STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265802	A. Building B. Wing	08/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Armour Oaks Senior Living Community	8100 Wornall Road Kansas City, MO 64114

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview, and record review, the facility failed to ensure the medication refrigerator had a thermometer and the temperature was checked daily, failed to ensure the freezer compartment of the medication refrigerator was not frozen solid, failed to ensure there were no loose pills in the medication cart, failed to ensure medications that were opened had the date they were opened written on them, failed to ensure there were no other items kept in the medication cart in with the resident's prescribed medications and failed to ensure there were not cleaning agents in the medication cart in with the resident's prescribed medications. The facility census was 36 residents.Review of the facility's policy, Storage of Medication Requiring Refrigeration, dated October 2022 showed:-The facility must provide safe and effective storage of all drugs and biologicals in a locked storage area under proper temperature controls.-The facility would ensure that all medications and biologicals would have been stored at proper temperatures and other appropriate environmental controls according to manufacturer's recommendations to preserve their integrity:-Refrigerated refers to temperature maintained between 36 to 46 degrees Fahrenheit (F).-Temperature to have been monitored daily to ensure proper temperature control and documented on the temperature log with the date, time, and signature of the person performing the check clearly written. Review of the facility's policy, Medication Administration, dated 2022 showed to keep the medication cart clean, organized, and stocked with adequate supplies. 1. Observation of the Certified Medication Technicians (CMT) medication cart on 8/20/2025 at 9:00 A.M. with CMT B showed:-There was a facility walkie talkie in with the resident's prescribed medications.-There were a container of bleach wipes in with the resident's prescribed medications.-A resident's prescribed container of Enulose (a medication used to treat constipation) 473 milliliter (ml) bottle was opened without the date it was opened written on it. -There were four white capsules in a medication cup without a name or room number on the medicine cup.-There was one round blue pill loose in the bottom of a drawer.-There was one orange capsule loose in the bottom of a drawer. During an interview on 8/20/25 at 9:20 A.M. CMT B said:-There should not have been any loose pills in the drawers of the medication cart.-There should not have been a container of bleach wipes in with the residents' medications.-Prescribed Medications that were opened should have the date it was opened written on it. -There should not have been a walkie talkie in with the resident's medications.-The staff member who used the cart was responsible for keeping it clean and ensuring the medication had a date written on it if it had been opened. 2. Observation on 8/20/25 at 9:30 A.M. of the Nurses' medication cart, medication room, and medication refrigerator with Licensed Practical Nurse (LPN) A showed:-There was no thermometer in the medication refrigerator. -The Nurse verified there was no thermometer in the medication refrigerator.-There was no temperature recorded on the temperature log for 8/19/25 or 8/20/25. -The freezer department in the medication refrigerator was one solid block of ice.-There were four boxes of Tuberculin (TB a skin test used to detect TB)1 ml vials in the refrigerator.-There was one Glargine Insulin (a long- acting insulin used to treat high blood sugar) pen in the medication refrigerator.-The medication cart showed one loose Ondansetron (a medication used for anti- nausea and vomiting) 4 (continued on next page)

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

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	milligram (mg) pill in a drawer.-A resident's prescribed Guaifenesin (medication used to relieve chest congestion) 473 ml bottle was open without an open date written on it. -There were a container of bleach wipes in with the resident's medications. Review of the Refrigerator Temperature Check for August 2025 showed:-It was recorded on August 5th there was no thermometer in the medication refrigerator. -There was no refrigerator temperature check done on August 18 or 19. During an interview on 8/20/25 at 9:50 A.M. LPN A said:-There should not have been any loose pills in the medication cart.-There should not have been any other objects in with the residents' medication.-There should not have been bleach wipes in with the residents' medications.-The nurse who used the medication cart should have been responsible for keeping it clean.-He/She did not know how staff would have checked the temperature of the medication refrigerator if there was no thermometer in it.-The night nurse was responsible for checking the temperature of the medication refrigerator and documenting it on the sheet.-He/She did not know who was responsible for ensuring the freezer in the medication refrigerator was defrosted. During an interview on 8/22/25 at 1:15 PM with the Director of Nursing (DON) said:-The night Nurse was responsible for checking the temperature of the medication refrigerator.-The temperature should have been checked every day.-The temperature should have been between 38 to 42 degrees F.-The temperature should have been recorded daily. -If something was off the nurse should have adjusted the temperature of the medication refrigerator then rechecked it. -The Nurse Manager or DON should have been informed if the temperature was off and that there was no thermometer.-The freezer compartment should not have been a block of ice, he/she did not know who was responsible for defrosting the freezer.-The Charge Nurse should have ensured the temperature was checked daily, the sink was clean, and there was soap so the staff could wash their hands before preparing medications. -There should not have been any personal items or loose pills in the medication cart.-The staff member who used the cart was responsible for ensuring it was kept clean and there were no loose pills.-The DON was ultimately responsible for the medication carts, medication refrigerator, and the medication room.

