STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265701	A. Building B. Wing	05/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St Joe Manor	10 Lake Drive Bonne Terre, MO 63628

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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 failed to store and distribute food under sanitary conditions, increasing the risk of cross-contamination and food-borne illness. This had the potential to affect all residents. The facility census was 147.Review of the facility's policy titled, Code of Dress and Personal Appearance, dated 2011, showed:- All Dining Services employees will comply with printed and posted personal hygiene and sanitation practices of this facility;- Hairnets, hair restraints, and beard guards shall be worn.Review of the facility's policy titled, Cleaning Instructions, dated 2011, showed:- The range will be cleaned and sanitized after each use, spills and food particles will be wiped up as they occur;- Ice machine and equipment will be kept clean and sanitized, according to the manufacturer's procedures if available, wipe down exterior with detergent solution, clean underneath and around the machine;- Kitchen floors will be swept and cleaned after each meal. At least once a month, large appliances will be moved to clean behind and underneath them;- Ceilings and walls will be cleaned and sanitized on a regular basis;- Both handheld and electric can openers will be cleaned following each use;- Check the dishwashing machine for cleanliness at least once a day, cleaning it as necessary.Review of the facility's policy titled, Refrigerator/Freezer Temperatures, dated 2011, showed:- If the temperature is outside the acceptable temperature range for safe food handling, the refrigerator/freezer will be emptied and foodstuff transferred to another refrigerator/freezer or discarded with Dining Services Manager's approval.Review of the facility's policy titled, Instructions on Fundamentals of a Safe Food Service, dated 2011, showed:- Right temperatures, cold (under 40 degrees Fahrenheit (ˆF) stops bacteria from growing, heat (over 135 ˆF) kills most bacteria, cold foods should be kept chilled, hot foods should be kept hot, foods should never be thawed on a counter or at room temperature.1. Observation on 05/17/26 at 12:23 P.M., of the kitchen showed:- Three unidentified dietary staff worked in food preparation areas without a hair restraint;- Dietary Aide (DA) S placed assorted deli style meats in storage bags without a hair restraint;- Seven approximately 10-pound plastic packages of pork loin thawed partially submerged in standing water in the three-compartment sink in the food prep area.During an interview on 05/17/26 at 12:25 P.M., DA S said the dietary workers were expected to follow the facility policy and should utilize hair nets. The other staff in the kitchen without hair restraints were part of the dietary department staff.During an interview on 05/17/26 at 12:29 P.M., the Dietary Supervisor said the frozen pork should have been placed in the walk-in refrigerator last night but wasn't done. It thawed today in the sink while the sink was plugged and filled with water. Staff did not leave the water running over the frozen food. The dietary workers should have worn hair restraints in the kitchen, and they were told to wear them.2. Observation on 05/17/26 at 12:27 P.M., and 05/19/26 at 2:23 P.M., of the kitchen showed:- The commercial dishwasher interior and exterior with flaky white grime (dirt ingrained on the surface of something) build-up;- The gas range with an oily grime build up and scattered food debris around each burner and on the floor beneath; - The ice machine with a white grime build-up on the exterior surfaces, ventilation louvers with a brown substance, a plastic drain line with black grime build-up, and scattered debris on the floor beneath;- One three quart dented can of spaghetti sauce, undated;- An approximate 5 foot (ft.) by 1 ft. section of ceramic flooring with (continued on next page)

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

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

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	white grime build-up below the three-compartment sink in the dishwashing area and the plastic drain pipes with a brown grime build up; - An approximate 2 ft. diameter section of damaged wallboard below the commercial dishwasher and a black grime build-up on the plastic drain pipes and floor below;- Two 4 inch (in.) x 4 in. ceramic tiles missing on the baseboard area wall sections in the dishwashing area near the exit door;- An approximate 4 ft. by 4 ft. section of the wall board peeled from the wall to the right of the dishwashing spray area near the corridor passageway;- Food debris and an oily film build-up on the floor beneath the range;- Three 2 ft. by 2 ft. ceiling diffusers (one of the few visible parts of an air conditioning system) with dust buildup and a brown substance on the front exterior surfaces and between the ventilation louvers;- The commercial style can opener with a worn cutting edge, oily film, and a black grime build-up.2. Observation of the serving area meal preparation on 05/18/26 at 12:20 P.M., showed:- DA T loaded plates onto food trays without a proper restraint for facial hair;- DA U scooped food from the steam table onto plates without a hair restraint. 3. Observation on 05/19/26 at 2:23 P.M., of the serving area showed:- An eight-ounce single serving milk container, dated 05/31/26, from the right-side reach in refrigerator at 45 ˆF;- Right side refrigerator at 58 ˆF filled with one crate of single serving milk containers;- Room temperature at 83 ˆF. Review of the facility's right side serving area Refrigeration/Freezer Temperature Log, dated May 2026, showed:- Evening refrigerator temperatures should range between 34 and 41 ˆF. - Evening temperatures on 05/01/26 and 05/02/26 not recorded, 05/03/26 at 48 ˆF, 05/04/26 at 48 ˆF, 05/05/26 at 48 ˆF, 05/06/26 at 38 ˆF, 05/07/26 at 50 ˆF, 05/08/26 at 46 ˆF, 05/09/26 at 46 ˆF, 05/10/26 at 40 ˆF, 05/11/26 at 50 ˆF, 05/12/26 at 50 ˆF, 05/13/26 at 52 ˆF, 05/14/26 at 48 ˆF, 05/15/26 at 48 ˆF, 05/16/26 at 50 ˆF, 05/17/26 at 44 ˆF, and 05/18/26 at 45 ˆF.During an interview on 05/19/26 at 2:27 P.M., DA V said the serving area room was always hot and it was hard to keep the refrigerator cooled down. The refrigerator door was left open at times, the room was warm due to the air conditioning vents not working, and the steam table and plate warmer were used in the area and made the room warmer. During an interview on 05/20/26 at 3:03 P.M., the Administrator, Dietary Manager and Dietary Supervisor said the dietary staff should be wearing hair restraints when working in the kitchen. There should not be missing tiles, the ceiling vents and all appliances should be cleaned. There were issues with water leaks in the dishwashing area causing problems and wall damage, but the walls should be intact. The refrigerator did not stay cold enough near the steam table because the air conditioner was unplugged. There were plans to add a new electrical outlet so it could be used to keep the room temperature lower. The milk and the reach-in refrigerator should be kept colder, and frozen meat should not be thawed in standing water. During an interview on 05/20/26 at 4:00 P.M., the Maintenance Assistant said he/she knew there were some missing floor tiles in the kitchen, and they had been noticed during inspections. He/She wasn't aware of wall damage under the dishwasher, but the walls should be kept intact, and vents should be clean. During an interview on 05/20/26 at 4:33 P.M., the Maintenance Supervisor said the Dietary Manager had mentioned the dishwashing area having issues with the floor and wall, the walls and floor should be kept intact, but it was always wet in that area and there were some problems. There were plans to replace the sprayer gasket. There were some holes in the wall where ceramic tiles should be replaced. The ceiling vents should be cleaned routinely but they had some dirt and dust built up.

