BOM said the employees hire date is their first date in the building, they spend the first day in the office with him/her doing paperwork and the then work on the floor day two through five, working on competency checks. During an interview on 03/26/26 at 4:41 P.M., the administrator said CBC, EDL, FCSR and CNA Registry checks are supposed to be ran on all staff, before the staff can start in the building. The administrator said the BOM is responsible to ensure all the checks are completed before staff start in the building. The administrator said he/she responsible to make sure the BOM gets the checks done, before the staff start in the building.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, facility staff failed to use proper hand hygiene and provide perineal care in a manner to reduce the risk of infection for one resident (Resident #32) out of three sampled residents, facility staff failed to use Enhanced Barrier Precautions (EBP) (an infection control practice that requires staff to wear personal protective equipment (PPE) (protective equipment such as gowns, gloves, goggles, and masks used to prevent or minimize exposure to hazards) for one resident (Resident #66) out of three sampled residents; and facility staff failed to implement appropriate infection control procedures to prevent the spread of communicable diseases when staff failed to screen five staff (Registered Nurse (RN) AA, Certified Nurse Aide (CNA) S, [NAME] V, Nurse Aide (NA) T, and Licensed Practical Nurse (LPN) U) out of ten staff for tuberculosis (TB), a contagious, air-borne bacterial infection primarily affecting the lungs, in accordance with facility policy. The facility census was 72. 1. Review of the facility's policy titled Hand Hygiene, dated 2021, showed hands should be washed with soap and water under the following conditions: -Before and after handling clean or soiled dressings, linens; -After handling items potentially contaminated with blood, body fluids, secretions, or excretions; -When, during resident care, moving from a contaminated body site to a clean body site. 2. Review of Resident #32's Quarterly Minimum Data Set (MDS), a federally mandated assessment tool, dated 03/25/26, showed staff assessed the resident as: -Had an indwelling urinary catheter; -Always incontinent of bowel; -One pressure ulcer. Observation on 03/25/26 at 10:51 A.M., showed LPN H and the Assistant Director of Nursing (ADON) entered the resident's room to provide wound care. The ADON and LPN applied gowns, washed hands and then applied gloves. The LPN removed the resident's personal items from his/her bedside table, left dried food debris on the table, placed a washcloth and put wound supplies on the washcloth. With the same soiled gloves, the LPN picked up the bed remote and adjusted the head of the bed. The ADON removed the resident's right sock and revealed a bandage on the resident's right heel saturated with blood. The LPN provided wound care, changed gloves and placed the same sock back on resident's foot over the new bandage. The ADON took the dirty foam wedge from under the resident's leg and placed it on the chair. With the same soiled gloves, the LPN removed the wound dressing over the resident's face wound. The LPN sprayed wound cleanser on the resident's face wound, walked away from the resident to perform hand hygiene, the resident's face started to bleed, the ADON continued to wear the same soiled gloves and placed clean gauze on the wound to the resident's face. The LPN returned to the resident and removed the dirty gauze from the resident's face and performed the wound treatment. Observation showed the LPN removed the resident's soiled brief with bowel movement and the bandage from the resident's coccyx wound. The LPN wiped bowel into the resident's wound several times. At this time, the ADON told the LPN, he/she needed to use a new wipe each time because the wipes were visibly soiled. The LPN continued to wear visibly soiled gloves picked up the resident's clean brief and placed it on the resident's bed. The LPN provided (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	wound care to the resident's coccyx wound and placed the brief on the resident he/she had touched with visibly soiled gloves on and picked up the bed remote and removed the wound treatment supplies from the resident's room and placed the supplies back on the treatment cart. During an interview on 03/26/26 at 10:42 A.M., LPN H said he/she should have changed his/her gloves and washed his/her hands after touching the bed remote and dirty bedside table. The LPN said he/she didn't, because he/she was nervous. The LPN said during the care the ADON should have removed gloves, washed hands and placed new gloves before he/she touched the clean gauze and applied it to open area on the resident's face, and after he/she had touched the dirty foam wedge that was under the resident's leg. The LPN said since the ADON touched the gauze with soiled gloves, he/she should have changed gloves and washed hands after removing the gauze from wound and should have applied clean gloves before he/she changed the dressing to the resident's face. The LPN said the resident had been incontinent of bowel, and he/she should have avoided touching the wound with feces, because it increases the risk of infection, but was not certain how to with the placement of the wound. The LPN said he/she should not have picked up the resident's clean brief with soiled gloves on. The LPN said they should not have placed that brief on the resident after cleaning him/her as it is now soiled. The LPN said after the treatments, when he/she touched the residents dirty bedside table with his/her bare hands, he/she should have washed hands, before picking up the wound care supplies for multiple residents. During an interview on 03/26/26 at 11:30 A.M., the ADON said when the LPN removed items from the bedside table, he/she should have made sure the table was clean and sanitized. The ADON said the LPN should have removed gloves, washed hands and applied clean gloves after he/she touched the dirty table. The LPN's gloves were not clean, and he/she risked introducing bacteria, or infection to the resident's wound. The ADON said he/she should have changed gloves and washed his/her hands before he/she put the clean gauze on the resident's face especially after he/she touched the dirty foam wedge. The ADON said the LPN should have removed gloves and washed hands after he/she touched the gauze on the resident's face. The ADON said when the LPN wiped bowel into the resident's open wound on his/her coccyx he/she introduced