STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265787	A. Building B. Wing	03/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Laverna Manor Health & Rehabilitation	904 Hall Avenue Savannah, MO 64485

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident?s advance directives. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide Cardiopulmonary Resuscitation (CPR) for one of 15 sampled residents, (Resident #63), who was a full code. On [DATE] the resident's visiting family member alerted staff to the resident's room stating the resident had a seizure and was gasping for air. Licensed Practical Nurse (LPN) B arrived and found the resident was not breathing and had no pulse or lung sounds present, and then observed the resident with agonal breathing (abnormal, slow, gasping breaths that happen when death is close, or the heart has stopped). LPN B asked the resident's family member if he/she wanted him/her to begin CPR and informed the family member the resident was gasping, because he/she was trying to get oxygen to his/her brain. Approximately 3-4 minutes after being asked, the family member told LPN B not to perform CPR because it's not what the resident wanted. LPN B did not perform CPR, and the resident passed away at the facility. The facility census was 61.The Administrator was notified on [DATE], of Past Non-Compliance Immediate Jeopardy which occurred on [DATE]. The Administrator immediately began an investigation, suspended the LPN pending the investigation, completed audits of code status of all current residents, all licensed nurses and certified nurse aides (CNAs) were inserviced regarding when to perform CPR, what CPR entailed, what DNR was, and how to verify code status. Color coded dots were added to residents' doors for code status. The IJ was corrected on [DATE].Review of the facility's policy for Emergency Procedure - Cardiopulmonary Resuscitation (CPR), revised February 2018, showed:- Personnel have completed training on the initiation of CPR and basic life support (BLS), including defibrillation, for victims of sudden cardiac arrest (SCA).- SCA is a loss of heart function due to abnormal heart rhythms (arrhythmias). Cardiac arrest occurs soon after symptoms appear. It is the leading cause of death among adults.- Victims of cardiac arrest may initially have gasping respirations or may appear to be having a seizure. Training in BLS includes recognizing presentations of SCA. -The chances of surviving SCA may be increased if CPR is initiated immediately upon collapse.-If an individual is found unresponsive and not breathing normally, a licensed staff member who is certified in CPR/BLS shall initiate CPR unless: it is known that a do not resuscitate (DNR) order that specifically prohibits CPR and/or external defibrillation exists for that individual; or there are obvious signs of irreversible death.- If the resident's DNR status is unclear, CPR will be initiated until it is determined there is a DNR or physician's order not to administer CPR. - If an individual is found unresponsive, briefly assess for abnormal or absence of breathing. If sudden cardiac arrest is likely, begin CPR: instruct a staff member to activate the emergency response system (code) and call 911. Instruct a staff member to retrieve the automatic external defibrillator. Verify or instruct a staff member to verify the DNR or code status of the individual. Initiate the basic life support (BLS) sequence of events. - Continue with CPR/BLS until emergency medical personnel arrive. Review of the resident's Durable Power of Attorney (DPOA), dated [DATE], showed the resident listed his/her spouse as the agent and the DPOA was not invoked. Review of the resident's medical records showed the resident admitted on [DATE]. Review of the resident's Physician Order Sheet (POS), dated [DATE], showed:- Verbal Order, dated [DATE], for the resident to be a Full Code. (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 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-Diagnoses included Paroxysmal Atrial Fibrillation (irregular, rapid heart rhythm that starts and stops suddenly, typically lasting less than 7 days and resolving without intervention), Intracardiac Thrombosis (blood clot formed within the heart's chambers), Shortness of Breath, Congestive Heart Failure, and Ventricular Tachycardia (cardiovascular disorder in which fast heartrate occurs in the ventricles of the heart. Review of the resident's baseline care plan, dated [DATE] showed:- Discharge plan - discharge to home.- Code status - Full Code. Review of the Brief Interview for Mental Status, dated [DATE], showed: -Social Services Director (SSD) completed the interview. -Resident interview score: 14- indicating Cognitively Intact- Little to no impairment. Review of the resident's Transportable Physician Orders for Patient Preferences (TPOPP/POLST), dated [DATE], showed:- In the event that he/she has no pulse and is not breathing he/she requests staff attempt Resuscitation/CPR. - If he/she has a pulse and is breathing, he/she requests for staff to provide full treatment with the goal to attempt to sustain life by all medically effective means. Provide appropriate medical treatments as indicated in an attempt to prolong life, including intubation, advanced airway interventions, mechanical ventilation, and defibrillation/cardioversion, including intensive care. - The resident's spouse was named as the emergency contact. - In the section for information and signatures the SSD documented the information on the form was discussed with Resident #63. - The resident printed and signed his/her name on the TPOPP form.- The physician signed the form on [DATE]. Review of the resident's admission record face sheet showed Code Status: Full Code Record review of the resident's progress note, dated [DATE], showed:-Called to the resident's room at 10:02 A.M., the resident was in bed, but very short of breath. Oxygen saturation (amount of oxygen in the blood) was 90% on 2L/NC (two liters of oxygen via nasal cannula). Increased the oxygen to three liters via nasal cannula and the resident's oxygen saturation increased to 95%. Blood pressure was 126/84, pulse 106, respirations 34. The resident stated he/she felt a little better after increasing the oxygen to three liters. The resident's respirations decreased to 22. Assured the resident the nurse would be back later to check his/her vital signs again. -At 11:15 A.M., called to the resident's room by a family member, who stated, the resident had a seizure. No seizure was noted. The resident was in his/her recliner not breathing, had no heart sounds or pulse, and no lung sounds at that time. The resident gasped several times after the nurse got to the room and had no heart or lung sounds. LPN B asked the resident's family member if he/she wanted him/her to begin CPR and informed the family member the resident was gasping, because he/she was trying to get oxygen to his/her brain. Approximately 3-4 minutes after being asked, the family member told LPN B not to perform CPR because it's not what the resident wanted. LPN B did not perform CPR, and the resident passed away at the facility. During an interview on [DATE] at 11:54 A.M., the SSD said:- When a resident admits to the facility with a code status, he/she reviews the code status with the resident or responsible party to verify that is what they want. - When Resident #63 was admitted , he/she requested to be a full code. The resident signed the TPOPP on [DATE] in his/her presence. During an interview on [DATE] at 12:41 P.M., Certified Medication Technician (CMT) A said:-He/She worked on [DATE] with LPN B. -When LPN B and he/she entered the resident's room, the resident was having trouble breathing. -The family member present said he/she was the DPOA and the resident would not want CPR. -No one went and verified the resident's code status, and no one performed CPR. -Later, when he/she looked in the system, and saw the resident was a full code. During an interview on [DATE] at 5:53 P.M., LPN B said: - He/She was aware the resident was a Full Code.- On [DATE] the resident told him/her that morning he/she wanted to be a DNR.- He/She was busy and did not have time call the physician or the DON about the resident changing his/her mind about CPR.