STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265800	A. Building B. Wing	02/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Gower Convalescent Center, Inc	323 South Highway 169 Gower, MO 64454

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31102 Based on observation, interview and record review, the facility failed to ensure assure staff treated residents in a manner that maintained their dignity, when staff did not serve all residents who sat at the same table during meals, which affected any resident who ate in the dining room, and failed to ensure one of the 18 sampled residents, (Resident #47), was free of facial hair. The facility census was 78. Review of the facility's policy titled, Resident Rights, revised 8/22, showed staff were directed to do the following: - The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility; - A facility must treat each resident with respect and dignity and care of each resident in a manner and in an environment that promotes maintenance or enhancement of his/her quality of life, recognizing each resident's individuality; - The facility must protect and promote the rights of the resident. 47195 1. Review of Resident #47's Quarterly minimum data set (MDS), dated [DATE], showed: -The resident is severely cognitively impaired; -The resident displayed no behavioral symptoms directed towards others including hitting, kicking, pushing, scratching, or grabbing; -The resident required partial to moderate assistance with personal hygiene including shaving; -The resident was dependent on a wheelchair; -The resident required substantial or maximal assistance with rolling left and right; (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 - Some	-The resident was dependent to move from sitting to lying, lying to sitting on side of bed, sit to stand transfers, chair to be transfers, and toilet transfers; -Diagnoses included: dementia (a decline in thinking, memory, or reasoning that interferes with daily life), Alzheimer's disease (a progressive brain disorder that causes memory loss, thinking problems, and behavioral changes), muscle weakness, hearing loss, reduced mobility. Review of care plan, revised 12/6/24, showed: -Staff are directed to provide assistance with hygiene; -The resident preferred hospice staff provide showers twice weekly. The facility staff will provide showers as requested or needed. Observation on 2/18/25 at 10:12 A.M. showed resident had one inch long facial hair coming out of his/her chin. Observation on 2/19/25 at 8:26 A.M. showed resident had facial hair on their chin. Observation on 2/21/25 at 10:44 A.M. showed resident had quarter inch facial hair on their chin. During an interview on 2/20/25 at 10:35 A.M., Certified Nurse Aide (CNA) E said: -The resident liked to be shaved; -The reisdent's facial hair is shaved every time staff provide a shower; -Hospice staff provides the residents showers; -Last week the resident was not shaved so facility staff completed residents shaving while the reisdent was up in his/her reclining wheelchair. During an interview on 2/21/25 at 9:57 A.M., Licensed Practical Nurse B said: -Female residents should have their facial hair trimmed; -The resident did not always let staff shave them because they would swat at staff members; -The hospice and facility staff will attempt to shave resident; -Facility staff did not document when they provided shaving to resident because hospice did all of residents showers; -The resident had been declining steadily and stopped talking in last few months; During an interview on 2/21/25 at 10:24 A.M., CNA H said the hospice staff shaved resident and they shave residents when showered. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 2/21/25 at 1:15 P.M., Director of Nursing said: -He/she expected female residents to be free from facial hair; -Shaving was provided to residents during bathing; -The resident could be challenging with their moods and at times would be resistive to cares; -She expected for staff to care plan residents who may resist cares, including shaving. During an interview on 2/21/25 at 1:15 P.M., Administrator said she did not expect female residents to want their facial hair to be shaved or removed due to the change of times in our culture. 50980 2. Observation of 400-500 hall dining room on 2/18/25 showed: - 12:05 P.M. three residents served all at different tables with other residents at those tables not being served; - 12:10 P.M. lunch service continues to be random as to who receives their meal and the tables are not all served at the same time leaving residents at each table watching others eat in front of them while they wait; Review of resident #22's Admission MDS, dated [DATE], showed: - Cognitive skills for daily decision making intact; - Diagnosis included: Hypertension (high blood pressure), GERD (acid reflux), diabetes (chronic disease when body can't produce insulin), hyperlipidemia (high cholesterol), thyroid disorder (a condition where the thyroid gland produces an abnormal amount of thyroid hormones), arthritis (joint pain, swelling, and stiffness), osteoporosis (bone disease); Observation of 100-300 Hall dining room on 2/19/25 showed: - 12:19 P.M. Resident #22 with a plate of food in front of them, no other residents at their dining table have been served; - 12:27 P.M. Residents at the table still have not been served (8 min elapsed since first person served); During an interview on 2/19/25 at 12:20 P.M., when asked about meal service, Resident #22 said he/she is frustrated, I don't know how they determine who gets served, it's all random. During an interview on 2/19/25 at 2:49 P.M. with the Resident Council, residents said: - Resident #38 felt it was confusing how residents are served at meals; (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Resident #13 said it was frustrating how meal service is conducted when serving; - Resident #51 said they don't know when they are going to get served; - Resident #75 said the meal service selection of when residents are served doesn't make sense; - Resident #17 said it's like the staff chooses who gets fed at random; During an interview on 2/20/25 at 1:30 P.M., the Administrator and DON said all residents sitting at a table should be served meals at the start of dining service at the same time before moving onto a new table unless there is a diabetic resident that needs to be served;.

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31102 Based on observation, interview and record review, the facility failed to maintain the privacy of two of the 18 sampled residents, (Resident #43 and #73), when staff failed to post signage at the front door or outside each sampled resident's room to indicate 24 hour camera surveillance was in progress and failed to obtain consents from the responsible parties of the sampled residents. The facility census was 78. The facility did not provide a policy for video surveillance with or without audio. 1. Review of Resident #73's care plan, dated 9/20/24, did not address the use of video surveillance with audio. Review of the Resident's Quarterly Minimum Data Set (MDS), a federally mandated assessment tool, completed by facility staff, dated 11/20/24, showed: - Cognitive skills intact; - Dependent on the assistance of staff for toilet use, and transfers; - Required substantial to maximum assistance with showers, dressing, and personal hygiene; - Had a urinary catheter (sterile tube inserted into the bladder to drain urine); - Always incontinent of bowel; - No falls; - Diagnoses included cancer, diabetes mellitus, neurogenic bladder (a dysfunction that results from interference with the normal nerve pathways associated with urination), Congestive Heart Failure (CHF, accumulation of fluid in the lungs and other areas of the body) and Coronary Artery Disease (CAD, a disease in which there is a narrowing or blockage of the coronary arteries). Review of the resident's Physician Order Sheet, (POS), dated 1/19/25 - 2/19/25, did not include an order for video surveillance with audio. Observation on 2/18/25 at 10:17 A.M., showed: - The resident sat in a Broda chair (reclining geri chair) in his/her room and the over the bed table was placed in front of him/her with a video monitor on it. Also had a monitor on the resident's bedside table and on the window ledge; - Did not have a sign outside the resident's room to indicate video monitoring with audio was in use; (continued on next page)

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- No signage was posted at the entrance to the facility to indicate video/camera surveillance was in use; - The video monitor was at the nurse's station and the volume was turned down so you were unable to hear what was being said in the resident's room. Observation on 02/19/25 at 1:51 P.M., showed Certified Nurse Aide (CNA) A was on the phone with the resident's family because the recording device was not working correctly. A family member planned to fix it later in the day. 2. Review of Resident #43's Annual MDS, dated [DATE] showed: - Cognitive skills severely impaired; - Required substantial to maximum assistance with toilet use, showers, and transfers; - Frequently incontinent of bowel and bladder; - Diagnoses included Alzheimer's disease (a brain disorder that slowly destroys memory and thinking skills and , eventually, the ability to carry out the simplest tasks), non-traumatic brain dysfunction (causes damage tot he brain by internal factors, such as a lack of oxygen, exposure to toxins or pressure from a tumor), arthritis and depression; - No falls. Review of the resident's care plan, dated 12/17/24 showed the resident had dementia (inability to think) which affected his/her safety skills and had a history of falls. The resident's daughter brought a V-tech baby monitor with screen so staff were able to keep an eye on the resident. Review of the resident's POS, dated 1/19/25 - 2/19/25, showed and order dated 1/4/21 for a VTECH monitor, on at shifts continuous for frequent falls. Review of the resident's medical record showed he/she did not have a consent signed by the responsible party for 24 hour camera surveillance. Observation on 2/18/25 at 9:43 A.M., showed: - A video monitor on the counter by the resident's sink; - No signage was posted outside the resident's room to indicate camera monitoring was in progress; - No signage was posted at the entrance to the facility to indicate camera surveillance was in use; - The VTECH monitor at the nurse's station showed the resident sat in the wheelchair in his/her room. During an interview on 2/19/25 at 7:46 A.M., the Director of Nursing (DON) said: (continued on next page)

