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

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

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 0567 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to manage his or her financial affairs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to use the personal funds of a resident only when authorized in writing for two of four sampled residents (Residents #64 and #63). The census was 83.1. Review of Resident #64's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 10/20/25, showed:-Diagnoses included quadriplegia (paralysis of all four limbs), contracture of right hand and both shoulders;-Moderately impaired;-Minimum depression. Review of resident's care plan, in use during the survey, showed:-Focus: Activity care plans for individuals should be personalized to their needs and interests; -Goal: Will have his/her personal preferences honored as safely allowed;-Intervention: Tailor activities to the person's interests, abilities, and needs. Review of the resident's facility Withdraw Receipt form, dated 11/20/25, showed:-Receipt #W000003, record # 111925C, total amount of $325.54;-The resident's signature section and witness sections blank;-Transactions included:-On 10/8/25, amount: $4.03. From: Dollar General. Description: NTH 100;-On 10/9/25, amount: $18.42. From: Tucker's Place. Description: Salad. During an interview on 2/2/26 at 10:30 A.M., the resident said he/she was unaware of anyone in his/her family making the purchases on the receipt, dated 11/20/25. 2. Review of Resident #63's quarterly MDS, dated [DATE], showed:-Diagnoses included dysphagia following cerebral infarction (difficulty swallowing caused by a stroke);-Severe cognitive impairment;-Moderate depression.Review of resident's care plan, in use during the survey, showed:-Focus: Wishes to stay here long-term;-Goal: Continue to express satisfaction with living arrangements through the review period;-Intervention: Encourage social interactions and participation in activities with others that have similar interests. Review of the resident's facility Withdraw Receipt form, dated 11/24/25, showed:-Receipt #W000001, record #110925C, total amount of $146.43;-The resident's signature section and witness sections blank;-Transaction, amount: $146.43. From: Wal-Mart. Description: Clothing. During an interview on 2/3/26 at 1:58 P.M., the resident said he/she did not remember authorizing the purchase on 11/24/25 or receiving the items from Wal-Mart. During an interview on 2/3/26 at 2:20 P.M., the resident's financial Power of Attorney (POA) said he/she made the purchase but thought he/she signed something when the facility reimbursed him/her for the items but was not sure. During an interview on 2/4/26 at10:12 A.M., the Administrator said she expected the resident or the resident's responsible party to sign the facility's Withdraw Receipt prior to deducting money from the resident's patient trust account.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0568 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Properly hold, secure, and manage each resident's personal money which is deposited with the nursing home. Based on interview and record review, the facility failed to ensure general accounting principles were followed by failing to complete monthly resident trust fund (RTF) reconciliations, resulting in the inability to accurately account for money held in the RTF account. In addition, the facility failed to provide quarterly statements to residents and their representatives. This affected 41 residents whose funds were handled by the facility. The census was 83.Review of the facility's Resident Trust policy, dated 2/2022, showed:-Policy: To maintain a complete and accurate accounting for resident monies. The Administrator is responsible for the establishment and accurate maintenance of the RTF and the related resident trust petty cash account including the handling of the funds according to corporate policies as well as state and federal regulations;-Procedures: The resident may retain his/her right to receive, retain and manage his/her own personal funds;-Segregation of Duties: --Fund Custodian - Disburses RTF money after obtaining appropriate signatures; --Record-Keeper - Completes the monthly reconciliation of the RTF per resident trust petty cash account;--Authorization/Verification - Reviews for accuracy, approves and signs the monthly RTF reconciliation. Reviews the quarterly RTF statements before being mailed;--Witnesses to RTF Transactions - A person who witnesses signatures on Resident Trust Fund transactions is not a person directly responsible for receiving, disbursing, posting, reconciling or verifying the RTF;-Maintaining Documentation: RTF documentation is retained in a file labeled by the month. The monthly file needs to contain supporting documentation for any activity to the resident trust fund and the resident trust petty cash account including depositions, withdrawals, receipts, and interest allocations. Also retained in the monthly file are the signed monthly resident petty cash reconciliations, bank statements, and a copy of the quarterly statements-Deposits and Withdrawals: For those residents with direct deposit, the private portion is listed on the Deposit Transaction & Distribution Report. All cash disbursements from the resident trust petty cash require the resident's and/or his/her legal representative's signature on the Resident Trust Petty Cash Tracking Log or Withdrawal Slip. If a resident is unable to sign, two witness signatures are required on the withdrawal;-Monthly Reconciliation of RTF: --On a monthly basis, two reconciliations are completed: -- RTF Reconciliation is reviewed by the Accounting Office to confirm the trial balance, bank statement and reconciliation report agree;--Resident trust petty cash reconciliation is prepared to identify any outstanding balance remaining in the account at month end;--The resident trust reconciliations are completed by the 20th of the month;-Quarterly statement of account: The facility mails the quarterly statements no later than the 25th of the month following the end of the quarter. The Administrator reviews the statements prior to mailing. 1. Review of the facility's RTF reconciliation from January through December 2025, showed:-Account A held resident funds from January through May 2025. Reconciliations completed during that time;-May 2025:--RTF account balance: $73,118.12;--Trial balance: $73,117.50;--Reconciliation completed with $0.00 difference;-Account B held resident trust petty cash and Account C held resident funds from June through December 2025;-June 2025:--Trial balance for 41 accounts: $73,117.50;--No documentation of reconciliation completed;-July 2025:--Account B balance of $0.01;--Account C balance of $0.01;--No documentation of reconciliation completed;-August 2025:--Account B balance of $0.01;--Account C balance of $0.01;--No documentation of reconciliation completed;-September 2025:--Account B balance of $0.01;--Account C balance of $1,851.02;--Trial balance for 33 accounts: $1,851.00;--No documentation of reconciliation completed;-October 2025:--Account B balance of $1,945.15;--Account C balance of $46,595.24;--Trial balance of 37 accounts: $46,594.26;--Reconciliation completed with $0.00 difference;-No documented explanation of the $26,523.24 difference in the RTF between May and October 2025. 2. Review of Resident #10's medical record, showed:-Had a financial Power of Attorney (POA); -Diagnoses included end stage renal disease and diabetes;-Cognitively intact;-Funds held in RTF account.Review of resident's RTF statements and facility Trial Balance reports, (continued on next page)

