STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265791	A. Building B. Wing	03/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brooking Park	307 South Woods Mill Road Chesterfield, MO 63017

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 25073 Based on observation, interview and record review, the facility failed to ensure staff treated residents with dignity and respect when providing to perineal care (cleansing of genitalia and buttocks) to one resident (Resident #1). When providing peri care, staff failed to close the door to the resident's room, failed to close the window blinds failed to have a privacy curtain or other draping to prevent the exposure of the resident's genitalia and buttocks. The sample was seven. The census was 63 with 28 in certified beds. Review of Resident #1's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 1/3/25, showed: -Severe cognitive impairment; -Requires assistance from staff with eating; -Dependent on staff assistance going from lying to sitting position; -Diagnoses included: Diabetes, urinary tract infection in the last 30 days, Alzheimer's disease, and Parkinson's disease (a neurological disease that causes tremors and shaking of the body). Review of video footage, dated 3/9/25 at 12:12 P.M., showed an unidentified staff member entered the resident's room and asked the resident if he/she wanted to get up. The resident said yes. The staff person pulled the resident's blanket off and exposed the resident lying in a top and an adult brief. Without closing the resident's door, the staff member removed the resident's brief and applied a clean one. Observation on 3/19/25 at 2:57 P.M., showed Certified Nursing Aide (CNA) A and CNA B entered the resident's room with the resident and a stand up lift (a medical device designed to help individuals with limited mobility safely transition from a seated to a standing position, or vice versa). Staff told the resident they were going to change his/her brief. They lifted the resident out of his/her wheelchair using the sit to stand lift. Without closing the blinds to the outside and/or moving the resident in the bathroom, CNA A pulled down the resident's pants and removed a soiled brief. CNA B cleaned the resident and applied a clean brief. The resident's room was visible from a walkway outside. The resident's room did not have any privacy curtains so anyone who opened the door would see the resident naked and exposed. (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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with the Administrator, Director of Nursing (DON), and Regional Nurse Manager on 3/20/25 at 4:05 P.M., the Regional nurse manager said staff should always shut the resident's blinds to the outside when providing personal care. They did not know why the resident's room did not have privacy curtains since the room had tracks for privacy curtains. MO00249872

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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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. 25073 Based on interview and record review, the facility failed to maintain an effective grievance process for residents and family members to voice grievances. The facility also failed to promptly resolve grievances for one resident (Resident #1). The sample was seven. The census was 63 with 28 in certified beds. Review of the facility's grievance policy, reviewed on 12/20/24, showed: -It is the policy of this facility that each resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of the staff and of other residents, and other concerns regarding their Long Term Care (LTC) facility stay; -The facility will ensure prompt resolution to all grievances, keeping the resident and resident's representative informed throughout the investigation and resolution process; -The facility grievance process will be overseen by a designated Grievance Official who will be responsible for receiving and tracking grievances through their conclusion, lead necessary investigations, maintaining the confidentiality of all information associated with grievances, communicate with residents throughout the process to resolution and coordinate with staff; -The facility will provide a mechanism for filing a grievance/complaint without fear of retaliation and/or barriers of service and will provide residents, resident representatives, and other information about the mechanisms and procedure to file a grievance. The facility will provide a designated individual to oversee the grievance process, provide a planned systematic mechanism for receiving and prompting action upon issues expressed by residents and resident representatives. The facility will provide an ongoing system for monitoring and trending grievances and complaints; -Procedure: The facility will help promote the grievance process through the organization. This includes notifying residents of their rights related to grievances as well as education to all those affected by potential grievances or concerns on the family grievance processes, including but not limited to: -Resident; -Resident