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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 - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview and record review the facility failed to ensure appropriate measures were taken to provide safe and sanitary conditions for food storage and preparation by not maintain cleanliness of the kitchen and kitchen equipment; not labeling and dating opened food; not wearing appropriate hair coverings; not cleaning utensils; not documenting food temperatures during preparation; not documenting refrigeration temperatures. The facility census was 36 residents.Review of the facility's Record of Food Temperatures policy, undated, showed:-The facility recorded food temperatures daily to ensure food was at the proper serving temperatures.-Food temps were checked while items were prepared in the dietary department.-Hot foods were to be held at 135 Fahrenheit (F-a unit of measure for temperatures) or greater.-Potentially hazardous cold food temperatures were kept at or below 41 F.-Staff were to measure and record temperatures for each food product at all meals and document on the food temp logs.-No food was served that did not meet the food code standard temperatures.Review of the facility's Monitoring of Cooler/Freezer Temperature, undated, showed:-The facility maintained temperatures of coolers and freezers at the appropriate temperature to promote food safety.-Logs for recording temperatures for each refrigerator or freezer was posted in a visible location outside the freezer or refrigerator unit.-Temperatures were checked and logged at least twice per day by designated personnel.-Logs were changed out and completed monthly.-All refrigerator storage must be maintained at or below 41 F.-All frozen storage must be maintained at or below -4 F.-If temperatures were above 41 for coolers and 10 for freezers, the supervisor was notified and took corrective action:--The unit was repaired as soon as possible.--If not corrected within two hours all food items were relocated to a different unit.--Internal temperatures readings were taken on all perishables and potentially hazardous food was discarded if not in an acceptable range.-Refrigerated food was labeled, dated and monitored for it to be used by the use by date.Review of the facility's Date Marking for Food Safety policy, undated, showed:-The facility adhered to a date marking system to ensure food safety. -Refrigerated food was held at 41 F or less for a maximum of seven days.-Food was clearly marked to indicate the date.-The individual opening the food was responsible for date marking the food.-The Head [NAME] or designee was responsible for checking the refrigerator daily for food items that were expiring and discarded accordingly.-The Dietary Manager or designee spot checked refrigerators weekly for compliance and documented accordingly.Review of the facility's Dietary Employee Personal Hygiene policy, undated, showed:-Hair restraints were worn by all kitchen staff.-Hair restraints included hairnet, hat and beard restraints were to be worn to prevent hair from contacting food.Review of the facility's Routine Cleaning and Disinfection policy, undated, showed:-It was the policy of the facility to ensure routine cleaning and disinfection to provide a safe, sanitary environment.-Cleaning was defined as: removal of visible soil from objects and surfaces using water and detergents or enzymatic (a chemical used for cleaning) products.-Routine cleaning of visibly soiled surfaces was performed as needed.Review of the facility's Food Safety Requirements, undated, showed:-Food was stored, prepared, distributed and served in accordance with professional standards for food service safety.-Equipment used in the handling of food, including dishes, utensils, mixers, grinders and other equipment that came in contact with food was to be clean after use.-Dry food storage must be clean and dry.-Safe refrigerated storage included:--Monitoring food temperatures and functioning of the refrigeration equipment daily and at routine intervals.--Labeling, dating and monitoring refrigerated food.--Keeping foods covered or in tight containers.-All equipment used in the handling of food shall be cleaned and sanitized and handled in a manner to prevent contamination.-Clean dishes shall be kept separate from dirty dishes.-Dietary staff must wear hair restraints (including beards) to prevent hair from contacting food.-Hairnets should be worn when cooking, preparing or assembling food.Review of the facility's July 2025 Cooler Temperature Log, showed:-Cooler logs were missing temperatures on July 23rd (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	through July 27th.-NOTE: these logs were not the logs observed on the outside of the units during initial kitchen tour.-No equipment temperature logs were provided for August 2025.Review of the requested food temperature logs for July through August 2025 showed:-July 1st evening meal temperature check was not documented.-July 2, 3, 4 and 5 breakfast, noon and evening meals temperature checks were not documented.-July 7th noon meal temperature checks were not documented.-July 8th evening meal temperature check was not documented.-July 10, 11 and 12 no meals had temperature checks documented.-July 13th evening meal temperature check was not documented.-July 13, 14, 15 breakfast, noon and evening meals temperature checks were not documented.-July 16th evening meal temperature check was not documented.-July 17th and 18th evening meal temperature check was not documented.-July 21st no meals had temperature checks documented.-July 23rd evening meal temperature check was not documented.-July 24th breakfast and evening meals temperature check not documented.-July 25th noon meal temperature checks were not documented.-July 26th breakfast and noon meals temperature check not documented.-July 29th evening meal temperatures check not documented.-August 1st breakfast and noon meals temperature check not documented.-August 3rd noon and evening meals temperature checks were not documented. -August 4th and 5th evening meal temperature check was not documented. -August 5th evening meal temperature check was not documented.-NOTE: No additional August 2025 temperature logs were provided.Observation on 08/18/2025 at 10:58 A.M., showed:-Dry storage had opened and not labeled a bottle of pancake syrup.-There was one dented can of pineapple and one dented can of mandarin oranges on the ready-to-serve storage rack. -There were four Rubbermaid plastic storage containers on the prep table containing dry cereal, two of which were not labeled or dated. -The reach-in cooler had a July 2025 temperature log hanging on the outside of the door.--The temperature log was missing more than 50% of the entries for the month.-There was no temp log for August.