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a plan that describes the process for conducting QAPI and QAA activities. Based on interview and record review, the facility failed to demonstrate evidence of maintaining an ongoing effective, comprehensive, data-driven Quality Assurance Performance Improvement (QAPI) program that focuses on indicators of the outcomes of care and quality of life. This had the potential to affect all residents residing in the facility. The facility's census was 147.Review of the facility's policy titled, QAPI Program, revised February 2020, showed:- This facility shall develop, implement, and maintain an ongoing, facility-wide, data-driven QAPI program that is focused on indicators of the outcomes of care and quality of life for our residents;- The objectives of the QAPI program are to provide a means to measure current and potential indicators for outcomes of care and quality of life, provide a means to establish and implement performance improvement projects to correct identified negative or problematic indicators, reinforce and build upon effective systems and processes related to the delivery of quality care and services, and establish systems through which to monitor and evaluate corrective actions;- The owner and/or governing board (body) of our facility is ultimately responsible for the QAPI program;- The governing board/owner evaluates the effectiveness of its QAPI program at least annually and presents findings to the QAPI committee;- The administrator is responsible for assuring that this facility's QAPI program complies with federal, state, and local regulatory agency requirements;- The QAPI committee oversees implementation of our QAPI plan, which is the written component describing the specifics of the QAPI program, how the facility will conduct its QAPI functions, and the activities of the QAPI committee;- The QAPI plan describes the process for identifying and correcting quality deficiencies. Key components of this process include tracking and measuring performance; establishing goals and thresholds for performance measurement; identifying and prioritizing quality deficiencies; systematically analyzing underlying causes of systemic quality deficiencies; developing and implementing corrective action or performance improvement activities; and monitoring or evaluating the effectiveness of corrective action/performance improvement activities, and revising as needed;- The committee meets monthly to review reports, evaluate data, and monitor QAPI-related activities and make adjustments to the plan;- The QAPI coordinator manages QAPI committee activities and changes to the QAPI plan;- The QAPI coordinator assists other committees, individuals, departments, and/or services in developing quality indicators, monitoring tools, assessment methodologies and documentation, and in making adjustments to the plan.Review of the facility's policy titled, QAPI Program - Design and Scope, revised August 2025, showed the facility QAPI program is ongoing, comprehensive, and addresses all care and services provided by the facility.Review of the facility's 2020 QAPI Plan, dated February 2020, showed:- Annual evaluation of the QAPI Plan by the administrator will ensure appropriate engagement of applicable QAPI practices;- The QAPI Committee will, on at least an annual basis, complete a plan to identify opportunities for improvement. The prioritization plan will consider factors such as high risk, high volume, problem prone areas that affect outcomes, and quality of care;- At a minimum, the executive leadership will report on the status of the current QAPI Plan, the proposed QAPI Plan, and goals for the coming year. This report will be made available to the corporate compliance committee, leadership, and staff;- No current QAPI Plan or goals.During an interview on 05/20/26 at 3:52 P.M., the Administrator said she hadn't updated the QAPI Plan annually, but she was trying to do better with the Performance Improvement Projects (PIPs). She had two open right now. The Medical Director wasn't usually at the quarterly meetings, but she would send him the meeting minutes after the meeting. Sometimes he would comment on it and sometimes not. During an interview on 05/20/26 at 6:08 P.M., the Administrator said she would expect the facility to have a current QAPI Plan.

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure treatment decisions, including hospice election and code status decisions, were made by the resident or a legally authorized representative. This failure affected one resident (Resident #7) out of 29 sampled residents. The facility census was 147.Review of the facility policy titled, Advanced Directives, revised September 2022, showed:- The resident has the right to formulate an advanced directive, including the right to accept or refuse medical or surgical treatment, advanced directives are honored in accordance with state law and facility policy;- Prior to or upon admission of a resident, the social services director (SSD), or designee inquires of the resident, his/her family members, and/or his or her legal representative about the existence of any written, advanced directives; - If the resident is incapacitated and unable to receive information about his or her right to formulate an advanced directive, the information may be provided to the resident's legal representative; - Upon admission, the interdisciplinary team assesses the resident's decision-making capacity and identifies the primary decision-maker if the resident is determined not to have decision making capacity; - The interdisciplinary team conducts ongoing review of the resident's decision-making capacity, and invokes the resident's representative or healthcare agent if the resident is determined not to have decision-making capacity, changes are documented in the care plan and medical record;- The plan of care for each resident is consistent with his or her documented treatment, preferences, and/or advanced directive. Review of Resident #7's medical record showed:- admission date of 03/12/20;- Diagnoses of moderate protein calorie malnutrition (inadequate intake or malabsorption of protein and calories), high blood pressure, mood affective disorder (a mental health condition that primarily disrupts emotional state), Alzheimer's disease (a progressive, irreversible brain disorder that slowly destroys memory, thinking skills, and the ability to carry out simple daily tasks), major depressive disorder (a severe mental health condition characterized by a persistent, overwhelming low mood, sadness, and a complete loss of interest in activities), schizophrenia (serious mental illness that affects how a person thinks, feels, and behaves), and dementia with mood disturbance (emotional, psychological, and personality changes that commonly occur alongside a decline in memory and thinking skills). Review of the resident's care plan, revised 05/18/26, showed:- The resident has no contact with family or has no family involvement, initiated 12/13/21;- Impaired cognitive function/dementia, impaired thought processes, disorganized thinking, inattention, and delusions related to dementia, initiated 04/28/20;- Resident has a psychosocial well-being problem and has no contact with family and there are no family members on file, has one friend down as a contact but has very little contact with this individual related to no family involvement, lack of family, initiated 12/13/21;- Resident receives hospice care related to stage four lung cancer, initiated 04/30/26;- Resident would like his/her code status to remain a full code, initiated on 11/02/21, and revised on 03/26/25. Review of the resident's Minimum Data Set (MDS - a federally mandated assessment instrument completed by the facility staff), showed:- admission MDS, dated [DATE], resident