STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265813	A. Building B. Wing	03/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Morningside Center	1700 Morningside Drive Chillicothe, MO 64601

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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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 Do Not Resuscitate Order's (DNR, medical order that instructs the health care provider not to do resuscitative measures if a person's heart stops) for Resident #29, Resident #13 and Resident #21 were correct when the Durable Power of Attorney's (DPOA) a legal document that authorizes a designee to manage financial or medical affairs if the person became incapacitated, name was printed on the DNR instead of the name of the resident on Resident #29's DNR, and when the facility failed to ensure that two residents (Resident #13 and Resident #21) had physician letters of incapacitation prior to the Power of Attorney designee making decisions for him/her. This affected three of 14 sampled residents (Resident #29, Resident #13 and Resident #21). The facility census was 56. The facility did not provide the requested code status policy.1. Review of Resident #29's Quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 02/17/26 showed:-Severe cognitive impairment;-Partial assistance from staff for Activities of Daily Living (ADL)s;-Incontinent of bowel and bladder;-Diagnoses included dementia, high blood pressure and coronary artery disease. Review of the resident's care plan dated 03/22/26 showed the resident had a code status of DNR.Review of the resident's medical record showed:- On 11/17/25 a physician's order for Do Not Resuscitate;- DNR showed the name of the resident's DPOA printed on the line reserved for the name of the resident;- The DNR form was signed by the resident's DPOA on 11/14/25 and by the physician on 11/25/25.During an interview on 03/20/2026 at 9:40 A.M., the Social Services Director (SSD) said: - She was responsible for ensuring the code status was correct for each resident;- She was responsible for ensuring DPOA paperwork was in place if needed and incapacitation letters if the resident had been deemed incapacitated; -The resident's name should be on the top of the DNR not the DPOA's name;-The resident should be the one to sign the DNR if they have not been deemed incapacitated.2.Review of Resident #13's admission MDS dated [DATE] showed:-Moderate cognitive impairment;-Partial assistance from staff for ADLs;-Incontinent of bowel and bladder;-Diagnoses included Parkinson's Disease and depression.Review of the resident's care plan dated 02/12/26 showed:-The resident had a code status of DNR.Review of the resident's medical record showed:-On 05/02/25 a physician's order for Do Not Resuscitate;-The DNR signed by DPOA on 05/02/25;-No letter of incapacitation was found that deemed the resident to incapacitated.3.Review of Resident #21's Annual MDS dated [DATE] showed:-Severe cognitive impairment;-Substantial assistance with ADLs;-Incontinent of bowel and bladder-Diagnoses included Atrial fibrillation (an irregular heartbeat), kidney disease and dementia. Review of the resident's care plan dated 03/18/26 showed the resident had a code status of DNR.Review of the resident's medical record showed:-The DNR signed by DPOA on 01/15/25;-02/26/25 a physician's order for Do Not Resuscitate;-No letter of incapacitation was found that deemed the resident incapacitated.During an interview on 03/20/2026 at 9:40 A.M., the SSD said:-There were not letters for incapacity for resident #13 or #21;-She should have ensured resident #13 and resident #21 had incapacity verifications on file before the DPOAs signed the DNRs. During an interview on 03/20/2026 at 10:12 A.M., the Director of Nursing (DON) said:-The resident's (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	name should be printed on their DNR not the name of the responsible party;-She expects the DNRs to be correct;-SSD in charge of making sure the DNRs are correct.During an interview on 03/20/2026 at 10:46 A.M., the Administrator said:-The name of the DPOA should not be printed on the line designated for the resident;-The DNR for resident #13 and resident #21 are not correct;-There were no incapacitation letters for resident #13 and resident #21 on file;-The facility is responsible for ensuring incapacitation letters are in the resident's medical record;-She expected the DNRs for Resident #13 and Resident #21 to be correct.

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure resident assessments were completed accurately for two of 14 sampled residents (Resident #1 and Resident #7) when the facility failed to accurately document a diagnosis of Resident #1 and failed to accurately document a Urinary Tract Infection (UTI) for Resident #7. The facility census was 56.The facility did not provide a resident assessment or Minimum Data Set (MDS) policy. MDS is a federally mandated assessment completed by facility staff in accordance with specified formats and timelines in conducting comprehensive assessments as part of an ongoing process through which the facility identifies preferences and goals of care, functional and health status, strengths and needs. 1. Review of Resident #1's Quarterly MDS, a federally mandated assessment completed by facility staff, dated 02/03/26, showed:-Resident had no cognitive impairment;-Diagnoses included high blood pressure and kidney failure;-Chronic Obstructive Pulmonary Disease (COPD) was not selected as a diagnosis. Review of Physician Order Set (POS) showed:-An order dated 12/30/2025 for Azithromycin (an antibiotic) 250mg orally, daily for four days for an Upper Respiratory Infection;-An order dated 12/29/2025 for Mucinex (a medication used to thin and loosen mucus), twice daily for seven days for an Upper Respiratory Infection;-Orders dated 05/02/2025 for cough syrup as needed and supplemental oxygen as needed. Review of Electronic Medical Record (EMR) dated 01/13/2026, showed an emergent transport to the emergency room for low blood oxygen levels, shortness of breath and tachycardia (abnormally fast resting heart rate). Review of EMR dated 01/16/2026 showed resident had been admitted to the hospital with diagnosis of COPD exacerbation and Pneumonia. Review of resident's care plan dated 02/25/2026, showed:-Resident required Enhanced Barrier Precautions (EBP- an infection control strategy in nursing homes requiring the use of gowns and gloves during high-contact care for residents at risk of multidrug-resistant organisms (MDROs)) related to a chronic wound;-Poor safety awareness and confusion, both can be symptoms of low blood oxygen levels, a known complication of COPD;-No mention of any use of supplemental oxygen, or goals and interventions to prevent recurrent Upper Respiratory Infections (URI). During an Interview on 03/20/2026 at 12:00P.M., the MDS coordinator said that if a resident was admitted to facility with a diagnosis of COPD, then that diagnosis should be reflected on the MDS assessment after admission and that he/she often is not able to update care plans and MDS assessments as quickly as he/she should. 2. Review of Resident #7's Quarterly MDS dated [DATE], showed:-Resident had severe cognitive impairment;-Incontinent of bowel and bladder; total assist of nursing care;-Diagnoses included heart disease, osteoarthritis and failure to thrive;-Urinary Tract Infection (UTI) in last 30 days was not selected. Review of Resident's care plan dated 11/12/2025, showed:-He/She required assistance with dressing, toileting, transfers, and locomotion;-He/She had urinary incontinence and was at risk for UTI'S and skin breakdown;-Resident to have any UTI's detected and treated promptly;-At risk for not having needs met. Review of Resident's Physician Order Sheet (POS) showed an order for urinary analysis (UA) dated 03/10/2026; and a subsequent order for Keflex (an antibiotic) 500mg orally twice daily for 7 days for a UTI after a positive result on UA. During an Interview on 03/20/2026 at 12:00P.M., the MDS coordinator said:-If a resident was admitted to facility with a diagnosis of UTI and is on antibiotics, then that diagnosis should be reflected on the MDS assessment after admission;-He/she often is not able to update care plans and MDS assessments as quickly as he/she should;-Most information is obtained from electronic medical record and facility staff charting. During an interview on 03/20/2026, at 12:19P.M., the DON stated that all MDS assessments should be accurate and completed in a timely manner per CMS requirements.