STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265816	A. Building B. Wing	09/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Schuyler County Nursing Home District	1306 US Highway 63 Queen City, MO 63561

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation and interview, the facility failed to ensure food service equipment/surfaces were appropriately cleaned under sanitary conditions in accordance with professional standards for food service safety, and failed to ensure trash cans were covered when not in use. The facility census was 41.Observations on 9/7/25 between 11:30 A.M. and 5:53 P.M., and on 9/8/25 between 9:27 A.M. and 9:42 A.M., in the kitchen showed the following:-The kitchen Heating Ventilation and Air-Conditioning System (HVAC) unit surfaces/supports above the upright refrigerator, two compartment food prep sink, and two spice/seasoning shelves, with a moderate to heavy buildup of dust and debris;-A two-bulb emergency light fixture above two spice/seasoning shelves, with a moderate buildup of dust and debris;-Between and above the food tray prep table and coffee maker/clean glassware areas, three ceiling light fixtures, connecting flex conduit and ceiling chain supports with a moderate to heavy buildup of dust and debris;-Under the hand washing sink beside the coffee machine, a trash can containing used paper towels with no cover (staff not working in the area); -At the end of a food prep table and beside a floor food mixer, a garbage can containing disposed of food items/paper items with no cover (staff not working in the area);-In the dishwashing area beside the dining room serving door, a garbage can containing disposed of food items/paper items with no cover (staff not working in the area). During an interview on 9/8/25 at 9:35 A.M, Dietary [NAME] (L) said trash cans in the kitchen and dishwasher areas should be covered when not in use. During an interview on 9/8/25 at 9:45 A.M., the Dietary Director said the following:-He was not aware of the identified areas;-The areas identified are to be monitored by all dietary staff, on an on-going basis;-He expected the identified HVAC unit, emergency light fixture and the ceiling lights, supports and conduits to be free of dust and debris;-He expects all trash/garbage cans in the kitchen/dishwasher areas to be covered when not in use.

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	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 develop policies to monitor the water system and implement the facility policy to monitor for Legionella (a bacterium that can cause a serious type of pneumonia called Legionnaires' Disease (a bacterial disease commonly associated with water-based aerosols) in persons at risk) control that included specific control parameters based on Center for Disease Control and Prevention (CDC) and American Society of Heating, Refrigerating and Air Conditioning Engineers (ASHRAE)) standards. The facility failed to ensure staff performed hand hygiene when providing incontinence care to four residents (Resident #3, #6, #40, #28), failed to ensure the urinary catheter drainage system was maintained off the floor for two residents (Residents #3 and #40), and to follow enhanced barrier precautions (EBP) for one resident (Resident #3) who had a urinary catheter, in a review of 17 sampled residents. The facility census was 41. 1. Review of the facility policy, Legionella Surveillance and Detection, revised September 2022, showed the following:-Facility is committed to the prevention, detection and control of water-borne contaminants, including Legionella;-Legionnaire's disease is included as part of our infection surveillance activities;-Legionella can grow in parts of building water systems that are continually wet (e.g., pipes, faucets, water storage tanks, decorative fountains), and certain devices can spread contaminated water droplets via aerosolization;-Legionellosis outbreaks are generally linked to locations where water is held or accumulates, and pathogens can reproduce. Transmission from these water systems to humans occurs when the water is aerosolized (i.e., converted into a spray/mist in the air);-Legionella is less commonly spread by aspiration of drinking water or ice;-As part of the infection prevention and control program, all cases of pneumonia that are diagnosed in residents> 48 hours after admission are investigated for possible Legionnaire's disease;-Clinical staff are trained on the following signs and symptoms associated with pneumonia and Legionnaire's:a. Cough;b. Shortness of breath;c. Fever;d. Muscle aches;e. Headache; andf. Diarrhea, nausea and confusion associated with Legionnaire's disease.-Risk factors for developing Legionnaire's Disease include:a. Age greater than (>) 50 years;b. Smoking (current or historical);c. Chronic lung disease, such as emphysema or COPD (chronic obstructive pulmonary disease);d. Immune system disorders due to disease or medication;e. Systemic malignancy; andf. Underlying illness, such as diabetes, renal failure, or hepatic failure;-If pneumonia or Legionnaire's disease is suspected, the nurse will notify the physician or practitioner immediately;-Residents who have signs and symptoms of pneumonia may be pl aced on transmission-based (droplet) precautions, although person-to-person transmission is rare;-Diagnosis of Legionnaire's disease is based on a culture of lower respiratory secretions and urinary antigen testing (concurrently);-Depending on the severity of illness, a hospital transfer may be initiated;-If Legionella is detected in one or more residents, the infection preventionist will:a. Initiate active surveillance for Legionnaire's diseases;b. Notify the water management team;c. Notify the local health department; andd. Notify the administrator and the director of nursing services. Review of the facility policy did not include monitoring water temperatures, dead legs, flushing unused areas, monitoring for scaling, sediment, or biofilm within the water system or guidance on what to monitor and what actions to take if any findings were outside facility established parameters. Review of the Centers for Medicare and Medicaid Services (CMS) Survey and Certification (S&C) letter 17-30, dated 06/02/17 and revised on 06/09/17, showed the following:-The bacterium Legionella can cause a serious type of pneumonia called LD in persons at risk. Those at risk include persons who are at least [AGE] years old, smokers, or those with underlying medical conditions such as chronic lung disease or immunosuppression. Outbreaks have been linked to poorly maintained water systems in buildings with large or complex water systems including hospitals and long-term care facilities. Transmission can occur via aerosols from devices such as shower heads, cooking towers, hot tubs and decorative fountains;-Facilities must develop and adhere to policies and procedures that inhibit microbial growth (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	monitor for. 4. During an interview on 09/10/25 at 2:25 P.M., the Maintenance Director said the following:-He, the Director of Nursing, the Administrator and the Medical Director made up the water management team;-The water management team met once after the last survey, but had not met since;-He was not familiar with the ASHRAE standards;-He did not monitor the cold-water temperatures and did not know if cold water temperatures stayed below 77 degrees F;-He did not know about cold and hot water ranges to prevent the growth of legionella;-He made sure hot water temperatures were between 105 degrees F and 120 degrees F.;-He did not check for sediment, scaling, or biofilm. During an interview on 09/09/25 at 1:47 P.M., the Director of Nursing (DON) said the following:-She did not know what ASHRAE standards were;-She had not attended a water management meeting;-She did not know if the IP had done any monitoring of any residents for legionellosis and did not have a plan to monitor future residents with pneumonia, -She did not know how or who to screen for legionellosis; -She had not educated any staff on what symptoms of legionellosis to monitor for. During an interview on 09/10/25 at 2:35 P.M., the Administrator said the following:-The facility staff do not know what ASHRAE standards are;-The facility did not have an active water management team, but the Maintenance Supervisor checked water temperatures weekly;-The facility had not had a water management meeting;-Staff was to follow the facility's policies that were in place;-The facility's water flow map was not complete. They had entry and exit points of water and water heaters, but no other areas in the building;-The facility was not sure what all needed to be monitored to prevent Legionellosis. 5. Review of the facility policy, Handwashing and Hand Hygiene, last revised October 2023, showed the following:-Hand hygiene is indicated: a. Immediately before touching a resident; b. Before performing an aseptic task (for example, placing an indwelling device or handling an invasive medical device); c. After contact with blood, body fluids or contaminated surfaces; d. After touching a resident; e. After touching the resident's environment; f. Before moving from work on a soiled body site to a clean body site on the same resident; g. Immediately after gown removal;-Use an alcohol-based hand rub containing at least 60% alcohol for most clinical situations;-Wash hand with soap and water when hands are visibly soiled and after contact with a resident with infectious diarrhea including but not limited to infections caused by norovirus, salmonella, shigella and Clostridioides difficile (C. Diff);-Single-use disposable gloves should be used: a. Before aseptic procedures; b. When anticipating contact with blood or body fluids; c. When in contact with a resident, or the equipment of a resident, who is on contact precautions;-The use of gloves does not replace hand washing/hand hygiene;-Applying and removing gloves: a. Perform hand hygiene before applying non-sterile gloves; e. Perform hand hygiene after removing gloves. Review of the facility policy, Urinary Catheter Care, last revised August 2022, showed the following:-Purpose of the procedure is to prevent urinary catheter-associated complications, including urinary tract infections;-Use aseptic technique when handling or manipulating the drainage system;-Be sure the catheter tubing and drainage bag are kept off the floor. Review of the facility policy, Enhanced Barrier Precautions, dated August 2022, showed the following:-Enhanced barrier precautions (EBP) are utilized to prevent the spread of multi-drug resistant organisms (MDROs) to residents;-EBP employs targeted gown and glove use during high contact resident care activities when contact precautions do not otherwise apply;-Gloves and gowns are applied prior to performing the high contact resident care activity (as opposed to before entering the room);-Examples of high-contact resident care activities requiring the use of gown and gloves for EBP include: dressing, bathing/showering, transferring, providing hygiene, changing linens, changing briefs or assisting with toileting, device care or use (central line, urinary catheter, feeding tube, tracheostomy/ventilator), wound care;-EBP is indicated for residents with wounds and/or indwelling medical devices regardless of MDRO colonization;-EBP will remain in place for the duration of the resident's stay or until resolution of the wound or discontinuation of the indwelling medical device that places them at increased risk;-Standard precautions apply to the care of all residents regardless of suspected or confined infection or colonization status;-Staff are trained prior to caring for residents on EBP;-Signs (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	talking to the resident;-The resident urinary catheter bag was in privacy bag that hung under the resident's wheelchair. The urinary catheter tubing lay on the floor under the wheelchair. Observation on 9/09/25 at 8:46 A.M., showed the following:-The resident sat in his/her wheelchair in his/her room;-The resident's urinary catheter bag was not in a privacy bag and was hooked to the underneath side of his/her wheelchair; -The urinary catheter tubing lay on the floor under his/her wheelchair. Observation on 9/10/25 at 8:30 A.M., showed the following: -The resident sat in his/her wheelchair in the doorway of his/her room;-The resident's urinary catheter bag was in a privacy bag on the floor below his/her wheelchair;-The resident self-propelled the wheelchair in the hallway and the catheter bag and tubing dragged on the floor under his/her wheelchair;-Two CNAs walked by the resident in the hallway and did not assist the resident. During interview on 9/10/25 at 6:25 P.M., CNA K said the following:-The urinary catheter bag and tubing should be kept off the floor;-The urinary catheter bag and tubing should hang on the bar underneath the wheelchair. 7. Review of Resident #6's hospital Discharge summary, dated [DATE], showed the following:-Chief complaint: hematuria;-Final diagnosis: Urinary tract infectious disease and blood in the urine;-Hospital course: Foley catheter was placed and the emergency room Physician contacted Urology at another hospital who stated the resident could be seen as an outpatient. Since admission, bladder irrigation (a procedure to flush out the bladder to remove mucus, sediment, blood clots or other debris) was performed;-Urine culture showed E coli (a bacteria commonly found in the intestines of humans and other animals). Review of the resident's Care Plan, updated 06/11/25, showed the following:-The resident had frequent episodes of incontinence;-Provide the resident with good peri-care with all incontinent episodes. Review of the resident's quarterly MDS, dated [DATE], showed the following:-Requires partial/moderate assistance from staff for personal hygiene;-Requires substantial/maximal assistance from staff for upper body dressing, lower body dressing; -Dependent on staff for toileting hygiene, shower/bathe and to roll left and right; -Indwelling urinary catheter (tube inserted in bladder to drain urine);-Always incontinent of bowel. Observation on 09/10/25 at 9:50 A.M., showed the following:-The resident was in his/her bed;-The resident had Enhanced Barrier Precautions signage on his/her door;-CNA N, NA O and CNA P cleansed their hands with alcohol gel, donned gloves and gowns and entered the resident's room;-NA O cleaned the resident's front perineal area; -NA O picked up the resident's perineal rinse cleanser bottle and sprayed a cloth;-NA O cleaned the resident's catheter with the same gloves he/she wore to provide perineal care;-NA O assisted CNA N to roll the resident to his/her left side, touching the resident's skin and clothing with the same gloves;-CNA N said the resident had a small bowel movement and cleaned the resident's back peri area;-CNA N did not remove his/her gloves, then assisted NA O to roll the resident to the other side; both CNAs touched the resident's skin, bedding and new incontinence brief; -NA O removed items from the resident's drawers with the same gloves he/she wore to provide perineal care;-CNA N and NA O removed their gloves, did not perform hand hygiene, and rolled the resident to his/her back, pulled him/her up in bed, touched several pillows, and touched the resident's skin, clothing and blankets. During an interview on 09/10/25 at 10:11 A.M., NA O said it would make sense to clean his/her hands after providing perineal care and before he/she touched clean items. He/She didn't think about it before. During an interview on 09/10/25 at 10:11 A.M., CNA N said staff was to wash their hands before and after providing major cares for a resident, before putting on gloves, after removing gloves, and between touching dirty and clean areas. He/She and NA O did not wash their hands when they removed their gloves because they routinely didn't, but they should. 8. Review of Resident #40's face sheet, showed the resident's diagnoses included history of UTI. Review of the resident's Care Plan, dated 8/05/25, showed the following: -The resident had a urinary catheter;-Staff needed to perform hand hygiene before entering and after leaving the resident's room;-Staff was to provide catheter care every shift;-The resident needed assistance from one staff for transfers, personal hygiene, dressing and bed mobility. -The resident had a colostomy (surgical opening in the large intestine) and this put him/her at risk for developing multi-resistant organisms (MDROs) and spreading them to others. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of the resident's quarterly MDS, dated [DATE], showed the following:-Severe cognitive impairment;-Dependent on staff for toileting and personal hygiene;-Indwelling urinary catheter and ostomy (surgical opening in any part of the gastrointestinal tract). Review of resident's Physician Orders, dated September 2025, showed the following:-Provide urinary catheter care every shift.-Change urinary catheter every month. Observation on 9/07/25 at 5:26 P.M., showed the following:-The resident sat in his wheelchair at the dining room table;-The resident's urinary catheter bag was in a privacy bag that hung under the resident's wheelchair;-The urinary catheter tubing lay on the floor under the wheelchair. Observation on 9/08/25, at 2:37 P.M., showed the following:-The resident sat in his/her wheelchair at the nurse's station;-Certified Nurse Assistant (CNA) C talked to the resident;-The urinary catheter bag was in a privacy bag that hung under the resident's wheelchair;-The urinary catheter tubing lay on the floor under the wheelchair. During interview on 9/10/25, at 6:26 P.M., CNA C said the urinary catheter bag and tubing should be kept off the floor. Observation on 9/09/25, at 8:56 A.M., showed the following:-CNA G, did not wash his/her hands, and put on gloves and a gown; -The resident had a colostomy bag attached to his/her abdomen;-CNA G emptied the colostomy bag into a plastic bag in the trash can;-He/She cleaned the opening end of the bag with a wet wipe. Feces were observed on the wet wipe; -CNA G did not change his/her gloves, and placed the clip on the end of the colostomy bag with the same gloved hand he/she used to clean the feces from the bag; -He/She said he/she usually had a helper who put the clip on the bag with clean hands, but that person was busy;-CNA G removed his/her gloves, did not perform hand hygiene, and put on new gloves; -He/She emptied the resident's urinary catheter into a graduated cylinder and disposed of the urine in the toilet. 9. Review of Resident #28's face sheet showed the resident's diagnoses included history of UTI. Review of the resident's Care Plan, dated 4/04/25, showed the following: -The resident required assistance from one staff for personal hygiene;-He/She had frequent episodes of bladder and bowel incontinence;-Staff was to provide good peri care after each incontinent episode. Review of the resident's quarterly MDS, dated [DATE], showed the following:-Partial/moderate assistance required for personal hygiene;-Always incontinent of bladder;-Frequently incontinent of bowel. Observation on 9/08/25, at 2:42 P.M., showed the following:-CNA C and CNA K entered the resident's room, did not perform hand hygiene, and put on gloves; -The resident lay in bed;-CNA K assisted the resident to roll towards him/her in the bed;-CNA C removed the resident's urine-soiled incontinence brief and provided peri care;-Without removing his/her gloves, CNA C placed a clean bed pad under the resident and clean incontinence brief on the resident. During interview on 9/08/25, at 2:50 P.M., CNA C said the following:-He/She should wash his/her hands when entering a resident's room;-He/She should remove his/her gloves and wash his/her hands after he/she provided peri care.-He/She did not change his/her gloves or wash his/her hands between dirty and clean care today, but he/she usually did. 10. During interview on 9/10/25 at 7:30 P.M., the Director of Nursing (DON) said the following:-Urinary catheter bag and tubing should be kept off the floor at all times;-Staff was to wear gowns and gloves when providing high contact care to a resident who was on EBP; -Staff was to perform hand hygiene and change their gloves between dirty and clean tasks;-Staff should perform hand hygiene between gloves changes; -Staff was to wash their hands if their hands were visibly soiled;-Staff could sanitize their hands if they were not visibly soiled.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265816	A. Building B. Wing	09/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Schuyler County Nursing Home District	1306 US Highway 63 Queen City, MO 63561

