STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265760	A. Building B. Wing	01/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fulton Manor Care Center	520 Manor Drive Fulton, MO 65251

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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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39440 Based on observation, interview, and record review, facility staff failed to provide reasonable accommodations to meet the needs of the residents, when staff failed to ensure call lights were placed within reach for four residents (Resident #4, #10, #48, and #295) out of 16 sampled residents. The facility's census was 43. 1. Review of the facility's policy titled, Call Lights: Accessibility and Timely Response, dated 01/01/25, showed the purpose of the policy is to assure the facility is adequately equipped with a call light at each resident's bedside, toilet, and bathing facility to allow residents to call for assistance, and directed staff: -All staff will be educated on the proper use of the resident's call system, including how the system works and ensuring resident access to the call light; -All residents will be educated on how to call for help using the resident call system; -Staff will ensure the call light is within reach of the resident and secured, as needed; -The call system will be accessible to the residents while in their bed or other sleeping accommodations within the resident's room. 2. Review of Resident #4's Quarterly Minimum Data Set (MDS), a federally mandated assessment tool, dated 11/22/24, showed staff assessed the resident as follows: -Cognitive impairment; -Partial/moderate assistance needed for transfer, and toileting, and sit to stand. Observation on 01/28/25 at 2:00 P.M., showed the resident in his/her wheelchair next to his/her bed, the call light attached to a string on floor across the room out of his/her reach. At 2:26 P.M., the resident yelled out for help. The resident said, I need changed. Observation on 01/29/25 11:43 A.M., showed the resident in his/her wheelchair next to his/her bed with the call light on the floor, across the room out of his/her reach. (continued on next page)

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

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

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 01/30/25 10:20 A.M., showed the resident in bed with the call light across the room out of his/her reach. 3. Review of Resident #10's Quarterly MDS, dated [DATE], showed staff assessed the resident as: -Severe cognitive impairment; -Substantial/maximal assistance needed for toileting, and transfers. Observation on 01/28/25 at 10:30 A.M., showed the resident in his/her recliner. At this time, the resident asked for help up and said I don't know where the call light is. The call light was across the room at the end of the residents bed. Observation on 01/28/25 2:31 P.M., showed the resident in his/her bed with the call light at the end of bed out of reach. Observation on 01/30/25 10:15 A.M., showed the resident in his/her bed with the call light at the end of bed out of reach. 4. Review of Resident #48's Entry Tracking Record MDS, dated [DATE], showed the resident admitted to the facility on [DATE]. Review of the resident's care plan, dated 01/17/25, showed staff were directed to provide assistance with Activities of Daily Living (ADLs) as needed. Observation on 01/27/25 at 2:44 P.M., showed the resident in bed with his/her call light secured to the wall light pull-cord, out of his/her reach. The resident repeatedly yelled, help, I need to get up! During an interview on 01/27/25 at 2:44 P.M., the resident said he/she knows how to use the call light to call for help, but thinks the string might be on the bedside table, and he/she could not reach it. During an interview on 01/27/25 at 2:46 P.M., Certified Nursing Assistant (CNA) J said the resident can use the call light if it is within his/her reach. The CNA said the string to pull the call light is a bit short and he/she secured the string to the wall light pull-cord to place it closer to the resident, but it is still difficult for the resident to reach it when in bed. Observation on 01/29/25 at 10:31 A.M., showed the resident in bed with his/her call light secured to the wall light pull-cord, out of his/her reach and yelled, Nurse! Nurse! During an interview on 01/29/25 at 10:31 A.M., the resident said he/she could not reach the string to pull the call light for help from staff. Observation on 01/30/25 at 11:05 A.M., showed the resident in bed with his/her call light secured to the wall light pull-cord and out of his/her reach. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 01/30/25 at 11:05 A.M., Licensed Practical Nurse (LPN) H said the resident should be able to reach his/her call light to call for assistance from staff if needed, but the resident is not able to reach his/her call light now because the string is too short, even when fully extended from the lever on the wall. During an interview on 01/30/25 at 11:16 A.M., the Maintenance Director (MD) said he/she was not aware the resident's call light string was not long enough for him/her to reach it. The MD said after he/she used a tape measure to check, the call light string was two and a half feet away from the resident's reach, even with the string fully extended from the lever on the wall. He/She said he/she would go and cut a longer string for the call light. 5. Review of Resident #295's Medication Administration Record (MAR), dated 1/1/25-1/31/25, showed resident admitted to facility on 1/27/25. Observation on 01/30/25 at 10:08 A.M., showed resident's room call light string was laying on a stack of pillows in chair next to bed. Call light string was not long enough to reach the bed up against the wall. During an interview on 01/30/25 at 11:16 A.M., resident said he/she is unable to reach his/her call light when in room. He/She said the call light string is not long enough to reach when he/she is laying in bed. 6. During an interview on 01/30/25 at 2:58 P.M., LPN H said call lights should be within the residents' reach at all times when staff is not with the resident in his/her room, so the resident can pull the call light to alert staff if he/she needs assistance. During an interview on 01/30/25 at 3:04 P.M., CNA K said staff should always ensure the call light is placed within the resident's reach when the resident is left inside his/her room, so he/she can pull the light if he/she needs assistance from staff. During an interview on 01/30/25 at 3:52 P.M., the Director of Nursing (DON) said he/she expects staff to educate each resident, based on his/her cognition, on how to use the call light in his/her room. He/She said staff should place the residents' call lights within his/her reach before staff step away from the resident in the room. During an interview on 01/30/25 at 4:05 P.M., the Administrator said he/she expects staff to educate each resident on how to use the call light in his/her room. He/She said staff should ensure the resident's call light is within his/her reach prior to leaving the resident in the room. During an interview on 02/06/25 at 2:56 P.M., the MDS/Care Plan Coordinator said if a CNA realizes that a resident's call light string is not long enough for him/her to reach it, he/she is expected to notify the charge nurse or the MD, and if the MD is not available, the nurse should go to the maintenance office and get a longer string. He/She said there is no formal communication for that with the MD, staff just notifies him/her verbally. MO00248764 50422

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39440 Based on observation and interview, facility staff failed to ensure residents' personal information and privacy was protected when staff left the computer screen open in public hallways for two residents (Resident #9 and #13) of 16 sampled residents, and failed to close the privacy curtain and window blinds/curtain during incontinence care for one resident (Resident #48) out of two sampled residents observed during care. The facility's census was 43. 1. Review of the facility's policy titled, Quality of Life-Dignity, dated 01/01/24, showed: -Each resident shall be cared for in a manner that promotes and enhances his/her sense of well-being, level of satisfaction with life, feeling of self-worth and self-esteem; -Staff protect confidential clinical information; -Staff promote, maintain and protect resident privacy, including bodily privacy during assistance with personal care and during treatment procedures. 2. Observation on 01/28/25 at 8:18 A.M., showed the medication cart across from the nurses' station on the East Hall with a computer screen open with medication information for Resident #9 visible to the public while unattended. Observation showed residents and staff walked by the cart. Observation on 01/28/25 at 12:36 P.M., showed the medication cart across from the nurses' station on the East Hall with a computer screen open with medication information for Resident #13 visible to the public while unattended. Observation showed several staff walked by the cart. During an interview on 01/30/25 at 12:00 P.M., the Care Plan Coordinator said staff should lock the computer screen when they walk away from the cart to ensure resident privacy. He/She said he/she was just busy and did not realize he/she had left the computer screen open when he/she stepped into the medication storage room. During an interview on 01/30/25 at 11:45 A.M., Licensed Practical Nurse (LPN) H said staff should always minimize or lock the computer screen on the medication cart when he/she walks away from the cart to ensure privacy of the residents' medical information. 3. Review of Resident #48's Entry Tracking Record Minimum Data Set (MDS), a federally mandated assessment, dated 01/08/25, showed the resident admitted to the facility on [DATE]. Review of the resident's Physician's Order Sheet (POS), dated 01/08/25 through 01/29/25, showed an order to provide colostomy (an opening in the abdomen to the intestines) care every shift for ileostomy (a surgical procedure that creates an opening in the abdomen to excrete poop from the body). (continued on next page)

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 01/29/25 at 10:37 A.M., showed Certified Nursing Assistant (CNA) K provided incontinence care to the resident and attempted to empty the resident's colostomy bag, the resident's window blinds raised and open, with clear view of vehicles parked in the front parking lot of the building. The CNA did not pull the privacy curtain and did not close the window blinds/curtain to provide privacy during incontinence care. During an interview on 01/29/25 at 10:38 A.M., the resident said he/she did not like that you could see the cars in the parking lot while being changed. During an interview on 01/29/25 at 10:46 A.M., the CNA said he/she should have pulled the privacy curtain and the window curtain to provide privacy during care but he/she was nervous and did not think about it. During an interview on 01/30/25 at 11:45 A.M., LPN H said staff should pull the privacy curtain and close window curtains when they provide incontinence care to the resident to ensure privacy, and particularly if there is a clear view of the parking lot. 4. During an interview on 01/30/25 at 3:52 P.M., the Director of Nursing (DON) said he/she expects staff to minimize or lock the computer screen when he/she steps away from the medication cart. The DON said he/she expects staff to close doors and pull/close curtains in the room to provide privacy during incontinence care. During an interview on 01/30/25 at 4:05 P.M., the administrator said he/she expects staff to lock the computer screen when he/she steps away from the medication cart. The administrator said staff should close doors, privacy curtains, and window curtains in the room to provide privacy to the resident during incontinence care.

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39440 Based on interview and record review, facility staff failed to provide written notification information to the resident and/or the resident's representative of the bed hold policy at the time of transfer to the hospital, or therapeutic leave for four (Resident #3, #14, #20, and #26) out of four sampled residents. The facility's census was 43. 1. Review of the facility's policies showed the facility did not provide a policy for Bed Hold. 2. Review of Resident #3's medical record showed: -discharged from the facility on 11/19/24 and readmitted to the facility on [DATE]; -Did not contain written documentation staff notified the resident or the resident's responsible party of the facility's bed-hold policy. 3. Review of Resident #14's medical record showed: -discharged from the facility on 12/31/24 and readmitted to the facility on [DATE]; -Did not contain written documentation staff notified the resident or the resident's responsible party of the facility's bed-hold policy. 4. Review of Resident's 20's medical record showed: -discharged from the facility on 11/27/24 and readmitted to the facility on [DATE]; -Did not contain written documentation staff notified the resident or the resident's responsible party of the facility's bed-hold policy. 5. Review of Resident's #26's medical record showed: -discharged from the facility on 10/24/24 and readmitted to the facility on [DATE]; -Did not contain written documentation staff notified the resident or the resident's responsible party of the facility's bed-hold policy. During an interview on 01/30/25 at 3:40 P.M., the Director of Nursing (DON) said he does not know about the bed hold requirement or process. During an interview on 01/30/25 at 4:09 P.M., the administrator said she is aware of the bed hold paperwork in the admission packet but not aware of the requirement or process for bed hold at the time of the residents transfer and discharge.

