| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 265719 | A. Building<br>B. Wing | 02/04/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Amberwood Estates Nursing and Rehabilitation | 5303 Bermuda Drive<br>Saint Louis, MO 63121 |

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| F 0584<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>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.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure the residents had a homelike environment by failing to maintain a comfortable sound level throughout the facility, failed to maintain adequate hot water temperatures for three residents (Resident #67, #5 and #6) and failed to thoroughly clean one resident's room (Resident #42). The sample was 22. The census was 83.<br><br>Review of the facility's Environment of Care policy, dated 4/1/22, showed:<br><br>-The facility staff will provide a safe, clean, comfortable and homelike environment;<br><br>-The facility will provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior;<br><br>-The facility will provide for the maintenance of comfortable sound levels.<br><br>1. Observation and interviews during the meal service on 1/29/26 at 11:45 A.M., showed approximately 30 residents ate in the dining room. A fire exit door was located in the dining room. At 11:51 A.M., the alarm sounded. The sound was extremely loud. No staff responded to the alarm. The alarm sounded for approximately two minutes before a staff responded to the alarm. At 11:52 A.M., the alarm sounded again. The alarm continued to go on and off until 11:58 A.M., when the Activity Director (AD) entered the code into the alarm to turn it off. The AD said the plates to the door were not connecting, causing the alarm to constantly sound. The plates were not connecting due to the cold weather. During interviews with residents in the dining room, residents said the alarms were constantly sounding. One resident said This is so annoying and it's constant. Can't you all do something about this?<br><br>Observations during the survey from 1/29/26 through 1/30/26 and 2/2/26 through 2/4/26, showed alarms throughout the facility continued to sound throughout the days.<br><br>During an interview on 2/3/26 at 1:41 P.M., the Administrator said the alarms have been sounding continuously since she started working at the facility in October 2025. The alarms sounding off constantly was not homelike. The Maintenance Director ordered parts to repair the alarm.<br><br>2. Review of Resident #67's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by the facility staff, dated 11/19/25, showed:<br><br>-Cognitively intact;<br><br>(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 0584<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | -Dependent on staff for bathing and personal hygiene;<br><br>-Diagnoses included heart failure and high blood pressure.<br><br>Review of the care plan, in use at the time of survey, showed:<br><br>-Focus, resident had an Activities of Daily Living (ADL, grooming, dressing, bathing) self-care deficit;<br><br>-Goal, the resident will improve current level of function through the review date;<br><br>-Interventions, assist times one staff for a bed bath, twice a week and as needed as requested.<br><br>During an interview on 1/29/26 at 9:51 A.M., the resident said he/she had not been taking his/her shower lately because the water was cold. The water had been cold since it got cold outside.<br><br>Observation on 1/29/26 at 9:51 A.M., showed when the resident's sink faucet was turned on to cold, no cold water came out of the faucet. When the hot water ran continuously for two minutes, the temperature (T) of the hot water measured 58.9 degrees Fahrenheit (F) with a calibrated digital thermometer.<br><br>3. Review of Resident #5's admission MDS, dated [DATE], showed:<br><br>-Cognitively intact;<br><br>-Dependent on staff for bathing and personal hygiene;<br><br>-Diagnoses included anxiety, depression and post-traumatic stress disorder (PTSD).<br><br>Review of the care plan, in use at the time of survey, showed:<br><br>-Focus, resident had an ADL self-care performance deceit;<br><br>-Goal, the resident will maintain/improve level of functioning through the review date;<br><br>-Intervention, the resident is totally dependent on two staff to provide bath/shower and as necessary.<br><br>During an interview on 1/29/26 at 9:30 A.M., the resident said the facility only had hot water sometimes.<br><br>Observation on 1/29/26 at 9:30 A.M., showed when the resident's sink faucet was turned on to cold, no cold water came out of the faucet. When the hot water ran continuously for two minutes, the T of the hot water measured 52.0 degrees F with a calibrated digital thermometer<br><br>During an interview on 2/2/26 at 6:30 A.M., Certified Nurse Aide (CNA) B said some of the rooms did not have hot water since it got cold outside. He/She got hot water from the eye wash station for the residents to use for care.<br><br>(continued on next page) |