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F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. Based on interview and record review, the facility failed to ensure staff training needs, as identified in the facility assessment and the annual in-servicing calendar, were met for five nurse assistants (NA)'s/ certified nurse assistants (CNA)'s (NA O , NA J, CNA T, CNA K and CNA/Certified Medication Technician (CMT) S), in a sample of five NA's/CNA's reviewed, who had been employed over a year by the facility. Further review showed no documentation of the required 12 hours of training per year were completed, including dementia management and resident abuse prevention training. The facility census was 41. Review of the facility Assessment, dated 04/17/25, showed the following education requirements:-Communication - effective communications for direct care staff;-Resident's rights and facility responsibilities - ensure that staff members are educated on the rights of the resident and the responsibilities of a facility to properly care for its residents;-Abuse, neglect, and exploitation - training that at a minimum educates staff on-(1) Activities that constitute abuse, neglect, exploitation, and misappropriation of resident property; (2) Procedures for reporting incidents, of abuse, neglect, exploitation, or the misappropriation of resident property; and (3) Care/management for persons with dementia and resident abuse prevention;-Infection control - a facility must include as part of its infection prevention and control program mandatory training that includes the written standards, policies, and procedures for the program;-Culture change (that is, person-centered and person-directed care);2. Required in-service training for nurse aides. In-service training must:-a. Be sufficient to ensure the continuing competence of nurse aides but must be no less than 12 hours per year;-b. Include dementia management training and resident abuse prevention training;-c. Address areas of weakness as determined in nurse aides' performance reviews and facility assessment and may address the special needs of residents as determined by the facility staff;-d. For nurse aides providing services to individuals with cognitive impairments, also address the care of the cognitively impaired;-Required training of feeding assistants - through a State-approved training program for feeding assistants;- Identification of resident changes in condition, including how to identify medical issues appropriately, how to determine if symptoms represent problems in need of intervention, how to identify when medical interventions are causing rather than helping relieve suffering and improve quality of life;-Cultural competency (ability of organizations to effectively deliver health careservices that meet the social, cultural, and linguistic needs of residents);** Training and competencies will also be performed on an individual and/or as needed (PRN) basis depending on need. Review of the facility's Education Calendar showed the following trainings were to be offered/completed during the following months:-January: Abuse and Neglect, Resident Rights, Safety Management;-February: Universal Precautions, Infection Control, Blood-borne Pathogens;-March: Fall Prevention, Safe Transfers, Workplace Violence;-April: Fire Safety, Fire watch policy and procedure;-May: Alzheimer's Disease, Behavioral Health, Dementia;-June: Antipsychotics, Geriatric Depression, UTI (urinary tract infection) Prevention, Peri-Cath Cares;-July: Hospice Care and Services, Pressure Wounds;-August: HIPAA (Health Insurance Portability and Accountability Act), Emergency Preparedness, Disasters;-September: MDS (Minimum Data Set)/Care Plan, Pain Management;-October: Nutrition & Hydration, Feeding, Oral Cares;-November: State Survey Prep;-December: Customer Relations, Corporate Compliance, Communication, Teamwork, Quality Assurance and Performance Improvement (QAPI).1. Review of NA O's employee file showed a hire date of 04/24/24. 1.Review of the NA's employee education record, dated 09/01/24 to 09/09/25, showed the following:-Attended 03/25/25, prevention violence;-Attended 05/20/25, Alzheimer's/dementia;-Attended 06/19/25, UTI and depression;-Attended 07/17/25, hospice/wounds;-Attended 08/26/25, HIPAA/emergency preparedness.The record did not include hours attended. The NA had been employed for over a year, did not have documentation of 12 hours of in-services/training and missed required topics identified in the Facility Assessment including Abuse and Neglect, Resident Rights, Infection Control, (continued on next page)

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F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Communication and QAPI. 2. Review of NA J's employee file showed a hire date of 04/25/23 (over one year). Review of the NA's employee education record, dated 09/01/24 to 09/09/25, showed the following:-Attended 01/16/25, safety;-Attended 06/06/25, dementia/Alzheimer's;-Attended 06/19/25, UTI prevention.The record did not include hours attended. The NA had been employed for over a year, did not have documentation of 12 hours of in-services/training and missed required topics identified in the Facility Assessment including Infection Control, Behavioral Health, Communication and QAPI. 3. Review of CNA T's, employee file, showed a hire date of 04/30/24. Review of the CNA's employee education record, dated 09/01/24 to 09/09/25, showed the following:-Attended 09/18/24, MDS;-Attended 11/21/24, abuse;-Attended 01/16/25, workman's compensation;-Attended 04/18/25, fire safety;-Attended 06/20/25, UTI prevention;-Attended 08/26/25, HIPAA/emergency preparedness.The record did not include hours attended. The CNA had been employed for over a year, did not have documentation of 12 hours of in-services/training and missed required topics identified in the Facility Assessment including Communication, QAPI, Infection Control, Alzheimer's Disease, Behavioral Health and Dementia. 4. Review of CNA K's, employee file, showed a hire date of 02/25/24. Review of the CNA's employee education record, dated 09/01/24 to 09/09/25, showed the following:-Attended 09/15/24, emergency preparedness;-Attended 11/21/24, resident rights;-Attended 01/16/25, workman's compensation;-Attended 03/26/25, workplace violence;-Attended 04/18/25, fire safety;-Attended 05/19/25, Alzheimer's Dementia;-Attended 06/19/25, Hospice;-Attended 07/21/25, UTI and Depression;-Attended 08/26/25, HIPAA and emergency procedure.The record did not include hours attended. The CNA had been employed for over a year, did not have documentation of 12 hours of in-services/training and missed required topics identified in the Facility Assessment including Communication, QAPI and Infection Control. 5. Review of CNA/CMT S's, employee file, showed a hire date of 02/13/24. Review of the CNA/CMT's employee education record, dated 09/01/24 to 09/09/25, showed the following:-Attended 09/19/24, MDS/care plan;-Attended 11/21/24, resident rights;-Attended 01/16/25, workman's compensation;-Attended 03/20/25, workplace violence/fall prevention/safe transfers;-Attended 04/17/25, fire safety;-Attended 06/19/25, depression;-Attended 07/17/25, hospice;-Attended 08/21/25, HIPAA and emergency preparedness.The record did not include hours attended. The CNA/CMT had been employed for over a year, did not have documentation of 12 hours of in-services/training and missed required topics identified in the Facility Assessment including Communication, QAPI, Infection Control, Alzheimer's Disease, Behavioral Health and Dementia. 6. During an interview on 09/10/25 at 10:42 A.M., the Director of Nursing (DON) said the following:-She had an educational calendar she followed and provided monthly in-services on educational topics to the staff;-The educational calendar following the training section in the facility assessment;-She kept individual training records for staff. When they come to a staff meeting, they sign in for the meeting and sign in the individual record; -She does monthly in-services which are about an hour long every month to cover required trainings and meet the 12 hours per year requirement;-Staff often miss monthly meetings;-She will have a makeup in-service sometimes, but they do not attend that either;-NA, CNA's and CMT's are required to have 12 hours of annual training/year including required topics.

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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 observation, interview, and record review the facility failed to develop and implement a comprehensive person-centered care plan that included measurable objectives and timeframes to meet a resident's medical, nursing, mental and psychosocial needs that were identified in the comprehensive assessment (minimum data set, MDS) for three residents (Resident #5, #7, and #36)), in a review of 17 sampled residents. The facility census was 41. Review of the facility policy, Care Plans, Comprehensive Person-Centered, revised 2022, showed the following:-A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident;- The interdisciplinary team (IDT), in conjunction with the resident and his/her family or legal representative, develops and implements a comprehensive, person-centered care plan for each resident;-The comprehensive, person-centered care plan is developed within seven (7) days of the completion of the required MDS assessment (Admission, Annual or Significant Change in Status), and no more than 21 days after admission;-The care plan interventions are derived from a thorough analysis of the information gathered as part of the comprehensive assessment;-Each resident's comprehensive person-centered care plan is c0nsistent with the resident's rights to participate in the development and implementation of his or her plan of care, including the right to: a. Participate in the planning process;b. Identify individuals or roles to be included;c. Request meetings;d. Request revisions to the plan of care;e. Participate in establishing the expected goals and outcomes of care;f. Participate in determining the type, amount, frequency and duration of care;g. Receive the services and/or items included in the plan of care and;h. See the care plan and sign it after significant changes are made;-The resident is informed of his or her right to participate in his or her treatment, and provided advance notice of care planning conferences;-The comprehensive, person-centered care plan: a. Includes measurable objectives and timeframes; b. Describes the services that are to be furnished to attain or maintain the residents highest practicable physical, mental, and psychosocial well-being, including: 1. Services that would otherwise be provided for the above, but are not provided due to the resident exercising his or her rights, including the right to refuse treatment; 2. Any specialized services to be provided as a result of PASARR screening and its recommendations, and; 3. Which professional services are responsible for each element of care; c. Includes the resident's stated goals upon admission and desired outcomes; d. Builds on the resident's strengths and; e. Reflects currently recognized standards of practice for problem areas and conditions;-Care plan interventions are chosen only after data gathering, proper sequencing of events, careful consideration of the relationship between the resident's problem areas and their causes, and relevant clinical decision making;-When possible, interventions address the underlying source(s) of the problem area(s), not just symptoms or triggers;-Assessments of residents are ongoing and care plans are revised as information about the residents and the residents' conditions change;-The interdisciplinary team reviews and updates the care plan: a. When there has been a significant change in the resident's condition; b. When the desired outcome is not met; c. When the resident has been readmitted to the facility from a hospital stay; and d. At least quarterly, in conjunction with the required quarterly MDS assessment. 1.Review of Resident #5's face sheet showed the following:-admitted on [DATE];-Diagnoses of edema (a condition where excess fluid builds up in the body's tissues, causing swelling), shortness of breath, and diastolic congestive heart failure (a condition where the heart is unable to relax and fill with blood adequately, leading to a buildup of fluid in parts of the body). Review of the resident's admission Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 5/14/25, showed the following:-Diagnoses of heart failure;-Medications included a diuretic. Review of the resident's physician orders, dated 7/8/25, (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	showed the following:-Lasix (a diuretic) 40 milligram (mg) tablet once a morning;-Lasix 20 mg tablet daily, as needed, for a weight gain of greater than two pounds in 48 hours;-Monthly weights, once a morning on the 5th of the month. Review of the resident's physician orders, dated 7/10/25, showed an order for a fluid restriction of 1.5 liters a day. Review of the resident's care plan, revised 7/22/25, showed no documentation to address the resident's congestive heart failure, fluid restriction and weight monitoring. Review of the resident's quarterly MDS, dated [DATE], showed the following:-Diagnoses of heart failure;-Medications included a diuretic. During an interview on 9/10/25 at 6:28 P.M., Licensed Practical Nurse (LPN) A said the following:-The resident had congestive heart failure, and his/her weight fluctuated;-The resident had orders to be weighed monthly;-The resident had an order for as needed Lasix, with directions to administer based on weight changes in 48 hours, indicating staff should check the resident's weight daily. During an interview on 9/10/25 at 5:14 P.M., the Director of Nursing (DON) said the following:-The resident had an order for a fluid restriction;-Staff should monitor and document the resident's fluid intake;-The resident had an order for monthly weights;-The resident had an order for as needed Lasix, based on weight changes, but did not have an order for daily weights, and should;-There is no way to know or to truly monitor the resident's weights without checking daily weights. 2. Review of Resident #7's undated face sheet, showed the following:-admitted on [DATE];-Diagnoses of fracture of femur (the bone of the thigh), and pain. Review of the resident's physician orders, dated 7/14/25, showed an order for pain assessment every shift. Review of the resident's pain scores on 7/14/25 showed the following:-7 out of 10 pain (on a scale of 1-10 with 10 being the worst pain possible) at 1:05 P.M.;-7 out of 10 pain at 1:53 P.M.;-7 out of 10 pain at 9:05 P.M. Review of the resident's physician orders, dated 7/15/25, showed an order for acetaminophen pain relief, 500 milligram (mg) tablet, two tablets as needed. Review of the resident's pain scores on 7/15/25 showed the following:-7 out of 10 pain at 9:20 A.M.;-4 out of 10 pain at 9:55 P.M. Review of the resident's pain score on 7/16/25 at 11:38 A.M. showed 3 out of 10 for pain. Review of the resident's physician orders dated 7/17/25 showed an order for oxycodone (narcotic pain medication) 5 mg, take two capsules every four hours as needed for pain. Review of the resident's pain scores on 7/17/25 showed pain rated 5 out of 10 pain at 7:15 A.M. Review of the resident's pain scores on 7/18/25 showed the following:-6 out of 10 pain at 2:04 A.M.;-5 out of 10 pain at 9:21 A.M. Review of the resident's annual MDS, dated [DATE], showed the following:-Received pain medication on a scheduled and as needed basis;-Pain experienced frequently;-Pain rarely effected sleep or therapy activities;-Pain frequently effected day-to-day activities. Review of the resident's pain score on 7/21/25 at 8:07 A.M. showed 6 out of 10 pain. Review of the resident's pain score on 7/22/25 at 8:00 A.M. showed 7 out of 10 pain. Review of the resident's pain scores on 7/23/25 showed the following:-6 out of 10 pain at 12:58 A.M.;-7 out of 10 pain at 7:56 A.M. Review of the resident's pain scores on 7/24/25 at 6:30 A.M. showed 8 out of 10 pain. Review of the resident's pain scores on 7/26/25 showed the following:-6 out of 10 pain at 1:40 A.M.;-5 out of 10 pain at 12:25 P.M. Review of the resident's pain scores on 7/27/25 showed the following:-6 out of 10 pain at 3:21 A.M.;-4 out of 10 pain at 9:32 A.M. Review of the resident's pain scores on 7/28/25 showed the following:-8 out of 10 pain at 2:15 A.M.;-4 out of 10 pain at 4:09 P.M. Review of the resident's pain scores on 7/31/25 at 2:00 A.M. showed 6 out of 10 pain. Review of the resident's August pain scores showed the following:-8/3/25 at 1:49 A.M. 6 out of 10 pain;-8/3/25 at 6:50 A.M. 8 out of 10 pain;-8/4/25 at 1:42 A.M. 6 out of 10 pain;-8/4/25 at 12:19 P.M. 5 out of 10 pain;-8/7/25 at 1:30 A.M. 6 out of 10 pain;-8/8/25 at 1:00 A.M. 6 out of 10 pain;-8/9/25 at 12:19 P.M 4 out of 10 pain;-8/11/25 at 8:20 P.M. 4 out of 10 pain;-8/12/25 at 6:43 A.M. 5 out of 10 pain;-8/12/25 at 11:38 P.M. 6 out of 10 pain;-8/14/25 at 1:11 A.M. 6 out of 10 pain;-8/14/25 at 9:12 A.M. 5 out of 10 pain;-8/15/25 at 1:16 A.M. 6 out of 10 pain;-8/19/25 at 1:20 A.M. 6 out of 10 pain;-8/20/25 at 2:07 A.M. 6 out of 10 pain. Review of the resident's August medication administration record (MAR) showed the following:-As needed acetaminophen only administered once;-As needed oxycodone administered 43 times;-Pain assessment completed each shift. Review of the resident's care plan, (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	dated 8/27/25, showed nothing in the plan addressing the resident's pain or use of opioid pain medication. Review of the resident's care plan conference, dated 8/27/25, showed the resident was receiving as needed acetaminophen and oxycodone for pain. Review of the resident's progress notes showed no documentation of a care plan conference occurring prior to 8/27/25. 3. Review of Resident #36's face sheet showed the following:-admitted [DATE];-Diagnoses of dementia, and carcinoma in situ (cancer) of left breast. Review of the resident's census showed the following:-6/27/25: hospitalized ;-7/1/25: returned to the facility under the payer Hospice. Review of the resident's Hospice admission Note and Hospice Certification of Terminal Illness, dated 7/1/25, showed the resident was terminally ill with a life expectancy of six months or less if the disease followed its normal course, and was admitted to hospice. Review of Resident #36's physician notification fax, dated 7/1/25, showed the Director of Nursing faxed a notification to the physician, stating the resident would be returning from the hospital on hospice. Review of the resident's progress notes dated 7/1/25 at 12:42 P.M. showed the resident was readmitted to the facility. Review of the resident's progress notes dated 7/7/25 at 6:18 P.M. showed the resident continued hospice care. Review of the resident's significant change MDS, dated [DATE], showed the following:-Severe cognitive impairment;-Has a chronic disease that may result in a life expectancy of less than 6 months;-No special treatments, not on hospice. Review of the resident's care plan, revised 7/10/25, did not address hospice care. Review of the resident's physician orders, dated 9/8/25, showed no orders for hospice. During an interview on 09/08/25 at 10:10 A.M., the Director of Nursing said the resident was on hospice. During an interview on 09/18/25, at 10:37 A.M., the MDS Coordinator said the following:-Comprehensive care plans should be updated at least every three months;-They should be updated with major care areas changes that changed the cares provided.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure physician's orders were followed for five residents (Resident's #5, #11, #28, #34, #40) in a sample of 17 residents. The facility failed to follow physician's orders related to daily weights and administering Lasix (a diuretic) according to parameters set by the physician to ensure the resident did not experience fluid overload for Resident #11. The facility failed to follow physician's orders related to fluid restrictions, administering Lasix according to parameters set by the physician, and to check daily weights, according to the parameters set on the Lasix order, to ensure the resident did not experience fluid overload for Resident #5. The facility failed to follow physician's orders related to weight loss and notifying the physician and/or dietician when a significant or severe weight loss occurred for Residents #40, #28 and #34. The facility census was 41. Review of the facility policy Medication Orders, dated November 2014, showed the following:-The purpose of this procedure is to establish uniform guidelines in the receiving and recording of medication orders;-Each resident must be under the care of a Licensed Physician authorized to practice medicine in this state;-A current list of orders must be maintained in the clinical record of each resident;-Medication Orders - When recording orders for medication, specify the type, route, dosage, frequency and strength of the medication ordered;-PRN (as needed) Medication Orders - When recording PRN medication orders, specify the type, route, dosage, frequency, strength and the reason for administration.-Treatment Orders - When recording treatment orders, specify the treatment, frequency and duration of the treatment. Review of the facility policy Nutrition (Impaired)/Unplanned Weight Loss, last revised September 2017, showed the following:-Nursing staff will monitor and document the weight and dietary intake of residents in a format which permits comparisons over time; -The staff and physician will define the individuals with anorexia (lack or loss of appetite for food), weight loss or gain, and significant risk for impaired nutrition;-The staff will report to the physician significant weight gains or losses or any abrupt or persistent change from baseline appetite or food intake;-The physician will review for medical causes of weight gain, anorexia and weight loss before ordering interventions;-For individuals with recent or rapid weight gain or loss (more than a pound a day), the staff will review for possible fluid and electrolyte imbalance as a cause;-The physician will review carefully and rule out medical causes of oral or swallowing problems before authorizing other consults or interventions to modify diet consistency;-The staff and physician will identify pertinent interventions based on identified causes and overall resident condition, prognosis and wishes;-The staff and physician will review and consider existing dietary restrictions and modified consistency of diets;-Physician and staff will monitor nutritional status, an individual's response to interventions and possible complications of such interventions. Review of the facility's policy Weight Assessment and Intervention, revised March 2022, showed the following:-Resident weights are monitored for undesirable or unintended weight loss or gain;-Residents are weighed upon admission and at intervals established by the interdisciplinary team;-Weights are recorded in each unit's weight record chart and in the individual's medical record;-A weight change of 5% or more since the last weight assessment is retaken the next day for confirmation;-If the weight is verified, nursing will immediately notify the dietician in writing;-Unless notified of significant weight change, the dietician will review the unit weight record monthly to follow individual weight trends over time;-The threshold for significant unplanned and undesired weight loss will be based on the following criteria: a. 1 month- 5% weight loss is significant, greater than 5% is severe; b. 3 months- 7.5% weight loss is significant, greater than 7.5% is severe; c. 6 months- 10% weight loss is significant; greater than 10% is severe;-The physician and multidisciplinary team will identify conditions and medications that may be causing anorexia, weight loss or increasing the risk of weight loss;-Care planning for weight loss or impaired nutrition will be a multidisciplinary effort and will include the physician, nursing staff, the Dietician, the Consultant Pharmacist and the (continued on next page)

