STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265820	A. Building B. Wing	12/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Jackson Creek Post Acute	3980 South Jackson Drive Independence, MO 64057

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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, interview and record review, the facility failed to maintain the walk in cooler ceiling, fans, and floors; failed to maintain the cleanliness of the floors under the cooking equipment area; failed to maintain the cleanliness of the knife holder by the dish machine area; failed to sanitize the counter surface after a thermometer was placed on it after it fell on the floor; failed to ensure utensils were washed and sanitized; and a facility staff member working in the kitchen failed to wash their hands providing a risk of cross contamination between objects and food. Facility census was 108 residents. Review of the facility's Sanitization Policy revised dated 2022 showed:-The food area service area is maintained in a clean and sanitary manner.-All kitchens, kitchen areas and dining areas were kept clean, free from garbage and debris, and protected from rodents and insects. -All utensils, counters, shelves and equipment are kept clean, maintained in good repair and are free from breaks, corrosions, open seams, cracks, and chipped areas that may affect their use of proper cleaning.-All equipment, food contact surfaces and utensils were cleaned and sanitized using heat or chemical sanitizing solutions. -When cleaning fixed equipment (e.g., mixers, slicers, and other equipment that cannot readily be immersed in water), the removable parts are:--Washed and sanitized and non-removable parts cleaned with detergent and hot water, rinsed, air dried and sprayed with sanitizing solution (at the effective concentration).--The equipment was reassembled and any food contact surfaces that had been contaminated during the process area re-sanitized (according to the manufacturer's instructions).-Areas used for garbage disposal were to be free from odors waste fats and maintained to prevent pests. 1. Observation on 12/1/25 at 9:47 A.M. during the initial kitchen walk through showed:-The walk-in cooler had dust on the ceiling and on the fans.-The knife holder by the dish machine had food debris on it and droppings of food residue right below the holder on the ledge of the wall that connects to the dish machine area. Observation on 12/4/25 from 9:18 A.M. to 1:00 P.M. during the lunch meal preparation showed:-The walk-in cooler had dust on the ceiling and on the fans.-The walk-in cooler had a slick slimy brown substance in between the shelves by the wheels on the left-hand side. -Debris under the shelves in the walk-in cooler.-Six individual tubs of butter spread out on the floor under the shelves on the left side of the walk-in cooler. -Dietary Assistant A, dropped a probe thermometer on the floor picked it up and put it on the table then grabbed the scrapper and scrapped the top of the griddle, then moved the spatula, then moved the tongs, and then finally grabbed the thermometer and wiped it down with sanitizer wipes before probing the hot dogs. -Dietary Assistant A never washed his/her hands or changed gloves after picking up the thermometer off the floor. -Dietary Assistant A did not sanitize the thermometer right away therefore any floor debris that was on the thermometer was now on the counter and the counter did not get wiped down or sanitized and neither did all the utensils that the assistant touched. -Dietary Assistant A, walked into the kitchen and put gloves on, grabbed a cooked hamburger patty and put a slice of cheese on it, then put it in the microwave, then went to the walk-in cooler and came out of the walk-in cooler with lettuce and a tomato slice in his/her hand, and then gave it to the cook to put on the cheeseburger. Then took his/her gloves off and grabbed the empty tomato soup and chicken noodle soup cans on the counter. -Dietary Assistant A never washed his/her hands before entering the kitchen area. -Dietary (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Assistant A never performed proper hand hygiene in between touching nonfood contact surfaces and food contact with ready to eat foods. During an interview on 12/5/25 at 10:20 A.M. the Dietary Manager (DM) said:-Staff cleaned the kitchen daily.-Staff should wash their hands and change their gloves whenever they drop something on the floor or touch a surface that was not food related before touching food. -Staff should wash their hands when they enter the kitchen area.