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F 0568 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	showed:-Trial balance for resident as of 5/31/25: $6,613.08;-Trial balance for resident as of 10/31/25: $3,038.69;--A difference of $3,574.39 from May to October 2025;-Resident RTF statement for 10/7/25 through 11/28/25, showed a beginning balance of $1,558.00 and ending balance of $2,832.83;-Resident RTF statement 1/2/26 through 2/3/26, showed with a beginning balance of $869.05 and ending balance of $569.07. During an interview on 2/3/26 at 2:36 P.M., the resident's financial Power of Attorney (POA) said the facility previously notified him/her that the resident was required to spend down funds in the resident's trust account. He/She had not yet completed shopping and had spent approximately $200.00. He/She was unaware that the resident's trust account balance was $569.07, as of 2/2/26. The facility did not explain how the resident's trust account balance decreased from $6,613.08 in May 2025 to $3,038.69 in October 2025. The facility did not provide quarterly RTF statements and did not inform him/her that quarterly statements were available. 3. Review of Resident #33's medical record, showed:-Responsible for his/her own finances;-Diagnoses included Parkinson's disease and Alzheimer's disease;-Severe cognitive impairment;-Funds held in RTF account. Review of resident's RTF statements and facility Trial Balance reports, showed:-Trial balance for resident as of 5/31/25: $11,712.65;-Trial balance for resident as of 10/31/25: $8,342.03;--A difference of $3,370.62 from May to October 2025;-Resident RTF statement for 10/7/25 through 11/28/25, showed a beginning balance of $971.00 and ending balance of $8,367.22;-Resident RTF statement for 1/2/26 through 2/3/26, showed a beginning balance of $9,315.44 and ending balance of $8,715.87. During an interview on 2/3/26 at 1:15 P.M., the resident said he/she was unaware of the balance of his/her patient trust account and did not know why balance decreased from $11,712.65 in May 2025 to $8,342.03 in October 2025. A staff member previously discussed funeral arrangements with him/her; however, he/she did not understand the information provided. His/Her family member may have additional information regarding his/her resident trust account. During an interview on 2/3/26 at 1:15 P.M., the resident's family member said several months earlier, a nurse notified him/her that the resident had excess funds in his/her resident trust account. The family member requested the facility to speak directly to the resident to identify his/her needs so family member could assist with spending down the funds. The facility did not make further contact with the family member after that discussion and he/she was unaware how the resident's trust account balance decreased from $11,712.65 in May 2025 to $8,342.03 in October 2025. 4. Review of Resident #63's medical record, showed:-admission date 7/4/23;-Funds held in RTF account. Review of Resident #64's medical record, showed:-admission date 8/1/24;-Funds held in RTF account. During interviews on 2/2/26 at 11:58 A.M. and 1:28 P.M., 2/3/26 at 12:30 P.M., and 2/4/26 at 9:25 A.M., the Business Office Manager (BOM) was asked to provide documentation of the quarterly statements given to Residents #10, #33, #63, and #64, for the year 2025. 5. During an interview on 2/4/26 at 9:25 A.M., the BOM said she could not find documentation of the quarterly statements provided to all the residents who had funds held in the resident trust account. She began employment at the facility a few days ago and she did not have knowledge about the trust account details for Residents #10 and #33. She expected the facility to reconcile resident trust account monthly and to provide quarterly statements to residents and or their responsible parties. 6. During an interview on 2/4/26 at 10:12 A.M., the Administrator said she was aware the facility was required to maintain seven years of financial records and to ensure records were accessible within 24 hours of a request from the state survey agency. She had two e-mail addresses for corporate staff to whom she could direct questions about the RTF accounts, but she did not know their phone numbers or job titles. She had been employed at the facility for three months and did not have the reports detailing the variance between the May 2025 trial balance of $73,117.50 and the October 2025 trial balance of $46,594.26, a difference of $26,523.24. She expected the facility to reconcile resident trust accounts monthly and to provide quarterly statements to residents or their responsible parties each quarter.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, 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. Review of the facility's Environment of Care policy, dated 4/1/22, showed: -The facility staff will provide a safe, clean, comfortable and homelike environment; -The facility will provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; -The facility will provide for the maintenance of comfortable sound levels. 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? 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. 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. 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: -Cognitively intact; -Dependent on staff for bathing and personal hygiene; -Diagnoses included heart failure and high blood pressure. Review of the care plan, in use at the time of survey, showed: -Focus, resident had an Activities of Daily Living (ADL, grooming, dressing, bathing) self-care deficit; (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Goal, the resident will improve current level of function through the review date; -Interventions, assist times one staff for a bed bath, twice a week and as needed as requested. 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. 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. 3. Review of Resident #5's admission MDS, dated [DATE], showed: -Cognitively intact; -Dependent on staff for bathing and personal hygiene; -Diagnoses included anxiety, depression and post-traumatic stress disorder (PTSD). Review of the care plan, in use at the time of survey, showed: -Focus, resident had an ADL self-care performance deceit; -Goal, the resident will maintain/improve level of functioning through the review date; -Intervention, the resident is totally dependent on two staff to provide bath/shower and as necessary. During an interview on 1/29/26 at 9:30 A.M., the resident said the facility only had hot water sometimes. 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 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. 4. 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; (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-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. 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. 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. 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. 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. 5. Review of Resident #42's quarterly MDS, dated [DATE], showed: - Diagnoses included Parkinson's disease without dyskinesia (neurodegenerative disorder without erratic movements), with fluctuations and other lack of coordination and mild depression; - No behaviors. Review of the resident's care plan, in use during the survey, showed: -Focus: ADL self-care performance deficit related to stroke with residual effects; -Goal: Will have needs met daily through the review period; Interventions: Staff assistance to the extent needed to accomplish task. 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: - 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; - Accumulated dirt and debris along the perimeter of the room; - The bathroom toilet had visible brown staining and streaking on the exterior porcelain surface of the (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. 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. 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. 1594432 1594427 2679753 2566067

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F 0585 Level of Harm - Minimal harm or potential for actual harm 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. 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 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 (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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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	265719	A. Building B. Wing	02/04/2026