-An opened, undated and expired jar of pickles (5/22/25 based on manufacture dating) was in the reach-in cooler.-Floors in the kitchen, storage area and walk-in coolers were noted to have debris and were sticky in some areas. -An undated open bottle of grape jelly was sitting on a shelf in the food prep area, not refrigerated (manufacturer label showed refrigerate after opening).-The stove hoods were covered in grease.-There were drops of grease dripping on to the stove surface. -There was an opened package of sliced cheese in the walk-in cooler with no date.-There were no temperature logs for walk-in cooler.-The thermometer located on the outside of the walk-in cooler was broken. The hanging thermometer was in the back of the cooler and could not be read without moving three large jars of salad dressing.-Jars of salad dressing were in the walk-in cooler and were caked with dried on and gloopy dressing.-Stand up freezer, used for stored bread, had no temp log with a digital thermometer on the top.-Coffee filters were in a box with soaked in dried out brown substance sitting on a cafeteria tray on a portable stainless steel food cart.-A plastic circular container under the wall mounted knife holder was full of utensils. The cook reported they were clean, but upon inspection three knives were found inside the container with dried on food particles stuck to them.During an interview on 08/18/2025 at 10:58 A.M., the Dining Services Director said:-Dented food cans were sent back for credit and should not be on the storage racks.During an observation on 08/182025 at 11:00 A.M., a dishwasher was doing dishes with a beard net tucked below his/her chin.Observation on 08/20/2025 at 8:38 A.M., showed the Dining Services Director was in the food prep and cooking areas with no hair net or beard net.Observation on 08/20/2025 at 8:42 A.M., the August 2025 temp log for the reach-in cooler was blank, hanging on the outside of the door.Observation on 08/20/2025 at 8:44 A.M., an opened container of sour cream in the reach-in cooler was opened with no label showing the date it was opened. Observation on 08/20/2025 at 8:46 A.M., there were no food temp logs present in the cooking and food prep areas. During an interview on 08/20/2025 at 8:52 A.M., [NAME] A said:-He/She temped the foods after they were done cooking.-The food was immediately put on the steam table where it was temped.-Everybody in the kitchen checks food and equipment temperatures and wrote it on the log.-The log was in the kitchen in food prep area.-Reach-in and walk-in coolers and (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	freezers were temperature checked first thing in the morning.-After they were checked it was documented on the chart hanging on the wall next to the units.-The freezer should not be above 14 F and cooler around 30 F.-Hair nets were worn all day until it was time to leave.-A box of new hair nets was located under the serving table when you first walk in the kitchen doors.-When food was opened and not all used it was supposed to be labeled with a date when it was opened. -There should be a label on opened containers, and he/she threw it away if it did not have one. -Dented cans were put aside and were not used in the kitchen. -Jelly should be refrigerated after opening and should have a date label on it.-Cleaning was done everyday and there were schedules we followed.During an interview on 08/20/2025 at 9:36 A.M., [NAME] B said:-He/She checked the food temperatures when it came out of the oven and when the food left the kitchen. -He/She recorded the temperatures in the temp book.-This was done for every meal, every day.-We temp it and the Dining Services Director made sure it was done.-The walk-in and reach-in coolers temperatures should be in the 30s.-The temperature in the freezers should be below zero. -He/She noticed it wasn't working and told maintenance about last month. -If he/she did not see dates on opened food he/she removed it. -There should be dates on all the food, including leftovers. After the third day he/she threw it away.-When he/she opened foods he/she marked it with an open date. -Everyone in the kitchen wore hair nets, even when washing dishes. -Temperature logs were hanging on the outside of the reach-in, walk-in, and freezer doors. -There was a cleaning list.-He/She cleaned messes as he/she saw them. -All kitchen staff were responsible for cleaning the kitchen.-The kitchen and prep equipment were cleaned twice a day, after breakfast and after lunch.-He/she was unsure what the dinner crew did.During an interview on 08/20/2025 at 10:03 A.M., [NAME] C said:-He/She made sure there were no dented cans on the racks.-Dented cans went to a different area in the kitchen and were discarded.-They should never be on the rack to be served.-Kitchen staff put labels on boxes with the date it was opened. -He/She expected there to be dates on any opened containers.-He/She threw out items if they were not dated.-Food that said it should be refrigerated after opening should go in the walk-in or reach-in coolers. -He/She checked the food temps while preparing and put them in the logbook.-He/She checked cooler and freezer temperatures in the beginning and ending of his/her shift and recorded the temperatures on the log hanging outside of the door.-Hair nets were worn when we entered the kitchen.-Should not see anyone in the kitchen cooking area without a hairnet.-Dishwashers need hair nets and beard nets.-There was a clip board with cleaning schedules for the reach-ins and walk-ins.-Once it was cleaned the person who cleaned put their initials on the clipboard.-NOTE: no cleaning schedules of checklists were provided.During an interview on 08/20/2025 at 1:58 P.M., the Dietary Services Director said:-There was a cleaning schedule that staff completed, as well as closing lists for each position.-There is a weekly deep clean list that staff were responsible for doing.-Weekly list was signed-off by the Dietary Services Director. - The Dietary Services Director was responsible for ensuring the cleaning was being done. -He/She had noticed an issue with cleaning not getting done. -There have been some write ups and other disciplinary actions.-He/She provided reminders to staff every day.-He/She provided training and monthly in-services.-He/She expected the kitchen staff to complete the cleaning list.-Staff should have recorded food temperatures and documented them on the log.-Everyone in the kitchen was responsible for checking and documenting equipment temperatures, however it was mainly the cooks responsibility because they are the first one in the kitchen in the morning. -He/She expected the morning and night cooks to do equipment temperature checks.-Staff were expected staff to wear hairnets and beard nets, including the dishwashers.