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	265816	A. Building B. Wing	09/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Schuyler County Nursing Home District	1306 US Highway 63 Queen City, MO 63561

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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	resident's legal surrogate;-Individualized care plans shall address to the extent possible: a. The identified causes of weight loss; b. Goals and benchmarks for improvement; and c. Time frames and parameters for monitoring and reassessment;-Interventions for undesired weight gain consider resident preferences and rights, a weight loss regimen should not be initiated for a cognitively capable resident without his/her approval and involvement. 1. 1. Review of Resident #11's face sheet showed the resident admitted to the facility on [DATE]. Review of the resident's admission Minimum Data Set (MDS), a federally mandated assessment completed by staff, dated 04/21/25, showed the following:-Severe cognitive impairment;-Diagnoses of atrial fibrillation (irregular heart rhythm), high blood pressure, dementia, malnutrition and adult failure to thrive;-Weighed 184 pounds;-No diuretic use. Review of the resident's Care Plan, dated 04/23/25, showed the following:-The resident has diagnosis of acute kidney failure, edema (swelling in tissue), high blood pressure, atrial fibrillation (abnormal rapid heart rate), low blood pressure, dehydration, and fluid overload;-Monitor the resident's weight monthly;-Report the resident's weight to the charge nurse so they can report any abnormal change to the resident's physician; (The resident's fluid overload, Lasix PRN, and daily weight monitoring was not included in the resident's care plan.) Review of the resident's Physician Order Sheets (POS), dated July 2025, showed an order for Lasix 20 mg, administer one tablet PRN for weight gain of 3 pounds in one day or 5 pounds in one week. May also give for increased swelling in legs, diagnosis fluid overload, and daily weights (original order dated 04/14/25). Review of the resident's MAR, dated July 2025, showed the following:-07/02/25, no weight recorded; resident sleeping;-07/03/25, no weight recorded; no explanation;-07/04/25, no weight recorded; resident refused;-07/05/25, no weight recorded; resident didn't get up;-07/06/25, no weight recorded; resident asleep. Review of the resident's weight record, dated July 2025, showed the following:-07/07/25, 170.5 pounds;-07/08/25, 170.5 pounds;-07/09/25, 169 pounds;-07/10/25, 169.2 pounds;-07/11/25, 169.2 pounds;-07/12/25, 171 pounds;-07/13/25, 172 pounds. Review of the resident's MAR, dated 07/14/25, showed no weight recorded. The resident was asleep. Review of the resident's weight record, dated July 2025, showed the following:-07/15/25, 174.5 pounds;-07/16/25 175.5 pounds (a 6.5-pound weight gain since 07/09/25, one week). Review of the resident's MAR, dated 07/16/25, showed no documentation staff administered PRN Lasix as ordered for a 5-pound weight gain in one week. Review of the resident's Nurses Notes, dated 07/01/25-07/16/25, did not add any additional entries on why daily weights were not completed or why the Lasix was not administered as ordered on 07/16/25. The nurse's notes did not include any evidence staff notified the physician of missing weights or the resident's weight gain on 07/16/25. Review of the resident's MAR, dated July 2025, showed the following:-07/17/25, no weight recorded, no explanation;-07/18/25, no weight recorded, no explanation. Review of the resident's weight record, dated July 2025, showed on 07/19/25, the resident weighed 173.5 pounds. Review of the resident's MAR, dated 07/20/25, showed no weight recorded. The resident was asleep. Review of the resident's Nurses Notes, dated 07/17/25-07/21/25, showed no additional entries why daily weights were not completed or physician notification that the weights were unable to be obtained. Review of the resident's Weight Record, dated July 2025, showed the following:-On 07/21/25, the resident weighed 174 pounds;-On 07/22/25, the resident weighed 177 pounds (a 3-pound weight gain since 07/21/25, one day). Review of the resident's MAR, dated 07/22/25, showed no documentation staff administered Lasix as ordered for a 3-pound weight gain in one day. Review of the resident's Nurses Notes, dated 07/22/25, showed no additional entries why staff did not administer the resident's Lasix as ordered on 07/22/25. The nurse's notes did not include any evidence staff notified the physician of the resident's weight gain on 07/22/25. Review of the resident's Weight Record, dated July 2025, showed the following:-07/23/25, 176.5 pounds;-07/24/25, 177.5 pounds;-07/25/25, 178 pounds;-07/26/25, 181 pounds (a 3-pound weight gain since 07/25/25, one day; and a 7.5-pound weight gain since 07/19/25, one week). Review of the resident's MAR, dated 07/26/25, showed no documentation staff administered Lasix as ordered when the resident had 3-pound weight gain in one day and 7.5-pound weight gain in one week. Review of the (continued on next page)

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Schuyler County Nursing Home District	1306 US Highway 63 Queen City, MO 63561

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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	resident's Nurses Notes, dated 07/26/25, showed no additional entries why staff did not administer the resident's Lasix as ordered on 07/26/25. The nurse's notes did not include any evidence staff notified the physician of the resident's weight gain on 07/26/25. Review of the resident's Weight Record, dated July 2025, showed the following:-07/27/25, 181 pounds;-07/28/25, 182 pounds (an 8-pound weight gain since 07/21/25, one week). Review of the resident's MAR, dated 07/28/25, showed no documentation staff administered Lasix as ordered when the resident had an 8-pound weight gain in one week. Review of the resident's Nurses Notes, dated 07/28/25, showed no additional entries why staff did not administer the resident's Lasix as ordered on 07/28/25. The nurse's notes did not include evidence staff notified the physician of the resident's weight gain on 07/28/25. Review of the resident's Weight Record, dated July 2025, showed the following:-07/29/25, 181 pounds; -07/30/25, 181.5 pounds (a 5-pound weight gain since 07/23/25, one week). Review of the resident's MAR, dated 07/30/25, showed no documentation staff administered Lasix as directed when the resident had a 5-pound weight gain in one week. Review of the resident's Nurses Notes, dated 07/30/25, showed no additional entries why staff did not administer the resident's Lasix as ordered on 07/30/25. The nurse's notes did not include evidence staff notified the resident's physician of the resident's weight gain on 07/30/25. Review of the resident's POS, dated August 2025, showed an order for Lasix 20 mg, administer one tablet PRN for weight gain of 3 pounds in one day or 5 pounds in one week. May also give for increased swelling in legs, diagnosis fluid overload, and daily weights. Review of the resident's Weight Record, dated August 2025, showed the following:-08/01/25, no weight recorded;-08/02/25, 183 pounds (a 5-pound weight gain since 07/25/25, one week). Review of the resident's MAR, dated August 2025, showed the following:-08/01/25, no weight recorded; no reason documented;-08/02/25, no documentation staff administered Lasix as ordered for a 5-pound weight gain in one week. Review of the resident's Nurses Notes, dated 08/01/25-08/02/25, showed no additional entries why staff did not complete daily weights, or why staff did not administer the resident's Lasix as ordered on 08/02/25. The nurse's notes did not include evidence staff notified the resident's physician of missing weights or the resident's weight gain on 08/02/25. Review of the resident's MAR, dated 08/02/25, showed no weight recorded. The resident was asleep. Review of the resident's Weight Record, dated 08/04/25, showed the resident weighed 187.5 lbs. (a 4.5-pound weight gain since 08/02/25 and a 6.5-pound weight gain since 07/27/25, one week). Review of the resident's MAR, dated 08/04/25, showed no documentation staff administered Lasix as ordered for 4.5-pound weight gain in one day and a 6.5-pound weight gain in one week. Review of the resident's Nurses Notes, dated 08/03/25-08/04/25, showed no additional entries why staff did not complete daily weights, or why staff did not administer the resident's Lasix as ordered on 08/04/25. The nurse's notes did not include staff notified the resident's physician of missing weights or the resident's weight gain on 08/04/25. Review of the resident's MAR, dated August 2025, showed the following:-08/06/25, no weight recorded; no reason recorded;-08/07/25, no weight recorded; did not obtain;-08/11/25, no weight recorded; asleep;-08/13/25, no weight recorded; no reason recorded;-08/16/25, no weight recorded; no reason recorded;-08/18 /25, no weight recorded; due to condition. Review of the resident's Weight Record, dated August 2025, showed the following:-08/21/25, 186.5 pounds;-08/22/25, 189.5 pounds (a 3-pound weight gain since 08/21/25, one day). Review of the resident's MAR, dated 08/22/25, showed no documentation staff administered Lasix as ordered for 3-pound weight gain in one day. Review of the resident's Nurses Notes, dated 08/05/25-08/22/25, showed no additional entries why staff did not complete daily weights, or why staff did not administer the resident's Lasix as ordered on 08/22/25. The nurse's notes did not include evidence staff notified the resident's physician of missing weights or the resident's weight gain on 08/22/25. Review of the resident's MAR, dated August 2025, showed the following:-08/24/25, no weight recorded; no reason documented;-08/25/25, no weight recorded; the resident was asleep. Review of the resident's Weight Record, dated August 2025, showed the following:-08/28/25, 188.5 lbs.;-08/29/25, 191.5 lbs. (3-pound weight gain since (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	08/28/25, one day); Review of the resident's MAR, dated 08/29/25, showed no documentation staff administered Lasix as ordered for a 3-pound weight gain in one day. Review of the resident's Nurses Notes, dated 08/23/025-08/30/25, showed no additional entries why staff did not complete why daily weights, or why staff did not administer the resident's Lasix as ordered on 08/29/25. The nurse's notes did not include evidence staff notified the resident's physician of missing weights or the resident's weight gain on 08/29/25. Review of the resident's POS, dated September 2025, showed an order for Lasix 20 mg, administer one tablet PRN for weight gain of 3 pounds in one day or 5 pounds in one week. May also give for increased swelling in legs, diagnosis fluid overload, and daily weights. Review of the resident's Weight Record, dated September 2025, showed the following:-09/04/25, 189.5 pounds;-09/05/25, 195 pounds (a 5.5-pound weight gain since 09/04/25, one day). Review of the resident's MAR, dated 09/05/25, showed no documentation staff administered Lasix as ordered for a 5.5-pound weight gain in one day. Review of the resident's Nurses Notes, dated 09/05/25, showed no additional entries why staff did not administer the resident's Lasix as ordered on 09/05/25. The nurse's notes did not include evidence staff notified the resident's physician of the resident's weight gain on 09/05/25. Review of the resident's MAR, dated 09/07/25, showed no weight recorded; staff documented due to condition. Review of the resident's Nurses Notes, dated 09/07/25, showed no additional entries why staff did not complete the daily weight on 09/07/25. Observation on 09/07/2025 at 1:30 P.M. showed the resident sat in the recliner in his/her room. The resident's ankles showed some edema (fluid accumulation in tissues). The resident had creases in his/her skin from socks making indentions due to fluid. During an interview on 09/10/25 at 6:28 P.M., Licensed Practical Nurse (LPN) A said the following: -He/She worked as a charge nurse primarily on evening shift;-Resident #11 had a physician's order for daily weights;-Evening shift nurses and/or Certified Nurse Assistants (CNAs) complete daily weights. The resident frequently refused to be weighed. He/She had never reported this to the physician and was not aware of anyone else reporting this to the physician;-Staff were to document on the MAR or Nurses Notes when the resident refused weights;-Nurses complete the charting, not the CNAs. I if a CNA gets the weight, they give it to the nurse to chart;-The nurse was to compare the weight to the previous day's weight to determine if there was an increase and if the resident should receive any as needed medications or the nursed needed to notify the physician. 2. Review of Resident #5's face sheet showed the following:-admitted [DATE];-Diagnoses of edema, chronic atrial fibrillation, shortness of breath, hypertension, and diastolic congestive heart failure (a condition when the left ventricle of the heart becomes stiff and cannot relax properly to fill with enough blood between beats, leading to symptoms of heart failure). Review of the resident's weight record, dated 07/02/25, showed the resident weighed 170.5 pounds. Review of the resident's physician orders, dated 07/08/25, showed the following:-Lasix 20 mg tablet daily, as needed (PRN), for a weight gain of greater than 2 pounds in 48 hours;-Monthly weights, once a morning on the 5th of the month. Review of the resident's physician orders, dated 7/10/25, showed an order for a fluid restriction of 1.5 liters a day. Review of the resident's medical record showed no documentation staff obtained the resident's weight in July 2025 as ordered to accurately monitor for a 2-pound weight gain in 48 hours as directed in the physician's order for administration of PRN Lasix. Review of the resident's fluid intake record showed the following:-On 7/13/25, no documentation of fluid intake to ensure the resident's fluid intake did not exceed 1.5 liters a day (as ordered);-On 7/18/25, no documentation of fluid intake. Review of the resident's care plan, revised 7/22/25, showed to monitor weight monthly. Report weight to charge nurse so they can report any changes to physician. (The care plan did not include the resident's fluid restriction, daily weights to monitor for greater than 2 pound weight gain in 48 hours or any additional interventions to address his/her congestive heart failure.) Review of the resident's fluid intake record showed on 7/25/25, staff did not document the resident's fluid intake. Review of the resident's physician orders, dated August 2025, showed the following:-Lasix 20 mg tablet daily PRN for a weight gain of greater than 2 pounds in 48 hours;-Monthly weights, once a morning on the 5th of the month;-Fluid restriction of 1.5 liters a (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	day. Review of the resident's weight record, dated 08/02/25, showed he/she weighed 161.5 pounds. Review of the resident's fluid intake record showed on 08/10/25, staff did not document the resident's fluid intake. Review of the resident's quarterly MDS, dated [DATE], showed the following:-Moderate cognitive impairment;-Diagnoses of heart failure and hypertension;-Weight loss of 5% or more in the last month or 10% or more in the last six months;-No weight gain; -Weight 162 pounds;-Medications included a diuretic. Review of the resident's fluid intake record showed the following:-On 8/18/25, no documentation of the resident's fluid intake;-On 8/21/25, no documentation of the resident's fluid intake;-On 8/23/25, no documentation of the resident's fluid intake;-On 8/25/25, no documentation of the resident's fluid intake;-On 8/28/25, no documentation of the resident's fluid intake;-On 8/29/25, no documentation of the resident's fluid intake. Review of the resident's medical record showed no documentation staff obtained the resident's weight in August 2025 as ordered toaccurately monitor for a 2-pound weight gain in 48 hours as directed in the physician's order for administration of PRN Lasix. Review of the resident's August 2025 Medication Administration Record (MAR) showed no documentation staff administered Lasix 20 mg PRN, ordered for a weight gain of 2 pounds in 48 hours Review of the resident's physician orders, dated September 2025, showed the following:-Lasix 20 mg tablet daily PRN for a weight gain of greater than 2 pounds in 48 hours;-Monthly weights, once a morning on the 5th of the month;-Fluid restriction of 1.5 liters a day. Review of the resident's weight record showed on 09/01/25, the resident weighed 154.5 pounds. Review of the resident's fluid intake record showed the following:-On 9/3/25, no documentation of the resident's fluid intake;-On 9/7/25, no documentation of the resident's fluid intake. Review of the resident's medical record showed no documentation staff obtained the resident's weight in September 2025 as ordered to accurately monitor for a 2-pound weight gain in 48 hours as directed in the physician's order for administration of PRN Lasix. Review of the resident's September 2025 MAR showed no documentation staff administered Lasix 20 mg PRN, ordered for a weight gain of 2 pounds in 48 hours, from 9/1/25 through 9/8/25. During an interview on 9/10/25 at 6:28 P.M., Licensed Practical Nurse (LPN) A said the following:-The resident had congestive heart failure, and his/her weight fluctuated;-The resident had orders to be weighed monthly;-He/She would follow the physician's orders, but would expect the resident to be weighed, at minimum, weekly, due to his/her congestive heart failure;-The resident had an order for as needed Lasix, with directions based on weight changes, indicating the resident should be weighed daily, which was not reflected with the current orders. During an interview on 9/10/25 at 5:14 P.M., the Director of Nursing (DON) said the following:-The resident had a fluid restriction;-Staff should monitor and document the resident's fluid intake;-The resident had an order for as needed Lasix, based on weight changes, but did not have an order for daily weights;-There was no way to know or to truly monitor the resident's weights without checking the resident's weight daily. 3. Review of Resident #40's Care Plan, dated 8/05/25, showed the following: -Monitor weight weekly for significant weight changes;-Report his/her weight to the charge nurse so they can report any abnormal weights to the physician. Review of the resident's quarterly Minimum Data Set (MDS), a federally mandated assessment, dated 8/08/25, showed the following: -Severe cognitive impairment;-Weight 272 pounds;-No weight loss. Review of the resident's Nutritional Quarterly Assessment, dated 8/08/25, showed the following:-Current weight 271.5 pounds;-Weight last quarter 268 pounds. Review of the resident's physician orders, dated August 2025, showed an order for weekly weights to monitor for weight loss. Review of the resident's weight record showed the following:-On 08/02/25, the resident weighed 271.5 pounds;-On 08/12/25, the resident weighed 265 pounds;-On 08/26/25, the resident weighed 269 pounds. Review of the resident's weight record, dated 9/01/25, showed the resident weighed 206.5 pounds (a weight loss of 23.23% in one week). Review of the resident's medical record showed no evidence staff re-weighed the resident to ensure the weight obtained on 9/01/25 was accurate to reflect the resident's current weight. During an interview on 9/10/25, at 9:32 A.M., Licensed Practical Nurse (LPN) D said the following:-He/She or the Certified Nurse Assistants (CNAs) weighed the residents;-He/She entered (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the weight into the electronic health record (EHR);-If he/she saw a discrepancy in the weight, staff re-weighed the resident;-If the re-weigh showed a discrepancy from the previous weights, he/she did a comparison in the EHR that included checking vital signs and checking for edema and notified the physician;-He/She missed this resident's weight on 9/01/25. He/She should have re-weighed the resident and looked at the resident's intake. During an interview on 9/10/25, at 7:30 P.M., the Director of Nursing (DON) said the following:-Aides documented the residents' weights in the Electronic Health Record (HER);-If a weight appeared inaccurate, the nurses are to re-weigh the resident and compare the weight to previous weights. 4. Review of the Resident #28's Care Plan, dated 4/04/25, showed the following: -The resident was on a low concentrated sweets diet and could feed himself/herself;-Monitor weight monthly for significant weight changes;-Report his/her weight to the charge nurse so they can report any abnormal weights to the physician. Review of resident's quarterly MDS, dated [DATE], showed the following:-Moderate cognitive impairment;-Weight 116 pounds;-No weight loss of 5 percent (%) in one month or 10% in last six months;-Therapeutic diet. Review of the Nutritional Quarterly Assessment, dated 7/08/25, showed the following:-Current weight 115 pounds;-Weight last quarter 113 pounds. Review of the resident's physician orders, dated August 2025, showed an order for monthly weights. Review of the resident's weight record, dated 8/02/25, showed the resident weighed 155.5 pounds (a weight gain of 35% in one month). Review of the resident's medical record showed no evidence staff re-weighed the resident to ensure the weight obtained on 8/02/25 was accurate to reflect the resident's current weight. Review of the resident's weight record, dated 9/02/25, showed the resident weighed 119.5 pounds (a weight loss of 23.15% in one month). Review of the resident's medical record showed no evidence staff re-weighed the resident to ensure the weight obtained on 9/02/25 was accurate to reflect the resident's current weight. During an interview on 9/10/25, at 9:56 A.M., LPN E said he/she missed this resident's weight on 9/02/25. He/She should have re-weighed the resident. 5. Review of Resident #34's Nutritional Quarterly Assessment, dated 6/24/25, showed the following:-Current weight 201 pounds;-Weight last quarter 206 pounds. Review of resident's quarterly MDS, dated [DATE], showed the following:-Severe cognitive impairment;-Weight 201 pounds;-Weight loss of 5% in one month or 10% in the last six months;-Not on physician-prescribed weight-loss regimen;-Therapeutic diet. Review of the resident's weight record, dated 7/01/25, showed the resident weighed 210 pounds. Review of the resident's care plan, dated 7/15/25, showed the following: -Monitor weight monthly for significant weight changes;-Report his/her weight to the charge nurse so they can report any abnormal weights to the physician. Review of the resident's weight record, dated 8/02/25, showed the resident weighed 228 pounds (a weight gain of 8.57% in one month). Review of the resident's medical record showed no evidence staff re-weighed the resident to ensure the weight obtained on 8/02/25 was accurate to reflect the resident's current weight. Review of the resident's weight record, dated 9/01/25, showed the resident weighed 209 pounds (a weight loss of 8.33% in one month). Review of the resident's medical record showed no evidence staff re-weighed the resident to ensure the weight obtained on 9/02/25 was accurate to reflect the resident's current weight. During an interview on 9/10/25, at 9:51 A.M., LPN E said he/she missed this resident's weight on 9/01/25. He/She should have re-weighed the resident. 6. During interview on 9/18/25, at 10:37 A.M., the MDS coordinator said the following:-She monitored resident weights weekly and monthly; the charge nurses are supposed to compare the daily weights to the weight the day and week before;-She had not noticed the lack of weights being documented for Resident #111;-The CNA's obtain the weights and give them to the charge nurse to put in, the MDS coordinator reviews them and gives updates in the clinical meeting to dietary and the rest of nursing staff. She lets the computer do the calculation and it will say if they are a significant weight loss/gain;-The electronic system automatically calculates if the resident has weight loss;-If the weight is way off, staff will re-weigh the resident. During an interview on 9/10/25, at 7:30 P.M., the DON said the following:-Aides chart the meal intakes and weights in care assist; -MDS and care plan coordinator notifies DON if the resident has lost weight/weight gain;-Nurses are (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	expected to notify the physician if more than five pounds are gained or lost from last weight;-The nurse receiving a resident's daily weight should calculate weight gained or lost according to the parameters in the physician's orders.