representative; -Employees; -Volunteers; -Vendors; (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Other stakeholders. -Grievance Official (Social Services Director): The facility will train and designate an individual who is responsible for: -Overseeing the grievance process in conjunction with facility administration; -Receive and track all grievances through to their conclusion; -Lead any necessary investigations by the facility; -Work with facility staff utilizing root cause analysis processes for resolution of the grievance or concern; -Maintain confidentiality of all information associated with grievances; -Complete written grievance resolutions/decisions to the resident involved; -Resolution: The facility will strive for a prompt resolution outcome for all grievances or complaints rendered. A reasonable timeframe will be agreed upon with all parties involved; -The Grievance Official (Social Service Director) will complete a written response to the resident or resident representative which includes; -Date of Grievance; -Tracking number or identification; -Type of grievance; -Location/Department; -Person assigned to investigation; -Date response letter sent; -Comments/Actions. Review of the facility's Grievance/Concern Form, undated, showed: -Page 1: Space designated for: -Date of occurrence; -Location of occurrence; -Staff or Resident involved; (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Summary of concern; -Name of individual filling out the form; -Signature of person filling out the form; -Date form was filled out; -Page 2: Investigation: The investigation will consist of at least the following: -Review of the completed complaint report; -An interview with the person or persons reporting the incident; -Interviews with any witnesses to the incident; -A review of the resident's medical record if indicated; -A search of the resident's room (with resident's permission); -An interview with staff members having contact with the resident during reverent periods or shifts of the alleged incident; -Interviews with the resident's roommate, family members and visitors; -A root cause analysis of all circumstances surrounding the incident; -Summary of investigation; -Page 3: Resolution: Action taken to resolve grievance/complaint; -Spaces designated for date and time, to show if the resident and/or resident's representative, the resident's physician and/or Ombudsman were notified of the resolution (if applicable); -Spaces designated for date and signature of the Director of Nursing (DON), SSD and Executive Director (ED); -The grievance/complaint form did not have a designated space for a tracking number, person assigned to investigate, instructions on who or where the grievance form was to be turned in to, a date or timeframe the grievance should have a resolution or a root cause analysis. Review of Resident #1's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument competed by facility staff, dated 1/3/25, showed: -Severe cognitive impairment; -Diagnoses included: Alzheimer's disease and Parkinson's disease (a neurological disease that causes tremors and shaking of the body); (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Set up assistance with feeding; -Dependent (helper does all of the work) for toileting hygiene, showers/baths, dressing and transfers. Review of the grievance log showed: -A grievance form filled out by Family Member (FM) S regarding Resident #1; -Signed and dated by FM S on 2/5/25; -Date of occurrence: Multiple in January and February 2025; -Staff involved: Multiple; -Summary of concern: -On Friday night 1/17/25 to 1/18/25, no rounds from 9:21 P.M., eight hours no staff checked on resident; -Saturday 1/25/25, whole uncrushed pills given at 5:15 A.M., and at 9:00 P.M., causing choking, against physician's orders; -On Tuesday 1/28/25, missed breakfast hours, left in bed, breakfast tray brought later, there were 16 hours between meals; -On Saturday 2/1/25: -Whole uncrushed pills provided at 5:30 A.M.; -No shower provided; -At 11:32 A.M., the staff turned the camera (in the resident's room) and left it (turned) intentionally all night; -Staff called the resident boy; -On Sunday 2/2/25 to 2/3/25, no rounds from 8:35 P.M., to 5:48 A.M. (nine hours); -On Tuesday 2/4/25, evening medications not given until after midnight; -Page 2. Investigation sheet: Not with grievance packet and not provided to surveyor; -Resolutions: -Social Worker (SSD) called and left a message for daughter to address these concerns. Social Worker (SSD) will wait for a return phone call (no date and/or time, the call was placed); (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-No tracking number or identification; -No person assigned to investigation; -No date when response letter was sent; -A grievance filled out by FM S regarding Resident #1; -Dated 2/7/25, -Date of occurrence; 2/6 to 2/7/2025; -Staff or Resident involved: multiple; -Summary of concern: -Night rounds did not occur between 7:30 P.M. and 2:12 A.M., nearly seven hours between rounds; -Wheelchair still dirty; -Staff turned camera during lift; -Signed and dated by FM S; -No investigation page; -Resolution: -SSD called and left a message for FM S to address these concerns, this SSD will wait for return phone call (no date and/or time provided); -SSD spoke with FM S on 2/21/25, (no time provided); SSD set up a care plan meeting; -No resolutions; -No tracking number or identification; -No person assigned to investigation; -No date the response letter sent; -Space designated for resident and/or resident representative, physician and the Ombudsman notified of resolution: Left blank; -Grievance form signed only by SSD on 2/10/25. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interviews on 3/19/25 at 2:30 P.M., and 3/20/25, at 1:30 P.M., FM S said he/she discussed his/her concerns on the most recent grievance forms with the DON. The DON told FM S it would be very difficult for her to figure out which staff were involved with the allegations. FM S did not understand this because he/she provided very specific dates and times of the alleged concerns. There was supposed to be a meeting with the DON about his/her concerns on 3/7/25, but the DON did not show up for the meeting. When FM S asked to speak with the DON, he/she was told the DON was busy. FM S had never been told the results of the two grievances he/she filed in February. He/She visited the resident almost daily and had never missed a scheduled care plan meeting. FM S asked the facility to text and/or email him/her, but they continued to call his/her cell phone. FM S's preference for communication with the facility was by email or text. His/Her concerns had been an ongoing issue with the facility. The facility was not following their plan of correction from December 2024. He/She was not asking for anything above or beyond the basic nursing services he/she was paying for. There was no reason his/her family member should ever miss a meal, be left to lay in a soiled brief for extended periods of time, not be bathed or not provided routine personal hygiene. FM S had voiced his/her concerns in the past and still nothing had improved in regard to the care of the resident. The facility had grievance forms all over the facility. The form did not include who to turn the report into, when a response should be expected and/or who the grievance officer was. FM S asked to see the facility's policy concerning grievances, but the facility would not provide one. During an interview on 3/20/25 at 2:50 P.M., the SSD said he/she was the Grievance Officer. If he/she received a written grievance he/she would give it to the department head the grievance pertained to. Nursing complaints would go to the DON and dietary complaints would go to the Dietary Manager. He/She would expect the department heads to follow through with the investigation of the grievance and return it to him/her after it was completed. He/She maintained the grievance log. After she had gotten a summary of the grievance solution, he/she would notify the person who filed the grievance. He/She was not sure if or what the response time was for a grievance. The process should take no longer than one month. During an interview on 3/19/25 at 1:00 P.M., the DON said she had tried to set up a meeting with the resident's family member. The family member would not return her calls. A care plan meeting was set up, but the family member failed to show up. She was not able to provide an investigation regarding the specific allegations on the grievance forms. She did not interview any staff about the resident being left in bed for extended periods of time or receiving medications whole and/or late. She did not address moving the resident's camera with staff so the resident's care could not be monitored. She did put several agency staff on the do not return list because of the family member's complaints. The SSD was the Grievance Officer for the facility. The resident's family member had been very challenging. FM S expected too much from the facility and did not have realistic expectations for the resident's care. During an interview on 3/20/25 at 4:30 P.M., the ED said he was not the official Grievance Officer. The Grievance Officer for the facility was the Social Worker (SSD). Any staff person could take and try to resolve any grievances filed. He expected staff and department heads to address grievances in a timely manner. He should be notified of any grievance and the outcome of the investigation because he had to sign the completed grievance forms. MO00249872