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

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. Based on interview and record review, the facility failed to 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 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure residents 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 #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 (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 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 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the physician or designee responded to the pharmacy recommendations timely for three out of five residents sampled for medication review (Resident #11, #5, and #9). The sample was 22. The census was 83. During an interview on 2/4/26 at 8:55 A.M., the pharmacy review policy was requested. As of 4:00 P.M. on 2/4/26 no policy was received. 1. Review of Resident #11's medical record showed, a diagnosis of schizoaffective disorder (a serious mental illness blending symptoms of schizophrenia (psychosis like hallucinations, delusions, disorganized speech) with a mood disorder (major depression or bipolar mania/depression). Review of the care plan, in use at the time of survey, showed:-Focus: Resident used psychotropic medications;-Goal: Will be/remain free of psychotropic drug related complications, including movement disorder, discomfort, hypotension, gait disturbance, constipation/impaction or cognitive/behavioral impairment through review date;-Interventions included: Consult with pharmacy, medical doctor (MD) to consider dosage reduction when clinically appropriate at least quarterly. Review of the order summary sheet, in use at the time of survey, showed:-A physician order for Quetiapine 25 milligrams (mg), give one tablet at bedtime (hs) for schizoaffective disorder, start date was 6/25/25;-A physician order for Ramelteon 8 mg at hs for insomnia, start date was 6/25/25. Review of the note to attending physician/prescriber review dated 12/10/25 and 1/15/26, showed:-Resident was currently prescribed sedative/hypnotic. Ramelteon 8 mg every bedtime (hs) for the treatment of insomnia since 6/5/25; -According to Center for Medicare and Medicaid Services (CMS) guidance under F605 (chemical restraints), for any resident who is receiving a psychotropic medication, the facility must show evidence that a gradual dose reduction (GDR) has been attempted unless clinically contraindicated;-Please consider a trial dose reduction: Ramelteon 4 mg every hs;-If a GDR attempt is not indicated at this time, please indicate reasoning below:- Dose reduction attempt at this time would risk decompensation of patient;-Resident is taking lowest effective dose. Previous GDR attempt on (blank), resulted in adverse effects and/or exacerbation of resident's condition;-Other: See Physician's progress notes for rationale.-The forms were blank and unsigned by the physician/prescriber;- Resident is currently prescribed antipsychotic, Quetiapine 25 mg every hs for the treatment of schizoaffective disorder since 6/5/25;-According to CMS guidance under F605 (chemical restraints), for any resident who is receiving a psychotropic medication, the facility must show evidence that a gradual dose reduction has been attempted unless clinically contraindicated;-Please consider a trial dose reduction: Quetiapine 12.5 mg every hs;-If a GDR attempt is not indicated at this time, please indicate reasoning below:- Dose reduction attempt at this time would risk decompensation of patient;-Resident is taking lowest effective dose. Previous GDR attempt on (blank), resulted in adverse effects and/or exacerbation of resident's condition;-Other: See Physician's progress notes for rationale.-The form was blank and unsigned by the physician/prescriber. Review of the progress notes dated 12/10/25 through 2/4/26, showed there was no documentation showing the physician was made aware of the pharmacy review and recommendations. 2. Review of Resident #5's admission Minimum Data Set (MDS), a federally mandated assessment instrument completed by the facility staff, dated 11/5/25, showed:-Cognitively intact;-Diagnoses included anxiety, depression and post-traumatic stress disorder (PTSD). Review of the care plan in use at the time of survey, showed:-Focus: Resident used psychotropic medications related to bipolar disorder;-Interventions included: consult with pharmacy, medical doctor, to consider dosage reduction when clinically appropriate at least quarterly. Review of the note to attending physician/prescriber review dated 12/11/25, showed:-Resident was currently on as needed (prn) Lorazepam 2 mg twice a day with the following diagnosis: Anxiety;-Please evaluate current diagnosis, behaviors and usage patterns and evaluate continued need.-PRN psychotropic orders cannot exceed (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	14 days with the exception that the prescriber documents their rationale in the resident's medical record and indicate the duration for the prn order;-New order for prn: (blank) (include duration and rationale) handwritten was decrease to one mg by mouth everyday as needed. The form was signed by the physician and dated 12/17/25. There was no duration noted, or a rationale documented if the medication was to exceed the 14 days. Review of the physician order sheet, in use at the time of survey showed, a physician order for Lorazepam 1 mg every day prn anxiety. Start date was 12/31/25, end date was indefinite. Review of the note to attending physician/prescriber review dated 1/16/26, showed, this resident is currently on prn Lorazepam 1 mg every 24-hour prn with the following diagnosis: Anxiety;-Please evaluate current diagnosis, behaviors and usage patterns and evaluate continued need.-PRN psychotropic orders cannot exceed 14 days with the exception that the prescriber documents their rationale in the resident's medical record and indicate the duration for the prn order. Please consider discontinue prn Lorazepam; new order for prn: (blank) (Include duration and rationale); adjust routine order to (blank);-The form was blank and unsigned by the physician/prescriber. Review of the progress notes dated 12/31/25 through 2/4/26 showed, there was no documentation showing the physician documented the duration and/or rationale for the medication. 3. Review of Resident #9's annual MDS, dated [DATE], showed:-Diagnoses included Spastic quadriplegic cerebral palsy (brain injury), and dysphagia, oropharyngeal phase (difficulty swallowing);-Moderate severe depression;-No behaviors. Review of the resident's care plan in use at time of survey, showed:-Focus: Has admitted to hospice with admitting diagnosis sepsis (immune system triggers widespread inflammation that damages its own organs and tissues);-Goal: The resident's comfort will be maintained through the review date;-Interventions: Observe resident closely for signs of pain, administer pain medications as ordered, and notify physician immediately if there is breakthrough pain. Review of the resident's active order summary, showed:-A physician order for Morphine Sulfate Oral Solution 20 mg/5 milliliters (ML), Give 0.25 ml by mouth every two hours as needed for shortness of breath and/or severe pain;-A physician order for Erythromycin Ophthalmic Ointment 5 mg/gram (GM), instill 1 drop in both eyes two times a day related to unspecified superficial keratitis (inflammation of the cornea, the clear, front surface of the eye), unspecified eye. Review of the resident's Note to Attending Physician/Prescriber dated 11/18/25, showed:-Current order: Morphine 20 mg/5ML, give 0.25 ML every two hours prn;- Recommendation: Please clarify the strength for the above order. The typical strength for the dose listed above is Morphine 100 mg/5 ML. Please review stock on hand and be sure the order strength matches the strength on hand;-There was a line to mark agree, disagree or comment: The form was blank;-Current order: Erythromycin Ophthalmic (Ophth.) ointment and TobraDex ophth (prevents inflammation and infection of the eye). -Recommendation: Duplicate therapy. This resident is receiving the above medications which have similar effects and may be considered duplicate therapy. -Please evaluate the need for both ophth. antibiotics. If continued, please clarify the Erythromycin to include a stop date and be sure to separate applications;-There was a line to mark agree, disagree or comment: The form was blank.-The form was unsigned by the physician/prescriber. Review of the resident's Note to Attending Physician/Prescriber showed, dated 12/11/25, showed:-Current order: Morphine 20 mg/5ML give 0.25 ML every two hours prn;-Recommendation: Please clarify the strength for the above order. The typical strength for the dose listed above is Morphine 100 MG/5 ML. Please review stock on hand and be sure the order strength matches the strength on hand; -There was a circle around 20 mg/5ml and handwritten was error 20mg/ml;-Current order: Erythromycin Ophthalmic (Ophth.) ointment and TobraDex ophth.-Recommendation: Duplicate therapy. This resident is receiving the above medications which have similar effects and may be considered duplicate therapy. Please evaluate the need for both ophth antibiotics. If continued, please clarify the Erythromycin to include a stop date and be sure to separate applications; -Handwritten was discontinue both ointments;-The form was signed and dated 12/17/25. Review of the resident's Note to Attending Physician/Prescriber showed, dated 1/16/25, showed:-Current order: Morphine 20 mg/5ML give 0.25 ML every two hours prn;- (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Recommendation: please clarify the strength for the above order. The typical strength for the dose listed above is Morphine 100 mg/5 ML. Please review stock on hand and be sure the order strength matches the strength on hand;-There was line to mark agree, disagree or comment: The form was blank;-Current order: Erythromycin Ophthalmic (ophth.) ointment and TobraDex ophth; -Recommendation: Duplicate therapy. This resident is receiving the above medications which have similar effects and may be considered duplicate therapy. Please evaluate the need for both ophth. antibiotics. If continued, please clarify the Erythromycin to include a stop date and be sure to separate applications;-There was line to mark agree, disagree or comment: The form was blank.-The form was unsigned by the physician/prescriber. Review of the Medication Administration Record (MAR), dated 1/1/26 through 1/31/26 showed:-A physician order for Morphine Sulfate Oral Solution 20 mg/5ml, give 0.25 ml by mouth every two hours as needed for shortness of breath and/or severe pain, start date was 10/10/2025;-A physician order for Erythromycin Ophth. Ointment 5 mg/gm, instill 1 drop in both eyes two times a day related to unspecified superficial keratitis, unspecified eye, start date was 10/30/25;-Documentation showed the medication was administered. Review of the resident's progress notes from 12/16/25 through 1/28/26 showed no documentation related to Morphine Sulfate Oral Solution 20 mg/5ml or Erythromycin Ophth. 4. During an interview on 2/4/26 at 9:50 A.M. the Director of Nursing (DON) said when she got to the facility the Assistant Director of Nursing (ADON) was in charge of the pharmacy reviews. That ADON was no longer at the facility. The DON did not know if the pharmacy reviews were addressed by the physician or not. Going forward, the pharmacy will email the reviews to both the ADON and the DON. 5. During an interview on 2/4/26 at 2:50 P.M., the Administrator said she would expect for the pharmacy reviews to be completed monthly and the physician/provider to review the recommendations.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. **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 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 (continued on next page)

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	265719	A. Building B. Wing	02/04/2026

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

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0868 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have the Quality Assessment and Assurance group have the required members and meet at least quarterly Based on interview and record review, the facility failed to ensure quality assurance performance improvement (QAPI) meetings were documented as attended and consisted of the required committee members when the Administrator, Infection Preventionist Nurse (IP) and the Medical Director failed to attend the facility's QAPI meetings. The census was 83.Review of the facility's Quality Assessment and Assurance (QAA) policy and procedure, revised 10/1/123, showed:-Policy: It will be the policy of the facility to hold a QAA committee meeting at least quarterly;-Procedure: A facility will maintain a quality assessment and assurance committee consisting at a minimum of:--The director of nursing services (DON);--The Medical Director or his/her designee;--At least three other members of the facility's staff, at least one of whom must be the administrator, owner, a board member or other individual in a leadership role;--The infection preventionist. Review of the facility's QAPI sign in sheets, showed:-QAPI meeting held on 5/6/25. No IP staff in attendance;-QAPI meeting held on 6/10/25. No IP or Administrator in attendance;-QAPI meeting held on 8/27/25. No Administrator, IP or Medical Director in attendance;-QAPI meeting held 1/21/26. No IP staff in attendance. During an interview on 2/3/26 at 1:41 P.M., the Administrator said she was unable to locate the meeting minutes for February 2025 and October 2025, but knew the meetings were held. As of now, they did not have an IP nurse. She would have expected all required members to attend QAPI meetings and proof of attendance should have been documented.