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. When facility staff did not address UTI (urinary tract infection) with antibiotic usage for two residents (Resident #25 and Resident #14), did not address use of anticoagulant medication or therapeutic activities for one resident (Resident #52) and when dementia care had not been cared planned for one resident (Resident #29 & Resident #52). This affected four of the 14 sampled residents. The facility census was 56.Review of the facility's care plan policy, updated 8/2024 showed a comprehensive, person-centered care plan will include measurable objectives and timetables to [NAME] the resident's physical, psychosocial and functional needs is developed and implemented for reach resident. This includes services that will attain or maintain the resident's highest practicable self. Care plan will be completed by qualified persons, culturally competent and have careful consideration of the resident's problems and needs. Care plans are to be revised and updated according to the resident's needs and ongoing. 1.Review of Resident #25's Quarterly MDS, (minimum data set) A federally mandated assessment completed by facility staff., dated 2/24/26 showed: -Cognition not intact -Required assistance with all personal hygiene, grooming, transfers, and indwelling urinary catheter care. -Diagnoses: disease of the prostate with ongoing urinary tract symptoms, high blood pressure, dementia, and reoccurring antibiotic use for urinary infections. Review of the resident's care plan dated 3/11/26 showed no indication of antibiotic use for UTI or history of UTIs. During an interview on 3/19/26 at 1:45 P.M. the family member said the resident had problems with infections and frequent needs of antibiotics because of the catheter and was involved in the care planning for the resident. He/she expected that all needs regarding antibiotics and care of the UTI would be addressed so all staff know how to best care for the resident. During an interview on 3/19/26 at 2;45 P.M RN B said the resident's use of antibiotics should be care planned, and all care associated with the urinary catheter should be care planned. 2.Review of Resident #14's Quarterly MDS, dated [DATE] showed: -Cognition not intact -Behaviors associated with dementia -Total assist of personal hygiene, grooming and care. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Urinary incontinence with UTIs Review of care plan dated 1/15/2026 and reviewed again on 3/3/26 did not address frequent UTI and use of antibiotics to manage UTI or staff intervention to help manage UTI prevention. Behavioral monitoring on the care plan did not address the possibility of an active UTI as probable cause of behaviors. Review of lab results for urinalysis dated 3/18/26 showed active UTI and new antibiotics ordered for the treatment included Keflex 250mg daily with no stop date. During an interview on 3/19/26 RN A said that resident's with UTIs, history of UTI, and use of antibiotics should be care planned and was not sure why it was not listed on the resident's current care plan. 3.Review of Resident #52's Quarterly MDS, dated [DATE]., showed -Not Cognitively Intact related to Dementia; -Total assist of all personal care, hygiene, transfers, medication administration; -Used anticoagulants (a medication to keep blood from forming a clot) to prevent blood clots. Review of physician's orders showed the resident was prescribed Eliquis 5mg twice a day to prevent blood clots. Review of the resident's care plan completed on 3/18/25 and reviewed on 3/5/26 showed the resident's care plan did not address the resident's use of the blood thinner Eliquis or interventions needed for the monitoring of the resident while on this medication. The care plan additionally did not address any activity interests or dementia care with resident centered interventions to address psychosocial needs of the resident or staff interventions to help with behaviors when occur. During an interview on 3/19/26 at 3:30 P.M RN B said the resident takes a blood thinner twice a day and was not sure why it was not addressed on the care plan but should be. RN B was not sure who was responsible for doing this but did not think it was his/her responsibility to do that. RN B did not know the interests of the residents, other than sitting in his/her room when spouse visits. During an interview on 3/19/26 at 3:50 P.M. the MDS coordinator said she does her best to update care plans related to changes in the resident's needs when she can and when the information is provided to her. During an interview on 3/20/26 at 12:15 P.M the Director of Nursing said- Residents on antibiotics, blood thinners, infections, dementia care, and activity interest showed be care planned and updated as needed. 4.Review of Resident #7's Quarterly MDS dated [DATE], showed: -Severe cognitive impairment; -Incontinent of bowel and bladder; (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Two or more falls since previous MDS assessment; -Requires maximum assistance with eating, toileting, mobility and transfers; -Diagnoses included heart disease, osteoarthritis and failure to thrive. Review of Resident's care plan dated 11/12/2025, showed: -He/She requires assistance with dressing, toileting, ambulation with walker at times, transfers, and locomotion; -Protection sleeves to both arms and legs to prevent skin tears; -He/She is at risk for skin breakdown due to thin skin, poor nutrition, incontinence, and decreased activity level; -Skin integrity problem start date of 01/13/2025 with no updated goals, interventions or approaches since initiation. During an interview on 03/18/2026 at 1:43P.M., CNA B said: -Resident previously ambulated and went to restroom; -Resident now dependent in all cares, including eating, toileting, ADL's and mobility; -Resident is a mechanical lift transfer with two staff members; During an interview on 03/20/2026 at 12:00P.M., the MDS Coordinator said: -Care plans are updated every quarter; -Information is obtained from charting; -If a resident is a mechanical lift transfer, the resident should be listed as dependent not maximum assist; -It is not reasonable for a resident that has gone from continent and ambulatory to dependent with all cares and incontinent to not have skin integrity care plan updated or adjusted. During an interview on 03/20/2026 at 12:40P.M., the DON said that care plans are updated quarterly and should be accurate to ensure proper care of residents. 5. Review of Resident #1's Quarterly MDS dated [DATE], showed: -No cognitive impairment; -Dependent with transfers, lower body tasks and toileting hygiene; (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Participated in physical and occupational therapies; -Diagnoses included kidney failure, diabetes, high blood pressure and pain. Review of care plan dated 12/26/2025, showed: -He/She has a history of fall with hip fracture; -He/She is walking with a platform walker; -Mechanical lift for all transfers, currently non-weight bearing related to a wound. Review of Progress Notes showed: -11/04/2025 Resident chooses to use mechanical lift for transfer instead of pivot transfer or slide board transfers; -02/10/2026 Therapy discontinued mechanical lift, resident able to use sit to stand machine for transfers and toileting; -02/13/2026 Physician signed order to change transfer status; -02/26/2026 Discontinued sit to stand transfer and returning to mechanical lift due to inability to stand with staff. Review of activity order for Resident #1 showed: -Activity as tolerated ordered on 06/05/2024; -Activity order discontinued on 09/09/2024; -No additional activity or weight bearing order initiated. Review of Referral Form from Podiatrist dated 01/09/2026, showed resident may progress weight-bearing activity and has been cleared to stand and bear weight on both feet. Review of Referral Form from Podiatrist dated 02/19/2026, showed resident now full weight-bearing. 