- The visiting family member, who he/she believed was the DPOA, came out into the hallway and said the resident was having a seizure. - LPN B grabbed the vital sign equipment and went to the resident's room. - The resident was in his/her recliner and had no pulse and no lung sounds.-The resident started having agonal breathing (abnormal, slow, gasping breaths that happen when death is close, or the heart has stopped) and LPN B explained to the family member the resident was trying to get oxygen to his/her (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	brain.- LPN B asked the family member, whom he/she believed was the DPOA, if he/she wanted LPN B to perform CPR and the family member stood there for three to four minutes making his/her decision and then told him/her not to perform CPR because the resident would not want it. - LPN B said now that he/she had time to think about the situation, he/she felt like he/she should have started and followed through with CPR. During an interview on [DATE] at 9:29 A.M., Registered Nurse (RN) A said:- If a resident was not breathing or does not have a pulse, the staff who are CPR certified, should check the code status and start CPR.- What should have happened for Resident #63 was for the nurse to assess the resident, and when the resident did not have any respirations or a pulse, start CPR and call a code, regardless of what the family member said. The staff are required to follow the physician's order. During an interview on [DATE] at 11:38 A.M., Certified Nurse Aide (CNA) F said: -To verify the resident's code status, he/she would look at the resident's door to see if they had a green dot (full code) or a red dot (DNR). -There was also a code status book at the nurse's station, and he/she could also check on the computer. - If he/she observed a resident not breathing or had no pulse, he/she would check the resident's code status, notify the Charge Nurse (CN), and get the crash cart. During an interview on [DATE] at 1:41 P.M., CNA H said if he/she found a resident breathing or no pulse, he/she would verify the resident's code status, notify the CN and check the resident for a pulse or respirations. During an interview on [DATE] at 10:09 A.M., the DON said at the in-service on [DATE]:- If a resident is full code, has trouble breathing or does not have a pulse, the staff should check the code status, get the crash cart and start coding the resident. -It does not matter if the family is in the room or not. -Staff were informed the code status can be found on the color-coded dot outside of the room, the code book at the nurse's station and in the resident's electronic medical record. During an interview on [DATE] at 12:23 P.M., the Administrator said:- The staff should have verified the resident's code status and started CPR. - If a resident wants to change their code status, he/she would have to fill out a new TPOPP form and staff would need to obtain the physician's signature and new order. - Resident #63 was a full code and LPN B should have provided CPR. During an interview on [DATE] at 5:13 P.M., the Medical Director said Resident #63 was a Full Code and staff should have initiated CPR when they found the resident without a pulse or respirations.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure residents were served food that was palatable, attractive, and at safe and appetizing temperature during meal service, and additionally the facility failed to follow menus. This affected 8 of 15 sampled residents (Residents #10, #12, #18, #15, #4, #32, #49, and #58). The facility census was 61.Review of facility policy Food Temperatures, undated, showed:- All hot food items must be cooked to appropriate internal temperatures, held, and served at a temperature of at least 135 degrees Fahrenheit (F);- All cold food items must be stored at a temperature of 41 degrees F;- Temperatures should be taken periodically to assure hot foods stay above 135 degrees Fahrenheit and cold foods stay below 41 degrees F during the holding and plating process and until food leaves the service area;- Foods should be transported as quickly as possible to maintain temperatures for delivery and service. If food transportation time is extensive, food should be transported using a method that maintains temperatures (i.e. hot/cold carts);- Hold foods at or below 41 degrees F for cold foods and at or above 135 degrees F for hot foods to keep food out of the temperature danger zone;- Foods sent to the units for distribution will be transported and delivered to unit storage areas to maintain temperatures at or below 41 degrees F for cold foods and at or above 135 degrees F for hot foods. -There was nothing in the facility meal policies indicating how sandwiches should be prepped for delivery or storage. Review of facility policy Menu Planning, undated, showed:- A substantial evening meal consisting of three or more menu items will be offered, one of which includes high quality protein;- No guidance on lunch or breakfast menu planning was provided in the policy. -No guidance on a choice of meat at breakfast meals. 1. Review of Resident Council Meeting notes, dated November 2025 to March 2026, showed: - Food was not always hot and menu planning lacked variety; - There was a lack of fresh salads and fresh fruit; - Too many occurrences of hamburgers on the schedule. -No resolution of concerns was documented in the meeting notes. Review of the Alternate Menu, undated, showed the following menu items are available on request: Hamburgers with or without cheese, deli sandwich, grilled cheese, peanut butter and jelly sandwich, hotdogs, cold cereal, mashed potatoes with or without gravy, soup of the day, toast, hard boiled eggs, scrambled eggs, and items that were made over the last 48 hours if available. Review of the Cycle menu, dated Fall/Winter, showed:- The cycle menu consisted of four weeks of menus rotated over a 28-week schedule.- Breakfast menus were the same each week. Every Sunday in the 28-week schedule will always have the same menu and Monday will have the same breakfast menu each week for the 28-week schedule. All days of the week follow this format. - Meat was offered three out of seven days on the breakfast menu. Sunday and Wednesday bacon offered and sausage patty offered on Saturdays. There were no other meat items or varieties offered on the other days.- 50% of the 28 cycle meals served for dinner consisted of sandwiches as the main course.- 26 out of 28 cycle dinner desserts have chilled fruit or a similar variation of a fruit product served.- 5 out of 56 lunch and dinner entrees included a salad;- Hamburgers or cheeseburgers which are on the alternate menu are also scheduled once each week as a regular entrée.- Ice cream was offered (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	once and sherbet twice during the 28-day cycle menu. 2. Observation in the dining room on 3/13/26 at 7:25 A.M., showed:- The breakfast menu posted showed chilled assorted juice, assorted cold cereal, assorted hot cereal, cheese omelet, buttered biscuit with jelly, milk, and beverage;- Resident #10 asked Dietary [NAME] B if he/she could have some bacon. Dietary [NAME] B responded that the bacon was not on today's menu and did not offer any substitute for the bacon or any other option. Review of Resident #10's Quarterly Minimum Data Set (MDS, a federally mandated assessment tool completed by facility staff), dated 2/5/26, showed the resident was cognitively intact. During an interview on 3/13/26 at 7:35 A.M., Resident #10 said he/she was very disappointed that he/she could not get any bacon and really wanted to enjoy his/her breakfast with some meat after just receiving new dentures. During an interview on 3/13/26 at 6:50 A.M., Dietary [NAME] B said that residents always ask about meat for breakfast and want it served more frequently than it was currently scheduled on the cycle menu 3. Review of Resident #32's Quarterly MDS, dated [DATE], showed the resident was cognitively intact. During an interview on 3/10/26 at 10:37 A.M., the resident said the food was terrible and the facility needed better options for residents. The alternate menu was nothing but fast food items like hamburgers and hot dogs. He/She would like a salad and the menu to be healthier. The salad suggestion comes up at resident council meetings, but it always gets ignored. He/She was very frustrated with the situation. 