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Resident #73 had several daughters and they wanted an audio camera so they could talk to him/her. Resident #73 was the only resident with audio on the video monitoring; - Resident #43 did not have audio on his/her video monitor. During an interview on 2/20/25 at 11:30 A.M., Licensed Practical Nurse (LPN) A said: - It should be care planned for a resident to have video surveillance; - They did not have a physician's order for video surveillance because the family had requested it; - Did not know there should be a sign about video surveillance outside the resident's room. During an interview on 2/20/25 at 1:11 P.M., CNA D said they were told about the video monitoring device by their charge nurse. During an interview on 2/21/25 at 12:15 P.M., the DON said: - The video monitoring devices are just baby monitors; - The family put the monitors in the residents' room, not the facility. - She never thought of the need to post signs or notify anyone about it; - She considered the device to be a communication tool; - She did not think a physician's order for video monitoring was needed; - Resident #73 used the device also for his/her family to call him/her.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47195 Based on observations, interview, and record review, the facility failed to ensure staff developed and updated care plans consistent with resident's specific conditions and needs which affected five of eighteen sampled residents (Resident #23, #47,#71, #6 and #12), and failed to invite and document quarterly care plan meetings were held for three residents (Resident #23, #6, and #12). The facility additionally failed to provide an accurate care plan when a resident had multiple transfer types listed in the care plan and did not reflect the resident's current non-ambulatory status for one resident (Resident #47) and failed to ensure wheelchair use was care planned for one resident (Resident #71). The facility census was 78. Facility did not provide a policy on comprehensive care plans. 1. Review of Resident #23's Quarterly Minimum Data Set (MDS), a federally mandated assessment tool completed by facility staff, dated 12/11/24, showed: - Cognitively intact; - Dependent on a wheelchair for mobility; - Required partial to moderate assistance with personal hygiene, bathing rolling left and right, sit to lying and lying to sitting on side of bed mobility; - Dependent for transfers to the toilet or shower, sit to stand transfers and chair to bed transfers; -Diagnoses included: Dementia, diabetes, high blood pressure, and depression. Review of care plan, dated 9/12/24, showed the care plan was last updated on 9/12/24 when visual function and pressure ulcer/injury were added. During an interview on 2/18/25 at 9:05 A.M. the Resident said: -He/She did not think they had care plan meetings; -His/her daughter and granddaughter sometimes participated in their care. Review of the electronic medical record showed: -The last care conference was held on 3/29/23; -The next care conference was scheduled for 6/22/23. During an interview on 2/20/25 at 3:08 P.M., MDS Coordinator said: (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-He/She offered resident care plan meetings but they did not think resident came to meetings; -The last care plan conference was held March 2023; -When the resident's family member came to facility he/she talked to everyone while they were here; - The residents family member did not share any reason to have a care plan meeting held; - Care plan notes showed resident's family member had participated via phone March of 2023 for resident's care plan meeting. 2. Review of Resident #47's Quarterly MDS, dated [DATE], showed: - Severely cognitively impaired; - Dependent on a wheelchair and staff assist for mobility; transfers, and all ADLS (Activities of daily living); -Diagnoses included: Dementia. Review of care plan, dated 12/6/24, showed: -Hospice ordered the resident a reclining chair, dated 10/10/23; - Two staff are to assist with transfers with a gait belt, use a mechanical lift to transfer the reisdent in and out of bed, and use a sit to stand lift to transfer the resident when toileting, dated 10/10/23; -Ensure the reisdent wears non-skid footwear is worn, dated 10/10/23; -Ensure pathways are free and clear of clutter, dated 10/10/23 -Re-educated staff on proper gait belt use, dated 10/10/23; -Ensure the residents walker stays within him/her and is in reach, dated 10/10/23; -The care plan did not reflect the resident's current total dependence for all transfers via mechanical lift and that he/she was no longer ambulatory. Observation on 2/21/25 at 10:33 A.M. showed hospice staff used a mechanical lift to place the resident in their bed. During an interview on 2/21/25 at 9:57 A.M. Licensed Practical Nurse (LPN) B said: -The resident was transferred by a mechanical lift; -The resident had declined steadily and was no longer able to stand for transfers. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 2/21/25 at 10:24 A.M., CNA H said: -The resident was transferred by use of a mechanical lift; -The resident had not used the sit to stand mechanical lift on over eleven or twelve months; -The resident had not been able to stand and pivot for a long time; During an interview on 2/21/25 at 1:15 P.M., the Director of Nursing said a resident who was dependent on a mechanical lift for transfers should have a care plan that reflected the resident's current need for assistance. 3. Review of Resident #71's Admission MDS, dated [DATE], showed: - Severe cognitive impairment; - Did not use a mobility device; - Independent with walking up to 150 feet; - Independent with chair to bed transfers and sit to stand transfers; - Diagnoses included: Dementia, Back fracture,anxiety, dementia and history of falling. Review of care plan, dated 2/6/25, showed: - He/She wandered safely within specified boundaries; - He/She walked independently, had dementia, and required staff to remind them to use their walker; -He/She had difficulty processing information due to dementia and get easily distracted; -There was nothing care planned regarding use of a wheelchair. Observation on 2/19/25 at 9:33 A.M. showed the LPN A pushed resident from the dining room to the nurses station in their wheelchair. Observation on 2/19/25 at 9:57 A.M. showed the resident was pushed by hospice staff in their wheelchair to the shower room. Observation on 2/19/25 at 11:28 A.M. showed the CNA C pushed resident down hallway to the nurses station in their wheelchair. Observation on 2/20/25 at 12:48 P.M. showed the Social Services Designee pushed resident out of dining room in their wheelchair. During an interview on 2/21/25 at 9:57 A.M., LPN B said the resident would self-propel in their wheelchair; (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 2/21/25 at 10:24 A.M., CNA H said the resident would self-propel themselves in their wheelchair. 4. During an interview on 2/20/25 at 3:08 P.M., MDS Coordinator said: -The facility had care plan meetings; -Social Service designee sent out care plan meeting letters to families and hospice monthly; -Social Service designee would notify residents of their care plan meetings by handing them a letter; -The facility did not have any documentation when a resident did not want to attend their care plan meeting; -The facility did not have any written documentation showing who participated in care plan meetings; -He/She expected resident's care plans to reflect the resident's current level of care status. During an interview on 2/20/25 at 3:20 P.M., Social Services Designee said: -He/She sent letters out to resident families or DPOA the month prior to the designated care plan meetings; -When residents were their own person they would hand deliver a letter about the care plan to the resident; -The care plan letters that were sent by facility did not have a designated date and time of meetings; -The letters only indicated that the DPOA could call if they wanted to have a meeting; -MDS Coordinator would document when care plan meetings were held; -He/She did not write care plans; -Care plans were not occurring quarterly with each resident; -Care plans only occurred if the DPOA requested the meetings; -Care plans should be updated with any new interventions to the residents cares; -The resident's care plan should be updated more frequently if significant changes occur with the resident. During an interview on 2/21/25 at 1:15 P.M., Director of Nursing said: (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-She expected care plan meetings to be offered quarterly and as needed with changes; -She expected residents to be invited to their care plan meetings; -Majority of their residents did not want to participate in their care plan meetings; -Facility staff have had care plan meetings every week; -Facility staff did not document those care plan meetings; -Facility should document if resident was invited to their care plan meeting and declined to participate in the meeting. -She expected care plans to be individualized and be current to residents care needs; -She expected that by looking at the resident's care plan; they could tell whom that resident was, and what care was needed to be provided to the resident. 31102 5. Review of Resident #6's Quarterly MDS, dated [DATE], showed: - Cognitive skills moderately impaired; - Lower extremity impaired on one side; - Dependent on the assistance of staff for toilet use, showers, dressing, personal hygiene, and transfers; - Always incontinent of bowel and bladder; - One fall, no injury; - Diagnoses included stroke, depression, hemiplegia (paralysis affecting one side of the body) and chronic obstructive pulmonary disease (COPD, obstruction of air flow that interferes with normal breathing). Review of the resident's care plan, revised 2/7/25 showed: - The last care conference was 10/31/24; - The next care conference was scheduled for 1/24/25. During an interview on 2/18/25 at 10:59 A.M., the resident said he/she was not for sure if they had been invited to or attended their care plan meeting. 6. Review of Resident #12's Admission MDS, dated [DATE], showed: (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Cognitive skills moderately impaired; - Required partial to moderate assistance for toilet use, dressing and personal hygiene; - Required supervision or touch assistance with transfers; - Occasionally incontinent of urine; - Always continent of bowel; - No falls; - Diagnoses included depression, high blood pressure, arthritis, and atrial fibrillation (A-fib, an irregular heartbeat that occurs when the electrical signals in the atria (the two upper chambers of the heart) fire rapidly at the same time). Review of the resident's care plan, revised 11/26/24, showed the plan did not address when the resident's care conference was scheduled. During an interview on 2/18/25 at 11:18 A.M., the resident said he/she was not for sure if they had been invited or attended their care plan meeting. During an interview on 2/20/25 at 8:25 A.M., the MDS/Care Plan Coordinator said: - He/she was not for sure if Resident #12 had attended any care plan meetings; - He/she did not document if the resident was invited or if they attended; - He/she was unable to find a care conference for Resident #12; - Resident #6 had a care conference in October and was not for sure why they did not have one in January.

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Gower Convalescent Center, Inc	323 South Highway 169 Gower, MO 64454