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39440 Based on interview and record review, facility staff failed to complete the required Minimum Data Set (MDS), a federally mandated resident assessment, within the required time frame for three residents (Residents #20, #24 and #48) of six sampled residents. The facility's census was 43. 1. Review of the facility's policy titled, MDS Completion and Submission Timeframes, dated July 2017, showed staff are directed: -The Assessment Coordinator or designee is responsible for ensuring the resident assessments are submitted to Centers for Medicare and Medicaid Services (CMS) Quality Improvement and Evaluation Service (QIES) Assessment Submission and Processing (ASAP) system in accordance with the current federal and state guidelines; -Timeframes for completion and submission of assessments is based on the current requirements published in the Resident Assessment Instrument (RAI) Manual; -Submission of MDS records to the QIES ASAP is electronic. A hard copy of each record submitted is maintained in the resident's clinical record for a period of 15 months from the date submitted. Review of the RAI manual version 3.0 RAI Omnibus Budget Reconciliation Act (OBRA)-required Assessment Summary showed assessment time frames as follows: -Entry MDS completion date no later than the 7th calendar day from the resident's entry into the facility and submitted no later than 14 days from the date of entry into the facility; -Admission (Comprehensive) MDS completion date no later than 14th calendar day of the resident's admission and submitted no later than 14 calendar days from the care plan completion date; -Quarterly assessment for a resident must be completed at least every 92 days following the previous OBRA assessment of any type. 2. Review of Resident #20's Entry Tracking Record MDS, dated [DATE], showed the resident admitted to the facility on [DATE]. Review of the resident's MDS record, dated 12/17/24 through 01/30/25, showed the record did not contain an in-process, completed, or submitted admission assessment within the required time frame. During an interview on 01/30/25 at 3:08 P.M., the MDS Coordinator said the resident should have a completed Admission MDS, and he/she was not sure why he/she doesn't have one completed. 3. Review of Resident #24's Quarterly MDS, dated [DATE], showed the resident admitted to the facility on [DATE]. (continued on next page)

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the resident's MDS record, dated 10/18/24 through 01/30/25, showed the record did not contain an in-process, completed, or submitted quarterly assessment within the required time frame. 4. Review of Resident #48's Entry Tracking Record MDS, dated [DATE], showed the resident admitted to the facility on [DATE]. Review of the resident's Admission MDS, dated [DATE], showed the assessment in process and not submitted within the required time frame. Review showed 16 of 18 sections in progress and without information. During an interview on 01/29/25 at 11:06 A.M., the MDS Coordinator said the resident's admission MDS was currently eight days overdue for submission, and he/she was still working on gathering information for the assessment. 5. During an interview on 01/30/25 at 3:07 P.M., the MDS Coordinator said he/she is responsible to complete residents' MDS and the DON or an assigned Registered Nurse (RN) signs the MDS and submits electronically once completed. He/She said the admission MDS should be submitted within two weeks after admission, and then a quarterly MDS should be submitted at least every three months. He/She said he/she is behind on completing MDSs because he/she is being pulled to work the floor often. He/She said currently, no one double checks the MDSs are completed within the required time frame. During an interview on 01/30/25 at 3:52 P.M., the Director of Nursing (DON) said he/she was new to the facility and was not sure of the required time frames for MDS submissions. He/She said the MDS Coordinator is responsible to ensure the residents' MDSs are completed within the required time frames. During an interview on 01/30/25 at 4:05 P.M., the administrator said the MDS Coordinator is responsible to complete the residents' MDS within the required time frames, and the DON is reponsible to monitor for completion. He/She said the residents' admission MDS should be completed within seven to 14 days after admission, and then at least quarterly.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39440 Based on interviews and record review, facility staff failed to complete a baseline care plan within 48 hours of admission for five residents (Resident #20, #43, #45, #46, and #48) out of 16 sampled residents. The facility census was 43. 1. Review of the facility's policy titled, Care Plans-Baseline', dated December 2016, showed a baseline plan of care to meet the resident's immediate needs shall be developed for each resident within 48 hours of admission. 2. Review of Resident #20's electronic medical record (EMR), showed staff documented the resident admitted to the facility on [DATE]. The EMR did not contain documentation staff completed a baseline care plan within 48 hours of admission. 3. Review of Resident #43's EMR, showed staff documented the resident admitted to the facility on [DATE]. The EMR did not contain documentation staff completed a baseline care plan within 48 hours of admission. During an interview on 01/30/25 at 2:35 P.M., the Care Plan Coordinator said he/she was not sure why the resident did not have a baseline care plan in chart. He/She said resident should have had a baseline care plan within 48 hours of admission. 4. Review of Resident #45's EMR, showed staff documented the resident admitted to the facility on [DATE]. The EMR did not contain documentation staff completed a baseline care plan within 48 hours of admission. During an interview on 01/30/25 at 2:35 P.M., the Care Plan Coordinator said he/she was still trying to get information about the resident for the baseline care plan. He/She said resident should have had a cmpleted baseline care plan within 48 hours of admission. 5. Review of Resident #46's EMR, showed staff documented the resident admitted to the facility on [DATE]. The EMR did not contain documentation staff completed a baseline care plan within 48 hours of admission. 6. Review of Resident #48's EMR, showed staff documented the resident admitted to the facility on [DATE]. The EMR did not contain documentation staff completed a baseline care plan within 48 hours of admission. During an interview on 01/29/25 at 11:06 A.M., the Care Plan Coordinator said he/she did not have an explanation for why the resident's baseline care plan was still incomplete. 7. During an interview on 01/29/25 at 11:06 A.M., the Care Plan Coordinator he/she is responsible to complete baseline care plans after a resident is admitted . He/She said the baseline care plan should be completed within 48 hours, but he/she tries to complete them within the first week after a resident is admitted . (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 01/30/25 at 3:52 P.M., the Director of Nursing (DON) said he/she was not sure of the timeframe in which a resident's baseline care plan should be completed. He/She said the Care plan Coordinator is currently responsible to complete the baseline care plans. The DON said he/she was new to the facility and was not sure if anyone was double checking that baseline care plans were completed timely. During an interview on 01/30/25 at 4:05 P.M., the administrator said baseline care plans should be initiated by the nurse who initially admits the resident, and completed within seven days by the care plan coordinator. He/She said the coordinator and the DON are responsible to monitor for the completion of base line care plans. 50422

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39440 Based on observation, interview and record review, facility staff failed to develop a comprehensive person-centered care plan to meet the resident's medical, nursing, mental and psychosocial needs for three residents (Resident #1, #15, and #16) out of 16 sampled residents. The facility's census was 43. 1. Review of the facility's policy titled, Care Plans, Comprehensive Person-Centered, dated 01/01/24, showed: -A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident; -The care plan interventions are derived from a thorough analysis of the information gathered as part of the comprehensive assessment; -The comprehensive, person-centered care plan is developed within seven days of the completion of the required comprehensive assessment; -Assessments of residents are ongoing and care plans are revised as information about the residents' condition change. 2. Review of Resident #1's Significant change Minimum Data Set (MDS), a federally mandated assessment, dated 12/05/24, showed staff assessed the resident as follows: -Moderate cognitive impairment; -Diagnoses of Non-Traumatic Brain Dysfunction, Dementia and heart failure; -Hospice care. Review of the resident's hospice contract, dated 11/27/24, showed the resident started hospice services. Review of the resident's care plan, dated 12/21/24, showed the care plan did not contain direction for hospice services. During an interview on 01/30/25 at 11:20 A.M., the Social Services Director (SSD) said the resident admitted to the facility on hospice services, and directions for the hospice care and services should be documented on his/her care plan. He/She said the Care Plan Coordinator was responsible to document hospice information on the resident's care plan. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fulton Manor Care Center	520 Manor Drive Fulton, MO 65251

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 01/30/25 at 3:05 P.M., the MDS/Care Plan Coordinator said he/she was not sure why there were not directions for hospice services on the resident's comprehensive care plan, but there should be. He/She said although the hospice company has their own care plans for each resident, the resident should still have directions/interventions for hospice services on his/her comprehensive care plan. 3. Review of Resident #15's annual MDS, dated [DATE], showed staff assessed the resident as: -Cognitively intact; -Independent with bed mobility, toileting, and transfers. Review of resident's care plan, dated 08/23/24, showed the care plan did not contain direction of use of bed rails. Observation on 1/27/25 at 11:13 A.M., showed the resident in bed with bilateral U-Bars (a bed rail) in upright position. Observation on 1/28/25 at 9:06 A.M., showed the resident in bed with bilateral U-Bars in upright position. Observation on 1/29/25 at 9:45 A.M., showed the resident in bed with bilateral U-Bars in upright position. Observation on 1/30/25 at 10:07 A.M., showed the resident laying in bed with bilateral U-Bars in upright position. During an interview on 1/30/25 at 2:35 P.M., the MDS/Care Plan Coordinator said he/she thought the resident's bed rails were on the care plan. He/She said bed rails should be on the care plan. 4. Review of Resident #16's Quarterly MDS, dated [DATE], showed staff assessed the resident as: -Severe cognitive impairment; -Diagnoses of Non-Traumatic Brain Dysfunction, Dementia, and Alzheimer's Diease -Impairment on both side upper and lower extremities; -Dependant of staff bed mobility, tolieting, eating, dressing, and transfers. Review of the resident's care plan, dated 11/27/24, showed the care plan did not contain direction for bilateral upper and lower extremity contractures (a condition of shortening and hardening of muscles, tendons, or other tissue, often leading to deformity and rigidity of joints). Observation on 1/27/25 at 11:15 A.M., showed the resident in a broda chair (a reclined wheelchair that helps with body positioning) with both hands contracted. The resident did not have intervention in place with his/her hands. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 1/28/25 at 9:07 A.M., showed the resident in a broda chair with with both hands contracted. The resident did not have intervention in place with his/her hands. Observation on 1/28/25 at 2:02 P.M., showed the resident in a broda chair with both hands contracted. Observation showed the resident's left hand finger nail indent in palm. The resident did not have interventions in place for his/her contracted hands. Observation on 1/29/25 at 9:54 A.M., showed the resident in bed with both hands contracted. The resident did not have interventions in place for his/her contracted hands. During an interview on 01/30/25 at 2:35 P.M., the MDS/Care Plan Coordinator said he/she thought there was something on the care plan about the resident's contractures. He/She said staff are supposed to be putting wash cloths in the resident's hands. He/She said he/she is unsure why it is not on the care plan, but it should be. During an interview on 01/30/25 at 3:07 P.M., the MDS/Care Plan Coordinator said he/she is responsible for completing the residents' comprehensive care plans, and usually has the care plan completed within the first week of admission. He/She said he/she updates care plans as needed, and after each completed MDS assessment. He/She said the comprehsnive care plan should address each resident's specific medical, nursing, mental and psychosocial needs. During an interview on 01/30/25 at 3:40 P.M., the Director of Nursing (DON) said care plans should contain things like side rails and hospice. The DON said if these thing are not care planned they may have got missed. He/She said the person responsible does get pulled away often for other duties. During an interview on 01/30/25 at 4:05 P.M., the administrator said the MDS/Care plan Coordinator is responsible to complete the residents' comprehensive care plan within 14 days of the MDS assessment, and make updates to the care plan at least quarterly and as needed with any changes. The administrator said it is the MDS/Care plan Coordinator's responsibility to get things on the care plan and the DON to over see this. The current DON is has been here a little over a week, and the past DON was simply not doing it. 39644 50422