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	265816	A. Building B. Wing	09/10/2025

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Schuyler County Nursing Home District	1306 US Highway 63 Queen City, MO 63561

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to assess the residents for risk of entrapment from bed rails and failed to complete inspections of bed frames, mattresses and bed rails as part of a regular maintenance program to identify areas of possible entrapment for four residents (Residents #40, #5, #7, and #14), in a review of 17 sampled residents. The facility census was 41. During an interview on 09/09/10:15 A.M., the Director of Nursing (DON) said the facility did not have a policy for bed rails. 1. Review of Resident #40's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument, dated 8/08/25, showed the following:-Diagnoses of dementia and need for assistance with personal care; -Severe cognitive impairment;-Required substantial/maximal assistance for mobility and transfers. Review of the resident's Care Plan, dated 8/05/25, showed the following: -The resident was at risk for falls;-He/She required assistance from one staff for transfers and bed mobility;-Encourage the resident to ask for assistance;-No documentation related to bed rail use. Observation on 9/10/25, at 9:08 A.M., showed the resident lay asleep in bed. The halo rail (a circular grab/assist bar), located on the left side of the resident's bed, was in the raised position. Review of the resident's medical record showed no documentation staff obtained informed consent or assessed the resident's risk for entrapment prior to use of the halo rail. Review showed no documentation staff conducted a regular inspection of the resident's bed frame, mattress and the halo rail to identify areas of possible entrapment. 2. Review of Resident #5's undated face sheet, showed he/she admitted on [DATE]. Review of the resident's physician orders, dated 5/7/25, showed an order to have two quarter bed rails to assist with moving side to side in bed and to edge of bed for transfers, due to weakness and pain from recent abdominal surgery. Review of the resident's consent for use of side rails, dated 5/7/25, showed the following:-Left upper: quarter bed rail;-Right upper: quarter bed rail;-Bed rail or alternative interventions decision tree was not completed. Review of the resident's bed rail safety check, dated 5/20/25, showed the following:-Headboard measurement 0;-Footboard measurement 2;-Halo rail on the right side of the bed: -Zone 1: pass, measurement 3.5; -Zone 2: pass, no measurement; -Zone 3: pass, no measurement;(Staff completed the bed rail safety check for a halo rail, however, the resident had an order for two quarter bed rails. Review showed no documentation staff conducted a bed rail safety check to identify areas of possible entrapment between the bed frame, mattress and the quarter bed rails.) Review of the resident's side rails assessment and consent, completed 5/28/25, showed the following:-Medical symptoms requiring use of bed rails: new colostomy (an artificial opening in the abdominal wall to divert stool from the colon), abdominal pain, congestive heart failure, and atrial fibrillation;-Reason for bed rail usage: assist with transfer and bed mobility;-Types of rails to be used: top half, two sides;-Frequency of use: resident had two quarter bed rails to enable him/her to turn self and and reposition and to assist with sitting up on the edge of the bed.(Review showed no documentation staff assessed the resident's risk for entrapment between the bed and the bed rails.) Review of the resident's physician orders, dated 7/8/25, showed an order to have two quarter bed rails to assist with moving side to side in bed and to edge of bed for transfers, due to weakness and pain from recent abdominal surgery. Review of the resident's side rails assessment and consent, completed 7/23/25, showed the following:-Medical symptoms requiring use of bed rails: colostomy, atrial fibrillation, asthma, shortness of breath, and congestive heart failure;-Reason for bed rail usage: assist with transfer and bed mobility;-Types of rails to be used: top half, two sides;-Frequency of use: resident had two halo rails to assist with moving side to side in bed and sitting on edge of bed for transfers. (The assessment identified the resident had halo rails, however, the resident had a physician's order for quarter bed rails.)(Review showed no documentation staff assessed the resident's risk for entrapment between the bed and the (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	bed rails.) Review of the resident's quarterly Minimum Data Set (MDS), a federally mandated assessment tool completed by facility staff, dated 8/14/25, showed the following:-Moderate cognitive impairment;-Moderate assistance required for rolling left and right in bed, sitting on the side of the bed to lying flat on the bed, for sitting to standing, and chair/bed-to-chair transfers;-Set up assistance for lying flat on the back to sitting on the side of the bed with feet flat on the floor. Review of the resident's care plan, revised on 8/29/25, showed the following:-He/She required assistance from one staff with most activities of daily living (ADLs);-He/She was to have two quarter bedrails to assist with moving side to side in bed and to the edge of the bed for transfers since still weak from recent surgery. Observation on 9/10/25 at 8:49 A.M. showed the resident was asleep in bed. The resident had one quarter bed rail in the raised position on the left side of his/her bed. Review of the resident's medical record showed no documentation staff conducted a bed rail safety check to identify areas of possible entrapment between the bed frame, mattress and the quarter bed rail. 3. Review of Resident #7's undated face sheet, showed the resident was admitted on [DATE]. Review of the resident's physician orders, dated 7/14/25, showed an order to have two quarter bed rails to assist with moving side to side in bed and to edge of bed for transfers due to fracture of both femurs. Review of the resident's consent for use of side rails, dated 7/14/25, showed the following:-Left upper: quarter side rail;-Right upper: quarter side rail:-Bed rail or alternative intervention decision tree not completed. Review of the resident's admission MDS, dated [DATE], showed the following:-Moderate cognitive impairment;-Impairment in range of motion to both lower extremities;-Dependent on staff for rolling left and right in bed, sitting on the side of the bed to lying flat on the bed, lying flat on the back to sitting on the side of the bed with feet flat on the floor, sitting to standing and chair and bed-to-chair transfers. Review of the resident's care plan, revised 8/27/25, showed the following:-He/She required assistance with most ADLs;-He/She had two quarter bed rails to assist with moving side to side in bed and to edge of bed for therapy. Review of the resident's side rails assessment and consent, dated 8/27/25, showed the following:-Medical symptoms requiring use of bed rails: two fractured femurs, non-weight bearing, dementia, and pain;-Reason for use: assist with transfer and bed mobility;-Type of rails to be used: top half, two sides;-Frequency of use: resident had two quarter bed rails to enable him/her in self-turning and reposition and to assist in sitting up on the edge of bed;(Review showed no documentation staff assessed the resident's risk for entrapment between the bed and the bed rails.) Observation on 9/8/25 at 10:59 A.M. showed the resident was sleeping in bed. The resident had quarter bed rails in the raised position on both sides of his/her bed. Observation on 9/8/25 at 11:48 A.M. showed the resident was in bed. The quarter side rails on both sides of the resident's bed were in the raised position. The resident utilized the side rails to roll side to side in bed. Review of the resident's medical record showed no documentation staff conducted a regular inspection of the resident's bed frame, mattress and the quarter bed rails to identify areas of possible entrapment. 4. Review of Resident #14's undated face sheet showed he/she was admitted on [DATE]. Review of the resident's consent for use of side rails, dated 7/25/24, showed the following:-Left upper: halo rail;-Bed rail or alternative intervention decision tree not completed. Review of the resident's physician orders, dated 7/25/24, showed an order for one halo bed rail on the right side to assist with moving side to side in bed and to edge of bed for transfers. Review of the resident's side rails assessment and consent, dated 9/5/24, showed the following:-Medical symptoms requiring use of bed rails: coronary artery disease, osteoarthritis, angina pectoris (chest pain), gastroesophageal reflux disease (GERD);-Reason for use: assist with transfer and bed mobility;-Type of rails to be used: top half, one side;-Frequency of use: resident had a halo bed rail on upper left to enable him/her in self-turning and repositioning and to assist in setting on edge of bed.(Review showed no documentation staff assessed the resident's risk for entrapment between the bed and the bed rails.) Review of the resident's physician orders, dated 11/22/24, showed an order for one halo bed rail on the right side to assist with moving side to side in bed and to edge of bed for transfers due to unsteadiness on feet and weakness. Review of the resident's side (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	rails assessment and consent, dated 12/4/24, showed the resident had a halo bed rail on the upper right to enable him/her in self-turning and repositioning and to assist in setting on edge of bed. (Review showed no documentation staff assessed the resident's risk for entrapment between the bed and the bed rails.) Review of the resident's side rails assessment and consent, dated 3/12/25, showed the resident had a halo bed rail on upper right to enable him/her in self-turning and repositioning and to assist in setting on edge of bed. (Review showed no documentation staff assessed the resident's risk for entrapment between the bed and the bed rails.) Review of the resident's bed rail safety check, dated 5/20/25, showed the following:-Quarter bed rail on the right side of the bed: -Zone 1 (within the rail): pass, measurement 3.5; -Zone 2 (under the rail between the mattress): pass, no measurement; -Zone 3 (between the rail and the mattress): pass, no measurement; -Zone 4 (under the rail at the ends of the rail): pass, no measurement;-Quarter bed rail on the left side of the bed: -Zone 1: pass, measurement 3.5; -Zone 2: pass, no measurement; -Zone 3: pass, no measurement; -Zone 4: pass, no measurement;(Review showed no documentation staff completed a thorough inspection to identify areas of possible entrapment between the bed rails and the resident's mattress and bed frame.) Review of the resident's side rails assessment and consent, dated 6/12/25, showed the resident had a halo bed rail on the upper right to enable him/her in self-turning and repositioning and to assist in setting on edge of bed. (Review showed no documentation staff assessed the resident's risk for entrapment between the bed and the bed rails.) Review of the resident's annual MDS, dated [DATE], showed the following:-Severe cognitive impairment;-Maximum assistance required for rolling left and right in bed;-Dependent on staff for sitting on the side of the bed to lying flat on the bed, lying flat on the back to sitting on the side of the bed with feet flat, sitting to standing, and chair and bed-to-chair transfers. Review of the resident's side rails assessment and consent, dated 9/10/25, showed the following:-Reason for use: assist with transfer and bed mobility; -The resident had a halo bed rail on upper right to enable him/her in self-turning and repositioning and to assist in setting on edge of bed.(Review showed no documentation staff assessed the resident's risk for entrapment between the bed and the bed rails.) Review of the resident's care plan, revised 9/10/25, showed the resident had one halo rail on the left side to assist with moving side to side in bed and moving to edge of bed for transfers. Observation on 9/8/25 at 9:44 A.M. and 10:54 A.M. showed the quarter bed rails in the raised position on both sides of the resident's bed. 5. During an interview on 9/22/25 at 8:51 A.M., the Maintenance Director said the following:-The maintenance department was responsible for putting the bed rails on the residents' bed per physician orders;-He was not aware some residents were on beds with rails that did not match the physician order.-He evaluated the residents' beds and bed rails monthly. He conducted a visual check and quickly measured the zones. He kept a documentation to show he conducted the monthly inspection and measurements, but did not document the actual measurements;-He did not realize some residents with bed rails didn't have an inspection with measurements or that the most recent documented inspections with measurements did not match the bed rails the residents had on their beds.-He had a list of all residents and the types of rails they should have, but it was outdated and not correct. During interviews on 09/09/25 at 10:15 A.M. and on 09/10/25 at 7:30 P.M., the Director of Nursing (DON) said the following;-Staff was to complete the bed rail risk assessment prior to use of bed rails, including halo bed rails; -The MDS Coordinator monitored the bed rails on admission and quarterly;-Bed rail use should be on the resident's care plans.-The bed rail assessment did not assess the resident's risk for entrapment; -The facility did not have an assessment to evaluate the resident's risk or entrapment;-The facility did not have a system in place to know which residents with bed rails were at risk for entrapment. During an interview on 9/10/25 at 7:30 P.M., the Administrator said the following:-Staff should complete assessments prior to the use of all bed rails, including the halo rails. She did not know an entrapment risk assessment was required;-Maintenance staff was to measure the entrapment zones monthly.

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F 0728 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that nurse aides who have worked more than 4 months, are trained and competent; and nurse aides who have worked less than 4 months are enrolled in appropriate training. Based on interview and record review, the facility failed to ensure seven nurse aides (NAs) completed a state-approved training program within four months of hire. The facility census was 41. Review of the facility policy, Nurse Aid Qualifications and Training Requirements, revised August 2022, showed the following:-Nurse aides must undergo a state-approved training program;-The facility will not employ any individual as a nurse aide for more than four months, full-time, temporary, per diem, or otherwise, unless: a. That individual is competent to provide designated nursing care and nursing related services, and; b. That individual has completed a training program and competency evaluation program, or a competency evaluation program approved by the state or that individual has been deemed competent as provided in S483. IS0(a) and (b) of the requirements of participation;-Nursing assistants failing to successfully complete the required training program within the first four months of their date of employment may be terminated from employment or may be reassigned to non-nursing related services. 1. Review of NA J's employee file showed a hire date of 4/25/23. During an interview on 09/08/25, at 10:14 A.M., NA J said he/she worked at the facility as an NA for a couple of years. He/She was enrolled in a training program. During an interview on 9/10/25 at 5:14 P.M., the Director of Nursing (DON) said NA J was currently enrolled in an online training program. 2. Review of NA O's employee file showed a hire date of 4/24/24. During an interview on 9/10/25 at 5:14 P.M., the DON said the following:-NA O had a delayed start into his/her classes;-NA O started part time. He/She tried to enroll into a different program and had problems with the program not accepting the facility's form of payment, and then he/she was off for a while.-NA O was scheduled to test on 9/15/25. 3. Review of NA U's employee file showed a hire date of 8/23/24. During an interview on 9/10/25 at 5:14 P.M., the DON said the following:-NA U failed a portion of his/her test and had not retested;-NA U was still working as an NA. 4. Review of NA V's employee file showed a hire date of 10/14/24. During an interview on 9/10/25 at 5:14 P.M., the DON said the following:-NA V failed a portion of his/her test and had not retested;-NA V was still working as an NA. During an interview on 09/09/25, at 1:14 P.M., NA V said he/she started at the facility last Fall and worked full time as an NA on the day shift. 5. Review of NA H's employee file showed a hire date of 12/2/24. During an interview on 9/10/25 at 5:14 P.M., the DON said the following:-NA H had a delayed start for his/her classes. He/She worked evenings, and then was off work for a while; -NA H was scheduled to test on 9/15/25. 6. Review of NA W's employee file showed a hire date of 3/4/25. During an interview on 9/10/25 at 5:14 P.M., the DON said NA W was scheduled to test on 9/15/25. 7. Review of NA X's employee file showed a hire date of 5/12/25. During an interview on 9/10/25 at 5:14 P.M., the DON said NA X started classes on 9/8/25. The program the facility used only have one class every 12 weeks. NA X was hired after the start of the previous class, so he/she had to wait to start the class. 8. During an interview on 9/10/25 at 5:14 P.M., the Director of Nursing (DON) said the following:-NAs must be certified within four months of hire;-The facility usually had NAs enrolled in class prior to their four months, but they do not always have their classes completed and test taken within the four months; -The facility typically held off enrolling NAs because the facility paid for classes and testing and the NAs did not always stay; -The training program the facility used only had one class every 12 weeks, so depending on when the NA was hired, they may be delayed getting into a course; -It did not matter if the NA was full time, part time or as needed, they were supposed to be certified within four months; -If the NA was not certified within four months, they were supposed to be terminated or moved to a non-direct care position.