bacteria to the wound. The LPN should have removed his/her soiled gloves and washed hands before he/she touched the resident's clean brief. The ADON said the LPN should have washed hands after he/she handled the bedside table again, and before handling the wound supplies used for several residents. During an interview on 03/26/26 at 3:23 P.M., the Director of Nursing (DON) said when staff move from clean to dirty tasks when providing care. The staff should wash hands, apply gloves and gowns in room prior to providing care. The DON said staff should not touch clean items with soiled gloves on. The DON said if staff have dirty gloves, the staff should not place clean gauze on an open wound. The DON said after touching drawer handles, staff should remove gloves, and wash hands. The DON said staff should not wipe bowel over an open wound, it creates a cross contamination and infection risk. The DON said staff should not touch a bedside table with food debris on it, during wound care, if they do touch it, staff should remove their gloves, wash their hands and apply clean gloves and a new barrier. The DON said staff should not touch the wound supplies with dirty gloves on. 3. Review of the facility's policy titled, Enhanced Barrier Precautions (EBP), dated September 2022, showed EBP involves gown and glove use during high-contact resident care activities for residents known to be colonized or infected with a multidrug-resistant organisms (MDRO) as well as those at increased risk of MDRO acquisition like residents with wounds or indwelling medical devices for dressing, bathing, transferring, providing hygiene, changing linens, changing briefs or assisting with toileting, device care or use and wound care. The gown and gloves will be outside the resident room (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	for the staff to apply before entering the room and staff will remove inside the room before exiting. 4. Review of Resident #66's Quarterly MDS, dated [DATE], showed staff assessed the resident as one pressure ulcer. Observation on 03/24/26 at 9:43 A.M., showed an EBP sign posted by the door frame, at the entrance to the resident's room. Personal Protective Equipment can be observed in a three drawer, plastic bin, inside the door to the resident's room. Observation showed NA L, Certified Medication Technician (CMT) N and CNA K did not wear gowns as they assisted the resident with a shower. Observation showed the resident's mid- calf surgical wound unwrapped. Observation on 03/25/26 at 10:49 A.M., CNA R and CNA P entered the resident's room and provided incontinence care to the resident and did not wear PPE. During an interview on 03/25/26 at 12:05 P.M., CNA R said he/she provided incontinence care for the resident. The CNA said the resident was incontinent of urine and bowel. The CNA said he/she did not use a gown during the care, it slipped his/her mind. During an interview on 03/25/26 at 12:08 P.M., CNA P said the resident was incontinent of bowel and bladder. The CNA said he/she did not wear a gown, as he/she provided the incontinence care to the resident. The CNA said he/she didn't pay attention to the precautions. During an interview on 03/26/26 at 1:05 P.M., the Infection Preventionist (IP) said staff should follow EBP when they are providing direct care with residents. The IP said staff should wear gowns and gloves, when they provide incontinence care and showers for residents on EBP. The IP said he/she doesn't know why staff are not wearing gowns. The IP said he/she is responsible to make sure staff are following the precautions for EBP, and the floor nurse should be following up with staff on the floor. During an interview on 03/26/26 at 1:23 P.M., CNA G said EBP should be used anytime a resident has a wound or a catheter. The CNA said staff should wear a gown when providing a resident on EBP with a shower or incontinence care. During an interview on 03/26/26 at 1:38 P.M., LPN H said EBP, such as gown and gloves, should be used for residents with wounds and/or catheters. The LPN said staff should wear a gown if giving a resident with a wound a shower and with incontinence care. The LPN said he/she does not know why aides are not wearing gowns. The LPN said the charge nurse is responsible to make sure aides are wearing gowns with the cares, for residents on EBP. During an interview on 03/26/26 at 3:23 P.M., the DON said residents with chronic wounds, or internal medical devices should be on EBP. The DON said gowns and gloves should be used with transfers, or direct care of residents on EBP. The DON said staff should wear gowns with showers and incontinence care. The DON said he/she and the IP are responsible to make sure staff are wearing the correct PPE, when providing care to residents on EBP. 5. Review of the facility's policy titled Employee Tuberculosis Screening, dated December 2016, showed All employees shall be screened for tuberculosis (TB) infection and disease, using a two-step tuberculin skin test (TST) or blood assay for Mycobacterium tuberculosis (BAMT) and symptom screening, prior to beginning employment. Each newly hired employee will be screened for TB (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	infection and disease after an employment offer has been made but prior to the employee's duty assignment. 6. Review of RN AA's personnel records showed a hire date of 06/02/25, with a first date worked in the facility of 06/02/25. The resident's personnel records showed he/she received his/her step one of the two step TB screening administered on 06/02/25 and read on 06/04/25. 7. Review of CNA S's personnel records showed a hire date of 12/17/25, with a first date worked in the facility of 12/17/25. The resident's personnel records showed he/she received his/her step one of the two step TB screening administered on 12/17/25 and read on 12/19/25. 8. Review of [NAME] V's personnel records showed a hire date of 12/31/25, with a first date worked in the facility of 12/31/25. The resident's personnel records showed he/she received his/her step one of the two step TB screening administered on 12/31/25 and read on 01/03/26. 9. Review of NA T's personnel records showed a hire date of 02/11/26, with a first date worked in the facility of 02/11/26. The resident's personnel records showed he/she received his/her step one of the two step TB screening administered on 02/11/26 and read on 02/13/26. 