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, the facility failed to maintain two ceiling fans in the 400 Unit lobby free from a buildup of dust; failed to ensure the floors in resident rooms [ROOM NUMBERS] were maintained free from dust and debris buildup; and failed to maintain the ceiling vent in the beauty shop, free from a buildup of dust. This practice potentially affected an unknown number of residents who used or reside in those areas. The facility census was 108 residents.1. Observation on 12/1/25 at 10:39 A.M. with the Maintenance Director showed a buildup of dust on two ceiling fans in the 400 Unit lobby area where about seven residents were sitting.During an interview on 12/1/25 at 10:39 A.M., the Maintenance Director said he/she did not know the last time the fans were cleaned.During an interview on 12/3/25 at 2:01 P.M., the Housekeeping Supervisor said it was the responsibility of the maintenance department to clean the ceiling fans, and the ceiling fans should be cleaned once per month.2. Observation on 12/1/25 at 11:36 A.M., showed a buildup of dust and debris under the beds in resident room [ROOM NUMBER].Observation on 12/1/25 at 11:38 A.M., showed a buildup of dust and debris under the bed in resident room [ROOM NUMBER].During an interview on 12/3/25 at 2:06 P.M., the Housekeeping Supervisor said:-During regular mopping and sweeping the housekeeping staff should get under the beds to clean them.-The space under the beds in resident rooms [ROOM NUMBERS] should not have dust and debris.3. Observation on 12/2/25 at 1:16 P.M. showed a heavy buildup of dust on the ceiling vent in the beauty salon.During an interview on 12/2/25 at 1:16 P.M., the Maintenance director said it was the responsibility of the housekeeping department to clean the vent in the beauty salon.During a phone interview on 12/9/25 at 10:38 A.M. the Housekeeping Supervisor said it is normally the Maintenance Director's duty to clean the vent in the beauty salon.

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to transcribe detailed physician's orders for Hospice (end of life care) services that included supporting diagnosis and the name of the Hospice provider on the Physician's Order Sheet for four sampled residents (Resident #32, #92, #58, and #42) out of 22 sampled residents. The facility census was 108 residents.The facility physician's order policy was requested and not received at the time of exit. Review of the facility's Hospice Program policy revised January 2014 showed there was no guidance on transcription of a detailed physician order for Hospice care services. 1. Review of Resident #32's Face Sheet showed the resident was admitted to the facility with the following diagnoses:-Cerebral Palsy (a brain disorder that appears in infancy or early childhood and permanently affects body movement and muscle coordination.-Cognitive communication deficit.-Dysphagia (a condition that affects your ability to produce and understand spoken language).-Aphasia (difficulty swallowing).-Hemiplegia (paralysis that affects only one side of your body), and muscle weakness. Review of the resident's Nursing Note dated 9/29/25, showed:-The resident had been refusing meals, ate at most 25 percent, refused to get up, primarily in pain, Nurse Practitioner was aware. Called the resident's Durable Power of Attorney in a conference call, discussed the resident's status, and agreed with admitting the resident back into the same Hospice services. Notified the Hospice provider and waiting for a call back.-Nursing Notes did not show when Hospice services actually started. Review of the resident's Hospice Medical Record showed Hospice Notification dated 10/1/25 showed Hospice was initiated with a diagnosis of senile degeneration of the brain starting 10/1/25. Review of the resident's Physician's Order Sheet (POS) dated December 2025, showed physician's orders:-Hospice to assess and evaluate the resident (order dated 9/29/25).-There was no physician's order showing Hospice services were ordered that also identified the Hospice provider. During an interview on 12/5/25 at 11:09 A.M., Unit Manager A said there should be a physician's order for Hospice services on the resident's physician's order sheet. 2. Review of Resident #92's admission Face sheet showed: -An admitting diagnosis of Malignant Neoplasm (cancer) of prostate and Encounter of palliative care (improves the quality of life of patients and their families by relieving the pain, symptoms and stress of a serious or debilitating illness).-Had Hospice provider name and phone number. -Under the diagnosis section it did not indicate which supporting diagnosis for his/her Hospice admission. Review of the resident's care plan dated 6/2/25 showed the name of the Hospice provider and admitting to Hospice services with a diagnosis of prostate cancer. Review of the resident's POS and Medication Administration Record (MAR) dated December 2025 showed: -An order for the Hospice provider to evaluate with phone number listed in order dated 5/31/25. -There was no detailed admission to Hospice services order that included the supporting diagnosis documented in the order. (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 12/5/25 at 9:16 A.M., Licensed Practical Nurse (LPN) A said:-He/She reviewed the resident's electronic medical record and noted there was a special instruction banner that had the resident's Hospice company name, phone number, and supporting diagnosis.