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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 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** 31102 Based on observations, interviews and record review, the facility failed to ensure staff provided professional standards of quality in care. when staff failed to utilize the electronic medical record to verify orders when providing wound care for one of the 18 sampled residents, (Resident #72) and when obtaining blood sugars and administering insulin for two residents (Resident #49 and #11) and additionally when staff failed to obtain physician's orders for wound treatment for Resident #5. The facility census was 78. Review of the facility's undated policy titled, Medication Administration, showed staff were directed to do the following: - Medications are administered as prescribed, in accordance with good nursing principles and practices and only by persons legally authorized to do so; - Personnel authorized to administer medications do so only after sufficient information regarding the resident's condition and expected outcomes of medication therapy is known; - Medications are prepared, administered, and recorded only by licensed nursing, medical, pharmacy, or other personnel authorized by state laws and regulations; - Medications are administered in accordance with written orders of the attending physician; - Residents are identified before medication is administered: check identification band; check photograph attached to medical record, header card, or facility approved location; call resident by name; if necessary, verify resident information with other facility personnel; - Only the licensed or legally authorized personnel who prepare medication may administer it. This individual records the administraion on the resident's Medication Administration Record (MAR) at the time the medication is given; - During routine administration of medications, the medication cart is kept in the doorway of the resident's room, with open drawers facing inward and all other sides closed. No medications are kept on the top of the cart. The cart must be clearly visible to the personnel administering medications, and all outward sides must be inaccessible to residents or others passing by; - Prior to administration, the medication and dosage schedule on the resident's MAR is compared with the medication label. Review of the facility's undated policy titled, Ten Rights for Administration of Medications, showed staff were directed to do the following: - The right resident: before preparing the medication, identify each resident according to the facility's policies and procedures; (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- The right drug: verify each drug against the MAR before administering. Verify in at least three ways, such as by the drug's size, shape, color, or label; - The right dose and dosage form: verify against the MAR. 1. Review of Resident #49's Physician Order Sheet (POS), dated 1/19/25 - 2/19/25, showed: - Order date: 7/9/21 - Accu checks (a blood glucose meter that monitors blood sugars) before meals and at bedtime for diabetes mellitus. Review of the resident's MAR, dated 1/20/25 - 2/19/25 showed and order with a start date of 7/9/21 - Accu checks before meals and at bedtime for diabetes mellitus. Review of the resident's care plan, dated 7/9/24 showed: - The resident was diabetic and took insulin at night if the resident's blood sugar was greater than 300; - Monitor blood sugars before meals and at bedtime. Observation on 2/19/25 at 11:08 A.M., showed: - At 11:15 A.M., Registered Nurse (RN) A obtained the resident's blood sugar and discarded the supplies appropriately; - RN A did not have a computer with him/her and did not verify the resident's order prior to obtaining the resident's blood sugar. During an interview on 2/19/25 at 11:18 A.M., RN A said: - He/she normally did not take the computer with him/her when obtaining blood sugars because the resident had been at the facility for so long. 2. Review of Resident #11's Care Plan, dated 1/3/25 showed:- The resident was on Fiasp insulin before meals and took Lantus (long acting) insulin at bedtime; - Monitor blood sugars before meals and at bedtime. Review of the resident's POS, dated 1/20/25 - 2/20/25, showed: - Start date: 3/20/20 - Check blood sugars before meals and at bedtime; - Start date: 11/17/24 - Fiasp Flex touch (fast acting) insulin pen, 10 units twice daily for diabetes mellitus. Review of the website, https:// www.medicalnews.com for the use of Fiasp insulin pen showed: - Fiasp is a rapid-acting insulin which should be taken at mealtimes; (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Take at the start of the meal or within 20 minutes. Review of the resident's MAR, dated 2/6/25 - 2/20/25 showed: - Check blood sugars before meals and at bedtime; - Fiasp Flex touch insulin pen, 10 units twice daily for diabetes mellitus. Observation on 2/19/25 at 11:25 A.M., showed: - Licensed Practical Nurse (LPN) A obtained the resident's blood sugar and administered insulin to the resident; - LPN A did not have a computer with him/her and did not verify the resident's order prior to obtaining the resident's blood sugar or administering the insulin. During an interview on 2/19/25 at 3:08 P.M., LPN A said: - He/she should have looked at the computer to verify the order to check blood sugars and administer the insulin; - He/she did not have a laptop, just a computer at the nurse's desk. 3. Review of Resident #72's POS, dated 1/19/25 - 2/19/25 showed: - Start date: 12/18/24, discontinue (dc) date: 1/22/25; clean wound to right posterior hip, with wound cleanser, apply collagen powder (used to promote healing and tissue regeneration) to wound bed, calcium alginate (dressings used to treat wounds with moderate to heavy drainage), cover daily and as needed; - Start date: 2/19/25 - Collagen powder to right posterior hip wound and cover daily and as needed; - The order did not specify how much Collagen powder to use. Review of the resident's MAR, dated 1/20/25 - 2/19/25 showed and order with a start date of 2/19/25 for Collagen powder to right posterior hip wound and cover daily and as needed. Review of the resident's care plan, revised 2/13/25 showed: - The resident was at risk for a pressure ulcer (damage to an area of the skin caused by constant pressure on the area for a long time) due to moisture and limited mobility. Observation and interview on 2/20/25 at 1:42 P.M., showed: - LPN B washed his/her hands at the sink at the nurse's station and donned gloves then cleaned the surface of the south treatment cart, removed gloves and sanitized; - LPN B placed a piece of foil on the cart and placed the wound supplies on it; (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- LPN B sprinkled a little bit of Collagen powder in a med cup and said they are supposed to cover the wound bed and since it is done daily, he/she knew how much to put in the cup; - LPN B took the treatment cart to the resident's room and completed the wound treatment; - LPN B said they usually look at the computer before they do the wound treatments but he/she did not do that this time; - He/She is the wound nurse though so he/she knows the orders. - LPN B did not check the computer prior to starting the wound treatment and did not have a computer during the treatment. During an interview on 2/21/25 at 12:15 P.M., the Director of Nursing (DON) said; - He/she did not expect the staff to have a tablet to to verify the orders, the staff check the orders at the computer at the nurse's desk and then do the treatments, obtain blood sugars or administer insulin; - The orders will not change while the staff are doing the blood sugars; - The nurses look at the computer all day long; - The nurses should check the orders, obtain the blood sugars, administer insulin or do the wound treatment. The nurses know what they are supposed to do. 50980 4. Review of Resident #5's Quarterly MDS dated [DATE] showed: - Admission to the facility on [DATE]; - BIMS score of 14, indicating no cognitive deficit; - Diagnoses include: Heart Failure, high blood pressure; - Requires assistance for set up and clean up for meals; - Requires assistance or set up for toileting hygiene and dressing; - Requires partial/moderate assistance for showering/bathing. - Resident requires a walker for mobility; Review of resident's progress notes dated 12/14/24 showed: (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Resident has an area on their right lower leg. It is draining a little, area cleansed A&D ointment applied and covered. Resident lower leg is red and slightly ware to touch. Resident told to elevate their leg as much as possible. The area is 1 cm x 2 cm. Review of the resident's physician order sheet (POS), dated, 2/19/25, showed no orders relating to wound care or bandage for resident's right calf; Review of the resident's medication administration record (MAR), dated, 2/1-2/19 2025, showed no record of bandage change or cares for resident's right calf wound; Review of the resident's care plan, showed: - 7/24/24 resident is on Anti-Coagulant and staff should observe for signs of active bleeding; - 7/24/24 resident is at risk for pressure ulcer and staff should perform a skin inspection every shift during cares and use moisture barrier ointments as needed; During an interview on 2/20/25 at 5:25 P.M., Primary Physician stated: - Wound was due to a dermatology issue and it was taking a long time to get an appointment from the dermatologist and he/she was aware of the situation; - Was not aware that there were no orders for the care of the bandage and wound on resident's right calf; - He/she said there should be some order for care of the wound and that they would review the issue on the next visit; During an interview on 2/21/25 at 1:30 P.M., Administrator and DON said the nursing staff are not expected to date the bandages when they are changed.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47195 Based on observation, interview, and record review the facility failed to ensure staff provided quality of care and treatment in accordance with professional standards of practice when staff failed to reposition two residents and provide incontinent care to dependent residents (Resident #47 and #72) This affected two residents out of eighteen sampled residents. The facility census was 78. Facility did not provide policy on positioning. 1. Review of Resident #47's Quarterly minimum data set (MDS), a federally mandated assessment tool completed by facility staff, dated 12/26/24, showed: - Cognition severly impaired; - Dependent on a wheelchair for mobility and dependent of staff for turning, repositioning and transfers; - Total assist of all ADLS; - Diagnoses included: Alzheimer's disease (a progressive brain disorder that causes memory loss, thinking problems, and behavioral changes), muscle weakness, and reduced mobility. Review of care plan, revised 12/6/24, showed: -Decreased mobility and required staff dependence for turning and repositioning; High risk for skin injury and pressure sores. -Inspect skin daily with cares and report potential problems. -Keep bony prominences from direct contact with one another with pillows and wedges; -Keep clean and dry as possible; -Minimize exposure to moisture; -Report any signs of skin breakdown (sore tender , red, or broken areas). Review of physician's orders, dated 2/19/25, showed: -Start date 11/11/22, heel protectors on in bed; -Start date 11/21/23, admit to hospice Observation on 2/18/25 at 10:18 A.M. showed resident up in a reclining wheelchair. Air pressure mattress observed on residents bed. Sign hanging above resident's bed showed heel protectors on while in bed. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 2/19/25 at 8:25 A.M. showed resident up in reclining wheelchair. Observation on 2/19/25 at 9:42 A.M. showed resident was sleeping and remained up in reclining wheelchair. Observation on 2/19/25 at 1:17 P.M. showed resident was was seated in reclining wheelchair at nurses station. Continuous observation on 2/20/25 at 7:40 A.M.-11:50 P.M. showed: -8:03 A.M., resident pushed down hallway by Certified Nurse Aide (CNA) F and returned to resident's room. Resident remains up in their reclining wheelchair with call light in reach. -9:05 A.M., resident remains in their reclining wheelchair, resident had not been laid down or repositioned in the chair. -9:44 A.M., observation showed hospice staff entered residents room for visit, resident was not repositioned or laid down. -10:21 A.M., resident remained up in reclining wheelchair, had not been repositioned or taken out of chair -11:49 A.M., resident remained sitting in reclining wheelchair, had not been repositioned or taken out of reclining wheelchair; -11:50 A.M., CNA E said they had no room in dining room currently for resident to be assisted to dine and resident would remain in their room. During an interview on 2/20/25 at 10:35 A.M., CNA E said Resident #47 would not get laid down until after lunch and had been up in their reclining wheelchair since prior to breakfast. During an interview on 2/21/25 at 10:24 A.M., CNA H said: -Resident #47 stayed in broda chair most of the day; did not really lay down and stayed in chair most of the day; -Resident was laid down at 8:30 A.M. and got back up right away. During an interview on 2/15/25 at 1:15 P.M., Director of Nursing (DON) said Resident #47 would need help to be repositioned by staff. During an interview on 2/21/25 at 1:15 P.M., Administrator said: -Resident #47 should be repositioned if resident allows staff; -Resident could be resistive to cares. 2. Review of Resident #72's Quarterly MDS, dated [DATE], showed: (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Cognition severly impaired and unable to make needs known; - Dependent on a wheelchair for mobility; - Total assist of all ADLS, dependent of full staff support to include incontinent care, turning, positioning and transfers; -High risk of skin injury and pressure ulcers, and did have a stage 1 or higher pressure ulcer; -Documented one stage 4 pressure ulcer- A full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present on some parts of the wound bed. Often includes undermining and tunneling; -Dcoumented 1 unstageable pressure ulcer - slough and/or eschar: known but not stageable due to coverage of wound bed by slough and/or eschar; -Had a pressure reducing device for chair, bed, were on a turning/repositioning program, nutrition or hydration intervention to manage skin problems, pressure ulcer care, application of nonsurgical dressings (with or without topical medications) other than to feet, and applications of ointments/medications other than to feet; -Received hospice care; -Diagnoses included: Alzheimer's), collapsed vertebra and unspecified pain. Review of care plan, revised 2/13/25, showed: -Staff assist resident up in reclining wheelchair for meals and as tolerated. -Resident was two assist with Hoyer lift for transfers. -Resident was at risk for pressure ulcer due to moisture and limited mobility; -He/She was incontinent of bowel and bladder; -Dependent on staff for all cares. -Laydown after every meal. -Turn and reposition at least every 2 hours and as needed. Review of physician's orders, dated 2/19/25, showed: -Started 5/6/24, admit to hospice care; -Started 2/19/25, collagen powder to right posterior hip wound and cover daily and as needed, once a day. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 2/19/25 at 1:19 P.M. showed resident up in reclining wheelchair. During a continuous observation on 2/20/25 from 8:03 A.M.-11:50 A.M., showed: -8:03 A.M., Resident pushed down to their room by CNA F and placed in their room. Resident remained in their reclining wheelchair with call light in reach; -9:33 A.M., Resident remained up in their reclining wheelchair, had not been repositioned; -10:23 A.M., Resident remained seated in reclining wheelchair, had not been repositioned; -10:48 A M., CNA B entered resident's room and reclined residents wheelchair to add a blanket between resident's legs. CNA B placed resident's reclining back in upright position. During an interview on 2/20/25 at 10:35 A.M., CNA E said: -Resident #72 was one of the residents that would stay up in their chair until after lunch; -Resident was placed in their chair prior to breakfast. During an interview on 2/21/25 at 10:24 A.M., CNA H said: -Resident #72 should be repositioned every two hours; -Resident was laying in bed now and they were about to get her back up out of bed. During an interview on 2/21/25 at 1:15 P.M., DON said Resident #72 required assistance with being repositioned and was unable to reposition themselves. 3. During an interview on 2/20/25 at 10:35 A.M., CNA E said: -Residents should be repositioned every two hours; -Residents in broda chairs were up in their chairs from before breakfast until right after lunch, then staff give residents a little nap time by laying them down, and residents come back up for dinner; During an interview on 2/20/25 at 10:51 A.M., CNA B said: -Residents should be repositioned every two hours at a minimum; -Depending on resident's orders they are sometimes repositioned sooner than every two hours. During an interview on 2/21/25 at 9:57 A.M. Licensed Practical Nurse (LPN) B said residents need to be repositioned every two hours. During an interview on 2/21/25 at 10:24 A.M., CNA H said residents should be respositioned every two hours. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 2/21/25 at 1:15 P.M., Director of Nursing said: -She expected residents to be positioned every two hours; -She expected residents in reclining wheelchairs to be offered incontinent care every two hours; -Incontinent care and repositioning offered before lunch and after lunch; -Expected repositioning to occur when residents were not able to move themselves. During an interview on 2/21/25 at 1:15 P.M., Administrator said she expected residents to be repositioned every two hours.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 47195 Based on observation, interview, and record review, the facility staff failed to ensure residents remained free from accident hazards when staff pushed residents in their wheelchairs without foot pedals for four (Resident #1, #68, #71, and #58) residents. This affected four of eighteen sampled residents. The facility census was 78. Facility did not provide a policy on accidents. 1. Review of Resident #1's Quarterly minimum data set (MDS), a federally mandated assessment tool completed by facility staff, dated 12/19/24, showed: -Cognition severly impaired; -No impairment to upper or lower extremities; -Required assistance for Activities of Daily living to include transfers, mobility, hygiene needs. -Diagnoses included: Alzheimer's osteoarthritis , low back pain, unsteadiness on feet, and dementia Review of care plan, revised 9/12/24, showed: -He/She was ambulatory with assist; -Ensure assistive devices were available and in good condition (example included wheelchair); -Ensure proper footwear when they ambulated; -Resident was at risk of falls, and recently had a fall that fractured their pelvis; -He/She had cognitive impairment and could be impulsive which increased their risk for falls; -He/She had an anti roll back device on wheelchair; Observation on 2/18/25 at 10:42 A.M. showed resident self-propelled in their room. Resident had no leg rests observed on their wheelchair. Observation on 2/19/25 at 12:26 P.M. showed Certified Nurse Aide (CNA) C pushed resident's wheelchair into the dining room. Residents tops of their feet were dragged on the floor as staff pushed resident down the hall toward the dining room. Resident observed with no foot pedals on their wheelchair. During an interview on 2/21/25 at 9:57 A.M., Licensed Practical Nurse (LPN) B said: (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Resident self-propelled themselves in their wheelchair; -Resident had an auto lock brake on their wheelchair and an anti-tip device in place because they had a history of falling when getting into their chair. During an interview on 2/21/25 at 10:24 A.M., CNA H said: -Resident could self-propel themselves in their wheelchair; -Staff would push resident without foot pedals because resident could hold their feet up. During an interview on 2/21/25 at 12:15 P.M., Director of Nursing (DON) said: -Resident could walk and took off on their own in their wheelchair; -The resident should not have foot pedals on their wheelchair because resident could hold their feet up while being pushed in wheelchair. 2. Review of Resident #58's quarterly MDS, dated [DATE], showed: -Cognition severly impaired; -He/She had no upper or lower extremity impairment; - Dependent on a wheelchair; -Required substantial or maximal assistance with toileting, bathing, lower body dressing putting on and off footwear, rolling left and right, sit to lying, lying to sitting on side of bed, sit to stand transfers, chair to bed transfers, tub transfers, and toilet transfers; - Required partial to moderate assistance wheeling fifty feet with two turns in wheelchair; -Diagnoses included: dementia, Alzheimer's Disease, and muscle weakness. Review of care plan, revised 8/29/24, showed: -Resident used their wheelchair for mobility and propelled themselves, resident would loose their way so staff needed to assist them; -Resident needed assistance to their destinations during the day; -He/She had dementia and did not ambulate, but propelled themselves in their wheelchair. Observation on 2/19/25 at 10:13 A.M. showed resident being pushed by CNA D down center hall without foot pedals on their wheelchair. Observation on 2/19/25 at 1:13 P.M. showed LPN C pushed resident out of dining room with no foot pedals on resident's wheelchair. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 2/20/25 at 7:27 A.M. showed CNA E pushed resident out of their room with no foot pedals and proceeded to push resident from their room to the dining room. During an interview on 2/21/25 at 10:24 A.M., CNA H said: -Resident held their feet up well while staff were pushed them in their wheelchair. During an interview on 2/21/25 at 9:57 A.M., LPN B said: -Resident would self-propel in their wheelchair; -Resident had no falls from their wheelchair. 3. Review of Resident #68's Quarterly MDS, dated [DATE], showed: - Cognition was severely impaired; -He/She had functional limitation in range of motion on both sides of lower extremities; -He/She was dependent on a wheelchair; -He/She was dependent for mobility of sitting to lying, lying to sitting on side of bed, sit to stand, chair to bed transfers, toilet transfers, and tub/shower transfers; -Resident required substantial/maximal assistance rolling left and right; -Diagnoses included: dementia, advanced age, unspecified pain. Review of care plan, dated 1/20/25 , showed: -He/She had senile degeneration of the brain and dementia, were not able to bare weight anymore, and their legs were contracted at the knees; -Resident relied on others for their needs and cares; -Was at risk for falls and had a history of falls with fractures; -Took medication that could affect their level of consciousness, and had dementia with lack of safety skills; -Staff to ensure foot rests were set aside when not being propelled. Observation on 2/18/25 at 10:26 A.M. showed resident's foot pedal was observed under the sink in their resident room. Observation on 2/18/25 at 11:17 A.M. showed resident was sitting in front of nurses station with no foot pedals on their wheelchair. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Gower Convalescent Center, Inc	323 South Highway 169 Gower, MO 64454