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. 39440 Based on observation, interview and record review, facility staff failed to follow professional standards of practice when staff failed to obtain physician's orders for water flushes/flush medications with water per facility policy, failed to administer medications as directed by the physician and the medication administration record (MAR), and failed to ensure a licensed staff member documented medication administration via Gastric Tube (G-Tube), a surgically inserted tube which provides nutrition, hydration, or medicine directly into the stomach, for one resident (Resident #20) of one sampled resident. Licensed staff failed to perform colostomy (an opening in the abdomen to the intestines) care as directed by the physician for one resident (Resident #48) of one sampled resident. The facility census was 43. 1. Review of the facility's policy titled, Administering Medications through and Enteral Tube, dated November 2018, showed: -Verify that there is a physician's medication order for the procedure; -Dilute crushed medication with at least 30 milliliters (ml) of purified water (or prescribed amount); -Dilute liquid medication with 30 ml or more (depending on viscosity (thickness)) purified water; -If administering more than one medication, flush with 15 ml warm purified water (or prescribed amount) between medications. 2. Review of Resident #20's Physician's Order Sheet (POS), dated 01/01/25 through 01/27/25, showed the physician ordered Levothyroxine (for low thyroid levels), Midodrine (for low blood pressure), Vitamin D, Cyclobenzaprine (for muscle spasms), Eliquis (for blood thinner), Fludrocortisone (to treat low levels of adrenal gland hormones), Gabapentin (for nerve damage), Fluoxetine oral solution (for depression), and Prenatal tablet (vitamins with iron and folic acid), to be administered via G-Tube. Review of the POS showed it did not contain documentation of an order for water flushes with medication administration via G-tube. Review of the resident's MAR, dated 01/20/25 through 01/26/25, showed the MAR contained documentation of the administration of Levothyroxine, Midodrine, Vitamin D, Cyclobenzaprine, Eliquis, Fludrocortisone, Gabapentin, Prenatal, and Fluoxetine to the resident via his/her G-tube on: -01/20/25 at 10:08 A.M.; -01/21/25 at 8:39 A.M.; -01/22/25 at 9:23 A.M.; -01/23/25 at 7:54 A.M., -01/24/25 at 7:41 A.M.; (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-01/25/25 at 8:20 A.M.; -01/26/25 at 8:42 A.M. -Review showed the MAR did not contain direction for staff to flush the G-tube with water. Observation on 01/27/25 at 12:15 P.M. showed Licensed Practical Nurse (LPN) G crushed Levothyroxine, Midodrine, Vitamin D, Cyclobenzaprine, Eliquis, Fludrocortisone, Gabapentin, and Prenatal tablets together, emptied the mixture into a cup with the liquid Fluoxetine, and added 60 cubic centimeters (cc) of water to the cup. Observation on 01/27/25 at 12:20 P.M. showed LPN G did not flush the resident's G-tube with water before or after he/she administered the crushed and liquid medications. During an interview on 01/27/25 at 12:24 P.M., LPN G said the resident's G-tube should be flushed with 60 cc water, so he/she just added the 60 cc water to the medications and administered together. During an interview on 01/30/25 at 11:45 A.M., LPN H said the resident had an order for water flushes and should have one for medication administration but does not have a current order. He/She said the nurses are responsible to obtain an order from the physician. During an interview on 01/30/25 at 1:27 P.M., the Nurse Practitioner (NP) O said he/she was not aware there wasn't an order for water flushes, and he/she expects staff to reach out to him/her for an order. 3. Review of the facility's policy titled, Administering Medications, dated 01/01/24, showed medication administration times are determined by resident need and benefit, not staff convenience. Factors to consider include enhancing optimal therapeutic effect of the medication, and preventing potential medication or food interactions. 4. Review of Resident #20's MAR, dated 01/20/25 through 01/23/25, showed staff were directed to administer one Levothyroxine 75 micrograms (mcg) tablet via G-tube every morning on an empty stomach, do not give with any other medication. Review of the resident's MAR, dated 01/20/25 through 01/26/25, showed the MAR contained documentation of the administration of Levothyroxine at the same time as the administration of Midodrine, Vitamin D, Cyclobenzaprine, Eliquis, Fludrocortisone, Gabapentin, Prenatal, and Fluoxetine on 01/20/25 at 10:08 A.M., 01/21/25 at 8:39 A.M., 01/22/25 at 9:23 A.M., 01/23/25 at 7:54 A.M., 01/24/25 at 7:41 A.M., 01/25/25 at 8:20 A.M., and 01/26/25 at 8:42 A.M. Observation on 01/27/25 at 12:20 P.M. showed LPN G administered the Levothyroxine with Midodrine, Vitamin D, Cyclobenzaprine, Eliquis, Fludrocortisone, Gabapentin, Prenatal, and Fluoxetine to the resident. The LPN did not administer the Levothyroxine separately, as directed on the MAR. During an interview on 01/27/25 at 12:43 P.M., LPN G said Levothyroxine is usually administered by the night shift nurse early in the morning before breakfast, so he /she did not pay close attention to the directions on the MAR prior to administering the medication to the resident. The LPN said if the Levothyroxine is not given as directed, it may not work like it should. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 01/27/25 at 12:49 P.M., NP O said Levothyroxine is ordered to be given in the morning, and should be administered separate from other medications to increase the medication's effectiveness. 5. Review of the facility's policy titled, Administering Medications, dated 01/01/24, showed only persons licensed or permitted by this state to prepare, administer and document administration of medications may do so, and the individual administering the medication initials the resident's MAR on the appropriate line after giving each medication. 6. Review of Resident #20's MAR, dated 01/20/25 through 01/23/25, showed staff documented the administration of Levothyroxine, Midodrine, Vitamin D, Cyclobenzaprine, Eliquis, Fludrocortisone, Gabapentin, Prenatal, and Fluoxetine administered via G-tube: -01/20/25 at 10:08 A.M. by Certified Medication Technician (CMT) L; -01/21/25 at 8:39 A.M. by CMT L; -01/22/25 at 9:23 A.M. by CMT L; -01/23/25 at 7:54 A.M. by agencycmt. During an interview on 01/30/25 at 11:45 A.M., LPN H said only nurses are allowed to administer the resident's medications via G-tube and the CMTs do not administer the resident's medications via G-tube. He/She said he/she did not know why the CMTs signed the MAR at those times, and he/she always signs the MAR him/herself when he/she administers the medications via G-tube. During an interview on 01/30/25 at 3:07 P.M., the MDS/Care Plan Coordinator said when he/she pulled the MAR report to show the documented medication administration times, he/she noticed there were days signed by a CMT, but he/she does not think the CMT actually administered the medications via G-tube because they are not trained or authorized to do so. During an interview on 01/30/25 at 3:52 P.M., the Director of Nursing (DON) said the CMTs are not authorized to administer medications via G-tube, and he/she did not know the CMTs were documenting administration on the resident's MAR. He/She said only nurses are responsible to administer medications via G-tube and he/she expects the nurse to document the administration on the MAR once completed. He/She said he/she is new to the facility and is not sure if anyone is responsible for auditing the MARs. During an interview on 01/30/25 at 4:05 P.M., the administrator said the facility did not have a DON for about a month, and some things were just not being monitored. During an interview on 02/04/25 at 2:22 P.M., LPN G said the CMTs do not administer the resident's medications via G-tube. The LPN said when he/she is the charge nurse, he/she prepares the medications with the CMT at the medication cart, and the CMT signs the MAR, but he/she (the nurse) administers the medications. He/She said the person who signs the MAR is attesting that he/she administered the medications, but that is not always the case with the resident. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	7. Review of the facility's policy titled, Colostomy/Ileostomy care, dated October 2010, showed staff are directed to document in the resident's medical record: -The date and time the colostomy/ileostomy care is provided; -The name and title of the individual (s) who provided the colostomy/ileostomy care; -Any breaks in resident's skin, signs of infection (purulent discharge (pus), pain, redness, swelling, temperature) or excoriation of skin; 8. Review of Resident #48's POS, dated 01/08/25 through 01/30/25, showed an order to change colostomy appliance every three days on the day shift for ileostomy (a surgical procedure that creates an opening in the abdomen to excrete feces from the body) care, effective 01/17/25. Review of the resident's Treatment Administration Record (TAR), dated 01/08/25 through 01/30/25, showed licensed staff were directed to change the colostomy appliance every three days on the day shift for ileostomy care, effective 01/18/25. Review showed the colostomy bag was scheduled to be changed on 01/30/25. During an interview on 01/30/25 at 9:44 A.M., LPN H said the Certified Nurse Aides (CNAs) change the resident's colostomy bag, tell the nurse they completed it, and then the nurse signs the TAR. The LPN said he/she did not change the resident's colostomy bag earlier as directed on the TAR, but one of the CNAs did, and he/she signed the TAR that he/she completed the treatment. The LPN said when the nurse signs the TAR, he/she is attesting that he/she completed the ordered treatment, which sometimes is not accurate, but the CNA cannot sign the TAR. He/She said the nurses are expected to follow the physician's orders all the time. During an interview on 01/30/25 at 3:52 P.M., the DON said he/she expects staff to always follow the physician's orders. He/She said the charge nurse is responsible to complete treatments listed on the TAR and sign the TAR that he/she completed the treatment. The DON said he/she is new to the facility and is not sure if anyone is responsible for checking the MARs/TARs. During an interview on 01/30/25 at 4:05 P.M., the administrator said he/she expects staff to always follow the physician's orders. He/She said the charge nurse is responsible to complete any treatment listed on the TAR and sign the TAR after he/she completes the treatment. He/She said the facility did not have a DON for about a month, and some things were just not being monitored.