-He/She was not able to find a detailed physician's order transcribed to the resident's POS for admission to Hospice that included the name of the Hospice provider and supporting diagnosis. During an interview on 12/5/25 at 10:00 A.M., Unit Manager A said: -He/she would expect to have a detailed Hospice order to include admit to Hospice services with a supporting diagnosis documented and the name of Hospice provider. 3. Review of Resident #58's Face Sheet showed the resident was admitted with the following diagnoses:-Post Polio Syndrome (a condition that causes gradual muscle weakness and muscle atrophy (loss) that can affect people who've had polio).-Encounter for Palliative Care (specialized medical care that focuses on providing relief from pain and other symptoms of a serious illness).-Paraplegia (the inability to voluntarily move the lower parts of the body). Review of the resident's admission Minimum Data Set (MDS-a federally mandated assessment tool to be completed by facility staff for care planning) dated 11/17/25 (in progress), showed:-He/She was moderately cognitively impaired.-He/She needed extensive assistance with bed mobility, transfers, dressing, eating, hygiene and toileting.-He/She had impaired mobility to lower extremities.-Was receiving Hospice services. Review of the resident's Care Plan dated 11/18/25 showed the resident:-Was End of Life.-Was receiving Hospice services through a local Hospice service. Review of the resident's Hospice records showed the resident:-Was admitted to a local Hospice service on 11/7/25 with a diagnosis of Cerebral Vascular Disease (a group of conditions that affect blood flow and the blood vessels in the brain).-Had regular visits logged by Hospice staff including Certified Nursing Assistants (CNA) and nurses.-Hospice last visited on 11/26/25. Review of the resident's POS dated December 2025 showed there was no physician's order for Hospice services. During an interview on 12/3/25 at 12:53 P.M., LPN D said:-The resident had been receiving Hospice care since he/she was admitted .-Hospice visited twice a week to give resident showers.-The resident did not have a physician's order for Hospice services in his/her chart.-There should be a physician's order for Hospice that included the resident's diagnosis in the resident's chart. 4. Review of Resident #42's admission Sheet dated 2/28/25 showed the following diagnoses:-Parkinson's Disease (a chronic nervous disease characterized by a fine slowly spreading tremor, muscle weakness, muscle stiffness and a peculiar gait) with Dyskinesia (involuntary, uncontrolled muscle movements, ranging from fidgeting to writhing, often affecting limbs, face, or tongue) with Fluctuations (the changes in motor and non-motor symptoms that occur as medication levels in the body change, leading to periods of improvement (on) and worsening (off)).-Dysphagia oropharyngeal phase (inability or difficulty swallowing)-Unspecified Dementia, moderate with psychotic disturbance (a progressive organic mental disorder characterized by chronic personality disintegration, confusion, disorientation, stupor, deterioration of intellectual capacity and function, and impairment of control of memory, judgment, and impulses).-Paranoid schizophrenia (a form of schizophrenia [a chronic mental illness that interferes with a person's ability to think clearly, to (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	distinguish reality from fantasy, to manage emotions, make decisions, and relate to others] characterized by persistent preoccupation with illogical, absurd, and changeable delusions, usually of a persecutory, grandiose, or jealous nature, accompanied by related hallucinations).-Alzheimer's Disease Unspecified (a slowly progressive disease of the brain that is characterized by impairment of memory and eventually by disturbances in reasoning, planning, language, and perception).-Heart Failure. Review of the resident's quarterly MDS dated [DATE] showed: -He/She was not cognitively intact.