STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265727	A. Building B. Wing	05/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Carmel Hills Wellness & Rehabilitation	810 East Walnut Independence, MO 64050

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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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to notify the legal guardian of one discharged resident (Resident #6), in a timely manner (usually within 24 hours) after the resident passed away. The facility also failed to notify the facility's Business Office Manager (BOM) in a timely manner, which caused the business office to cash a check sent by the legal guardian's office to the facility, 14 days after the resident passed away out of 19 sampled residents. The facility census was 143 residents. On 5/21/25 the Administrator were notified of the past noncompliance that occurred on 3/26/25. All staff were educated on the notification policy. The deficiency was corrected on 4/22/25. Review of the Facility's policy entitled Change of Condition Notification revised 6/20, showed: -Purpose: To ensure residents, family, legal representatives, and physicians are informed of changes in the residents' condition in a timely manner. -Definition: An Acute Change of Condition (ACOC) is a sudden, clinically important deviation from a patient's baseline in physical, cognitive, behavioral, or functional domains, Clinically important means a deviation that without intervention, may result in complications or death. -Members of the Interdisciplinary Team (IDT) are expected to report and document signs and symptoms that might represent an ACOC. The facility will promptly inform the resident, consult with the resident's Attending Physician, and notify the resident's legal representative when the resident endures a significant change in their condition caused by, but not limited to: -Family Notification: The licensed Nurse will notify the resident, he resident's responsible party or the family/surrogate decision makers of any changes in the resident's condition as soon as possible. --Documentation: A licensed Nurse will document the following: --Date, time and pertinent details of the incident and the subsequent assessment in the nursing notes. (continued on next page)

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

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	--The time the attending physician was contacted, the method by which he/she was contacted, the response time and whether orders were received. --The time the family/responsible person was contacted. 1. Review of Resident #6's admission record printed on 5/16/25, showed he/she admitted on [DATE] with the following diagnosis: -Unsteadiness on his/her feet. -Alzheimer's disease (a progressive neurological disorder that primarily affects the brain, causing memory loss, thinking problems, and behavioral changes) with late onset; need for assistance with personal care. -Hyperlipidemia (a condition where there are elevated levels of fats (lipids) in the blood). -The resident's legal guardian was the Public Administrator's Office and was listed as the first contact. Review of the resident's Progress Notes dated 3/26/25, showed: -At 9:07 A.M. The resident was actively dying. Comfort medications only. There was no documentation of notification of the legal guardian. -At 10:15 A.M., The hospice (end of life care) Case Manager was at the facility with Comfort Medications. The resident's relative was at the bedside of the resident. There was no documentation of notification of the legal guardian. -At 11:02 A.M., The pulse and respirations quietly ceased at 10:57 A.M., with the resident's relative and the hospice nurse at the bedside of the resident. There was no documentation of notification of the legal guardian. -At 12:10 P.M., the Post Mortem provide by the hospice nurse. The body was released to the funeral home transportation at this time. Death report was faxed to the local County Medical Examiner. There was no documentation of notification of the legal guardian. Review of a check dated 4/3/25, showed a check from the legal guardian was made payable to the facility for $1,580.09. Review of the deposit sheet dated 4/9/25 and the batch report (a report which showed a batch of checks which were processed into the facility's account) dated 4/9/25, showed the check from the legal guardian was processed on 4/9/25, 14 days after the resident passed away. During an interview on 5/14/25 at 9:24 A.M., the Business Office Manager (BOM) said: -He/she was on vacation from 3/12/25 through 4/1/25. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Therefore, he/she did not find out the resident passed away until 21 days after he/she returned to duty at the facility. -He/she notified the corporate business office on 4/23/25 that the legal guardian needed a refund because the resident passed away. During a phone interview on 5/14/25 at 12:04 P.M., the legal guardian said the following: -The office of the legal guardian was not notified of the Resident's death. -He/she expected his/her office within 24 hours after a ward (a person, for whom a guardian has been appointed by a court or who has become directly subject to the authority of that court) of that office has passed away, because the Office of the legal guardian has to notify Medicaid, Social Security, and Medicare because the ward may have been recipient of some of that aide. -The resident was on hospice (a program that gives special care to people who are near the end of life and have stopped treatment to cure or control their disease). -The methods of contacting him/her were the main office phone number, the after-hours number, his/her e-mail, and his/her work phone. -The process of notifying the guardian's office, if the Deputy Legal Guardian, were not there, would be let the clerical person know there was a death of one of the wards and the phone call would be transferred to another deputy Legal Guardian. -It was not until 4/22/25, that his/her assistant was informed the resident had passed away when his/her assistant went to the facility to do a monthly visit of their wards at that facility. -The facility did not submit any paperwork During a phone interview on 5/14/25 at 3:04 P.M., the Deputy Legal Guardian's Assistant said the following: -He/she went to the facility on 4/22/25 for a monthly visit and stated he/she wanted to Resident #6. He/she was directed to the business office. -At the business office, he/she was told that Resident #6 passed away and the date that Resident #6, passed away. -He/she was very surprised to hear than one of the wards of the Legal Guardian's office had passed away. -He/she did not hear about the resident's death, until she got to the facility. and -No one in her office received a phone call from the facility regarding the death of the resident. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/16/25 at 10:38 A.M., Licensed Practical Nurse (LPN) A said: -He/she was the charge nurse for his/her unit the day the resident passed away. -He/she had not notified the business Office the resident passed away. -He/she did not notify the legal guardian's office because when Hospice was in the facility, Hospice was in charge of notify the family and legal guardians. During an interview on 5/16/25 at 10:48 A.M., the Director of Nursing (DON) said hospice mentioned they notified the Legal Guardian's office. During an interview on 5/16/25 at 11:38 A.M., Assistant Director of Nursing (ADON) A said: -If a hospice staff member was in the facility when a death occurs, hospice was supposed to notify the Legal Guardian. -He/she was told by a hospice staff member that a nurse from hospice notified the PA's office. During an interview on 5/16/25 at 1:36 P.M., the Administrator said: -The former Social Service Director (SSD) said he/she reached out by calling the Deputy Legal Guardian's mobile phone. -He/she found out later that the SSD did not reach out to anyone at the Legal Guardian's Office. -He/she found out in April 2025 that the Deputy Legal Guardian was not notified after the death of the resident. -Based on his/her understanding of the situation, the BOM posted the checks into the accounts, without looking at the dashboard he/she was supposed to normally look at. During a phone interview on 5/19/25 at 2:48 P.M., Hospice Licensed Practical Nurse (LPN) A said: -On 3/25/25, he/she called the legal guardian and left a message for the legal guardian that the Resident was in the process of dying. -The hospice Agency only does the notification to the legal guardian if there was no one at the bedside on the resident behalf and since the resident's relative was at the bedside, the hospice agency did not have to notify the legal guardian. -The Facility should have notified the legal guardian. MO00253155