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| F 0584<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | 4. Review of Resident #6's comprehensive MDS dated [DATE], showed:<br><br>-Cognitively intact;<br><br>-No rejection of care;<br><br>-Very important in choosing between a shower, tub bath, bed bath and sponge bath;<br><br>-Required substantial/maximal assistant with shower/bathing;<br><br>-Diagnoses included renal failure, neurogenic bladder (loss of bladder control caused by a nerve damage from a medical condition or injury that affects the brain, spinal cord or nerves) and paraplegia.<br><br>Observation on 1/29/26 at 9:26 A.M., showed the resident's water in his/her room sink ran for approximately three minutes. The water never got warm and was cool to the touch.<br><br>During an interview on 1/29/26 at 9:27 A.M., the resident said the water in his/her room had not worked in several months. The shower rooms on the unit he/she resides on do not have hot water.<br><br>During an interview on 2/3/26 at 11:09 A.M., CNA G said the resident had not been showered on a regular basis due to the water on the unit being cold. When CNA G worked, he/she offered to take residents to a different unit for a shower. Due to the cold water on the unit, the residents on the unit were not receiving at least two showers or bed baths per week.<br><br>During an interview on 1/29/26 at 10:37 A.M., the facility Maintenance Director said there had been an issue with water temperature levels in some of the rooms and he had been investigating the issue for about a week. Initially circulation pumps in the facility were down and replaced by the Maintenance Director, establishing hot water circulation, but some resident rooms were still not receiving hot water. A number of the rooms were able to be adjusted appropriately via the mixing valves at the sinks, but many resident rooms continued having issues with water temperature levels. The Maintenance Director was now going room by room to investigate the sink-side piping in each resident room to determine the issue. The hot water temperatures should be between 108 degrees Fahrenheit but no higher than 115 degrees Fahrenheit, as indicated by the set temperature gauge at the main water heater distribution valve.<br><br>5. Review of Resident #42's quarterly MDS, dated [DATE], showed:<br><br>- Diagnoses included Parkinson's disease without dyskinesia (neurodegenerative disorder without erratic movements), with fluctuations and other lack of coordination and mild depression;<br><br>- No behaviors.<br><br>Review of the resident's care plan, in use during the survey, showed:<br><br>-Focus: ADL self-care performance deficit related to stroke with residual effects;<br><br>-Goal: Will have needs met daily through the review period;<br><br>(continued on next page) |

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| F 0584<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Interventions: Staff assistance to the extent needed to accomplish task.<br><br>Observations on 1/30/26 at 8:41 A.M., 2/2/26 at 10:25 A.M. and 2/3/26 at 9:50 A.M., of the resident's room and bathroom, showed:<br><br>- The perimeter of the room's walls had multiple small, dark pellet-like substances scattered along the floor surface and within crevices adjacent to the wall and furniture base;<br><br>- Accumulated dirt and debris along the perimeter of the room;<br><br>- The bathroom toilet had visible brown staining and streaking on the exterior porcelain surface of the toilet base, extending vertically down the front of the fixture. Accumulated dirt and discoloration was around the base of the toilet where it met the flooring, with darkened residue and debris noted along the perimeter of the toilet base. The flooring immediately surrounding the toilet base was soiled and discolored.<br><br>During an interview on 1/30/26 at 8:43 A.M., the resident said housekeeping staff entered the room and mopped briefly, but did not do a thorough cleaning.<br><br>6. During an interview on 2/4/26 at 2:55 P.M., the Administrator said she expected the facility to provide a safe, clean, comfortable and homelike environment.<br><br>1594432<br><br>1594427<br><br>2679753<br><br>2566067 |

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| F 0585<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances.<br><br>Based on observation, interview and record review, the facility failed to identify a grievance official responsible for overseeing the grievance process. In addition, the facility failed to post signage informing residents of the location of grievance forms or the process for filing grievances orally, in writing or anonymously. This deficient practice had the potential to affect all residents in the facility. The census was 83.Review of the facility's grievance policy, dated 4/1/2022, showed:-Policy: Of this facility to provide residents, resident representatives, family and visitors with methods of sharing grievances and/or concerns with the facility;-Procedure: -The facility will have Grievance Forms available 24 hours per day , 7 days per week in an unsecured common area. The facility will notify the resident individually and/or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing and the right to file grievances anonymously. -Grievance Official: Is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances (for example, the identity of the resident for those grievances submitted anonymously); issuing written grievance decisions to the resident and coordinating with state and federal agencies as necessary in light of specific allegations; -Grievance Official: Shall be considered the Social Services Director unless otherwise indicated or directed by the Executive Director/Nursing Home Administrator/Risk Manager. The Grievance Official will have their name, business address (mailing and email) and a business phone number posted in prominent locations throughout the facility. The facility Grievance Official can be contacted by calling the facility during week day, day time business hours or contacting the NHA,/Executive Director for evenings, weekends, holidays or other times when the designated Grievance Official may not be present in the facility; -The Individual filing the grievance has the right to a reasonable expected time frame for completing the review of the grievance, being kept apprised of progress toward a resolution and a right to obtain a written decision regarding his or her grievance. - Staff