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 2/19/25 at 10:00 A.M. showed CNA F pushed resident from dining room to nurses station. Resident had no foot pedals on their wheelchair. Feet were on the ground as they was pushed. Resident was wearing socks and white sandals. Observation on 2/19/25 at 2:08 P.M. showed CNA D pushed resident down hallway to their room. Resident did not have foot pedals on their wheelchair. Residents feet were observed touching the floor. Resident taken into their bedroom. Observation on 2/19/25 at 2:17 P.M. showed CNA D pushed resident out of their room and down the hallway with no foot pedals on their wheelchair. Resident was placed in front of nurses station. Residents feet were observed moving back and forth in a walking motion as resident was pushed down the hallway. Observation on 2/20/25 at 8:53 A.M. showed hospice staff A pushed resident down hallway to their room with no foot pedals on residents wheelchair. Observation on 2/20/25 at 9:32 A.M. showed hospice staff B pushed resident out of their room in their wheelchair, their feet were observed skimming across the floor as they pushed resident down hallway toward the nurses station. During an interview on 2/21/25 at 10:24 A.M., CNA H said: -Resident could not keep their feet up very well; -Resident had foot pedals on their wheelchair. Observation on 2/21/25 at 9:57 A.M., showed LPN B said: -Resident would self ambulate in their wheelchair; -Resident slid out of her chair on 2/7/25 and it was determined that the foot pedals were the cause of the fall. 4. Review of Resident #71's Admission MDS, dated [DATE], showed: -Severe cognitive impairment; - Did not use a mobility device; - Independent with walking up to 150 feet; - Independent with chair to bed transfers and sit to stand transfers; Diagnoses included: Dementia, displaced fracture of seventh cervical vertebra (a broken bone in the seventh cervical vertebra in the neck), anxiety, and history of falling. Review of care plan, dated 2/6/25, showed: (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- He/She would wander safely within specified boundaries; - Resident was at risk for falls; - Walked independently and had dementia, and required staff to remind them to use their walker; - Had difficulty processing information due to dementia and get easily distracted; -Required staff to set up, cueing, support and assistance level for activities of daily living; -There was nothing care planned regarding use of wheelchair. Observation on 2/19/25 at 9:33 A.M. showed LPN A pushed resident from dining room to nurses station without foot pedals on their wheelchair. Observation on 2/19/25 at 9:57 A.M. showed resident was pushed by hospice staff without foot pedals to shower room. Observation on 2/19/25 at 11:28 A.M. showed CNA C pushed resident down hallways to nurses station without foot pedals on wheelchair. Observation on 2/20/25 at 12:48 P.M. showed Social Services Designee pushed resident out of dining room with no foot pedals on residents wheelchair. During an interview on 2/21/25 at 9:57 A.M., LPN B said the resident would self-propel in their wheelchair. During an interview on 2/21/25 at 10:24 A.M., CNA H said: -Resident could hold their feet up well when staff push them in their wheelchair; -Resident could self-propel themselves in their wheelchair. 5. During an interview on 2/20/25 at 10:35 A.M., CNA E said: -Some residents could hold their feet up on their own and push themselves around -Before we move a resident without their foot pedals we ask the resident if they could hold their feet up; -Staff would make sure the residents foot pedals are out; -Residents should have foot pedals when being pushed in their wheelchairs; -They sometimes could not locate foot pedals because residents would hide their foot pedals under their beds. During an interview 2/20/25 at 10:51 A.M., CNA G said: (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Residents could be pushed without foot pedals on their wheelchairs if the resident could hold their feet up; -He/She knew which residents were able to hold their feet up on their own; -A resident would ask for foot pedals when they felt they needed them by saying they were weak on that day; -He/She did not worry about residents hurting or falling cause they would notify staff if they needed their foot pedals; -Foot pedals were not something on the care cards they use for knowing resident specific cares; During an interview on 2/21/25 at 9:57 A.M., LPN B said: -Residents could be pushed in their wheelchairs without foot pedals if the resident could hold their feet up; -Many residents self-propelled themselves in their wheelchairs; -Foot pedals could create a fall hazard for some residents to have them on their wheelchairs. During an interview on 2/21/25 at 10:24 A.M., CNA H said: -Foot pedal use was dependent on whether the resident could lift their feet for facility staff while they pushed them. During an interview on 2/21/25 at 1:15 P.M., Director of Nursing (DON) said: -The facility had multiple residents who self-propel themselves in their wheelchairs; -He/She expected residents being pushed in their wheelchairs and was dependent on staff for mobility had the ability to hold their feet up; -Foot pedals on wheelchairs should be individualized per resident preference; -Residents could obtain skin tears from their foot pedals and it could increase the residents fall risk by having foot pedals on their wheelchair. During an interview on 2/21/25 at 1:15 P.M., Administrator said: -The expectation for residents having foot pedals on their wheelchairs was dependent on the individual resident situation; -She had multiple residents who obtained skin tears as a result of their foot pedals.