4. Review of Resident #58's Quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 01/08/26, showed the resident was cognitively intact and had a diagnosis of diabetes. Review of the resident's care plan, dated 01/14/26, showed:- Staff are to provide small frequent meals rather than three large ones and encourage the resident to avoid fried or fatty foods;- Staff are to encourage intake of foods rich in iron such as green leafy vegetables, eggs, nuts, and grains; - The resident had a mood problem related to anxiety and depression;- Staff are to regulate protein and potassium intake related to renal failure. During an interview on 03/11/26 at 7:40 A.M., the resident said: - He/She wasn't happy with the food situation, how everything was ordered by management, and how the Dietary Manager doesn't have much say in what food was ordered and provided to the residents;- He/She felt that budget wise, the facility served a lot of sandwiches and the residents don't prefer them;- Salads were very rare and when they did have a salad it was mainly head lettuce and a few chunks of tomato if the residents are lucky. Beautiful salad would be wonderful;- The facility runs out of things like condiments and salad dressings so fast;- He/She had recently been served a taco salad with no chips, no sauces, and no salad dressings to put on it. Basically, a salad without dressing. Review of the Menu Substitution Log, dated May 2025 to March 2026, showed the menu did not list the missing chips and salsa required for a Taco Salad entrée which was on the menu during (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	the cycle. No suitable substitute was annotated in the log to utilize in place as substitution for chips and salsa During an interview on 03/12/26 at 3:23 P.M., the Dietary Manager said: - The facility received the menu from the corporate staff and can make suggestions and requests but since they would be transitioning to the spring menu, they haven't made any changes;- The facility typically did not run out of the dressings or condiments, but recalled recently in the last month the taco salad had an issue with no chips or salsa. The chips and salsa hadn't been on the spreadsheet and we didn't have them. They should have have been ordered according to the menu but we didn't. 5. During an interview on 03/13/26 at 9:30 A.M., Resident #49 said: - He/She was a diabetic and needed more protein in his/her diet which was lacking at the facility;- The facility served so many carbs it made it hard to control his/her blood sugar. 6. During an interview on 3/13/26 at 9:30 A.M., the Dietary Manager (DM) said: - Menu decisions are made by the Registered Dietician (RD), and he had to get approval for all menu changes. The main factors that go into a cycle menu are nutrition and financial budget.- They try to serve fresh salads to the residents for lunch or dinner at least weekly.- If we don't have an item scheduled on the menu such as meat, we don't have the authority to add it to the menu just because it was requested by a resident. - He felt the menu was very repetitive and didn't represent a home like menu because there are too many sandwiches scheduled. During an interview on 03/13/26 at 2:35 P.M., the Administrator said: - The residents should be able to have salads, fruits, or healthier options if they wish;- Diabetic residents should be able to have higher protein and lower carb options. During an interview on 03/13/26 at 2:56 P.M., the Director of Nursing (DON) said: - The residents should be able to have salads, fruits, and healthier menu options like a chef's salad if the facility can provide it;- A diabetic resident should be able to have higher protein and lower carb options available to them. 7. Observation in the dining room on 3/12/26 at 5:15 P.M., showed all residents served one unsliced deluxe club sandwich per resident in a plastic bag on a plate. Review of Resident #18's Quarterly Minimum Data Set (MDS, a federally mandated assessment tool completed by facility staff), dated 3/13/26, showed;- The resident had moderate cognitive impairment;- Diagnoses included: Stroke, anemia, coronary artery disease (heart disease), Alzheimer's Disease, anxiety disorder, and depression. During an interview on 3/12/26 at 5:20 P.M., the resident said sandwiches were often placed in plastic sandwich bags and recently the club sandwich, which was served to him/her during the evening meal, was hard to get out of the bag with his/her hands, but he/she could handle it eventually. He/She would prefer the sandwich be served on a plate without the plastic, because his/her stroke makes it hard to use hands to open the small packages. During an interview on 3/13/26 at 9:30 A.M., the DM said we put the sandwiches in the plastic bags to keep them from getting soggy, we don't want to just place it on a plate with potato chips and soup. 8. Observation in the kitchen on 3/13/26, showed Dietary [NAME] A:- At 5:45 A.M., prepared all hot breakfast items (biscuits, oatmeal, and cheese omelets) completed cooking, placed in metal containers with foil covers, and stored in the oven at 5:45 A.M. - At 6:35 A.M., all hot food items removed from the oven, no temperatures were taken by kitchen staff. - At 6:42 A.M., food items of cheese omelets, oatmeal, and biscuits traveled via elevator to the first floor and placed on the steam (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	line; -No observations the DM checked the food temperatures. Observation in the dining room on 3/13/26 at 7:00 A.M., showed Dietary [NAME] B uncovered the hot food items on the steam line, cheese omelets, oatmeal, and biscuits and did not take any temperatures of the hot or cold food items prior to serving to residents. No observation the DM checked the food temperatures. Observation on the 200 Hall on 3/13/26 at 8:08 A.M., showed:- The breakfast test tray, which was the last tray served to residents on the halls, was received by the surveyor, two hours and 23 minutes after the food items were cooked in the kitchen. - The biscuit was 88.7 degrees F and would not melt the margarine provided as a condiment when spread on the biscuit. The biscuit was not hot by taste and was dry and greasy with the lukewarm margarine used as a condiment spread. Expected temperature was 120 degrees F.- The cheese omelet was 134.0 degrees F, but visually the food item was crumbled up scrambled eggs with one ball of cheese in the mixture measuring one millimeter in diameter. Visually it did not resemble a cheese omelet, but instead scrambled eggs. The texture was dry and tasteless.- Milk temperature was at 52.2 degrees F.- Orange Juice temperature was at 60.3 degrees F. During an interview on 3/13/26 at 8:14 A.M., Certified Nurse Assistant (CNA) G said the cheese omelet did not look at all what he/she would expect a cheese omelet to look like. He/she would expect a cheese omelet to have a shape to it and contain cheese, not be crumbled up and dry. 9. Observation during lunch in the dining room on 3/13/26 at 12:20 P.M., showed: - Menu listed main course as chicken salad on a croissant.- There were no croissants on the steam line for making the chicken salad sandwich.- Dietary [NAME] B prepared sandwiches on the steam line. He/she used a ice cream scoop to place a portion of chicken salad in the middle of a plain piece of white bread and then placed a second piece of white bread on top of the chicken salad. Visually the bread completely obscured the ball of chicken salad and showed as a lump underneath and in the middle of the top piece of the bread. The chicken salad wasn't evenly spread onto the bread and the bread wasn't toasted or sliced to increase the visual appeal of the meal to compensate for not having the original menu item which was a croissant. -Residents were observed in the dining room only taking one bite of the chicken salad on white bread and the chicken salad had not been touched in the center of the bread. 