had a severely impaired cognition;- Significant change MDS, dated [DATE], resident had a severely impaired cognition. Review of the resident's Emergency Healthcare Directive, signed on 07/09/25, showed the resident gave a verbal response to remain a full code. Review of the Hospice Informed Consent Electing Hospice Care, dated 04/30/26, showed the form was signed by the Administrator. Review of the Do Not Resuscitate (DNR) request, dated 04/30/26, showed the form signed by the Administrator. Review of a Notarized Written Deposition, dated 11/20/25, showed the resident's physician indicated in the best interest of this person that a guardian be appointed to protect his/her person, and/or a conservator be appointed to manage his/her property. Observation of the resident on 05/17/26 at 2:46 P.M., showed the resident lay in bed with eyes opened and did not respond when spoken to.During an interview on 05/19/26 at 12:50 P.M., the SSD said the prior SSD instructed the (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	staff to obtain a written deposition to appoint a guardian for the resident. After this was completed, the staff found out the facility would have to pay for it and so this was not followed through with. During an interview on 05/19/26 at 1:45 P.M., the Administrator said she did not usually act as a resident's representative, in this case, after discussing the resident's condition with the resident's physician, the hospital, and the interdisciplinary team, she acted as the resident's representative by signing the code status form and the hospice form. She said corporate told her residents with a Brief Interview for Mental Status (BIMS, 13-15: no or very little cognitive impairment, 8-12: moderate cognitive impairment, and 0-7: severe cognitive impairment) score of less than 13 needed a Power of Attorney or a guardianship but she felt a resident had no rights after being assigned a guardian. During an interview on 05/20/26 at 2:35 P.M., Registered Nurse (RN) I said the resident could feed self and talk previously but could not recall a time when the resident was orientated but did feel the resident could understand things depending on the situation in the past. RN I said the resident only had a friend listed as a contact and he/she had previously expressed he/she did not feel comfortable making decisions on the resident's behalf. During an interview on 05/20/26 at 4:22 P.M., the Assistant Director of Nursing (ADON) said residents with severely impaired cognition should not sign consent forms. The responsible party should be contacted, if the resident did not have a next responsible party, then the hope would be that a guardian or another person would be assigned to make decisions for the resident. During an interview on 05/20/26 at 4:24 P.M., the Director of Nursing (DON) said when the resident was discharged from the hospital, the hospital ethics committee told the Administrator she could sign for the hospice care, and the resident left the hospital with an order for hospice. During a phone interview on 06/02/26 2:35 P.M., the resident's Physician P said the resident did meet the qualifications for hospice, would have to look more into the specifics of this situation to say for sure but would typically expect the resident, their guardian, or their Power of Attorney to sign documents on the resident's behalf, and was not aware the guardianship was not followed through.During a phone interview on 06/02/26 3:33 P.M., the hospice Office Administrator said when the Do Not Resuscitate request came into the office, he/she had an available physician sign the document and neither physician would necessarily know who signed as the resident's representative as these documents came to the office already signed.During a phone interview on 06/03/26 at 7:48 A.M., the Patient Safety and Quality Specialist for the hospital said they did not say the Facility Administrator could sign on the resident's behalf, they were told by the facility that they would use a two-physician authorization.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to notify the resident and/or the resident's representative in writing of a transfer to the hospital and failed to provide a copy of the bed-hold policy with the daily rate amount upon transfer to the hospital for six residents (Residents #1, #2, #4, #11, #114, and #123) out of 29 sampled residents. The facility's census was 147. Review of the facility's policy titled, Bed Holds and Returns, revised October 2022, showed: - Residents and/or representatives are informed (in writing) of the facility and state (if applicable) bed-hold policies; - All residents/representatives are provided written information regarding the facility and state bed-hold policies, which address holding or reserving a resident's bed during periods of absence (hospitalization or therapeutic leave). Residents, regardless of payer source, are provided written notice about these policies at least twice: well in advance of any transfer (e.g., in the admission packet); and at the time of transfer (or, if the transfer was an emergency, within 24 hours); - The written bed-hold notices provided to the residents/representatives explain in detail: the duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the facility; the reserve bed payment policy as indicated by the state plan (for Medicaid residents); the facility policy regarding bed-hold periods; the facility per-diem rate required to hold a bed (for non-Medicaid residents), or to hold a bed beyond the state bed hold period (for Medicaid residents}; and the facility return policy. Review of the facility's policy titled, Transfer or Discharge, Facility-Initiated, revised October 2022, showed: - The resident and representative are notified in writing of the following information: The specific reason for the transfer or discharge, including the basis under 483.IS(c)(l)(i}(A}-(F}; the effective date of the transfer or discharge; the specific location (such as the name of the new provider or description and/or address of the location) to which the resident is being transferred or discharged ; an explanation of the resident's rights to appeal the transfer or discharge to the state, including the name, address, email and telephone number of the entity which receives such appeal hearing requests; information about how to obtain an appeal form; and how to get assistance in completing and submitting the appeal hearing request; the Notice of Facility Bed-Hold and policies; the name, address, and telephone number of the Office of the State Long-term Care Ombudsman; the name, address, email and telephone number of the agency responsible for the protection and advocacy of residents with intellectual and developmental (or related) disabilities (as applies); the name, address, email and telephone number of the agency responsible for the protection and advocacy of residents with a mental disorder or related disabilities (as applies); and the name, address, and telephone number of the state health department agency that has been designated to handle appeals of transfers and discharge notices; - Notice of Transfer or Discharge (Emergent or Therapeutic Leave): When residents who are sent emergently to an acute care setting, these scenarios are considered facility-initiated transfers, not discharges, because the resident's return is generally expected; (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Under the following circumstances, the notice is given as soon as it is practicable but before the transfer or discharge: The health and/or safety of individuals in the facility would be endangered due to the clinical or behavioral status of the resident; the resident's health improves sufficiently to allow a more immediate transfer or discharge; an immediate transfer or discharge is required by the resident's urgent medical needs; or a resident has not resided in the facility for 30 days; - Notice of Transfer is provided to the resident and representative as soon as practicable before the transfer and to the long-term care (LTC) ombudsman when practicable; - Notice of Facility Bed-Hold and Return policies are provided to the resident and representative within 24 hours of emergency transfer. 