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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** 39440 Based on observation, interview, and record review, facility staff failed to provide care to meet basic hygiene needs for four residents (Resident #24, #32, #35, and #48) out of six sampled residents. The facility census was 43. 1. Review of the facility's, Bath, Shower/Tub Policy, dated February 2018, showed staff are directed: -The purpose of this procedure is to promote cleanliness, provide comfort to the resident and to observe the condition of the resident's skin; -Document the date and time the shower/bath was performed; -If the resident refused the shower/tub bath, the reason(s) why and the intervention taken; -Notify the supervisor if the resident refuses the shower/tub bath. 2. Review of Resident #24's Quarterly Minimum Data Set (MDS), a federally mandated assessment, dated 10/17/24, showed staff assessed the resident as follows: -Mild cognitive impairment; -Did not reject care (such as Activities of Daily Living (ADL) assistance); -Required partial assistance from staff with personal hygiene, transfers, and to shower/bathe. Review of the resident's care plan, dated 04/12/24, showed staff were directed to assist the resident with ADLs as needed. Review of the resident's shower sheets, date 10/01/24 through 01/29/25, showed staff documented showers were provided on 11/6/24, 11/11/24, 11/13/24, 11/20/24, and one resident refusal on 11/28/24. Observation on 01/28/25 at 9:21 A.M., showed the resident laid in bed with greasy hair. Observation on 01/29/25 at 9:49 A.M., showed the resident in the dining room with greasy hair protruding from under his/her baseball cap. 3. Review of Resident #32's Quarterly MDS, dated [DATE], showed staff assessed the resident as follows: -Cognitively intact; -Did not reject care; (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Independent with transfers, ambulation, personal hygiene, but required supervision to shower/bathe. Review of the resident's care plan, dated 01/18/25, showed the care plan did not contain directions for assistance with ADLs. Review of the resident's shower sheets, dated 10/01/24 through 01/29/25, showed staff documented showers were provided on 11/19/24, 11/26/24, 12/10/24, 12/27/24, 01/10/25 and one resident refusal on 12/31/24. Observation on 01/27/25 at 3:27 P.M., showed the resident in the dining room with greasy hair. During an interview on 01/27/25 at 3:28 P.M., the resident said he/she has not had a shower in several weeks. He/She said staff does not even offer him/her a shower anymore, and it makes him/her feel left out and not cared for. He/She said he/she can do his/her own facial and oral hygiene, but has not asked staff recently for help with a shower, because they don't seem to have enough help. 4. Review of Resident #35's Quarterly MDS, dated [DATE], showed staff assessed the resident as follows: -Cognitively intact; -Requires supervision or touching assistance with showers, and personal hygiene and transfers; -Does not reject care. Review of the resident care plan, dated 12/01/24, showed the care plan did not contain directions for assistance with ADLs. Review of the resident shower sheets, dated 10/2024 through 01/2025 showed staff documented showers were provided on 11/05/24, 11/08/24, 11/15/24, 11/22/24, 12/11/24, 12/19/24. 12/21/24 and 01/13/25. Observation on 01/27/25 at 1:30 P.M., showed the resident in his/her bed with greasy hair, and long fingernails with a dark substance underneath. Observation on 01/28/25 at 10:20 A.M., showed the resident in his/her chair with greasy hair, and long fingernails with a dark substance underneath. During an interview on 01/28/25 at 10:21 A.M., the resident said it had been a while since they had a shower, he/she can't remember the last time. The resident said it does not make him/her feel very good to not get showers. 5. Review of Resident #48's Entry Tracking Record MDS, dated [DATE], showed the resident admitted to the facility on [DATE]. Review of the resident's care plan, dated 01/17/25, showed staff were directed to assist the resident with ADLs as needed. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the resident's shower sheets, dated 01/08/25 through 01/30/25, showed the sheets did not contain documentation of a bath/shower since his/her admission, and did not documentation the resident refused any baths/showers. Observation on 01/27/25 at 2:45 P.M., showed the resident in his/her bed with greasy hair. Observation on 01/28/25 at 9:10 A.M., showed the resident in his/her bed with greasy hair, and his her teeth covered with food debris. During an interview on 01/28/25 at 9:10 A.M., the resident said he/she needed help from staff to take a shower, and he/she had not had one since admission. Observation on 01/29/25 at 10:44 A.M., during incontinence care, the resident asked Certified Nursing Assistant (CNA) K, can one of you wash my hair or something, my hair is really dirty? The CNA responded that he/she thought the resident was scheduled to get a shower that day. During an interview on 01/30/25 at 3:04 P.M., CNA K said he/she did not assist the resident with a shower the day prior. 6. During an interview on 01/30/25 at 2:58 P.M., Licensed Practical Nurse (LPN) H said residents are offered showers twice per week by the CNAs. He/She said the CNA documents on the shower sheet when he/she offers a resident a shower, and gives the completed shower sheet to the nurse to review and sign. The LPN said if a resident refuses a shower, the CNA is expected to document the refusal on the shower sheet and give to the nurse for follow up, the nurse should re-approach the resident, and if he/she she still refuses, then the nurse is expected to document a nurse's note regarding the resident's refusal. He/She said the previous DON would update the shower schedule, but the facility was without a DON for a while, During an interview on 01/30/25 at 3:04 P.M., CNA K said the CNAs are responsible to offer/assist residents with a shower per the shower schedule and document on the shower sheet once completed. He/She said if a resident refused his/her shower, the CNA is expected to document the resident's refusal on the shower sheet and give to the charge nurse for follow up. He/She said if there wasn't a completed shower sheet, the resident likely was not offered a shower. During an interview on 01/30/25 at 4:05 P.M., the administrator said he/she expects the CNAs to offer and assist residents with showers per schedule at least twice per week or more often if the resident prefers. He/She said if the resident refuses, the CNA should let the nurse know so he/she can follow up with the resident. He/She said the facility did not have a DON for about a month and some things were just not being monitored. 39644

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39440 Based on observation, interview, and record review, facility staff failed to obtain signed consents for side rails and failed to complete side rail assessments for four residents (Resident #3, #15, #20 and #46), out of four sampled residents. The facility census was 43. 1. Review of the facility's Proper use of Side Rails Policy, undated, showed: -Examples of bedrails include, but are not limited to side rails, bed side rails, safety rails, grab bars, and assist bars; -The resident assessment must assess the resident's risk from using bed rails such as entrapment; -The resident assessment should assess the resident's risk of entrapment between the mattress and bed rail or in the bed rail itself; -Informed consent from the resident or resident representative must be obtained after appropriate alternative have been attempted prior to installation and use of bed rails; -Upon receiving informed consent, the facility will obtain a physician's order for the use of the specified bed rail and medical diagnosis, condition, symptom, or functional reason for the use of the bed rail; -A nurse assigned to the resident will complete reassessments in accordance with the facility's assessment schedule, but not less than quarterly, upon significant change in status, or a change in the type of bed/mattress/rail. 2. Review of Resident #3's Admission Minimum Data Set (MDS), a federally mandated assessment tool, dated 12/05/24, showed staff assessed the resident as follows: -Severe cognitive impairment; -Substantial/maximal with toileting, and transfers. Review of the resident's medical record showed the record did not contain a signed informed consent from the resident or resident representative for the use of bed rails or a quarterly bed rail assessment. Observation on 1/28/25 at 10:00 A.M., showed resident in bed with the left side rail in the upright position. Observation on 1/30/25 at 2:45 P.M., showed resident in bed with the left side rail in the upright position. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fulton Manor Care Center	520 Manor Drive Fulton, MO 65251

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. Review of Resident #15's annual MDS, dated [DATE], showed staff assessed the resident as: -Cognitively intact; -Independent with bed mobility, toileting, and transfers. Review of the resident's medical record showed the record did not contain a signed informed consent from the resident or resident representative for the use of bed rails or a quarterly bed rail assessment. Observation on 1/27/25 at 11:13 A.M., showed the resident in bed with bilateral side rails in the upright position. Observation on 1/28/25 at 9:06 A.M., showed the resident in bed with bilateral side rails in the upright position. Observation on 1/29/25 at 9:45 A.M., showed the resident in bed with bilateral side rails in the upright position. Observation on 1/30/25 at 10:07 A.M., showed the resident in bed with bilateral side rails in the upright position. 4. Review of Resident #20's Entry Tracking Record MDS, dated [DATE], showed the resident admitted to the facility on [DATE]. Review of the resident's medical record showed the record did not contain a signed informed consent from the resident or resident representative for the use of bed rails or a physician's order, as directed by the policy. Observation on 01/27/25 at 3:24 P.M., showed the resident in bed with side rails on both sides in the upright position. Observation on 01/29/25 at 1:38 P.M., showed the resident in bed with side rails on both sides in the upright position. During an interview on 01/27/25 at 11:43 A.M., the resident said he/she uses the side rails to help with bed mobility. 5. Review of Resident #46'', showed staff documented the resident admitted to the facility on [DATE]. Review of the Resident #46's medical record showed the record did not contain a signed informed consent from the resident or resident representative for the use of bed rails, a side rail assessment, or a physician's order, as directed by the policy. Observation on 01/27/25 at 11:55 A.M., showed the resident in bed with side rails on both sides in the upright position. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 01/27/25 at 2:41 P.M., showed the resident in bed with side rails on both sides in the upright position. Observation on 01/29/25 at 2:13 P.M., showed the resident in bed with side rails on both sides in the upright position. 6. During an interview on 01/30/25 at 2:58 P.M., Licensed Practical Nurse (LPN) H said the charge nurse is responsible to complete a side rail assessment as a part of the resident's admission process, so he/she did not know why one was not done. He/She said he/she has never seen a side rail consent so he/she is not sure who is responsible to obtain a signed consent from the resident or resident representative. During an interview on 01/30/25 at 2:44 P.M., LPN H said asking the resident if they want bed rails is part of the admission process. He/She said he/she is unsure if there is a consent form for bed rails. He/She said a bed rail assessment is done upon admission and quarterly. He/She said the charge nurses are responsible for ensuring bed rail assessments are completed. He/She is unsure why the bed rail assessments are not being done quarterly. During an interview on 01/30/25 at 3:26 P.M., the Director of Nursing (DON) said bed rail forms are all together upon admission and consent is obtained upon admission. He/She said he/she is unsure if the bed rail assessments. He/She said the charge nurses do the assessments. He/She said he/she is unsure of the regulation but believes assessments should be done every six months. During an interview on 01/30/25 at 3:56 P.M., the administrator said charge nurses are responsible for completing bed rail assessments quarterly to ensure the resident still needs the bed rails. He/She said bed rail consent should be obtained and signed before bed rails are put onto bed. He/She is unsure why assessment are not being done quarterly. 50422