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 2. Review of Resident #5's Face Sheet showed the resident was admitted on [DATE], with diagnoses including diabetes, heart disease, stroke, high blood pressure and asthma. Review of the resident's admission MDS dated [DATE], showed the resident: -Was alert with significant confusion. -Needed substantial assistance with transfers, mobility, bathing and dressing. Review of the resident's Care Plan updated 2/13/25, showed the resident had impaired cognitive functioning, vision loss, was at risk for falls, was incontinent and had a self care deficit. Interventions showed the resident was dependent on staff for bathing and staff was to provide maximum assistance to the resident. Review of the resident's bathing sheets from 3/24/25 to 5/8/25, showed the resident received bathing on the following dates: -March-3/24/25 -April-4/2/25, 4/11/25, 4/18/25, 4/25/25 -May-5/1/25, 5/8/25 -Bathing for the resident was once per week. Review of the resident's Medical Record showed there was no documentation showing the resident declined bathing. During an interview on 5/16/25 at 11:01 A.M., showed Certified Medication Technician (CMT) A said: -He/She worked with the resident and the resident had some cognitive impairment and needed total assistance for transfers. -The resident needed total care, to include bathing and mobility assistance. -The resident was supposed to receive bathing twice daily. -They have bathing assistants but he/she was not sure if the resident received bathing twice every week while he/she was living there. 3. During an interview on 5/16/25 at 1:38 P.M., showed CMT B said: -They try to have two bath aides to give the baths to residents. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-One of the bath aides worked consistently on Monday, Tuesday, Thursday and Friday and the other bath aide worked on the other days, but they do not have a bath aide on weekends. -Both bath aides try to get as many baths completed as possible when they are here but they are giving baths to 90 or more people. -Residents do not always get two baths weekly. During an interview on 5/16/25 at 1:42 A.M., CNA A said: -The bath aides were responsible for giving baths twice weekly. -The primary bath aide gave baths four days weekly and they try to get as many baths as they can, but the resident's get at least one bath weekly. -There were no bath aides working today. -When the bath aides call in, the CNA staff try to get baths done as they are able and they complete the shower/bathing sheet and turn it in. During an interview on 5/16/25 at 1:48 P.M. Registered Nurse (RN) A said: -The bath aides were supposed to give each resident a bath/shower twice weekly. -When the bath aide was not in the building, or was unable to give baths, the CNA staff was supposed to try to give the baths or make up the bath for the resident. -He/She had not been in the facility for a few weeks, but the CNAs were expected to assist with giving baths so the residents get baths twice weekly. -The bath aide had called in today and no baths had been given today. During an interview on 5/16/25 at 1:51 P.M., Assistant Director of Nursing (ADON) A said: -Residents were supposed to get baths/showers at least twice weekly. -There were two bath aides on the long term care unit and one on the rehabilitation unit. -There was no bath aide on the dementia unit and the CNA staff on the unit completed the baths weekly. -All of the nursing staff were educated that if the bath aide was not there they were supposed to give baths/showers. -He/She has also given baths/showers to residents -They were trying to find additional staff to fill a bath aide position. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Currently, residents were getting at least one bath per week, but not two. -He/She did not believe the CNA staff were meeting their expectation because baths should be given on every shift and not by only the bath aide. 3. During an interview on 5/16/24 at 2:00 P.M., the Director of Nursing (DON) said: - Assigned Restorative Aides (RA) and Bath Aides were over all responsible for offering and providing the resident a bath or shower two times a week. -He/she would expect the CNA's and bath aides to ensure the resident was offered and received showers/bathing at least two times a week. -He/she would expect the CNA's who were assigned to a specific hallway, to be responsible for ensuring the residents received scheduled baths/showers assigned for that day and the resident was kept well-groomed and clean. -He/she would expect the shower sheet be completed by the staff who had provided the resident's shower/bath. -He/she would expect the shower sheet to be reviewed by the charge nurse and signed as reviewed. MO00252740 & MO00253115 Based on observation, interview and record review, the facility failed to follow their policy to ensure bathing was completed two times a week for two sampled residents (Resident's #9 & #5) out of 19 sampled residents. The facility resident census of 143 residents. Review of the facility's undated Bathing/Shower Program policy showed: -The resident will initially be placed on the schedule of two baths/showers per week, which may be adjusted to more or less often according to the resident's preference. -Showers/baths will be available 24 hours per day as the resident request. 1. Review of resident #9's admission Record showed he/she had the following diagnosis: -Absence of a right leg below the knee. -Needs assistance with personal care. Review of the resident's Quarterly Minimum Data Set (MDS-a federally mandated assessment tool to be completed by facility staff for care planning) dated 2/21/25 showed he/she: -Had a moderate cognitive impairment. -Was frequently incontinent of urine and frequently incontinent of bowel. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Had no documentation related to rejection of cares noted. Review of the resident's Activity of Daily Living (ADL'S) Care Plan revised on 2/13/25 showed: -He/she has self care deficit related to a right below the knee amputation. -He/she was dependent on facility staff for personal cares and bathing. Review of the resident's Certified Nursing Assistant (CNA) Care Kardex (summary of how to care for the resident) showed the resident required assistance with bathing and personal. Review of the resident's CNA Shower Sheet and Skin Condition reporting form from 4/1/25 to 4/29/25 showed: -On 4/1/25 and 4/4/25, he/she had received a bath. -On the week of 4/6/25 to 4/12/25, he/she received one bath on 4/11/25. -On 4/15/25 he/she received a bath and none the rest of the week. -No baths were recorded for the week of 4/20/25 to 4/26/25. -On 4/29/25 he/she received a bath. -The resident received five showers out of nine opportunities. Review of the resident's CNA Shower Sheet and Skin Condition reporting form showed: -On 5/2/25 documentation of a shower given and no skin issue noted. -On 5/5/25, the staff did not indicate type bath or shower was given. -On 5/8/25, the staff did not indicate type of bath or shower was given. Observation and interview 5/14/25 at 10:25 A.M., the resident said: -He/she was getting at least one bath a week. -He/she had no lingering odors at that time of interview. During an interview on 5/16/25 at 8:00 A.M., CNA B said: -The facility has one or two bath aides assigned during the week to provide the residents baths/showers. -If the facility does not have a bath aide assigned that day, then CNA staff assigned to each hall would be responsible for ensuring and completing their resident's scheduled shower that day. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-CNA staff who provide the shower for their assigned resident would be responsible for completing the shower sheets and they were to be reviewed by nursing staff. During an interview on 5/16/25 at 10:55 A.M., CNA C said: -The resident was able to make his/her care needs known. -The residents were scheduled to have a bath or shower two times a week. -The resident would normally receive bath/shower from the bath aides at least weekly, if not two times a week when bath aides are scheduled. -The CNA's are also responsible for providing showers/baths to those residents assigned that day, if no bath aides were scheduled. -He/she does not always have time to provide a shower/bath for the resident when a bath aide not available. -The bath aide had called in sick today (5/16/25), so most likely those residents scheduled for baths today will not be completed. -The staff providing the shower would be responsible for completing the shower sheet to include type of bathing provided.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure one sampled resident (Resident #17) was supervised during smoking times. On 5/15/25 the resident was outside on the smoking patio when the wind came up and the resident's hair caught fire. Hospitality Aide B failed to report the smoking incident which resulted in a delayed burn treatment for the resident. The facility further failed to ensure resident electronic smoking materials were stored safely and not used in the facility for one sampled resident (Resident #9) who had a Electronic-cigarettes (also known as e-cigarettes/vape pen are battery-operated devices that heat a liquid and produce an aerosol) found in the resident bed, and also observed on bedside table, out of 19 sampled residents. The facility census was 143 residents. Review of the Facility's Smoking by Resident Policy revised on 6/2020 showed: -This policy applies to the use of both cigarettes and e-cigarettes. -Smoking is not allowed anywhere inside the facility. -Resident who choose to smoke will be assessed for their ability to smoke safely prior to being allowed to smoke in designated smoke areas. -Resident will be allowed to smoke in designated smoking areas only. -All smoking materials will be stored in a secure area to ensure they are kept safe. -All smoking area session will be supervised by facility staff members. Review of copy of undated Resident's Smoking Violation policy/Agreement showed: -Smoking by resident will occur under the direct supervision of facility staff or delegated volunteer. The resident smoking care plan indicate type supervision needed. -The resident will be assessed and evaluated for safe smoking and if can smoke independently or with supervision. -Smoking supplies will be labeled with the resident name, room number and bed number, maintained by facility staff and stored in a suitable cabinet the kept lock at nursing station. -If resident cognitively and physically able to secure all smoking materials, the facility may allow him/her to maintain his/her own tobacco or electronic cigarette product in a locked compartment. -No resident will be allowed to maintain their own lighter fluid or matches. Review of the facility undated guidelines for Hospitality Aid and All staff, resident smoking showed: (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Smoking materials locked up in the smoking cart. Resident should not have smoking material in possession. Review of the Facility's policy entitled Change of Condition Notification revised 6/2020, showed: -Purpose: To ensure residents, family, legal representatives, and physicians are informed of changes in the resident's condition in a timely manner. -The facility will promptly inform the resident, consult with the resident's Attending Physician, and notify the resident's legal representative when the resident endures a significant change in their condition caused by an injury /accident, The Licensed Nurse will notify the residents Attending Physician when there is an: -Incident/accident involving the resident which results injury and has the potential for requiring physician intervention. Review of the Facility's Smoking by Resident Policy revised on 6/2020 showed: -Resident who choose to smoke will be assessed for their ability to smoke safely prior to being allowed to smoke in these smoke areas. -All smoking area session will be supervised by facility staff members. Review of copy of undated Resident's Smoking Violation policy/Agreement showed: -Smoking by resident will occur under the direct supervision of facility staff or delegated volunteer. The resident smoking care plan indicate type supervision needed. -The resident will be assessed and evaluated for safe smoking and if can smoke independently or with supervision. Review of the facility undated guidelines for Hospitality Aid and All staff related to monitoring residents who smoke showed burns should be reported immediately to the nurse on duty. Review of the Hospitality Aid job description revised 12/2023 showed: -Monitor residents during smoking hours (in the facility designated smoke area). Chart and keeps track of cigarette counts for each resident, updates and organizes smoking book, log and storage. -Identifies and correct safety hazards and reports safety concerns as required. 1. Record review of Resident #17's admission Record showed he/she had the following diagnoses: -Cerebrovascular Accident (CVA, stroke a blockage in the one or more of the arteries supplying blood to the brain) affecting left non-dominant side. -Nicotine Dependence-cigarettes. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Chronic Obstructive Pulmonary Disease (COPD-a disease process that decreases the ability of the lungs to perform ventilation.) -Bipolar (A disorder associated with episodes of mood swings ranging from depressive lows to manic highs). -Lack of coordination. -He/she was own responsible party. Review of the resident's smoking care plan dated 11/19/24 showed: -He/she had been advised of the facility smoking policy. -The resident required supervision while smoking. -Reassess the resident's smoking ability quarterly and after reported unsafe smoking practices. Review of the resident's Annual Minimum Data Set (MDS-a federally mandated assessment tool completed by facility staff for care planning), dated 3/25/25 showed he/she: -Was cognitively intact. -He/she was able to understand others and make his/her needs known. -Required supervision from staff for most cares. -Used tobacco. Review of the resident's Burn and Blister Incident Report from 5/15/25 at 11:00 A.M., showed: -The report was documented and reported on 5/17/25. -Nurse description: The resident received burns to his/her left ear while outside smoking. The resident stated the wind was blowing and the ashes from the end his/her cigarette blew in his/her hair and caught his/her hair on fire and burned his/her ear. The resident said he/she had asked HA B not to report the incident to the nurse because he/she did not want to have to wear burn apron. HA B did not report this information to nursing, the Director of Nursing (DON) or to the Administrator. The resident did finally tell the nurse on 5/17/25 that he/she was burned three days ago, and his/her ear was hurting. -Intervention were put in place at that time. All staff was educated on all incidents must be reported regardless of what the resident requests. The resident care plan has been updated to wear a burn apron when smoking and to braid his/her hair or ensure his/her hair is secured while smoking. (continued on next page)