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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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50980 Based on observation, interview and record review, the facility failed to ensure staff provided proper respiratory care when staff failed to date when oxygen tubing was cleaned and left oxygen tubing lying on the ground for two residents (Resident #44, #21) resulting in possible exposure to bacteria during oxygen usage. Additionally the facility failed to keep water in the oxygen humidifier for proper humidity control for one resident (Resident #44) resulting in minor discomfort. This affected two of 18 sampled residents. The facility census was 78. Review of the facility's Oxygen administration policy not provided; 1. Review of Resident #44's Annual Minimum Data Set (MDS, a federally mandated assessment completed by the facility staff), dated 12/2/24, showed: - Cognitive skills intact; - Minimal difficulty hearing, clear speech, makes self understood, has clear comprehension, and impaired vision; - Diagnoses: Anemia, heart failure, high blood pressure, diabetes, seizure disorder, asthma, and cataracts. Review of the resident care plan, revised 12/3/24, showed: - Resident requires oxygen therapy with exertion due to dyspnea (shortness of breath) on exertion, COPD (chronic obstructive pulmonary disease). Staff will administer oxygen at 2L via nasal canula during exertion; - Oxygen per physician order 12/2/24 Review of the resident's Physician Order Report, dated 1/19 - 2/19/25, showed an order for Oxygen 2 Liters per nasal cannulat and adjust to keep O2 saturation percentage over 90% with exertion; Review of the resident's Medications Administration History, dated 1/1 - 2/19/25, showed: - No record of Oxygen administration or cleaning of tubing; Review of the resident's Treatment's Administration Record, dated 1/1 - 2/19/25, showed: - No record of Oxygen administration or cleaning of tubing; Observation on 2/18/25 at 4:09 P.M. showed: - Oxygen tubing lying on the resident's floor, water container in oxygen humidifier 1/3 full, no dates on tubing or water bottle indicating last change or cleaned date; (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation and interview on 2/21/25 at 8:55 A.M. showed oxygen tubing lying on the resident's floor, water container completely empty while resident is using the oxygen humidifier and oxygen tubing is inserted in resident's nose; - The resident said their nose hurt slightly due to it being very dry; 2. Review of Resident #21's Significant Change in Status MDS, dated [DATE], showed: - Resident was cognitively moderately impaired; - Independent for eating; - Set-up assistance for oral hygiene; - Partial/moderate assistance for toileting, bathing, and dressing; - Supervisor for personal hygiene; - Diagnosis: atrial fibrillation (heart rhythm disorder), coronary artery disease (condition in which the arteries that supply blood to the heart become narrowed or blocked), heart failure, peripheral vascular disease (narrowing and blockage of arteries), GERD (acid reflux), MRDO (resistant to multiple antibiotics), diabetes (chronic disease when body can't produce insulin), hyperlipidemia (high cholesterol); Review of resident's care plan, revised 2/11/25, showed no care planning for oxygen therapy at night; Review of resident physician orders dated 11/29/24, showed an order for O2 2L/NC while sleeping, no end date; Observation on 2/21/25 at 9:10 A.M. showed oxygen tubing lying on the ground with nose cannula completely exposed and making contact with the dirty surface of the floor. No dates of last tube change or cleaning were taped to the tubing; During an interview on 2/20/24 at 12:45 P.M., CMT B said maintenance cleans the filters on the oxygen humidifiers in resident's rooms. Tubes and water cannisters get cleaned weekly. There are orders on the MAR or TAR to change and date the tubing. Tubing is not to be left on the floor and staff are to Ziplock bag the tubing so it doesn't touch the floor. The proper name for the device is an O2 nasal cannula. Water level should be at least above the minimum line on the water cannister and the water helps prevent residents from getting a bloody nose from dry oxygen; During an interview on 2/21/24 at 1:30 P.M., the administrator and DON said: - Oxygen tubing and nasal cannula should not be on the ground; - When oxygen tubing is cleaned or changed staff should put a piece of tape with their initials and date to show when it was changed;