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39644 Based on observation, interview, and record review, the facility failed to provide staff in accordance with their Facility Assessment to meet the needs of the residents. Staff failed to provide care to meet basic hygiene needs for four residents (Resident #24, #32, #35, and #48) out of six sampled residents. The facility census was 43. 1. Review of the Facility Assessment, dated 01/07/25, showed direct care staff required to care for their facility census: -Days- Five nurse aides with census above 43 or three-four nurse aides with census lower than 40; -Evenings- Four nurse aides with census above 43 or two-three nurse aides with census below 40; -Nights- Two nurse aides; -Staffing plan is to ensure that facility has sufficient staff to meet the needs of the residents at any given time. Review of the employee schedule, dated August 2024, with average census of 42, showed: -Thursday 08/01/24: one nurse aide on day shift; -Friday 08/02/24: one nurse aide on night shift; -Saturday 08/03/24: two nurse aides on day shift; -Sunday 08/04/24: two nurse aides on day shift and one nurse aide on night shift; -Monday 08/05/24: two nurse aides on evening shift; -Wednesday 08/07/24: two nurse aides on evening shift; -Tuesday 08/08/24: two nurse aides on evening shift; -Friday 08/09/24: two nurse aides on day shift; -Saturday 08/10/24: two nurse aides on evening shift and one nurse aide on night shift; -Sunday 08/11/24: two nurse aides on evening shift; -Friday 08/23/24: two nurse aides on evening shift; -Saturday 08/24/24: two nurse aides on day shift; (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Sunday 08/25/24: two nurse aides on evening shift and one nurse aide on night shift; -Monday 08/26/24: two nurse aides on day shift and two nurse aides on evening shift; -Saturday 08/31/24; two nurse aides on day shift and two nurse aides on evening shift. Review of the employee schedule, dated September 2024, with average census of 40, showed: -On Wednesday 09/04/24: two nurse aides on day shift, one nurse aide on evening shift, one nurse aide on night shift; -Saturday 09/07/24: one nurse aide on day shift; -Sunday 09/08/24: two nurse aides on day shift; -Thursday 09/12/24: one nurse aide on night shift; -Monday 09/16/24: two nurse aides on day shift and one nurse aide on evening shift. -Saturday 09/21/24: two nurse aides on day shift; -Saturday 09/28/24: two nurse aides on day shift. Review of the employee schedule, dated October 2024, with average census of 43, showed: -On Thursday 10/03/24: two nurse aides on evening shift; -Friday 10/04/24: two nurse aides on evening shift; -Saturday 10/05/24: two nurse aides on evening shift; -Sunday 10/06/24: two nurse aides on evening shift. Review of the employee schedule, dated November 2024, with average census of 42, showed Saturday 11/23/24: two nurse aides on day shift. Review of the employee schedule, dated December 2024, with average census of 42, showed: -On Sunday 12/01/24: two nurse aides on day shift and two nurse aides on evening shift; -Saturday 12/14/24: two nurse aides on evening shift; -Sunday 12/15/24: two nurse aides on evening shift; -Friday 12/20/24: two nurse aides on evening shift; -Saturday 12/28/24: two nurse aides on day shift and two nurse aides on evening shift; (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Sunday 12/29/24: two nurse aides on evening shift. 2. Review of Resident #24's Quarterly Minimum Data Set (MDS), a federally mandated assessment, dated 10/17/24, showed staff assessed the resident as follows: -Mild cognitive impairment; -Did not reject care (such as Activities of Daily Living (ADL) assistance); -Required partial assistance from staff with personal hygiene, transfers, and to shower/bathe. Review of the resident's care plan, dated 04/12/24, showed staff were directed to assist the resident with ADLs as needed. Review of the resident's shower sheets, from 10/01/24 through 01/29/25, showed staff documented showers on 11/6/24, 11/11/24, 11/13/24, 11/20/24, and one resident refusal on 11/28/24. Observation on 01/28/25 at 9:21 A.M., showed the resident in bed with greasy hair. Observation on 01/29/25 at 9:49 A.M., showed the resident in the dining room with greasy hair protruding from under his/her baseball cap. 3. Review of Resident #32's Quarterly MDS, dated [DATE], showed staff assessed the resident as follows: -Cognitively intact; -Did not reject care; -Independent with transfers, ambulation, personal hygiene, but required supervision to shower/bathe. Review of the resident's care plan, dated 01/18/25, showed the care plan did not contain directions for assistance with ADLs. Review of the resident's shower sheets, from 10/01/24 through 01/29/25, showed staff documented showers on 11/19/24, 11/26/24, 12/10/24, 12/27/24, 01/10/25 and one resident refusal on 12/31/24. Observation on 01/27/25 at 3:27 P.M., showed the resident in the dining room with greasy hair. During an interview on 01/27/25 at 3:28 P.M., the resident said he/she has not had a shower in several weeks. He/She said staff does not even offer him/her a shower anymore, and it makes him/her feel left out and not cared for. He/She said he/she can do his/her own facial and oral hygiene, but has not asked staff recently for help with a shower, because they don't seem to have enough help. 4. Review of Resident #35's Quarterly MDS, dated [DATE], showed staff assessed the resident as follows: (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Cognitively intact; -Requires supervision or touching assistance with showers, and personal hygiene and transfers; -Does not reject care. Review of the resident care plan, dated 12/01/24, showed the care plan did not contain direction for assistance with ADLS. Review of the resident shower sheets, from October 2024 through January 2025 showed staff documented showers for the following dates, 01/13/25, 12/11/24, 12/19/24. 12/21/24, 11/05/24, 11/08/24, 11/15/24, and 11/22/24. Observation on 02/27/25 at 1:30 P.M., showed the resident in his/her bed with greasy hair, and long fingernails with a dark substance underneath. Observation on 02/28/25 at 10:20 A.M., showed the resident in his/her chair with greasy hair, and long fingernails with a dark substance underneath. During an interview on 02/28/25 at 10:21 A.M., the resident said it had been a while since they had a shower, he/she can't remember the last time. The resident said it does not make him/her feel very good to not get showers. 5. Review of Resident #48's Entry Tracking Record MDS, dated [DATE], showed the resident admitted to the facility on [DATE]. Review of the resident's care plan, dated 01/17/25, showed staff were directed to assist the resident with ADLs as needed. Review of the resident's shower sheets, from 01/08/25 through 01/30/25, showed staff did not document they assisted the resident with a bath/shower since his/her admission, and did not document the resident refused any baths/showers. Observation on 01/27/25 at 2:45 P.M., showed the resident in his/her bed with greasy hair. Observation on 01/28/25 at 9:10 A.M., showed the resident in his/her bed with greasy hair, and his her teeth covered with food debris. During an interview on 01/28/25 at 9:10 A.M., the resident said he/she needed help from staff to take a shower, and he/she had not had one since admission. Observation on 01/29/25 at 10:44 A.M., during incontinence care, the resident asked Certified Nursing Assistant (CNA) K, can one of you wash my hair or something, my hair is really dirty? The CNA responded that he/she thought the resident was scheduled to get a shower that day. During an interview on 01/30/25 at 3:04 P.M., CNA K said he/she did not assist the resident with a shower the day prior. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	6. During an interview on 1/27/25 at 11:31 A.M., Resident #30 said he/she feels the facility is short staffed on all shifts. He/She said showers are supposed to be twice a week, but he/she is lucky if he/she gets a shower once a week because of short staffing. During an interview on 01/27/25 at 3:09 P.M., Resident #47 said he/she admitted about a week prior for therapy and had not been offered a shower yet. He/She said the facility did not have enough staff. He/She said a female staff told him/her over the weekend that he/she looked like he/she needed a shower but did not offer to assist him/her with a shower, and it made him/her feel like he/she was not being cared for. During an interview on 01/28/25 at 10:21 A.M., Resident #7 said the facility does not have enough staff. He/She said they are short on nurse aides all shifts, but more on the weekends. He/She said he/she only gets about one bath a week if that because they don't have enough staff to give us a bath twice a week. During an interview on 01/30/25 at 2:58 P.M., Licensed Practical Nurse (LPN) H said residents are offered showers twice per week by the CNAs. He/She said the CNA documents on the shower sheet when he/she offers a resident a shower, and gives the completed shower sheet to the nurse to review and sign. The LPN said if a resident refuses a shower, the CNA is expected to document the refusal on the shower sheet and give to the nurse for follow up, the nurse should re-approach the resident, and if he/she she still refuses, then the nurse is expected to document a nurse's note regarding the resident's refusal. During an interview on 01/30/25 at 3:04 P.M., CNA K said the CNAs are responsible to offer/assist residents with a shower per the shower schedule and document on the shower sheet once completed. He/She said if there wasn't a completed shower sheet, the resident likely was not offered a shower. During an interview on 01/30/25 at 3:34 P.M., the Director of Nursing (DON) said he/she is unsure of the facility assessment. He/She said should be about three-four nurse aides on day shift and two nurse aides on evening and night shift. During an interview on 01/30/25 at 4:05 P.M., the administrator said he/she expects the CNAs to offer and assist residents with showers per schedule at least twice per week or more often if the resident prefers. He/She said if the resident refuses, the CNA should let the nurse know so he/she can follow up with the resident. He/She said the facility did not have a DON for about a month and some things were just not being monitored. He/She tries to ensure there is enough staff in facility to meet fire code. He/She said one person per 10 residents during day shift, one staff per 15 residents on evening shift, and one staff per 20 residents on night shift. He/She said he/she was not going off of facility assessment but using fire code regulation.

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. 50422 Based on interview and record review, facility staff failed to provide the services of a Registered Nurse (RN), for at least eight consecutive hours per day, seven days a week. The facility census was 43. 1. Review of the facility's policy titled, Nursing Services-Registered Nurse (RN), dated 01/01/24, showed the facility will utilize the services of a Registered Nurse for at least eight consecutive hours per day, seven days per week. 2. Review of the facility's RN staff schedule, dated July 2024, showed the facility did not have an RN, eight consecutive hours a day, in the building for the dates of: -Monday, 07/01/24; -Tuesday, 07/02/24; -Wednesday, 07/03/24; -Thursday, 07/04/24; -Monday, 07/08/24; -Tuesday, 07/09/24; -Wednesday, 07/10/24; -Thursday, 07/11/24; -Friday, 07/12/24; -Saturday, 07/13/24; -Sunday, 07/14/24; -Monday, 07/15/24; -Tuesday, 07/16/24; -Wednesday, 07/17/24; -Thursday, 07/18/24; -Monday, 07/22/24; (continued on next page)

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Sunday, 08/25/24; -Monday, 08/26/24; -Tuesday, 08/27/24; -Wednesday, 08/28/24; -Thursday, 08/29/24; -Friday, 08/30/24; -Saturday, 08/31/24. 4. Review of the facility's RN staff schedule, dated September 2024, showed the facility did not have an RN, eight consecutive hours a day, in the building for the month of September. 5. Review of the facility's RN staff schedule, dated October 2024, showed the facility did not have an RN, eight consecutive hours a day, in the building for the month of October. 6. Review of the facility's RN staff schedule, dated November 2024, showed the facility did not have an RN, eight consecutive hours a day, in the building for the dates on: -Saturday, 11/02/24; -Sunday, 11/03/24; -Saturday, 11/09/24; -Sunday, 11/10/24; -Saturday, 11/16/24; -Sunday, 11/17/24; -Saturday, 11/23/24; -Sunday, 11/24/24; -Saturday, 11/30/24. 7. Review of the facility's RN staff schedule, dated December 2024, showed the facility did not have an RN, eight consecutive hours a day, in the building for the dates of: -Sunday, 12/01/24; -Saturday, 12/07/24; (continued on next page)

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Sunday, 12/08/24; -Saturday, 12/14/24; -Sunday, 12/15/24; -Sunday, 12/22/24; -Sunday, 12/29/24. 8. Review of the facility's RN staff schedule, dated January 2025, showed the facility did not have an RN, eight consecutive hours a day, in the building for the dates of: -Saturday, 01/04/25; -Sunday, 01/05/24; -Saturday, 01/11/24; -Sunday, 01/12/24; -Thursday, 01/16/24. 9. During an interview on 01/30/25 at 3:30 P.M., the Director of Nursing (DON) said he/she was unsure of the regulation for RN coverage in the facility. He/She said he/she would have to look at the policy. He/She said the importance of having an RN in the facility eight consecutive hours daily is expertise advice and RN's have more knowledge about nursing with their license. During an interview on 01/30/25 at 4:05 P.M., the administrator said the facility should have an RN in the facility at least eight consecutive hours daily. He/She said he/she was aware that there were several months that they just didn't have an RN. He/She the importance of having an RN in the facility is having more knowledge.