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Carmel Hills Wellness & Rehabilitation	810 East Walnut Independence, MO 64050

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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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-On 5/18/25 root cause documented by DON showed: The incident was primarily due to environmental factors, specifically the wind conditions and an isolated failure by HA B to follow established oversight protocols. -Reinforce of the facility policy that all incidents must be reported immediately. -Regular training session for staff on safety protocols and incident reporting. -Environmental assessments to mitigate risk associated with outdoor smoking areas. Review of the resident's Weekly Skin Check dated 5/17/25 at 8:45 A.M. showed: -He/she had new skin impairment of burn to his/her left ear. -No detail description noted of the area burn. Review of resident's Wound Assessment Detail Report dated 5/17/25 at 1:47 P.M. showed: -The resident had a facility acquired burn injury to his/her left ear. -The left ear tissue was deep purple with scant amount of drainage noted. -The burn area measured length of 1.20 centimeters (cm) by width of 0.9 cm. -Apply Silvadene ointment every shift. Review of the resident's Physician Order Sheet (POS) dated 5/17/25 showed an physician order for Silvadene External Cream 1% (is a topical antibiotic used to prevent and treat infections in second- and third-degree burns) to apply cream to his/her left ear every shift for burn. Review of the facility's Summary of Events date reported on 5/17/25 showed: -Incidents happen on 5/15/25 at 11:00 A.M. in outside smoking area. -On 5/15/25, the resident was outside smoking when the wind cause ashes from the end of his/her cigarette to blow into his/her hair, igniting his/her hair and resulting in a burn to his/her left ear. -The resident chose not to report the incident immediately due to concerns about wearing a burn apron. -HA B who was with the resident had not reported the incident per the resident's request. -On 5/17/25, the resident informed the nurse about the burn, which had been causing him/her pain for three days. The DON, Administrator, and Primary Care physician (PCP) were notified immediately. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Conclusion documented: The incident was primarily due to environmental factors, specifically the wind conditions and an isolated failure by HA B to follow established oversight protocols. This incident underscores the importance of strict adherence to safety protocols and environmental consideration in preventing accidents. The failure to report the incident promptly was an isolated case involving a staff member who did not follow the rules. Measure have been taken to prevent recurrence and ensure the safety and well-being of all residents. Review of the resident's POS dated 5/19/25 showed a physician order for Doxycycline Hyalite (antibiotic It's used to treat a wide range of bacterial infections and also has anti-inflammatory properties) oral capsule 100 milligrams (mg) give one tab by mouth every 12 hours for the burn to his/her ear until 5/27/25. Review of the resident's Medical Nurse Practitioner (NP) Note dated 5/19/25 at 3:10 P.M. showed: -Reason for visit due to resident's burn to his/her left ear. -Evaluation for follow-up of burns to the resident's left ear cause by a smoking incident. -Exam showed the resident had a first-degree burn and second degree burn to his/her left ear. -Started treatment for the burns with Silvadene cream and will start Doxycycline antibiotic prophylactic and will continue to monitor the resident. -Wound care by nursing staff to monitor daily and call with adverse reaction. -Monitor resident during smoking as per facility protocols. Observation on 5/20/25 showed the resident's left ear had white cream on lower lobe and noted yellowish dried crusted drainage on the lower ear lobe. Review of the resident's handwritten witness statement dated 5/17/25, documented and witness signature by License Practical Nurses (LPN) B showed the resident said: -On 5/15/25, While out at the smoke area, he/she tried to light a cigarette. -It was windy, and his/her hair caught fire. -He/she and the roommate shouted for HA-B to bring the fire blanket. -HA-B did not act very quickly and his/her roommate rubbed out the fire. -He/she had pleaded with HA-B not to report the resident's fire, because he/she was afraid of consequences for the incident. -On 5/17/25 he/she started to scratch his/her ear and now was painful. -He/she was not aware he/she had a burn injury on his/her ear. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/20/25 at 8:25 A.M., the resident said: -On 5/15/25 in the afternoon (unsure time, after lunch) the resident was outside in smoke area. -He/she was sitting with his/her roommate in the uncovered smoke area. -He/she was not in visual site of HA-B, who inside the smoking covered carport area. -It was very windy that day, he/she did not have his/her hair in a braid or ponytail, that day. -He/she was trying to light his/her cigarette, when his/her hair had caught on fire. -He/she was not aware that his/her hair was on fire until his/her roommate notice and tried to put the fire out him/herself while yelling for HA -B to assist and to grab the smoke blanket. -HA-B came around the corner to assist his/her roommate put the fire out. -He/she had begged HA-B not to report the fire incident to nursing staff. -HA-B informed the resident he/she need to notify the nursing staff, but the resident did not want nursing staff to know because he/she did not want to have wear the safety smoke apron while smoking. -He/she did not realize he/she burnt his/her left ear until two days later on 5/17/25, after he/she scratched his/her ear and broken a blister. -On 5/17/25, LPN B found out about the smoking incident and did a skin assessment of the resident's left ear. LPN B had received orders for burn treatment, to apply burn ointment two times a day. -He/she was educated by the DON on safe smoking to included prevention safety measure to include he/she was to ensure to place hair in braid or ponytail while smoking and he/she was required to wear the smoke apron while outside smoking. Observation on 5/20/25 at 8:35 A.M., showed: -The resident was wheeled himself/herself outside to the smoking area. -He/she grabbed a smoke apron prior to exiting the facility. -While outside, HA A assisted the resident with placement of the smoke apron. -The resident had wheeled himself/herself over to place where the fire incident happened on 5/15/25. -He/she was located outside the smoke carport area to right and sat by the open smoke area by the covered ashtray. Record review of Resident's #11's (roommate) dated 4/11/25, showed he/she was cognitively Intact. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #11's handwritten undated witness statement showed: -On 5/15/25, while out at the smoke area all of sudden Resident #17 was yelling for help that something was biting his/her ear. -As, he/she turned around to look at the resident the left and right side of his/her hair was on fire as well as his/her left ear. -He/she immediately started smacking Resident #17's head and yelling for help, specifically for the fire blanket. -HA B came around the corner to see what was going on. -HA B seemed to be confused as what to do. -HA B told Resident #17 needed to report the incident. -Resident #17 was afraid of the consequences. -The resident's left the smoke area went back into their room. During an interview on 5/20/25 at 10:04 A.M., Resident #11 said: -On 5/15/25 in afternoon he/she and Resident #17 were outside smoking. -The HA B was located inside the smoking carport area. HA B was not able to see them because they were out in courtyard area smoking. -He/she heard Resident #17 yelling for help that something had stung his/her ear. -He/she turned around and saw Resident #17's hair was inflamed with fire. -He/she went over started hitting Resident #17's head to get the flames out. -He/she was scared at that time. -Resident #17 thought he/she was stung by a wasp but Resident #17's hair was on fire. -He/she yelled for HA B to come to assist and bring the smoke blanket. -His/her fingers were tingling after he/she slapped the fire out on Resident #17's head but he/she had no burns . -No resident or staff were notified of what happened. -He/she encouraged Resident #17 to call his/her daughter and tell the nursing staff about the burn. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-HA B flipped the resident's hair back but did not look at the resident's ear or skin. -On 5/16/25 he/she noticed Resident #17 had blisters on his/her left ear. -On 5/17/25 he/she told LPN B about the smoking incident and Resident #17 had a burn blister to his/her left ear. Review HA B employee file on 5/20/25 showed: -A Corrective Action Memo dated 5/17/25. -Type of violation was insubordination. -Employer stated the employee neglected to notify anyone of incident when a resident caught his/her hair on fire which resulted in a burn. -The employee was suspended pending investigation. Review of HA B handwritten witness statement dated 5/19/25 showed: -He/she was outside on Thursday 5/15/25 in the smoke area. -Resident #17 and Resident #11 were outside smoking with other unknown residents. -Resident had called for HA-B to help Resident #17. -He/she came around the corner of smoking carport, and sure enough Resident #17 hair was on fire. -HA-B and Resident #11 assisted getting the fire out. -Many times, he/she had told Resident #17 they needed to report the smoking incident to the nurse. -Resident #17 did not want HA B to report smoking incident to the nurse. -He/she should had reported the smoking incident but, he/she did not report the fire. He/she had written, was My fault, and he/she was sorry. -He/she was notified by the DON on 5/17/25 related to the incident on 5/15/25 and did not complete a witness statement until 5/19/25. During an interview on 5/20/25 at 8:10 A.M., HA A said: -He/she worked as a smoke aid from 7:00 A.M. to 3:00 P.M. -He/she was not working on 5/15/25 when smoke incident happened. -He/she had worked on Friday 5/16/25 as a smoke aid and Resident #17 had his/her hair down that day and did not see the resident's left ear. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-He/she was not informed nor aware of any smoking incident that had happen on 5/15/25 until 5/17/25. -On Saturday 5/17/25 he/she was completing his/her resident safety smoking check which include checking resident clothing for burn holes and burn on the resident hands and fingers from smoking. -He/she would have notified the charge nurse immediately if noted any resident with clothes with burn holes or skin burns noted. -On 5/17/25 Resident #17 was going out to smoke with his/her hair in a braid and that's when he/she notice Resident #17 had blisters on his/her left ear. -He/she immediately asked Resident #17 what happen to his/her ear. -Resident #17 said on Thursday 5/15/25, he/she and peers were out smoking while being supervised by HA B when his/her hair caught on fire trying to ash his/her cigarette. -Resident #17 had asked HA B not to report his/her smoking/fire incident from 5/15/25 to nursing staff. -He/she would immediately report any smoking incident immediately to charge nurse or administrative staff. Review of Resident #18 Quarterly MDS dated [DATE] showed he/she was cognitively Intact. During an interview on 5/20/25 at 8:13 A.M., Resident #18 said: -He/she was outside smoking on 5/15/25 when the fire incident happened. -He/she and HA B were under the smoking carport area. -Resident #17 and Resident #11 were sitting outside to right of the carport out view by HA B. -Resident #17's hair caught on fire, as heard Resident #11 yelling for HA B to get the smoke blanket. -HA B went around to outside of the carport to see what had happened and the fire was already put out by Resident #11. -He/she heard Resident #17 asking HA B not to report the smoking incident to nursing staff. -He/she did not report the smoking incident from 5/15/25 to nursing staff. During an interview on 5/20/25 at 9:40 A.M., Administrator said: -He/she was not notified of the smoking incident occurred on Thursday 5/15/25 until Saturday 5/17/25. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The facility started their smoking incident report and investigation on 5/17/25 to include obtaining witness statements from resident and staff and assessment of the resident. -Resident #17 was assessed by LPN B and burn treatment order received on 5/17/25. -Resident #17 did not require emergency medical treatment or hospitalization for burn care. -HA B was suspended until further investigation for not reporting smoking incident immediately to nursing staff after it happen on 5/15/25. -He/she would expect all facility staff to report any resident incident immediately to nursing staff and administrative staff. During an interview on 5/20/25 at 11:56 A.M., LPN B said: -On 5/17/25 HA A reported Resident #17 had a burn blister to his/her left ear from a smoking incident that happen on 5/15/25. The resident had scratched his/her ear was painful and had opened up the blister. -Resident #17 said on 5/15/25 it was very windy and his/her hair had caught fire. Resident #17 and HA B did not report the smoking incident to nursing staff. During an interview on 5/20/25 at 12:08 P.M., NP A said: -On 5/17/25 he/she was notified by LPN B of the resident's smoking incident that happen on 5/15/25. -On 5/17/25 the resident was examined and had a second degree/third degree burn to his/her left ear, the skin was broken open. -He/she had ordered Silvadene cream 1% apply every shift. -On 5/19/25 he/she ordered an antibiotic to be given due to increased risk for infection with burns. -He/she would expect all facility staff to follow the policy of reporting any incident immediately to nursing staff or administrative staff member. -He/she would expect the resident to follow the smoking policy related safe smoking. During an interview on 5/20/25 at 1:30 P.M., DON said: -He/she was notified on the morning of 5/17/25, that Resident #17 had a smoking incident on 5/15/25 that resulted in a burn to his/her left ear. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Root cause analysis of the smoking incident showed it was a windy day causing ash to fly into the resident's hair cause the fire. HA B, Resident #17 and Resident #11 did not report the smoking incident on 5/15/25 to nursing staff which delayed medical care for Resident #17's burn to left ear for two days. 2. Review of resident #9's admission Record showed he/she had the following diagnosis: -Absence of right leg below the knee. -Needs assistance with personal care. -Uses tobacco. Review of the resident's Plan of Care revised on 11/24/25 showed: -The resident was dependent on tobacco. -All facility staff were to notify the social services or Administrator immediately if it is a suspected resident had violated the facility smoking policy. -NOTE: The resident's care plan did not show the resident vaped using a e-cigarette. Review of the resident's Quarterly Minimum Data Set (MDS-a federally mandated assessment tool completed by facility staff for care planning), dated 2/21/25 showed he/she: -Had a moderate cognitive impairment. -Had no documentation related to rejection of cares noted. -Uses tobacco. Review of the resident's Safe Smoking Evaluation dated 2/28/25 showed: -The resident smokes. -He/she able to independently light smoking material safely. -He/she was safe to smoke with minimal supervision. -Had no documentation that smoking material was storage in the resident's room. -The facility did not have a specific Safe Smoking Assessment for residents that use e-cigarettes. Review of the resident's medical record on 5/20/25 showed no documentation that the resident used e-cigarettes or could store smoking material at bedside. Observation and interview on 5/14/25 at 10:25 A.M., showed: (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The resident laid in his/her bed covered up with blankets. He/she was looking for his/her e-cigarette. -He/she had found the square vape pen, the size of his/her palm of his/her hand, located under the resident's blankets. -He/she does use the e-cigarettes while in his/her room most of the time. -He/she requires assistance with transfer and was easier to just use e-cigarettes while in room. Observation on 5/16/25 at 5:45 A.M. the resident showed: -He/she was in bed with eyes closed. -The e-cigarette was located on top of bedside table within the resident's reach. Observation on 5/16/25 at 11:02 A.M., showed: -The resident was sitting up in wheelchair. -He/she had e-cigarette on bedside table, he/she asks for assistance reaching for the e-cigarette off the bedside table. During an interview on 5/16/25 at 11:03 A.M., the resident said: -He/she will go out to smoke some days, but he/she uses his/her e-cigarette while in his/her room. -He/she did not have secure place to store vape pens. During an interview on 5/14/25 at 12:35 A.M., Hospitality Aid (HA) A said: -He/she has a list of residents that smoke, and the type of assistance needed. -The resident does go outside to smoke, but does not go out to smoke every day. -He/she noted the resident did use his/her e-cigarettes outside in smoke area. During an interview on 5/16/25 at 7:55 A.M., HA A said: -He/she not aware of any resident that uses e-cigarette while inside the facility. -E-cigarettes should be use in supervised designated smoke areas only. -All tobacco smoking material should be stored in the locked smoking cart. -The resident that use e-cigarettes atre normally kept in the resident's room or carried with the resident. (continued on next page)