-Opened containers should be labeled and dated with open date and expiration date.-Expect kitchen staff to wipe off bottles and containers before putting them in the coolers.During an interview on 08/20/2025 at 2:33 P.M., the Administrator said:-He/She expected the Dietary Services Director to make sure temps were being logged for all food and equipment.-He/She expected dietary staff to be always wearing hair coverings, including beards and dishwashers.-He/She expected kitchen staff to be cleaning daily. -He/She expected the (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Dining Services Director to notify him/her of failing equipment. Observation on 08/21/2025 at 1:28 P.M. of the refrigerator in the kitchenette in the dining room on the unit showed:-Opened sliced cheese with no label or date.-Opened gallon of milk with no opened date. -Opened bottle of grape jelly on the counter with no label and no open date.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to implement Enhanced Barrier Precautions (EBP - precautions taken by a facility for the prevention of transmission of multidrug-resistant organisms) for three sampled residents (Resident #24, Resident #7, and Resident #8); failed to ensure accurate documentation of a resident's tuberculosis (TB - a communicable disease that affects especially the lungs, that is characterized by fever, cough, difficulty in breathing, abnormal lung tissue and function) skin test for five sampled residents (Residents #3, #4, #6, #9, and #18) out of 12 sampled residents and failed to ensure hand hygiene was completed during medication pass. The facility census was 36 residents. Review of the facility's policy, Enhanced Barrier Precautions, dated 2022 showed: -The use of gown and gloves for use during high contact resident care activities. High contact activities include: Dressing, bathing, transferring, providing hygiene. changing linens, changing briefs or assisting with toileting, device care: urinary catheters, feeding tubes, any skin opening requiring a dressing. -All staff would have received training on enhanced barrier precautions upon hire and at least annually and were expected to comply with all designated precautions. -Clear signage would have been posted on the door or wall outside of the resident's room which indicated the type of precautions, required personal protective equipment (PPE – safety gear used to reduce exposure to substances, germs, and objects), and the high contact resident care activities that require the use of gown and gloves. -An order for EBP would have been for residents with any of the following: Pressure ulcers (injury to the skin and underlying tissue resulting from prolonged pressure on the skin), diabetic foot ulcers (a breakdown of the skin and deeper tissues of the foot), unhealed surgical wounds, and chronic venous stasis ulcers (a wound on the leg or ankle caused by abnormal or damaged veins), and indwelling medical devices (central lines (a flexible tube inserted into a large vein), urinary catheters (a tube inserted into the bladder for urinary drainage), feeding tubes (a medical device that delivers liquid nutrition directly to the stomach through a flexible tube). -Implementation of EBP included: -Make gowns and gloves available immediately outside of the resident's room. -Ensure access to alcohol-based hand rub in every resident room. -Position a trash can inside the resident room near the exit for discarding PPE after removal. -The Infection Preventionist would have incorporated periodic monitoring and assessment of adherence to determine the need for additional training and education. Review of the facility's policy, Medication Administration, dated 10/2022 showed: -Staff was to wash hands prior to administering medication per facility protocol. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1. Review of Resident # 24's face sheet showed he/she was admitted on [DATE] with a Stage 2 pressure ulcer (a superficial wound affecting the top two layers of the skin) on his/her buttock. Review of the resident's admission Minimum Data Set (MDS-a federally mandated assessment tool completed by the facility for care planning) dated 6/19/25 showed: -He/She had a pressure ulcer. -He/She was moderately cognitively impaired. Review of the resident's August 2025 Physician's Order Sheet (POS) showed the following orders: -EBP related to dressings to his/her buttock. Gown and gloves during cares for dressing, dated 8/18/25 at 7:00 P.M. -Cleanse his/her bilateral buttock with Wound Cleanser, pat dry, apply zinc ointment (medication used to heal skin), and cover with bordered dressing (a non-woven adhesive tape that hold the dressing in place and maintains a moist wound environment) daily and as needed, dated 8/19/25. -Wash lateral thigh with normal saline, apply Santyl (ointment used for wound debridement), cover with non-adherent dressing then cover with Abdominal pad (ABD highly absorbent used for wound care) every day shift, dated 8/19/25. Observation and interview on 8/18/25 at 9:26 A.M. showed: -Staff had went into the resident's room and did not don (apply) PPE. -Staff had provided care to the resident and had not used PPE. -There was no sign on the door stating the resident was on EBP. -There was no isolation cart at the resident's room or along the hallway. -The resident said he/she had a wound on his/her hip. -He/she said the staff did not wear PPE when caring for him/her. 2. Review of Resident #7's face sheet showed he/she was admitted with the following diagnoses: -Protein calorie malnutrition (a nutritional disorder resulting from insufficient intake of protein and calorie). -Adult failure to thrive (unexplained weight loss, malnutrition, and disability that affects older adults). -Dysphagia (difficulty swallowing foods or liquids). Review of the residents quarterly MDS dated [DATE] showed: -He/She was moderately cognitively impaired. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-He/She had a feeding tube. Review of the August 2025 POS showed the following orders: -Enteral feed every six hours: Jevity (a calorie dense therapeutic nutrition) 1.5 240 milliliters (ml) via Percutaneous Endoscopic Gastrostomy tube (PEG tube – a feeding tube that provides direct access to the stomach for nutrition, hydration, and medication), dated 5/8/25. -EBP related to Peg tube, gown and gloves during cares for peg tube, every shift, dated 8/18/25. Observation and interview on 8/18/25 at 9:40 A.M. showed: -Staff went into the resident's room and did not don (apply) PPE. -Staff provided care to the resident and had not used PPE. -There was no sign on the door stating the resident was on EBP. -There was no isolation cart at the resident's room or along the hallway. -The resident had a feeding tube. -He/she did not feel up to being interviewed. 