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. 31102 Based on observation, interview, and record review, the facility failed to ensure staff maintained a medication error rate of less than five percent when nursing taff made two medication errors out of 25 opportunities for error, which resulted in a medication error rate of 8%, which affected two of the 18 sampled residents, (Resident #64 and #11). The facility census was 78. Review of the facility's undated policy titled, Medication Administration, showed staff were directed to do the following: - Medications are administered as prescribed, in accordance with good nursing principles and practices and only by persons legally authorized to do so; - Personnel authorized to administer medications do so only after sufficient information regarding the resident's condition and expected outcomes of medication therapy is known; - Medications are prepared, administered, and recorded only by licensed nursing, medical, pharmacy, or other personnel authorized by state laws and regulations; - Medications are administered in accordance with written orders of the attending physician; - Residents are identified before medication is administered: check identification band; check photograph attached to medical record, header card, or facility approved location; call resident by name; if necessary, verify resident information with other facility personnel; - Only the licensed or legally authorized personnel who prepare medication may administer it. This individual records the administration on the resident's Medication Administration Record (MAR) at the time the medication is given; - During routine administration of medications, the medication cart is kept in the doorway of the resident's room, with open drawers facing inward and all other sides closed. No medications are kept on the top of the cart. The cart must be clearly visible to the personnel administering medications, and all outward sides must be inaccessible to residents or others passing by; - Prior to administration, the medication and dosage schedule on the resident's MAR is compared with the medication label. Review of the facility's undated policy titled, Ten Rights for Administration of Medications, showed staff were directed to do the following: - The right resident: before preparing the medication, identify each resident according to the facility's policies and procedures; - The right drug: verify each drug against the MAR before administering. Verify in at least three ways, such as by the drug's size, shape, color, or label; (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- The right dose and dosage form: verify against the MAR. 1. Review of the website, https://www.clevelandclinic.org for the administration of artificial tears showed: - Wash your hands; - Tilt your head backward, look up and pull down your lower eyelid with your finger; - With the other hand, position the bottle over your open eye and squeeze out the correct number of drops; - Don't touch the tip of the bottle or let it touch your eye; - Close your eye and keep it closed for a little while; - Put a finger on the part of your eye nearest to your nose to keep the medicine in your eye; - Avoid rubbing your eyes right after using artificial tears. Review of Resident #64's Physician's Order Sheet (POS), dated 2/5/25 - 3/5/25 showed: - Start date: 11/3/23 - Geri Care Artificial Tears, instill one drop in both eyes twice daily for dry eyes. Review of MAR, dated 2/6/25 - 2/20/25, showed: - Start date: 11/3/23 - Geri Care Artificial Tears, instill one drop in both eyes twice daily for dry eyes. Observation on 2/19/25 at 8:57 A.M., showed: - Certified Medication Technician (CMT) A washed his/her hands, and donned gloves; - The resident pulled down both lower eyelids; - CMT A placed one drop in the left eye and one drop in the right eye; - The tip of the eye dropper touched the resident's eye lids and eye lashes; - The resident closed his/her eyes for 30 seconds; - CMT A removed gloves and washed his/her hands. During an interview on 2/19/25 at 12:18 P.M., CMT A said: - The tip of the eye dropper should not touch the resident's eye lids or eye lashes. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 2/21/25 at 12:15 P.M., the Director of Nursing (DON) said: - The tip of the eye dropper should not touch the eye lid or eye lashes. 2. Review of the website, https:// www.medicalnews.com for the use of Fiasp insulin pen showed: - Fiasp is a rapid-acting insulin which should be taken at mealtimes; - Take at the start of the meal or within 20 minutes. Review of Resident #11's plan, dated 1/3/25 showed: - The resident was on Fiasp insulin before meals and took Lantus (long acting) insulin at bedtime; - Monitor blood sugars before meals and at bedtime. Review of the resident's POS, dated 1/20/25 - 2/20/25, showed: - Start date: 3/20/20 - Check blood sugars before meals and at bedtime; - Start date: 11/17/24 - Fiasp Flex touch (fast acting) insulin pen, 10 units twice daily for diabetes mellitus. Review of the resident's MAR, dated 2/6/25 - 2/20/25 showed: - Check blood sugars before meals and at bedtime; - Fiasp Flex touch insulin pen, 10 units twice daily for diabetes mellitus. Observation on 2/19/25 at 11:31 A.M., showed: - Licensed Practical Nurse (LPN) A obtained the resident's blood sugar which was 243; - At 11:43 A.M., LPN A administered Fiasp insulin, 10 units to the resident and informed the dietary staff the resident had taken his/her insulin; - At 12:14 P.M., the resident had his/her tray and started eating, 31 minutes after he/she received the fast acting insulin. During an interview on 2/19/25 at 3:08 P.M., LPN A said after the resident received fast acting insulin, they should be served a meal within 15 minutes. During an interview on 2/21/25 at 12:15 P.M., the DON said the resident should be served their meal immediately after getting the insulin.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50980 Based on observation, interview and record review, the facility failed to store medications in a locked storage area to ensure medications for two residents (Residents #5, #44) were inaccessible to unauthorized staff and residents and failed to keep medications secured when the key was left in the lock of the medication treatment cart. Additionally the facility, failed to destroy expired and loose medications in the medication room and cart. This affected two out of 18 sampled residents. The facility census was 78. Review of facility Policy and Procedure for Physicians Orders, revised 1/15/12, showed - An interdisciplinary team determines the resident's ability to self-administer medications by means of a skill assessment; - If the resident demonstrates the ability to safely self-administer medications, a further assessment of the safety of bedside medication storage is conducted; - A physician order is obtained to self-administer medications if the storage and skill assessment has been approved for the resident by the interdisciplinary team. The order is recorded on the Medication Administration Record (MAR); - Noncompliant residents are informed by the nurse or nurse supervisor that they may not self-administer medications or treatments; -Update the residents care plan quarterly of the resident's knowledge and ability to self-administer medications; Review of facility policy, medication storage in the facility, undated, showed: -Medications and biologicals are stored safely, securely, and properly following the manufacturer or supplier recommendations. The medication supply is accessible only to licensed nursing personnel, pharmacy personnel, or staff members lawfully authorized to administer medications. -Medication carts are locked or attend by person with authorized access;; -External medications including ointments for skin irritations and medication for application to wounds should be kept in a treatment cart, or in a separate drawer in the medication cart which is labeled as such. 1. Review of Resident #44's Annual Minimum Data Set (MDS, a federally mandated assessment completed by the facility staff), dated 12/2/24, showed: - Cognitive skills intact; (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Minimal difficulty hearing, clear speech, makes self understood, has clear comprehension, and has impaired vision; - Independent for eating, oral hygiene, and toileting; - Substantial/maximal assistance needed for bathing and dressing - Diagnosis: Anemia (blood disorder), heart failure, hypertension (high blood pressure), GERD (acid reflux), pneumonia, diabetes, hyperlipidemia (high cholesterol), seizure disorder, asthma (chronic lung disease), cataracts (clouding of the lens of the eye): Review of resident's care plan dated, 12/3/24, showed: - Resident's vision is highly impaired due to Macular degeneration and Glaucoma; - No record of resident being allowed to self-administer medications; Review of resident's Physician Order Report (POR), dated 1/19 - 2/19/25, showed: - No orders for Refresh eye drops; Observation of resident room on 2/20/25 at 7:46 AM., showed: - 0.5 oz bottle of Refresh Tears at bedside within reach of resident; During an interview on 2/20/25 at 7:48 A.M., the resident said: - His/her daughter [NAME] the bottle around 1/21/25 after a medical procedure and that he/she uses the medication when their eyes get dry; 2. Review of Resident #5's Quarterly MDS dated [DATE] showed: - Admission to the facility on [DATE]; - Cognition intact; - Diagnoses include: Heart Failure, Hypertension (high blood pressure); - Requires staff to provide medications. Review of Resident care plant revised, 1/17/25, showed: - No orders for self-administrator of medication; Observation of resident room on 2/20/25 at 11:15 A.M., showed: - One plastic med cup sitting in front of the resident containing 3 pills (2 white and 1 blue); (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 2/20/25 at 11:16 A.M., resident said: - Staff came into his/her room and gave them their morning medication and when he/she asked the staff member what pills they were, the staff member did not reply and left the room; - The resident said he/she would not take the last three pills until they knew what they were; During an interview on 2/20/25 at 11:45 A.M., CMT B said: - Medications at beside are not allowed unless the resident has an order and this would apply even to over the counter medications; - If he/she saw medications at bedside they would confiscate them and put them in the med storage room; - He/she administered medications to Resident #5 on the morning pass of 2/20/25 and had given the resident their medications. He/she left the room thinking the resident had taken all of their pills but said they must have been mistaken since the resident still had 3 pills at bedside when the surveyor entered the room at 11:15 A.M. that same morning; - He/she said the CMT is supposed to make sure the resident takes all of their medications prior to leaving the room or take them and destroy them if the resident refuses to take the medication; During an interview on 2/21/25 at 12:15 P.M., the DON said: - They would not expect resident's to have over the counter medications at bedside without an order; - They would expect resident's without a bedside order for medications to take all of their medications before the med tech leaves the room; 47195 3. Observation on 2/18/25 at 11:14 A.M. showed the medication treatment cart was left with key in the lock. Cart is located parked outside nurses station and no staff was observed near the cart. There was a sharps container resting on top of the medication treatment cart. Observation on 2/18/25 at 11:16 A.M. showed Licensed Practical Nurse (LPN) C obtained cart with key in it and pushed medication treatment cart down 200 hallway to a resident room. Observation on 2/18/25 at 2:45 P.M. showed medication treatment cart is parked beside nurses station with key left in the lock. No staff observed near the medication cart. During a continuous observation of medication treatment cart on 2/19/25 at 9:35 A.M.-10:35 A.M., showed: (continued on next page)

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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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-9:35 A.M., showed medication treatment cart was left with key in lock on unit. Staff were observed sitting down at nurses station. Medication treatment cart was outside of nurses station accessible to residents. -9:36 A.M., showed LPN A obtained treatments from cart, removed key from cart. Key was observed left hanging on blue lanyard on side of trash can on the cart. -9:44 A.M., Observation showed key in treatment cart - blue lanyard in the key lock. -10:02 A.M. showed medication treatment cart was left unattended with key in the lock of the medication cart. LPN A observed walking up to the treatment cart and obtained a topical cream out of cart. LPN A walked away from cart and left key remaining in treatment cart. -10:10 A.M., key to cart remained in lock of medication treatment cart, no staff members near cart; -10:22 A.M., key to cart remains in lock of treatment cart with no staff members directly at cart; -10:27 A.M., LPN A returned to medication treatment cart. LPN A opened cart, cut off ace bandage with scissors, and removed key from the lock of cart. Key was left hanging on side of cart from trash can on a blue lanyard. Observation on 2/19/25 at 2:33 P.M. showed medication treatment cart had key left in lock with no staff around medication cart. Observation on 2/20/25 at 11:53 A.M. showed the medication treatment cart had key left in lock, the blue lanyard remains attached to the key to the side of the cart. No staff near cart or accessing treatment cart. The medication cart was parked outside of nurses station. Observation on 2/20/25 at 3:18 P.M. showed key was left in treatment cart on lanyard, no staff observed near the cart. Observation on 2/21/25 at 9:56 A.M. showed treatment cart was unattended with key left in the lock on cart. The key remains attached to blue lanyard which lanyard connects to side of cart by trash can. During an interview on 2/21/25 at 9:57 A.M., LPN B said: -The medication treatment cart key should no be left in treatment cart lock; -The treatment cart contained medicated treatments; -The facility always left the key hanging on the side of the treatment cart. During an interview on 02/21/25 10:47 A.M., LPN A said: -Medication treatment card should be locked; -Licensed Nursing staff should not leave the key stuck in treatment cart lock; (continued on next page)

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	265800	A. Building B. Wing	02/21/2025

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-The medication treatment cart should not be left unlocked and unattended; -He/She always leaves the key hanging on side of treatment cart on blue lanyard. During an interview on 2/21/25 at 1:15 P.M., Director of Nursing said: -She expected the medication treatment cart to be secured and locked when it was unattended; -Staff should be within arms reach if it the medication treatment cart was left unsecured; -She expected the medication cart key not be left in the lock and the cart to be unattended; -The treatment key could be left hanging on the medication treatment cart if staff was standing at the treatment cart perparing a medication treatment; -She expected staff to pull key out of the lock when they were not at treatment cart. 31102 4. Observation on 2/19/25 at 8:19 A.M., of the North medication cart and the North medication room showed: - One loose oblong while capsule in the medication drawer; - Resident #44 had an opened bottle of Age Related Eye Disease Studies (AREDS), an eye vitamin and mineral supplement, expired 1/25; - Resident #44 had an opened bottle of Coreg 3.125 milligrams (mg.) (used to treat high blood pressure), expired 1/16/25. During an interview on 2/19/25 at 12:18 P.M., Certified Medication Technician (CMT) A said: - The CMTs check the medication carts and the medication rooms at least weekly and the pharmacist comes in monthly; - Should not have any loose pills in the medication drawer, it should be destroyed; - Should not use expired medications, they should be destroyed. During an interview on 2/21/25 at 12:15 P.M., the DON said there should not be any loose pills or expired medication in the medication carts or the medication rooms, they should be destroyed.