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to obtain a 14 day stop date on as needed (PRN) psychotropic medication for two residents (Residents #11 and #28), in a review of 17 sampled residents, and did not provide documentation of a clinical reason to extend the PRN medication beyond 14 days. Resident #11's PRN antipsychotic medication was administered for reasons that were not approved and lacked documentation of why the medication was administered. The facility census was 41. Review of drugs.com showed the following:-Seroquel is an antipsychotic medication that may increase the risk of death in older adults with mental health problems related to dementia.-Seroquel can cause a serious heart problem. Your risk may be higher if you also use certain other medicines for infections, asthma, heart problems, high blood pressure, depression, mental illness, and cancer.-Seroquel is approved for use for:-Schizophrenia in adults and children who are at least [AGE] years old.-Used alone or with divalproex or lithium to treat episodes of mania (frenzied, abnormally excited or irritated mood) or depression in patients with bipolar disorder (manic depressive disorder; a disease that causes episodes of depression, episodes of mania, and other abnormal moods).-To prevent episodes of depression in patients with bipolar disorder.-Seroquel extended release is used in combination with antidepressant medications to treat major depressive disorder in adults. Review of the facility's policy, Antipsychotic Medication Use, last revised July 2022, showed the following: -Residents will not receive medications that are not clinically indicated to treat a specific condition;-Antipsychotic medications will be prescribed at the lowest possible dosage for the shortest period of time and are subject to gradual dose reduction and re-review;-Residents will only receive antipsychotic medications when necessary to treat specific conditions for which they are indicated and effective;-The attending physician will identify, evaluate and document symptoms that may warrant the use of antipsychotic medications;-Antipsychotic medications shall generally be used only for the following conditions/diagnoses as documented in the record, consistent with the definitions in the Diagnostic and Statistical Manual of Mental Disorders: a. Schizophrenia; b. schizoaffective disorder; c. Schizophreniform disorder; d. Delusional disorder; e. Mood disorders; f. Psychosis in the absence of dementia; g. medical illnesses with psychotic symptoms and/or treatment-related psychosis or mania; h. Tourette's Disorder; I. Huntington Disease; j. Hiccups; k. Nausea and vomiting associated with cancer or chemotherapy;-Diagnoses alone do not warrant the use of antipsychotic medication. In addition to the above criteria, antipsychotic medications will generally only be considered if the following conditions are also met: a. The behavioral symptoms present a danger to the resident and others; AND; 1. The symptoms are identified as being due to mania or psychosis or; 2. Behavioral interventions have been attempted and included in the plan of care, except in an emergency;-Antipsychotic medications will not be used if the only symptoms are one or more of the following: a. Wandering; b. Poor self-care; c. Restlessness; d. Impaired memory; e. Mild anxiety; f. Insomnia; g. Inattention or indifference to surroundings; h. Sadness or crying along that is not related to depression or other psychiatric disorders; i. Fidgeting; j. Nervousness; k. Uncooperativeness;-Residents will not receive PRN doses of psychotropic medications unless that medication is necessary to treat a specific condition that is documented in the clinical record;-PRN orders for antipsychotic medications will not be renewed beyond 14 days unless the healthcare practitioner has evaluated the resident for the appropriateness of that medication and documented the rationale for continued use;-The duration of the PRN order will be indicated in the order;-Staff will observe, document and report to the attending physician information regarding the effectiveness of any interventions, including antipsychotic medications;-The physician shall respond appropriately by stopping problematic doses or medications or clearly documenting why the benefits of the medication outweigh the risks or suspected confirmed adverse consequences. 1. Review of Resident #11's (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Nurses Notes, dated 04/14/25 at 8:37 P.M., showed the resident admitted to the facility at 11:50 A.M. on 4/14/25. The resident was restless, forgets to ask for help, and gets up and starts to walk without his/her walker. The resident wanted to go home. Review of the resident's undated Baseline Care Plan showed the resident was alert, confused, moody and wandered. The resident was an elopement risk and had a Wanderguard (electronic alert worn on the body). The baseline care plan did not include any other specific behaviors or interventions for behaviors. Review of the resident's Physician's Orders Sheet (POS), dated 04/14/25, showed Seroquel (quetiapine) 25 milligrams (mg), 1/2 tab (dose of 12.5 mg) daily PRN (as needed) for agitation. The order did not include a stop date of 14 days or less. Review of the resident's Medication Administration Record (MAR), dated 04/14/25 at 9:11 P.M., showed staff administered Seroquel 12.5 mg, for behavior issues, with a follow up entry noted as effective. (Behavior issues were not an approved use for the PRN Seroquel as directed in the physician's orders. The resident's record included no documentation to describe the resident's noted behavior issues or staff interventions prior to administration of Seroquel.) Review of the resident's MAR, dated 04/15/25 at 7:08 P.M., showed the resident received Seroquel 12.5 mg, for other, and a follow up entry effective. (Other is not an approved use for Seroquel). Review of the resident's Nurses Notes, dated 04/15/25, did not show any additional behaviors or documentation why staff administered Seroquel at 7:08 P.M. or staff interventions prior to administration of Seroquel. Review of the resident's MAR, dated 04/17/25 at 7:24 P.M., showed staff administered Seroquel 12.5 mg, for sleep. There was no follow up entry documented. (The resident's physician orders directed use for agitation). Review of the resident's Nurses Notes, dated 04/17/25, did not show any additional behaviors for the evening shift or documentation why staff administered Seroquel at 7:24 P.M or staff interventions prior to administration of Seroquel. Review of the resident's MAR, dated 04/18/25 at 5:09 P.M., showed staff administered Seroquel 12.5 mg, for other. There was no follow up entry regarding effectiveness. (Other is not an approved use for Seroquel). Review of the resident's Nurses Notes, dated 04/18/25, did not show any additional behaviors or documentation why staff administered Seroquel at 5:09 P.M. or staff interventions prior to administration of Seroquel. Review of the resident's MAR, dated 04/19/25 at 5:44 P.M., showed staff administered Seroquel 12.5 mg, for behavioral issue. A follow up entry noted somewhat effective. Review of the resident's Nurses Notes, dated 04/19/25, did not show any additional behaviors or documentation why staff administered Seroquel at 5:44 P.M or staff interventions prior to administration of Seroquel. At 8:36 P.M., staff documented family visit one on one with resident until just before the supper meal service. Resident prowling the hallways and forgetting his/her walker. The resident was cooperative and enjoyed talking to others. Will sit briefly in his/her recliner to watch television. Review of the resident's MAR, dated 04/20/25 at 7:18 P.M., showed staff administered Seroquel 12.5 mg, for behavioral issue. A follow up entry noted somewhat effective. Review of the resident's Nurses Notes, dated 04/20/25, did not show any additional behaviors or documentation why staff administered Seroquel at 7:18 P.M. or staff interventions prior to administration of Seroquel. At 9:26 P.M., staff documented for this shift (2 P.M to 10 P.M.), family at bedside and resident asleep in bedside recliner. Family left at 4:45 P.M., and then resident was fully awake. The resident ambulated in his/her room, then returned to his/her recliner watching westerns on television. No aggressive behaviors this shift. Review of the resident's admission Minimum Data Set (MDS), a federally mandated assessment completed by staff, dated 04/21/25, showed the following:-Severe cognitive impairment;-Diagnoses included Alzheimer's dementia, metabolic encephalopathy (neurological syndrome where brain function is impaired due to systemic illnesses), atrial fibrillation (irregular heartbeat), high blood pressure, pain, adult failure to thrive, and history of falling;- Usually understands-misses some part/intent of message but comprehends most conversation;-Wandering occurred one to three days;-Antipsychotic used on a PRN basis. Review of the resident's MAR, dated 04/22/25 at 8:24 P.M., showed staff administered Seroquel 12.5 mg, for other, restlessness. A follow up entry noted somewhat effective. (Restlessness and other is not an approved use for Seroquel). Review of the resident's Nurses Notes, dated (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	04/22/25, at 8:45 P.M., showed staff documented the resident was resting in bed watching television. Alert and oriented to self, pleasant and cooperative. Resident has been up several times this evening walking into the hallway but was easily redirected to room. No violent or aggressive behaviors noted this shift. Review of the resident's Nurses Notes, dated 04/22/25, did not show any additional behaviors or documentation why staff administered Seroquel at 8:24 P.M. or staff interventions prior to administration of Seroquel. Review of the resident's Care Plan, dated 04/23/25, showed the following:-Psychotropic Drug Use: The resident has a diagnosis of dementia and sometimeshas aggressive behaviors towards staff when they are trying to help him/her;-Resident to have less aggressive behaviors by next review date;-Resident has Seroquel PRN if he/she has aggressive behaviors;-Monitor the resident after administering Seroquel for side effects such as orthostatic hypotension (low blood pressure), lethargy, headache, weight gain, weakness, insomnia, dizziness and drowsiness. The resident's care plan did not include specific behaviors other than wandering, or interventions for specific behaviors other than wandering. The resident wore a Wanderguard. Review of the resident's Nurses Notes, dated 04/23/25, at 4:16 P.M., showed the resident sat in the dining room. The resident was calm and had not displayed any behaviors. Review of the resident's MAR, dated 04/23/25 at 8:27 P.M., showed staff administered Seroquel 12.5 mg, for other, restlessness. A follow up entry noted effective. (Restlessness is not an approved use for Seroquel). Review of the resident's Nurses Notes, dated 04/23/25, did not show any additional behaviors or documentation why staff administered Seroquel at 8:27 P.M. or staff interventions prior to administration of Seroquel. Review of the resident's Nurses Notes, dated 04/23/25, at 10:31 P.M., showed staff documented the resident was cooperative and had not tried to leave or talk about leaving. Review of the resident's MAR, dated 04/25/25 at 6:47 P.M., showed staff administered Seroquel 12.5 mg, for other, restlessness. A follow up entry noted effective. (Restlessness is not an approved use for Seroquel). Review of the resident's Nurses Notes, dated 04/25/25, did not show any additional behaviors or documentation why staff administered Seroquel at 6:47 P.M. or staff interventions prior to administration of Seroquel. Review of the resident's Nurses Notes, dated 04/25/25, at 7:22 P.M., showed the resident had been roaming the hall or sitting in front of the nurses desk. The resident required repeated reminders to use his/her rolling walker when ambulating. The resident had been calm. Review of the resident's Nurses Notes, dated 04/30/25, at 6:41 P.M., showed the resident wandered in the hallway. The resident forgets to use his/her walker. Review of the resident's MAR, dated 04/30/25 at 7:33 P.M., showed staff administered Seroquel 12.5 mg, for other, restlessness. A follow up entry noted effective. Review of the resident's Nurses Notes, dated 04/30/25, did not show any additional behaviors or documentation why staff administered Seroquel at 7:33 P.M. or staff interventions prior to administration of Seroquel. Review of the resident's MAR, dated 05/04/25 at 8:57 A.M., showed staff administered Seroquel 12.5 mg, for behavioral issue. A follow up entry noted somewhat effective. Review of the resident's Nurses Notes, dated 05/04/25, did not show any additional behaviors or documentation why staff administered Seroquel at 8:57 A.M. or staff interventions prior to administration of Seroquel. Review of the resident's MAR, dated 05/06/25 at 5:43 P.M., showed staff administered Seroquel 12.5 mg, for behavioral issue. A follow up entry noted effective. Review of the resident's Nurses Notes, dated 05/06/25, did not show any additional behaviors or documentation why staff administered Seroquel at 5:43 P.M., or staff interventions prior to administration of Seroquel. Review of the resident's MAR, dated 05/31/25 at 1:24 A.M., showed staff administered Seroquel 12.5 mg, for behavioral issue, exit seeking and resistance. A follow up entry noted effective. Review of the resident's Nurses Notes, dated 05/31/25, at 01:30 A.M., showed the resident was wandered in the hallway. He/She came to the nurses station and fixated on a chair by the fish tank. The resident picked up and walked around with the chair. The resident said he/she wanted to find his/her truck and go home. The resident put the chair in front of the dining room doors and sat, then went into the dining room. All attempts to redirect were unsuccessful. Resident agreed to take PRN Seroquel. Review of the resident's quarterly MDS, dated [DATE], showed the (continued on next page)

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	265816	A. Building B. Wing	09/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Schuyler County Nursing Home District	1306 US Highway 63 Queen City, MO 63561

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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 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	following:-Severe cognition impairment;-Physical behavioral symptoms directed toward others occurred one to three days;-Wandering one to three days;- Usually understands-misses some part/intent of message but comprehends most conversation. Review of the resident's MAR, dated 08/31/25 at 8:19 P.M., showed staff administered Seroquel for sleep. Follow up documentation noted effective. Review of the resident's Nurses Notes, dated 08/31/25, showed no behaviors or documentation why staff administered Seroquel at 8:18 P.M., or staff interventions prior to administration of Seroquel. Review of the resident's medical record showed no documentation of a rationale from the resident's physician to indicate why it was appropriate to provide no indication for duration of the resident's Seroquel. 2. Review of Resident #28's care plan, dated 4/4/25, showed the following:-The resident had a diagnosis of anxiety and depression;-Monitor for signs and symptoms of depression and anxiety; -If the resident showed any signs, notify the charge nurse. Review of resident's quarterly MDS, dated [DATE], showed the following:-Moderate cognitive impairment;-No physical or verbal behaviors or rejection of cares;-Diagnoses of anxiety and depression;-Received an antidepressant medication. Review of the resident's Physician Orders, dated August 2025, showed an order for clorazepate dipotassium (a psychotropic medication used to treat anxiety) 7.5 milligrams (mg) twice daily PRN for anxiety (original order dated 4/17/25). (The PRN order did not include a stop date.) Review of the resident's Physician's Orders, dated September 2025, showed an order for clorazepate dipotassium 7.5 mg twice daily PRN for anxiety (original order dated 4/17/25). (The PRN order did not include a stop date.) Review of the resident's MAR, dated September 2025, showed the resident received four doses of clorazepate dipotassium. Review of the resident's medical record showed no documentation of a rationale from the resident's physician to indicate why it was appropriate to extend the PRN order for clorazepate dipotassium beyond 14 days and no indication for the duration of the PRN order. 3. During an interview on 9/10/25, at 7:30 P.M., the Director of Nursing (DON) said the following:-Staff should obtain stop dates of 14 days or less for PRN psychotropic medications;-Staff should inform the physician on how a resident responded to psychotropic medication and obtain an order to discontinue or continue the PRN psychotropic medication for 14 days at a time;-Staff should administer PRN medications for the indications for which they are approved.

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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 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident when there is a significant change in condition **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to complete a significant change in status assessment (SCSA) Minimum Data Set (MDS), a federally mandated assessment instrument required to be completed by facility staff, for two residents (Residents #4 and #6), in a review of 17 sampled residents, within 14 days after the facility determined, or should have determined, there had been a significant change in the resident's physical or mental condition which had an impact on more than one area of the resident's health status and required interdisciplinary review and/or revision of the care plan. The facility census was 41. Review of the Long Term Care Facility RAI User's Manual, version 3.0 showed a significant change is a decline or improvement in a resident's status that:-Will not normally resolve itself without intervention by staff or by implementing standard disease-related clinical interventions and is not self-limiting;-Impacts more than one area of the resident's health status;-Requires interdisciplinary review and/or revision the care plan.-The manual also showed a SCSA was appropriate if there was a consistent pattern of changes, with either two or more areas of decline, or two or more areas of improvement. This may include two changes within a particular domain (e.g., two areas of activities of daily living (ADL) decline or improvement).1. Review of Resident #4's admission Minimum Data Set (MDS), a federally mandated assessment completed by staff, dated 05/29/25, showed the following:-Cognitively intact;-Diagnosis of chronic pain, sepsis (infection leading to bacteria in the blood), sacral (tailbone) fracture on admission; -Pain Management: Scheduled pain meds, PRN (as needed) pain medications, frequent pain, pain occasionally effects sleep, worst pain last five days the resident rated at a 10 on a 1-10 scale (10 being worst pain);-Walker use;-Set up or clean up assistance from staff for oral hygiene and personal hygiene;-Requires supervision/touching assistance from staff members for upper body dressing,;-Requires partial/moderate assistance from staff for toileting hygiene;-Requires substantial/maximal assistance from staff for lower body dressing, to roll right and left and for lying to sitting on bed side; -Dependent on staff for sit to stand, chair/bed-to-chair, toilet transfer and tub/shower transfer.Review of the resident's quarterly MDS, dated [DATE], showed the following:-New use of a wheelchair;-Independent with wheelchair mobility 50 feet with two turns (improvement); -Requires partial/moderate assistance from staff for oral hygiene (decline), personal hygiene (decline), to roll right and left (improvement), from lying to sitting on bed side (improvement), sit to stand (improvement), chair/bed-to-chair (improvement) and tub/toilet transfer (improvement);-Dependent on staff for toilet hygiene (decline), upper body dressing (decline), lower body dressing (decline), wheeling 150 feet (improvement); -No use of PRN (as needed) pain medication and no pain on interview (improvement).Observation on 09/07/25, at 12:30 and 1:25, showed the following:-The resident sat up in his/her wheelchair at lunch;-The resident fed himself/herself without any difficulty;-After lunch, the resident propelled his/her own wheelchair down the hall.The facility did not complete a SCSA when the resident had new wheelchair use and mobility, increased ability for bed mobility, increased ability for transfers, a decrease in ADLs such as oral hygiene, personal hygiene, toileting hygiene, dressing, and a decrease in pain and PRN pain medication use. 2. Review of Resident #6's annual MDS, dated [DATE], showed the following:-Minimal visual and hearing difficulties; has hearing aid and glasses;-Cognitively intact;-Diagnosis include sepsis, dysrhythmia (irregular heartbeat), heart failure, chronic pulmonary (respiratory) disease, tremor, convulsions unspecified, pain and edema;-Impairment of functional ROM (range of motion) in one lower extremity;-Wheelchair use;-Independent with eating;-Requires partial/moderate assistance from staff for oral hygiene and personal hygiene;-Requires substantial/maximal assistance from staff for upper body dressing, lower body dressing, footwear, and wheeling 50 feet with 2 turns;-Dependent on staff for toileting hygiene, to shower/bathe, to roll left and right, from sitting to lying and lying to sitting on bed side, and sit to stand;Could not attempt (continued on next page)