10. Review of LPN U's personnel records showed a hire date of 02/18/26, with a first date worked in the facility of 02/18/26. The resident's personnel records showed he/she received his/her step one of the two step TB screening administered on 02/18/26 and read on 02/20/26. During an interview on 03/26/2026 at 9:56 A.M., the Business Office Manager (BOM) said the Infection Preventionist (IP) does the TB screenings for new hires and keeps a binder. The BOM said on the new hire's first day in the building, the staff are in the office with him/her completing paperwork and then day two through five, staff are on the floor. During an interview on 03/26/26 at 1:05 P.M., the IP said when the BOM does orientation with new staff, a nurse here gives the first TB. The IP said the new staff's first day of orientation is with the BOM in office, the next five days the staff complete orientation on the floor. The IP said the first TB must be read, before the staff work on the floor. The IP said he/she is not in charge of the schedule anymore; it is whatever department head the new staff falls under. The IP said when he/she completed the schedule, he/she made sure the first TB was read before the new staff worked on the floor. During an interview on 03/26/26 at 3:23 P.M., the DON said the new staff come in and do orientation. The DON said the new staff work the first day in the business office and their second day, the staff are out on the floor. The DON said the corporation told him/her staff could work the floor before their first step TB is read.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, facility staff failed to document a complete and accurate Minimum Data Set (MDS) assessment (a federally mandated assessment tool), when they did not accurately code anticoagulant use for two residents (Resident #5 and #6), oxygen and/or Continuous Positive Airway Pressure (CPAP - Machine that keeps the airways open during sleep for persons with sleep apnea) use for two residents (Resident #1 and #4), falls with injury for one resident (Resident #3), and a psychiatric diagnosis for one resident (Resident #41) out of 20 sampled residents. The facility census was 72. 1. Review of the facility policy titled, MDS Completion and Submission Timeframes, dated July 2017, showed the facility will conduct and submit resident assessments in accordance with current federal and state submission timeframes. The assessment coordinator or designee is responsible for ensuring that resident assessments are submitted in accordance with current federal and state guidelines. The policy did not address the accuracy of MDS assessments. Review of the Centers for Medicare and Medicaid Services (CMS) Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's manual, dated October 2023, showed an accurate assessment requires collecting information from multiple sources, some of which are mandated by regulations. Those sources must include the resident and direct care staff on all shifts, and should also include the resident's medical record, physician, and family, guardian and/or other legally authorized representative, or significant other as appropriate or acceptable. Information obtained should cover the same observation period as specified by the MDS items on the assessment and should be validated for accuracy (what the resident's actual status was during the observation period) by the Interdisciplinary Team (IDT) completing the assessment. 2. Review of Resident #5's Significant Change MDS, dated [DATE], showed staff assessed the resident as cognitively intact and taking an anticoagulant. Review of the resident's Physician Order Sheet (POS), dated March 2026, did not show an order for an anticoagulant. 3. Review of Resident #6's Quarterly MDS, dated [DATE], showed staff assessed the resident as cognitively intact and received an anticoagulant. Review of the resident's POS, dated March 2026, did not show an order for an anticoagulant. During an interview on 03/26/26 at 2:54 P.M., the MDS Coordinator said he/she uses physician orders and the Medication Administration Record (MAR) for coding of medications. He/She thought Resident #5 and Resident #6 received anticoagulants, but it must have been an error. He/She said if they are not on an anticoagulant then the MDS should have been marked no. During an interview on 03/26/26 at 3:22 P.M., the Director of Nursing (DON) said the MDS Coordinator is responsible for coding the assessment correctly and would expect medications to be coded correctly on MDS. The DON said he/she was not aware Resident #5 and Resident #6 were coded for anticoagulants but was not currently taking an anticoagulant. The DON said he/she believes there is a corporate person who oversees the MDS assessments are being completed. During an interview on 03/26/26 at 4:41 P.M., the administrator said the MDS Coordinator is responsible for completing the assessments. The administrator said he/she expects all medications (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	to be coded correctly on MDS assessment. 4. Review of Resident #1's admission MDS, dated [DATE], showed staff assessed the resident as cognitively intact, did not use non-invasive mechanical ventilation/CPAP, with diagnoses of atrial fibrillation (a common, often rapid, and irregular heart rhythm), heart failure, high blood pressure, and pneumonia. Review of the resident's POS, dated March 2026, did not show an order for use of CPAP. Review of the resident's care plan, dated 03/17/26, showed a diagnosis of sleep apnea, unspecified, and staff did not document the resident's use of a CPAP. Observation on 03/23/26 at 11:03 A.M. and 3:29 P.M., showed the resident's CPAP on his/her nightstand. Observation on 03/24/26 at 9:15 A.M., showed the resident's CPAP on his/her nightstand. Observation on 03/25/26 at 8:41 A.M., showed the resident's CPAP on his/her nightstand. During an interview on 03/23/26 at 3:29 P.M., the resident said he/she has used his/her CPAP for many years now and uses it at night. During an interview on 03/26/26 at 2:54 P.M., the MDS Coordinator said he/she uses physician orders and the MAR for coding of medications and treatments. He/she said if a resident uses a CPAP it should be coded on the MDS correctly, and he/she would not have known to code it without the physician orders. During an interview on 03/26/26 at 3:22 P.M., the DON said the MDS Coordinator is responsible for coding the assessment correctly and would expect if a resident was using a CPAP it should be on the assessment. The DON said he/she believes there is a corporate person who oversees the MDS assessments are being completed. During an interview on 03/26/26 at 4:41 P.M., the administrator said the resident's use of CPAP should be coded correctly on the MDS assessment. He/she said the MDS Coordinator is responsible for completing the assessments. The administrator said he/she did not know the resident was admitted with a CPAP. 5. Review of Resident #4's Quarterly MDS, dated [DATE], showed staff assessed the resident as cognitively intact, did not use non-invasive mechanical ventilation/CPAP or oxygen therapy, with diagnosis of asthma, Chronic Obstructive Pulmonary Disease (COPD), or chronic lung disease, and respiratory failure. Review of Resident's POS, dated March 2026, showed the following orders: -CPAP at 4/20 with 2 liters (L) of oxygen at bedtime; -Oxygen 2 Liters via nasal cannula for oxygen saturation below 90% or short of breath (SOB); -Change tubing and humidifier bottle, change once weekly on Sunday, and date both tubing and bottle. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the resident's care plan, dated 03/25/26, showed a diagnosis of COPD and staff did not document the resident's use of a CPAP or oxygen. Observation on 03/23/26 at 10:59 A.M., showed the resident in his/her recliner on 4L of oxygen via nasal cannula and a CPAP machine on the table next to the recliner. Observation on 03/23/26 at 11:23 A.M., showed the resident wheeled himself/herself in his/her wheelchair down the with oxygen on via nasal cannula. Observation on 03/24/26 at 9:35 A.M., showed the resident in his/her wheelchair in the activity room with his/her oxygen on via nasal cannula. Observation on 03/26/26 at 8:30 A.M., showed the resident in his/her recliner on 4L of oxygen via nasal cannula and a CPAP machine on the table next to the recliner. During an interview on 03/26/26 at 8:30 A.M., the resident said he/she uses oxygen continuously when in the room and when in the wheelchair outside of his/her room. He/She said he/she uses CPAP machine at bedtime and has since he/she has been at the facility. During an interview on 03/26/26 at 2:54 P.M., the MDS Coordinator said that he/she uses physician orders and the MAR for coding of medications and treatments. He/she said that if a resident uses a CPAP and oxygen it should be coded on the MDS correctly. During an interview on 03/26/26 at 3:22 P.M., the DON said the MDS Coordinator is responsible for coding the assessment correctly and would expect if a resident was using a CPAP or oxygen it should be on the assessment. The DON said he/she believes there is a corporate person who oversees the MDS assessments are being completed. During an interview on 03/26/26 at 4:41 P.M., the administrator said the resident's use of CPAP and Oxygen should be coded correctly on the MDS assessment. He/she said the MDS Coordinator is responsible for completing the assessments. 6. Review of Resident #3's Quarterly MDS, dated [DATE], showed staff assessed the resident as unable to assess cognition, with short/long-term memory problems, had no falls since the prior assessment, and diagnosis of Alzheimer's Disease. Review of the resident's MDS assessments showed the previous assessment was a Significant Change in Status Assessment, dated 01/07/26. Review of the resident's progress notes showed the resident had falls on the following dates: - 01/10/26 fall with injury; - 02/05/26 fall with injury; - 02/23/26 fall with injury. During an interview on 03/26/26 at 2:54 P.M., the MDS Coordinator said he/she reviews resident's progress notes, fall assessments and related documentation such as care plans to see if the resident (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	has had any falls since the prior assessment. The MDS Coordinator said falls are reviewed at the morning meeting, and he/she did not know how he/she missed that. He/she said it should be coded correctly on the MDS assessment. During an interview on 03/26/26 at 3:22 P.M., the DON said the MDS Coordinator is responsible for coding the assessment correctly and would expect if a resident had falls or falls with injury it should be on the assessment. The DON said he/she believes there is a corporate person who oversees the MDS assessments are being completed. During an interview on 03/26/26 at 4:41 P.M., the administrator said falls should be coded correctly on the MDS assessment and he/she did not know that it was not done for the resident. 7. Review of Resident #41's Quarterly MDS, dated [DATE], showed staff assessed the resident as received antipsychotic medication and did not check the resident had a psychotic Disorder. Review of the resident's POS, dated March 2026, showed an order for Olazapine 2.5 Milligram (MG) (Antipsychotic) with Diagnosis of Psychotic Disorder. During an interview on 03/26/26 at 2:54 P.M., the MDS Coordinator said when he/she completes MDS section N for medications, he/she gets those medications from MARS and POS. The MDS Coordinator said he/she find the diagnosis under the medical diagnosis tab. The MDS Coordinator said he/she does not know what the nurses do, when a resident gets a new diagnosis. The MDS Coordinator said the MDS for the resident would not be accurate, and he/she would need to do the modification and resubmit the MDS. During an interview on 03/26/26 at 3:23 P.M., The DON said the MDS Coordinator is responsible for accurate MDS assessments. The DON said the administrator is responsible to make sure the MDS Coordinator is completing MDS accurately. The DON said if a resident's POS says antipsychotic for Psychotic disorder, psychotic disorder should be identified on the MDS. During an interview on 03/26/26 at 4:41 P.M., the administrator said if a resident has a diagnosis of Psychotic Disorder on POS, the diagnosis should be on MDS.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, facility staff failed to develop measurable goals and interventions for comprehensive care plans and update existing care plans to reflect care needs for four residents (Residents #4, #11, #23, and #41) out of 20 sampled residents. The facility census was 72.1. Review of the facility's policy titled Comprehensive Care Plans, dated 09/22, showed the care planning process will include an assessment of the resident's strengths and needs, and will incorporate the resident's personal and cultural preferences in developing goals of care; -The Comprehensive care plan will describe at a minimum, the following: -The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being; -The residents' goals for admission, desired outcomes, and preferences for future discharge; -The comprehensive care plan will be reviewed and revised by the interdisciplinary team after each comprehensive and quarterly MDS assessment. 