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50980 Based on observation, interview and record review, the facility failed to store, prepare and serve food in accordance with professional standards of food service safety when staff failed to date the receipt of incoming products in the dry storeroom, label and date used products in the freezer and refrigerator, label, date and dispose of leftovers in the refrigerator, monitor refrigerator and freezer temperatures on a daily basis, and follow sanitation requirements for cleanliness, handwashing and hairnets in the kitchen and dining room. This affected all residents by putting them at risk for a food borne illness. The facility census was 78. Review of facility policy Hair Restraints for Dining Service, revised [DATE], showed: - Hair restraints shall be worn by all Dining Services staff when in food production, dishwashing areas or when serving food from the steam table. Hair restraints must be worn in the kitchen at all times; - Hair restraints, hats, and/or beard guards shall be used to prevent hair from contacting exposed food, any facial hair that is longer than the eyebrow shall require coverage with a beard guard in the production and dishwashing areas; Review of facility policy Food Storage, revised [DATE], showed: - All food will be stored on shelves. No food will be stored directly on any floor surface; - Perishable foods will be stored either in the walk-in cooler/refrigerator or the freezer. Cooler will maintain a temperature of ,d+[DATE] degrees F, freezer will be maintained at 0 degrees F; - All food stock will be rotated and consumed in the sequence obtained, First in - First out; - All opened or prepared foods will be stored in air tight/ sealable containers; - All containers will be labeled and dated; - Quality Control: the temperature of both the cooler and freezer will be checked twice daily, a log will be maintained to record the temperatures, the Dietary Manager (DM) will verify that these checks are done; - Food storage areas will be checked on a weekly basis to ensure that foods are being dated when opened and foods are being discarded in a timely manner. All food dates will be checked prior to each use; - Food Storage Times: Cooked meat or poultry (3 days), luncheon meat opened (4 days), Juices & Fruit Drinks (7 days) 1. Continuous observation in the kitchen on [DATE] showed: (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	- 8:45 A.M. hand washing station did not have paper towels to dry hands off; Food Prep Area: - (5) Bags of cereal opened with no dates or labels; - Plastic cups stored face up; - Floor need middle area near stove has old food debris and stains; - Top of dishwasher has dirt buildup; - (6) Broken tiles throughout kitchen area, trip hazard and sanitation issue; - Sauerkraut in colander/strainer has loose metal strainer wires exposed and the metal sealing around the utensil is coming off which can house bacteria, metal introduction into food, and safety issue; - Weekly cleaning schedule posted but is blank for ,d+[DATE] and ,d+[DATE] and shows not completed; - 11:30 A.M. [NAME] (B) does not have beard covered with hair net; - Kitchen area very cluttered and unorganized with (3) carts blocking a door; - Kitchen prep area has very little working surfaces due to utensils and dishware not stored and taking up space; - Broken ice chest with various random items stored in it lying on top of a clean dish cart; - The temperature log for the refrigerator and freezer are not up to date; Dry Storeroom: - Bag of rice opened and undated; - Bag of graham cracker crumbs, opened and undated; - Box of sprinkles, opened and undated; - 1000 island dressing containers (3) no receipt dates; - Dented can of nacho cheese used to hold door open to storeroom; - Single servings of applesauce loose with no dates; - No dates on Oreo cookie case boxes, honey bun case boxes, or Ritz bits cracker case boxes, unable to determine if first in first out is followed by this receipt and storage system; (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	- (3) large plastic containers of heavy-duty mayo no dates; Freezer - Opened, resealed fish parts no label or date; - Red raspberry sherbet opened, no date; - Loose bags of peas (5), green beans (10), brussel sprouts (5), unopened, no dates; - Frozen french fries, resealed no dates; - Large frozen turkey in corner of freezer lying on the floor; - Bowl of single serving sherbet on the ground, no label or covered; - Single serving package of pudding on the ground; - Box of pork chops uncovered and exposed in box to air; - Frozen meat raw on the ground; - (2) single serving sherbet on ground under rack; - No thermometer to read in the freezer to record temperature; Refrigerator - Virginia ham package 32oz undated; - [NAME] onion (raw and rotten) hanging off shelf grid; - Leftover expired corn beef dated ,d+[DATE] (12 days old); - Leftover expired oven roasted turkey breast dated ,d+[DATE] (5 days old); - (3) cannisters of cottage cheese no dates unopened; - Leftover expired thick and easy nectar opened ,d+[DATE] (13 days old); - Spilled oil under three storage racks; Continuous observation in the ,d+[DATE] hall dining room on [DATE] showed: - 12:04 P.M. Staff member in dining room wipes mouth with the back side of their gloved hand, continues serving; (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	- 12:07 P.M. Dietary staff passing trays to residents wearing gloves and not changing them between each tray of food passed out. Staff member touches back of he chair, a wheelchair and then enters kitchen to pour drinks and opens and closed the refrigerator without hand washing; - Dishwasher (A) in kitchen has a beard cover that is positioned under the beard and not covering the exposed hair; - Staff member in kitchen has a beard cover but it does not cover moustache or sideburns; - Dietary staff resting their gloved hands-on serving surfaces between residents; - 12:09 P.M. Staff are not changing gloves or sanitizing between serving resident meals; - 12:10 P.M. CNA (I) assisting resident in drinking bends over resident's food cups and staff member's beard is touching resident's straw that is in one of their food cups; - 12:22 P.M. Dining Assistant (B) comes out of kitchen and serves resident, goes back to the serving counter still wearing gloves and does not wash hands upon entry to kitchen. CNA (I) comes out of kitchen and serves resident, re-enters kitchen, does not wash hands, still wearing same gloves; - 12:23 P.M. CNA (I) waiting for next tray and still hasn't washed hands, goes back into the kitchen and gets a new plate and serves resident and returns to kitchen, no hand washing; - 12:33 P.M. CNA (I) continues to enter and exit kitchen serving meals and not washing hands or changing gloves; Continuous observation in the ,d+[DATE] hall dining room on [DATE] showed: - 12:10 P.M. CMT (B) without gloves on or washing their hands touched a resident's silverware to help them to eat; - 12:21 P.M. Ice water pre-staged in dining room are in glasses which are not covered and open to the air and dust; Continuous observation in the ,d+[DATE] hall dining room on [DATE] showed: - 11:56 A.M. Dining Assistant (A) pushed food cart from kitchen to dining room with gloved hands, handled dirty electrical cord at bottom of cart and plugged it into socket. Started serving drinks to residents without washing hands or changing gloves; - Dining Assistant (A) served residents fresh fruit cups at a table and left to serve another table. Residents from the first table said they didn't want the cups so the Dining Assistant (A) removed the two fruit cups and put them back into the stock of fruit cups that were handled out to the rest of the residents; Continuous observation in the kitchen on [DATE] at 9:10 A.M. showed: - Dented can still holding open door to storeroom; (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	- Monday morning cleaning log now signed off, ,d+[DATE], ,d+[DATE], & ,d+[DATE] cleaning log is blank as completed; - (4) carts around dishwashing station causing a cluttered environment with trip hazards; - Tubing from the sanitizer next to the stove is unconnected and lying on the floor in the walking path, trip hazard; - Front and side of stove has dried food stains on the surfaces and appears not cleaned for some time; Storeroom [ROOM NUMBER] - Bread on trays with no receipt dates; - (5) 5lb containers of peanut butter, no dates; - Dirty dust mop stored next to bottled water and bread; - Plastic ware utensils stored on shelf open and not covered; Refrigerator - Opened and resealed turkey meat no dates; - Carton of whipping cream unsealed with no date; - Snack box of cheese sticks, fresh fruit and Ensure boxes with no dates on the non-fruit items; Continuous observation during lunch preparation in the kitchen on [DATE] showed: - 10:20 A.M. no paper towels at the hand washing station; - Bread stored on top of menu books against the wall; - DM enters kitchen from hallway without hand washing and picks up dessert containers of food and stores them; - Dining Assistant (B) washes hands at washing station but turns off faucet with bare hand contaminating his/her hands in the process because there were no paper towels; - Dining Assistant (C) changed gloves but did not wash hands; - 10:45 A.M. [NAME] (A) pulls up pants with gloved hands then touches frozen/defrosting meat in sink, puts on new pair of gloves without washing hands; - [NAME] (A) working with raw meat while wearing gloves, removes gloves and grabs tin foil to cover meat without washing hands, outside of tin foil is now contaminated; (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview conducted on [DATE] at 10:05 A.M., the DM said: - They expect that daily cleaning is done and deep cleaning is conducted every 3 months by wiping down walls and shelves and getting behind equipment; - The cooks, aides and the DM are doing the daily cleaning and expectations are that equipment, countertops and floors are cleaned including the steam table and sweeping and moping the floors; - If the cleaning log is not signed off the DM doesn't know if the daily cleaning has been completed; - The policy on dented cans is to not use them but they don't put any marking on them and there's nothing to stop someone from grabbing the dented can holding the door open and using it when the DM is not around; - It is expected that no food items will be stored on the ground and all incoming material is put away in two hours; - It is expected that received dates are put on all items incoming into the storeroom; - Opened boxes of cans and food also get a date when the case carton is opened; - All refrigerator and freezer temperatures are monitored by the administrator and maintenance through a computer system and they no longer record temperatures daily or check to see if the food temperatures are being maintained visually; During an interview on [DATE] at 1:45 P.M., Dietician said: - Would expect kitchen surfaces and floor to be cleaned daily; - Would expect the pathways through the kitchen to be free of clutter and trip hazards; - Would expect refrigerators, freezers and storerooms to not have food containers or items on the floor; - Would expect packages to have open dates placed on the outside of each package; - Would expect daily temperature checks for the freezer and refrigerator to be monitored and recorded daily one to two times; - Would expect leftovers to be kept 3 days only before disposing of and in accordance with published policies; - Would expect all packaged food items to be labeled as to their contents; - Cups should be stored upside down; During an interview on [DATE] at 2:40 P.M., Maintenance Supervisor said: (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	- The Administrator implemented a new temperature application that monitors the refrigerator and freezer. The monitoring program is not officially online and there is no policy, but he has a phone application he can open to see the temperatures and it should send an alarm to him if the temperatures are out of specification. The system hasn't been tested as far as he knows and he doesn't check the temperatures daily or record what they are during the day; During an interview on [DATE] at 11:21 A.M., Dishwasher (A) said: - Hairnet requirements are to cover all the hair on your head including beard and mustache; - He/she has had training in hygiene, proper handling of utensils, and drink handling; - Their job covers doing the dishes, passing out halls trays and sometimes serve meals in the dining room but no food preparation; - Observation during the interview showed that Dishwasher (A) was wearing a beard net in the kitchen but did not cover up his/her moustache; During an interview on [DATE] at 1:30 P.M., Administrator said: - Staff members should wash their hands and/or don gloves prior to touching a resident's silverware to assist them in eating; - Pre-staged drinks should not be left uncovered and sitting in the dining room; - If staffs gloves become dirty, torn, or contaminated at meal service staff members need to wash their hands after taking off the gloves and put on fresh gloves; - It is expected that kitchen personnel with wear hair coverings and beard nets to cover all hair longer than their eyebrows; - Staff should wash their hands upon entering the kitchen each time; - She expects paper towels to be available at the hand washing station in the kitchen; - She expects cooking utensils to be in good repair and report to the administrator if they are not; - She expects that staff members annotate on boxes when items are received into the kitchen but if they are removed from the cartons no dates are required; - She expects leftovers to have storage dates and labels; - She expects opened containers in storage to be resealed tightly with open dates and food labels affixed; - She would not expect food items to be stored on the ground; (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	- Cans with visible dents should be sent back or disposed of immediately; - There is a temperature monitoring application in place that is not completely finished. There are sensors in the freezer and the refrigerator to notify staff when it's out of specification. It's is not completely documented in the QAQI process and no one is recording temperatures and there have been no checks to verify the temperatures are accurate between the program and the actual temperature sensors. She would not expect to have thermometers in the freezer or refrigerator anymore with the application in place. There is no plan in place if the sensors fail because there's no reason to believe that technology will fail in this process; - There will also be checks in the application to make sure daily cleaning is signed off by staff.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47195 Based on observations, interviews, and record review the facility failed to provide proper infection control when facility staff did not immediately place one resident (Resident #23) on contact isolation precautions after readmitting to the facility with a positive test for influenza (a highly contagious respiratory illness of nose, throat, and lungs) A, did not have signage in place for (Resident #23) when on transmission based precautions, and did not cover clean laundry during transportation to prevent contamination. The facility census was 78. Review of facility policy, infection prevention and control policy and program, dated 3/12/21, showed: -Staff will reference the Centers for Medicare and Medicaid Services (CMS) guide and Center for Disease Control and Prevent (CDC) guidelines. These references will serve as the facilities guidelines to infection control. Review of CDC guidance titled interim guidance for influenza outbreak management in long-term care and post-acute care facilities, dated September 2024, showed: -Ill residents should be placed on droplet precautions with room restriction and be excluded from participating in group activities as prescribed below: -Droplet Precautions should be implemented for residents with suspected or confirmed influenza for 7 days after illness onset or until 24 hours after the resolution of fever and respiratory symptoms, whichever is longer, while a resident is in a healthcare facility. -Placing ill residents in a private room. If a private room is not available, place (cohort) residents suspected of having influenza residents with one another; -Wear a facemask (e.g., surgical or procedure mask) upon entering the resident's room. Remove the facemask when leaving the resident's room and dispose of the facemask in a waste container. If resident movement or transport is necessary, have the resident wear a facemask (e.g., surgical or procedure mask), if possible. 1. Review of Resident #23's Quarterly minimum data set (MDS), a federally mandated assessment tool completed by facility staff, dated 12/11/24, showed: -Cognition intact; -He/She was dependent on a wheelchair; -He/She required substantial or maximal assistance with toileting and lower body dressing; -Resident required partial to moderate assistance with personal hygiene, bathing rolling left and right, sit to lying and lying to sitting on side of bed mobility; (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-He/She was dependent for transfers to the toilet or shower, sit to stand transfers and chair to bed transfers; -Diagnoses included: Dementia, diabetes, high blood pressure, depression and weakness. Review of physician's orders, dated 1/19/25-2/19/25, showed: -Started 2/17/25, ended 2/19/25, levogloxacin tablet (tab); 750 milligram (mg); amount (amt): 1 tab; oral, diagnosis: bronchiectasis, once a day: 7:00 A.M.-10:00 A.M.; -Started 2/17/25, ended 2/18/25, oseltamivir capsule; 30mg; amt: 1 cap by mouth, diagnosis: influenza due to other identified influenza virus with other respiratory manifestation, twice a day 7:00 A.M.-10:00 A.M., and 6:00 P.M.-9:00 P.M.; -Started 2/17/25, ended 2/19/25, prednisone tablet; 20mg; amt: 2 tabs; oral, diagnosis: influenza due to other identified influenza virus with other respiratory manifestations, once a day, 7:00 A.M.-10:00 A.M. Review of census report showed resident discharged from facility on 2/13/25 and returned 2/17/25. Review of nursing progress notes for the month of February., showed: -2/13/25 at Licensed Practical Nurse (LPN) E wrote resident's family member came to nurse regarding concern for residents breathing. Residents oxygen saturations on room air was 82%. Physician was notified and resident was sent to the hospital for evaluation and treatment. Resident's family member called the facility later to advise that the resident was admitted to hospital with influenza type A. -2/17/25 at 1:45 P.M., LPN D wrote resident returned to facility. Report was received from hospital indicating resident had been admitted on [DATE] for shortness of air and testing positive for influenza A. During an interview on 2/18/25 at 9:03 A.M. resident said they just got out of the hospital after having influenza. Observation on 2/18/25 at 9:03 A.M. showed resident had no transmission based precautions in place inside or outside of residents room or posted on residents door. Observation on 2/18/25 at 9:44 A.M. showed resident had a three drawer cart added outside their room with gloves, masks, gowns and hand sanitizer. There was no posting on door to indicate why precautions were being followed for this resident room. Observation on 2/18/25 at 9:54 A.M. showed two red barrels were now located outside resident's room. Observation on 2/18/25 at 9:56 A.M. showed two hospice workers pushing two red barrels into residents room from the hallway. (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 2/18/25 at 9:57 A.M. showed Nurse Aide (NA) A and Certified Nurse Aide (CNA) C outside resident's doorway and advising resident that they were asked to keep residents door closed and asking for residents consent to close their bedroom door. Observation on 2/19/25 at 8:31 A.M. showed no signage on resident's door. Personal protective equipment remained outside residents room. During an interview on 2/19/25 at 8:31 A.M., Resident said he/she was on quarantine but did not know why. Observation on 2/19/25 at 8:31 A.M. showed two red barrels were in residents room had gowns sticking out over top of container and the lids would not fit on the barrels due to the overflowing containers of doffed personal protective equipment. During an interview on 2/19/25 at 8:33 A.M., CNA C said: -The resident had been hospitalized for influenza; -The resident was on droplet precautions until they were symptom free; -He/she was not sure how long resident was on precautions. During an interview on 2/20/25 at 10:35 A.M., CNA E said: -Resident had influenza currently; -Resident had been hospitalized a week ago with influenza A and returned to facility yesterday; -When residents had influenza staff were to be gowning up and gloving before all cares; -He/She determined the difference between transmission-based precautions and enhanced barrier precautions by the signage on the residents door; -The residents on transmission-based precautions had a sign that read stop and check with nurse prior to entering resident room; -He/She was not sure why resident did not have a sign indicating stop on their door to their room. During an interview on 2/20/25 at 10:51 A.M., CNA G said he/she did not know difference between transmission based precautions and enhanced barrier precautions; During an interview on 2/20/25 at 2:08 P.M., Infection Preventionist said: -He/She worked in the facility full time as the facility infection preventionist; -Resident #23 returned to facility from hospitalization on [DATE]; -Transmission based precautions should have been implemented on 2/17/25 for Resident #23; (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265800	A. Building B. Wing	02/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Gower Convalescent Center, Inc	323 South Highway 169 Gower, MO 64454