3. Review of Resident #8's face sheet showed he/she was admitted to the facility on [DATE] with the following diagnoses: -Obstructive uropathy (a disorder that occurs when urine flow is obstructed). -Retention of urine (difficulty urinating and completely emptying the bladder). -History of urinary tract infections (an illness in any part of the urinary tract). -Artificial opening of urinary tract (a surgically created pathway for urine to exit the body). Review of the resident's quarterly MDS dated [DATE] showed: -He/She was severely cognitively impaired. -He/She had a catheter (a tube inserted into the bladder to drain urine). Review of the resident's August 2025 POS showed the following orders: -18 French (Fr – size of the catheter)10 cubic centimeters (cc – the amount of fluid to fill the balloon it takes to secure the catheter in place) supra pubic catheter (a thin, flexible tube inserted through a small incision in the lower abdomen just above the pubic bone to drain urine when a person cannot urinate), change monthly and as needed for occlusion, dated 8/7/25. -EBP related to supra pubic catheter, gown and gloves during cares every shift, dated 8/18/25. (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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation and interview on 8/18/25 at 1:10 P.M. showed: -Staff had completed resident cares and had not used PPE. -There was no sign on the door stating the resident was on EBP. -There was no isolation cart at the resident's room or in the hallway. -The resident said staff had emptied his/her foley and had not worn a gown only gloves. 4. During an interview on 8/20/25 at 9:00 A.M. CMT B said: -They just started using EBP this week. -There should have been a sign on the door that showed you what to wear when doing cares with the resident. -The Director of Nursing (DON) came around and provided education on EBP by doing 1:1 education. -The facility had not been doing EBP before the survey started. During an interview on 8/20/25 at 9:40 A.M. Certified Nursing Assistant (CNA) A said: -He/She had worked at the facility for a few months. -He/She thought that EBP meant washing your hands. -He/She could not remember if the DON had provided education about EBP during orientation. -The just started using EBP this week after survey started. -He/She had not received EBP education from the DON this week. During an interview on 8/20/25 at 9:50 A.M. Licensed Practical Nurse (LPN) A said: -They have just started doing EBP since survey started. -If you had any opening in your body such as a foley catheter, feeding tube, or open wound you should have been on EBP. -There should have been a sign on the resident's door indicating what PPE to have been worn when performing cares with the resident. -There should have been an isolation cart outside the resident's room with PPE in it. -The DON just came around yesterday providing education 1:1 with the staff. -The DON was responsible for ensuring EBP were in place and providing education to the staff. (continued on next page)

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	265802	A. Building B. Wing	08/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	5. During an observation of the medication pass on 8/20/25 at 8:20 A.M. with CMT B showed: -He/She did not cleanse his/her hands before administering medication to the resident in room [ROOM NUMBER] A. -He/She did not cleanse his/her hands after administering medication to the resident in room [ROOM NUMBER] A. -He/She did not cleanse his/her hands after administering medication to the resident in room [ROOM NUMBER] B. -CMT A continued to pass medications to the rest of the residents. During an interview on 8/20/25 at 9:00 A.M. CMT B said: -You should wash your hands or use a hand sanitizer before starting the medication pass, before administering medications to each resident, and after you were done passing medications. -The facility had provided a lot of education about when you were to wash your hands. -The DON was responsible for ensuring staff washed their hands when they were supposed to have cleansed their hands. During an interview on 8/20/25 at 9:50 A.M. LPN A said: -During medication pass staff should cleanse their hands before starting the medication pass, after the medication pass and after passing medications to each resident. -The DON had provided education almost monthly about washing your hands. During an interview on 8/22/25 at 1:15 PM the DON said: -He/She had just initiated EBP after the first day of survey. -He/She had identified seven residents who should have been on EBP. -He/She had provided education to the staff on Monday night. -He/She should have started it previously. -The CMT or Nurse should have washed/cleansed their hands before and after the medication pass, as well as after each resident. 6. Review of the facility's undated Resident Screening for Tuberculosis policy showed: -Prior to or at the time of admission all residents will receive TB testing. -All initial and follow up TB tests shall be administered and interpreted (48-72 hours for skin test) by a trained health care professional on staff. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	7. Review of Resident #6's face sheet showed he/she was admitted to the facility on [DATE]. Review of the resident's immunization report showed an annual TB skin test was administered on 9/23/24. The test was documented as 0 mm induration with no read date. 8. Review of Resident #9's face sheet showed he/she was admitted to the facility on [DATE]. Review of the resident's immunization report showed an annual TB skin test was administered on 4/21/25. The test was documented as 0 mm induration with no read date. 9. Review of Resident 3's Face sheet showed he/she was admitted to the facility on [DATE]. Review of the resident's immunization report showed an annual TB skin test was administered on 3/17/25. The test was documented as 0 mm induration with no read date. 10. Review of Resident #18's face sheet showed he/she was admitted to the facility on [DATE]. Review of the resident's immunization report showed an annual TB skin test was administered on 3/24/25. The test was documented as 0 mm induration with no read date. 11. Review of Resident #4's face sheet showed he/she was admitted to the facility on [DATE]. Review of the resident's immunization report showed an admission TB skin test was administered on 7/3/25. The test was documented as 0 mm induration with no read date. The resident did not have a second step TB skin test. During an interview on 8/22/25 at 1:15 PM, the Director of Nursing (DON) said: -TB skin test results should be read 48-72 hours after they are administered. The read date should be documented. -The facility's electronic medical records system did not have a spot to document the TB skin test read dates. -All new admissions should have a two-step skin test.