will assist residents/resident representatives/visitors who cannot write or who choose not to write if they request to file a formal grievance. Grievances that are verbally noted by a staff member will be recorded utilizing the facility Grievance Form (on paper or entered in the electronic grievance tracking system form).During a group interview on 1/30/26 at 10:30 A.M., eight residents, who the facility identified as alert and oriented, attended the group meeting. All eight residents did not know where the grievance form was located. Six residents did not know how to file a grievance if one was located. All in attendance did not know who the Grievance Official was. The previous Grievance Official was the Social Worker, but the facility did not have a Social Worker. Six residents said they did not know who else to go to for grievances or concerns. Observations on 1/29/26 through 2/4/26, showed: - -Grievance forms not readily accessible to residents;- -No visible information posted identifying who the Grievance Officer was, where the forms were located or how residents could file grievances orally, writing or anonymously; - -Grievance forms were observed in the receptionist's office, behind a desk in an unmarked folder and were provided only upon request;- -The receptionist's office was kept locked at night.During an interview on 1/30/26 at12:22 P.M., the front desk staff H, said residents requesting to file a grievance were directed to the receptionist desk to obtain a grievance form. Front desk staff H said if a resident required assistance completing the form, the resident was referred to the social worker. Front desk staff H said the facility did not have a social worker at the time of the interview and residents requiring assistance were referred to the Human<br><br>(continued on next page) |

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| F 0585<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Resource (HR) office. Front desk staff H said his/her involvement ended at that point and he/she was not aware of what occurred with the grievance after the resident was referred.Observations during the investigation on 1/29/26 through 2/4/26, showed Grievance forms were not readily accessible to residents. No visible information was posted identifying who the Grievance Officer was, where the forms were located or how residents could file grievances orally, in writing or anonymously. Grievance forms were observed in the receptionist's office, behind a desk in an unmarked folder and were provided only upon request. The receptionist's office was kept locked at night.During an interview on 1/30/26 at12:30 P.M., the Human Resource (HR) Manager said grievance forms were turned in to her because the facility did not have a social worker at the time of the interview. The HR Manager said if additional assistance was needed, she requested support from the Activity Director. The HR Manager said if a grievance could not be resolved, the grievance was forwarded to the Administrator or the Director of Nursing. The HR Manager said her involvement ended once the grievance was forwarded. The HR Manager said she did not know who was designated as the grievance officer and assumed the social worker would serve in that role. During an interview on 2/4/26 at 2:10 P.M., the administrator said she expected the facility to have signage posted identifying the Grievance Officer and to have grievance forms freely accessible to resident, family members, and visitors without requiring staff assistance. The administrator said the grievance process should allow grievances to be filed anonymously. |

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| F 0628<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies.<br><br>Based on interview and record review, the facility failed to provide residents and/or resident representatives a bed hold policy at the time of transfer or as soon as practicable when residents were transferred to the hospital. In addition, the facility failed to send a copy of discharge notices to the representative of the Office of State Long Term Care (LTC) Ombudsman. The census was 83.Review of the facility's Transfer and Discharge policy, dated 4/1/22, showed:-30-day facility-initiated discharge (notice requirements before transfer/discharge):--The facility must send a copy of the discharge notice to a representative of the Office of the State LTC Ombudsman;-Planned discharges and transfer to the hospital: If the facility initiates the discharge, a copy of the notice of intent to transfer or discharge should be sent to the Office of the State LTC Ombudsman;--Unplanned discharges/emergency transfer to hospital: In situations where the facility has decided to discharge the resident while the resident was still hospitalized , the facility will send a copy of the discharge notice to a representative of the Office of the State LTC Ombudsman. Review of the facility's Ombudsman notifications showed the last notification was provided in July 2025. Review of the facility's discharge report, dated 4/18/24 through 2/2/26, showed from 9/1/25 through 2/2/26, 31 residents were transferred to acute care hospitals, 15 residents discharged home, and three residents discharged to another facility. During an interview on 1/23/26 at 1:27 P.M., the Ombudsman representative said the last transfer log he/she received was from August 2025. During an interview on 2/3/26 at 9:15 A.M., the Administrator said the nurse on the floor was responsible for giving the resident and/or resident representative the facility's bed hold policy when a resident was transferred to the hospital. The facility did not have the bed holds documentation for resident's who were transferred to the hospital, and they did not have a copy of the notices of discharges after July 2025. During an interview on 2/4/26 at 2:50 P.M., the Administrator said she would expect for the bed hold policy to be given at the time of transfer, and she would expect the Ombudsman be provided the notice of discharge monthly. |