6.Review of Resident #5's Quarterly MDS dated [DATE], showed: -Severe cognitive impairment; -Dependent in all care areas including eating, mobility, toileting and hygiene; -Diagnoses included Non-Alzheimer's Dementia, pain and Urinary Tract Infection (UTI). Review of care plan dated 11/13/2025, showed: (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Dependent on staff for Activities of Daily Living (ADLs); -Flat call light to be at Resident's side where it will activate if he/she attempts to get out of bed without assistance. -At risk for UTI's and skin breakdown. During an interview on 03/20/2026 at 12:00P.M., the MDS Coordinator said: -If an MDS is submitted 03/05/2026, there are 14 days to update comprehensive care plan; -All nursing staff is able to access each resident's care plan in Electronic Medical Record (EMR) system; -Nursing staff work all units and are responsible to ensure they are looking at care plans to provide appropriate care.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed ensure professional standards of quality of care and all services are provided according to accepted standards of clinical practice when licensed nursing staff administered medications without verification of the order prior to administration for two residents (Resident #1 and Resident #34) and when not maintaining proper nursing techniques and infection control measures for the removal and insertion of an indwelling urinary catheter for two residents (Resident #25 and Resident #5). The affected four residents out of the 14 sampled residents. The facility census was 56.Review of the facility's undated Catheter Insertion and Removal Policy showed: -After donning sterile gloves, use one hand to expose urinary meatus, with the other hand, cleanse resident using one stroke downward and discarding cleanser, repeat the same procedure with other side of meatus; -Cleanse directly over the urinary meatus with a clean wipe, one stroke downward and discard;-Insert catheter into meatus at an upward angle; -Give peri-care and leave resident clean and comfortable; -Always keep drainage bag off the floor. Review of the Journal of Infection Control and Epidemiology article titled Guideline for Prevention of Catheter Associated Urinary Tract Infections dated 01/02/2019, showed: -Do not allow the drainage bag to touch or rest on the floor; -Maintain unobstructed urine flow by keeping the drainage tube above the collection bag and free of kinks; -Avoid dependent loops. 1. Review of Resident #1's admission care plan showed the resident was alert and oriented with cognition intact and a recent re-admission to the facility. The resident was an insulin dependent diabetic and took insulin with all meals. Resident was dependent on nursing staff to administer medications per physician orders. Record review showed the resident had a current physician's order dated 01/16/2026 for Lispro Insulin injection of 100 units per milliliter (ml) and orders to have 3ml subcutaneous (fatty layer of tissue between the skin and muscle) with meals. Observation on March 19, 2026 at 11:56 A.M., showed RN B at the medication cart, with computer screen closed preparing supplies to administer the resident's lispro insulin, dose was dialed to 3 ml and the medication was administered to the resident. The order was not verified in the electronic medical record at any time by RN B prior to administration of the insulin, and it was not observed that the insulin was documented as given at the time it was observed being administered by RN B from memory. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Review of Resident #34's Quarterly MDS (Minimum Data Set), a federally required assessment completed by facility staff, was completed on 11/6/2025 and showed the resident was cognitively intact and was being treated for pain. Record review showed the resident had a current physician's order dated 01/05/26 for Hydrocodone/APAP 10/325mg 1 tablet to be administered four times a day for pain. Observation on March 19, 2026, at 12:11 P.M. showed RN B at the medication cart, opened the locked medication box and removed one tablet from the bubble-packed narcotic card (a cardboard piece of paper containing multiple pills) of Hydrocodone/APA P 10/325mg pills and administered the medication to the resident. RN B did not look at the order on the electronic medical records to verify if there had been any changes to this medication. The medication was given from RN B's memory. During an interview on March 19, 2026, at 3:10 P.M. RN B said he/she knew what medications to give, did not verify the physician's medication orders prior to administering the medications to both residents, but should have and should always verify an order prior to giving any medications. During an interview on March 19, 2026, at 3:45 P.M, the Administrator and Director of Nursing said it is the expectation that all physician orders should be verified and reviewed prior to the administration to any resident and then documented immediately when given. It was also the expectation that as an RN he/she should always ensure that this was done properly and according to the facility policy and best nursing practice. 3. Review of Resident #25's Quarterly MDS, dated [DATE] showed: -Cognition not intact -Required assistance with all personal hygiene, grooming, transfers, and indwelling urinary catheter care. -Diagnoses: disease of the prostate with ongoing urinary tract symptoms, high blood pressure, dementia. Review of physician orders dated 1/30/26 showed change indwelling urinary catheter monthly on the 19th and as needed for nodular prostrate. Observation and interview with RN B during an indwelling urinary catheter removal and insertion of new indwelling urinary catheter on 3/19/26 at 1:40 P.M., showed: -Resident was assisted to the bed to lay down. -RN B with gloved hands, took a pair of used scissors and cut the port to catheter balloon port, with zero return of any fluid in to collecting container. RN B stated I am old school and this is the way I do it -RN B through away removed catheter, and gloves and washed hands. -RN B laid down a clean towel and sat urinary catheter insertion tray on top of towel, dropped the insertion tray on the floor picked up and placed back on top of the clean towel. Opened the sterile (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	insertion tray, applied sterile gloves, and opened the cleansing swabs, used one swab at a time, and cleaned the urinary opening in a circular motion and did not cleanse away from the urinary opening. Catheter tubing was inserted into the urinary opening with a 20-cc balloon bulb inflated to secure inside the placement. No immediate return of urine was noted, with sterile gloves dropped the leg secure strap on the floor then bent over and picked it up and then with contaminated glove attempted to advance the urinary catheter further into the resident's urinary opening. 