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	due to safety chair/bed-to-chair transfer or toilet transfer and walking;-Frequently incontinent of bowel and bladder; constipation present;-Scheduled pain meds, no PRN pain medications;-No weight loss. The facility did not complete a quarterly MDS for the resident in December 2024. Review of the resident's quarterly MDS, dated [DATE], showed the following:-No limitations in functional ROM (improvement);-Set up or clean up assistance from staff for eating (decline);-Dependent on staff for oral hygiene (decline), upper body dressing (decline), lower body dressing (decline), footwear (decline), personal hygiene(decline) and wheeling 50 feet with two turns (decline);-New indwelling urinary catheter (tube inserted in bladder to drain urine);-The addition of PRN medications for pain;-Occasionally has moderate pain. The facility did not complete a SCSA when the resident had decline in the ability to eat, perform oral/personal hygiene, dressing, wheelchair mobility, a new indwelling urinary catheter, and increased pain requiring PRN medications to ensure the resident received proper care.Review of the resident's quarterly MDS, dated [DATE], showed the following:-Requires substantial/maximal assistance from staff for toilet transfer (improvement);-Always incontinent of bowel (decline);-No PRN medication for pain (improvement);-Significant weight loss, not prescribed by a physician (decline);-Started on a therapeutic diet (decline). The facility did not complete a SCSA when the resident had decline in incontinence of bowel, weight loss with a new diet, and improvement in toilet transfer and pain. Review of the resident's Nurses Notes, dated 07/18/25 at 9:52 A.M., 2:09 P.M. and 3:21 P.M., showed the following:-The resident sat in his/her power electric recliner when his/her elbow became pressed against the remote;-Due to resident's general weakness, he/she was unable to move his/her elbow in time before it bucked him/her out of the recliner onto the floor;-The resident landed on the left side of his/her body and tangled himself/herself up into the bedside table;-The resident immediately began complaining of pain in his/her right lower extremity;-Noted swelling present in the resident's right knee;-After assessments and notifications, the resident was sent to the emergency room for evaluation;-2:09 P.M. update: hospital reported the resident will be admitted for two separate fractures in bilateral (both) legs. First fracture is a right distal femur (the lower end of the femur, or thigh bone above the knee) fracture and the second fracture is a left proximal tibial (the upper portion of the tibia, or shinbone, located at the top of the bone and forming part of the knee joint) fracture;-3:21 P.M., updated from resident's family member, the resident will have surgery on Monday, 07/21/25, to repair the left tibial fracture. Resident does not need surgical intervention on the right femur fracture and will have it soft casted. Review of the resident's Nurses Notes, dated 07/25/25 at 4:00 A.M., showed the hospital called and said the resident will be coming back to this facility but will have to be transferred by ambulance related to his/her fractured legs and non-weight bearing (NWB) status. Observation on 09/10/25 at 9:50 A.M., showed the following:-The resident was in bed;-Certified Nurse Assistant (CAN) N, Nurse Aide (NA) O and CNA P provided perineal and catheter care;-The resident was unable to move his/her legs (decrease in functional ROM);-Both legs were wrapped with bandages;-The resident had pain with movement. During an interview on 9/08/25 at 10:47 A.M., NA V said the following:-The resident only gets up when he/she wants to;-Since the resident fractured his/her legs in July, he/she requires a mechanical lift to transfer;-Now (since the fractures) staff turn him/her every two hours and he/she does not get out of bed as often;-The resident had pain at his/her surgical site because it had not healed well;-The resident was not up and about as much as he/she used to be and has a lot more pain when staff work with him/her. The facility staff did not complete a SCSA assessment after the resident had a fall with major fractures requiring surgery. The injuries decreased the resident's ability to transfer (now required a mechanical lift to get out of bed), the resident does not leave his/her room, has more pain and has dressings with a surgical incision. 3. During an interview on 09/18/25 at 10:37 A.M., the MDS Coordinator said the following:-She was responsible to complete SCSAs;-SCSAs are done when the resident has had a significant weight loss, decline in ADL's (activities of daily living) and was needing more help, starting hospice or palliative care for example;-Staff have 14 days to complete the SCSAs after the (continued on next page)

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	decline was identified;-She compared the MDS to the last assessment to see if there was a significant change (she was not aware that she should compare to the last comprehensive assessment);-SCSAs are expected to be completed with two or more changes in two care areas or two changes in section GG of the MDS. During an interview on 9/10/25 at 7:30 P.M., the Director of Nursing said the following:-The MDS coordinator was responsible to initiate and complete SCSAs according to the RAI manual;-SCSAs are required to be completed when there are two or more areas of decline in a resident's condition. During an interview on 9/10/25 at 7:30 P.M., the Administrator said the following:-The MDS coordinator was responsible to initiate and complete SCSAs according to the RAI manual;-SCSAs are required to be completed when a resident has a decline or has a significant change, such as incontinence or they cannot feed themselves.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide adequate supervision and oversight to prevent falls for one resident (Resident #20), in a review of 17 sampled residents. The resident experienced multiple falls and was high risk for falls. The facility failed to plan and reevaluate interventions to address the resident's falls. The facility did not have a consistent system to identify residents at risk for falls. The facility census was 41. Review of the undated facility policy, Resident Safety and Fall Management, showed the following:-The facility will implement comprehensive fall prevention and post fall management;-All residents will undergo a fall risk assessment upon admission and periodically thereafter;-An event checklist will be utilized that includes evaluation of environmental hazards, mobility status, medication review and individualized care needs;-Staff are responsible for implementing appropriate interventions such as ensure proper lighting, nonslip footwear, assistive devices and scheduled toileting to reduce fall risks;-After a fall, staff must complete the following steps: a. Complete the event in the matrix; b. Notify the doctor; c. Notify the family; d. Update care plan; e. Add a progress note; f. Print the event report from the reports section; g. Obtain witness statement from staff who observed the event; h. Complete a fall huddle; i. Conduct and print a fall risk assessment.;-Submit completed packet to the Director of Nursing (DON);-The facility will ensure ongoing staff training on fall prevention strategies, regular environmental safety checks and resident education to promote a safe, secure environment for all residents. 1. Review of Resident #20's Baseline Care Plan, dated 12/31/24, showed the following:-The resident has some confusion;-The resident is a fall risk;-Requires assist of one and a gait belt for activities of daily living (ADL's). Review of the resident's event history page of the resident's electronic medical record showed the resident had a fall on 01/03/25. Review of the resident's admission Minimum Data Set (MDS), a federally mandated assessment completed by staff, dated 01/07/25, showed the following:-Diagnosis include pneumonia, dementia, seizure disorder and COPD (chronic obstructive pulmonary disease);-Moderate cognitive impairment;-Understands but misses some part/intent of message;-No behaviors;-Uses a walker;-Resident had one fall prior to admission;-One, no injury fall, since admission to the facility;-Requires supervision/touching assistance from staff members for walking 10 feet, picking up an object from the floor and sit to stand;-Requires partial/moderate assistance from staff for chair/bed-to-chair transfer and ambulating 50 feet with two turns. Review of the resident's Care Plan, dated 01/09/25, showed the following:-The resident had a fall at home on [DATE] prior to admission;-The resident was weak and unsteady on his/her feet;-He/She ambulates with a walker and assist of one;-Goal to have no falls through next review;-Remind resident to have staff assist him/her and to use his/her walker;-Encourage the resident to use his/her call light;-Ensure the resident has shoes or gripper socks on while up. Review of the resident's event history page, of the resident's electronic medical record, showed the resident had falls on 01/12/25 (non-injury) and 01/19/25 (witnessed). Review of the resident's care plan showed no additional interventions or updates after the resident's falls on 01/12/25 or 01/19/25. Review of the resident's Safety Event Fall, dated 01/26/25 at 9:37 A.M., showed the following:-Resident fell in his/her room;-Resident was lying in bed prior to the fall;-Fall was unwitnessed;-No injuries. Review of the resident's care plan showed no additional interventions or updates after the resident's on 01/26/25. Review of the resident's quarterly MDS, dated [DATE], showed the following:-No walker or wheelchair use;-One, non-injury fall, since last assessment (there had been two falls since the last assessment);-Independent with sit to stand, chair/bed-to-chair transfer, toilet transfer and walking 150 feet. Review of the resident's Safety Event Fall, dated 04/15/25 at 10:42 A.M., showed the following:-Resident fell in his/her room;-Using bathroom prior to fall;-Resident had regular socks on (not gripper socks like the care plan directed);-The resident said (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	he/she came out of the bathroom, fell and slid down the wall;-No injury. Review of the resident's care plan showed no additional interventions or updates after the fall on 04/15/25. Review of the resident's Safety Event Fall, dated 04/19/25 at 8:15 A.M., showed the following:-Resident fell in his/her room;-Resident carrying cards prior to the fall;-Resident was found on his/her back holding the back of his/her head;-Resident states that he/she hit his/her head on the door trim;-Denies pain, except for some mild tenderness where he/she hit head;-Resident assisted into bed at this time per his/her request and educated oncall light use;-At 0840, resident found on the floor in his/her room again. This time he/she was lying on his/her right side on the floor at the end of his/her bed;-Resident said he/she hit his/her head again and also his/her right elbow;-Some mild redness present over right elbow but no other abnormalities;-Resident also appears much more confused compared to baseline;-Per nursing judgement, resident to be sent to the emergency room at this time related to increased confusion and repeated falls. Review of the resident's nurses notes, dated 04/19/25, showed the resident was admitted to the hospital with diagnosis of pneumonia. Review of the resident's care plan showed no additional interventions or updates after the resident's two falls on 04/19/25. Review of the resident's nurses notes showed the resident returned from the hospital on [DATE]. Review of the resident's Safety Event Fall, dated 4/22/25 at 6:34 A.M., showed the following:-The resident fell at the nurses station;-Prior to the fall, the resident was sitting in a chair;-The fall was not witnessed;-A nurse sitting behind the nurses station, heard a noise and witnessed the resident face down on the floor with his/her hand under his/her head;-The resident had a bruise above his/her left eyebrow and mid-forehead; ice pack applied;-The resident said, I was just leaning over and fell. Resident said he/she was tired. The night shift nurse reported the resident did not sleep much last night and the resident tends to be up most nights and sleep late;-The resident was sent to the emergency room for evaluation. Review of the resident's care plan updated 4/24/25, showed the resident has had several falls since admission to the facility and was in the hospital from [DATE] to 4/21/25 for a fall and COPD exacerbation with pneumonia. The care plan had no new interventions to address the resident's multiple falls. Review of the resident's Safety Event Fall, dated 4/28/25 at 1:52 P.M., showed the following:-Resident fell in his/her room;-He/She was lying in bed prior to the fall;-Facility was having a fire drill. Writer walked by the resident's room and saw the resident getting out of bed;-Writer looked in the resident's room again and saw the resident sitting on the floor, on his/her buttocks, with his/her feet straight out in front of him/her;-The resident asked what the noise was and that it scared him/her;-Resident wore non-skid socks and only one slipper. Review of the resident's care plan showed no additional interventions or updates after the resident's fall on 04/28/25, including interventions to address the resident's reaction to and fall resulting from the activation of the fire alarm. Review of the resident's Nursing Progress Notes, dated 06/09/25 at 12:53 P.M., showed the following:-CNA witnessed the resident fall;-The resident fell forward, landing on his/her knees, elbows, then hands and stomach;-The resident's elbows were red; his/her knees were red and beginning to bruise;-Left knee has a small linear open area;-Resident was wearing his/her slippers, which were too big;-These slippers were thrown away and new slippers with non-skid soles put on the resident at this time. Review of the resident's care plan showed no additional interventions or updates after the resident's fall on 06/09/25. Review of the resident's quarterly MDS, dated [DATE], showed the following:-Two or more non injury falls since last assessment;-Two or more falls with injury since last assessment. Observation on 09/10/25 at 10:15 A.M., showed the facility announced a fire drill. The resident was stood outside of his/her door. The resident said, Fire drill, it's going to be loud. The resident started pacing and showed signs of distress. No staff came to ensure the resident was safe and not at risk for falling. During an interview on 09/18/25 at 10:37 A.M., the MDS Coordinator said she completes updates to the care plans with new falls, weight loss, bed alarms, hourly checks, anything that changed care. She tried to update the care plan as those events occurred, but she missed things sometimes. During interviews on 9/10/25 at 2:30 P.M and 7:30 P.M., the Director of Nursing (DON) said the following:-She expected the MDS (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	coordinator to evaluate and update a resident's care plan interventions after each fall; -Care plans are expected to be specific to the resident and give guidance to staff on how to care for them and keep them safe; -Resident #20 should have updates to his/her care plan with each fall. During interview on 9/10/25 at 7:30 P.M., the administrator said she expected staff to follow care planned interventions to prevent falls. Care plans should be updated after a fall with evaluation and any new or revised interventions on the next business day (24 to 48 hours depending on if it is a weekend).

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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 - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to identify and reevaluate indications for use of indwelling urinary catheter (a thin, flexible tube inserted into the bladder to drain urine) to prevent complications including urinary tract infections (UTI) for two residents (Resident #4 and #6), of 17 sampled residents. The facility failed to ensure that catheters were secured to the resident's leg with a device to reduce friction and movement at the site (also decreasing the chance of accidental removal and infection). The facility census was 41. Review of the facility policy, Urinary Catheter Care, revised October 2010, showed the following:-The purpose of this procedure is to prevent urinary catheter-associated complications, including urinary tract infections;-Ensure that the catheter remains secured with a securement device to reduce friction and movement at the insertion site;-Review and document the clinical indications for catheter use prior to inserting;-Nursing and the interdisciplinary team should assess and document the ongoing need for a catheter that is in place. Use a standardized tool for documenting clinical indications for catheter use;-Remove the catheter as soon as it is no longer needed. 1. Review of Resident #6's annual Minimum Data Set (MDS), a federally mandated assessment instrument, dated 09/27/24, showed the following:-Diagnosis of sepsis (when bacteria enter the blood from an infection) and urinary tract infection in the last 30 days;-Dependent on staff for toileting hygiene;-Frequently incontinent of bowel and bladder;-Antibiotic use. Review of the resident's Nurses Notes, dated 12/15/24 at 1:00 A.M., showed staff reported hematuria (blood in the urine) with moderate amounts of clots and increased incontinence. Review of the resident's Nurses Notes, dated 12/15/2024 at 10:17 A.M., showed bright red blood noted in the resident's brief, no clotting noted. Physician ordered to send the resident to the emergency room. Review of the resident's census showed the resident went to the hospital on [DATE] and then returned to the facility on [DATE]. Review of the resident's hospital Discharge summary, dated [DATE], showed the following:-Chief complaint: hematuria;-Final diagnosis: Urinary tract infectious disease and blood in the urine;-Computerized tomography (CT) scan (a type of imaging that uses X-ray techniques to create detailed images of the body) from 12/15/24 showed no hydronephrosis (excess fluid in a kidney due to a backup of urine), no urinary tract calcification (deposits of calcium and other minerals within the kidneys, bladder or other parts of the urinary tract) or obstruction;-Irregular increased density (abnormality) is present in the posterior bladder (the back or lower portion of the urinary bladder) measuring 2.5 centimeters (cm) in diameter, consistent with soft tissue mass versus blood clot;-Thickened urinary bladder wall, suspicious for cystitis (inflammation of the bladder), correlate with urine analysis (UA);-Posterior bladder soft tissue mass due to hematoma (a localized collection of blood outside the circulatory system that forms when blood vessels are damaged) less likely represents bladder neoplasm (an abnormal growth, or tumor, in the bladder that can be either benign (non-cancerous) or malignant (cancerous));-Consider cystoscopy (a medical procedure that allows a healthcare professional to examine the bladder and urethra using a thin, flexible tube called a cystoscope);-Hospital course: Urinary catheter was placed. Since admission, bladder irrigation (a procedure to flush out the bladder to remove mucus, sediment, blood clots or other debris) was performed;-Urine culture showed E coli (a bacteria commonly found in the intestines of humans and other animals);-Recommend follow up with urology on an outpatient basis. Review of the resident's Progress Notes dated 12/18/24 - 03/25/25, including Nursing, Social Services, and Physician notes, showed no information about follow up with urology or when to discontinue or continue using the urinary catheter with an indication for use. Review of the resident's quarterly MDS, dated [DATE], showed the following:-Primary diagnosis of chronic heart failure;-Dependent on staff for toileting and personal hygiene, -New use of an indwelling urinary catheter; The MDS does not list a diagnosis that would be an appropriate indication for a urinary (continued on next page)

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	265816	A. Building B. Wing	09/10/2025