2. Review of Resident # 4's Annual Minimum Data Set (MDS), a federally mandated assessment tool, dated 10/30/25, showed staff documented the resident as: -Cognitively intact; -Very Important to listen to music, and go outside for fresh air; -Somewhat important to do things with groups of people, do favorite activities, and participate in religious services; -Did not use Continuous Positive Airway Pressure (CPAP), a machine that keeps the airways open during sleep for persons with sleep apnea) or oxygen therapy -Diagnoses of asthma, Chronic Obstructive Pulmonary Disease (COPD), or chronic lung disease, and respiratory failure. Review of the Resident's POS, dated March 2026, showed the following orders: -CPAP at 4/20 with two liters (L) of oxygen at bedtime; -Oxygen two Liters via nasal cannula for oxygen saturation below 90% or shortness of breath; -Change tubing and humidifier bottle weekly on Sunday. Review of the resident's care plan, dated 03/25/26, showed staff did not document the resident's activities preferences, oxygen therapy, or CPAP usage. Observation on 03/23/26 at 10:59 A.M., showed the resident in his/her room with his/her oxygen on (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	at 4 liters via nasal cannula and the CPAP machine on a table. Observation on 03/23/26 at 11:23 A.M., showed the resident wheeled down the hallway in his/her wheelchair with his/her oxygen on. Observation on 03/24/26 at 9:35 A.M., showed the resident in an activity with his/her oxygen on. Observation on 03/26/26 at 8:30 A.M showed the resident in his/her room with his/her oxygen on via nasal cannula and the CPAP machine on a table. During an interview on 03/26/26 at 8:30 A.M., the resident said he/she uses oxygen continuously. He/She said he/she uses the CPAP machine at bedtime and has since he/she has been at the facility. He/She said he/she enjoys going to activities and tries to attend them all. 3. Review of Resident #11's Significant Change MDS, dated [DATE], showed staff assessed the resident as: -Moderate Cognitive Impairment; -Diagnosis of diabetes; -Received seven Insulin injections in the last seven days; -Receives a hypoglycemic medication (used to lower blood sugar). Review of the resident's care plan, revised 03/17/26, showed staff did not document the resident's diagnosis of diabetes or interventions. 4. Review of Resident #23's Comprehensive MDS, dated [DATE], showed staff assessed the resident as cognitively intact and very important to listen to music, keep up with the news, do things with groups of people, do favorite activity, go outside to get fresh air, and participate in religious services. Review of the resident's care plan, dated 02/13/26, showed staff did not document the resident's activity preferences or interests. During an interview on 03/25/26 at 8:17 A.M., the resident said he/she enjoys going to activities. During an interview on 03/26/26 at 1:32 P.M., Licensed Practical Nurse (LPN) F said if a resident receives Oxygen or uses a CPAP that information should be on the residents' care plan. He/She said a diagnosis like diabetes and activity preferences should also be the care plans. He/She said care plans guide staff on how to care for that resident. He/She said if a nurse notices something is not on the care plan, they should let the MDS coordinator know. During an interview on 03/26/26 at 2:55 P.M., the MDS Coordinator said he/she uses physician orders, progress notes, meetings, and assessment documentation for updating care plans. He/she said if a resident uses a CPAP, Oxygen, and has a diagnosis of diabetes that should be included on the care plan. He/She activity preferences are asked about upon admission and should be on care plan, so staff know what the resident likes. Care plans shape what the staff should be doing for the residents and lets staff know how to care for residents. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 03/26/26 at 3:22 P.M., the Director of Nursing (DON) said oxygen use and CPAPs should be on the care plan along with a diagnosis of diabetes and residents' activity preferences. He/She said the MDS coordinator updates the care plans. He/She said care plans are important, so staff know how to care for that resident. During an interview on 03/26/26 at 4:41 P.M., the administrator said he/she expects CPAP's, oxygen therapy, a diagnosis of diabetes, and activity preferences to be on the care plan. He/She said care plans are important to identify all needs and its communication, so all staff know the individual and how to care for them. 5. Review of Resident #41's Quarterly MDS, dated [DATE], showed staff assessed the resident requires a mechanically altered diet. Review of the resident's Dietary Slip, dated 03/23/26, showed pureed texture for the resident. Observation on 03/23/26 at 12:37 P.M., showed the resident ate a lunch meat sandwich in the dining room. Review of the resident's Dietary Slip, dated 03/24/26, showed pureed texture for the resident. Observation on 03/23/26 at 12:02 P.M., showed the resident ate a lunch meat sandwich in the dining room. Review of the resident's care plan, dated 01/29/26, showed staff documented the resident receives a regular diet with pureed texture. Staff did not document the resident may have exceptions to the diet for comfort. During an interview on 03/26/26 at 1:23 P.M., Certified Nursing Assistant (CNA) G said the resident should receive Pureed food. The CNA said he/she doesn't know why the resident is getting sandwiches, unless an aide is going to get the resident a sandwich, because the resident is asking for it. The CNA said if the resident can have comfort foods, it should be on the resident's care plan, so staff knows. During an interview on 03/26/26 at 1:38 P.M., LPN H said he/she believes the resident should receive a pureed diet. The LPN said he/she was not under the impression the resident received sandwiches, his/her diet order does not indicate he/she can have that. The LPN said sometimes residents can have pleasure foods, if the resident and family are educated of the risk. The LPN said if sandwiches are for comfort purposes, it should be on the resident's care plan. The LPN said he/she would assume it is not on the care plan. During an interview on 03/26/26 at 2:54 P.M., the MDS Coordinator said a resident's diet consistency should be on the care plan. The MDS Coordinator said if a resident has exceptions to consistency, like comfort food, it should be on care plan. During an interview on 03/26/26 at 4:41 P.M., the administrator said if a resident is on a pureed diet, it should be on the resident's care plan. The administrator said exceptions to the diet, like comfort food, should be identified on the care plan.