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-He/She had to work as a nurse on the floor on 2/17 and did not know Resident #23 had returned to facility; -He/She did not know expectation for transmission-based precautions when the resident #23 returned to facility with influenza and had a roommate in same room; -Resident #23's roommate had been residing in the same room with resident on transmission based precautions; -Resident #23's roommate had been in dining room and out and about in facility while Resident #23 was on isolation precautions in their room; -Facility in past would offer open single rooms to residents who were on transmission-based precautions or move residents into rooms with residents on same transmission based precautions. During an interview on 2/20/25 at 2:08 P.M., Director of Nursing (DON) said: -When resident has influenza, they expected signage on resident door that read to stop see the nurse; -Facility did not put on their signage what precaution the resident was on; -Resident #23 was coming off transmission-based precautions on 2/21, because they tested positive for influenza on 2/13/25; -The red barrels or doffing containers in transmission-based precaution rooms should not be overflowing; -Red barrels or doffing containers were emptied at end of each shift; During an interview on 2/21/25 at 1:15 P.M., DON said: -She expected transmission-based precaution signage to be posted outside resident's door; -Facility used a sign that said stop and see the nurse; - She expected doffing barrels to be covered and not overflowing During an interview on 2/21/25 at 1:15 P.M., Administrator said: -He/She expected facility policy to be followed; -He/She expected a stop see the nurse sign posted on resident doors on transmission based precautions. 2. Facility did not provide a policy on linen transport. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of CDC guidance, Laundry and Bedding Guidelines for Environmental Infection Control In Health Care facilities, Parameters of the laundry process, dated 2003, showed: -Placing clean linen in a properly cleaned cart and covering the cart with disposable material or a properly cleaned reusable textile material that can be secured to the cart. Observation on 2/19/25 at 9:35 A.M. showed Laundry Aide A transporting clean laundry to include resident gowns, clean underpads, and resident clothes being wheeled on an uncovered metal cart down 200 hall way and returning clean items to resident rooms and linen storage closets. Observation on 2/19/25 at 9:46 A.M. showed Laundry Aide A transporting clean laundry including resident clothes on hangars that were uncovered. Observation on 2/19/25 at 2:22 P.M. showed Laundry Aide A transporting clean linens including underpads and blankets in an uncovered metal cart. During an interview on 2/20/25 at 2:57 P.M, Laundry Aide B said: -The metal carts were used for clean laundry carts only -Clean laundry was transported to resident rooms using metal cart; -Clean laundry in metal cart were not covered prior to transport to hallways and resident rooms. During an interview on 2/21/25 at 1:15 P.M., DON said she expected laundry to be protected clean laundry to be protected from contamination. During an interview on 2/21/25 at 1:15 P.M., Administrator said she did not expect clean laundry to be protected from contamination during transport.

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F 0948 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that paid feeding assistants have the training they need. 50980 Based on interview and record review, the facility failed to provide required state approved training for paid feeding assistants which affected 18 residents. The facility census was 78. 1. A policy on paid feeding assistants was not provided for review. Review of a list of paid feeding assistants provided by the facility, dated 2/20/25, showed 5 feeding assistants with no state approved formal paid feeding assistant training. During an interview on 2/20/24 at 3:30 P.M., Nurse Aide (B) said: - He/she did not attend any formal state approved course for feeding assistant but instead got one on one training with the DON and experienced staff members; - He/she has been a feeding assistant for a few months and assists residents on the floor with meals; During an interview on 2/20/24 at 5:00 P.M., Director of Nursing (DON) said: - Each feeding assistant goes through one on one training over a very specific list of topics before going to the floor; - She was not aware of the requirement of a state approved training course for paid feeding assistants but would investigate and get her staff enrolled.