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| F 0677<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide care and assistance to perform activities of daily living for any resident who is unable.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure residents who required assistance with activities of daily living (ADL) care received at least two showers weekly for three of 22 sampled residents (Residents #80, #6, and #67). The census was 83.Review of the facility's Showering/Bathing policy, dated 4/1/22, showed:-Policy: It will be the policy of this facility to assure that showers/bathing are offered to residents at least two times weekly or per resident/resident representative preference unless specifically ordered otherwise by the physician or care planned otherwise;-A schedule will be developed for each resident with showers (or bed bath or alternate means of bathing) according to room placement or resident preferences;-Certified Nursing Assistants (CNAs)/Nursing staff should complete the assignment sheet/shower sheet or POC electronic documentation on each day shower/bathing is provided-Refusals for showers/bathing should be reported to the licensed nursing staff;-If a resident desires an alternative shower/bathing schedule it is their right to have an alternative shower/bathing schedule that fits their individualized needs and efforts should be made to accommodate these wishes once the staff are notified of the desired changes During an interview on 2/4/26 at 8:55 A.M., the shower schedule was requested. As of 2/4/26 at 4:00 P.M., no shower schedule was provided. 1. Review of Resident #80's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 10/30/25, showed:-Moderate cognitive impairment;-No behaviors;-Mobility device: walker;-Independent with toileting and personal hygiene, shower or bath, upper and lower body dressing;-Required assistance in eating and oral hygiene;-Diagnoses included high blood pressure, stroke, non-Alzheimer's dementia, depression, and generalized muscle weakness. Review of the resident's care plan, in use at time of survey, showed:Focus: The resident requires assistance with mobility/transfers and requires equipment;Goal: The resident will have their transfer and mobility needs met with the necessary equipment and assistance;-Interventions: [NAME] type - rollator;-Focus: The resident has an ADL (activities of daily living) self-care performance deficit related to impaired mobility, he/she bilateral lower extremities edema (swelling);-Goal: The resident will maintain or improve level of functioning;-Interventions: Bathing/showering - avoid scrubbing and pat dry sensitive skin, check nail length, trim, and clean on bath days and as necessary. Requires limited assistance of one staff with showering twice weekly and as necessary;-Focus: The resident has potential for impairment to skin integrity;-Goal: The resident will maintain or develop clean and intact skin;-Intervention: Monitor and report to physician for any sign and symptoms of skin breakdown. Review of the resident's Shower Sheet/Skin Condition forms, showed:-October 2025: Shower or bed bath completed 10/21/25;-November 2025: Shower or bed bath completed on 11/11/25 and 11/14/25;-December 2025: Shower or bed bath completed on 12/16/25;-January 2026: Refused shower or bed bath on 1/16/25. Observation and interview on 1/29/26 at 9:26 A.M., showed the resident with long, messy and greasy hair with a strong body odor. He/She said he/she got showers every two weeks or once a month. He/She tried to have showers once a week but there were not enough shower rooms for everybody. They all used the same shower room. He/She needed assistance to go to the shower room but was able wash self independently. Observation and interview on 1/30/26 at 9:15 A.M., showed the resident wore a baseball cap, uncombed and greasy hair. He/She said he/she had not had a shower for a while now. Observation on 2/3/26 at 12:21 P.M., showed the resident continued to wear a baseball cap and wore the same clothes from the day prior. During an interview on 2/3/26 at 5:32 P.M., the Assistant Director of Nursing (ADON) said the residents should have showers at least twice a week. The staff fill out the shower sheets when providing residents' showers. It should be documented when resident refused. Resident<br><br>(continued on next page) |

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| F 0677<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | #80 refused showers at times. 2. Review of Resident #6's comprehensive MDS, dated [DATE], showed:-Cognitively intact;-No rejection of care;-Very important in choosing between a shower, tub bath, bed bath and sponge bath;-Required substantial/maximal assistant with shower/bathing;-Diagnoses included renal failure, neurogenic bladder (loss of bladder control caused by a nerve damage from a medical condition or injury that affects the brain, spinal cord or nerves) and paraplegia. Review of the resident's care plan, revised 1/7/25, in use during the time of the investigation, showed:-Focus: The resident prefers to have a bed bath daily;-Goal: The resident prefers to have a bed bath through review date;-Interventions: The resident prefers to have a bed bath but no preference on the time of day. Review of the resident's Skin Monitoring: Comprehensive CNA Shower Review, showed:-November 2025: Shower or bed bath completed 11/1/25, 11/12/25, 11/22/25 and 11/28/25;-December 2025: Shower or bed bath completed 12/6/25, 12/13/25, 12/24/25 and 12/31/25. Review of the resident's Shower Sheet/Skin Condition Reports for January 2026, showed shower or bed bath completed on 1/17/26 and 1/23/26. During an interview on 1/29/26 at 9:27 A.M., the resident said the water in his/her room had not worked in several months. The shower rooms on the unit he/she resided on did not have hot water. As a result, he/she was not offered bed baths or showers. He/She could not recall the last time he/she had a shower and preferred a shower or bed bath daily. During an interview on 2/2/26 at 10:12 A.M., the resident said this past Saturday, 1/31/26, his/her aide offered a shower. The resident informed the aide the hot water was not working on his/her unit, and asked if the aide could take him/her to another unit. The aide said he/she did not have time to go to another unit and offered a bed bath instead. The resident agreed to the bed bath and asked the aide to obtain hot water from a different unit. The aide said it was too much and documented the resident refused a shower. When asked if the resident reported this to the nurse, he/she said No. Nothing would be done about it. The resident said he/she was upset that he/she did not receive a shower or bed bath. During an interview on 2/3/26 at 11:09 A.M., CNA G said the resident had not been showered on a regular basis due to the water on the unit being cold. When CNA G worked, he/she offered to take residents to a different unit for a shower. The resident preferred a shower or bed bath daily, but his/her preferences had not been met. Other residents were to receive showers or bed baths twice per week. Due to the cold water on the unit, the residents on the unit were not receiving at least two showers or bed baths per week. 3. Review of Resident #67's admission MDS, dated [DATE], showed:-Cognitively intact;-No rejection of care;-Dependent on staff for bathing and personal care;-Diagnoses included high blood pressure, heart failure and chronic obstructive pulmonary disease (COPD). Review of the resident's care plan, in use at the time of survey, showed,-Focus: Resident has an ADL self-care performance deficit;-Goal: Will improve current level of function through the review date;-Interventions: Bathing/showering: check nail length and trim and clean on bath day and as necessary. Report changes to the nurse. During an interview on 1/29/26 at 9:51 A.M., the resident said he/she [NAME] been taking his/her shower lately because the water was cold. During an interview on 1/30/26 at 11:05 A.M., the resident he/she has been taking a whore bath (washing only the arm pits, breast and genital area in the bathroom sink) because there was no hot water. Review of the shower sheets provided by the facility dated 11/1/25 through 1/26/26, showed 19 forms were provided. One out of 19 showed the resident received a shower, nine out of 19 opportunities a bed bath was completed, and nine out of 19 opportunities were refused. 4. During an interview on 2/3/26 at 5:20 P.M., the Director of Nursing (DON) and ADON said showers or bed baths were to be offered at least twice per week. If a resident preferred to have a shower or bed bath daily, the resident's preferences should have been honored. Some residents may not have received a shower or bed bath twice weekly due to water temperatures not being adequate. If a resident wanted a<br><br>(continued on next page) |

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| | 265719 | A. Building<br>B. Wing | 02/04/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Amberwood Estates Nursing and Rehabilitation | 5303 Bermuda Drive<br>Saint Louis, MO 63121 |

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| F 0677<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | shower, staff could take a resident to a different unit. If the resident preferred a bed bath, staff could have obtained hot water from another unit. There was no excuse for the resident to have not received a shower. 5. During an interview on 2/4/26 at 2:50 P.M., the Administrator, DON, and MDS Coordinator said resident choices should be honored. If a resident preferred a shower or bath daily, his/her preferences should have been honored. 15944272562981269947 8 |

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| F 0804<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure food was served at a palatable, safe and appetizing temperature during tray service by failing to maintain the temperature of hot foods to at least 120 degrees Fahrenheit (F). This deficient practice affected all residents who ate at the facility, including (Residents #19, #67, #6 and #74). The sample size was 22. The census was 83.Review of the facility's Final Cooking Temperatures policy, revised 10/1/23, showed:-Policy: Food is to be cooked to specified temperatures and times to mitigate the presence of dangerous microorganisms. The danger zone for food temperatures is above 41 degrees Fahrenheit (F) and below 135 degrees F. This temperature range promotes the rapid growth of pathogenic microorganisms that cause foodborne illness. 