-He/She was on Hospice. Review of the resident's POS dated December 2025 showed the resident did not have orders listed for Hospice. Review of the resident's care plan dated 12/3/25 showed the resident had been on Hospice since 3/4/25. During an interview on 12/5/25 at 10:30 A.M., CNA E said he/she thought there should be orders for a resident to be on Hospice. During an interview on 12/5/25 at 10:45 A.M., LPN D said there should be Hospice orders along with the Hospice company's name on the residents POS. During an interview on 12/5/25 at 1:44 P.M., the Director of Nursing (DON) said: -They had a Hospice banner in the computer that showed the nurse whether the resident was on Hospice services.-They had a physician's order for a referral to Hospice for evaluation, but this order dropped off of the physician's order sheet eventually.-The charge nurse typically received the physician's order for Hospice services.-He/she would expect the resident's physician's orders for Hospice to include admitted to Hospice with the name of the provider and supporting diagnosis. -The resident's detailed Hospice orders would also be documented in the electronic medical record under the special instruction banner.-The resident's special instruction banner remained even if the physician's orders dropped off. -The physician's order audit should be completed by the Unit Manager within 24 hours of new admissions and reviewed during the daily Interdisciplinary team's morning meeting.-He/She would expect physician's order to be reviewed every month to ensure orders were accurate and up to date.-Orders sometimes fall off, but the banner was permanent.-The charge nurse, unit manager, or whomever received the order was responsible for entering the order into the resident's chart.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure infection control practices to prevent cross-contamination with proper placement of medical devices to include indwelling foley catheter (a soft, plastic or rubber tube that is inserted into the bladder to drain the urine) drainage tube that was placed underneath a wheelchair and the tubing was dragging on the floor for one sampled resident (Resident #29) who was at risk for Urinary Tack Infections (UTI - an infection of one or more structures in the urinary system); and for a wound vacuum device (negative pressure wound vac, removes this pressure over the area of the wound. This can help a wound heal in several ways) that was not on a protective barrier or hung on the side of the bedframe for one sampled resident (Resident #118) who was being treated for a bone infection; and failed to ensure handwashing and glove changing was completed to prevent cross contamination during incontinence and treatment care for one sampled resident (Resident #58) out of 22 sampled residents. The facility census was 108 residents. The facility catheter care and wound vacuum policy were requested and not received at the time of exit. 1. Review of Resident #29's admission Face Sheet showed he/she admitted with the following diagnoses: -End stage renal disease (ESRD, is when you have permanent kidney failure that requires a regular course of dialysis or a kidney transplant). -Neuromuscular Dysfunction of the bladder (is nerve damage that keeps the bladder from working properly to include loss of bladder control and retaining urine). Review of the resident's admission Minimum Data Set (MDS - a federally mandated assessment instrument completed by facility staff for care planning) dated 10/27/25, showed he/she:-Was moderately cognitively impaired.-He/she was able to understand others and make his/her needs known.-Required total assistance from staff for toileting.-admitted with an indwelling catheter. Review of the resident's Physician Order Sheet (POS) dated 12/1/25 showed:-Nursing staff were to provide foley catheter care every shift was ordered on 10/8/25.-Nursing staff were to change the indwelling foley catheter (use an 18 French (Fr, a measure of the outer diameter of a catheter) tip with a 10 centimeters (cc) bulb attached to gravity drainage bag, change every month on the 27th and as needed if plugged, leaking or dislodged, related to diagnosis of urinary retention, was ordered on 11/28/25. Review of the resident's nursing progress noted dated 11/28/25 at 5:28 P.M. showed: -The resident complained of his/her genital area hurting. -His/her foley catheter was changed to an 18 Fr catheter with a 10 ml bulb. The resident tolerated the catheter change well. -An order for a Urinalysis (UA) would be collected on Sunday, 11/30/25 and was to be sent for testing on Monday morning 12/1/25. -The resident's family member was notified. Observation on 12/2/25 at 1:11 P.M., of the resident showed:-He/She had just returned from dialysis clinic sitting in a wheelchair by the nursing station. -The resident's catheter tubing was dragging on the ground underneath his/her wheelchair. -The resident was moaning in pain, and he/she said over and over that he/she wanted to go to the hospital. -He/she had complaints of severe pain in the groin area and lower back pain. -At 1:16 P.M., an unknown charge nurse informed the resident he/she would contact the resident's physician related to his/her complaint of pain and with no relief from the pain medications that was given. -The resident told the nurse he/she did not want just pain medication that he/she wanted treatment to fix the issue causing the pain. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the resident's Nursing Note dated 12/2/25 at 2:18 P.M., showed: -The resident told the nurse he/she was in pain after returning to the facility from dialysis. -He/she was given as needed (PRN) pain medication and pain patch to left side of his/her back near kidneys. -The resident said his/her pain was a 7/10 on the pain scale (10 worst), when he/she moved, he was hurting more. -The resident's family member voiced concerns about the resident's catheter and UA that was done on Friday. The nurse addressed family concerns, and no further questions were asked. -Per resident request he/she was sent to the hospital for severe uncontrolled pain. Nurse notified unit manager and physician. Review of the resident's follow-up nursing note dated 12/2/25 at 2:18 P.M., the resident had returned from the emergency room with a diagnosis of UTI and new orders for an antibiotic. Review of the resident's POS dated 12/3/25 at 9:00 A.M. showed a new order for Cephalexin (antibiotic) tablet 500 milligrams (mg) Give one tablet by mouth every 12 hours for urinary tract infection for five days. Observation on 12/3/25 at 12:51 P.M. of the resident showed: -He/she was sitting in a wheelchair next to the nursing station. -Underneath his/her wheelchair noted the catheter tubing dragging on the ground. During an interview on 12/5/2025 at 9:00 A.M., Certified Nursing Assistant (CNA) A and CNA B said: -The catheter drainage bag should be below the bladder.-The catheter tubing should be secured underneath the wheelchair and not dragging on the ground. During an interview on 12/5/25 at 9:16 A.M., Licensed Practical Nurse (LPN) A said he/she would secure catheter tubing under the resident's wheelchair and ensure the catheter tubing was not dragging on the ground underneath the wheelchair. During an interview on 12/5/25 at 10:00 A.M., Unit Manager A said he/she would expect care staff to ensure the resident's foley catheter tubing was placed secure underneath the wheelchair and the tubing was not dragging or touching the ground. During an interview on 12/5/25 at 1:45 P.M. the Director of Nursing (DON) said:-He/she would expect care staff to ensure the catheter tubing was secured underneath the wheelchair and the tubing should not be dragging or laid on ground. -When catheter tubing was found touching the ground he/she would expect nursing staff to change the catheter drainage system. 2. Review of Resident #118's admission Face Sheet showed he/she was admitted to the facility with the following diagnoses:-Osteomyelitis (bone infection) of the right ankle. -Cognitive communication deficit.-He/she was his/her own responsible person. Review of the resident's MDS showed it had not been completed at the time of review. Review of the resident's nursing progress note dated 11/29/25 at 6:48 P.M. showed the resident readmitted with a right heel wound and would have a wound vac that would be put in place as soon as the wound vac arrived at the facility. Review of the resident's POS dated 12/1/25 to 12/3/25 showed:-Piperacillin Sod-Tazobactam So (antibiotic) Solution Reconstituted 4-0.5 grams (gm), use 4.5 gram intravenously (IV) every six hours, infuse at 4.5g at 200 milliliters (ml) per hour over 30 minutes, for Osteomyelitis for seven days, was ordered on 11/30/25.-Monitor wound vac every two hours for proper function. If malfunctioning, (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	remove and place a wet-to-dry dressing on wound, was ordered on 12/1/25. -Cleanse right heel with normal saline, then apply skin prep to peri wound area and pack wound with black foam attach to the wound vac, set at 125 millimeter of Mercury (mm Hg) continuous flow; change wound vac dressing on Monday, Wednesday and Friday for surgical wound care was ordered on 12/3/25. Review of the resident's Wound Care Plan dated on 12/1/25 showed:-He/she was admitted to the facility with unstageable pressure injury to the right heel.-Wound vac to right heel, setting at 125 mm Hg continuously. -Wound vac therapy as ordered. Observation on 12/1/25 at 11:38 A.M., of the resident showed:-On the right side of his/her bed on the floor was a black carrying case with a wound vac device running inside the case.