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to 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. 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 (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 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 (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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

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F 0882 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Designate a qualified infection preventionist to be responsible for the infection prevent and control program in the nursing home. Based on interview and record review, the facility failed to designate one or more individuals with specialized training in infection prevention and control as the Infection Preventionist (IP) for the facility's infection control and prevention program (IPCP). The census was 83.Review of the facility's Infection Prevention and Control Program policy, revised 11/28/22, showed, the facility will designate one or more individual(s) as the infection preventionist(s) who is responsible for the facility's IPCP. The IP will have completed specialized training in infection prevention and control. During an interview on 1/29/26 at 8:57 A.M., the Administrator said the IP worked part time, and the Assistant Director of Nursing (ADON) was currently in the process of obtaining her specialized training. During an interview on 2/4/26 at 10:55 A.M., the Administrator said the facility currently did not have an IP. The IP they had was no longer responding to the Administrator's calls. The Administrator would expect for the facility to have an IP.

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F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. Based on interview and record review, the facility failed to ensure they had a system in place to track the required Certified Nurse Aide (CNA) 12 hours annual education (in-services). The facility identified 10 CNAs who worked for the facility for at least one year. The facility failed to document the length of time the in-services were provided for each individual CNA's training hours. The census was 83.A policy related to CNA 12-hour training was not provided by the facility.Review of the facility's In-Service Training Report sheets, dated from 3/19/25 through 1/5/26 and provided as training records for CNA B, CNA J, CNA K. CNA L, CNA M, CNA N, CNA O, CNA P, CNA Q, and CNA R, showed the heading consisted of facility name, date, subject, time start and end, type of in-service, and instructor. Time start and end lines were all blank. Four columns were labeled for summary of meeting, employee name, position, and employee signature. They were signed by employees with different positions. There were no individual records for each CNA that showed they completed 12 hours of in-services in a year.During an interview on 2/3/26 at 4:10 P.M., the Director of Nurses (DON) said the education did not include the duration of the education, and there should be material showing what was discussed. She expected CNAs to receive 12 hours of required education each year. The duration of the in-service should be documented along with the education material with the sign in sheet.

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. Based on observation, interview and record review, the facility failed to promote and facilitate self-determination for one resident (Resident #6) who was dependent on staff for bathing/showering by failing to ensure the resident received showers or bed baths, in accordance with the resident's preferences. The sample size was 22. The census was 83. Review of the facility's Resident Rights, Dignity and Visitation Rights policy, issued 4/1/22, showed:-Policy: It will be the policy of this facility that employees shall treat residents with kindness, respect and dignity. The facility promotes the exercise of rights for each resident, including any who face barriers in the exercise of these rights. The facility will ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. A resident, even though determined to be incompetent, should be able to assert these rights based on his or her degree of capability;-Procedure: -Residents are entitled to exercise their rights and privileges to the fullest extent possible; --The facility will make effort to assist each resident in exercising his/her rights to assure that the resident is always treated with respect, kindness and dignity; providing care that is comfortable and consistent with his/her normal life habits, observing resident's choices whenever able. Review of the Resident #6'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 Certified Nursing Assistant (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 comprehensive Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 12/31/25, 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 Shower Sheet/Skin Condition Report for January 2026, showed shower or bed bath completed on 1/17/26 and 1/23/26. Observation on 1/29/26 at 9:26 A.M., showed the resident's water in his/her room ran for approximately three minutes. The water never got warm and was cool to the touch. During an interview on 1/29/26 at 9:27 A.M., the resident lay in bed in his/her room. He/She said the water in his/her room had not worked in several months. The shower rooms on the unit he/she resides on does 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, his/her aide offered him/her 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 has 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. During an interview on 2/3/26 at 5:20 P.M., the Director of Nursing (DON) and Assistant (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Director of Nursing (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 shower, staff could take the 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. 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.

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

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F 0569 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify each resident of certain balances and convey resident funds upon discharge, eviction, or death. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure third party liability (TPL) forms were completed within 30 days for the final accounting of residents who expired, for one of one sampled resident who expired and had money left in their resident trust account (Resident #9). The census was 83.Review of Resident Trust policy dated 2/2022, showed no funds are released until a final audit of the account is completed. Such funds are to be provided within 30 days of the death of the resident. Reference state regulations for further guidelines.Review of Resident #9's resident trust fund account, showed:-Resident expired on [DATE];-A balance of $5,175.22;-A TPL had not be completed and money remained in the resident trust fund account. During an interview on [DATE] at 11:13 A.M., the Business Office Manager (BOM) said she had started her position four days earlier and she was aware that TPL letters were required to be sent to the State of Missouri's Department of Social Services (DSS) within 30 days of a resident's death. The BOM said she was awaiting a check from the corporate office reflecting closure of the resident's patient trust account, which would accompany the TPL letter. During an interview on [DATE] at 10:25 A.M., the Administrator said she expected TPL forms to be sent within 30 days of a resident's death.

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F 0577 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to easily view the nursing home's survey results and communicate with advocate agencies. Based on observation, interview and record review, the facility failed to make accessible for examination, the results of the most recent survey, certifications and complaint investigations of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility available to residents, visitors and resident representatives. The sample size was 22. The census was 83.Review of the facility's Resident Rights policy, showed the policy did not address residents' rights to examine the results of the most recent federal or state survey and any plan of correction in effect for the facility.Observation on 1/29/26 through 2/4/26, showed the facility did not post the results of the most recent survey, certifications and complaint investigations made respecting the facility in a place readily accessible to residents, and family members and legal representatives of residents. 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 residents said they were not sure where they would look to review the survey results from the prior annual survey and complaints investigated. During an interview on 2/4/26 at 2:07 P.M., front desk staff H said the survey binder was typically kept on a shelf behind the receptionist desk and provided upon request, but currently was being kept in the administrator's office. He/She and was unaware of the reason.During an interview on 2/4/26 at 2:10 P.M., the Administrator said she would expect the statement of deficiencies and plans of correction from the prior survey, to include any complaints investigated, to be available to the residents and the public.