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F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Post nurse staffing information every day. 50422 Based on observation, interview, and record review, facility staff failed to complete the required nurse staffing information, which included the facility census, the actual hours worked by both licensed and unlicensed nursing staff directly responsible for resident care, per shift, on a daily basis in an area readily accessible to residents and visitors. The facility census was 43. 1.Review of the facility's policy titled, Posting Direct Care Daily Staffing Numbers, dated 07/2016, showed: -Within two hours of the beginning of each shift, the number of licensed nurses and the number of unlicensed nursing personnel directly responsible for resident care will be posted in a prominent location (accessible to residents and visitors) in a clear and readable format; -Shift staffing information shall be recorded on the Daily Staffing form for each shift, the information recorded on the form shall include: -The name of the facility; -The date for which the information is posted; -The resident census at the beginning of the shift for which the information is posted; -Twenty-four hour shift schedule operated by the facility; -The shift for which the information is posted; -Type and category (licensed or non-licensed) of nursing staff working during that shift; -The actual time worked during that shift for each category and type of nursing staff; -Total number of licensed and non-licensed nursing staff working for the posted shift. 2. Review of facility's daily staffing sheets, dated November 2024 and December 2024, showed the daily staffing sheets did not contain facility census or actual hours worked for licensed and non-licensed staff. 3. Review of facility's daily staffing sheets, dated 1/1/2025 through 1/30/2025, showed the daily staffing sheets did not contain facility census or actual hours worked for licensed and non-licensed staff. Observation on 01/27/25 at 12:32 P.M., showed the facility staff posting did not contain a facility census or actual hours worked by licensed and non-licensed staff and not readily accessible to residents and visitors. (continued on next page)

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F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 01/28/25 at 09:21 A.M., showed the facility staff posting did not contain a facility census or actual hours worked by licensed and non-licensed staff and not readily accessible to residents and visitors. Observation on 01/29/25 at 10:06 A.M., showed the facility staff posting did not contain a facility census or actual hours worked by licensed and non-licensed staff and not readily accessible to residents and visitors. Observation on 01/30/25 at 10:21 A.M., showed the facility staff posting did not contain a facility census or actual hours worked by licensed and non-licensed staff and not readily accessible to residents and visitors. 4. During an interview on 02/03/25 at 10:00 A.M., the Director of Nursing (DON) said daily staff posting should include actual hours not scheduled hours for nurses and certified nurses aides. He/She said the facility census should be listed on daily shift. He/She said it is the charge nurses responsibilty to make sure daily staffing sheet is completed. He/She said he/she was not aware the daily staffing sheets did not include facility census or actual hours worked. He/She said daily staff posted should be accessible to all residents and visitors. During an interview on 02/03/25 at 10:10 A.M., the administrator said daily staff posting should include facility census and actual hours worked for licensed and non-licensed staff in the building. He/She said it is the night charge nurse who is responsible for filling out the daily staffing sheet and posting it daily. He/She was not aware that the daily staff sheets did not contain facility census or actual hours worked by staff. He/She said there is no reason why the daily staff posting was not readily available for residents or visitors, but it should be.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. 39440 Based on observation, interview, and record review, facility staff failed to ensure a medication error rate of less than five percent (5%). Out of 32 opportunities observed, nine errors occurred, resulting in a 28.13% error rate, which affected one resident (Resident #20) out of four sampled residents. The facility's census was 43. 1. Review of the facility's policy titled, Medication Errors, dated 01/01/24, showed the facility must ensure that it is free of medication error rates of 5% or greater. Review of the facility's policy titled, Administering Medications, dated April 2019, showed: -Medications are administered in a safe and timely manner, and as prescribed; -Medications are administered within one hour of their prescribed time, unless otherwise specified (for example, before and after meal orders); -The individual administering the medication checks the label three times to verify the right resident, right medication, right dosage, right time, and right method (route) of administration before giving the medication. Review of the facility's Medication Pass times, provided by the administrator showed morning (A.M.) medication pass from 8:00 A.M. - 9:00 A.M. with allowance of an hour before or after (7:00 A.M. - 10:00 A.M.) 2. Review of Resident #20's Physician's Order Sheet (POS), dated 01/01/25 through 01/27/25, showed the physician ordered medications to be administered via Gastric Tube ((G-Tube) a surgically inserted tube which provides nutrition, hydration, or medicine directly into the stomach) as follows: -Levothyroxine 75 micrograms (mcg) tablet, give one tablet in the morning for Hypothyroidism (low levels of thyroid hormones in the body); -Midodrine 2.5 milligrams (mg) tablet, give 2.5 mg one time a day for low blood pressure; -Cholecalciferol tablet 1000 units (to treat low vitamin D), give one tablet in the morning and at bedtime for supplement; -Cyclobenzaprine 5 mg tablet, give one tablet in the morning for muscle spasms; -Eliquis 5 mg tablet, give 5 mg twice per day for blood thinner; -Fludrocortisone Acetate tablet 0.1 mg (to treat Addison's disease (low hormone levels produced by the adrenal glands)), give half tablet one time a day for supplementation; -Gabapentin 300 mg capsule, give 300 mg three times a day for neuropathy (nerve damage resulting in numbness or weakness); (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Fluoxetine oral solution 20 mg/5 milliliters (ml), give 7.5 ml one time a day for depression; -Prenatal 27-.08 mg tablet (vitamins with iron and folic acid), give one tablet one time a day for supplementation. Review of the Resident's Medication Administration Record (MAR), dated 01/01/25 through 01/27/25, showed staff were directed to administer the medications during the A.M. med pass times as follows: -Levothyroxine 75 mcg tablet, give every morning on an empty stomach, do not give with any other medication; -Midodrine 2.5 mg tablet; -Cholecalciferol tablet 1000 units; -Cyclobenzaprine 5 mg tablet; -Eliquis 5 mg tablet; -Fludrocortisone Acetate tablet 0.1 mg, give half tablet; -Gabapentin 300 mg capsule; -Fluoxetine oral solution 20 mg/5 ml, give 7.5 ml; -Prenatal 27-.08 mg tablet. During an interview on 01/27/25 at 12:02 P.M., the resident said his/her main concern was not getting his/her medications as scheduled in the mornings. He/She said it was already noon and he/she had not received any medications as yet for the day. Observation on 01/27/25 at 12:15 P.M. showed Licensed Practical Nurse (LPN) G crushed Levothyroxine, Midodrine, Vitamin D, Cyclobenzaprine, Eliquis, Fludrocortisone, Gabapentin, and Prenatal tablets together, emptied the mixture into a cup with the liquid Fluoxetine, and added water to the cup. Observation on 01/27/25 at 12:20 P.M. showed LPN G administered the Levothyroxine, Midodrine, Vitamin D, Cyclobenzaprine, Eliquis, Fludrocortisone, Gabapentin, Prenatal, and Fluoxetine to the resident via his/her G-tube. The LPN administered the medications two hours and twenty minutes after the scheduled administration time. During an interview on 01/27/25 at 12:24 P.M., LPN G said the nurse is responsible to administer the resident's medications via G-tube, and he/she forgot to check and administer the resident's medications earlier. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 01/27/25 at 12:43 P.M., LPN G said he/she administered the resident's medications late, and medications given that late was a medication error. The LPN said the resident has a few medications ordered to be administered two to three times daily that should be reviewed so they are not given too close together, to prevent side effects or overdose. He/She said he/she should notify the Director of Nursing, and the resident's physician of the late medications and med error for further directions, and he/she had not notified anyone as yet but he/she would. During an interview on 01/27/25 at 12:49 P.M., Nurse Practitioner (NP) O said he/she expects to be notified if the resident's medications are administered late so he/she could give staff further directions. During an interview on 01/30/25 at 3:52 P.M., the Director of Nursing (DON) said staff have from 7:00 A.M. to 10:00 A.M. for the morning medication pass, so medications administered after 10:00 A.M. are late and considered a medication error. He/She said to address a medication error, staff should complete an incident report, notify the charge nurse, DON, and the physician for further instructions. During an interview on 01/30/25 at 4:05 P.M., the administrator said late medications are considered a med error, and he/she would expect the nurse to notify the DON and the physician for further instructions after a medication error.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 45564 Based on observation, interview and record review, facility staff failed to ensure the dish washing machine operated according to manufacturer's instructions in a manner adequate to prevent cross contamination of kitchen wares. Facility staff failed to properly sanitize soiled kitchen wares to prevent cross-contamination. Facility staff failed to maintain an ice machine drain air gap. The facility census was 43. 1. Review of the facility's Dishwashing: Machine Operation policy, dated 2020, showed staff were instructed to: -Operate dishwashing machines according to manufacturer recommendations; -Record log documents twice daily for either final rinse temperature (high temperature machine) or sanitizer concentration (low temperature machine with chemical sanitizer); -If the machine is found to be out of the acceptable range for either final rinse temperature or proper chemical sanitizing concentration, do not proceed to wash dishes; -After troubleshooting, if the dish washing machine is not functioning, the employee should contact the Dining Services Manager or maintenance or outside vendor per facility guidelines to coordinate repair. The dish machine should be labeled out of service and not utilized until the dishwashing machine is repaired; -If the dishwashing machine cannot be repaired in a timely manner, the facility will utilize the manual dishwashing procedure or paper goods may be used as a temporary measure until the dishwashing machine is repaired. 2. Observation on 01/28/25 at 9:45 A.M., showed the front of the dish machine contained a label which indicated minimum wash and rinse temperatures of 120 degrees Fahrenheit (F). Observation on 01/28/25 at 9:35 A.M., showed Dietary Aide (DA) F ran a load of dirty dishes through the dish machine. Observation showed the machine wash temperature was 108 degrees F. Observation on 01/28/25 at 10:07 A.M., showed Dietary Aide (DA) F ran a load of dirty dishes through the dish machine. Observation showed the machine wash temperature was 104 degrees F and the machine rinse temperature was 112 degrees F. Observation showed a sanitizer test strip did not change color, which indicated a sanitizer concentration level below detection. Observation showed the Dietary Manager (DM) removed the clean dishes from the clean side of the machine and placed the dishes on a cart to dry. Observation on 01/28/25 at 1:55 P.M., showed DA F ran a load of dirty dishes through the dish machine. Observation showed the machine reached a wash temperature of 90 degrees F and a rinse temperature of 110 degrees F. Observation showed a sanitizer test strip did not change color, which indicated a sanitizer concentration level below detection. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 01/28/25 at 1:58 P.M., showed DA F removed a load of clean dishes and ran a load of dirty dishes through the dish machine. Observation showed the wash temperature was 90 degrees F and the rinse temperature was 110 degrees F. During an interview on 01/28/25 at 2:00 P.M., the DM said if the dish machine was not functioning correctly staff should use a bleach and water solution to sanitize dishes for at least 10 seconds. The DM said when the dish machine first started it did not always reach the correct temperature. The DM said the dish machine temperature should be 125 to 130 degrees F. The DM said the dish machine sanitizer concentration should be greater than 50. The DM said he/she was not aware the dish machine was not reaching the proper temperature or sanitizer concentration. 3. Review of the facility's Manual Warewashing-3 Compartment Sink policy, reviewed 1/1/25, showed the facility utilizes a 3-compartment sink to wash, rinse and sanitize pots, pans and other utensils to prevent the spread of bacteria that may spread food borne illness. Review showed staff were instructed to sanitize utensils with either hot water (at least 170 degrees Fahrenheit) for 30 seconds or a chemical sanitizing solution used according to manufacturer's instructions. Review of the sanitizing solution manufacturer's instructions showed: -Prior to application, remove gross food particles and soil by a pre flush, scrape or when necessary, a pre soak; -Thoroughly wash or flush objects with a good detergent followed by a potable water rinse; -Apply a use solution of 1.04-2.72 ounces of sanitizer per four gallons of water (150-400 parts per million active solution); -Expose all surfaces to the sanitizing solution for a period of not less than one minute. Review of the January 2025 Low Temperature Chemical Sanitation Log, which was mounted above the three-compartment sink, showed staff recorded sanitizer concentrations three times per day. Review showed 79 entries were recorded for the period of 01/01/25 through breakfast on 01/27/25. Review showed all 79 sanitizer concentration entries recorded as 50 or 100 ppm (parts per million). Observation on 01/28/25 at 10:04 A.M., showed DA N manually cleaned a large pan and strainer. DA N rinsed the pan and strainer and placed the items in the sanitizer sink. DA N removed the pan and strainer after one minute and placed the items on the drain board. Observation showed a sanitizer test strip indicated a sanitizer concentration of 100 ppm. Observation on 01/28/25 at 12:15 P.M., showed the DM washed food processor parts and placed the parts in the sanitizer sink. Observation showed the DM allowed the processor parts to soak for one minute then removed the parts and placed them on the drain board to dry. Observation showed a sanitizer test strip indicated a sanitizer concentration of 100 ppm. Observation on 01/28/25 at 12:33 P.M., showed DA N washed and rinsed food processor parts. DA N placed the processor parts in the sanitizer sink for 30 seconds then removed the parts and placed them on the drain board. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 01/28/25 at 1:50 P.M., showed DA N placed two cutting boards and four steam able pans in the sanitizer solution. DA N removed the cutting boards and steam table pans from the sanitizer sink and placed the items on the drain board to dry. Observation showed a sanitizer test strip indicated a sanitizer concentration of 100 ppm. During an interview on 01/28/25 at 10:14 A.M., DA N said the log sheet on the cabinet door was for documenting the three compartment sink sanitizer concentration. DA N said the sanitizer concentration should be 50 ppm or higher. During an interview on 01/28/25 at 12:19 P.M., [NAME] M said the sanitizer concentration should be 50 to 100 ppm. [NAME] M said kitchen staff check the sanitizer concentration every time the sanitizer sink is filled and every hour after filling to ensure proper strength. During an interview on 01/28/25 at 9:50 A.M., the DM said the dietician was at the facility four days ago and said the sanitizer tested okay. The DM said the sanitizer concentration was running around 100 ppm. The DM said he/she had never read the sanitizer directions for use. During an interview on 01/29/25 at 9:15 A.M., the maintenance director said the facility vendor took care of the dish machine and the sanitizer pump at the three-compartment sink. The maintenance director said there were issues with water temperatures in the past but he/she was not aware of any current issues. 4. Observation on 01/29/25 at 8:50 A.M., showed the facility had one ice machine, which was located in a room on the east resident hall. Observation showed the ice machine contained a black drain hose, which was connected to a metal flange, which was connected directly to the floor drain. Observation showed the hose and flange were secured to the floor drain and there was not an air gap. During an interview on 01/29/25 at 8:50 A.M., the maintenance director said he/she did not know the ice machine drain required an air gap. During an interview on 01/30/25 at 12:00 P.M., the administrator said the DM was responsible for ensuring the dish machine was working correctly. The administrator said the dish machine should reach 120 degrees F and the machine sanitizer should be at least 50 ppm. The administrator said the three compartment sink sanitizer concentration should be in accordance with facility policy. The administrator said all kitchen staff were responsible for checking the dish machine and three-part sink to ensure kitchen wares were correctly disinfected. The administrator said the maintenance director was responsible for the ice machine and he/she was not aware the ice machine did not contain the required air gap.