1. Review of Resident #1's medical record showed:- The resident transferred to the hospital on [DATE], and returned to the facility on [DATE];- No documentation the written notification of the transfer or a copy of the bed-hold policy, including the daily rate amount, was provided to the resident and/or the resident's representative at the time of the transfer. 2. Review of Resident #2's medical record showed:- The resident transferred to the hospital on [DATE] and returned to the facility on [DATE]; - The resident was transferred to the hospital on [DATE], and returned to the facility on [DATE];- No documentation the written notification of the transfer or a copy of the bed-hold policy, including the daily rate amount, was provided to the resident and/or the resident's representative at the time of the transfer. 3. Review of Resident #4's medical record showed:- The resident transferred to the hospital on [DATE], and returned to the facility the same day;- No documentation the written notification of the transfer or a copy of the bed-hold policy, including the daily rate amount, was provided to the resident and/or the resident's representative at the time of the transfer. 4. Review of Resident #11's medical record showed: - The resident transferred to the hospital on [DATE], and returned to the facility the same day; - No documentation the written notification of the transfer or a copy of the bed-hold policy, including the daily rate amount, was provided to the resident and/or the resident's representative at the time of the transfer; - The resident transferred to the hospital on [DATE], and returned to the facility on [DATE]; - The resident transferred to the hospital on [DATE], and returned to the facility on the same day; - The resident transferred to the hospital on [DATE], and returned to the facility on [DATE]; - The resident transferred to the hospital on [DATE], and returned to the facility the same day; - The resident transferred to the hospital on [DATE], and returned to the facility the same day; - No documentation of the daily rate amount on the bed hold policies; (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- The resident transferred to the hospital on [DATE], and returned to the facility on [DATE]; - No documentation the written notification of the transfer or a copy of the bed-hold policy, including the daily rate amount, was provided to the resident and/or the resident's representative at the time of the transfer. 5. Review of Resident #114's medical record showed:- The resident transferred to the hospital on [DATE], and returned to the facility on [DATE];- No documentation the written notification of the transfer or a copy of the bed-hold policy, including the daily rate amount, was provided to the resident and/or the resident's representative at the time of the transfer. 6. Review of Resident #123's medical record showed:- The resident transferred to the hospital on [DATE], and returned to the facility on [DATE];- No documentation the written notification of the transfer or a copy of the bed-hold policy, including the daily rate amount, was provided to the resident and/or the resident's representative at the time of the transfer. During an interview on 05/20/26 at 3:00 P.M., the Director of Nursing (DON) said staff were supposed to do a progress note when someone went out to the hospital. They notified the family and gave the bed-hold policy. They sent it to the family or personal representative (PR) if the resident couldn't understand. They did a discharge assessment form. They printed two copies of the discharge record to send with Emergency Medical Services (EMS) and to give to the hospital. They should do the transfer/discharge notice for everyone who went out, even if it was just to the ER and they would likely come back soon. In looking at Resident #11's chart, it looked like some were missed. During an interview on 05/20/26 at 6:08 P.M., the Administrator, DON, Assistant Director of Nursing, and Social Services Director said they would expect written notification of transfers to be completed with transfers and discharges, including ER visits, and the bed-hold rate amount to be included. It would be the private pay rate, but it was not included on the bed-hold policy. The rate was included on the admission paperwork.

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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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. Based on observation, interview, and record review, the facility failed to obtain urinary catheter (a sterile tube inserted into the bladder to drain urine) orders for one resident (Resident #15) out of three sampled residents with a urinary catheter and failed to follow physician's orders for one resident (Resident #13) out of 29 sampled residents. The facility census was 147. Review of the facility policy titled, Catheter Care, Urinary, revised August 2022, showed: - Empty the collection bag at least every eight hours; - Review and document the clinical indications for catheter use prior to inserting; - Nursing and the interdisciplinary team should assess and document the ongoing need for a catheter that is in place; - Remove the catheter as soon as it is no longer needed. The facility did not provide a policy regarding gastrostomy tube (G-tube - a thin flexible tube surgically inserted through the abdomen into the stomach to provide fluids, nutrition and medications) orders. 1. Review of Resident #13's medical record showed: - admission date of 02/13/20; - Diagnoses of multiple sclerosis (MS - a chronic autoimmune disease of the central nervous system), gastrostomy status, protein calorie malnutrition (an inadequate intake of protein and calories for the body's needs) and dysphagia (difficulty swallowing). Review of the resident's physician order sheet (POS), dated 05/19/26, showed: - An order for nothing per mouth (NPO) diet, dated 08/31/25; - An order to check the G-tube placement four times a day prior to use by aspiration (medical procedure of removing fluids by suction), tube length 32 centimeters (cm) from stomach, or checking potential of hydrogen (pH - a measurement that indicates how acidic or basic a substance is) of gastric contents, dated 09/01/25; - An order for Baclofen (muscle relaxant) 10 milligrams (mg), one tablet crushed per G-tube three times a day, dated 02/14/26; - An order for Jevity (a brand of medical liquid nutrition) 1.5, 300 cubic centimeters (cc) at 110-150 milliliters (ml) per hour, three times a day as resident tolerates, hold for residual (volume of fluid and formula remaining in the stomach) greater than 150 ml, three times a day per G-tube, dated 04/22/26; - An order for 550 ml water flush four times a day per G-tube, dated 04/22/26. Observation on 05/19/26 at 8:00 A.M., showed Licensed Practical Nurse (LPN) M did not obtain gastric contents during aspiration, did not measure the tube length, and did not check the pH level (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	prior to administering Baclofen or before administering a 550 ml water flush or enteral (placed directly into the gastrointestinal (GI) tract) feeding. During an interview on 05/19/26 at 8:15 A.M., LPN M said if there was no residual and no gastric contents obtained with aspiration, he/she should check the G-tube placement by using a stethoscope (a medical device used to listen to internal