4.Review of Resident #5's MDS dated [DATE], showed: -Severe cognitive impairment; -Dependent in all care areas including eating, mobility, toileting and hygiene; -Diagnoses included Non-Alzheimer's Dementia, pain and Urinary Tract Infection (UTI). Review of care plan dated 11/13/2025, showed: -Dependent on staff for Activities of Daily Living (ADLs); -Staff to provide catheter care every shift and as needed; -At risk for UTI's and skin breakdown. Observation on 03/19/2026 at12:20P.M. showed: -RN A removed sterile catheter from kit, tore the plastic packaging of the catheter, approximately 3-4 inches from tip of catheter, and handed catheter to CNA A; -RN A open and applied sterile gloves; -RN A placed each of his/her hands on inner thighs of each of Resident's legs, breaking one hand sterile technique of catheter insertion; -RN A used his/her left hand to stabilize resident's genitals, removed an antiseptic swab from packaging with his/her right hand; -RN A wiped antiseptic swab in a circular motion, then placed used swab into catheter kit packaging; -RN A obtained another antiseptic swab and wiped resident's genitals with swab in a circular motion, placed used swab into catheter kit and then repeated same process with remaining antiseptic swab; this should be done in one motion in a downward swipe and then discarded to ensure antisepsis (the application of antimicrobial chemicals to living tissue to destroy pathogens and prevent infection.) -RN A removed the lubricant packaging from catheter and obtained catheter from CNA A; -RN A inserted the catheter into resident's urethra, slightly removed catheter and then re-inserted catheter until urine was seen flowing from catheter; -RN A removed gloves, while applying a new sterile glove to his/her right hand, experienced (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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	difficulties, used his/her ungloved left hand to manipulate fingers of glove on to his/her right hand; -RN A used contaminated sterile gloved hand to further advance catheter into urethral opening; -RN A used both contaminated gloved hands to fill internal catheter stabilizing balloon through provided port on catheter tubing; -CNA A attached drainage bag and tubing to bed frame; -CNA A then lowered resident's bed causing a dependent loop in tubing and the drainage bag to lay directly on the floor. During an interview on 03/20/2026 at 10:00A.M., RN C said: there should be no dependent loop or coiling in tubing as this stops flow of urine and can lead to infection and Resident #5 is prone to frequent UTI's; During an interview on 03/19/2026 at 4:00P.M., RN A said: -He/She was not used to working with CNA C and that messed up the flow of the process; -He/She uses a circular motion to cleanse genitals instead of using a downward stroke; -He/She should have cleansed peri area of resident after inserting new catheter. During an interview on 03/20/2026 at 12:00P.M., the DON said: -Sterile procedure to be maintained during catheter insertion; -Staff should provide perineal care after insertion of catheter; -Staff should provide catheter care each shift and as needed for soiling.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure dependent residents who were unable to carry out activities of daily living (ADLs) received the necessary services to maintain good personal hygiene when staff failed to provide complete perineal care for Residents #13, #5, #7, #50 after an incontinence episode. This affected four of 14 sampled residents. The facility census was 56. Review of the facility's Perineal Care policy dated 2024 showed:-This procedure provides cleanliness and comfort to the resident and prevents infections;-Review the resident's care plan for any special needs of the resident;-Assemble any special supplies that are needed;-Use personal protective equipment;-Wipe from front to back cleaning all areas that urine and feces have touched;-Document how the resident tolerated the procedure and if the resident refused care;-Report any other information in accordance with facility policy and professional standards of practice. 1. Review of Resident #13's admission Minimum Data Set (MDS) a federally mandated assessment instrument completed by facility staff, dated 01/27/26 showed:-Moderate cognitive impairment;-Partial assistance from staff for activities of daily living (ADL)s;-Incontinent of bowel and bladder;-Diagnoses included Parkinson's Disease and depression. Review of the resident's care plan dated 02/12/26 showed:- Assistance of one staff for toileting;-Incontinent of urine;- Observe for signs and symptoms of a urinary tract infection (UTI) a common bacterial infection of the bladder or kidneys causing pain and burning. Review of the resident's Physician's Order Sheet (POS) dated February 2026 showed:-3/9/26 order for urinalysis (a test that can detect a urinary tract infection);-Order start date: 3/11/26, Bactrim DS (an antibiotic used to treat infections) 800 milligram (mg) /160 mg, give twice daily for UTI;-Order start date: 3/17/26, Amoxicillin (an antibiotic used to treat infections) 500 mg, give one tablet every 8 hours. Review of the resident's medical record showed:-3/11/26 lab results showed the resident's urine contained bacteria;-3/18/26 progress note, continued on Amoxicillin (antibiotic used to treat infection) for UTI. The resident was incontinent of urine and required assistance with perineal care;-03/16/2026 new order received to discontinue Bactrim DS and start Amoxicillin. Observation on 03/19/2026 at 08:43 A.M., showed:-Nurse's Aide (NA) A entered the resident's room;-The resident sat on the toilet;-There were droplets of yellow liquid on the top of the resident's upper thighs and in between his/her legs;-NA A washed his/her hands and applied gloves;-NA A removed the resident's wet brief while he/she sat on the toilet;-NA A placed a clean brief on the resident;-NA A cleaned the back of the resident using one wipe for each cleansing;-NA A assisted the resident to his/her feet and pulled the resident's clean brief and pants up;-NA A did not offer or attempt to clean the front of the resident where urine and/or feces had touched. During an interview on 03/19/2026 at 09:05 A.M., NA A said:-He/She had not been on the resident's hall very often;-He/She should have asked or offered to do perineal care on the resident's front side but he/she did not;-When doing perineal care he/she should have cleaned all areas that urine or feces had touched or offer to do so. During an interview on 03/19/2026 at 09:24 A.M., Registered Nurse (RN) A said:-The resident required assistance of one staff for toileting;-The resident could get himself/herself to the toilet but needed (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	help with cleaning up;-The resident refused cares at times but he/she expected NA A to offer to clean all areas that urine or feces had touched;-The resident was on an antibiotic for a UTI;-Failing to clean all areas that urine and feces had touched can contribute to a uti. During an interview on 03/20/2026 at 10:12 A.M., the Director of Nursing (DON) said:-She expected staff to clean all areas where urine or feces had touched;-She expected NA A to offer to do perineal care on the resident's front side;-The resident was on an antibiotic for a UTI;-Incomplete perineal care was an important step to prevent infections. During an interview on 03/19/2026 at 10:38 A.M., the Administrator said:-She expected care to be given to prevent infections and provide comfort to the residents. 2.Review of Resident #5's MDS dated [DATE], showed: -Severe cognitive impairment; -Dependent in all care areas including eating, mobility, toileting and hygiene; -Diagnoses included Non-Alzheimer's Dementia, pain and Urinary Tract Infection (UTI). Review of care plan dated 11/13/2025, showed: -Dependent on staff for Activities of Daily Living (ADLs); -Staff to provide catheter care every shift and as needed; -Requires enhanced barrier precautions to help prevent resident from infection; -At risk for UTI's and skin breakdown. Observation of evening ADLs on 03/17/2026 at 07:43P.M., showed: -LPN A reminded MDS to apply Personal Protection Equipment (PPE) prior to providing cares; -During incontinence cares, LPN A wiped buttocks and coccyx four times with the same disposable wipe before discarding; -External catheter stabilizing device not properly attached, which can cause internal tension and injury; -Neither staff member provided a drink to dependent resident; -No oral care or hair care provided to resident. During an interview on 03/19/2026 at 03:30P.M., LPN A said that disposable wipes should not be folded and reused, after a wipe is used, it must be discarded. During an interview on 03/20/2026 at 12:00P.M., the DON said: (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Incontinent residents to be checked for incontinence and changed every two hours and as needed; -Dependent residents should be assisted with oral care and ADLs twice daily; -Staff should offer a drink to dependent resident when in the room and when providing cares. 