10. Review of Resident #12's Annual MDS, dated [DATE], showed the resident was cognitively intact and had a diagnosis of malnutrition. During an interview on 3/10/26 at 10:47 A.M., the resident said he/she ate in his/her room for most meals and the food was often cold when it gets to him/her. He/She did not feel comfortable asking staff to routinely warm the food up, because it happens so frequently. The cold food makes meals very unappetizing for him/her. 11. Review of Resident #15's Annual MDS, dated [DATE], showed the resident had moderate cognitive impairment. During an interview on 3/10/26 at 9:32 A.M., the resident said often the food was cold and maybe (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	once a month they will get warm mashed potatoes and gravy, but that was a long time to wait. It was frustrating. He/She had reported the concern to the staff. The menu was just rotated, nothing was new, just shuffled up menu items. Lots of times the food was cold and soggy and the meat was so dry you can't swallow it. 12. Review of Resident #4's Quarterly MDS, dated [DATE], showed the resident was cognitively intact and had a diagnosis of malnutrition. During an interview on 3/10/26 at 2:30 P.M., the resident said:- The food was not hot when he/she gets it in the dining room and had reported it to the staff.- The meat was not tender. - The facility served a lot of broccoli and it was overcooked. - Overall he/she was not satisfied with the food served at the facility. 13. Review of Resident #49's Quarterly MDS, dated [DATE], showed the resident was cognitively intact and had a diagnoses of anemia and diabetes. During an interview on 3/10/26 at 11:42 A.M., the resident said:- The cheeseburgers and hamburgers are served burnt. The bottom of the lasagna was burnt the other day. -The meat was sometimes tough to eat and the green beans were undercooked. They are rubbery. - It made him/her feel like he/she did not want to eat. -He/She had to try and pick through the meal plate for something good to eat at mealtimes. 14. During an interview on 3/13/26 at 9:30 A.M., the Dietary Manager (DM) said: - Food temperatures should be taken after cooking is complete, when food goes to the steam line, prior to serving the first resident and periodically while food is on the steam line during the meal service. The only time temperatures are written down into a log is when the food item is completely cooked to the correct temperature. The other temperature checks are not logged anywhere but he has witnessed his staff taking temperatures at other times but can't prove that they do it all the time since it's never recorded anywhere. - A cheese omelet should be an egg patty with some cheese on it. The residents do not like cheese on their eggs at all, they say it makes the eggs greasy. During an interview on 3/13/26 at 1:48 P.M., the Administrator said: - Meals should be appealing and appropriate to a resident's diet. Plastic bags are probably used for sanitary reasons for the residents, but it was not very homelike.- Expectations for taking food temperatures would be they are taken at the steam table prior to serving, check them as hall trays go out, and upon completing the preparation of all food items in the kitchen.- She would expect the variety of breakfast main courses would be driven by resident preferences and the planned menu. Feedback from residents were given to the RD so the menu can be adjusted to their preferences. - She was normally informed of food substitutions at the morning meeting, but this week with the state surveyors on site we have not had our meeting so any substitutions that have been made she was not informed. - If the facility is out of croissants for a meal they can be purchased locally or a suitable substitution of equal nutritional value offered. During an interview on 3/23/26 at 3:18 P.M., the RD said: - Cyclical menus cover seasons such as Fall/Winter and Spring/Summer. Fifty percent of the calories are for carbohydrates, 20% protein, and 30% fat with some minor variances allowed.- The goal was to hit 2800-3000 calories a day. More eggs in the morning for protein and more calcium in it for the wheelchair residents.- She expected staff to follow the menu as planned and she had contracts in place to support the food items required. The (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Laverna Manor Health & Rehabilitation	904 Hall Avenue Savannah, MO 64485

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	main challenges with the menus were the Medicare reimbursement was not going up, but food prices are going up quickly which can cause an issue. She worked with owners and representatives of facilities to address any shortfalls.- The menu was repeated for breakfast each week. Each day of the week has the same menu each week to help the residents with orientation so they can more easily remember events based on what they remember having for breakfast. The variety in the menu comes into play during lunch and dinner planning.- The reason meat was only offered three days a week for breakfast was the culture of the residents at the facility don't need to eat meat each day. That type of eating was from the generation that consisted of farmers. The menu though can be adjusted to cater to individuals if they want bacon each day, then the staff could make some bacon each day for that resident. - If a resident was a diabetic and they don't want to eat eggs for each meal there really isn't a substitute planned into the breakfast menu other than hot cereal. The resident will naturally gravitate to eating items that aren't as healthy for them and don't have the necessary protein if they eat meat instead of eggs. - Biscuits don't need to be served at 120 degrees F but they need to be served hot enough to melt butter or margarine to maintain a good taste for the resident.- Assorted hot cereal was a place holder for the menu and it means anything the cook decides to rotate into the menu for that day. The choices could be oatmeal or cream of wheat to name a few. These should be annotated on the daily menu for the residents and not listed as assorted hot cereal since only one cereal was being brought up to the serving line for each breakfast.- The menu contained so many sandwich entrees for dinner to provide residents with more starches and we try to limit the number of sandwiches we serve on the cycle menu.- The lack of variety for dinner desserts was due to the fruit requirement we have for residents, so it gets loaded up for the dinner menus to serve chilled fruit. Baked goods are normally at lunch for dessert. - The staff could do better about handling substitutes such as missing croissants and putting more effort into presentation especially when serving sandwiches on plain white bread. His/Her intention was to provide a healthy portion for residents with a good presentation. These are issues she would address with the staff.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure the services provided or arranged by the facility met professional standards of quality, when the facility failed to obtain an order to flush a peg tube (a tube placed in the stomach to provide a route to deliver nutrition, medications and fluids) for Resident #6, failed to ensure Resident #1 had a Physician's order for Hospice (end of life care), and failed to ensure a resident (Resident #39) who required crushed medication had an order for their medications to be crushed. These failures affected three of 15 sampled residents. The facility census was 61. 1.Review of the facility's policy for Maintaining Patency of a Feeding Tube (Flushing), revised November 2024, showed: - The purpose of this procedure is to maintain patency of a feeding tube. - Verify that there is a physician's order for this procedure. - For maintaining patency of a feeding tube: Flush enteral feeding tube every four hours with 30 milliliters (ml.), or prescribed amount, of warm water during continuous feeding. - Flush enteral feeding tubes with 30 ml., or prescribed amount, of warm water before and after intermittent feedings. - Flush enteral feeding tube with 15 ml., or prescribed amount, of warm water before and after administration of medications. If administering more than one medication, flush with 15 ml., or prescribed amount, of warm water between each medication. - Flush with 30 ml., or prescribed amount, of warm water after checking gastric residual volume. Review of Resident #6's Quarterly MDS (Minimum Data Set), a federally mandated assessment completed by facility staff, dated 3/25/26, showed -Not cognitively intact; -Dependent on nursing staff for all cares; -Diagnoses included stroke, inability to swallow, and required tube feedings for nutritional needs. Review of the resident's Physician Order Sheet (POS), dated March 2026, showed: - Start date: 8/16/25 - Enteral Feed Order every 24 hours for diet - Enteral Feed order: Two Cal HN 50 ml./hour for 20 hours. Water flush with 200 ml. every four hours. - Start date: 4/8/25 - Enteral Feed Order - every shift for gastrostomy. Check tube placement before initiation of formula, medication administration, and flushing tube. - No order to flush the tube before or after medications, how much water to use to flush the tube or how often. Review of the resident's Medication Administration Record (MAR), dated March 2026, showed: (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Enteral Feed Order every 24 hours for diet - Enteral Feed order: Two Cal HN 50 ml./hour for 20 hours. Water flush with 200 ml. every four hours.