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. Based on interview and record review, facility staff failed to provide an ongoing activity program designed to meet the residents' interest, mental, and psychosocial well-being on the weekends for three residents (Resident #4, #23, and #28) out of 20 sampled residents. The facility census was 72.1. Review of the facility's policy titled, Life Enrichment Program, dated 10/2017, showed facility-sponsored group and individual activities and independent activities will be designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, as well as encourage both independence and interaction within the community. 2. Review of the facility's Activity Calendar, dated February 2026, showed: -Saturdays, 02/07, 02/14, 02/21, 02/28 Games/Puzzles;-Sundays, 02/01, 02/15 Games/Puzzles;-Sunday, 02/08 Superbowl Sunday 5 P.M. Wear your Colors;-Sunday, 02/22 Church everyone. Review of the facility's Activity Calendar, dated March 2026, showed: -Saturdays, 03/07, 03/14, 03/21, 03/28 Games, Puzzles, Read a book;-Sundays, 03/01, 03/08, 03/15, 03/22 TV, Church, Games, Puzzles;-Sunday, 03/29 Church, All Welcomed. During an interview on 03/24/26 at 12:22 P.M., Resident #4 said he/she tries to go to all activities. He/She said there are no weekend activities. He/She said, I feel kind of lost on the weekends without activities, I wish there was activities on the weekends. During an interview on 03/25/26 at 8:17 A.M., Resident #23 said he/she enjoys going to activities. He/She said there are no activities on the weekends. He/She said he/she wishes there was activities on the weekends, he/she said I'm bored when there are no activities. During an interview on 03/26/26 at 10:43 A.M., Resident #28 said I love going to activities, I go to all of them. He/She said there are no weekend activities. Resident said without weekend activities, It leaves me just laying here, I wish they had activities on the weekends. During an interview on 03/26/26 at 1:29 P.M., Certified Nurse Assistant (CNA) J said on the weekends the aides can do some activities like puzzles or a movie if they have time. He/She said a lot of residents enjoy doing cross word puzzles on weekends. He/She said there are no staff led activities on the weekends. During an interview on 03/26/26 at 1:32 P.M., Licensed Practical Nurse (LPN) F said some residents go to church and once a month a church comes into facility on a Sunday. He/She said the residents can watch a movie in the activity room or do Puzzles. He/She said there are no staff led activities on the weekends. During an interview on 03/26/26 at 1:22 P.M., the activities director said on the weekends the residents have puzzles, books, and movies in the activity room they can do. He/She said, the weekends are kind of down time for the residents. He/She said there are no staff led activities on the weekends. He/She said he/she was not aware they needed staff-led activities on the weekends. During an interview on 03/26/26 at 3:22 P.M., the Director of Nursing (DON) said on the weekends there are puzzles, movies, books, and music playing. He/She said activities are not scheduled on the weekends. He/She said he/she was not aware of regulation and staff led activities on the weekends. During an interview on 03/26/26 at 4:41 P.M., the administrator said on the weekends the residents have board games, movies, and church on Sunday. He/She said there are no staff led activities on the weekends. He/She said he/she was aware of regulation, he/she said they recently hired an assistant to help with activities but need to see if they can come in on the weekends to do activities.