3.Review of Resident #7's Quarterly MDS dated [DATE], showed: -Severe cognitive impairment; -Incontinent of bowel and bladder; -Requires maximum assistance with eating, toileting, mobility and transfers; -Diagnoses included heart disease, osteoarthritis and failure to thrive. Review of Resident's care plan dated 11/12/2025, showed: -He/She requires assistance with dressing, toileting, ambulation with walker at times, transfers, and locomotion; -Protection sleeves to both arms and legs to prevent skin tears; -He/She is at risk for skin breakdown due to thin skin, poor nutrition, incontinence, and decreased activity level; An observation during evening cares on 03/17/2026 at 06:48P.M., showed: -LPN A and MDS transferred resident to bed using a mechanical lift, revealing resident's saturated pants; -Incontinence brief is dated and timed as 03/17/26 at 02:07P.M; -LPN A placed clean brief underneath soiled brief during incontinence cares; LPN A wiped bowel with disposable wipe twice, not disposing after first use; -LPN A wiped resident's genitals with disposable wipe, folded wipe and wiped three more times before disposing of used wipe; LPN A repeated this action two additional times before disposing of wipe; -No barrier cream was applied; -Resident was heard telling staff that his/her tailbone was hurting. An observation on 03/18/2026 at 1:43P.M., showed: -CNA C and CNA D transferred resident to bed utilizing a mechanical lift, revealing saturated pants; (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Brief is timed and dated 03/18/2026 at 08:07A.M.; -During incontinence cares, CNA D wiped resident's coccyx and buttocks with a disposable wipe, folded and re-used wipe three times; -Staff did not provide oral care or hydration during cares. An observation of morning cares on 03/19/2026 at 09:29A.M., showed: -Incontinence brief was saturated, timed and dated for 03/19/2026 at 06:25A.M.; -CNA A wiped resident's genitals and tucked used disposable wipe in between legs; -CNA A obtained a new wipe, wiped resident and tucked used wipe in between resident's legs; CNA A repeated this action two additional times, tucking used wipe in between resident's legs; -Resident was rolled on to side, CNA A removed soiled brief, rolled and placed on resident's bed; -CNA A and ADON did not perform hand hygiene or use ABHR between dirty and clean tasks; -No oral care or hydration provided to resident. During an observation on 03/20/2026 at 9:06A.M., showed: -CNA B and CNA C provided incontinence cares to resident, brief not timed or dated and is saturated; -Resident is wearing same clothing as previous day; -No oral care or hydration provided to resident. 4.Review of Resident #50's Comprehensive MDS dated [DATE], showed: -Resident has severe cognitive impairment; -Incontinent of bowel and bladder; -Dependent on facility staff for ADL's toileting, hygiene and eating; -Diagnoses included reflux, thyroid disorder and Alzheimer's Dementia. Review of care plan dated 01/08/2026, showed: - Requires assistance with ADLs due to poor cognition; - Staff must anticipate needs; -Assist with oral care to keep mouth clean; -At risk for skin breakdown due to incontinence and immobility. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 03/17/2026 at 7:33P.M., showed: -Resident has no bedside table, water pitcher on dresser, resident unable to reach when in bed; -Resident was assisted via mechanical lift to bed, revealing a saturated pants; -Brief was timed and dated 03/17/2026 at 4:00P.M.; -Brief and pants were soiled and saturated; -LPN A wiped resident with disposable wipe, folded wipe and wiped groin again; -LPN A removed lift sling from underneath resident by pulling material, shearing across back, instead of rolling resident to remove; -No drink was offered to resident or oral care provided. During an interview on 03/20/2026 at 9:15A.M., CNA B said: -Incontinent residents should be checked every 2 hours and changed as needed; -If a brief is checked and is dry, staff will indicate that on brief and put new time and date on brief; -Barrier cream should be applied to incontinent residents with each brief change. During an interview on 03/20/2026 at 11:15A.M., CNA A said: -Residents should not be left in wheelchair long enough to saturate brief and pants; -Incontinent residents should have their brief checked every two hours and changed as needed; -He/She doesn't apply barrier cream as often as he/she should. During an interview on 03/20/2026 at 10:00A.M., RN C said: -If a brief is checked and is dry, it is best practice to change brief anyway; -Barrier cream should be applied with each brief change; -Drinks should be offered to residents when in room; -Oral care should be completed upon rising, after meals and before going to bed in evening; -Used disposable wipes should no be tucked in between resident's legs after use as this can lead to infection. During an interview on 03/20/2026 at 12:00P.M., the DON said: -Each incontinent resident should have brief checked every two hours and changed as needed; (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Barrier cream to be applied to incontinent residents with each incontinent episode; -Resident's should not be left in a brief long enough to saturate brief and pants; -Staff complete yearly skills check-offs for resident cares.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure that two residents (Resident #5 & #25) who had urinary catheter (a tube inserted into the bladder to drain urine from the body), received appropriate treatment and services to prevent urinary tract infections when the facility failed to provide proper catheter care management. The affected two of the sampled 14 residents. The facility census was 56Review of the facility's undated Catheter Insertion and Removal Policy showed: -To remove catheter: put on disposable gloves, attach syringe to balloon port of catheter and aspirate entire amount of sterile water in balloon; -Pinch catheter and withdraw gently and slowly; -After donning sterile gloves, use one hand to expose urinary meatus, with the other hand, cleanse resident using one stroke downward and discarding cleanser, repeat the same procedure with other side of urinary opening; -Cleanse directly over the urinary meatus with a clean wipe, one stroke downward and discard;-Insert catheter into urinary opening at an upward angle; -Secure catheter tubing to leg; -Give peri-care and leave resident clean and comfortable; -Always keep drainage bag off the floor. Review of the facility's undated Indwelling Catheter Care Policy showed: -Pour warm water over perineal area; -Wash perineum well with soap and warm water, taking care to wash from front to back; -Cleanse well at catheter insertion, taking care not to pull on catheter or advance further into urinary opening; -Rinse well with warm water and pat dry gently with clean towel. Review of the Journal of Infection Control and Epidemiology article titled Guideline for Prevention of Catheter Associated Urinary Tract Infections dated 01/02/2019, showed: -Do not allow the drainage bag to touch or rest on the floor; -Maintain unobstructed urine flow by keeping the drainage tube above the collection bag and free of kinks; -Avoid dependent loops. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1.Review of Resident #5's MDS dated [DATE], showed: -Severe cognitive impairment; -Dependent in all care areas including eating, mobility, toileting and hygiene; -Recent admission to hospice services; -Diagnoses included Non-Alzheimer's Dementia, pain and Urinary Tract Infection (UTI). Review of care plan dated 11/13/2025, showed: -Dependent on staff for Activities of Daily Living (ADLs); -Staff to provide catheter care every shift and as needed; -At risk for UTI's and skin breakdown. Review of the Physician Order Sheet (POS) dated 03/18/2026 showed an order for Macrobid (an antibiotic) 100mg orally twice daily for seven days for a UTI. Review of Electronic Medical Record (EMR) showed resident hospitalized [DATE]-[DATE] with a UTI; a new urinary catheter was placed during hospital admission. Observation of removal of previous catheter and insertion of new indwelling catheter change on 03/19/2026 at12:20P.M. showed: -RN A placed a clean towel at foot of bed and a clean towel between him/her and Resident. RN A opened dependent drainage bag with attached tubing, handing it to CNA A instructing him/her to hold it in his/her hand; -RN A used scissors to cut the internal catheter stabilizing device port on catheter tubing, draining clear fluid into a 1000mL graduate. When the fluid stopped draining from tubing, RN A did not look at graduate to determine amount collected; sat graduate down on Resident's bed, it became disturbed, the graduate fell over, spilling fluid on Resident's bed and bedsheets. RN A did not follow the facility policy or appropriate nursing techniques when removing the indwelling catheter. -ADON removed the graduate, used catheter, used tubing with drainage bag and disposed of them in the garbage; -RN A and ADON washed hands and applied new gloves. -RN A placed gathered supplies in between Resident's calves. He/She opened manufacturer prepared sterile Catheter kit, removing packaged lubricant and packaged sterile gloves and placing on the towel between him/her and the Resident. -RN A opened packaged sterile antiseptic swabs and then returned swabs contained in original packaging into the catheter kit. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-RN A removed sterile catheter from kit, tore the plastic packaging of the catheter, approximately 3-4 inches from tip of catheter, and handed catheter to CNA A, instructing her to hold the catheter with his/her left hand and not to touch the exposed catheter or move it. -RN A tore open the lubricant package he/she obtained from towel and instructed CNA A to guide foley into opening on lubricant packaging; when this was completed, CNA A continued to hold catheter tubing wrapped in remaining plastic packaging; -RN A opened and applied sterile gloves, explained remaining procedure steps to the resident and asked him/her to open and relax his/her legs; -RN A placed each of his/her hands on inner thighs of each of Resident's legs, breaking one hand sterile technique of catheter insertion; -RN A used his/her left hand to stabilize resident's genitals, removed an antiseptic swab from packaging with his/her right hand; -RN A wiped antiseptic swab in a circular motion, then placed used swab into catheter kit packaging; -RN A obtained another antiseptic swab and wiped resident's genitals with swab in a circular motion, placed used swab into catheter kit and then repeated same process with remaining antiseptic swab; Did not clean away from the resident's urinary opening. -RN A removed the lubricant packaging from catheter and obtained catheter from CNA A; -RN A inserted the catheter into resident's urethra, slightly removed catheter and then re-inserted catheter until urine was seen flowing from catheter, RN clamped catheter by pinching tubing, stopping flow of urine; -RN A instructed CNA A to remove protective cap from tubing and drainage bag and connect tubing to catheter; -RN A removed gloves, applied a glove to his/her right hand, experienced difficulties, used his/her ungloved left hand to manipulate fingers of glove on to his/her right hand; -RN A applied left glove; -RN A used his/her right hand to further advance catheter into urethral opening without maintaining sterile technique. -RN A used both his/her hands to fill internal catheter stabilizing balloon through provided port on catheter tubing; -CNA A attached drainage bag and tubing to bed frame, RN A gathered and disposed of used supplies, removed gloves, washed hands and applied new pair; -CNA A removed gloves and applied a new pair; -RN A returned to resident's bedside, used alcohol pads to remove sticker from external catheter (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	stabilizing device on resident's left inner thigh and then placed new external catheter stabilizing device to same location on resident's left inner thigh; -CNA A then lowered resident's bed causing a dependent loop in tubing and the drainage bag to lay directly on the floor. During an observation on 03/20/2026 at 09:30A.M., -CNA B did not anchor catheter tubing at insertion prior to cleaning tubing; -Resident's external catheter stabilizing device not secured properly; -CNA B asked surveyor if drainage bag should lay on floor; -CNA C said that resident likely had a UTI based on apple juice colored urine. During an interview on 03/20/2026 at 09:30A.M., CNA C stated that catheter tubing should be anchored at insertion prior to cleansing. During an interview on 03/20/2026 at 10:00A.M., RN C said: -There should be no dependent loop or coiling in tubing as this stops flow of urine and can lead to infection and Resident is prone to frequent UTI's; -The catheter tubing should be attached to external stabilizing device by groove in tubing, not allowed to move freely in stabilizing device; -Staff has been trained in proper placement of external catheter stabilizing devices. During an interview on 03/19/2026 at 4:00P.M., RN A said: -He/She has always cut the balloon port because he/she is old school; -Cannot be sure how much fluid was removed from internal stabilizing balloon as fluid spilled on bed; -He/She uses a circular motion to cleanse genitals instead of a front to back swipe; -He/She should have cleansed peri area of resident after inserting new catheter. 2.Review of Resident #25's Quarterly MDS, dated [DATE] showed: -Cognition not intact -Required assistance with all personal hygiene, grooming, transfers, and indwelling urinary catheter care. -Diagnoses: disease of the prostate with ongoing urinary tract symptoms, high blood pressure, dementia. (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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of physician orders, dated 1/30/26 showed change indwelling urinary catheter monthly on the 19th and as needed for nodular prostrate. Observation and interview with RN B during a indwelling urinary catheter removal and insertion of new indwelling urinary catheter on 3/19/26 at 1:40 P.M., showed: -Resident was assisted to the bed to lay down. -RN B with gloved hands, took a pair of used scissors and cut the port to catheter balloon port, with zero return of any fluid in to collecting container. RN B stated I am old school and this is the way I do it -RN B through away removed catheter, and gloves and washed hands. -RN B laid down a clean towel and sat urinary catheter insertion tray on top of towel, dropped the insertion tray on the floor picked up and placed back on top of the clean towel. Opened the sterile insertion tray, applied sterile gloves, and opened the cleansing swabs, used one swab at a time, and cleaned the urinary opening in a circular motion and did not cleanse away from the urinary opening. Catheter tubing was inserted into the urinary opening with a 20 cc balloon bulb inflated to secure inside the placement. No immediate return of urine was noted, with sterile gloves dropped the leg secure strap on the floor then bent over and picked it up and then with contaminated glove attempted to advance the urinary catheter further into the resident's urinary opening. During an interview on 03/19/2026 at 4:00P.M., RN A said: -He/She has always cut the balloon port because he/she is old school; -Cannot be sure how much fluid was removed from internal stabilizing balloon as fluid spilled on bed; -He/She uses a circular motion to cleanse genitals instead of a front to back swipe; -He/She should have cleansed peri area of resident after inserting new catheter. During an interview on 03/20/2026 at 12:00P.M., the DON said: -Staff should provide catheter care each shift and as needed for soiling; -Catheter tubing should be anchored at insertion site prior to cleaning; -Staff should not fold and re-use wipes; -There should be coiling and a dependent loop in catheter tubing when hanging below level of resident's bladder.