sounds within the body). During an interview on 05/20/26 at 6:08 P.M., the Director of Nursing (DON) said she would expect staff to check placement of a G-tube before medication administration, especially if no gastric contents were aspirated. The facility just received litmus paper (specialized filter paper treated with a natural dye that acts as a pH indicator) and just recently educated staff on the need to check G-tube placement prior to using it. 2. Review of Resident #15's medical record showed: - admission date of 04/23/26; - Diagnoses of left tibia (larger, stronger, and inner bone of the lower leg) fracture, right tibia fracture, left fibula (long, slender bone located on the outer side of the lower leg) fracture, right fibula fracture, muscle weakness, cognitive communication deficit, history of falling, and stroke; - No order for a urinary catheter; - No order for urinary catheter care. Review of the resident's care plan, revised 04/30/26, showed the resident had an indwelling urinary catheter. Observation of the resident on 05/17/26 at 2:17 P.M., showed the resident lay in bed with a urinary drainage bag hanging on the side of the bed in a dignity bag. During an interview on 05/17/26 at 2:18 P.M., the resident's representative said the resident came from the hospital with the catheter and believed he/she had it because he/she couldn't get out of bed. During an interview on 05/20/26 at 2:35 P.M., Registered Nurse (RN) I said residents with urinary catheters should have an order for the catheter with the diagnosis for the catheter, and an order for catheter care. If no order was available, the physician would be contacted and either the catheter would be discontinued, or an order and diagnosis would be obtained. During an interview on 05/20/26 at 3:30 P.M., the Director of Nursing (DON) said residents with catheters should have an order for the catheter and catheter care. During an interview on 05/20/26 at 6:08 P.M., the Administrator said residents with catheters should have an order for the catheter.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. Based on interview and record review, the facility failed to ensure communication forms that reflected ongoing coordination and collaboration between facility staff and the dialysis (a life-sustaining medical treatment that filters waste, toxins, and excess fluids from the blood when the kidneys have failed) staff were sent with two residents (Residents #11 and #62) out of two sampled dialysis residents on all dialysis days and failed to ensure one resident (Resident #11) had an order for dialysis. The facility's census was 147. Review of the facility's policy titled, Dialysis, dated 03/25/20, showed: - Effective immediately: Anyone going to dialysis will bring a dialysis communication form with them that has the most recent vital signs or order changes for the patient on it as well as any concerns you may have; - The sheet is to come back with the patient after dialysis, and it should have any concerns or instructions from the dialysis center; - Please remember to send this each time the patient goes to dialysis. Check it upon return for any orders or concerns and place on the patient's chart; - Any patient on dialysis must have a dialysis order and treatment orders to check shunt (a small surgically implanted tube that diverts the flow of blood from one part of the body to another) or ports (a surgically created site that allows blood to be removed from the body). 1. Review of Resident #11's medical record showed: - admission date of 10/21/25; - Diagnoses of end stage renal disease (ESRD – the final, permanent stage of chronic kidney disease), muscle weakness, and dependence on renal dialysis. Review of the resident's Physician Order Sheet (POS), dated 05/20/26, showed: - An order to send Velphoro (a phosphate binder) 500 milligrams (mg) with the resident to dialysis on dialysis days in the morning every Monday, Wednesday, and Friday for phosphorus binder, dated 01/22/26; - No other orders related to dialysis. Review of the resident's care plan, revised 12/04/25, showed: - Dependence on renal dialysis related to renal failure; - Receiving dialysis three times weekly on Monday, Wednesday, and Friday; - Check and change dressing daily at dialysis access site; - Monitor the resident's vital signs as ordered by a physician or per facility policy; (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Monitor/Assess for signs and symptoms of infection, renal insufficiency, steal syndrome (complication where an arteriovenous (AV) fistula or graft steals blood away from the hand), edema (swelling), bruit (whooshing) and thrill (vibration). Review of the resident's progress notes showed: - On 01/26/26, dialysis was canceled; - On 02/09/26, the resident did not go to dialysis. Review of the resident's Dialysis Communication Forms, dated 01/01/26 through 05/20/26, showed forms not completed for a total of 56 out of 58 opportunities. During an interview on 05/20/26 at 1:10 P.M., Resident #11 said no one checked his/her shunt. When he/she got back from dialysis, staff didn't do anything. They just let him/her sleep. He/She sometimes got a communication form when going to dialysis. During an interview on 05/20/26 at 2:52 P.M., Licensed Practical Nurse (LPN) F said he/she did not do the dialysis communication form for Resident #11 this morning because he/she was late, but they should complete them and send them to dialysis with the residents. 2. Review of Resident #62's medical record showed: - admission date of 03/06/26; - Diagnoses of ESRD, granulomatosis with polyangiitis (a rare autoimmune disease that caused inflammation of the blood vessels, forming inflamed tissue masses) with kidney involvement, and dependence on renal dialysis. Review of the resident's POS, dated 05/20/26, showed: - Attends dialysis on Tuesday, Thursday and Saturday, assure breakfast prior to leaving; - Monitor signs and symptoms of steal syndrome every shift, report signs and symptoms to dialysis unit or physician; - Assess, monitor and report concerns to primary care physician (PCP) and dialysis center such as bruit, thrill, collateral vein distention (vein in access arm becoming larger), bruising, hematoma (collection of clotted blood that pools outside of a blood vessel), significant changes when compared to opposite extremity, every shift; - No blood pressure taken in the right arm; - Nurse to fill out the dialysis communication form and send to dialysis with the resident. Review of the resident's care plan, revised 03/06/26, showed: - Assess and monitor before and after dialysis treatments; (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Assess for bruit and thrill at access site; - Resident prefers to eat meals at facility before and after dialysis treatments; - Monitor for signs and symptoms of infection; - Monitor for signs and symptoms of steal syndrome; - No blood pressure to limb with access site; - Monitor weight daily. Review of the resident's progress notes showed no documentation of dialysis refusal. Review of the resident's Dialysis Communication Forms, dated 03/09/26 through 05/19/26, showed forms not completed for a total of 13 out of 32 opportunities. During an interview on 05/20/26 at 2:45 P.M., Registered Nurse (RN) I said the resident received breakfast before he/she left and a sack lunch; however, the resident normally would just eat here when he/she returned, about 11:45 A.M. RN I was not sure why the forms had not been filled out completely and why there were some missing. During an interview on 05/20/26 at 6:08 P.M., the Administrator, Director of Nursing, and Assistant Director of Nursing said they would expect dialysis communication forms to be filled out completely and on every dialysis day and for a resident who received dialysis to have orders for dialysis.