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	265670	A. Building B. Wing	03/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Stonebridge Owensville	1016 W Highway 28 Owensville, MO 65066

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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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. Based on observation, interview and record review, facility staff failed to provide care and services to meet professional standards in regard to the use of a Continuous Positive Airway Pressure (CPAP) device, the standard treatment for obstructive sleep apnea using a mask and gentle air pressure to keep airways open during sleep, when facility staff failed to obtain an order for the use of the CPAP, and include the use of CPAP on the resident's care plan, for one resident (Resident #1) of two sampled residents. The facility census was 72. 1. Review of the facility policy titled CPAP/Bi-level positive airway pressure (BiPAP) Support, dated March 2025, showed the following: -Review the physician's order to determine the oxygen concentration and flow, and the Positive End-Expiratory Pressure (PEEP) pressure for the machine; -Wipe machine with warm, soapy water and rinse at least once a week and as needed; -Humidifier: use clean, distilled water only in the humidifier chamber, clean humidifier weekly and air dry; to disinfect, place vinegar-water solution (1:3) in a clean humidifier, soak for 30 minutes and rinse thoroughly; -Filter cleaning: rinse washable filter under running water once a week to remove dust and debris, replace disposable filters monthly; -Masks, nasal pillows and tubing: Clean daily by placing in warm, soapy water and soaking/agitating for five minutes, mild dish detergent is recommended, rinse with warm water and allow to air dry between uses; -Document the following in the resident's medical record:-General assessment (including vital signs, oxygen saturation, respiratory, circulatory and gastrointestinal status) prior to procedure; -Time CPAP was started and duration of the therapy; -Mode and settings for the CPAP; -How the resident tolerated the procedure; -Oxygen saturation during therapy. 2. Review of Resident #1's admission Minimum Data Set (MDS), a federally mandated assessment tool, dated 02/25/26, showed staff assessed the resident as cognitively intact, did not use non-invasive mechanical ventilation/CPAP, with diagnoses of atrial fibrillation (irregular heart rhythm), heart failure, high blood pressure, and pneumonia. Review of the resident's care plan, dated 03/17/26, showed staff documented a diagnosis of sleep apnea, unspecified, and the care plan did not contain guidance or information for CPAP use.Review of the resident's Physician Order Sheet (POS), dated March 2026, showed the orders did not contain use of CPAP with the required information for the type of unit, pressure settings, frequency of therapy and cleaning schedule. Review of the resident's medical record showed staff did not document a resident assessment regarding the resident's use of CPAP including time and duration of therapy, mode and settings, how the resident tolerated CPAP use or the oxygen saturation during therapy. Observation on 03/23/26 at 11:03 A.M., showed the resident's CPAP on his/her nightstand. Observation on 03/24/26 at 9:15 A.M., showed the resident's CPAP on his/her nightstand. Observation on 03/25/26 at 8:41 A.M., showed the resident's CPAP on his/her nightstand. Observation on 03/26/26 at 8:22 A.M., showed the resident's CPAP on his/her nightstand. During an interview on 03/23/26 at 3:29 P.M., the resident said he/she had used his/her CPAP for years, and staff forgets to put water in the CPAP, which causes his/her mouth to become dry and his/her nose to burn. During an interview on 03/26/26 at 8:22 A.M., the resident said staff must put the water in the machine and then press the button to turn it on, but he/she can usually take the mask off and on. The resident said he/she was not sure what the settings were for the CPAP, but he/she can tell when it is not blowing enough air and will ask staff to adjust the settings. He/she said a night or so ago, it did not feel like it was working right, so staff adjusted the settings. The resident said he/she was not sure how staff would know the settings, he/she just tells them when it does not feel right, but he/she does not believe the CPAP has auto settings, where it would self-adjust. The resident said he/she has not seen staff clean the CPAP mask, tubing or machine. During an interview on 03/26/26 at 1:07 P.M., Certified Nurse Aide/Certified Medication Technician (CNA/CMT) G said CPAPs should be on a resident care plan, so staff know when it should be on, what to watch out for if the resident has sleep apnea, when it needs to be cleaned or if water needs to be added. During an interview on 03/26/26 at 1:11 P.M., Licensed Practical Nurse (LPN) H said there should be orders for (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	CPAP and it is important to have the orders because it helps the resident breathe at night. He/She said the order should include the settings, when to clean it, when it should be put on and taken off, and if water is required. The LPN said he/she would think it needs to be cleaned every day. LPN H said the CPAP should be on the care plan because it lets staff know when it needs to be cleaned, when it should be put on and when the resident uses it. LPN H said he/she did not know the resident did not have orders for the CPAP. LPN H said usually the admitting nurse gets the orders from the physician and enters them in the computer system. During an interview on 03/26/26 at 2:54 P.M., the MDS Coordinator said if a resident uses a CPAP, it should be on the care plan, and that he/she is responsible for updating the care plans. The MDS Coordinator said he/she did not know that the resident used a CPAP as there were no orders, and the CPAP was not on the MDS assessment, which would trigger him/her to add it to the care plan. During an interview on 03/26/26 at 3:22 P.M., the Director of Nursing (DON) said there should be orders for CPAP use, with the settings and cleaning schedule and use of distilled water. He/she said the admitting nurse is responsible for putting the CPAP orders in, and then he/she or the Assistant Director of Nursing (ADON) follow through if something has been missed. The DON said he/she did not know the resident had CPAP. He/She said those kinds of things are usually talked about weekly on Tuesday morning, and it would be important to make sure it is used correctly. The DON said CPAP use should be on the care plan, and the MDS Coordinator is responsible for updating the care plans. He/she believes there is a corporate staff that oversees the facility's MDS Coordinator. The DON did not know why the orders were missing.During an interview on 03/26/26 at 4:41 P.M., the Administrator said it is important to have orders for CPAP use, to know the settings, to make sure infection control is being followed, and for cleaning directions. The administrator said CPAP use should be on the resident's care plan, because care plans identify all resident care needs, so that all departments and staff know the individual care for that specific resident. The administrator said he/she did not know the resident was admitted with CPAP, he/she has a spreadsheet with all special equipment that residents use, like CPAP, BiPAP and nebulizers, and he/she goes over it every Tuesday at the weekly meeting and it was not listed. The administrator said the admitting or charge nurse is responsible for entering the necessary orders, and the DON and ADON are responsible for overseeing the charge nurse.