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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 hot foods (vegetables on 5/14/25) and (French Toast on 5/16/25) were at or close to 120 ºF (degrees Fahrenheit) for two different meals. This practice potentially affected at least four residents (Residents #11, #3, #2 and #13) out of 19 sampled residents. The facility census was 143 residents. Review of the facility's policy entitled Food Temperatures and revised on 12/20, showed: - Purpose: To provide the nutrition services department with guidelines for food preparation and service temperatures. - Policy: Foods prepared and served in the facility will be served at proper temperatures to ensure food safety. - Procedure: Measuring Food Temperature It is recommended to use a thermometer with a practical range of 0 ºF to 220 ºF. - Wash, rinse, and sanitize a dial face, metal probe type thermometer with an alcohol wipe. - Insert the thermometer into the center of the product. - Allow time for stabilization. Wait until there is no movement for 15 seconds. Several readings may be required to determine hot and cold spots. -Take the temperature of each pan product before serving. - Resanitize the thermometer after each use. 1. Observation on 5/14/25 at 12:34 P.M., showed the vegetables on a test tray on the 100 Hall, had a temperature of 111.4 ºF, when the vegetables were checked for temperature. During an interview on 5/14/25 at 12:51 P.M., Resident #11 (a resident who was assessed by the annual Minimum Data Set (MDS- a federally mandated assessment tool completed by the facility for care planning) dated 4/11/25, as cognitively intact, said his/her food is delivered cold sometimes. Observation on 5/16/25 at 8:07 A.M., showed the temperature of the French Toast on a test tray for the 100 Hall was 106.3 ºF. During an interview on 5/16/25 at 11:15 A.M., Resident #3 (a resident who was assessed as cognitively intact) by the annual MDS dated [DATE], said: - He/she received cold food on 5 of 5 days. - There was no difference amongst the meals (breakfast, lunch or dinner) as to which ones were cold. (continued on next page)