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	catheter. Review of the resident's Progress Notes dated 03/26/25-06/11/25, including Nursing, Social Services, and Physician notes, showed no information about follow up with urology or when to discontinue or continue using the urinary catheter with an indication for use. Review of resident's diagnosis list, in the electronic medical record, did not show a diagnosis that indicated a need for a urinary catheter. Review of the resident's Care Plan, dated 06/11/25, showed the following:-Resident has an indwelling urinary catheter;-Urinary catheter puts the resident at risk for developing multidrug-resistant organisms (MDROS) and spreading them to others;-Monitor the resident for signs and symptoms of a MDRO infection such as fever, chills, fatigue, lethargy, headache, cough, pain, pus discharge and wound breakdown. Review of the resident's quarterly MDS, dated [DATE], showed the following:-Requires substantial/maximal assistance from staff for toilet transfer;-Urinary catheter present;-Always incontinent of bowel.The MDS did not list diagnosis that would be an appropriate indication for a urinary catheter. Review of the resident's Progress Notes dated 06/26/25-09/08/25, including Nursing, Social Services, and Physician notes, showed they did not include any information about follow up with urology or when to discontinue or continue using the urinary catheter with an indication for use. Observation on 09/08/25 at 3:12 P.M., showed the resident in bed, his/her urinary catheter bag was under the bed and sat in a bath basin. Observation on 09/10/25 at 9:50 A.M., showed the following:-The resident was in bed;-Certified Nurse Assistant (CNA) N, Nurse Aide (NA) O and CNA P entered the resident's room;-NA O cleansed the resident's front perineal area;-Visualization of the resident's catheter showed it was not secured to the resident's leg with a device;-When the staff turned the resident during cares the catheter tubing moved freely and would pull and then go slack repeatedly. During an interview on 09/10/25 at 10:11 A.M., CNA N said he/she was not sure if the facility had devices to secure the resident's catheter to his/her leg. During an interview on 09/08/25 at 5:25 P.M., Registered Nurse (RN) M, said the following:-She thought the resident had a urinary catheter for urinary retention, but was not sure; -She did know if the resident's catheter was permanent or if he/she was to have follow up with urology. 2. Review of Resident #4's Baseline Care Plan, dated 05/22/25, showed the following:-Resident admitted to the facility on [DATE];-Alert and oriented;-Resident has a catheter and requires catheter care. Review of the resident's Physician Order's Sheet, dated 05/25/25, showed an order for a urinary catheter with a 30 cubic centimeter (cc) bulb (amount of fluid held in the device to keep the catheter in place), change monthly on the 15th of the month. The order did not include an indication for use.Review of the resident's admission MDS, dated [DATE], showed the following:-Cognitively intact;-Diagnosis of urinary tract infection (UTI) in the last 30 days, chronic pain, sepsis and sacral (tailbone) fracture;-Pain Management: Scheduled pain meds, as needed (PRN) pain medications, frequent pain that occasionally effects sleep, the worst pain last 5 days the resident rated a 10 (on a one to ten scale with 10 being the worst pain ever felt);-Requires partial/moderate assistance from staff for toileting hygiene; -Requires substantial/maximal assistance from staff for lower body dressing, roll right and left; -Dependent on staff for sit to stand, toilet transfer;-Indwelling catheter present;-Daily opioid (pain medication) use;-Physical and occupational therapy. Review of the resident's Physician Order's Sheet, dated 07/22/25, showed a new order to change the urinary catheter bag every two weeks. The catheter order did not have an indication for catheter use. Review of the resident's quarterly MDS, dated [DATE], showed the following:-Catheter use;-Diagnosis did not include an indication for catheter use. Review of the resident's Care Plan, dated 09/02/25, showed the following:-Resident has a urianry catheter;-Urinary catheter puts the resident at risk for developing multidrug-resistant organisms (MDROS) and spreading them to others;(There were no indications why or plan for the catheter to be discontinued on the resident's care plan). Review of the resident's Physician's Order Sheet, dated 9/05/25, showed a new order to bladder train the resident and discontinue the catheter. Observation on 09/07/25 at 12:30 P.M., showed the resident sitting in the dining room in his/her wheelchair. The resident's catheter bag was located under the resident's wheelchair in a privacy bag. During an interview on 09/07/25, at 2:15 P.M., the resident said he/she (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	didn't know why he/she still had a catheter. The hospital put it in when he/she had a pelvic fracture, and no one ever removed it. During an interview on 9/08/25 at 10:35 A.M., NA Q said the resident had a catheter. He/She was not sure why the resident had a catheter. The resident had been getting up in the wheelchair for quite a while. The resident did not complaint of pain and hasn't for a while. During an interview on 09/08/25 at 5:25 P.M., RN M, said the following:-The resident came from the hospital with a urinary catheter due to trauma; he/she had a pelvic fracture; a catheter would be appropriate for severe pain with a pelvic fracture, until the resident could get out of bed and transfer to the toilet;-The resident should not have had the catheter this long. The resident has been getting out of bed, sits in his/her wheelchair and goes to the bathroom for a while now;-The indication for continued use was overlooked. 3. During an interview on 09/10/25 at 3:12 P.M. and 7:30 P.M., the Director of Nursing (DON) said the following:-Care plans are expected to be updated with new catheter use;-Staff are expected to secure the resident's catheter to his/her leg with leg straps or tape to avoid complications; -Staff are expected to ensure catheters have an appropriate indication or diagnosis for use such as neurogenic bladder, retention and prostate issues;-If there was no appropriate indication for use of a urinary catheter, staff are expected to obtain an order and discontinue the catheter. During an interview on 09/10/25 at 7:30 P.M., the Administrator (ADM) said the following:-Care plans are expected to be updated with new catheter use within a couple of days;-Staff are expected to ensure catheters have an appropriate indication or diagnosis for use such as retention, and prostate issues;-If the hospital recommends follow up appointments, the appointments should be made or a note documenting why they were not.

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F 0691 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate colostomy, urostomy, or ileostomy care/services for a resident who requires such services. Based on observation, interview, and record review, the facility failed to obtain a physician's order for colostomy (a surgical opening in the large intestine also called a stoma) care and failed to develop a plan of care to address the care and monitoring of the colostomy for one resident (Resident #40), in a review of 17 sampled residents. The facility census was 41. Review of the facility policy, Medication Orders, last revised November 2014, showed the following:-Current list of orders must be maintained in the clinical record for each resident;-Treatment orders must specify the treatment, frequency and duration of the treatment. 1. Review of Resident #40's Care Plan, dated 7/15/25, showed the following: -The resident had a colostomy; -Staff to wear gloves and gowns when assisting him/her with dressing, toileting or emptying the colostomy;(The resident's care plan did not address the care, treatment, and monitoring of the resident's colostomy.) Review of resident's quarterly Minimum Data Set (MDS), a federally mandated assessment, dated 8/08/25, showed the following:-Diagnoses of malignant neoplasm of colon and other functional intestinal disorders;-Severe cognitive impairment;-Dependent for toileting hygiene and personal hygiene;-Had an ostomy. Review of the resident's Physician's Orders, dated September 2025, showed no physician's order for colostomy care. Review of the resident's Treatment Administration Record (TAR) and Medication Administration Record (MAR), dated September 2025, showed no documentation related to the care and treatment of a colostomy. Observation on 9/09/25, at 8:56 A.M., showed the following:-The resident had a colostomy bag (a waterproof pouch that attaches to the body to collect feces) attached to his/her abdomen;-There was no date on the colostomy bag or wafer (sticky skin barrier that goes around the stoma (a surgically created opening on the abdomen, through which a section of the large intestine (colon) is brought to the surface of the skin) to attach the bag to the skin and protect the skin from waste) (to indicate when they were last changed);-Certified Nurse Assistant (CNA) G emptied the contents of the colostomy bag into a plastic bag in the trash can;-He/She cleaned the end of the bag with a wet wipe and placed a clip on the colostomy bag. During interview on 09/09/25, at 8:56 A.M., CNA G said the following:-The nurses changed the resident's colostomy bag and wafer on the night shift;-He/She did not know how often staff changed the colostomy bag and wafer;-The wafer usually had a date on it to indicate when it was changed. During interview on 9/09/25, at 11:20 A.M., Licensed Practical Nurse (LPN) D said the following:-Staff changed the resident's colostomy bag every three to four days and as needed (PRN);-He/She was not sure how often staff changed the wafer; -He/She did not think staff documented the colostomy care anywhere; -The CNAs changed the colostomy bags and wafer;-He/She was not aware of orders in the resident's medical record for colostomy care that included frequency of changing the colostomy bag and wafer. During interview on 9/09/25, at 4:16 P.M., LPN A said the following:-The night shift nurses changed the resident's colostomy bag and wafer every four days and as needed; -Staff should document colostomy care in the nurse's notes. During interviews on 9/10/25 at 10:30 A.M. and 7:30 P.M., the Director of Nursing said the following:-The wound nurse saw the resident every Friday to check the resident's stoma (surgically created opening in the abdominal wall that allows waste to leave the body instead of going through the rectum and anus) and area around the stoma;-The wound nurse should document the information in the progress notes;-She could not find any notes from the wound nurse related to the stoma in the resident's medical record;-She expected the resident to have physician's orders for colostomy care and specify how often staff was to change the colostomy and the wafer.-Documentation of colostomy bag and wafer change should be on the medication administration record (MAR) and treatment administration record (TAR).

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to consistently monitor residents' weights as ordered, failed to identify weight loss and notify the resident's physician and the dietician of the weight loss, failed to ensure staff evaluated current interventions and/or implemented new interventions to prevent further weight loss for two residents (Residents #2 and #39), in a review of 17 sampled residents. The facility census was 41.Review of the facility policy Nutrition (Impaired)/Unplanned Weight Loss, last revised September 2017, showed the following:-The staff will report to the physician significant weight gains or losses or any abrupt or persistent change from baseline appetite or food intake;-The physician will review for medical causes of weight gain, anorexia and weight loss before ordering interventions;-The staff and physician will identify pertinent interventions based on identified causes and overall resident condition, prognosis and wishes;-The staff and physician will review and consider existing dietary restrictions and modified consistency of diets;-Physician and staff will monitor nutritional status, an individual's response to interventions and possible complications of such interventions. Review of the facility's policy Weight Assessment and Intervention, revised March 2022, showed the following:-Resident weights are monitored for undesirable or unintended weight loss or gain;-Residents are weighed upon admission and at intervals established by the interdisciplinary team;-Weights are recorded in each unit's weight record chart and in the individual's medical record;-A weight change of 5 percent (%) or more since the last weight assessment is retaken the next day for confirmation;-If the weight is verified, nursing will immediately notify the dietician in writing;-Unless notified of significant weight change, the dietician will review the unit weight record monthly to follow individual weight trends over time;-The threshold for significant unplanned and undesired weight loss will be based on the following criteria: a. One month- 5% weight loss is significant, greater than 5% is severe; b. Three months- 7.5% weight loss is significant, greater than 7.5% is severe; c. Six months- 10% weight loss is significant; greater than 10% is severe;-The physician and multidisciplinary team will identify conditions and medications that may be causing anorexia, weight loss or increasing the risk of weight loss;-Care planning for weight loss or impaired nutrition will be a multidisciplinary effort and will include the physician, nursing staff, the dietician, the consultant pharmacist and the resident's legal surrogate;-Individualized care plans shall address to the extent possible: a. The identified causes of weight loss; b. Goals and benchmarks for improvement; and c. Time frames and parameters for monitoring and reassessment;-Interventions for undesired weight gain consider resident preferences and rights, a weight loss regimen should not be initiated for a cognitively capable resident without his/her approval and involvement. 1. Review of Resident #2's quarterly Minimum Data Set (MDS), a federally mandated assessment, dated 7/10/25, showed the following:-Severe cognitive impairment;-Weight 102 pounds;-Set up or clean-up assistance with eating;-No weight loss of 5 percent (%) in one month or 10% in last six months. Review of the resident's care plan, dated 7/15/25, showed the following: -The resident was on a regular diet and could feed himself/herself after staff set up his/her tray;-Make sure the resident was getting foods/drinks he/she enjoyed;-Report his/her weight to the charge nurse so they can report any abnormal weights to the physician. Review of the Nutritional Quarterly Assessment, dated 7/17/25, showed the following:-Regular diet;-House supplement twice a day (BID);-Current weight 104.5 pounds;-Weight last quarter 111.5 pounds;-Intake 50%-75%;-The resident feeds himself/herself. Review of the resident's Physician Orders, dated August 2025, showed an order for weekly weights (original order dated 4/23/25). Review of the resident's weight record, dated August 2025, showed the following:-On 8/02/25, the resident weighed 105.5 pounds;-On 8/06/25, the resident weighed 105 pounds;-On 8/13/25, the resident weighed 103.5 pounds;-On 8/27/25, the resident weighed 106 pounds. Review of the resident's Physician Orders, dated September 2025, showed an order for weekly weights. Review of the resident's weight record, dated 9/03/25, showed the resident weighed (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	95.5 pounds (a weight loss of 9.48% in one month). Review of the resident's medical record showed no documentation staff re-weighed the resident on 09/03/25 to ensure the weight was accurate, no documentation staff evaluated the resident for weight loss or notified the resident's physician or the dietician when the resident had a 9.48% weight loss in one month, and no documentation staff evaluated or implemented new interventions to prevent further weight loss. During interviews on 9/10/25 at 10:30 A.M. and 7:30 P.M., the Director of Nursing (DON) said the following:-When a resident lost weight, the nurses were to check the resident's intake and assess the resident's appetite;-The nurses were to notify the physician if a resident gained or lost more than 5 pounds from the previous weight;-The nurses were to notify the dietician if a resident gained or lost weight; -The MDS Coordinator notifies the DON when a resident loses weight;-The MDS Coordinator said the resident did not have issues with weight loss. During an interview on 9/18/25, at 9:39 A.M., the Infection Preventionist said the following:-If a resident's weight showed a significant weight loss or gain, the staff were to reweigh the resident within 24 hours to ensure the weight was accurate;-If the weight was accurate and showed weight loss, staff notified the MDS Coordinator;-The MDS Coordinator put the weight loss on the care plan, notified the dietician and monitored interventions;-The aides obtained Resident #2's weight on 9/03/25 and gave it to her to enter into the electronic health record;-She missed that this weight showed a weight loss;-She should have told the MDS Coordinator on 09/03/25 of the resident's weight loss. During interview on 9/18/25, at 10:37 A.M., the MDS Coordinator said the following:-The CNAs obtained the residents' weights and gave the weights to the charge nurse to put in the computer. The computer system calculated if there was a weight loss and if the loss was significant. She reviewed the weights and gave updates to the Dietary Manager and nursing staff in the clinical meeting. She let the computer do the calculation and it would show if there was a significant weight loss;-Significant weight loss was 10 percent in the last six months and 5 percent in the last month. She looked at weight loss at three months, but she did not ever consult the dietitian. She told staff in the clinical meeting, and the dietary manager was responsible to work with the dietitian related to the weight loss;-He/She notified the physician, speech therapy, family, and the dietary manager who notifies the dietician when a resident had a significant weight loss;-Staff discussed weight loss in the morning meetings so not one person was responsible for reporting and implementing interventions.-He/She tried to catch gradual, unintentional weight loss over time, and tried to determine why the resident was losing weight and if the care plan needed reevaluated; -She was not aware the resident had lost weight. During interview on 9/18/25, at 1:18 P.M., the Registered Dietician said the following:-He/She went to the facility one to two times per month;-He/She did not look at the residents' weights in the electronic health record; staff told him/her if a resident had a weight issue;-He/She completed annual and as needed nutritional assessments and documented these in the residents' medical records; -He/She was not directly involved in care planning; however, the facility would contact him/her for advice regarding interventions related to weight loss such as adding nutritional supplements. -He/She expected staff to notify him/her if a resident had a 5% or more weight change that was related to nutrition; -Staff was to notify him/her by text or call when staff identified a weight change;-He/She communicated nutritional interventions to the Dietary Manager or the charge nurse;-He/She was not aware Resident #2 had a recent weight change;-He/She expected staff to notify him/her of Resident #2's 9.48% weight loss from 8/02/25 to 9/03/25. During interview on 9/18/25, at 2:06 P.M., Physician F, the resident's physician, said the following:-He/She expected staff to notify him/her of a weight loss or gain monthly unless he/she needed to be notified more frequently, such as a resident had a decrease in intake or had weights ordered more frequently;-He/She was not aware of Resident #2's weight loss until last week (during the recertification survey) and prescribed an appetite stimulant for the resident. 2. Review of Resident #39's admission MDS, dated [DATE], showed the following:-Severe cognitive impairment;-Weight 185 pounds;-Required supervision or touching assistance for eating;-No weight loss of 5% or more in the last month or loss of 10% or more in the last 6 months. Review of the (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	resident's weight record, dated 6/02/25, showed the resident weighed 190 pounds. Review of the resident's Physician Orders, dated July 2025, showed an order to obtain monthly weights (original order dated 05/05/25). Review of the resident's weight record showed no documentation staff obtained the resident's weight in July 2025 as ordered. Review of resident's weight record, dated 8/02/25, showed the resident weighed 173.5 pounds (a weight loss of 8.68% in two months). Review of the resident's care plan, dated 8/13/25, showed the following: -On a regular diet and can feed himself/herself;-Make sure the resident receives foods/drinks he/she enjoys;-Monitor weight monthly and report his/her weight to the charge nurse so they can report any abnormal weights to the physician. Review of the resident's quarterly MDS, dated [DATE], showed the following:-Severe cognitive impairment;-Weight 174 pounds;-Required set up or clean-up assistance for eating;-Weight loss, but not on a physician prescribed weight-loss regimen;-Therapeutic diet. Review of the resident's weight record, dated 9/01/25, showed the resident weighed 172 pounds (a weight loss of 9.47% in three months). Review of the resident's medical record showed no documentation staff notified the resident's physician of a 9.47% weight loss in three months. Review showed no documentation the facility notified the registered dietician of the resident's weight loss, and no documentation staff re-evaluated current interventions or identified new interventions to prevent further weight loss. During an interview on 9/10/25, at 9:51 A.M., Licensed Practical Nurse (LPN) E said the following:-He/She or the CNAs weigh the residents;-He/She entered the resident's weight into the electronic health record (EHR);-If he/she saw a discrepancy in the weight, staff reweigh the resident;-If the reweigh shows a discrepancy from the previous weights, he/she would do a comparison in the EHR that included checking meal intakes and checking for edema;-If the weight was accurate, he/she notified the physician and documented in the progress notes;-He/She missed this resident's weight on 9/01/25 and should have had the resident reweighed and looked at the resident's intake. If the weight was accurate, he/she should have called the resident's physician. During interview on 9/10/25, at 7:30 P.M., the DON said the following:-She was not aware the resident had weight loss;-The MDS Coordinator notifies the DON when a resident loses weight;-The MDS Coordinator said the resident did not have issues with weight loss. During interview on 9/18/25, at 10:11 A.M., the resident's responsible party said the following: -He/She was not aware the resident had a weight loss in the last three months;-He/She expected the facility to notify him/her if the resident had a significant weight change. During interview on 9/18/25, at 10:37 A.M., the MDS Coordinator said the following: -When staff identified a resident lost weight, she was to add the weight loss and any new interventions to the care plan;-He/She was not aware of the resident's weight loss. During interview on 9/18/25, at 1:18 P.M., the Registered Dietician said the following:-He/She was not aware of a recent weight change for Resident #39;-He/She expected staff to notify him/her of Resident #39's 9.47% weight loss from 6/02/25 to 9/01/25.