- Enteral Feed Order - every shift for gastrostomy. Check tube placement before initiation of formula, medication administration, and flushing tube. -No order to flush the tube before or after medications, how much water to use to flush the tube or how often. Observation and interview on 3/12/26 at 8:30 A.M., showed: - Registered Nurse (RN) A administered medication with 10 ml. of water to flush the tube before and after the medication. - RN A said he/she thought if you were giving more than one medication, you had to flush with more water. There should have been an order to flush the tube with water before and after medications. There was no order to flush the tube before or after medications, or how much water to use to flush the tube, or how often. During an interview on 3/13/26 at 3:54 P.M., the Director of Nursing (DON) said there should be a physician's order to flush the peg tube with water, how much to use, and when. 2. Review of Resident #1's admission MDS, dated [DATE], showed: - Cognitive skills moderately impaired. - Required substantial to maximum assistance with toilet use, showers, and lower extremity dressing. - Required partial to moderate assistance with upper extremity dressing and transfers. - Occasionally incontinent of urine. - Always continent of bowel. - Diagnoses included dementia, anxiety, depression, and muscle weakness. Review of the resident's face sheet showed the resident's primary payer was Hospice. Review of the resident's POS, dated March 2026, showed the resident did not have an order for Hospice. Review of the resident's Electronic Medical Record showed a hospice order, dated 3/11/26, and hospice was to be notified if pain medication was not being given to the resident. There was no admission/start date for hospice services located in the resident's electronic medical record. During an interview on 3/13/26 at 9:29 A.M., RN A said the resident was admitted on Hospice, but there should still be a physician's order for it. During an interview on 3/13/26 at 3:54 P.M., the DON said there should be a physician's order for a resident to be on Hospice. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. Review of the facility's General Guidelines for Medication Administration, dated August 2020, showed: -Crushing tablets may require a physician's order: -The instructions for crushing medications should be included on residents orders and on residents medication administration record (MAR) so that all personnel administering medications are aware of the need. Review of Resident #39's care plan, revised 1/9/25, showed: -The resident was not cognitively intact; -The resident was taking medication for depression; -The resident had a communication problem related to dementia. Review of the resident's Oder Summary Report, dated 3/13/26, showed the resident did not have an order for medications to be crushed. Review of the resident's Medication Administration Record (MAR), dated March 2026, showed no instructions for the resident's medications to be crushed. Observation on 03/12/2026 at 7:49 A.M., showed: -Certified Medication Technician (CMT) B prepared medications for the resident; -CMT B crushed the resident's anastrozole (a medication used to treat or prevent breast cancer in postmenopausal women); -CMT B crushed the resident's furosemide (a medication used to treat fluid retention); -CMT B crushed the resident's gabapentin (a medication used to treat nerve pain); -CMT B crushed the resident's paroxetine (a medication used to treat depression); -CMT B crushed the resident's Vitamin D; -CMT B crushed the resident's aspirin (a medication used to treat atrial fibrillation, a condition causing irregular heartbeat); -CMT B crushed the resident's Echinacea (a herbal medication used to support the immune system); -Placed crushed meds in pudding and administered the medications to the resident. During an interview on 3/12/2026 at 8:15 A.M., CMT B said: -He/she remembered which residents needed their medications crushed; (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-There was not an order for the medications to be crushed for the resident; -There should have been an order in the resident's medical record for medications to be crushed so if a new staff member had to pass meds they would know which residents would need their medications crushed. It was much easier for the resident to swallow the pills if they were crushed. During an interview on 3/13/2026 at 10:48 A.M., RN A said: -There should have been an order for medications to be crushed; -Usually, an order was put in during admission that medications may be crushed if needed. During an interview on 3/13/2026 at 11:00 A.M., the Infection Control Nurse said: -Residents were usually given a may crush medications if needed: order during admission; -Resident #39 did not have that order in their medical record. During an interview on 03/13/2026 at 3:15 P.M., the DON said residents that required medications to be crushed should have a physicians to do so.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview, and record review, the facility failed to ensure staff discarded expired medications and biologicals stored in the North medication room and in the North nurse's cart per policy, failed to date opened bottles of Lorazepam (used to treat anxiety) per policy for four of 15 sampled residents (Resident #1, #5, #59, and #67), and failed to date an opened vial of Tuberculin (TB) Purified Protein Derivative (PPD, a skin test used to help diagnose tuberculosis infection) per policy, and failed to date an opened insulin pen for one resident (Resident #56) Additionally, the staff failed to regularly check the refrigerator temperatures that contained medications and failed to defrost the freezer per policy. The facility census was 61. Review of the facility's policy for Storage of Medications, revised 12/2025, showed: -The facility stores all drugs and biologicals in a safe, secure, and orderly manner. -Drugs and biologicals are stored in the packaging, containers or other dispensing systems in which they are received. -The nursing staff are responsible for maintaining medication storage and preparation areas in a clean, safe, and sanitary manner. -Drug containers that have missing, incomplete, improper, or incorrect labels are returned to the pharmacy for proper labeling before storing. Discontinued, outdated, or deteriorated drugs or biologicals are returned to the dispensing pharmacy or destroyed. Review of the facility's policy for Storage of Medications, revised 8/20, showed: -Medications requiring refrigeration are kept in a refrigerator at temperatures between 36 degrees Fahrenheit and 46 degrees with a thermometer to allow temperature monitoring. -Medications that should be frozen are stored in the freezer at -13 degrees Fahrenheit to 14 degrees Fahrenheit. -The facility should maintain a temperature log in the storage area to record temperatures at least once a day or in accordance with the facility policy. -The nurse shall place a date opened sticker on the medication and record the date opened and the new date of expiration. The expiration date of the vial or container will be 30 days from opening, unless the manufacturer recommends another date or regulations/guidelines require different dating. -The nurse will check the expiration date of each medication before administering it. -No expired medication will be administered to a resident. Review of the manufacturer guidelines for liquid Lorazepam oral concentrate (medication used to treat anxiety) showed that once the bottle was opened the liquid Lorazepam was good for 90 days when stored properly. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1. Observation and interview on 3/12/26 at 9:24 A.M., of the North Medication Room showed: -A small refrigerator on top of a normal size refrigerator. The freezer had a large amount of ice buildup. The small refrigerator did not have a temperature log. -Registered Nurse (RN) A said the night nurse should check the temperature on the refrigerators and should be defrosting the freezers. The Certified Medication Technicians (CMTs) and nurses check the medication carts for expired medications. -Resident #67 had an opened vial of Lorazepam that did not have a date when opened. It was filled on 1/19/26. The box read should be discarded 90 days after opening. -Resident #5 had an opened vial of Lorazepam that was not dated when opened. It was filled by pharmacy on 10/4/25. The box said it should be discarded 90 days after opening. -Resident #1 had an opened vial of Lorazepam that did not have a date when it was opened. It was filled on 2/16/26. The box said it should be discarded after 90 days. -Licensed Practical Nurse (LPN) A said the Lorazepam should be dated when opened. -A house stock vial of Tuberculin (TB) Purified Protein Derivative did not have a date when it was opened. LPN A said it should have been dated when opened and discarded after 30 days per policy. During an observation and interview on 3/12/26 at 10:31 A.M., of the North Nurse's cart showed: -Resident #59 had an opened vial of Lorazepam that did not have a date when it was opened. The box said it expired 90 days after opening. -The pharmacy label was removed from a Narcan Nasal Spray. The Narcan Nasal spray had with an expiration date of February 2026 and had no resident's name on the bottle. -An opened bottle of Multivitamin expired 2/2026. -LPN A said the nurses should check the carts for expired medications and make sure they are clean and organized daily. The medications should have a pharmacy label on them. Staff should not use medications that are expired, they should be destroyed. 2. Observation on 03/11/2026 at 3:12 P.M., showed: -The refrigerator in the memory care unit medication storage room did not have a log to keep track of the temperature of the refrigerator; -The refrigerator contained insulin pens, suppositories, soda for the residents, and Ensure (a supplemental drink used for those with limited nutritional intake). 3. During an interview on 03/11/2026 at 3:12 P.M., CMT D said: -There was usually a log to keep track of the medication refrigerator temperatures hung on the medication refrigerator; (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-CMTs were responsible for checking the medication refrigerator temperature daily. During an interview on 03/13/2026 at 8:58 A.M., CMT B said: -The medication refrigerator temperature should have been checked daily; -Sometimes checking the medication refrigerator temperature gets forgotten. During an interview on 03/13/2026 at 10:48 A.M., RN A said Medication refrigerator temperatures should be checked daily. During an interview on 03/13/2026 at 2:51 P.M., the Administrator said medication refrigerators temperatures should be checked daily by the CMTs. During interviews on 03/13/2026 at 3:15 P.M. and 03/13/26 at 3:54 P.M, the Director of Nursing (DON) said: - Medication refrigerator temperatures should be checked daily by the CMTs. -The CMTs are responsible for documenting the refrigerator temperatures and freezer temperatures in the medication room. -Lorazepam should be dated when opened. -Staff should not use expired medications; they should be destroyed -She should be checking the medication room and the medication carts for expired medications weekly and the nurses and CMTS should be checking as they pass their medications. -Housekeeping was responsible to defrost the freezer. 4. Review of the manufacturer guidelines for Degludec insulin pen showed the pen is only good for 56 days after opening. Review of Resident #56's care plan, dated 1/27/25, showed: -The resident was dependent on staff for meeting physical, emotional, and intellectual needs; -The resident had Type Two Diabetes (a chronic condition where the body does not produce enough insulin) and was dependent on insulin. Review of the resident's Order Summary Report, dated March 2026, showed: the resident had an order for insulin Degludec (a long-acting basal insulin) 14 units subcutaneous at bedtime for type two diabetes. Observation on 03/11/2026 at 3:12 P.M., showed the resident's Degludec insulin pen was opened with no date listing the day the insulin pen was opened in the memory care unit medication cart. During an interview on 03/11/2026 at 3:12 P.M., CMT D said the insulin pen should have been dated (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	when it was opened so staff would know how long the pen is good for. During an interview on 03/13/2026 at 8:58 A.M., CMT B said insulin pens should be dated when they are first opened. During an interview on 03/13/2026 at 10:48 A.M., RN A said insulin pens should have the date they are opened on them so staff will know when the medication expires. During an interview on 03/13/2026 at 3:15 P.M., the DON said insulin pens should be dated when they are opened.

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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. Based on observation, interview, and record review, the facility failed to prepare and serve food in accordance with professional standards for food service safety, when facility staff failed to observe proper hairnet procedures in the kitchen, failed to monitor food items for expiration dates, and failed to properly monitor food cooking and serving temperatures. This affected all residents in the facility. The facility census was 61. Review of facility policy Food Temperatures, undated, showed:- The temperatures of all food items will be taken and properly recorded prior to service of each meal;- All hot food items must be cooked to appropriate internal temperatures, held, and served at a temperature of at least 135 degrees Fahrenheit;- All cold food items must be stored at a temperature of 41 degrees Fahrenheit;- Temperatures should be taken periodically to assure hot foods stay above 135 degrees Fahrenheit and cold foods stay below 41 degrees Fahrenheit during the holding and plating process and until food leaves the service area;- Pork should be cooked to a minimum of 145 degrees Fahrenheit;Review of facility policy Food Safety and Sanitation, undated, showed: - Employees are required to have hair restraints and should cover all hair on the head;- [NAME] nets are required when facial hair is visible;- All time and temperature control for safety (TCS) foods (including leftovers) should be labeled, covered, and dated when stored;- When a food package is opened, the food item should be marked to indicate the open date. This date is used to determine when to discard the food;- Leftovers are used within 72 hours (or discarded). - Perishable foods with expiration dates should be used prior to the use by date on the package;Observation of the kitchen on 3/10/26 at 8:30 A.M., showed:- Refrigerator had stored tuna casserole expired on 3/9/26;- Refrigerator had stored sliced cheese wrapped in plastic, expired on 3/7/26;- Refrigerator had stored seven containers of whipped topping individual portions in two ounce plastic cups, expired on 3/3/26;- Refrigerator had stored 16 containers of individual portions of salad dressing in two ounce plastic cups prepared on 3/4/26, expired on 3/7/26; - Refrigerator had stored Miracle Whip 16oz jar, opened on 10/21/25, expired on 3/9/26.Observation of the kitchen on 3/12/26 starting at 3:15 P.M., showed:- Garnish plastic container with sliced tomatoes and pickles with use by date of 3/11/26 expired;- Bowl of sliced strawberries in juice, 8 ounces, with plastic wrap covering bowl, not labeled or dated;- Dietary [NAME] A not wearing a beard net over moustache while preparing deluxe club sandwich;- Dietary Assistant A not wearing a beard net over beard and not wearing a hairnet under his/her ballcap. A substantial amount of uncovered hair was exposed on both sides of his/her head from under the ball cap;- Refrigerator stored mustard, one gallon plastic container, opened on 10/21/25, expired on 2/13/26;- 3:26 P.M., pre-cooked bacon removed