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	265727	A. Building B. Wing	05/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Carmel Hills Wellness & Rehabilitation	810 East Walnut Independence, MO 64050

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- When he/she ate lunch, both the entrée and the side items were cold. During an interview on 5/16/25 at 11:21 A.M., Resident #2 (a resident who was assessed as cognitively intact) by the quarterly MDS dated [DATE], said: -The food including the entrees was cold almost daily. - Usually there was one staff member working to deliver trays on the halls where he/she resided on. During an interview on 5/16/25 at 11:50 A.M., Resident #13 (a resident who was assessed as cognitively intact) by the quarterly MDS dated [DATE], said: - Most of the time all the items were cold. Sometimes, he/she requested the alternative menu. -Many of the items on the alternative menus are delivered cold as well. During an interview on 5/16/25 at 11:24 A.M., Resident #11 said: - The food was delivered to his/her room cold at least 3 out of 5 days per week. - Lunch was cold more often than other meals. - There were not many staff who delivered room trays to the rooms. During a phone interview on 5/22/25 at 3:38 P.M., the Dietary Manager said: - Test trays are done by dietary staff 2-3 times per week. - It was the last tray on the hall they chose for that day that was tested. - If cold food food is found on a test tray, they keep the cooked food inside an oven until about 15 minutes before service. - The dietary staff is then encouraged to check temperatures of the food on the steam table, and - The dietary staff knows how to check temperatures, but he/she had to stay on them. MO00252740 & MO00252293

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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 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to offer substitutes and honor preferences for one sampled resident (Resident #2) out of 19 sampled residents. The facility census was 143 residents. Review of the facility's policy, Resident Preference Interview, revised December 2020 showed: -Resident preferences will be reflected on the tray card and updated in a timely manner. --If a preferred item is not available, a suitable substitute should be provided. 1. Review of Resident #2's admission record showed he/she was admitted [DATE] with diagnoses to include: -Congestive heart failure (disorder that impairs the ability of the heart to fill with or pump a sufficient amount of blood throughout the body) - Diabetes Mellitus (a complex disorder of carbohydrate, fat, and protein metabolism that is primarily a result of a deficiency or complete lack of insulin secretion in the pancreas or resistance to insulin) -Anxiety Disorder (a psychiatric disorder causing feelings of persistent anxiety) Review of the resident's Order Summary report for May 2025 showed he/she was on a regular diet with a fluid restriction of 2000 milliliters in a 24-hour period. Review of the resident's care plan showed: -He/She eats a heart healthy diet with regular consistency food and thin fluids. --Monitor tolerance and acceptance of diet. --Monitor, document, and report any signs and symptoms he/she appears concerned during meals. During an interview on 5/14/25 at 9:59 A.M. the resident said: -The facility has run out of food at times. -He/She should be on a cardiac diet. -The food was horrible. -He/She liked fresh fruit and salads. -He/She had to buy her own food. (continued on next page)