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. Based on interview and record review, the facility failed to provide a Skilled Nursing Facility Advance Beneficiary Notice (SNFABN-form CMS-10055) or a denial letter at the initiation, reduction or termination of Medicare Part A services and Notice of Medicare Non-Coverage (NOMNC-form CMS-10123, a notice that indicates when care is set to end from a skilled nursing facility) for three sampled residents upon discharge from Medicare Part A services. Two residents (Residents #3 and #82) remained in the facility. One resident (Resident #95) discharged to the community. The census was 83. Review of the Centers for Medicare and Medicaid Services Survey and Certification memo (S&C-09-20), dated 1/9/09, showed the following:-If the skilled nursing facility (SNF) believes on admission or during a resident's stay that Medicare will not pay for skilled nursing or specialized rehabilitative services and the provider believes that an otherwise covered item or service may be denied as not reasonable or necessary, the facility must inform the resident or his/her legal representative in writing why these specific services may not be covered and the beneficiary's potential liability for payment for the non-covered services. The SNF's responsibility to provide notice to the resident can be fulfilled by the use of either the SNFABN (form CMS-10055) or one of the five uniform denial letters;-The SNFABN provides an estimated cost of items or services in case the beneficiary had to pay for them him/herself or through other insurance they may have; and-If the SNF provides the beneficiary with either the SNFABN or a denial letter at the initiation, reduction, or termination of Medicare Part A benefits, the provider has met its obligation to inform the beneficiary of his/her potential liability for payment and related standard claim appeal rights. Review of the facility's Advanced Beneficiary Notice (ABN) and Notice of Medicare Non-Coverage (NOMNC) policy, issued 4/1/22, showed:-Policy: Both Medicare beneficiaries and providers have certain rights and protections related to financial liability under the Fee-for-Fee (FFS) Medicare and the Medicare Advantage Programs. The financial liability, appeal rights, and protections are communicated to beneficiaries through notices given by providers;-Procedure: -If the facility believes on admission or during a resident's stay that Medicare will not pay for skilled nursing or specialized rehabilitation services based upon not reasonable and necessary, the facility will notify the resident or his/her authorized representative in writing. The notice requirement will be fulfilled using the SNFABN; -The facility will issue the NOMNC when there is a termination of all Medicare Part A services for coverage reasons; -The NOMNC is issued when all covered services end for coverage reasons. If after issuing the NOMNC, the SNF expects the beneficiary to remain in the facility in a non-covered stay, the SNFABN must be issued to inform the beneficiary of potential liability for the non-covered stay; -The NOMNC and the SNFABN will be issued to the resident no later than two days before the termination of skilled services. 1. Review of Resident #3's medical record, showed:-Medicare Part A skilled services start date of 5/29/25 and end date of 9/5/25;-Remained in the facility;-No NOMNC form issued;-No SNFABN form issued. 2. Review of Resident #82's medical record, showed:-Medicare Part A skilled services start date of 6/6/25 and end date of 9/12/25;-Remained in the facility;-No NOMNC form issued;-No SNFABN form issued. 3. Review of Resident #95's medical record, showed:-Medicare Part A skilled services start date of 6/27/25 and end date of 8/5/25;-discharged to the community;-No NOMNC form issued. During an interview on 2/3/26 at 1:41 P.M., the Administrator said the facility had not issued any SNFABN or NOMNC forms upon discharge from Medicare Part A. She would have expected the notices to be provided upon discharge from Medicare Part A services.