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Keep all essential equipment working safely. Based on observation, interview and record review, the facility failed to ensure appropriate measures were taken to provide safe conditions for food storage by not maintaining documentation of walk-in freezer temperatures. The facility census was 36 residents.Review of the facility's Monitoring of Cooler/Freezer Temperature, undated, showed:-The facility maintained temperatures of coolers and freezers at the appropriate temperature to promote food safety.-Logs for recording temperatures for each refrigerator or freezer was posted in a visible location outside the freezer or refrigerator unit.-Temperatures were checked and logged at least twice per day by designated personnel.-Logs were changed out and completed monthly.-All frozen storage was maintained at or below -4 Fahrenheit (F-a unit of measuring temperatures).-If temperatures were above 10 for freezers the supervisor was notified and took corrective action:--The unit was repaired as soon as possible.--If not corrected within two hours all food items were relocated to a different unit.--Internal temperatures readings were taken on all perishables, and potentially hazardous food was discarded if not in an acceptable range.1.Review of the facility's July 2025 Freezer Temperature Log, showed:-Freezer logs were missing temperatures the entire month of July 2025 with a squiggly line drawn down column. -NOTE: these logs were not the logs observed on the outside of the unit during initial kitchen tour.-No walk-in freezer temperature logs were provided for August 2025.Observation on 8/18/25 at 10:58 A.M. showed:-The walk-in freezer had a broken thermometer located outside of the unit.-The thermometer inside of the walk-in freezer read 22 F.-A large container of chocolate ice cream was noted to be melting.-The clip board hanging on the outside of the freezer door, used for documenting daily temperatures was dated July 2025, with multiple dates left blank.During an interview on 8/18/25 at 10:58 A.M., the Dining Services Manager said:-He/She had not been made aware of the freezer not being at the correct temperature.-He/She was going to put in a work order to have it looked at. During an interview on 08/20/2025 at 8:52 A.M., [NAME] A said:-Everybody in the kitchen checked food and equipment temperatures and wrote it on the log.-Reach-in coolers and freezers were temperature checked first thing in the morning.-After they were checked it was documented on the chart hanging on the wall next to the walk-in cooler and freezer.-Freezer should not be above 14 F. During an interview on 08/20/2025 at 9:36 A.M., [NAME] B said:-The temperature in the freezers should be below zero. -He/She noticed it wasn't working and told maintenance about it last month. -Temperature logs were hanging on the outside of the walk-in freezer doors. During an interview on 08/20/2025 at 10:03 A.M., [NAME] C said:-He/She checked freezer temperatures in the beginning and ending of his/her shift.-He/she recorded the temperatures on the log hanging outside of the door.During an interview on 08/20/2025 at 1:58 P.M., the Dietary Services Director said:-Everyone in the kitchen was responsible for checking and documenting equipment temperatures, however it was mainly the cook's responsibility because they are the first one in the kitchen in the morning. -He/She expected the morning and night cooks to do equipment temperature checks and report any issues to him/her.During an interview on 08/20/2025 at 2:33 P.M., the Administrator said:-He expected the Dietary Services Director to make sure temps were being logged for all equipment.-He/She should have been notified if the equipment was not working.

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure resident rights were being honored by not treating one resident (Resident #9) out of 12 sampled residents, with dignity while standing up next to the resident and being assisted with eating during scheduled mealtimes. The facility census was 36 residents.A policy regarding feeding assistance was requested and not received.1. Review of the resident's face sheet, undated, showed:-The resident was admitted [DATE].-The resident was diagnosed with aphasia (a condition affecting speech caused by a stroke).Review of the resident's admission Minimum Data Set (MDS-a federally mandated assessment tool used in nursing homes to evaluate resident health and functional needs), dated 6/19/25, showed:-The resident had moderate cognitive impairment.-The resident lacked ability to use suitable utensils to bring food and/or liquid to his/her mouth and swallow food and/or liquid once the meal was placed before the resident-The resident needed supervision and touching assistance while eating.Review of the resident's Care Plan (a personalized document outlining a resident's medical, emotional, and daily living needs and the specific strategies used to meet them, ensuring person-centered care), dated 7/12/25, showed:-The resident required assistance with eating.-The resident had a swallowing problem related to aphasia.Observation on 08/19/2025 at 11:31 A.M., showed:-Seven residents were sitting at a round table; one was Resident #9.-Staff were noted to walk around the table and offered feeding assistance to residents.-Residents were fitted with clothing protectors.-Resident #9 was fed by an aide who was standing up next to the resident and between the resident and another resident. -Another aide was standing next to another unidentified resident, also feeding him/her while standing.-Resident ate 25-50% of the lunch meal.During an interview on 08/20/2025 at 9:13 A.M., Certified Nursing Assistant (CNA) A said:-The resident needed feeding assistance.-He/She helped the resident with feeding.-He/She knows how to feed residents, he/she had been a CNA for ten years.-That is the only training he/she received.-He/She sat down to feed the residents.-He/She had seen other aides standing up to feed residents.During an interview on 08/20/2025 at 9:49 A.M., Certified Medication Technician (CMT) A said:-He/She did not usually assist with feeding.-He/She would sit down to feed the residents.-He/She noticed some aides standing over the residents while helping them eat.Observation on 08/21/2025 at 8:45 A.M., showed:-The resident was not at the breakfast table.-Another resident in a Broda chair received feeding assistance from an aide.-The aide stood over the resident while wiping his/her face during the meal.During an interview on 08/21/2025 at 9:13 A.M., Licensed Practical Nurse (LPN) A said:-Aides were expected to sit down and feed the residents.-He/She expected them to have conversations during mealtimes and feeding assistance. During an interview on 08/22/2025 at 1:15 P.M., the Director of Nursing (DON) said:-Aides were expected to know the diet and how to feed residents when they required assistance.-Aides also checked resident preferences to make sure it is what the resident.-Aides were expected to communicate with residents as they were feeding the resident.-All staff were encouraged to sit next to the residents they were assisting and not tower over the top of them.-Clothing protectors should be offered before putting them on the residents.