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observe each nurse aide's job performance and give regular training. Based on interview and record review, the facility failed to ensure two of three sampled Certified Nurse Aides (CNAs) received an annual performance review. The facility census was 147.Review of the facility's employee handbook, dated 12/08/23, showed:- Performance Improvement: The facility will make efforts to periodically review your work performance;- The performance improvement process will take place annually or as business needs dictate;- You may specifically request that your supervisor assist you in developing a performance improvement plan at any time.The facility did not provide a policy related to annual performance reviews.1. Review of CNA K's personnel file showed:- Hire date of 04/09/25;- No documentation of an annual performance review.2. Review of CNA L's personnel file showed:- Hire date of 05/08/25;- No documentation of an annual performance review.During an interview on 05/18/26 at 1:30 P.M., the Human Resources Director said the facility did not do performance reviews and if there was a write-up, then they would add those to their record.During an interview on 05/20/26 at 6:08 P.M., the Administrator and Director of Nursing (DON) said they would expect performance reviews for nurse aides to be completed at least once every 12 months. The DON also said they do performance education all year long.During an interview on 05/20/26 at 6:18 P.M., the DON said performance reviews had not been completed for CNA K or CNA L.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, interview, and record review, the facility failed to follow enhanced barrier precautions (EBP - precautions for use during high-contact resident care activities for residents infected with a multidrug-resistant organism (MDRO - microorganisms that are resistant to one or more classes of antimicrobial agents) or any resident who has a chronic wound and/or indwelling medical device) for two residents (Residents #13 and Resident #83) out of two sampled residents. The facility failed to follow proper infection control practices during incontinent care for two residents (Residents #1 and #154) out of three sampled residents. The facility also failed to provide appropriate infection control measures during medication pass for three residents (Residents #11, #14, and #86) out of six sampled residents and glucometer (a machine used to check blood sugars) cleaning for two residents (Residents #11 and #86) out of three sampled residents who required glucose monitoring. The facility census was 147. Review of the facility's policy titled, Enhanced Barrier Precautions, dated August 2022, showed: - EBPs are used as an infection prevention and control intervention to reduce the spread of MDROs to residents;- EBPs employ targeted gown and glove use during high contact resident care activities when contact precautions do not otherwise apply;- Examples of high-contact resident care activities requiring the use of gown and gloves for EBPs include: providing hygiene, changing briefs or assisting with toileting, device care or use (urinary catheter – a sterile tube inserted into the bladder to drain urine), and wound care. Review of the facility's policy titled, Handwashing/Hand Hygiene, revised October 2023, showed: - Hand hygiene is indicated immediately before touching a resident, before performing an aseptic (environment that is free from contamination by harmful microorganisms such as bacteria, viruses and fungi) task, after contact with blood, body fluids or contaminated surfaces, after touching a resident or resident's environment, before moving from soiled body site to clean body site and immediately after glove removal; - Use an alcohol-based hand rub containing at least 60 percent alcohol for most clinical situations; - Wash hands with soap and water when hands are visibly soiled and after contact with resident with infectious diarrhea; - Single use disposable gloves should be used before aseptic procedures, when anticipating contact with blood or body fluids, and when in contact with resident on contact precautions; - The use of gloves does not replace hand washing/hand hygiene. Review of the facility's policy titled, Perineal Care, revised February 2018, showed: - The purposes of this procedure are to provide cleanliness and comfort to the resident, to prevent infections and skin irritation, and to observe the resident's skin condition; - Steps in the Procedure: 1. Place the equipment on the bedside stand. Arrange the supplies so they can be easily reached. 2. Wash and dry your hands thoroughly. Put on gloves. 3. Fill the wash basin one-half (1/2) full of warm water. Place the wash basin on the bedside stand within easy reach. 4. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Fold the bedspread or blanket toward the foot of the bed. 5. Fold the sheet down to the lower part of the body. Cover the upper torso with a sheet. 6. Raise the gown or lower the pajamas. Avoid unnecessary exposure of the resident's body. 7. Put on gloves. 8. Ask the resident to bend his or her knees and put his or her feet flat on the mattress. Assist as necessary. 9. Discard disposable items into designated containers. 10. Remove gloves and discard into designated container. 11. Wash and dry your hands thoroughly. 12. Reposition the bed covers. Make the resident comfortable. 13. Place the call light within easy reach of the resident. 14. Clean wash basin and return to designated storage area. 15. Clean the bedside stand. 16. Wash and dry your hands thoroughly. Review of the facility's policy titled, Obtaining a Fingerstick Glucose Level, revised October 2011, showed: - Place the equipment on the bedside stand or overbed table, arrange the supplies so that they can be easily reached; - Always ensure that blood glucose meters intended for reuse are cleaned and disinfected between resident uses. Single-resident use fingerstick devices (pen-like devices) should never be used by more than one resident; - Wear clean gloves; - Wash the selected fingertip, obtain a blood sample, place drop of blood on reagent strip (diagnostic tool made of a plastic or paper strip embedded with chemical pads), wipe fingertip with cotton ball, dispose of the lancet (tiny, sterile pricking device used to draw small blood samples) in the sharps container; - Clean and disinfect reusable equipment between uses according to the manufacturer's instructions and current infection control standards of practice; - Remove gloves and discard into designated container; - Wash hands. Review of the facility's policy titled, Administering Medications, revised April 2019, showed: - Medications are administered in a safe and timely manner, and as prescribed; - Staff follow established facility infection control procedures (handwashing, antiseptic technique, gloves, isolation precautions, etc.) for the administration of medications, as applicable. Review of the Wipes Plus disinfecting wipes manufacturer's instructions, via www.wipesplus.com, revised 08/30/22, showed: - Use Wipes Plus disinfecting wipes to clean, sanitize, and disinfect commonly touched surfaces in one easy step. Kills 99.9% of bacteria and viruses, including the COVID 19 virus and cold and flu virus; - To disinfect - wipe surface and allow surface to remain wet for four minutes. 1. Observation on 05/18/26 at 6:15 P.M., of Resident #1's perineal care showed: (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Nurse Aide (NA) D and Certified Nurse Aide (CNA) E entered the room and put on gloves without washing hands; - NA D placed two bags at the end of the bed and both staff pulled the resident up using bed pad. NA D raised the bed with controller; - NA D pulled the resident's pant bottoms down and CNA E removed the resident's brief; - NA D cleaned the resident's perineal area and placed soiled washcloth in bag; - With the same soiled gloves, the resident was rolled toward CNA E, NA D obtained a clean washcloth and cleaned fecal material from the resident's buttocks; - NA D removed gloves, did not wash hands, and left the room to get more washcloths. CNA E covered the resident with sheet while waiting; - NA D returned to room, placed washcloths under running water, and put gloves on without washing hands; - CNA E removed sheet, NA D cleaned the resident's buttocks and CNA E placed the soiled brief in a trash bag; - With the same soiled gloves, NA D placed a clean brief under the resident, straightened bed pad, adjusted brief, straightened pillows and raised head of bed with controller; - CNA E tied up bags and with the same soiled gloves, both staff pulled sheet and blanket over the resident and NA D placed call light on resident's blanket within reach; - NA D and CNA E touched clean supplies, clean linens, the bed controller, call light, and resident care items with contaminated gloves after contact with urine and/or fecal material; - Both staff removed gloves and left the room without washing or sanitizing hands. During an interview on 05/18/26 at 6:30 P.M., NA D and CNA E said they should have removed gloves and washed hands between dirty and clean care, and before touching the clean sheets, blanket, call light, and bed controller. NA D said he/she was allergic to the facility soap but could use the sanitizer. NA D thought he/she used sanitizer before leaving the room and when he/she entered after getting more washcloths. 