from package and placed in oven to cook for evening meal;- 3:50 P.M., bacon removed from the oven and no temperature check was taken by Dietary [NAME] A.Observation in the kitchen on 3/13/26 starting at 5:45 A.M., showed:- Dietary [NAME] B placed completed breakfast food items into the oven and recorded completed cooking temperatures;- 6:35 A.M., biscuits, cheese omelets, and oatmeal items all in metal containers and covered with tin foil removed from oven and placed in heating cart to transport to the first floor dining room. No food temperatures taken;- 6:42 A.M., all breakfast items placed on the steam line in the dining room (cheese omelet, biscuits, oatmeal) in metal containers with covered foil to maintain temperature so they could be served hot.During an interview on 3/13/26 at 6:55 A.M., Dietary [NAME] B said the residents always ask about meat for breakfast, they want more than we have scheduled on the menu.Observation in the dining room on 3/13/26 at 7:00 A.M., showed:- Food was uncovered and ready to serve on the steam line and no temperatures taken before serving the first meal to the residents.Observation in the kitchen on 3/13/26 at 7:00 P.M., showed dietary staff cleaning, handling leftovers, and washing dishes without hairnets and beard nets being worn.During an interview on 3/13/26 at 9:45 A.M., the Dietary Manager (DM) said:- For leftovers we only keep items for three days and then they must be discarded as soon as they are expired;- Temperatures should be taken of food (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	items when they are doing cooking, when they are removed from the oven prior to service, and just prior to serving from the steam line;- Opened containers and packages should have date opened and date expired written on package;- Training for staff is done by daily on-the-job training, no formal training schedule established;- Hairnets are required of all kitchen staff and visitors to the kitchen. If there is facial hair growth they must wear a beard net as well. A ballcap can be worn but a hairnet must be underneath it covering all of the hair.During an interview on 3/13/26 at 1:45 P.M, the Administrator said:- Leftovers should be discarded when they are expired per facility regulations;- Hairnets and beard nets are required during kitchen operations;- Items should be properly labeled and sealed in the refrigerator.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement a program that monitors antibiotic use. Based on interview and record review, the facility failed to establish an antibiotic stewardship program that included consistent monitoring by facility staff for antibiotic use protocols and a system to monitor antibiotic use when the facility failed to keep a consistent record of antibiotic use for four residents at the facility (Residents #29, #43, #49, and #66). This had the potential to affect all residents. The facility census was 61. Review of the facility's Antibiotic Stewardship policy, dated December 2024, showed the purpose of the antibiotic stewardship program was to monitor the use of antibiotics in the facility's residents with seven core elements which included leadership commitment, accountability, drug expertise, action, tracking, reporting, and education. Tracking to include how and why antibiotics are used, the amount of antibiotics used, and tracking adverse outcomes from antibiotics. Education of staff, residents and family regarding the use of antibiotics. Review of the facility's antibiotic stewardship and infection surveillance book showed no tracking of antibiotic use or infection surveillance for the August 2025, September 2025, October 2025, February 2026, and March 2026. Review of clinical progress notes showed the following residents were on antibiotics in the month of March 2026:-Resident #29 was started on Cephalexin for Urinary Tract Infection (UTI) on 03/10/2026;-Resident #43 was started on Cefpodoxime for Upper Respiratory Infection (URI) on 03/07/2026;-Resident #49 was started on Trimethoprim for UTI on 03/02/2026;-Resident #66 was started on Cefpodoxime for URI on 3/9/26. During an interview on 03/12/2026 at 3:45 P.M., the Infection Control Nurse said:- The facility's Director of Nursing (DON) was also the Infection Control Nurse from May 2025 to November 2025;- The infection surveillance and antibiotic stewardship tracking should be an ongoing process since this information changed so frequently;- Infection surveillance and antibiotic stewardship should have been completed for August 2025, September 2025, October 2025, and February 2026. During interviews on 03/13/2026 at 8:29 A.M. and 2:51 P.M., the Administrator said:-When the current Infection Control Nurse took over, she noticed the missing antibiotic stewardship data for August, September, October of 2025, February 2026, and March 2026.-A performance improvement plan was put into place.-The Infection Nurse had been working more as a nurse on the floor and less time to the Infection Prevention role. -The infection surveillance and antibiotic stewardship binder should have been kept up to date;-The infection surveillance and antibiotic stewardship tracking for February and March of 2026 should have been completed. During an interview on 03/13/2026 at 3:15 P.M., the DON said:- The infection surveillance and antibiotic stewardship binder should have been kept up to date;- The infection surveillance and antibiotic stewardship tracking for February and March of 2026 should have been completed. During an interview on 03/13/2026 at 11:00 A.M., the Infection Control Nurse said:- She was working on the mapping and tracking of the antibiotic stewardship and infection surveillance for February and March of 2026;- She had to work as a charge nurse frequently and had not had time to complete the antibiotic stewardship and infection surveillance for February and March 2026, and should kept up to date weekly for surveillance and tracking.

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. Based on interview and record review, the facility failed to issue advanced beneficiary notice of non-coverage form to notify one resident (Resident #66) of changes in coverage to items and services covered by Medicare and/or by the Medicaid State plan and failed to notify one resident (Resident #70) of their right to appeal a notice of non-coverage of items and services covered by Medicare and/or by the Medicaid State plan, affecting two out of 15 sampled residents. The facility census was 61.Request of facility policy Medicare Advance Beneficiary and Medicare Notice not provided.1.Review of Resident #70's electronic medical record and Beneficiary Protection Notification Review, dated 3/11/26, showed:- A physician's order for the resident's last covered day for Medicare Part A service was 9/25/25;- Progress notes showed the facility initiated the discharge from Medicare Part A services when benefit days were not exhausted on 9/25/25.- The facility was unable to show that a Notice of Medicare Non-Coverage (Form CMS 10123-NOMNC - A form that informs the resident on their right to appeal and how to ask for an immediate appeal) was issued to the resident.2. Review of Resident #66's electronic medical record and Beneficiary Protection Notification Review, dated 3/11/26, showed:- A physician's order for the resident's last covered day for Medicare service was 3/6/26; - Progress notes showed the facility initiated the discharge from Medicare Part A services when benefit days were not exhausted on 3/6/26; -The facility was unable to show that a Skilled Nursing Facility Advance Beneficiary Notice of Non-coverage (SNF ABN - A form that explains to the resident what coverages are no longer covered and the cost associated with continuing those coverages. Additionally, this form allows the resident to indicate the preference with continuing or stopping therapeutic services) was signed by the resident.During an interview on 3/12/26 at 9:45 A.M., the Social Services Director said she was responsible for completing these forms and she was unable to find the missing documents for Resident #70 and #66. During an interview on 3/13/26 at 1:25 P.M., the Administrator said residents should be notified when they have a notice of Medicare non-coverage and their right to appeal. Additionally, all of the associated documents should be on file for review.