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the correct code status (a form or statement that indicated preferences to receive life sustaining measures such as cardio-pulmonary resuscitation (CPR)) was documented in the Electronic Health Record (EHR) for one resident (Resident #4) out of 12 sampled residents. The facility census was 36 residents.Review of the facility's Residents' Rights Regarding Treatment and Advance Directives (a legal document that stated specific healthcare wishes), undated, showed:-The facility supported each resident's right to formulate an advance directive.-On admission the facility determined if the resident had an Advance Directive, and if not, determined whether the resident would like to formulate one.-Upon admission if the resident had an Advance Directive, copies were made and placed on the chart and communicated with staff.-During the development of the care plan (a detailed document summarizing a person's health conditions, goals, and the specific treatments or services needed to achieve those goals) the facility identified, clarified and reviewed with the resident or legal representative whether they desired to make any changes related to the Advance Directive.-Any decisions were documented in the resident's medical record and communicated to the staff. 1. Review of Resident #4's face sheet, undated, showed:-He/She was admitted into the facility on [DATE].-He/She was cognitively intact. Review of the resident's Physician Order Summary (POS), dated [DATE], showed:-The resident was listed as Do Not Resuscitate (DNR). -There was no DNR form located in the resident's file. Review of the resident's Care Plan, dated [DATE], showed:-The resident was listed as DNR. During an interview on [DATE] at 9:13 A.M., Certified Nursing Assistant (CNA) A said:-The code status was in the resident's chart.-If he/she needed to know the code status he/she looked in the chart. During an interview on [DATE] at 9:49 A.M., Certified Medication Technician (CMT) A said:-Charting in the EHR said what the resident's code status was.-The EHR said at the top of the face page what the code status was. During an interview on [DATE] at 11:17 A.M., the resident was interviewed but did not clearly understand the questions regarding his/her code status. During an interview on [DATE] at 9:13 A.M., Licensed Practical Nurse (LPN) A said:-Advance Directives were in the resident's record.-Paper copies were kept at the nurse's station in a book.-The nurse was asked to provide the book, and it was not at the nurse's station.-The Director of Nursing (DON) must have had it. During an interview on [DATE] at 11:21 A.M., the DON said:-We had a DNR book located at the nurse's station, categorized by last name.-There was a paper copy in the resident's paper chart, and it was scanned into the EHR. -He/She would expect the code status to be in the EHR and the paper chart. -He/She would expect the care plan to say DNR or full code. During an interview on [DATE] at 11:54 A.M., the Minimum Data Set (MDS-a comprehensive assessment tool used in nursing facilities to evaluate resident health and identify needs) Coordinator provided a copy of the resident's progress EHR note and said:-The EHR was showing the resident was a full code (the resident wished to have CPR).-He/She accidentally put the wrong code status in the resident's file.-He/She put another resident's code status in the resident's file. During an interview on [DATE] at 1:15 P.M., the DON said:-He/She expected the resident's code status to be documented as an order in the EHR.-Residents were considered a full code unless there was a DNR signed and dated by the resident or representative and physician and care planned.-He/She would expect the correct code status be assigned to correct resident.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to follow physician orders when weights were not monitored, documented and reported for one resident (Resident #9) diagnosed with Congestive Heart Failure (CHF- condition where the heart muscle did not pump blood effectively enough to meet the body's needs) out of 12 sampled residents. The facility census was 36 residents.Review of the facility's Medication Administration policy, dated 10/2022, showed to obtain and record vitals (heart rate, pulse, blood pressure and weights) per physician orders.1.Review of the Resident #9's face sheet, undated, showed:-The resident was admitted to the facility on [DATE].-The resident had moderate cognitive impairment.Review of the resident's Physician Order Summary (POS), dated August 2025, showed:-The resident was diagnosed with CHF.-The resident was ordered Torsemide (water pill that helped rid excess fluid) oral table, 40 milligrams (mg), related to edema (swelling that resulted from an abnormal accumulation of fluid in the body's tissues) and CHF.- Weigh daily for 14 days one time a day related to edema and CHF for 14 days.--Notify doctor if there was a weight gain of more than three pounds in 24 hours.--Starting 8/17/25.Review of the resident's Medication Administration Record (MAR), dated August 2025, showed the resident received Torsemide as ordered.Review of the resident's Treatment Administration Record (TAR), dated August 2025, showed:-The resident was not weighed on August 17, 18, 19, 20.-The resident was weighed on August 21 at 136.8 pounds.-The resident was not weighed on August 22.During an interview on 08/20/2025 at 9:13 A.M., Certified Nursing Assistant (CNA) A said:-The aides and sometimes the nurses weighed the residents.-He/She had a list of residents who needed to be weighed and weighed them.-He/She wrote the information on paper and gave it the nurse, or he/she would enter into electronic charting.During an interview on 08/20/2025 at 9:49 A.M., Certified Medication Technician (CMT) A said:-The resident was supposed to be weighed twice a month.-The aides or the nurses did the weights.-The clinical manager printed off a list of residents who needed weighed and he/she wrote the weights down and gave them to the nurse.During an interview on 08/21/2025 at 9:13 A.M., Licensed Practical Nurse (LPN) A said:-The resident was on weight monitoring for nutrition and eating tracking.-The resident was on daily weights.-The aides did the weights for the residents that were assigned to them.-The aides wrote the weights down and gave it to the nurse who documented in the resident's Electronic Health Record (EHR).-He/She expected daily weights to be done for the residents who had orders for it.-If residents had a fluctuating weight it was reported to the physician.-Aides were able to weigh the residents but not able enter into the EHR.During an interview on 08/21/2025 at 11:21 A.M., the Director of Nursing (DON) said:-The resident received daily weights.-The CNAs completed the weights.