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. 39644 Based on interview and record review, the facility staff failed to develop and implement an effective Quality Assurance (QA)/Quality Assurance Performance Improvement (QAPI) program which included documentation and implementation of on-going systemic issues with resolution. The facility census was 43. 1. Review of the facility's policies showed the facility did not provide a policy for QA/QAPI program. During an interview on 01/30/25 at 10:23 A.M., the administrator said the department heads come together quarterly and discuss different items within the facility, however there is no documentation to provide about these meetings or issues and resolutions. The administrator said she was not aware the information needed to be documented and maintained.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39440 Based on observation, interview and record review, facility staff failed to ensure the two-step purified protein derivative ((PPD) skin test for Tuberculosis (TB)) were completed in accordance with their policy for six employees (Licensed Practical Nurse (LPN) A, Nurse Aide (NA) B, NA C, NA D, Certified Nurse Aide (CNA) E, and Dietary aide F) out of ten employee files reviewed. Facility staff failed to implement the Enhanced Barrier Precautions (EBP) policy when they did not educate, or alert staff of residents who required EBP, and failed to place appropriate personal protective equipment (PPE) in close proximity for three residents (Resident #20, #45, and #48) of three sampled residents. The facility's cenus was 43. 1. Review of the Facility's Employee Screening for TB, revised August 2019, showed: -All employees are screened for latent tuberculosis (LTBI) and active TB disease, using tuberculin skin test (TST) or interferon gamma release assay (IGRA) and symptom screening prior to beginning employment; -Each newly hired employee is screened for LTBI and active TB disease after an employment offer has been made but prior to the employee's duty assignment. Review of the Facility's TB Screening- Administration and Interpretation of TST policy, revised October 2019, showed: -Inject 0.1 ml (milliliter) of PPD intradermally on the inner surface of the forearm; -Interpret the TST forty-eight to seventy-two hours after administration; -Unless otherwise indicated, administer a booster of 0.1ml of PPD one to two weeks after the initial TST for individuals with less that 10mm of induration. Review of the Center for Disease Control and Prevention's, Clinical Testing Guidance for TB: TB Skin Tests, Dated May 14, 2024, showed: -Two-Step testing; -If the first skin test is negative, a second TB skin test should be done one to three weeks later; -If the second TB skin test result is positive, it is probably a boosted reaction; -Interpreting test results; -The skin test reaction should be read between 48-72 hours after administration by a health care worker trained to read TB skin results. 2. Review of LPN A's employee file showed: (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Hire date of 11/22/24; -First step PPD administered on 11/21/24 and read on 11/23/24; -Second step PPD administered on 11/26/24 and read on 11/28/24; -Staff did not wait seven -21 days after the first dose to administer the second step PPD. 3. Review of NA B's employee file showed: -Hire date of 10/10/24; -First step PPD administered on 10/08/24 and read on 10/10/24; -The file did not contain documentation staff administered the second step PPD. During an interview on 01/28/25 at 1:54 P.M., the Minimum Data Set (MDS) Coordinator said he/she is not sure why the employee did not have a two-step TB completed. 4. Review of NA C's employee file showed: -Hire date of 09/30/24; -First step PPD administered on 09/27/24 and read on 09/29/24; -Second step PPD administered on 10/04/24 and read on 10/06/24; -Staff did not wait seven-21 days after the first dose to administer the second step PPD. 5. Review of NA D's employee file showed: -Hire date of 12/18/24; -First step PPD administered on 12/13/24 and read on 12/16/24; -Second step PPD administered on 12/20/24 and read on 12/22/24; -Staff did not wait seven-21 days after the first dose to administer the second step PPD. 6. Review of CNA E's employee file showed: -Hire date of 06/20/24; -First step PPD administered on 06/20/24 and read on 06/22/24; -Second step PPD administered on 06/27/24 and read on 06/29/24; -Staff did not wait seven -21 days after the first dose to administer the second step PPD. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	7. Review of Dietary Aide F's employee file showed: -Hire date of 06/11/24; -First step PPD administered on 06/10/24 and read on 06/12/24; -Second step PPD administered on 06/17/24 and read on 06/19/24; -Staff did not wait seven -21 days after the first dose to administer the second step PPD. 8. During an interview on 01/28/25 at 1:54 P.M., the MDS Coordinator said he/she is responsible for ensuring all new employee two-step TBs are completed accurately. He/She said he/she believes the facility policy is to perform the second step five days after reading the first-step TB. He/She said if the TB's were too close together it is either because he/she had something going on or the staff member was scheduled to be off. He/She said he/she does not like to ask staff to come in for TBs on their days off. During an interview on 01/28/25 at 2:08 P.M., Social services (SS) said the MDS coordinator is responsible for ensuring staff TBs are completed timely. He/She was not aware they were not being completed accurately and timely. He/She said he/she notifies the MDS coordinator when they have a new hire and staff get their first step TB done that day. He/She said after it is the MDS coordinators job to ensure it is read and that the second step TB is completed. During an interview on 01/28/25 at 2:29 P.M., the Director of Nursing (DON) said the MDS coordinator is responsible for new employee two step TB's. He/She said he/she is new to the facility and was not aware they were not being done timely. He/She said time frames are to administer them upon hire, read the TB 48-72 hours after, and then the facility policy is to do the second step one to two weeks after reading the first step. He/She said staff should never do second step less than seven days after reading the first step. During an interview on 01/28/25 at 2:48 P.M., the administrator said when an employee is hired, SS takes them to any nurse that is working, and they administer the First step TB. He/She said it is the MDS coordinators job to ensure the TB is read and the second step TB is done timely. He/She said TBs are read within 48 hours and that the second step is done one to two weeks after it is read. He/She was not aware they were not being done correctly and he/she is not sure why. 9. Review of the facility's policy titled, Enhanced Barrier Precautions (EBP), dated 03/23/24 showed: -All staff receive training on enhanced barrier precautions upon hire and at least annually and are expected to comply with all designated precautions; -The facility will have the discretion on how to communicate to staff which residents require the use of EBP, as long as staff are aware of which residents require the use of EBP prior to providing high-contact care activities; -An order for enhanced barrier precautions will be obtained for residents with any of the following: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265760	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fulton Manor Care Center	520 Manor Drive Fulton, MO 65251

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Wounds; -Indwelling medical devices (central lines, urinary catheters, feeding tubes); -Make gowns and gloves available immediately near or outside of the resident's room; -Position a trash can inside the residents room and near the exit for discarding Personal Protective Equipment (PPE) after removal; -Provide education to residents and visitors; -PPE for enhanced barrier precautions is only necessary when performing high-contact care activities such as: -Dressing; -Bathing; -Transferring; -Providing Hygiene; -Changing Linens; -Changing briefs or assisting with toileting; -Device care or use: central lines, urinary catheters, and feeding tubes; -Wound Care: any skin opening requiring a dressing. 10. Review of Resident #20's Entry Tracking Record MDS, dated [DATE], showed the resident admitted to the facility on [DATE]. Review of the resident's Physician's Order Sheet (POS), dated 01/01/25 through 01/27/25, showed the physician ordered medications to be administered via Gastric Tube ((G-Tube) a surgically inserted tube which provides nutrition, hydration, or medicine directly into the stomach). Observation on 01/27/25 at 12:19 PM., showed the resident's room did not contain a sign to alert staff on the use of EBP or PPE in close proximity of the room. Observation on 01/27/25 at 12:20 PM., showed LPN G did not wear a gown when he/she administered the resident's medications via his/her G-tube. During an interview on 02/04/25 at 2:22 P.M., the LPN said he/she was not familiar with any extra PPE required for EBP when administering medications via the resident's G-tube. He/She said he/she could not recall attending an in-service at the facility regarding EBP. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265760	A. Building B. Wing	01/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fulton Manor Care Center	520 Manor Drive Fulton, MO 65251