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to develop and implement comprehensive policies and procedures to prevent potential sexual abuse for two residents who were identified by staff as being in a sexual relationship (Residents #86 and #80). The census was 83.Review of the facility's Abuse, Neglect and Exploitation policy, revised on 3/3/22, showed:-Policy: It is the policy of this facility to provide protections for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation and misappropriation of resident property;-Definition of sexual abuse: non-consensual sexual contact of any type with a resident;-Policy Explanation and Compliance Guidelines;-The facility will develop and implement written policies and procedures that:--Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property;--Establish policies and procedures to investigate any such allegations; --Include training for new and existing staff on activities that constitute abuse, neglect, exploitation, and misappropriate of resident property, reporting procedures, and dementia management and resident abuse prevention; --Establish coordination with the QAPI (Quality Assurance and Performance Improvement) program; --The facility will designate an Abuse Coordinator in the facility who is responsible for reporting allegations or suspected abuse, neglect, or exploitation to the state survey agency and other officials in accordance with state law;--The facility will provide ongoing oversight and supervision of staff in order to assure that its policies are implemented as written;-The policy did not include establishing a safe environment that supports, to the extent possible, a resident's consensual sexual relationship and by establishing policies and protocols for preventing sexual abuse, such as to identify when, how, and by whom determinations of capacity to consent to a sexual contact will be made and where this documentation will be recorded. Review of Resident #86's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by the facility staff, dated 10/7/25, showed:-Cognitively intact;-No behaviors exhibited;-Diagnoses included high blood pressure, diabetes, unspecified injury of head, and generalized muscle weakness. Review of the resident's Social Services Sexuality Assessment, dated 7/11/24, showed:-Cognitively able to complete the assessment;-No history of sexually inappropriate behavior;-No cultural, spiritual or religious beliefs that influence his/her views, beliefs or attitudes of sexuality;-Never been hurt in a sexual way or forced to have sex when he/she didn't want to;-Never been tested for STIs (sexually transmitted infections) or human immunodeficiency virus (HIV, a virus that attacks the body's immune system);-Does not want to be tested for STIs. Review of Resident #80's quarterly MDS, dated [DATE], showed:-Moderate cognitive impairment;-No behaviors exhibited;-Diagnoses included high blood pressure, stroke, non-Alzheimer's dementia, depression, and generalized muscle weakness. Review of the resident's Social Services Sexuality Assessment, dated 8/7/24, showed:-Cognitively able to complete the assessment;-Did not wish to participate in the assessment. During an interview on 2/3/26 at 5:32 P.M., the Director of Nursing (DON) and the Assistant Director of Nursing (ADON) said Residents #86 and #80 were a couple and were sexually active. They allowed the residents to have privacy in a room when they became intimate. During an interview on 2/4/26 at approximately 11:00 A.M., the DON said she was notified by staff that a Certified Nurse Assistant (CNA) stood by the closed door when the residents had sexual activity to make sure no other residents or staff entered the room. She was not sure if the facility had policies, residents' consents, or any type of documents regarding the residents' consensual sexual activities. During an interview on 2/4/26 at 1:40 P.M. and 2:50 P.M., the Administrator said the facility did not have policies or protocols in place for sexually active residents. This was needed to ensure all residents had the capacity to consent. The facility should have policies and procedures in place that include protocol for sexually active residents to determine capacity to consent to sexual contact with other residents.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. Based on interview and record review, the facility failed to follow physician orders for one resident when staff documented a resident's weight loss medication as unavailable when the medication was available and did not administer the medication as ordered (Resident #19). The census was 83.Review of the facility's Charting and Documentation policy, dated 4/1/22, showed:-It is the policy of this facility that services provided to the resident, or any changes in the resident's medical or mental condition, shall be documented in the resident's clinical record as is needed;-Observations, medications administered, services performed, etc., should be documented in the resident's clinical records;-Entries into the clinical record should be made by the appropriate staff members;-If it is necessary to change or add information in the resident's medical record, it shall be completed by means of an addendum, appropriate striking technique and signed and dated by the person making such change or addition. 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), anxiety and depression. Review of the care plan in use at the time of survey showed:-Focus: Regular diet;-Goal: Will comply with recommended diet through review date;-Interventions included administer medications as ordered. Monitor/document for side effects and effectivities; assist the resident with developing a support system to aid in weight loss efforts, including friends, family, other residents, volunteers, etc. During an interview on 1/29/26 at 10:52 A.M., the resident said he/she has not been receiving his/her Zepbound injections (medication used for weight loss). He/She has only received two injections. Review of the physician order sheet, in use at the time of survey, showed a physician order for Zepbound subcutaneous solution 2.5 milligram (mg)/0.5 milliliters (mL), inject 2.5 mg subcutaneously (under the skin) one time a week on Thursday for weight management. Start date 12/04/25. Review of the resident's Medication Administration Record (MAR) for the month of December 2025, showed a physician order for Zepbound inject 2.5 mg subcutaneously one time a week on Thursday for weight management. Two out of four opportunities staff documented other, see nurse's notes, and one out of four opportunities was blank. Review of the resident's progress notes, dated 12/1/25 through 12/31/25, showed on 12/4/25 at 10:21 A.M., medication unavailable, reordered 12/3/25 and on 12/18/25 at 11:00 A.M. medication unavailable, reordered 12/18/25. There was no other documentation. Review of the resident's MAR dated 1/1/26 through 1/31/25, showed a physician order for Zepbound inject 2.5 mg subcutaneously one time a week on Thursday for weight management; Documentation showed two out of five opportunities staff documented other, see nurse's notes. Review of the resident's progress notes dated 1/1/26 through 1/31/26, showed on 1/1/26 at 4:55 P.M., medication unavailable and on 1/22/26 at 7:06 P.M. medication unavailable. During an interview on 2/3/26 at 12:03 P.M., the pharmacist said the resident's Zepbound was filled on 12/4/25 and 12/28/25. Each box had four pens. During an interview on 2/3/26 at 5:50 P.M., Nurse S checked the refrigerator in the medication room and said the resident had six Zepbound 2.5 mg pens in the refrigerator. During an interview on 2/4/26 at 2:50 P.M., the Director of Nursing (DON) said she expected staff to accurately document medications and treatments in the residents' clinical record, as ordered.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure double portions and a divided plate and sack lunch were provided for one resident (Resident #74) per the physician's and Registered Dietician's (RD) orders. The facility failed to ensure the RD assessed residents upon admission, quarterly, annually, and as needed for three sampled residents (Resident #74, #19, and #5). In addition, the facility failed to notify the physician or RD of fluctuations in resident's weights for two residents (Residents #19 and #5). The sample size was 22. The census was 83.Review of the facility's undated Nutritional Assessment and Diet History Policy, showed:-A nutritional assessment and diet history will be completed for each resident according to State and Federal requirements. The assessment/history form should be initiated within 72 hours; however, it is desirable to visit each new resident within the first 24 hours of admission and diet history should be completed by the Dietary Manager within seven days of admission;-The nutritional assessment will include appropriate clinical data as required. Pertinent lab data, diagnoses, food-drug interactions, hydration status and ideal body weight range, weight loss or gain percentages, if applicable. Review of the facility's undated Nutritional Reassessments policy, showed:-Policy: Reassessments shall be performed when there is a significant change in the nutritional status of a resident. All residents will be reassessed on a yearly basis using the admission date as a guide;-Procedure: The RD will reassess the high-risk residents and those identified with special needs by the Dietary Manager on the Dietician's progress notes form. Review of the facility's Weights and Weight Loss policy, dated 4/1/22, showed:-Policy: It will be the practice of this facility to implement the following systems regarding weight documentation;-New admits and readmissions will be weighed upon admission, monthly and/or as ordered by the physician;-The RD is to review all admission weights for possible interventions;-Significant weight loss shall be addressed by the physician and/or RD through discussions with the resident and/or resident representative for known preferences and desires and development and implementation of interventions to attempt to address the weight loss;-Monthly weights will be completed by the nursing department, unless otherwise indicated or ordered;-Weekly and daily weights may be obtained per RD or physician orders in order to monitor clinical status of a resident requiring closer monitoring and intervention. 1. Review of Resident #74's Nutrition Assessment, dated 4/11/24, showed:-Regular diet, no oranges, bananas, beans, potatoes or tomatoes. Double eggs at breakfast and double meat with lunch and dinner;-Divided dish;-Weight on 4/10/24 measured 207 pounds. Review of the resident's medical record showed no additional Nutrition Assessments after 4/11/24. Review of the resident's care plan, revised 12/26/24, in use during the time of the investigation, showed:-Focus: The resident has nutritional problems or potential nutritional problems. He/She is on a regular diet;--The resident will maintain adequate nutritional status as evidence by maintaining weight, no signs and symptoms of malnutrition through review date;--Interventions: Monitor/record/report to medical doctor as needed for signs of malnutrition, muscle wasting and significant weight loss. Provide and serve diet as ordered;-Focus: The resident needs dialysis (process of filtering the blood for individuals with kidney failure) related to renal (kidney) failure;-Goal: The resident will have minimized risk of complications related to dialysis through the review date;-Interventions: Provide sack lunch and/or snacks for the resident to take to dialysis on dialysis days. Review of the resident's undated current active orders showed an order dated 7/23/25: Provide sack lunch and/or snack for patient to take to dialysis on dialysis days. Review of the resident's monthly weights for August, September, October and November 2025, showed a weight of 187.2 pounds. Review of the resident's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 11/19/25, showed:-Cognitively intact;-Exhibited no behaviors;-Required set up or assistance with eating;-Diagnoses included renal disease and diabetes;-Weight of 185 pounds;-No weight loss or gain (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	in six months. Review of the resident's weight report, showed:-On 12/9/25, a weight of 187 pounds;-On 1/7/26, a weight of 187 pounds. During an interview on 1/29/26 at approximately 9:45 A.M., the resident said he/she had been at the facility for about four years. He/She attended dialysis and was supposed to be provided with a sack lunch to take. He/She never received a sack lunch. The resident was also supposed to get double portions and never did. He/She weighed over 200 pounds when he/she was first admitted to the facility. There were times when he/she returned from dialysis, and there was no food available for him/her. Observation on 1/29/26 at 11:49 A.M., showed the resident ate lunch in the dining room. His/Her meal consisted of one serving of turkey, one serving of stuffing and a scoop of mixed vegetables. The meal was on a regular plate. The resident used a spoon and attempted to cut the turkey. Observation and interview on 1/30/26 at 9:31 A.M., showed the resident at the front lobby waiting on transportation to dialysis. The resident had no sack lunch. The resident said he/she was not offered a sack lunch or snack to take to dialysis. During an interview on 2/2/26 at 9:04 A.M., the resident said he/she ate breakfast and did not receive double portions. He/She never received double portions and wanted them. He/She was weighed at dialysis and was 187 pounds. The only time he/she was weighed was when he/she went to dialysis. The facility had not provided snacks or a sack lunch. His/Her family members brought bread, lunch meat, milk and cereal so the resident would have food upon his/her return from dialysis. The resident also said he/she had not seen a dietician in about two years. Observation on 2/2/26 at 10:10 A.M., showed the resident at the front lobby about to attend dialysis. The resident did not have a sack lunch, or snacks provided by the facility. Observation on 2/3/26 at 12:17 P.M., showed the resident received a lunch tray. The meal consisted of one serving of lasagna, one serving of coleslaw, one piece of bread and juice. The food served on a regular plate. No double portions or divided plate was provided. The resident said he/she wanted double portions. Observation on 2/3/26 at 3:41 P.M., showed the resident weighed by Certified Nursing Assistants (CNAs) I and CNA J. The resident weighed 185.4 pounds. CNA I said the resident was regularly weighed at the dialysis center. During an interview on 2/4/26 at 9:14 A.M., the Dietary Manager said she observed meal services and double portions had not been served to residents. Residents receiving dialysis were not provided with sack lunches. Residents were expected to receive double portions and sack lunches, as ordered. The Dietary Manager said she now had a list of residents who were to receive double portions and sack lunches and would ensure they received them going forward. 2. Review of Resident #19's admission MDS, dated [DATE], 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). Review of the care plan in use at the time of survey showed:-Focus: Resident on a regular diet;-Goal: Will comply with recommended diet through review date;-Interventions included RD to evaluate and make diet changes recommendations as needed. During an interview on 2/3/26 at 12:15 P.M., the resident said the food was terrible. He/She barely ate the food provided by the facility. He/She mostly ate his/her own food and snacks. Review of the resident's weight log showed:-On 11/18/25 weight measured 378 pounds;-On 12/9/25 weight measured 362 pounds;.-On 1/7/26 weight measured 356 pounds. Observation on 2/3/26 at 3:56 P.M., showed staff weighed the resident using the mechanical lift. The resident's weight measured 341pounds. Review of the resident's medical record showed there was no dietary evaluation completed and there was no progress note showing the DM/RD was made aware of the weight fluctuations. 3. Review of Resident #5's admission MDS, dated [DATE], showed:-Cognitively intact;-Diagnoses included anxiety, depression and post-traumatic stress disorder (PTSD). Review of the resident's care plan in use at the time of survey, showed:-Focus: Resident has diabetes;-Goal: Will have no complications related to diabetes through review date;-Interventions included dietary consultation for nutritional regimen and ongoing monitoring. Review of the resident's medical record, showed:-An admission dietary profile dated 11/10/25 showed on 10/30/25 weight measured 331.5 pounds;-A weight log, showed on 1/7/26 the resident measured 340 pounds. No other weights (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	documented on the weight log; -No RD note or documentation showing the DM/RD was aware of the resident's weight fluctuations. Observation on 2/3/26 at 3:56 P.M., showed staff weighed the resident using the mechanical lift scale. The resident was moving while being weighed. The resident's weight measured 325 pounds. 4. During an interview on 2/3/26 at 4:10 P.M., the Director of Nursing (DON) said residents should have a dietary assessment on admission, quarterly and when there is a significant change. The facility did not have dietary notes for the residents. 5. During an interview on 2/3/26 at 5:10 P.M., the Administrator said there were no dietary notes/assessments in the medical records since 2024. The RD started in December 2025. There was a dietary technician who visited with the residents and documented on behalf of the RD. If there were any dietary or nutritional concerns, staff were to notify the RD or Dietary Technician. Dietary notes should be documented regularly. Dietary assessments were to be completed upon admission, quarterly, annually and if there was a significant change. If a resident had an order to receive double portions and a sack lunch, the resident should have received it.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. Based on observation, interview and record review, the facility failed to ensure staff followed acceptable standards of practice for one resident with an enteral tube feeding (TF, delivers liquid nutrition directly into the stomach or small intestine via a tube for patients unable to meet their nutritional needs by mouth). The facility identified one resident as having a tube feeding (Resident #9), and issues were identified. Staff failed to follow the TF flush infusion rate and duration as ordered by the physician. In addition, staff failed to stop or hold the infusion while providing personal care while the resident's head of bed was lowered, increasing the risk of aspiration of the tube feeding formula. The census was 83. Review of the facility's Enteral Tube Feeding policy, dated 1/1/22, showed:-Verify/obtain physician order for enteral feeding;-Be certain that the order for the enteral feeding tube specifies rate, amount, times of administration and any specific orders related to stopping/holding tube feeding;-Verify/obtain orders related to water flushes per shift for additional hydration, auto-flush for additional hydration, flushes prior to and after medication administration;-Standard orders for flushes prior to and after medication administration should be 30-50 milliliters (ml) or as ordered by physician;-Flushes between medications administered are 5 -10 ml or as ordered by physician;-Enteral tube feeding may be accomplished via use of a feeding pump, gravity bag or utilization of syringe/bolus methods as ordered by physician depending on the tolerance to tube feeding and nutritional needs of the resident;-Elevate the head of bed (HOB) 30-45 degrees or per physician orders while tube feeding is infusing, with the exceptions of brief personal/incontinence care, positioning or as indicated by physician orders;-Orders may be received to hold enteral tube feeding for periods during the course of the day for medication administration, therapy involvement or to allow for care and services. Review of Resident #9's significant change in status Minimum Data Set (MDS), a federally mandated assessment instrument completed by the facility staff, dated 10/21/25, showed:-Impairment of both upper and lower extremities;-Diagnoses included non-traumatic spinal cord dysfunction, cerebral palsy (CP, is a brain disorder that appears in infancy or early childhood and permanently affects body movement and muscle coordination), and malnutrition;-Nutritional approach: Feeding tube. Review of the resident's care plan in use at time of survey showed:-Focus: The resident requires tube feeding related to dysphagia (difficulty swallowing), weight loss;-Goals: The resident will remain free of side effects or complications related to tube feeding. The resident's insertion site will be free of signs and symptoms of infection. The resident will be free of aspiration;-Interventions: Flush gastrostomy tube (g-tube) with water per order. The resident is dependent with tube feeding and water flushes. See physician orders for current feeding orders. Review of the resident's electronic Physician's Order Sheet (ePOS) showed:-An order for enteral feed every day and night shift for nutrition, Glucerna 1.5 (high calorie liquid nutrition) at 60 milliliters per hour (ml/hr) to run 22 hours a day;-An order for enteral feed, every shift, flush tube with 200 ml of water every six hours. Observation on 2/2/26 at 5:27 A.M., showed the resident's TF pump screen showed feeds infusing at 60 ml per hour, with the flush at 160 ml every 0 hours. The Glucerna bottle dated 2/2/26 at 12:45 A.M., while the water flush bag was marked, 2/ . The liquid in the water flush bag was full to 1000 ml level. During an interview and observation on 2/2/26 at 5:35 A.M., Licensed Practical Nurse (LPN) A said the flush should not be on zero. He/She flushed the tube when the TF and water were hung at 12:45 A.M. He/She did not complete the date on the water flush bag because it was wet when he/she tried to mark the date. If the pump screen showed every 0 hours, it means the pump was not flushing. He/She then adjusted the pump for the flush duration time to every 4 hours. Observation on 2/2/26 at 6:13 A.M., showed the resident lay flat in bed with his/her TF infusing at 60 ml/hr. Certified Nurse Aide (CNA) C provided personal care. The staff turned the resident from side to side. After CNA C finished care, he/she raised the head of the bed up. The TF infusion was not held or stopped while care was provided. Observation on 2/2/26 at (continued on next page)