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The facility was not offering alternatives. -When he/she requested a chef salad she received a huge mound of mashed potatoes and gravy, approximately three helpings. Interview on 5/14/25 at 1:09 P.M. the resident said: -He/She was waiting his/her lunch tray. -He/She had requested a chef salad from Certified Nursing Assistant (CNA) C. -He/She was told there was no chef salad. -He/She made a salad from his/her refrigerator. Observation on 5/14/25 at 1:14 P.M. showed the resident received a lunch tray with chili and no salad. The resident refused the tray and asked staff to follow up on his/her requested salad. The meal ticket showed a chef salad but was marked out. Review the resident's progress note dated 5/14/25 at 4:33 P.M. the Director of Nutritional Services showed: -He/She spoke with resident after meal service to get an update on food preferences. -The resident stated he/she would request a chef salad when he/she wanted one. -The resident also said either lettuce or fresh cabbage as his/her base for salad was acceptable. During and interview on 5/16/25 at 7:10 A.M. the resident said he/she discussed food preference again with the Dietician on 5/14/25 and a new Food Profile was completed. During an interview on 5/16/25 at 9:53 A.M. the resident said: -He/She did not get the chef salad again last night. -He/She received enchiladas. He/She had a colon issue and could not eat the food they serve. During an interview on 5/16/25 at 10:00 A.M. the Dietary Manager said: -Yes, we have lettuce. -He/She went to the store to get some and some came on the truck. -He/She was not aware resident did not get chef salad on 5/15/25 as requested for the evening meal. -He/She would educate dietary staff. (continued on next page)

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/16/25 at 11:24 A.M. the Administrator said: -He/She expected residents to get diet requests within reason. -Staff should offer alternative food choices. -The always available food choice was too large and had food wasted so it was reduced. -The facility had not run out of food. -The facility had gone to the store to buy lettuce. -He/She was not aware the resident did not get a chef salad. MO00251558

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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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure snacks were being offered on the long term care unit consistently between meal times during the day and evening for two sampled residents (Resident #11 and #13) out of 19 sampled residents. The facility census was 143 residents. Record review of the facility snack schedule showed facility snacks were supposed to be at 10:00 A.M., 2:00 P.M., and 7:00 P.M. daily. 1. Review of Resident #11's Face Sheet showed the resident was admitted on [DATE], with diagnoses including diabetes, high cholesterol, high blood pressure and cancer. Review of the resident's annual Minimum Data Set (MDS-a federally mandated assessment tool to be completed by facility staff for care planning) dated 4/11/25, showed the resident: -Was alert and oriented with no confusion. -Ambulated with a walker and was able to eat with supervision only. Observation and interview on 5/14/25 at 1:15 P.M., showed the resident was ambulatory in his/her room but also used a wheelchair. On the resident's dresser were a variety of snacks. During an interview on 5/16/25 at 12:40 P.M., the resident said: -He/she had snacks in his/her room that were his/her personal snacks (self-purchased). -Dietary staff brought snacks to the nursing station up to three times daily but they don't always get the snacks on evenings. -When snacks are delivered, some residents take a lot of the snacks and other residents don't get anything, depending on when they get to the nursing station after snacks were delivered. -Snacks were not delivered this morning. 2. Review of Resident #13's Face Sheet showed the resident was admitted on [DATE], with diagnoses including heart failure, high cholesterol, diabetes and malnutrition. Review of the resident's quarterly MDS dated [DATE], showed the resident: -Was alert and oriented with no confusion. -Ambulated with a walker and wheelchair and was able to eat with supervision only. (continued on next page)

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F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 5/14/25 at 10:41 A.M. showed the resident was laying in his/her bed watching television. There were beverages and graham crackers on his/her tray table that was next to his/her bed. The resident said he/she was able to ambulate independently but used a walker and wheelchair as needed. He/she was able to eat independently but usually ate all meals in his/her room. During an interview on 5/16/25 at 11:50 A.M. the resident said: -He/She received breakfast between 7:30-8:15 A.M., lunch between 12:30-1:30 A.M., dinner between 6-6:30 A.M. -He/She ate independently. -At 12:44 P.M., he/she kept his/her own snacks in his/her room. -The snacks the facility passed out were placed at the nursing station between meals. -Residents could go to the nursing station to get snacks, but staff did not pass snacks out. -The dietary staff did not bring snacks to the unit on the evening shift/at bedtime. Observation on 5/16/25 showed from 9:00 A.M. to 12:00 P.M., there were no snack trays brought to the long term care unit. During an interview on 5/16/25 at 12:34 P.M., Certified Medication Technician (CMT) C said: -Dietary staff usually brought snacks out to the nursing station between 10:00 A.M. and 11:00 A.M. after breakfast and before lunch. -Dietary staff usually brought a variety of chips, fudge bars, peanut butter and jelly sandwiches, bananas and apples on the trays and residents came up to the nursing station to get snacks if they wanted them. -He/She did not see dietary deliver any snacks this morning and he/she did not know why they were not brought out. -He/She usually left work at 3:00 P.M. before the evening snacks were delivered and did not know if evening snacks were delivered. During an interview on 5/16/25 at 12:35 P.M. Certified Nursing Assistant (CNA) D said: -He/She worked during the week and on the weekends and snacks were usually brought out between 10:00 A.M. and 11: 00 A.M., and then again between 2:30 P.M. and 4:00 P.M. before dinner. -Dietary staff brought out two snack trays and placed them at the nursing station. -Dietary staff does not bring enough snacks for all of the residents to have a snack. (continued on next page)