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	11. Review of Resident #45 Entry tracking record, dated 01/17/25, showed the resident admitted to the facility on [DATE]. Observation on 1/27/25 at 11:05 A.M., showed the resident's room did not have PPE in close proximity outside the door as directed per the facility EBP policy. Observation on 1/27/25 at 03:02 P.M., showed the resident's room did not have PPE in close proximity outside the door. LPN G administered a supplement feeding via feeding tube wearing only gloves. During an interview on 01/27/25 at 3:10 P.M. LPN G said he/she was administering a supplement feeding via feeding tube that is done three times a day to help with nutrition. He/She said resident can eat and take medication orally. He/She said staff only wears gloves when administering feedings. He/She said they do not wear gowns while caring for the resident. He/She said he/she is not aware of other precautions besides wearing gloves. Observation on 1/28/25 at 09:23 A.M., showed the resident's room did not have PPE in close proximity outside the door as directed per the facility EBP policy. Observation on 01/28/25 at 9:28 A.M., showed CNA K did not wear a gown when he/she provided incontinence care to the resident. During an interview on 01/28/25 at 9:45 A.M., CNA K said he/she is not aware of any enhanced barrier precautions to use besides gloves while caring for resident. He/She said he/she has not been to any in-services regarding enhanced barrier precautions. Observation on 1/29/25 at 10:03 A.M., showed the resident's room did not have PPE in close proximity outside the door as directed per the facility EBP policy. Observation on 1/30/25 at 10:21 A.M., showed the resident's room did not have PPE in close proximity outside the door as directed per the facility EBP policy. 12. Review of Resident #48's Entry Tracking Record MDS, dated [DATE], showed the resident admitted to the facility on [DATE]. Review of the resident's POS, dated 01/08/25 through 01/29/25, showed an order to provide colostomy (an opening in the abdomen to the intestines) care every shift for ileostomy (a surgical procedure that creates an opening in the abdomen to excrete poop from the body). Review of the resident's care plan, dated 01/17/25, showed staff were directed to educate the resident to empty his/her colostomy pouch when it is one third to half full. Observation on 01/27/25 at 2:45 P.M., showed the resident in bed with a colostomy bag approximately one-third full to his/her right abdomen. The resident's room did not contain a sign to alert staff on the use of EBP or PPE in close proximity of the room. Observation on 01/29/25 at 10:33 A.M., showed the resident's room did not contain a sign to alert staff on the use of EBP or PPE in close proximity of the room. (continued on next page)

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	265760	A. Building B. Wing	01/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 01/29/25 at 10:37 A.M., showed CNA K did not wear a gown when he/she provided incontinence care to the resident and attempted to empty the resident's colostomy bag. During an interview on 01/29/25 at 10:46 A.M., CNA K said he/she did not know what EBP was or that extra PPE was required when performing incontinence care or emptying the resident's colostomy bag. The CNA said he/she had not received any in-service at the facility regarding EBP. 13. During an interview on 01/30/25 at 10:05 A.M., the Corporate Registered Nurse (RN) said EBP education was shared with each Director Of Nursing (DON) at each facility when it came out initially. He/She said the education was given again to this facilities DON at the beginning of December, however there was no over site by the previous DON so nothing was being done here with regard to EBP. He/She said there is a new DON who has been here for about a week, so the facility is in need of more education. During an interview on 1/30/245 at 3:30 P.M., the DON said he/she is aware that EBP was not being done. He/She said the previous DON did not know what they were doing and that's why it was not getting done. He/She said EBP should be implemented on residents with feeding tubes, catheters, and wounds. He/She said the importance of EBP is infection control. During an interview on 1/30/25 at 4:05 P.M., the administrator said EBP should be done on residents with colostomy's, ileostomy, feeding tubes, and catheters. He/She said EBP supplies should be readily accessible to use. He/She said the charge nurse should give report at the beginning of the shift on who requires EBP. He/She said the EBP precautions have not been getting done. He/She said there is no reason why it hasn't been getting done. He/She said the importance of EBP is infection control. 39644 47193 50422

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F 0881 Level of Harm - Potential for minimal harm Residents Affected - Many	Implement a program that monitors antibiotic use. 39644 Based on interview and record review, facility staff failed to implement an Antibiotic Stewardship Program with antibiotic use protocols and a system to monitor and track antibiotic use within the facility. The facility census was 43. 1. Review of the facility's policies showed the facility did not provide a policy for Antibiotic Stewardship. Review of the facility's antibiotic stewardship program showed facility staff did not have a process in place to track and trend antibiotic usage. During an interview on 01/28/25 at 8:30 A.M., the Director of Nursing (DON) said he has the Infection Preventionist but has only been employed at the facility for eight days. He said he is unsure what was being done before he came, but unfortunately he does not have an antibiotic stewardship program to provide. During an interview on 01/28/25 at 9:30 A.M., Corporate Nurse said the previous DON did not track and trend antibiotic use in the facility. He/She said To be honest, no one has been doing it and we will use this as a learning experience. During an interview on 01/30/25 at 4:09 P.M., the administrator said the Infection Preventionist is responsible for the antibiotic stewardship program. This would have been the previous DON, and over site of the DON is done by the corporate nurse(s). The administrator said she was unaware it was not completed and does not know why it wasn't.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Regularly inspect all bed frames, mattresses, and bed rails (if any) for safety; and all bed rails and mattresses must attach safely to the bed frame. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39440 Based on observation, interview, and record review, facility staff failed to complete regular inspections of all bed frames, mattresses, and bed rails as part of a regular maintenance program to identify areas of possible entrapment for four residents (Residents #3, #15, #20, and #46) out of four sampled residents. The facility census was 43. 1. Review of the facility's policies showed staff did not provide a policy for Entrapment Risk Assessments. Review of the facility's policy titled, Proper Use of Side Rails, undated, showed the facility will assure the correct installation and maintenance of bed rails prior to use ensuring that the beds dimensions are appropriate for the resident by: -Confirming the bed rails are appropriate for the size and weight of the resident using the bed; -Inspecting and regularly checking the mattress and bed rails for ares of possible entrapment; -Ensuring the bed frame, bed rail, and mattress do not leave a gap wide enough to entrap a resident's head or body, regardless of mattress width, length, and/or depth; -Checking bed rails regularly to make sure they are still installed correctly, and have not shifted or loosened over time; -The maintenance director, or designee, is responsible for adhering to a routine maintenance and inspection schedule for all bed frames, mattresses, and bed rails. Review of the facility's policy titled, Bed Safety, revised 12/07, showed to try and prevent death/injury from the beds and related equipment (including the frame, mattress, side rails, headboard, footboard, and bed accessories), the facility shall promote the following approaches: -Inspection by maintenance staff of all beds and related equipment as part of our regular bed safety program to identify risks and problems including potential entrapment risks; -Review that gaps within the bed system are within the dimensions established by Food and Drug Administration (FDA) (Note: the review shall consider situations that could be caused by the resident's weight, movement or bed position). 2. Review of Resident #3's Admission Minimum Data Set (MDS), a federally mandated assessment tool, dated 12/05/24, showed staff assessed the resident as follows: -Severe cognitive impairment; -Substantial/maximal with toileting, and transfers. (continued on next page)

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F 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the resident's electronic medical record (EMR), showed the record did not contain an entrapment risk assessment for the use of side rails, or a maintenance inspection to ensure the side rails were properly secured to the resident's bed. Observation on 1/28/25 at 10:00 A.M., showed the resident in bed with the left side rail in the upright position. Observation on 1/30/25 at 2:45 P.M., showed the resident in bed with the left side rail in the upright position. 3. Review of Resident #15's Annual MDS, dated [DATE], showed staff assessed the resident as: - Cognitively intact; -Independent with bed mobility, toileting, and transfers. Review of the resident's EMR, showed the record did not contain an entrapment risk assessment for the use of side rails, or a maintenance inspection to ensure side rails were properly secured to the resident's bed. Observation on 1/27/25 at 11:13 A.M., showed the resident in bed with bilateral side rails in the upright position. Observation on 1/28/25 at 9:06 A.M., showed the resident in bed with bilateral side rails in the upright position. Observation on 1/29/25 at 9:45 A.M., showed the resident in bed with bilateral side rails in the upright position. Observation on 1/30/25 at 10:07 A.M., showed the resident in bed with bilateral side rails in the upright position. 4. Review of Resident #20's Entry Tracking Record MDS, dated [DATE], showed the resident admitted to the facility on [DATE]. Review of the resident's EMR showed the record did not contain an entrapment risk assessment for the use of side rails, or a maintenance inspection to ensure the side rails were properly secured to the resident's bed. Observation on 01/27/25 at 3:24 P.M., showed the resident in bed with side rails on both sides in the upright position. Observation on 01/29/25 at 1:38 P.M., showed the resident in bed with side rails on both sides in the upright position. 5. Review of Resident #46's EMR, showed staff documented the resident admitted to the facility on [DATE]. (continued on next page)

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F 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the resident's EMR showed the record did not contain an entrapment risk assessment for the use of side rails, or a maintenance inspection to ensure the side rails were properly secured to the resident's bed. Observation on 01/27/25 at 11:55 A.M., showed the resident in bed with side rails on both sides in the upright position. Observation on 01/29/25 at 2:13 P.M., showed the resident in bed with side rails on both sides in the upright position. 6. During an interview on 01/29/25 at 3:00 P.M., the Maintenance Director said he/she only puts the bed rails on the bed and takes them off. He/She said there is one sheet that has the measurements on it and that how he/she knows how to put the bed rails on the bed. He/She said he/she does not do any measurements regularly of the bed rails once the bed rails have been put on the bed. He/she said no measurements are ever done with the resident in the bed. He/She said he/she was not aware of any regulation about doing regular measurements of the bed rails after they are on the bed. During an interview on 01/30/25 at 3:26 P.M., the Director of Nursing (DON) said he/she believes that the MDS coordinator does bed rail measuring. He/She said he/she is not aware of regulation for bed rails and believes entrapment assessment should be done every six-twelve months. During an interview on 01/30/24 at 3:56 P.M., the administrator said the maintenance director has a sheet with measurements and that is how they know where the bars are to be placed on the bed. He/She said entrapment assessment should be done quarterly. He/She said he/she was not aware entrapment assessments were not being done quarterly. He/She said the importance of doing an entrapment assessment is so the resident does not get stuck. 39644 50422