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F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician. Based on interview and record review, the facility failed to ensure the Dietary Director had the appropriate competencies and skills set to carry out the function of the food and nutrition services. The facility census was 41.Review of the facility's current employee list, dated 9/7/25, showed the Dietary Director began employment with the facility on 5/9/22. Review of the facility's signed, undated Dietary Supervisor Responsibilities, showed the following:-Oversee daily food service operations to ensure the preparation and delivery of nutritious, appealing meals in accordance with dietary guidelines and residents' individual needs;-Develop, review, and update menus in collaboration with dietitians and management to meet nutritional standards and resident preferences;-Create, manage, and coordinate monthly work schedules for dietary department staff to ensure adequate coverage and efficient operation;-Supervise, train, and evaluate dietary staff, including cooks and aides;-Ensure proper food handling, sanitation and safety procedures are always followed in accordance with heath regulations;-Monitor inventory levels of food, supplies, and equipment, place orders as needed, and keep within budget constraints if applicable;-Coordinate special diets and meal modifications for residents with specific health conditions or dietary restrictions;-Schedule and oversee meal service times, including tray delivery and dining assistance when necessary;-Address and resolve resident concerns related to meals or dietary services promptly and professionally;-Fill in for shifts or staffing shortages if no coverage is available, ensuring continuous operation of food services;-Handle monthly scheduling for department staff to ensure proper coverage and workload distribution;-Complete all required certifications and maintain current credentials as mandated by local, state and federal regulations;-Perform other duties or acts as directed by the administrator to support the overall functioning of the dietary department. During an interview on 9/8/25 at 9:45 A.M., the Dietary Director said the following:-He was enrolled and working through a university course, but had not completed the food safety and management training with topics such as foodborne illness, sanitation, and food purchasing/receiving;-He began the course in February 2024, then asked for and received a nine-month extension in February 2025;-The course completion had taken longer due to staff turnover and the need for him to work open positions until new staff members were hired. During an interview on 9/10/25 at 3:35 P.M., the Administrator said she was aware the Dietary Director had not completed the Food Safety and Management Training through a university program, and he was granted a nine-month extension. The Dietary Department has had open positions, and he would work those positions until new dietary staff could be hired. This placed him behind in the training program. She would expect the Dietary Director to complete the program by the end of November 2025.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Schuyler County Nursing Home District	1306 US Highway 63 Queen City, MO 63561

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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 0628 Level of Harm - Potential for minimal harm Residents Affected - Some	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide a written notice of transfer/discharge with required information to the resident and/or resident representative for three residents (Residents #5, #6, and #39), in a review of 17 sampled residents, when the facility initiated a transfer to the hospital. The facility also failed to provide a copy of the bed hold notice on transfer/discharge. The facility census was 41.Review of the facility policy, Facility-Initiated Transfer or Discharge, revised October 2022, showed the following:-Facility-initiated transfers and discharges, when necessary, must meet specific criteria and require resident/representative notification and orientation, and documentation as specified in this policy;-The resident and representative are notified in writing of the following information: a. The specific reason for the transfer or discharge; b. The effective date of the transfer or discharge; c. The specific location (such as the name of the new provider or description and/or address if the location is a residence) to which the resident is being transferred or discharged ; d. An explanation of the resident's rights to appeal the transfer or discharge to the state, including: -The name, address, email and telephone number of the entity which receives such appeal hearing requests; -Information about how to obtain an appeal form and; -How to get assistance in completing and submitting the appeal hearing request; e. The notice of facility bed-hold and policies; f. The name, address, and telephone number of the office of the state long-term care ombudsman; g. The name, address, email and telephone number of the agency responsible for the protection and advocacy of residents with intellectual and developmental (or related) disabilities (as applies); h. The name, address, email and telephone number of the agency responsible for the protection and advocacy of resident with a mental disorder or related disabilities (as applies), and; i. The name, address, and telephone number of the state health department agency that has been designated to handle appeals of transfers and discharge notices;-When residents who are sent emergently to an acute care setting, these scenarios are considered facility-initiated transfers, not discharges, because the resident's return is generally expected;-Under the following circumstances, the notice is given as soon as it is practicable but before the transfer or discharge: a. The health and/or safety of individuals in the facility would be endangered due to the clinical or behavioral status of the resident; b. The resident's health improves sufficiently to allow a more immediate transfer or discharge; c. An immediate transfer or discharge is required by the resident's urgent medical needs or; d. A resident has not resided in the facility for 30 days;-Notice of transfer is provided to the resident and representative as soon as practicable before the transfers and to the long-term care ombudsman when practicable;-Notice of facility bed-hold and return policies are provided to the resident and representative within 24 hours of emergency transfer;-Notices are provided in a form and manner that the resident can understand, taking into account the resident's educational level, language, communication barriers, and physical or mental impairments. 1. Review of Resident #5's face sheet showed the following:-admitted on [DATE];-He/She had a durable power of attorney. Review of the resident's progress notes, dated 6/18/25, showed the resident was sent to the hospital for evaluation due to abnormal lab results. Staff notified the resident's durable power of attorney of the transfer by phone. Review of the resident's medical record showed no documentation the facility provided the resident's representative with a written notice of transfer or with a written notice of the bed hold policy at the time of transfer to the hospital on [DATE]. Review of the resident's census report showed the resident returned to the facility on 6/28/25. Review of the resident's progress notes, dated 7/7/25, showed the resident was sent to the emergency room for evaluation due to shortness of breath and chest tightness. The facility notified the resident's durable power of attorney by phone call, a message was left. Review of the resident's census report showed the resident returned to the facility on [DATE]. Review of the resident's medical record showed no documentation the facility provided the resident's representative (continued on next page)

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F 0628 Level of Harm - Potential for minimal harm Residents Affected - Some	with a written notice of transfer or with a written notice of the bed hold policy at the time of transfer to the hospital on [DATE]. 2. Review of Resident #6's face sheet showed he/she was responsible for himself/herself. He/She also had two family members who would have durable power of attorney if the resident was deemed incapacitated. Review of the resident's Nurses Notes, dated 07/18/25 at 9:52 A.M., showed the following:-The resident sat in his/her power electric recliner when his/her elbow pressed against the remote;-Due to resident's general weakness, he/she was unable to move his/her elbow in time before he/she fell out of the recliner onto the floor;-The resident immediately complained of pain in his/her right lower extremity with swelling present in his/her right knee; -Staff notified the physician and family and called emergency medical services to take the resident to the emergency room. Review of the resident's Nurses Notes, dated 07/18/25 at 2:09 P.M., showed staff called the emergency room for an update. The resident was admitted for two separate fractures in both his/her legs. The first fracture was a right distal femur (lower end of the thigh bone above the knee) fracture, and the second fracture was a left proximal tibial (upper end of shin bone close to the knee) fracture. Review of the resident's medical records showed no documentation staff completed a notice of transfer/discharge when the resident was sent to the hospital on [DATE]. Review showed no documentation staff provided the resident with a bed hold notice at the time of transfer. During an interview on 09/09/25 at 1:32 P.M., the resident and his/her family member said they did not recall every getting a discharge/transfer notice when the resident went to the hospital (on 07/18/25). The facility did not give the resident a copy of any papers. 3. Review of Resident #39's undated face sheet showed the resident's family members were listed as his/her emergency contacts. Review of the resident's Nursing Progress Notes, dated 5/08/25 at 2:17 P.M., showed the resident fell and was sent to the hospital for evaluation. The resident was admitted with a hip fracture. Review of the resident's medical records showed no documentation staff completed a notice of transfer/discharge when the resident was sent to the hospital on [DATE]. Review showed no documentation staff provided the resident with a bed hold notice at the time of transfer. 4. During interviews on 09/09/25 at 5:24 P.M and 09/10/25 at 7:00 P.M., the Director of Nursing said the following:-She expected staff to provide a copy of the discharge/transfer form to the resident or resident representative every time a resident was transferred to the hospital; -The nurses were not good about giving the forms to the resident or resident representative; -The facility did not give a copy of the bed hold notice at the time of transfer, but the residents had one in their admission packet. During an interview on 9/10/25 at 7:30 P.M., the Administrator said the following:-She expected staff to provide a written notice of transfer or discharge to the resident or their representative with every transfer to the hospital;-The bed hold policy was only provided to the resident or resident representative on admission and was not provided to the resident or resident representative with every transfer to the hospital.

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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 0641 Level of Harm - Potential for minimal harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to accurately assess the resident and correctly code the minimum data set (MDS) assessment for five residents (Residents #11, #14, #36, #6, and #7), in a review of 17 sampled residents, and one additional resident (Resident #47). The facility failed to accurately code a wound that was present on admission for Resident #7, failed to accurately code a Wanderguard alarm for Residents #11 and #14, failed to accurately code hospice for Residents #36 and #47, and failed to code active diagnoses for Resident #6. The facility census was 41.During an interview on 09/10/25 at 7:30 P.M., the Director of Nursing (DON) said the facility followed the Resident Assessment Instrument (RAI) manual for completion of the MDS. Review of the Long Term Care Facility Resident Assessment Instrument (RAI) User's Manual, version 3.0, showed the following:-Document active diagnoses on the MDS as follows: Diagnoses are listed by major disease category: cancer, heart/circulation, gastrointestinal, genitourinary, infections, metabolic, musculoskeletal, neurological, nutritional, psychiatric/mood disorder, pulmonary, and vision; -Examples of diseases are included for some disease categories. Diseases to be coded in these categories are not meant to be limited to only those listed in the examples; Check off each active disease. Check all that apply. I0600 (question on the MDS) heart failure (e.g., congestive heart failure [CHF], pulmonary edema); I2100 (question on the MDS) septicemia (also known as sepsis, a life-threatening complication of an infection); I2000 (question on the MDS) pneumonia;-Alarms - An alarm is any physical or electronic device that monitors resident movement and alerts the staff, by either audible or inaudible means, when movement is detected, and may include bed, chair and floor sensor pads, cords that clip to the resident's clothing, motion sensors, door alarms, or elopement/wandering devices;-Wander/elopement alarm includes devices such as bracelets, pins/buttons worn on the resident's clothing, sensors in shoes, or building/unit exit sensors worn by/attached to the resident that activate an alarm and/or alert the staff when the resident nears or exits a specific area or the building;-Coding Instructions: Identify all alarms that were used at any time (day or night) during the 7-day look-back period. After determining whether an item listed in P0200 was used during the 7-day look-back period, code the frequency of use:-Hospice: O0110K1 (question on MDS) Hospice care- Code residents identified as being in a hospice program for terminally ill persons where an array of services is provided for the palliation and management of terminal illness and related conditions. 1. Review of Resident #11's Physician's Order Sheet, dated 04/18/25, showed an order for the resident to wear a Wanderguard (electronic monitoring device) alarm and to check for placement and functioning every night. Review of the resident's Nurses Notes, dated 04/18/25 at 12:30 A.M., showed the resident followed visitors out of the door, his/her Wanderquard sounded, and staff followed the resident out of the door and redirected him/her back inside. Review of the resident's admission MDS, dated [DATE], showed the following:-Severe cognitive impairment;-Diagnosis of Alzheimer's disease;-Wandering occurred one to three days (in the seven-day look back period);-No documentation the resident had wander/elopement alarm. Review of the resident's Care Plan, dated 04/23/25, showed the resident had a Wanderguard on his/her wrist which sounded an alarm if he/she got too close to the outside door since he/she forgets where he/she is at times and may try to leave the building. Review of the resident's July 2025 Physician's Order Sheets showed an order for the resident to wear a Wanderguard alarm and to check for placement and functioning every night. Review of the resident's Julys 2025 Medication Administration Record (MAR) showed staff documented staff checked the resident's Wanderguard for placement and functioning every night. Review of the resident's quarterly MDS, dated [DATE], showed the following:-Severe cognition impairment;-No alarm devices present. Observation on 09/09/25 at 1:30 P.M., showed the resident wandered the 100 hallway. The resident had a Wanderguard device on his/her wrist. During an interview on 09/09/25 at 10:09 A.M., Licensed Practical Nurse (LPN) G said (continued on next page)

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F 0641 Level of Harm - Potential for minimal harm Residents Affected - Some	the resident had a Wanderguard on his/her left wrist. Night shift staff checked for placement and made sure it was functioning correctly. 2. Review of Resident #14's Physician's Orders, dated June 2025, showed an order for the resident to wear a Wanderguard alarm and to check for placement and functioning every night (original order dated 4/25/25). Review of the resident's quarterly MDS, dated [DATE], showed the following:-Severe cognitive impairment;-Wandering occurred 4 to 6 days;-No documentation the resident had wander/elopement alarm. Review of the resident's Physician's Orders, dated July 2025, showed an order for the resident to wear a Wanderguard alarm and to check for placement and functioning every night (original order dated 4/25/25). Review of the resident's progress notes, dated 7/28/25 at 2:30 A.M. and 7/31/25 at 2:12 A.M., showed staff checked the resident's Wande guard bracelet and noted it was in place and functioning. Review of the resident's annual MDS, dated [DATE], showed the following:-Severe cognitive impairment;-No documentation the resident had wander/elopement alarm. Observation on 9/7/25 at 12:45 P.M. showed the resident ate lunch in the dining room with a Wanderguard in place on his/her left ankle. Review of the resident's care plan, revised 9/10/25, showed the resident had a Wanderguard in place due to frequent wandering at night. During an interview on 9/10/25 at 5:14 P.M., the Director of Nursing (DON) said the following:-The resident had a sudden increase in behaviors and wandering a few months back, resulting in the addition of a Wanderguard; -The resident still had orders for and wore a wander guard. During an interview on 9/18/25 at 10:37 A.M., the MDS Coordinator said the following:-If the resident had a Wanderguard it should be coded in section P;-She was not aware alarms needed to be coded. 3. Review of Resident #36's physician notification fax, dated 7/1/25, showed the Director of Nursing faxed a notification to the physician, stating the resident would be returning from the hospital on hospice. Review of the resident's Hospice admission Note and Hospice Certification of Terminal Illness, dated 7/1/25, showed the resident was terminally ill with a life expectancy of six months or less if the disease followed its normal course, and was admitted to hospice. Review of the resident's progress notes, dated 7/7/25 at 6:18 P.M., showed the resident continued hospice care. Review of the resident's significant change MDS, dated [DATE], showed the following:-The resident had a chronic disease that may result in a life expectancy of less than 6 months;-No special treatments, not on hospice. Review of the resident's physician progress note, dated 7/10/25, showed the resident was currently on hospice care. During an interview on 9/18/25 at 10:37 A.M. the MDS Coordinator said hospice should be marked in Section O for this resident. She was unsure as to why it wasn't marked. During an interview on 09/08/25 at 10:10 A.M., the Director of Nursing said the resident was on hospice. Hospice should be indicated on the resident's MDS. 4. Review of Resident #47's Physician's Orders Sheet, showed the resident started hospice services on 4/16/25. Review of the resident's Hospice binder showed the resident was admitted to hospice on 04/16/25. Review of the resident's significant change in status MDS, dated [DATE], showed hospice while a resident in section O0110K1 was blank. Review of the resident's quarterly MDS, dated [DATE], showed hospice while a resident in section O0110K1 was blank. Review of the resident's census showed he/she remained on hospice. During an interview on 09/08/25 at 10:10 A.M., the Director of Nursing said the resident was on hospice. Hospice should be indicated on the resident's MDS5. Review of Resident #6's face sheet showed the resident has diagnosis of chronic heart failure, sepsis and pneumonia. Review of the resident's annual Minimum Data Set (MDS), a federally mandated assessment completed by staff, dated 09/27/24, showed the resident's primary diagnosis was sepsis. Review of section I of the MDS showed staff did not check the box in question I2100 septicemia as the RAI manual directed. Review of the resident's quarterly MDS, dated [DATE], showed the staff coded the resident's primary diagnosis as chronic heart failure. Review of section I of the MDS showed staff did not check the box in question I0600 heart failure as the RAI manual directed. Review of the resident's quarterly MDS, dated [DATE], showed the staff coded the resident's primary diagnosis as pneumonia. Review of section I of the MDS showed staff did not check the box in question I2000 pneumonia as the RAI manual directed. 6. Review of Resident #7's (continued on next page)

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F 0641 Level of Harm - Potential for minimal harm Residents Affected - Some	face sheet showed the resident was admitted to the facility on [DATE]. Review of the resident's progress notes, dated 7/14/25, showed the resident was admitted to the facility from the hospital with a superficial open area to the right buttock that was covered with a small mepilex (foam dressing). Review of the resident's admission MDS, dated [DATE], showed the resident had a stage II pressure ulcer (partial thickness loss of dermis presenting as a shallow open ulcer with a red-pink wound bed without slough or bruising) that was not present on admission. During an interview on 9/10/25 at 5:14 P.M. the Director of Nursing said the resident was admitted with a pressure ulcer. During an interview on 9/18/25 at 10:37 A.M., the MDS Coordinator said if a resident had a pressure ulcer present on admission it should be coded as present on admission. 7.During an interview on 09/18/25, at 10:37 A.M., the MDS Coordinator said the following:-She followed the RAI manual to accurately code the MDS and followed the instructions in the MDS manual;-If there were errors on the MDSs, it was probably just an oversight. During an interview on 9/10/25 at 7:30 P.M., the Administrator said she expected the residents' MDSs to be accurate.

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F 0655 Level of Harm - Potential for minimal harm Residents Affected - Some	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide the resident or resident representative a copy of the resident's baseline care plan for three residents Resident (#5, #7, and #14). The facility census was 41. Review of the facility policy, Care Plans - Baseline, revised 2022, showed the following:-A baseline plan of care to meet the resident's immediate health and safety needs is developed for each resident within 48 hours of admission;-The resident and/or representative are provided a written summary of the baseline care plan (in a language that the resident/representative can understand) that includes, but is not limited to the following: -The stated goals and objectives of the resident; -A summary of the resident's medications and dietary instructions; -Any services or treatments to be administered by the facility and personnel acting on behalf of the facility, and; -Any updated information based on the details of the comprehensive care plan, as necessary;-Provision of the summary to the resident and/or resident representative is documented in the medical record. 1. Review of Resident #5's face sheet showed the resident admitted on [DATE]. Review of the resident's baseline care plan, dated 5/7/25, showed no documentation the facility provided a copy or a written summary of the baseline care plan to the resident or resident representative. Review of the resident's medical record showed no documentation the facility provided a copy or a written summary of the baseline care plan to the resident or resident representative. 2. Review of Resident #7's face sheet showed the resident admitted on [DATE]. Review of the resident's baseline care plan, dated 7/14/25, showed no documentation the facility provided a copy or a written summary of the baseline care plan to the resident or resident representative. Review of the resident's medical record showed no documentation the facility provided a copy or a written summary of the baseline care plan to the resident or resident representative. 3. Review of Resident #14's face sheet showed the resident was admitted on [DATE]. Review of the resident's undated baseline care plan showed no documentation the facility provided a copy or a written summary of the baseline care plan to the resident or resident representative. Review of the resident's medical record showed no documentation the facility provided a copy or a written summary of the baseline care plan to the resident or resident representative. 4. During an interview on 9/10/25 at 6:28 P.M., Licensed Practical Nurse (LPN) A (charge nurse who admits residents) said the Director of Nursing (DON) completed the baseline care plans. He/She did not know what to do with the completed baseline care plans. During an interview on 09/18/25, at 10:37 A.M., the MDS Coordinator said the admitting nurse should complete the baseline care plan, have the resident or representative sign the care plan and to give them a copy During an interview on 9/10/25 at 7:30 P.M., the Director of Nursing (DON) said she the admitting nurse was to complete the baseline care plan on admission. The admitting nurse should have the resident or representative sign a copy of the baseline care plan, give a copy of the care plan to the resident or representative, and scan a completed and signed copy into the resident's medical record. She had not monitored if baseline care plans were completed, provided to the resident or if the baseline care plan was signed and scanned into the electronic health record.