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. 25073 Based on observation, interview and record review, the facility failed to ensure residents who required assistance with activities of daily living (ADL, bathing, dressing and toileting) received the necessary services to maintain adequate personal hygiene. Staff failed to assist one resident with personal hygiene and failed to provide physician ordered showers. (Resident #1). The sample was seven. The census was 63 with 28 residents in certified beds. Review of the facility's Bathing policy, dated February 2019, showed: Policy: -To cleanse the skin on micro-organisms (small bacteria) thus preventing infections and preserving the integrity of the skin; -To provide comfort and relaxation, stimulate circulation, encourage passive and active range of motion (ROM) and improve self-esteem through appearance; -Bath days and the type of bath to be given will be assigned by the Charge Nurse. Review of Resident #1's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument competed by facility staff, dated 1/3/25, showed: -Severe cognitive impairment; -Diagnoses included: Alzheimer's disease and Parkinson's disease (a neurological disease that causes tremors and shaking of the body); -Dependent (helper does all of the work) for toileting hygiene, showers/baths, dressing and transfers. Review of the resident's physician order sheet, in use at time of the onsite visit, showed an order for the resident to receive a shower/bath twice weekly on Wednesday and Saturday on the evening shift. Review of the resident's care plan, in use at the time of survey, showed: -Need: The resident has a history of urinary tract infections (UTIs, infection of the urinary tract); -Intervention: Resident/Family/Caregiver teaching should include good hygiene practices; -Need: The resident has an ADL self-care performance deficit; -Intervention: The resident requires extensive assist by one staff member for showering and bathing twice weekly and as needed (PRN). (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 3/19/25 at 2:28 P.M., showed the resident seated in a wheelchair. Certified Nursing Aide (CNA) A and CNA B, used a stand up lift (mechanical lift to assist residents with standing) to stand the resident up and change his/her brief and provide perineal care (peri-care, cleansing of the genitals). The resident's hair appeared very oily, flat and stringy. The resident had long facial hair including a mustache. The resident had a strong body odor. CNA A and CNA B placed the resident back in his/her wheelchair and propelled him/her to the dining room. During an interview on 3/19/25 at 2:30 P.M., Family Member S said he/she did not think the resident had had a shower since the end of last month. The resident always looked disheveled and his/her hair was oily. It was a struggle to get staff to bathe the resident twice weekly. The resident never had a beard and/or mustache prior to admission. The resident always smelled of urine and body odor. During an interview on 3/19/25 at 2:40 P.M., CNA B said residents were supposed to get showers twice weekly. The shower sheets were posted at the nurse's station. Sometimes the nurse would write it down on the assignment sheets. During an interview on 3/20/25, at 7:08 A.M., Licensed Practical Nurse (LPN) C said residents were supposed to be showered at least twice a week. CNAs gave the showers and nurses signed off on the shower sheets. Review of the shower/bath schedule on 3/19/25, showed the resident was to have a shower/bath on Wednesdays and Saturdays on the evening shift. Review of the resident's shower sheets for February 2025, showed: -Shower sheet dated 2/13/25, -Shower sheet dated 2/19/25; -Shower sheet dated 2/22/25; -Shower sheet dated 2/26/25; -No additional shower sheets were provided. Review of the resident's shower sheets for March 2025. Showed the facility provided one shower sheet dated 3/19/25. No additional shower sheets were provided. During interviews on 3/20/25 at 1:00 P.M. and 4:00 P.M., the Director of Nurses (DON) said she did not have any additional shower sheet documentation for the resident. The residents should receive showers twice a week. The nurses should sign off on the shower sheets. Any skin issues that were new or old should be marked on the shower sheets. Staff should shave residents on the residents' shower days and as needed. MO00249872

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 25073 Based on observation, interview and record review, the facility failed to follow their policy and the resident's care plan by ensuring two staff members safely assisted a resident who required a sit-to-stand mechanical lift for transfers (Resident #1). Staff failed to have two staff present at each transfer and failed to secure the safety belt around the resident's waist during a transfer. The sample size was seven. The census was 63 with 28 residents in certified beds. Review of the facility's Sara lift (a type of sit-to-stand mechanical lift) policy, dated September 2017, showed: -Purpose: To provide a safe transfer for all residents who are unable to be transferred by staff due to a physical condition; -Procedure: -Two nursing persons must be used for a Sara lift transfer; -Position sling around resident's back so it is approximately two inches above the waistline; -Fasten safety belt around the resident's waist; -Unclasp sling from lift, remove safety belt from the resident; -Note: Nursing staff not using two nursing personnel for a Sara lift transfer will begin counseling process for failure to follow facility policy and procedures for safe transfer. Review of Resident #1's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument competed by facility staff, dated 1/3/25, showed: -Severe cognitive impairment; -Diagnoses included: Alzheimer's disease and Parkinson's disease (a neurological disease that causes tremors and shaking of the body); -Dependent (helper does all of the work) for toileting hygiene, showers/baths, dressing and transfers. Review of the resident's care plan, in use at the time of the survey, showed: -Need: The resident has an activities of daily living (ADL) self-care performance deficit; -Interventions: The resident requires max of two staff assistance to move between surfaces as necessary. The resident requires mechanical lift sit-to-stand with two person staff assistance. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of video footage dated 2/1/25 at 8:02 A.M., showed the resident lay in bed. An unidentified Certified Nurse Aide (CNA) could be seen using the sit-to-stand lift, with no other assistance, the CNA transferred the resident from the bed to the wheelchair. The belt from the lift was not secured around the resident's waist and hung unattached at the resident's side. Review of video footage, dated 2/1/25 at 6:47 P.M., showed the resident sat in a wheelchair. An unidentified CNA entered the resident's room alone with the sit-to-stand lift. The CNA turned the camera away from view and said, I am not having you watch me, sorry. During the audio portion of the video, the staff member can be heard talking to the resident. The resident can be heard saying ouch, ouch. Approximately five minutes later, the CNA put the camera back in view. The resident lay in bed. At no time during the audio, could a second staff person be heard entering the room to assist with the sit-to-stand transfer. Observation on 3/19/25 at 2:28 P.M., showed the resident seated in a wheelchair. CNA A and CNA B entered the resident's room with a sit-to-stand lift. CNA A assisted CNA B with applying the lift belt. Neither CNA clasped the belt around the resident's waist. CNA A lifted the resident to a semi-standing position. CNA B pulled down the resident's pants down, removed his/her adult brief, provided perineal care (cleansing of the genital area and buttocks), applied a clean brief, pulled up the resident's pants and lowered him/her back into the wheelchair. CNA B removed the belt from around the resident's waist by pulling the belt and releasing the Velcro. CNA A then propelled the resident to the activity room. During an interview on 3/19/25 at 2:38 P.M., CNA B said it was policy for two people to be present when using a sit-to-stand lift. He/She thought the belt had been clasped during the transfer. He/She knew the Velcro was attached but didn't think about the buckle [NAME] being secured. During an interview on 3/20/25 at 3:00 P.M., the Director of Nursing said she expected staff to use two person assistance when using the mechanical sit-to-stand lift with a resident. The belt should be secured with Velcro and the belt should be clasped with the buckle provided with the belt. The sit-to-stand lift required two people in case the resident's knees buckled or the machine began to topple over. MO00249872

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 25073 Based on observation and interview, the facility failed to ensure one treatment cart remained locked when left unattended with medications on top of the cart. This practice could affect all residents residing in the facility. The census was 63 with 28 in certified beds. Review of the facility's Medication Administration-General Guidelines policy dated July 2021, showed all medication storage areas (carts, medication rooms, central supply) are locked at all times unless in use and under the direct observation of the medication nurse/aide. Observation on 3/19/25 at 11:00 A.M. to 11:17 A.M., showed the treatment cart on the Avalon unit unattended and unlocked. Multiple medications sat on top of the cart. Residents were seated and stood in the hallway near the cart. There were two Exelon patches (used for the treatment of dementia) and one Tamiflu (used to treat flu symptoms) tablet on top of the cart. All the drawers were able to be opened. The cart contained treatment supplies and various medications. During an interview on 3/19/25 at 11:18 A.M., the Director of Nursing said she expected all treatment and medication carts to be locked and secured. No medications should ever be left unsupervised on a medication/treatment cart.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265791	A. Building B. Wing	03/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brooking Park	307 South Woods Mill Road Chesterfield, MO 63017