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	265719	A. Building B. Wing	02/04/2026

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

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1:21 P.M., showed the resident's TF pump screen read feeds continued infusing at 60 ml/hr with flush set to 160 ml every 4 hours. Observation on 2/3/26 at 12:16 P.M., showed the resident's TF pump read feeds infusing at 60 ml/hr, with flush at 160 ml/hr, every 0 hours. Observation and interview on 2/3/26 at 4:37 P.M., showed the resident's TF pump still showed feeds infusing at 60 ml/hr, with flush at 160 ml/hr, every 0 hours. The Glucerna bottle dated 2/3/26 at 12:00 A.M. The flush documented as started at 12:00 A.M with 900 ml. Observation showed the water was at approximately at 700 ml. LPN F said he/she was not sure why the flush was set to every 0 hours. He/She was not assigned to the resident. He/She then left the room to ask the nurse assigned to the resident. Upon return, LPN F said LPN E told him/her the flush order was at 200 ml/hr every 6 hours. LPN F then adjusted the pump per order. During an interview on 2/3/26 at 4:43 P.M., LPN E said he/she had just checked the resident's order. He/She unclogged the tube earlier that day. He/She did not see the TF infusion rate and duration in the pump because it was beeping with clogged error on the screen. He/She unclogged the tube and restarted the infusion without paying attention to the infusion rate on the screen. During an interview on 2/3/26 at 5:32 P.M., the Director of Nursing (DON) said she expected staff to follow the physician's orders, including TF infusion rates and duration. The nurse assigned to the residents was responsible for checking orders and the TF pump. The management personnel: DON, Assistant DON (ADON), Minimum Data Set (MDS) Coordinator, wound nurse, and therapy, conduct daily morning meetings, and they review the 24-hour nursing report, including new orders. On 2/4/26 at 9:49 A.M., the DON said she expected the staff to hold or stop the TF infusion when lying flat and providing care or repositioning. The CNAs should not touch the TF pump and should notify the nurses prior to providing residents' care who receive TF.