-The CNAs documented the weights in the vitals tab in the EHR or gave it to the charge nurse or nurse manager.-The nurses input the weights into the EHR quickly. -If they were not documented in the EHR they could be in the nurse manager's office.-He/She would check and provide them if found. -The resident was on daily weights due to CHF. -NOTE: no additional weight documentation was provided.During a follow up interview on 08/22/2025 at 1:15 P.M., the DON said:-He/She expected physician orders to be followed.-If the orders were to obtain daily weights, he/she expected nursing staff to follow those orders.-Normally the CNA assigned to that resident weighed the resident.-Weights were documented in the TAR or the vitals tab in the resident's EHR. -Weights were reported to the charge nurse or nurse manager.-CNAs were able to enter weights into the EHR or they gave a written copy to the nurse to enter.-If there was a change in the weight the charge nurse notified the physician.A message was left with the physician's messenger services 08/26/2025 at 8:40 A.M. Return call has not been received.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure a resident's oxygen equipment was kept in a sanitary manner when not in used for two sampled residents, (Resident #36 and Resident #37) out of 12 sampled residents. The facility census was 36 residents.Review of the facility's policy, Oxygen Concentrator, dated 2022 showed:-Staff was responsible for the use and care of oxygen concentrators.-Keep delivery devices covered in a plastic bag when not in use.-Change oxygen tubing and mask weekly and as needed if it becomes soiled or contaminated.-Change nebulizer tubing devices every 72 hours. 1. Review of Resident #36's face sheet showed he/she was admitted to the facility on [DATE] with a diagnosis of Chronic Obstructive Pulmonary Disease (COPD - a group of lung diseases that block airflow and make it difficult to breathe). Review of the resident's quarterly Minimum Data Set (MDS - a federally mandated assessment tool completed by the facility for care planning) dated 6/26/25 showed:-He/She was cognitively intact.-Continuous positive airway pressure (CPAP - a treatment for sleep apnea which uses a mask to deliver constant and steady air pressure to help you breath while asleep) was not checked.-Oxygen (a therapy treatment that provides extra oxygen to help people with breathing difficulties) was not checked. Review of the resident's Physician's Order Sheet (POS) and Treatment Administration Record (TAR) for August 2025 showed to check and change CPAP tubing weekly every Sunday night shift, dated 2/26/23. Observation on 8/18/25 at 9:43 A.M. showed the resident had a CPAP machine and the mask sitting in the resident's drawer not in a bag. During an interview on 8/18/25 at 9:45 A.M. the resident said he/she needs assistance to get in and out of bed, the staff put his/her CPAP in the drawer. Observation on 08/19/25 at 11:50 A.M. showed the resident's CPAP mask sitting on a visible solid pad. Observation on 08/20/25 at 10:00 A.M. showed the resident's CPAP mask sitting on the same dirty pad. Observation on 8/21/25 at 9:45 A.M. showed the resident's CPAP mask was inside his/her pillowcase. 2. Review of Resident #37's Face sheet showed he/she was admitted on [DATE] with a diagnosis of COPD and Chronic Respiratory Failure (a long- term condition where the lungs can't effectively exchange oxygen and carbon dioxide, leading to shortness of breath). Review of the resident's August 2025 POS showed an order for Ipratropium-Albuterol (a combination medication used to treat and prevent wheezing and shortness of breath) Solution 0.5 to 2.5 (3) milligrams (mg)/3 milliliters (ml) one vial orally every six hours for cough related to COPD, dated 8/5/25. Observation on 8/18/2025 at 9:47 A.M. and on 8/20/25 at 10:50 A.M. showed the nebulizer mask was sitting in the drawer of the resident's nightstand not in a bag. 3. During an interview on 8/20/25 at 11:00 A.M. Certified Medication Technician (CMT) B said:-Oxygen equipment when not in use should have been stored in a bag.-They had received education from the Director of Nursing (DON) many times concerning oxygen/oxygen equipment storage.-It was the nurses' responsibility to ensure the oxygen equipment was stored correctly. During an interview on 8/20/25 at 11:10 A.M. Licensed Practical Nurse (LPN) A said:-Oxygen equipment when not in use should have been stored in a bag.-If the CPAP mask was sitting on a soiled pad, it should have been changed out.-They had received education from the DON many times concerning oxygen/oxygen equipment storage.-It was the nurses' responsibility to ensure the oxygen equipment was stored correctly. During an interview on 8/22/25 at 1:15 PM. the DON said when not in use oxygen equipment should have been stored in a bag and dated when it had been changed out.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, the facility failed to maintain the door between the kitchenette and the dining room in good repair; failed to prevent the accumulation of debris inside the climate control units of resident rooms [ROOM NUMBERS]; failed to ensure the cover of the cleanout was secured firmly to the floor. This practice potentially affected at least 25 residents who used the dining room and 4 residents who resided in resident rooms [ROOM NUMBERS]. The facility census was 36 residents.1. Observation on 8/18/25 at 10:32 A.M., showed the half door, which separated the dining room from the serving kitchenette dragged on the floor when it was opened and closed.During an interview on 8/18/25 at 10:33 A.M., Maintenance Person A said the door dragged on the floor due to a loose hinge.During an interview on 8/20/25 at 12:44 P.M. the Assistant Plant Operations Director said facility staff lean on that door when it is open and that caused the door to drag.2. Observation on 8/18/25 at 10:51 A.M., showed the presence of debris including a decoration inside the climate control unit in resident room [ROOM NUMBER].3. Observation on 8/18/25 at 10:58 A.M., showed a buildup of debris inside the climate control unit in resident rom 21.During an interview on 8/18/25 at 11:01 A.M., Maintenance Person A said the slats of the grate which covered the inside of the climate control unit, were too wide so more items accumulated within the climate control units in certain rooms and he/she was unaware of items which accumulated into the climate control units.4. Observation on 8/18/25 at 12:43 P.M., showed the cover of the cleanout (a capped pipe that provides access to a sewer or drain line, allowing for inspection, cleaning, and maintenance of the system) outside of laundry in the basement smoke zone, moved, when the cover was stepped on. During an interview on 8/18/25 at 12:43 P.M., Maintenance Person A said he/she did not know the cleanout cover was loose and not tightened.