2. Observation on 05/18/26 at 7:02 P.M., of Resident #83's urinary catheter care showed: - CNAs A and B did not put on a gown, performed hand hygiene, and put on gloves;- CNA B leaned over the resident without a protective barrier and touched the resident with his/her clothing to tuck the lift pad underneath the resident;- CNA B did not use disinfectant wash or soap to disinfect the catheter during cleaning;- CNA B used washcloths to clean fecal material from the resident's back peri area;- CNA B did not change gloves or perform hand hygiene before applying a clean brief;- CNAs A and B removed gloves and did not perform hand hygiene. During an interview on 05/20/26 at 3:15 P.M., CNA B said he/she just forgot to put a gown on when (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	providing catheter care for Resident #83. Residents with wounds, catheters or any other opening were put on EBP. 3. Observation on 05/19/26 of the medication administration showed: - At 6:21 A.M., Certified Medication Technician (CMT) N did not perform hand hygiene prior to Resident #11's medication administration; - CMT N obtained medication from the cart, placed two tablets into a pill cup and administered the two tablets to Resident #11; - CMT N obtained two glucometers from the cart and laid them on top of the cart without a barrier; - CMT N, without performing hand hygiene, put on clean gloves and obtained a Wipes Plus disinfecting wipe from a container, wiped off both glucometers with the same wipe, did not wrap the glucometers so the surface remained wet for four minutes per the manufacturer's instructions, laid both glucometers back on the cart without a barrier, and removed gloves; - CMT N, without performing hand hygiene, put on clean gloves, obtained finger stick blood sugar (FSBS) and administered Resident #11's insulin; - CMT N obtained a disinfecting wipe, wiped off the glucometer, did not wrap the glucometer so the surface remained wet for four minutes per the manufacturer's instructions, and laid the glucometer back on the cart without a barrier; - CMT N used the same wipe on multiple glucometers, did not ensure the device remained visibly wet for the required four minute contact time, and returned the glucometer to service immediately after wiping. - CMT N did not perform hand hygiene after the medication administration; - At 7:00 A.M., CMT N did not perform hand hygiene prior to Resident #86's medication administration; - CMT N obtained 10 medications from the cart, placed them in a pill cup, obtained an inhaler from the cart, and administered the medications and inhaler to Resident #86; - CMT N, without performing hand hygiene, put on clean gloves, obtained a glucometer from the top of the cart, obtained a FSBS on Resident #86, removed gloves and washed hands; - CMT N obtained a disinfecting wipe, wiped off the glucometer, did not wrap the glucometer so the surface remained wet for four minutes per the manufacturer's instructions, lay the glucometer back on the cart without a barrier and did not perform hand hygiene; - At 7:01 A.M., CMT N did not perform hand hygiene prior to Resident #14's medication administration; - CMT N obtained 10 medications from the cart, placed them in a pill cup and administered the medications to Resident #14; - CMT N did not perform hand hygiene after the medication administration. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 05/19/26 at 7:15 A.M., CMT N said he/she should wash or sanitize his/her hands prior to and after medication administration. Glucometers should be disinfected per the Wipes Plus disinfecting wipes instructions. 4. Observation on 05/19/26 at 6:31 A.M., of Resident #154's peri care showed: - CNA G washed his/her hands in the resident's restroom, left the room to get a basin and washcloths, filled the basin with water, placed it on the resident's bedside table, lay a trash bag on the floor, and without performing hand hygiene, put on clean gloves; - NA H, without performing hand hygiene, pulled gloves from his/her pocket and put them on after moving the resident's wheelchair from between the resident's bed and wall; - CNA G cleaned the resident's front peri area with a washcloth and placed in a trash bag on the floor; - With the same soiled gloves, CNA G turned the resident toward himself/herself and, touched the resident's back, held the resident in place as NA H wiped fecal material from the resident's buttocks, then NA H removed gloves; - CNA G told NA H that he/she needed to wash his/her hands. NA H threw gloves in trash and washed hands in the resident's restroom; - CNA G removed gloves, left the room to retrieve a box of gloves and, without performing hand hygiene, put on clean gloves, then NA H put on clean gloves; - NA H put a new bed pad on the bed, rolling it under the dirty pads. Both CNA G and NA H rolled the resident toward NA H as CNA G pulled the dirty bed pads out and placed them in the trash bag on the floor and rolled the clean bed pad out under the resident; - With the same soiled gloves, CNA G obtained a clean washcloth from the basin and washed the resident's buttocks again; - Both staff removed gloves and left the room, with CNA G carrying the bag of dirty linens to the cart in hall. During an interview on 05/19/26 at 6:51 A.M., NA H said he/she did not wash his/her hands prior to starting, but he/she should wash before, between dirty and clean care, and after care. CNA G agreed and said he/she should not have cleaned the resident and then touched the resident with the same dirty gloves. 5. Observation on 05/19/26 at 8:00 A.M., of Resident #13's gastrostomy tube (g-tube – a tube surgically inserted into the stomach to provide hydration, nutrition, and medications) medication administration showed: - EBP signage on the resident's door; - Licensed Practical Nurse (LPN) M entered the resident's room and washed his/her hands, then exited the room; (continued on next page)

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	265701	A. Building B. Wing	05/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St Joe Manor	10 Lake Drive Bonne Terre, MO 63628

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- LPN M obtained a medication tablet from the medication cart, placed it into a plastic sleeve, crushed the medication in the sleeve, placed his/her bare finger into the plastic sleeve to open it and dumped the medication into a small plastic cup; - LPN M entered the resident's room, did not put on a gown for EBP, washed hands, put on clean gloves, and filled the plastic cup containing the medication with water; - LPN M filled a graduated cylinder (container used to measure liquid) with 550 milliliters (ml) of water and placed it, along with the plastic cup containing the medication, on the bedside table, - LPN M obtained a syringe from the package, connected it to the g-tube, removed the plunger from the syringe and administered the crushed medication mixed with water to gravity flow; - LPN M flushed the g-tube with 550 ml of water to gravity flow and closed the g-tube stopper; - LPN M removed gloves and washed his/her hands; - LPN M poured the enteral feeding into the bag, primed the tubing and connected the tubing to the resident's g-tube, started the feeding tube pump and washed hands. During an interview on 05/19/26 at 8:15 A.M., LPN M said he/she should wear a gown and gloves for EBP. During an interview on 05/20/26 at 6:08 P.M., the Administrator and Director of Nursing (DON) said they would expect staff to wash/sanitize their hands prior to and after medication administration, for glucometers to be cleaned/sanitized per manufacturer's directions and for staff to wear a gown and gloves if needed for g-tube medication.