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, facility staff failed to complete entrapment assessments for five residents (Resident #11, #32, #63, #66, and #70) who used bed rails out of 20 sampled residents. The facility census was 72. 1. Review of the facility's policy titled Proper Use of Side Rails, dated 09/2022, showed:-The resident assessment should assess the resident's risk of entrapment between the mattress and bed rail or in the bed rail itself;-Inspecting and regularly checking the mattress and bed rails for areas of possible entrapment;-Ensuring the bed frame, bed rail, and mattress do not leave a gap wide enough to entrap a resident's head of body, regardless of mattress width, length, and/or depth;-The maintenance director, or designee, is responsible for adhering to a routine maintenance and inspection schedule of all bed frames, mattresses, and bed rails.2. Review of Resident #11's Significant Change Minimum Data Set (MDS), a federally mandated assessment tool, dated 03/25/26, showed staff assessed the resident as moderate cognitive impairment and restraints not used.Review of the resident's care plan, revised 03/20/26, showed staff documented assist bar on the upper left side of bed.Review of the resident's medical record showed the record did not contain an entrapment assessment.Observation on 03/23/26 at 1:14 P.M., showed resident in bed with the left grab bar in upright position on the bed.Observation on 03/24/26 at 08:36 A.M., showed resident in bed with left grab bar in upright position on the bed.Observation on 03/25/26 at 11:01 A.M., showed resident in bed with left grab bar in upright position on the bed.Observation on 03/26/26 at 10:45 A.M., showed resident in bed with left grab bar in upright position on the bed.3. Review of Resident #32's Quarterly MDS, dated [DATE], showed staff assessed the resident as moderate cognitive impairment and restraints not used.Review of the resident's medical record showed the record did not contain an entrapment assessment.Observation on 03/23/26 at 11:32 A.M., showed the resident in bed with grab bars in upright position on both sides of the bed. Observation on 03/25/26 at 10:37 A.M., showed the resident in bed with grab bars in upright position on both sides of the bed. Observation on 03/26/26 at 9:25 A.M., showed the resident in bed with grab bars in the upright position on both sides of the bed. 4. Review of Resident #63's Quarterly MDS, dated [DATE], showed staff assessed the resident as cognitively intact and restraints not used.Review of the resident's care plan, revised 03/10/26, showed staff documented bilateral assist rails.Review of the resident's medical record showed the record did not contain an entrapment assessment. Observation on 03/23/26 at 1:01 P.M., showed the resident in bed with bilateral grab bars in upright position on the bed.Observation on 03/24/26 at 1:32 P.M., showed the resident in bed with bilateral grab bars in upright position on the bed.Observation on 03/25/26 at 8:52 A.M., showed the resident in bed with bilateral grab bars in upright position on the bed.Observation on 03/26/26 at 10:30 A.M., showed the resident in bed with bilateral grab bars in upright position on the bed.5. Review of Resident #66's Quarterly MDS, dated [DATE], showed staff assessed the resident as moderate cognitive impairment and restraints not used.Review of the resident's medical record showed the record did not contain an entrapment assessment.Observation on 03/25/26 at 10:49 A.M., showed the resident in bed with a grab bar in the upright position, on left side of the bed.Observation on 03/26/26 at 9:23 A.M., showed the resident in bed with a grab bar in the upright position, on left side of the bed.6. Review of Resident #70's Annual MDS, dated [DATE], showed staff assessed the resident as intact cognition and restraints not used.Review of the resident's medical record showed the record did not contain an entrapment assessment.Observation on 03/23/26 at 12:02 P.M., showed the resident in bed with quarter siderails in the upright position on both sides of the bed.Observation on 03/26/26 at 9:21 A.M., showed the resident in bed with quarter siderails in the upright position on both sides of the bed.7. During an interview on 03/25/26 at 4:32 P.M., the maintenance director said (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	he/she only installs the bedrails after the MDS coordinator says the assessment is completed. He/She said he/she only installs the bedrails. He/She said he/she thinks the MDS coordinator does the measurements after he installs them. During an interview on 03/26/26 at 8:44 A.M., the MDS coordinator said he/she only does the bed rail assessments. He/She said he/she does not do anything with measuring bed rails for entrapment. He/She said he/she thought maintenance does the measurements. He/She said he/she tells maintenance what rails to put on the bed and they have the form to fill out with measurements that they keep.During an interview on 03/26/26 at 2:36 P.M., the maintenance director said after the bed rail assessment is completed, he/she will go put the assist bar on the bed. He/She said he/she does not do any type of measurements when he/she puts the assist bars on the bed, he/she said he/she was never informed to do entrapment measurements. He/She said he/she was never instructed to go back and do any measurements with a mattress change or quarterly. He/She said entrapment assessments are important, so the resident's arm or neck does not get entrapped in the bed rail.During an interview on 03/26/26 at 3:22 P.M., the Director of Nursing (DON) said the MDS Coordinator and him/herself perform the bed rail assessment and inform maintenance to put the assist bars on the bed. He/She said maintenance is supposed to be doing entrapment measurements when he/she puts them on the bed. He/She said he/she was not aware maintenance was not doing entrapment measurements. The Administrator is responsible for ensuring that it is being completed. He/She said the importance of entrapment assessment is, so the resident does not get trapped or cause an injury. During an interview on 03/26/26 at 1:22 P.M., the administrator said he/she believes there was miscommunication about who is responsible for entrapment assessments. He/She said the MDS coordinator does the bed rail assessment, then maintenance is supposed to be doing the entrapment measurements when the rails are put on the bed. He/She said he/she was not aware that it was not being done. He/She said entrapment assessments are important to prevent rolling off the bed and injury.