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F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-They do not pass snacks out to the residents. The residents have to go to the nursing station to get a snack if they wanted one. -For residents who are primarily in their room or who cannot come to the nursing station, if they want a snack the nursing staff will bring one to them. -Some residents will take several snacks so they run out quickly. -The Dietary staff don't always bring snacks at night and did not bring any snacks last night when he/she worked. -Dietary staff did not bring snacks this morning before lunch today. -It was not uncommon for the dietary staff to miss bringing snacks out to the nursing station because they have had several staff changes in the kitchen and they may not know they were supposed to bring snacks between meals. During an interview on 5/16/25 at 12:37 P.M., CNA E said: -He/She worked from 7:00 A.M. to 3:00 P.M. during the week and sometimes worked the evening shift. -The dietary staff brought snacks between breakfast and lunch and again between lunch and dinner. -When dietary staff brought snacks, they put them at the nursing station. -The dietary staff did not bring snacks today. -He/She worked last night until 7:30 P.M. and they did not bring the evening snacks. -There are certain dietary staff who make sure they get the snacks when they are working but when those dietary staff are not working, they may not have the snacks delivered on evenings. -They did not deliver snacks to the resident rooms, the residents usually came to get their own snacks. -Residents who were unable to go to the nursing station could have staff bring their snack to them if they wanted a snack. During an interview on 5/16/25 at 12:47 P.M., Dietary Aide A said: -He/She was a newer employee and said he/she worked the evening shift. -They were supposed deliver snacks to each unit twice during his/her shift at 2:00 P.M. and at 7:00 P.M. -Each unit receives one tray of snacks and the long term care unit received two trays due to the number of residents on the unit. (continued on next page)

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F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Once the dietary staff deliver the trays, the nursing staff pass the snacks out. -He/She was not aware that the snacks were not brought to the long term care unit last night or this morning. -If the nursing staff let them know they did not have the snacks delivered, they would bring snacks to the unit. During an interview on 5/16/25 at 12:54 P.M., [NAME] A said: -The schedule for snacks to be delivered to the unit are at 10:00 A.M., 2:00 P.M., and 7:00 P.M. -He/She made sure snacks were passed out during the day shift at 10:00 A.M., and 2:00 P.M. -He/She was not at the facility during the evening shift and did not know if snacks were passed out then. -Each unit should get a tray of snacks (variety) and the long term care unit was supposed to receive to trays of snacks. -They deliver the snack trays to the nursing station. -He/She did not remember if snacks were passed out at 10:00 A.M. today because there was a lot going on in the kitchen. -He/She would ensure that snacks would be passed out at 2:00 P.M. During an interview on 5/16/25 at 1:00 P.M., the Dietary Manager said: -Kitchen staff is to make and provide snacks at 10:00 A.M., 2:00 P.M., and 7:00 P.M. -Snacks got missed today. -Staff knows to pass snacks daily. Aides who usually work on the food side make snacks. -Snack schedule times are posted in dining room. During an interview on 5/16/25 at 2:00 P.M., Registered Nurse (RN) A said: -Snacks are not provided daily per the schedule. -He/She had not seen snacks provided for weeks. During an interview on 5/16/25 at 2:13 P.M., the Assistant Director of Nursing (ADON) A said: -Snacks were supposed to be offered to the residents three times daily. (continued on next page)

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F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The Dietary staff brought the snack trays to each nursing station and residents could go to get their choice of snack and nursing staff also take snacks to those resident who are unable to obtain their own snack. -They have had some issues with residents taking several snacks and there not being enough (running out) and that they were not always being passed three times daily. -Dietary staff was getting better about bringing snacks out between meals. MO00251977

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation and interview, the facility failed to maintain the sprinkler heads above the food preparation and food serving areas, free from dust and grease; maintain the oven mittens in good repair; maintain the drainage pipes, metal fixtures and walls under the dishwasher area, free of a buildup of grime and discarded dishes; ensure items (lemon juice and beef base), were refrigerated; maintain the handwashing sink free of obstructions; maintain hot foods (pureed French Toast and regular French Toast) at or close to 135 ºF (degrees Fahrenheit) at the steam table; to ensure that fresh fruits (grapes) were washed prior to mixing them with the fruit salad for breakfast and to ensure Dietary Aide (DA) B use tongs or gloves while he/she handled French Toast from the steam table. This practice potentially affected 143 residents who received food from the kitchen. The facility census was 143 residents. 1. Observations on 5/14/25 at 12:17 P.M., during the lunch meal, showed: - A buildup of grease and dust on the sprinkler heads and ceiling tiles over the food serving and food preparation areas. - The presence of grime on the metal fixtures under the dishwasher and the walls behind the dishwasher. - Two oven mittens with rips that were about two inches (in.) - One bottle of lemon juice that was on the counter next to the microwave with a label which stated to refrigerate after opening. 2. Observations on 5/16/25 from 6:19 A.M. through 8:20 A.M., during the breakfast meal preparation showed: - A buildup of dust and grease on the sprinkler heads and ceiling tiles over food preparation and food serving areas. - The presence of grime on the metal fixtures and pipes under the dishwasher and the walls behind the dishwasher. - The presence of a red tray, a gray cup, and a plastic glass that was under the dishwasher. - The presence of a black speaker which laid right across the handwashing sink. - Dietary Aide (DA) B slicing grapes to add to the fruit bowl mixture, without washing them. - One bottle of lemon juice that was on the table next to the microwave that was not refrigerated - Two containers of beef base on the same table as the soda dispenser that were not refrigerated. During an interview on 5/16/25 at 7:35 A.M., Dietary [NAME] (DC) A said the mittens have been like that for 2-3 days. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Observation on 5/16/25 at 7:46 A.M., showed the pureed French Toast was 124.5 ºF on the steam table. Observation on 5/16/25 at 7:53 A.M., showed the slices of French Toast which were not under the metal cover in the pan at the steam table, were between 104 ºF -- 107 ºF. Observation on 5/16/25 at 8:22 A.M., showed DC B picked up a slice of French Toast with his/her bare hands after he/she was requested to taste the French Toast. Observation on 5/16/25 at 8:23 A.M., showed the Dietary Manager (DM) told DC B to place gloves on and take a different slice. During an interview on 5/16/25 at 8:42 A.M., DA C said he/she has worked at the facility for about 7 months and he/she remembered that the area under the dishwasher has only been cleaned twice. During an interview on 5/16/25 at 8:46 A.M. the Maintenance Director said he/she had a work order that was dated 5/14/25 for cleaning behind the dishwasher and the dishrack table. During an interview on 5/16/25 at 8:52 A.M., DA B said he/she was not trained to and did not know how to wash grapes before adding them to the fruit bowl. During an interview on 5/16/25 at 9:10 A.M., the DM said he/she told the Maintenance Director about cleaning the dust and grease from the sprinkler heads and ceiling tiles on 5/16/25. During an interview on 5/16/25 at 9:14 A.M., the DM said he/she expected the DAs to wash fruit before adding fruit to the fruit bowl. MO00253234.