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	265813	A. Building B. Wing	03/20/2026

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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. Based on observation, interview, and record review, the facility failed to ensure staff administered medications with an error rate of less than five percent (5%). When staff failed to verify a physician's order prior to the administration of insulin and narcotic medications resulting in two errors out of 25 opportunities for error, which resulted in an error rate of 8%. This affected two of the 14 sampled residents, (Resident #1 and #34). The facility census was 56.Review of the facility's policy titled, Medication administration-general guidelines, revised 8/16, showed: - 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 they have familiarized themselves with the medication;- Prior to administration, the medication and dosage schedule on the resident's medication administration record (MAR)/eMAR (electronic MAR) is compared with the medication label;- Information on the medication should be checked against the MAR/eMAR or treatment administration record (TAR)/electronic TAR (eTAR) at least three times during the med preparation and administration process;- If the label and MAR/eMAR or TAR/eTAR are different and the container is not flagged indicating a change in directions or if there is any other reason to question the dosage or directions, the physician's orders are checked for the correct dosage schedule prior to administering. 1. Review of Resident #1's admission baseline care plan showed the resident was alert and oriented with cognition intact and a recent re-admission to the facility. The resident was an insulin dependent diabetic and took insulin with all meals. Record review showed the resident had a current physician's order began on 1/16/2026 for Lispro Insulin injection of 100 units per milliliter (ml) and orders to have 3ml subcutaneous (fatty layer of tissue between the skin and muscle) with meals. Observation on March 19, 2026 at 11:56 A.M. , showed RN B at the medication cart, with computer screen closed preparing supplies to administer the resident's lispro insulin, dose was dialed to 3 ml and the medication was administered to the resident. The order was was not verified in the electronic medical record at any time by RN B prior to administration of the insulin, and it was not observed that the insulin was documented as given at the time it was observed being administered by RN B from memory. 2. Review of Resident #34's Quarterly MDS (Minimum Data Set), a federally required assessment completed by facility staff, was completed on 11/6/2025 and showed the resident was cognitively intact and was being treated for pain. Record review showed the resident had a physician's order Hydrocodone/APAP 10/325mg 1 tablet to be administered four times a day for pain and began on 1/5/2026 Observation on March 19, 2026 at 12:11 P.M. showed RN B at the medication cart, opened the locked medication box and removed one tablet from the bubble-packed narcotic card (a card board piece of paper containing multiple pills) of Hydrocodone/APA P 10/325mg pills and administered the medication to the resident. RN B did not look at the order on the electronic medical records to verify if their had been any changes to this medication. The medication was given from RN B's memory. During an interview on March 19, 2026 at 3:10 P.M. RN B said he/she knew what medications to give, did not verify the physician's medication orders prior to administering the medications to both resident, but should have and should always verify an order prior to giving any medications. During an interview on March 19, 2026 at 3:45 P.M, the Administrator and Director of Nursing said it is the expectation that all physician orders should be verified and reviewed prior to the administration to any resident, and then documented immediately when given. It was also the expectation that as an RN he/she should always ensure that this was done properly and according to the facility policy and best nursing practice.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are free from significant medication errors. Based on observation and interview the facility failed to ensure that two residents (Resident #1, and Resident # 34) were free from significant medication errors when RN B failed to verify an insulin and narcotic order prior to the administration of both, placing both residents at risk for negative outcome to their health and safety. This affected two residents out of 25 possibilities for a significant medication order. The facility census was 56. The facility was unable to provide any policy regarding a significant medication error. 1. Review of Resident #1's admission baseline care plan showed the resident was alert and oriented with cognition intact and a recent re-admission to the facility. The resident was an insulin dependent diabetic and took insulin with all meals. Record review showed the resident had a current physician's order for Lispro Insulin injection of 100 units per milliliter (ml) and orders to have 3ml subcutaneous (fatty layer of tissue between the skin and muscle) with meals. Order began on 1/16/2026 Observation on March 19, 2026 at 11:56 A.M. , showed RN B at the medication cart, with computer screen closed preparing supplies to administer the resident's lispro insulin, dose was dialed to 3 ml and the medication was administered to the resident. The order was was not verified in the electronic medical record at any time by RN B prior to administration of the insulin, and it was not observed that the insulin was documented as given at the time it was observed being administered by RN B from memory. 2. Review of Resident #34's Quarterly MDS (Minimum Data Set), a federally required assessment completed by facility staff, was completed on 11/6/2025 and showed the resident was cognitively intact and was being treated for pain. Record review showed the resident had a current physician's order for Hydrocodone/APAP 10/325mg 1 tablet to be administered four times a day for pain. Order began on 1/5/2026 Observation on March 19, 2026 at 12:11 P.M. showed RN B at the medication cart, opened the locked medication box and removed one tablet from the bubble-packed narcotic card (a card board piece of paper containing multiple pills) of Hydrocodone/APA P 10/325mg pills and administered the medication to the resident. RN B did not look at the order on the electronic medical records to verify if their had been any changes to this medication. The medication was given from RN B's memory. During an interview on March 19, 2026 at 3:10 P.M. RN B said he/she knew what medications to give, did not verify the physician's medication orders prior to administering the medications to both resident, but should have and should always verify an order prior to giving any medications. RN B said not verifying an order prior to the administration of a medication is a significant medication error. During an interview on March 19, 2026 at 3:45 P.M, the Administrator and Director of Nursing said it is the expectation that all physician orders should be verified and reviewed prior to the administration to any resident, and then documented immediately when given. It was also the expectation that as an RN he/she should always ensure that medication orders are verified to prevent a significant medication error from occurring.