-There was no protective barrier under the wound vac carrying case. Observation on 12/2/25 at 11:46 A.M. of the resident in bed showed:-His/her the wound vac was on the ground on the right side of his/her bed. -There was no barrier under the wound vac device inside the black carrying case bag. Observation on 12/3/25 at 2:00 P.M, of the resident in bed showed: -The wound vac device was on the ground next to the resident's bed. -There was no barrier under the medical wound vac device. Observation on 12/4/25 at 10:43 A.M. of the resident's wound care showed:-His/her wound vac machine was on the ground on top of a barrier.-The wound nurse placed the wound vac canister and storage bag on top of the resident's bed to change out the old drainage canister. -The resident had a right heel wound about the size soft ball.-The outer wound area had staples all around and a few on the inner wound bed. -The inner wound bed had two areas that had purplish red tissue. -Wound care was completed following the orders. -The wound nurse hung the wound vac machine on right side of the bed prior to leaving the resident room. During interview on 12/4/25 at 10:50 A.M., the wound nurse said:-The resident had surgical debridement of the wound in the hospital and returned with the wound vac device and staples in and around the wound bed. -The resident's wound vac device should be hung off his/her bed rail and not touch the floor.- He/she would not have placed the wound vac device directly on the ground. -The wound vac pump and drainage system would also cause a tripping hazard if it was on the ground. During an interview on 12/5/2025 at 9:00 A.M., Certified Nursing Assistant CNA A and CNA B said: -He/she would have hung the resident's wound vac in the storage bag on the resident's bed rail, so it was not tugging on the wound. -If the wound vac device was placed on ground, there should be a barrier underneath the wound vac device. During an interview 12/5/2025 at 1:45 P.M., the DON said:-He/She would expect the wound vac device to be hung on the back of the wheelchair or on the resident's bedframe-The wound vac device could be placed on the floor because the black carrying case bag would protect it as it was a closed system. -All care staff would be responsible for ensuring the proper placement of the wound vac during any interaction with the resident and monitored during care. A policy on hand hygiene was requested but not provided by the time of exit. 3. Review of Resident #58's Face Sheet showed he/she was admitted with the following diagnoses:-Post Polio Syndrome (a condition that causes gradual muscle weakness and muscle (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Jackson Creek Post Acute	3980 South Jackson Drive Independence, MO 64057

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	atrophy (loss) that can affect people who've had polio).-Palliative care (specialized medical care that focuses on providing relief from pain and other symptoms of a serious illness).-Paraplegia (the inability to voluntarily move the lower parts of the body). Review of the resident's admission MDS dated [DATE] (in progress), showed:-He/She was moderately cognitively impaired.-He/She needed extensive assistance with bed mobility, transfers, dressing, eating, hygiene and toileting.-He/She had impaired mobility to lower extremities. Review of the resident's Care Plan dated 11/18/25 showed he/she:-Was at risk for skin breakdown related to impaired Activities of Daily Living (ADL) ability, impaired mobility and bowel incontinence.-Had limited mobility and was dependent on staff for personal hygiene care.-Had paraplegia.-Had a catheter. Observation on 12/2/25 at 10:48 A.M., showed:- LPN E performed hand hygiene prior to entering room, donned (put on) a gown and gloves then entered the room. -Hospice CNA G was already in the room and gloved at the resident's bedside. -CNA G opened the resident's unsoiled brief and held the resident in place on his/her right side using the left hand and used wet wipes to clean the resident's buttocks (either of the two round fleshy parts that form the lower rear area of a human trunk) and peri area (region between the anus and the external genitalia) with the right hand. After cleaning the resident, without discarding gloves or sanitizing his/her hands, CNA G continued holding the resident on his/her side.-LPN E cleaned the resident's peri area with a wet wipe in the left hand and alternately applied Cavalon (A liquid that dries to a breathable, waterproof film, protecting skin from body fluids, adhesives, friction, and shear) with the right hand to the resident's coccyx (a small triangular bone at the base of the spinal column) and buttock areas. -CNA G and LPN E, with the same gloves on reapplied the resident's brief. -LPN E with the same gloves on, re-adjusted the resident's nasal cannula, picked up the resident's water pitcher and held the straw in place while resident drank from pitcher, attached resident's call light to the resident's covers.