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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 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Regularly inspect all bed frames, mattresses, and bed rails (if any) for safety; and all bed rails and mattresses must attach safely to the bed frame. Based on observation, interview, and record review, facility staff failed to conduct regular inspections of all bed frames, mattresses, and side rails as part of a regular maintenance program for three residents (Residents #52, #96, and #154) out of 29 sampled residents with side rails. The facility's census was 147. Review of the facility's policy titled, Bed Safety and Bed Rail, revised September 2025, showed: - The resident's sleeping environment is evaluated by the interdisciplinary team; - Consideration is given to the resident's safety. Medical conditions, comfort and freedom of movement, as well as input from the resident and family regarding previous sleeping habits and bed environment; - Bed frames, mattresses, and bed rails are checked for compatibility and size prior to use; - Bed dimensions are appropriate for the resident's size; - Regardless of mattress type, width, length, and/or depth, the bed frame, bed rail, and mattress will leave no gap wide enough to entrap a resident's head or body. Any gaps in the bed system are within safety dimensions established by the Food and Drug Administration (FDA - a federal public health agency that promotes public health by ensuring safety, efficacy, and security of human, veterinary drugs, biological products, medical devices and the nation's food supply); - Maintenance staff routinely inspect all beds and related equipment to identify risks and problems including potential entrapment risks; - The maintenance department provides a copy of inspections to the Administrator and reports results to the Quality Assurance Performance Improvement (QAPI) committee for appropriate action; - Any worn or malfunctioning bed system components are repaired or replaced using components that meet manufacturer's specifications; - Bed rails are properly installed and used according to the manufacturer's instructions, specifications, and other pertinent safety guidance to ensure proper fit; - Additional safety measures are implemented for residents who have been identified as having a higher than usual risk for injury including bed entrapment; - The facility's education and training activities will include instruction about risk factors for resident injury due to beds and strategies for reducing risk factors for injury, including entrapment. 1. Review of Resident #52's medical record showed:- An order for quarter upper side rail bilateral (both sides) for repositioning and transfers, dated 11/14/25;- A side rail consent, signed 03/25/26;- Bed Rail Measurement assessment, completed 03/25/26;- Side Rail Resident assessment, completed 03/25/26;- Side rail use addressed on the care plan, revised 03/25/25. (continued on next page)

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F 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 05/17/26 at 3:26 P.M., showed the resident used the right side rail to assist himself/herself to stand and the rail moved with minimal effort from the resident. During an interview on 05/17/26 at 3:26 P.M., the resident said he/she used the side rails on the bed to help with transfers from the bed and from the chair. The resident said the right rail had been loose for a while. The resident said he/she couldn't remember if any staff were notified that the rail was loose. 2. Review of Resident #96's medical record showed:- An order for one quarter, right, upper side rail for repositioning and transfers, dated 07/14/25;- A side rail consent, signed 04/09/26;- Bed Rail Measurement assessment, completed 04/09/26;- Side Rail Resident assessment, completed 04/16/26;- Side rail use addressed on the care plan, revised 05/06/26. Observations showed: - On 05/17/26 at 3:15 P.M., the resident lay in bed with his/her eyes closed and the one quarter rail up on right side of the bed; - On 05/19/26 at 2:50 P.M., the one quarter rail was up on the right side of the bed while the resident was out of the room. The rail was able to be moved with minimal effort. 3. Review of Resident #154's medical record showed:- An order for one quarter upper side rail bilateral for repositioning and transfers, dated 04/27/2026;- A side rail consent, signed 01/26/26;- Bed Rail Measurement assessment, completed 02/26/26;- Side Rail Resident assessment, completed 04/27/26;- Side rails addressed on the care plan, revised 03/20/26. Observation on 05/19/26 at 6:31 A.M., showed the resident turned toward Certified Nurse Aide (CNA) G during peri-care and grabbed the bed rail. The bed rail moved with minimal effort and tilted in toward the bed as the resident held it. During an interview on 05/20/26 at 10:45 A.M., the resident said the right side rail was broken. He/She didn't know when the staff came around to check the side rails. He/She used the bed rails to help turn over in bed and when staff changed him/her. During an interview on 05/20/26 at 9:20 A.M., the Maintenance Supervisor said the Quality Assurance (QA) Nurse and the Housekeeping Supervisor did the side rail assessments. They checked for the correct size, fit, and tightened the side rails. During an interview on 05/20/26 at 9:22 A.M., the Housekeeping Supervisor said the QA Nurse will see if bed rails were a good fit for the resident and would give him/her a work order. He/She would then put rails on and tighten them. He/She said they were tightened twice a month. During an interview on 05/20/26 at 9:25 A.M., the QA Nurse said he/she would write work orders for side rails and assess them for tightness when the checks were completed, which were every three months. Staff were not allowed to put on or take off bed rails. He/She would assess for those who need it and, if they were no longer needed, the rails were taken off. Some bed rails didn't fit very well. If they were found to be loose, then a work order would be put in, and they would get tightened, but some seemed to get loose again. (continued on next page)

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F 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 05/20/26 at 6:08 P.M., the Administrator, Director of Nursing, Assistant Director of Nursing, and the Social Service Director said they would expect bed rails to be tight and secure. Maintenance or Housekeeping would tighten the rails after staff filled out a maintenance request.

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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 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. Based on observation, interview, and record review, the facility failed to include the actual hours, and total hours worked per shift for licensed and unlicensed staff responsible for resident care and failed to include the daily census for four of the four observed days. The facility census was 147.Review of the facility's policy titled, Posting Direct Care Daily Staffing Numbers, revised August 2022, showed:- Our facility will post on a daily basis for each shift nurse staffing data, including the number of nursing personnel responsible for providing direct care to residents;- Shift staffing information is recorded on a form for each shift. The information recorded on the form shall include the following:a. The name of the facility;b. The current date;c. The resident census for the beginning of the shift for which the information is posted;d. Twenty-four-hour shift schedule operated by the facility;e. The shift for which the information is posted;f. Type (Registered Nurse (RN), Licensed Vocational Nurse (LVN), Certified Nurse Aide (CNA)) and category (licensed or non-licensed) of nursing staff working during that shift who are paid by the facility (including contract staff);g. The actual time worked during that shift for each category and type of nursing staff and;h. Total number of licensed and non-licensed nursing staff working for the posted shift.Observations of the staffing sheet taped to the window between the 500 and 600 Halls showed:- On 05/17/26 at 4:37 P.M., 05/18/26 at 3:00 P.M., 05/19/26 at 7:30 A.M., and 05/20/26 at 8:45 A.M., staffing data posted did not include actual and total hours worked per shift for licensed and unlicensed staff or the census.During an interview on 05/20/26 at 8:50 A.M., Employee J said he/she made and posted the daily staffing data sheets, and they should probably have the total and actual hours worked per shift for licensed and unlicensed staff and they should include the daily census. He/She was told in the past that there was no need to include the actual and total hours worked.During an interview on 05/20/26 at 6:08 P.M., the Administrator and Director of Nursing (DON) said they would expect the daily staffing data posting to include the total and actual hours worked per shift for licensed and unlicensed staff and for the posting to include the census.