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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 ensure staff provided care in a manner to prevent infection or the possibility of infection when the facility staff failed to maintain sterile precautions when placing a urinary catheter (a tube placed in the bladder to drain urine) for one Residents (Residents #5) out of the 14 sampled residents, and additionally when dietary staff failed to wash hands when serving water on 300 hall without performing hand hygiene between dirty and clean tasks. The facility census was 56.Review of the facility's undated Catheter Insertion and Removal Policy showed: -After donning sterile gloves, use one hand to expose urinary meatus, with the other hand, cleanse resident using one stroke downward and discarding cleanser, repeat the same procedure with other side of meatus; -Cleanse directly over the urinary meatus with a clean wipe, one stroke downward and discard;-Insert catheter into meatus at an upward angle; -Give peri-care and leave resident clean and comfortable; -Always keep drainage bag off the floor. Review of the facility's Handwashing/Hand Hygiene Policy dated 08/2024, showed: -All personnel are trained and regularly in-serviced on the importance of hand hygiene in preventing the transmission of healthcare-associated infections; -Hand hygiene is indicated after touching the resident's environment or contaminated surfaces; -An alcohol-based hand rub (ABHR) is sufficient for most clinical situations. 1.Review of Resident #5's MDS dated [DATE], showed: -Severe cognitive impairment; -Dependent in all care areas including eating, mobility, toileting and hygiene; -Diagnoses included Non-Alzheimer's Dementia, pain and Urinary Tract Infection (UTI). Review of care plan dated 11/13/2025, showed: -Dependent on staff for Activities of Daily Living (ADLs); -Staff to provide catheter care every shift and as needed; -At risk for UTI's and skin breakdown. Observation on 03/19/2026 at12:20P.M. showed: (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-RN A removed sterile catheter from kit, tore the plastic packaging of the catheter, approximately 3-4 inches from tip of catheter, and handed catheter to CNA A; -RN A open and applied sterile gloves; -RN A placed each of his/her hands on inner thighs of each of Resident's legs, breaking one hand sterile technique of catheter insertion; -RN A used his/her left hand to stabilize resident's genitals, removed an antiseptic swab from packaging with his/her right hand; -RN A wiped antiseptic swab in a circular motion, then placed used swab into catheter kit packaging; -RN A obtained another antiseptic swab and wiped resident's genitals with swab in a circular motion, placed used swab into catheter kit and then repeated same process with remaining antiseptic swab; this should be done in one motion in a downward swipe and then discarded to ensure antisepsis (the application of antimicrobial chemicals to living tissue to destroy pathogens and prevent infection.) -RN A removed the lubricant packaging from catheter and obtained catheter from CNA A; -RN A inserted the catheter into resident's urethra, slightly removed catheter and then re-inserted catheter until urine was seen flowing from catheter; -RN A removed gloves, while applying a new sterile glove to his/her right hand, experienced difficulties, used his/her ungloved left hand to manipulate fingers of glove on to his/her right hand; -RN A used contaminated sterile gloved hand to further advance catheter into urethral opening; -RN A used both contaminated gloved hands to fill internal catheter stabilizing balloon through provided port on catheter tubing; -CNA A attached drainage bag and tubing to bed frame; -CNA A then lowered resident's bed causing a dependent loop in tubing and the drainage bag to lay directly on the floor. During an interview on 03/20/2026 at 10:00A.M., RN C said there should be no dependent loop or coiling in tubing as this stops flow of urine. This can lead to infection and Resident #5 is prone to frequent UTI's. During an interview on 03/19/2026 at 4:00P.M., RN A said: -He/She was not used to working with CNA C and that messed up the flow of the process; -He/She uses a circular motion to cleanse genitals instead of using a downward stroke; -He/She should have cleansed peri area of resident after inserting new catheter. During an interview on 03/20/2026 at 12:00P.M., the DON said: (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Sterile procedure to be maintained during catheter insertion; -Staff should provide perineal care after insertion of catheter; -Staff should provide catheter care each shift and as needed for soiling. 2. Observation of the 300 hall on 03/19/2026 at 08:49 A.M., showed: -Dietary Aid (DA) entered unit with two carts, one empty and one containing approximately 20 pitchers of water; -DA entered room [ROOM NUMBER] with two clean water pitchers obtained from cart, he/she exited the room with two different cups and placed them on a different cart; -DA did not wash hands or sanitize with ABHR; -DA obtained two new pitchers of water from cart, entered room [ROOM NUMBER], and exited room with two different pitchers of water and placed on soiled cart; -DA did not wash hands or sanitize with ABHR; -DA repeated this going into rooms: 302, 304, 305, 306, 308 without performing any hand washing or using ABHR; Observation of the 300 hall on 03/20/2026 at 08:48A.M., showed: -Dietary Aid (DA) entered unit with two carts, one empty and one containing approximately 20 pitchers of water; -DA entered room [ROOM NUMBER] with two clean water pitchers obtained from cart, he/she exited the room with two different cups and placed them on a different cart; -DA did not wash hands or sanitize with ABHR; -DA obtained two new pitchers of water from cart, entered room [ROOM NUMBER], and exited room with two different pitchers of water and placed on soiled cart; -DA did not wash hands or sanitize with ABHR; -DA repeated this going into rooms: 303, 304, 305, 306, 307, 308 without performing any hand washing or using ABHR; During an interview on 03/20/2026 at 08:54A.M., the DA said: -He/She passes fresh water each day they work; -Dietary staff responsible for passing fresh water multiple times each day; -He/She should use ABHR between resident rooms when passing fresh water. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 03/20/2026 at 12:00P.M., the DON said: all staff are frequently in-serviced and observed performing hand hygiene and should use ABHR or wash hands between dirty and clean tasks. Observation of the dining room on 3/18/26 at 11:55 A.M., showed:- Dietary Aide (B) pushed a salad cart from table to table serving residents made to order salads. Staff member was serving without gloves.- 12:08 P.M. Dietary Aide (B) did not wash hands between serving each resident. Dietary Aide (B) touched the back of a resident with bare hands and then proceeded to serve another resident a salad. The salad was made by Dietary Aide (B) using tongs to place various salad items into a small bowl which was then placed in front of the resident with a plastic fork.- 12:10 P.M. Staff member continued to touch various residents and then served them a salad with no hand washing between residents served. During an interview on 3/19/26 at 11:40 A.M., Dietary Aide (B) said:- He/she operates the salad cart in the dining room and serves the residents salads based on their preferences.- He/she should wash hands between residents if touching a non-food service clean surface. He/she should wash his/her hands between touching residents and serving another resident due to the spread of germs. During an interview on 3/20/26 at 10:45 A.M., the Administrator said that staff should wash or sanitize their hands after touching a resident when serving meals in the dining room.