1.Review of Resident #19's admission Minimum Data Set (MDS), a federally mandated assessment instrument completed by the facility staff, dated 11/23/25, showed:-Cognitively intact;-Diagnoses included anemia (low red blood cell count), ulcerative colitis (inflammation and sores in the colon and rectum), Crohn's disease (chronic inflammatory bowel disease) and inflammatory bowel disease. Review of the care plan in use at the time of survey showed:-Focus: Resident was on a regular diet;-Goal: Will comply with recommended diet through review date;-Interventions: Explain and reinforce to the resident the importance of maintaining the diet ordered. Encourage the resident to comply. Explain consequences of refusal, obesity/malnutrition risk factors. During an interview on 2/3/26 at 12:15 P.M., the resident said he/she barely ate the food here. The food was terrible and he/she ate his/her own snacks and food. 2. Review of Resident #67's quarterly MDS, dated [DATE], showed:-Cognitively intact;- Diagnoses included heart failure and high blood pressure. Review of the care plan in use at the time of survey, showed:-Focus: Has nutritional problem or potential nutritional problem related to obesity. He/She was on a regular diet;-Goal: Will not develop complications related to obesity, including skin breakdown, ineffective breathing pattern, altered cardiac output, diabetes, impaired mobility through review date;-Interventions: Provide and serve diet as ordered. During an interview on 1/29/26 at 9:57 A.M. the resident said the food tasted bad. 3. Review of Resident #6's comprehensive MDS, dated [DATE], showed:-Cognitively intact;-Exhibited no behaviors;-Diagnoses included malnutrition. During an interview on 1/29/26 at 9:27 A.M., the resident said the food was not good and was often cold when it arrived. 4. Review of Resident #74's quarterly MDS, dated [DATE], showed:-Cognitively intact;-Exhibited no behaviors;-Diagnoses included renal disease and diabetes. During an interview on 1/29/26 at approximately 9:45 A.M., the resident said the food was okay when he/she was able to eat at the facility. Sometimes it was served cold. 5. Observation on 2/3/26 at 12:37 P.M., showed lunch served on the 200 unit. A tray was removed from the cart. Lunch consisted of lasagna, coleslaw and orange sherbet. The food temperature was taken with a digital thermometer. The lasagna was lukewarm and initially showed a temperature of 125 degrees (F). After 15 seconds, the temperature dropped to 112 degrees (F). The coleslaw was cool to the taste and wilted. The temperature was at 66 degrees (F). The sherbet was melted. 6. Observation on 2/3/26 at 12:41 P.M., showed the food cart arrived on the 100 unit hall. At 12:48 P.M., two staff members began passing the hall trays. At 12:56 P.M. the last tray was passed. A test tray was removed from the cart. Food temperatures were taken using a digital thermometer. The salad had a white creamy dressing on it. The salad was warm to taste and the temperature was 76.0 degrees F. The lasagna was warm to the taste and the temperature was 102.6 degrees F. The rainbow sherbet was mostly melted. The sherbet was cool to taste and the temperature was 28.2 degrees F. 7. Observation on 2/3/26 at 5:40 P.M., showed the hall trays arrived on the 100 hall unit. One staff member began delivering trays to the residents' rooms. At 5:48 P.M. the last tray was<br><br>(continued on next page) |

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| F 0804<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | delivered. A test tray was taken to the nurse's station. Food temperatures were taken using a digital thermometer. Licensed Practical Nurse (LPN) E said the temperature of the chicken bites was 95.4 degrees F. The temperature of the corn was 109.9 degrees F and the temperature of the fruit cup (oranges) was 70.5 degrees F. 8. During an interview on 2/4/26 at 9:14 A.M., the Dietary Manager said she would expect food to be served at an appetizing and safe level. Food should be served at 135 degrees (F) when it reached the resident. Cold foods should be at freezing level and sherbet should be served frozen. If food was not served at appropriate levels, residents ran the risk off food-borne illnesses. 9. During an interview on 2/4/26 at 2:50 P.M., the Administrator said she would expect food to be served at a safe and appetizing level. 1594427 [NAME], [NAME] (74) [NAME], [NAME] (37681) - Food No NotesBRADFORD, [NAME] (6) [NAME], [NAME] (37681) - Food No NotesPROWELL, [NAME] (74) [NAME], [NAME] (37681) - RESIDENT NOTE No NotesBRADFORD, [NAME] (6) [NAME], [NAME] (37681) - RESIDENT NOTE No Notes |

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| F 0809<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure meals and snacks are served at times in accordance with resident's needs, preferences, and requests. Suitable and nourishing alternative meals and snacks must be provided for residents who want to eat at non-traditional times or outside of scheduled meal times.<br><br>Based on interview and record review, the facility failed to provide and offer nourishing snacks at bed time. This affected all residents who ate at the facility. The census was 83.Review of the facility's undated Between Meal Snack/Bedtime Nourishments policy, showed:-Policy: Between meal snacks and bedtime nourishments are to be offered to all residents unless contraindicated by the physician diet order;-Procedure:--The bedtime nourishment must consist of foods that are nourishing. These include milk, 100% fruit juice, cookies, crackers, fruit;--Dietary should develop a snack nourishment stock level for each nursing stations;--According to regulation, nursing is to pass snacks and nourishments from room to room. It is not acceptable to announce that snacks are being served from the nursing station. During an interview on 1/29/26 at 8:15 A.M., Dietary Aide (DA) D said breakfast was served at 7:30 A.M., lunch at 11:45 A.M. and dinner at 5:30 P.M. Review of the Resident Council Meeting minutes, dated 11/19/25, showed the nurse told the residents there were no snacks at their desk. Review of the Resident Council Meeting minutes, dated 1/14/26, showed dietary was not passing out snacks. During a group interview on 1/30/26 at 10:30 A.M., eight residents, who the facility identified as alert and oriented, attended the group meeting. Six out of eight attendees said they were not offered snacks at bedtime. One resident said sometimes staff had snacks at the nurse's station. Residents who were able to ambulate to the nurse's station would get snacks. Staff did not come to resident rooms and offer snacks. This issue has been addressed in the Resident Council meetings. Observations on 1/29/26 through 2/4/26, during the course of the investigation, showed no snacks at the 100, 200, and 300 unit nursing station. During an interview on 2/4/26 at 9:14 A.M., the Dietary Manager said they have not provided snacks to the nursing staff for the snacks to be delivered to the residents. Residents would start receiving snacks going forward. 