-LPNE and CNA G pulled the resident up in bed and pulled covers over resident.-LPN E used the bed remote to adjust the resident's bed position and moved the bedside tray table close to the bed.-LPN E discarded the gloves and gown then performed hand hygiene before leaving the room. During an interview on 12/5/25 at 9:21 A.M., CNA H said:-He/She should sanitize or wash his/her hands before and after resident care, before meals, before and after handling linen, after toileting, after peri care, after caring for one route of the body before moving to another.-Hand hygiene should be performed, and gloves should be changed after performing peri care.-Gloves should be changed and hand hygiene should be performed after peri care and before touching anything else in the room such as the resident's items, room items and the resident themselves.-He/She had received hand hygiene training. During an interview on 12/5/25 on 11:47 A.M., LPN E said:-Times to perform hand hygiene were before entering and exiting the resident's room, before and after patient contact, after toileting, after eating, and whenever needed.-The process when performing cares for a resident on EBP were to put on a gown, perform hand hygiene, put on gloves, do cares, remove gown and gloves then perform hand hygiene.-Gloves should be changed and hand hygiene should be performed before going from one route/area on a resident's body to another.-Gloves should be changed and hand hygiene should be performed after peri care and before touching anything else in the room such as the resident's items, room items and the resident themselves. During an interview on 12/5/25 at 1:50 P.M., the DON said:-Hand hygiene should be performed, and (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	gloves should be changed after performing peri care on residents.-Gloves should be changed and hand hygiene should be performed after peri care and before touching anything else in resident's room.-Concerning hand hygiene, training for staff was done every two weeks and as needed. -Skills checks for staff were done annually.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to maintain the hot water at the handwashing faucets in resident rooms 334, 333, 310, 402, 403, 414, 322, 326, 329, 312, 310, 308, 302, 301, 305, at a temperature at or below 120 F (degrees Fahrenheit); failed to maintain the hot water temperature in the following rooms (resident rooms [ROOM NUMBERS]) at a temperature of at least 105 F. This practice potentially affected at least 21 residents who resided in those rooms. The facility also failed to maintain the laminate sections in resident rooms [ROOM NUMBERS], firmly attached to the subfloor; failed to maintain the floor in a non-resident area free of a buildup of dust and debris; and failed to maintain the drainage area around the dish machine causing the drain itself to have a black residue on it and the area of the drain to release a foul odor potentially a sewage smell. The facility census was 108 residents.** All water temperatures were recorded after the hot was allowed to flow for at least two minutes in accordance with Department Policy Item 311.00 paragraph 3 revised on 2/18/16. Review of the undated facility's policy showed plumbing fixtures that require hot water and are resident accessible, shall be supplied with water thermostatically controlled to provide a water temperature of between one hundred five degrees (105 degrees F) to one hundred twenty degrees (120 degrees F) at the fixture or faucet 1. Observation on 12/1/25 showed the following hot water temperatures which were above 120 degrees F in the following resident's rooms:-At 10:04 A.M., the hot water temperature in room [ROOM NUMBER], was 124.3 degrees F.-At 10:07 A.M., the hot water temperature in room [ROOM NUMBER], was 124.3 degrees F.-At 10:23 A.M., the hot water temperature in room [ROOM NUMBER], was 128.4 degrees F.-At 10:45 A.M., the hot water temperature in room [ROOM NUMBER], was 123.6 degrees F.-At 10:47 A.M., the hot water temperature in room [ROOM NUMBER], was 125.5 degrees F.-At 10:52 A.M., the hot water temperature in room [ROOM NUMBER], was 123.4 degrees F. Observation on 12/1/25 showed the following hot water temperatures which were below 105 degrees F in the following resident's rooms:-At 10:11 A.M., the hot water temperature in room [ROOM NUMBER], was 66.8 degrees F.-At 12:00 P.M., during a recheck, the hot water temperature in room [ROOM NUMBER] was 66.3 degrees F. Observation on 12/2/25 showed the following hot water temperatures which were above 120 degrees F in the following resident's rooms:-At 10:19 A.M., the hot water temperature in room [ROOM NUMBER], was 128.4 degrees F.-At 10:27 A.M., the hot water temperature in room [ROOM NUMBER], was 125.0 degrees F.-At 11:03 A.M., the hot water temperature in room [ROOM NUMBER], was 125.9 degrees F.