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide medically-related social services to help each resident achieve the highest possible quality of life. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide medically related social services and appropriate person-centered care to meet his/her highest practicable psychosocial well-being for one resident (Resident #93), who recently admitted to the facility. The sample size was 22. The census was 83. Review of the facility's Social Services policy, issued 4/1/22, showed:-Policy: It will be the policy of this facility to provide medically related social services to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident to assure that sufficient and appropriate social services are provided to meet resident's needs;-Examples of medically related social services include; -Making arrangements for obtaining items such as clothing and personal items; -Assisting residents with financial and legal matters;-Situations in which the facility should provide social services or obtain needed services from outside entities include, but are not limited to the following; -Lack of an effective family or community support system; -Difficulty coping with change or loss; -Need for emotional support;-Procedure: Each facility will have a designated Social Services representative. Those facilities requiring greater assistance may have more than one staff member dedicated to the social services staff. In the interim of a dedicated social services staff member, the facility may choose to utilize another staff member to assist residents with provision of needs as allowed by State and Federal law. 1.Review of Resident #93's admission Record, showed the resident was admitted to the facility on [DATE]. Review of the resident's Baseline Care Plan, dated 1/16/26, showed:-Cognitively intact;-No discharge plans initiated. Review of the resident's Social Services Comprehensive Evaluation, dated 1/20/26, showed:-Has lack of transportation kept you from medical appointments, meetings, work, or getting things needed for daily living? Resident declined to respond;-Does the resident plan to discharge from the facility? No;-Memory okay. During an interview on 2/2/26 at 10:40 A.M., the resident said he/she had been at the facility going on three weeks. The resident was at another facility prior to his/her admission. He/she had a fall and was sent to the hospital. The resident had issues with his/her roommate at the previous facility and told the hospital social worker he/she wanted to move to a different facility. The resident ended up at this facility and has not received any assistance. The resident's finances had not been transferred to the facility. He/She also had property at the previous facility and had no means to retrieve them. He/She purchased glasses from an eye clinic, and they were ready for pick up. When the resident tried speaking with the Administrator regarding his/her concerns, he/she was told there was nothing they could do because they did not have a social worker at the time. The resident did not have any family outside of the facility to assist. He/she felt helpless and that he/she was dumped here with no assistance. During an interview on 2/3/26 at 11:09 A.M., Certified Nursing Assistant (CNA) G said there was no social worker at the facility. Residents complained about it, particularly Resident #93, who had been trying to receive services since he/she was admitted to the facility. 2. 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 said there was no social worker available. One resident said there was a social worker present but left. There were a lot of issues. Residents complained about not getting help or expected to figure it out on their own. 3. During an interview on 2/3/26 at 1:41 P.M., the Administrator said she started at the facility in October 2025 and the social worker started with her. Two weeks after the social worker started, there was a family event that caused the social worker to leave. The social worker returned from leave after the family event and quit without notice. The facility had been without a social worker since the end of November. The Administrator was familiar with Resident #93 and recalled him/her requesting services. The Administrator said she told the resident there was no social worker at the time and she could not assist the resident with his/her requests. The Administrator would expect resident needs to be met in regard to social services.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview and record review, the facility failed to ensure drugs and biologicals were stored in accordance with acceptable standards of practice. The facility identified two medication rooms, two nurse carts, two Certified Medication Technician (CMT) carts, and one treatment cart. Both medication rooms, two CMT carts, and one nurse cart were checked for medication storage. Issues were found in all three medication carts and one medication room. Staff failed to double-lock the refrigerated controlled medications. In addition, staff failed to dispose of expired over-the-counter (OTC) medications. Furthermore, staff placed an unlabeled capsule in the drawer of a medication cart. The census was 83.Review of the facility's Medication/Biological Storage Policy and Procedure, dated 4/1/22, showed:-It will be the policy of this facility to store medications, drugs and biologicals in a safe, secure and orderly manner;-Compartments (including, but not limited to, drawers, cabinets, rooms, refrigerators, carts and boxes) containing medications, drugs, and biologicals shall be locked when not in use and trays or carts used to transport such items shall not be left unlocked if out of a nurse's view;-Drugs shall be stored in an orderly manner in cabinets, drawers, carts or automatic dispensing systems;-Each resident's medications shall be assigned to an individual cubicle, drawer or other holding area to prevent the possibility of mixing medications of several residents;-Medications requiring refrigeration must be stored in a refrigerator located in the drug room at the nurse's station or other secured location;-Routine temperature monitoring should take place to ensure proper maintenance of appliance and medication storage. 1. Observation on 2/2/26 at 7:47 A.M., of the CMT cart for Hall 200 showed the cart contained the following OTC expired medications bottles:-Calcium (dietary supplement) 600 + D 10 micrograms (mcg), opened 7/19/25, expired 11/25;-Aspirin 325 milligrams (mg), opened 10/28/25, expired 10/25;-Colace (stool softener) 10 mg, opened 7/31/25, expired 1/26;-Mucus Relief Expectorant 400 mg, opened 3/20/25, expired 7/25;-Magnesium Oxide (supplement) 400 mg, unopened, expired 7/25;-Sodium Chloride (electrolyte replenisher)1 gram (gm), opened 3/17/24, expired 12/25;-Vitamin B6 50 mg, opened 4/9/25, expired 1/26;-Oyster Shell Calcium 250 mg plus Vitamin D (supplement for bone health), opened 11/30/24, expired 7/25;-Optimum Dairy Rescue (treats lactose intolerance), opened 8/23/24, expired 11/25;-Vitamin B12 1000 mg, opened 3/1/25, expired 1/26;-Vitamin D 10 mcg, opened 10/2/24, expired 11/24. During an interview on 2/2/26 at 7:47 A.M., Licensed Practical Nurse (LPN) E said the expired medications should not be used and should be disposed immediately. 2. Observation and interview on 2/2/26 at 8:02 A.M., showed the top drawer of the nurse cart for Hall 100/200 had an unlabeled medication cup with a blue capsule in it. LPN E said he/she did know what and whose medication it was. He/She did not know who prepared and pre-popped the medication. He/She would not administer unlabeled medications to the residents. He/She then disposed the medication 3. Observation on 2/2/26 at 8:10 A.M., showed an unlocked medication refrigerator in the locked medication room. The padlock for the refrigerator was placed on top of the refrigerator. There were two bottles of sealed Lorazepam liquid (controlled medication that treats anxiety) in the refrigerator, along with several insulin pens. During an interview on 2/2/26 at 8:10 A.M,.LPN E said he/she did not know who left the refrigerator unlocked. During an interview on 2/2/26 at 8:10 A.M., the Assistant Director of Nursing (ADON) said the refrigerator should be locked at all times. Lorazepam should be placed in a double-locking system. 4. Observation and interview on 2/2/26 at 8:42 A.M., showed the CMT cart for Hall 400/500 had an OTC bottle of Vitamin C 250 mg, opened on 5/8/25, and expired in 1/26. Another OTC bottle of Aspirin 325 mg was opened, undated, and expired on 10/25. The ADON said expired medications should not be used and be disposed immediately. 5. During an interview on 2/3/26 at 5:32 P.M., the Director of Nursing (DON) said the unit manager who works night shift was responsible for checking expired medications. The pharmacy checks and audits (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the medications monthly. The DON also expected the nurses and CMTs to check their carts and the medications' expiration dates. Expired medications should be disposed appropriately. Staff should not pop or pull the medications when not ready to be administered. If residents refused the medications, they should be destroyed appropriately. The DON expected staff to always lock the medication refrigerator. Lorazepam should be double-locked.

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F 0809 Level of Harm - Minimal harm or potential for actual harm 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. 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