2699478 |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide and implement an infection prevention and control program.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to follow acceptable infection control standards and failed to follow Enhanced Barrier Precautions (EBP, an infection control intervention designed to reduce the transmission of multi-drug resistant organisms (MDRO) that employs targeted gown and glove use during high contact care activities as recommended by Center for Disease Control and Prevention (CDC) and required by the Centers for Medicare and Medicaid Service (CMS)), when staff failed to wear a gown while providing high contact care for four out of five residents observed for care (Resident #79, #81, #72, and #9). The facility also failed to use correct infection control techniques while providing peri-care to one of the five residents observed (Resident #79), and when staff placed linens on the floor and on another resident's bed for two of the five residents observed for care (Residents #79 and #81). The sample size was 22. The census was 83. Review of the facility's EBP policy, dated 8/25/25, showed:-An order for EBP will be obtained for residents with any of the following chronic wounds, indwelling medical devices (feeding tube) and/or infection or colonization with a novel or targeted MDRO when contact precautions do not apply;-Clear signage will be posted on the door or wall outside of the resident room indicating the type of precautions, required personal protective equipment (PPE), and the high contact resident care activities that require the use of gown and gloves;-For residents for whom EBP are indicated, EBP is employed when performing the following high contact resident care activities dressing, transferring, providing hygiene, changing linens and changing briefs or assisting with toileting. Review of the facility's Standard Precautions for Infection Control policy, revised 4/1/22, showed it will be the policy of the facility to assume that every person is potentially infected or colonized with an organism that could be transmitted in the healthcare setting and apply the following infection control practices during the delivery of health care. Contaminated laundry shall be minimally handled with the appropriate use of personal protective equipment and placed in bags that prevent leakage, at the location of use. 1. Review of Resident #79's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by the facility staff, dated 12/22/25, showed:-Severe cognitive impairment;-Dependent on staff for toilet and personal hygiene;-Always incontinent of bladder and bowel;-Diagnoses included stroke, multiple sclerosis (MS, a chronic, progressive disease involving damage to the nerve cells in the brain and spinal cord, which may cause numbness, impairment of speech and muscular coordination, blurred vision and severe fatigue) and altered mental status. Review of the care plan, in use at the time of survey, showed:-Focus: Resident was always incontinent of bladder;-Goal: Will decrease frequency of urinary incontinence through the next review date;Interventions included clean peri-area (the cleansing of the genital and anal areas) with each incontinence episode. Observation on 2/2/26 at 6:48 A.M., showed an EBP sign and PPE on the door to the resident's room. The resident was in bed. Certified Nurse Aide (CNA) C put gloves on, rolled the resident onto his/her side, and cleaned the resident's back side. CNA C changed his/her gloves and rolled the resident onto his/her back and cleaned the resident from the genital to the abdomen (back to front). He/She changed his/her gloves and rolled the resident toward the window, and removed the soiled pad and placed it on the floor, without a barrier between the soiled linens and floor. CNA C removed the blankets off the resident's bed and placed them on his/her roommate's bed, tucked a pad and brief halfway underneath the resident and rolled the resident to straighten the pad and fasten the brief. CNA C assisted the resident in getting dressed and transferred the resident into the wheelchair. CNA C took the blankets he/she placed on the roommate's bed and used them to make the residents bed. CNA C did not wear a gown while providing care to the resident or while making his/her bed.