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 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure meals and snacks are served at times in accordance with resident's needs, preferences, and requests. Suitable and nourishing alternative meals and snacks must be provided for residents who want to eat at non-traditional times or outside of scheduled meal times. 25073 Based on observation, interview, and record review, the facility failed to ensure one resident was served meals in a timely manner when staff served meals outside the timeframes designated by the facility (Resident #1). The sample was seven. The census was 63 with 28 in certified beds. Review of the facility's mealtimes showed: -Breakfast is served at 7:30 A.M. through 9:00 A.M.; -Lunch is served at 11:30 A.M. through 1:00 P.M.; -Dinner is served at 4:30 P.M. through 6:30 P.M. -Review on 3/19/25 at 10:05 A.M., of the meal service logbook, showed the space for each day to record the start and stop time for each meal service. There were multiple days staff failed to document any times in the designated dates and/or times for each meal services The dates and times the staff did document showed they documented the start and end of each meal on each day mirrored the facility's mealtimes showing that Breakfast was started at 7:30 A.M. and ended at 9:00 A.M., lunch was started at 11:30 A.M. and ended at 1:00 P.M., dinner started at 4:30 P.M. and ended at 6:30 P.M. Review of Resident #1's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument competed by facility staff, dated 1/3/25, showed: -Severe cognitive impairment; -Requires moderate assistance from staff with eating; -Diagnose included: Diabetes, urinary tract infection in the last 30 days, Alzheimer's disease, and Parkinson's disease (a neurological disease that causes tremors and shaking of the body). Review of the resident's care plan, in use at the time of survey, showed: -Need: The resident has Activity of Daily Living (ADL) deficit related to Alzheimer's; -Interventions: Eating-regular diet, requires set up assistance and encouragement at times. Review of camera footage dated 3/9/25 from 12:15 A.M., until 12:12 P.M., showed the resident lay in bed. At no time did the motion activated camera show staff brought a breakfast tray for the resident. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 3/19/25 at 9:30 A.M., showed the resident lay in bed. Certified Nursing Assistant (CNA) A and CNA B provided the resident assistance with dressing and getting out of bed. At 9:57 A.M., the resident was assisted out of bed and placed in his/her wheelchair. CNA A propelled the resident into the dining room and served the resident breakfast. During an interview on 2/19/24 at 2:25 P.M., Family Member (FM) S said the resident was frequently left in bed for breakfast or until after breakfast. The resident was able to feed himself/herself but was totally dependent on staff to get him/her out of bed for meals. Staff frequently let 14 to 16 hours elapse between dinner and breakfast. It had been an ongoing issue. FM S had a camera in the resident's room, and could see when the resident was gotten up and taken out for meals. At times staff would bring a tray to the resident's room and just leave it sitting on the over the bed table without sitting the resident up and/or assisting with set up of the meal. There had been multiple occasions when the resident was not fed a meal all day. Staff at the facility were not organized and had no system in place to make sure every resident was served a meal at every mealtime, every day. During an interview on 3/19/25 at 10:00 A.M., Dietary Aide F said the resident was served breakfast late because staff failed to bring the resident to the dining room prior to 9:00 A.M. Nursing staff frequently brought residents to the dining room after scheduled mealtimes. Nursing staff were responsible to let dietary staff know which residents would be eating meals in their rooms. Nursing staff took trays to resident rooms. During an interview on 3/19/25 at 9:55 A.M., Dietary Manager E said the facility had an open meal plan. Breakfast could be served from 7:30 A.M., to 9:00 A.M. Dietary staff served off of a steam table in the unit dining rooms. All residents should have their meal no later than 9:00 A.M. Dietary staff would remain on the unit with the steam table until all residents were served. There were times the meals were served late because there could be a problem with dietary staff and/or nursing staff. The dietary department was open from 7:00 A.M. until 7:00 P.M. Dietary staff should use dietary tickets to assure each resident was served a meal. He/She did not know how a resident would not be served a tray. There was no other system to make sure each resident received a tray at each meal. Dietary tickets were printed by the dietary department. The resident received his/her meal late because nursing staff got the resident up late. During an interview on 3/19/24 at 1:00 P.M., the Director of Nursing said she would expect meals to be served timely. There were a lot of agency nursing staff, and they were not familiar with the residents and the mealtime process. During an interview on 2/19/25 at 1:30 P.M., the Executive Director said he would expect meals to be served timely and within the times listed on the menus. He would expect nursing and dietary staff to work together to serve the residents meals. During an interview on 3/20/25 at 2:30 P.M., the Regional Corporate Nurse said residents should receive a meal tray within the designated meal timeframes. Dietary staff were supposed to keep a log to show when meals were served outside of the designated mealtimes. She did not know why the log was not updated and/or accurate when staff documented all meals for the month had been served within the timeframes. MO00249872