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F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Encode each resident?s assessment data and transmit these data to the State within 7 days of assessment. Based on interview and record review, the facility failed to electronically transmit Minimum Data Set assessments (MDS, a federally mandated assessment completed by the facility) in a timely manner and in accordance with guidelines for one resident (Resident #60) out of 15 sampled residents. The facility census was 61.Review of the facility's policy, MDS Completion and Submission Timeframes, revised July 2017, showed:- Our facility will conduct and submit resident assessments in accordance with current federal and state submission timeframes;- The assessment coordinator or designee is responsible for ensuring that resident assessments are submitted to Centers for Medicare & Medicaid Services (CMS) in accordance with current federal and state guidelines;- Timeframes for completion and submission is based on the current requirements published in the Resident Assessment Instrument Manual.Review of the Resident Assessment Instrument (RAI) Manual for assessment transmission showed the following:- Comprehensive assessments must be transmitted electronically within 14 days of the care plan completion date;- All other MDS assessments must be submitted within 14 days of the MDS completion date.Review of Resident #60's medical record showed: - A quarterly MDS assessment with a care plan completion date of 02/03/26;- The quarterly MDS assessment transmitted and accepted on 03/12/26 (37 days late).During an interview on 03/13/26 at 9:40 A.M., the Regional Nurse Consultant said:- She had been responsible for the MDS for the past month and a half and the resident's quarterly MDS was late;- The previous MDS coordinator quit around mid-January and the facility utilized an outside vendor that just notified them yesterday there were sections of the MDS that were incomplete;- She fixed the sections yesterday and sent the completed MDS;- A performance improvement project (PIP) was done mid-February concerning the MDS. During an interview on 03/13/26 at 2:35 P.M., the Administrator said MDS assessments should be completed and sent within the required timeframes.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. Based on observation, interview, and record review, the facility failed to ensure a resident with an indwelling catheter (a thin tube inserted into the bladder through the urethral opening to drain urine), received the appropriate care and services to prevent urinary tract infections to the extent possible, when the facility staff failed to ensure proper urinary catheter care was performed for one (Resident #29) of 15 sampled residents. The facility census was 61.Review of the facility's Urinary Catheter Care policy, dated September 2014, showed:- Use a clean washcloth with warm water and soap to cleanse and rinse the catheter from insertion site to approximately four inches outward;- The facility's policy did not address the use of disposable wipes when providing catheter care. Review of Resident #29's admission Minimum Data Set (MDS), a federally required assessment tool completed by facility staff, dated 1/22/26, showed the resident:- not cognitively intact;- dependent on staff for carrying out activities of daily living;- had diagnoses of non-Alzheimer's dementia, anxiety, and depression. Review of the resident's care plan, dated 1/9/26, showed the resident:- resided on the memory care unit;- received hospice care;- incontinent of bowel and required staff assistance for personal hygiene and grooming. Review of the resident's order summary report, dated 3/13/26, showed the resident had an order for cephalexin 500 milligrams (mg) twice a day every 12 hours by mouth for a urinary tract infection from 3/10/25 to 3/24/26. Observation on 03/10/2026 at 2:20 P.M., showed:- Certified nursing assistant (CNA) C and CNA D performed catheter care on the resident;- CNA D used a disposable cleansing wipe to clean the resident's catheter tubing and wiped the catheter tubing towards the catheter insertion site;- CNA D used a new disposable cleansing wipe to clean the resident's catheter tubing and wiped the catheter tubing towards the catheter insertion site. During an Interview on 03/12/2026 at 10:40 A.M., CNA C said when performing catheter care the tubing should be cleaned with a disposable cleansing wipe, wiping away from the catheter insertion site down the catheter tubing. During an Interview on 03/12/2026 at 11:00 A.M., CNA D said:- He/she knew better than to clean the catheter tubing towards the catheter insertion site;- He/she should have cleaned the catheter tubing wiping away from the catheter insertion site. During an Interview on 03/13/2026 at 8:58 A.M., Certified Medication Technician (CMT) B catheter tubing should be cleaned by wiping away from the catheter insertion site. During an Interview on 03/13/2026 at 10:48 A.M., Registered Nurse (RN) A said catheter tubing should be cleaned by wiping away from the catheter insertion site. During an Interview on 03/12/2026 at 3:45 P.M., the Infection Control Nurse said catheter tubing should be cleaned by wiping away from the catheter insertion site. During an Interview on 03/13/2026 at 3:15 P.M., the Director of Nursing (DON) said catheter tubing should be cleaned by wiping away from the catheter insertion site.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, interview, and record review, the facility failed to establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections when the facility failed to ensure enhanced barrier precautions (EBP) (a strategy to decrease transmission of multidrug resistant organisms where staff wear a gown and gloves during high contact care for residents with wounds and/or indwelling medical devices) when providing direct care for a resident that had an indwelling urinary catheter (a thin tube inserted into the bladder through the ureteral opening to drain urine) (Resident #29) and additionally, when the staff failed to clean the port of an insulin pen prior to attaching the needle which affected Resident #69. The facility census was 61. Review of the facility's Enhanced Barrier Precautions policy, dated 2/3/26, showed: - EBP is indicated for residents with wound and/or indwelling medical devices such as urinary catheters and feeding tubes; - For residents whom EBP is indicated, EBP should be utilized during the following high-contact resident care activities: dressing, transferring, bathing, providing hygiene, and changing briefs or assisting with toileting; - Facility should ensure personal protective equipment (PPE) and alcohol based hand rub are readily available to staff. 1. Review of Resident #29's admission Minimum Data Set (MDS), a federally required assessment tool completed by facility staff, dated 1/22/26, showed: -The resident was not cognitively intact; -The resident was dependent on staff for carrying out activities of daily living; -Had a indwelling urinary catheter; -The resident had diagnoses of Non-Alzheimer's Dementia, anxiety, and depression. Review of the resident's care plan, dated 1/9/26, showed: - The resident resided on the memory care unit; - The resident received hospice care; - The resident was incontinent of bowel and had an indwelling urinary catheter. Observation on 03/11/2026 at 2:38 P.M. showed: - Certified Nursing Assistant (CNA) E and Certified Medication Technician (CMT) D transferred the resident from his/her wheelchair to the bed; - CNA E and CMT D did not utilize EBP (glove and a gown) while transferring the resident; (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- CNA E touched the resident's brief to see if the brief needed changed without wearing gloves or a gown. During an interview on 03/11/2026 at 3:12 P.M., CMT D said he/she should have worn EBP while transferring the resident. During an interview on 03/11/2026 at 3:17 P.M., CNA E said: - He/she should have worn EBP when transferring the resident; - He/she should have worn gloves when checking to see if the resident's brief needed to be changed. There were no gloves in the resident's room. During an interview on 03/13/2026 at 8:58 A.M., CMT B said: - EBP should be worn when providing direct care to residents with a catheter; - Gloves should be worn when checking to see if a resident's brief needs to be changed. During an interview on 03/13/2026 at 10:48 A.M., Registered Nurse (RN) A said: - EBP should be worn when providing direct care to residents with a catheter; - Gloves should be worn when checking to see if a resident's brief needs to be changed. During an interview on 03/12/2026 at 3:45 P.M., the Infection Control Nurse said: - EBP should be worn when proving direct care to a resident with a catheter, such as when transferring a resident; - Gloves should be worn when checking to see if a resident's brief needs to be changed. During an interview on 03/13/2026 at 3:15 P.M., the Director of Nursing (DON) said: - EBP should be worn when providing direct care to residents with a catheter; - Gloves should be worn when checking to see if a resident's brief need to be changed. 2. The facility did not provide a policy for how to use an insulin pen. Review of record showed manufacturer guideline for Basaglar KwikPen suggests that all insulin pens be swabbed with an alcohol wipe for 15 seconds, allow to dry, prior to attaching the needed to the insulin pen. Review of Resident #69's Physician Order Sheet (POS) dated March 2026 showed a start date: 3/3/26 - Basaglar KwikPen Solution Pen-injector, inject 50 units daily for diabetes mellitus. Review of the resident's Medication Administration Record (MAR), dated March 2026 showed Basaglar KwikPen Solution Pen-injector, inject 50 units daily for diabetes mellitus. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 3/12/26 at 8:22 A.M., showed: - CMT A sanitized his/her hands, applied gloves, and attached the needle to the insulin pen. CMT A did not clean the tip of insulin pen with alcohol pad prior attaching the needle. - CMT A primed the insulin pen with two units of insulin then dialed it to 50 and administered to the resident at 8:26 A.M. During an interview on 3/13/26 at 3:38 P.M., CMT A said he/she did not know if the port of the insulin pen should have been cleaned with an alcohol wipe before he/she attached the needle. During an interview on 3/13/26 at 9:29 A.M., RN A said staff should clean the port of the insulin pen with an alcohol wipe before they attached the needle. During an interview on 3/13/26 at 3:54 P.M., the DON and the Regional Nurse Consultant (RNC) said staff should clean the port of the insulin pen with an alcohol wipe before they attach the needle.