<br><br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During an interview on 2/4/26 at 10:20 A.M., the Assistant Director of Nursing (ADON) said when staff provide peri-care to a female resident, they should wipe the resident from the front to the back. Linens should not be taken from one resident's bed, placed on another resident's bed, and then placed back on the resident's bed because of cross contamination. Staff knew which residents required EBP by the signage on their door. Staff should wear a gown, gloves and mask as needed when providing high contact care. 2. Review of Resident #81's quarterly MDS, dated [DATE], showed:-Cognitively intact;-Dependent on staff for toilet and personal hygiene;-Always incontinent of bladder and frequent incontinent of bowel;-Diagnoses included stroke. Review of the resident's care plan, in use at the time of survey, showed:-Focus: Resident had an activities of daily living (ADL, grooming, dressing, bathing) deficit;-Goal: Will maintain improve level of functioning;-Inventions included staff assistance to the extent needed to accomplish task;-Focus: EBP for wounds, gown and gloves required for high contact resident care activities;-Goal: Will maintain or develop clean and intact skin by the review date;-Interventions included keep the skin clean and dry, use lotion to dry skin. Review of the resident's physician order sheet, in use at the time of survey, showed a physician order, start date 6/3/25, for EBP for chronic wound. Gown and gloves required for high contact resident care activities. Observation on 2/2/26 at 5:25 A.M., showed an EBP sign and PPE on the resident's door. CNA C entered the resident's room, performed hand hygiene and put on two pair of gloves. No gown was worn. CNA C unfastened the resident's brief and cleaned his/her groin and between the resident's legs and assisted the resident to roll onto his/her side. CNA C removed the soiled blanket from the bed and placed it on the floor, with no barrier between the soiled linens and the floor. CNA C cleaned the resident's back side, removed one glove from his/her right hand, and with one glove still on the right hand, tucked the soiled pad halfway under the resident. CNA C changed his/her gloves, then folded a blanket into one forth and placed a brief on top of it and tucked it halfway under the resident. CNA C rolled the resident onto the other side and straightened the blanket and brief out and fastened the brief. He/She said the facility ran out of pads. CNA C changed his/her gloves and picked up the linens off the floor and placed in a trashed bag and removed them from the room. During an interview on 2/4/26 at 10:20 A.M., the ADON said staff should not double glove. They should remove their gloves and perform hand hygiene. Soiled linens should not be placed on the floor. 3. Review of Resident #72's quarterly MDS, dated [DATE], showed:-Moderate cognitive impairment;-Dependent on staff for toilet and personal hygiene;-Always incontinent of bladder and frequent incontinent of bowel;-Diagnoses included stroke and hemiplegia (paralysis of the arm, leg, and trunk on the same side of the body) or hemiparesis (slight weakness in a leg, arm, or face). Review of the resident's care plan, in use at the time of survey, showed:-Focus: Has an ADL self-care performance deficit related to bed immobility status post stroke and amputation. Resident preferred to stay in bed at all times;-Goal: Will maintain current level of function through review date;-Interventions included, resident was totally dependent of one staff for toilet use. He/She used incontinent products. Review of the resident's physician order sheet, in use at the time of survey, showed a physician order, start date 6/3/25, for EBP for chronic wound. Gown and gloves required for high contact resident care activities. Observation on 2/2/26 at 5:05 A.M., showed the resident in bed. CNA B put gloves on and rolled the resident side to side and provided peri-care. No gown was worn by CNA B while he/she provided care. 4. Review of Resident #9's significant change MDS, dated [DATE], showed:-Rarely/never understood;-Dependent on staff for toilet and personal hygiene;-Always incontinent of bladder and bowel;-Diagnoses cerebral palsy (a disorder of movement, muscle tone or posture), and gastrostomy (g-tube, feeding tube) status. Review of the resident's care plan, in use at the time of survey, showed:-Focus: Has an ADL<br><br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | self-care performance deficit related to cerebral palsy and being dependent on staff for his needs;-Goal: Resident will be met daily through the review date;-Interventions: Resident was totally dependent on one staff for personal hygiene and oral care;-Focus: EBP for g-tube, gown and gloves required for high contact resident care activities;-Goal: Will remain free of side effects or complications related to tube feeding through review date;-Interventions, check resident for tube placement and gastric contents/residual volume per facility protocol and record. Review of the resident's physician order sheet, in use at the time of survey, showed no physician order for EBP. Observation on 2/2/26 at 6:13 A.M., showed an EBP sign and PPE on the door to the resident's room. The resident was in bed. CNA C had gloves on and rolled the resident side to side while providing peri-care. No gown was worn by CNA C while he/she provided peri-care. 5. During an interview on 2/3/26 at 4:50 P.M., CNA G said he/she knew which residents required EBP because there was a sign on the door and PPE on or by the door. Staff should wear a gown, mask, face shield and gloves every time they enter the room and remove it before they exited the room. Staff should not double glove. Soiled linens should be placed in a trash bag and not on the floor or on other resident's beds. When providing peri-care, staff should wipe residents from front to back. 6. During an interview on 2/3/26 at 4:55 P.M., CNA J said when peri-care was provided to the residents, staff should wipe the residents from front to back. Staff should not double glove. Soiled linens should be placed in a linen cart or in a trash bag. He/She knew which residents required EBP because they would have a sign and PPE on the door. Staff should wear gown, gloves, and mask when providing close contact care to the residents. 7. During an interview on 2/4/26 at 2:50 P.M., the Administrator said she expected staff to follow the facility's infection control policies and procedures. 2717294 |