-At 11:09 A.M., the hot water temperature in room [ROOM NUMBER], was 125.9 degrees F.-At 11:11 A.M., the hot water temperature in room [ROOM NUMBER], was 125.0 degrees F.-At 11:21 A.M., the hot water temperature in room [ROOM NUMBER], was 126.6 degrees F.-At 11:25 A.M., the hot water temperature in room [ROOM NUMBER], was 126.8 degrees F.- At 11:30 A.M., the hot water temperature in room [ROOM NUMBER], was 125.5 degrees F. Observation on 12/2/25 showed the following hot water temperatures which were below 105 degrees F in the following resident's rooms:-At 10:51 A.M., the hot water temperature in room [ROOM NUMBER], was 67.2 degrees F.-At 10:52 A.M., the hot water temperature in room [ROOM NUMBER] was 66.0 degrees F. (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 12/2/25 at 3:34 P.M., the Maintenance Director said:-The temperature of the hot water heaters was set between 138 degrees F and 140 degrees F.-On 12/2/25 (prior to this interview) he/she reset the temperature to 135 degrees F.-The hot water for the section of 300 Unit where rooms 319, 320, 321, and 322 were located could get hot, but it could take 5 minutes or longer.-He/she was not sure how the plumbing for the 300 Hall was arranged, but the circulating pump was working. 2. Observation on 12/1/25 at 11:16 A.M., showed a 2 feet (ft.) long arched section of the floor that was peeled away from the subfloor underneath in resident room [ROOM NUMBER]. During an interview in 12/1/25 at 11:16 A.M., the Maintenance Director said he/she did not know about that area of damage. 3. Observation on 12/2/25 at 11:25 A.M., showed a 10 ft. long by 6 ft. 5 inches (in.) wide section of laminate flooring which peeled away from the floor in resident room [ROOM NUMBER]. During an interview on 12/2/25 at 11:25 A.M., the Maintenance Director said no one had told him/her about the damaged floor in the resident room [ROOM NUMBER]. During an interview on 12/3/25 at 2:10 P.M., the Housekeeping Supervisor said:-Housekeepers should report damaged floors to the Maintenance Director.-In the past, housekeepers had reported damaged floors to the Maintenance department.-Housekeepers were used to seeing damaged carpet not necessarily damaged laminate flooring. 4. Observation on 12/2/25 at 1:19 P.M., showed a heavy buildup of debris between the fridge and the wall in the employee breakroom. During a phone interview on 12/9/25 at 10:37 A.M., the Housekeeping Supervisor said it was the housekeeping department's job to clean the breakroom floor, but the housekeeping staff needed help in moving the refrigerator to reach certain areas on the floor. Review of the facility's Sanitization Policy and procedure revised dated 2022 showed:-The food area service area is maintained in a clean and sanitary manner.-All kitchens, kitchen areas and dining areas were kept clean, free from garbage and debris, and protected from rodents and insects. -All equipment, food contact surfaces and utensils were cleaned and sanitized using heat or chemical sanitizing solutions. -Areas used for garbage disposal were to be free from odors waste fats and maintained to prevent pests. 5. Observation on 12/1/25 at 9:47 A.M. during the initial kitchen walk through showed:-Black residue on the drain under the dish machine.-A foul odor coming from the dish machine area. Observation on 12/4/25 from 9:18 A.M. to 1:00 P.M. during the lunch meal preparation showed:-Black residue on the drain under the dish machine.-A foul odor coming from the dish machine area. During an interview on 12/5/25 at 10:20 A.M. the Dietary Manager (DM) said:-The odor had been noticed for a couple of months. -The dish machine water was dumped after every meal. -The drain was cleaned every night with soap and water.-He/She knew maintenance had dumped an enzyme down the drain to help keep gnats away but couldn't remember how often that was done. -He/She thought the smell could be coming from the grout, the wall, and a little bit of the drain.-Had plans to get the wall and grout replaced but no current plans for the drain.

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on observation, interview and record review, the facility failed to maintain the cleanliness of a resident's wheelchair potentially affecting his/her dignity for one sampled resident (Resident #42) out of 22 sampled residents. The facility census was 108 residents. 1. Review of Resident #42's face sheet showed the following diagnoses:-Parkinson's Disease (a chronic nervous disease characterized by a fine slowly spreading tremor, muscle weakness, muscle stiffness and a peculiar gait) with Dyskinesia (involuntary, uncontrolled muscle movements, ranging from fidgeting to writhing, often affecting limbs, face, or tongue) with fluctuations (the changes in motor and non-motor symptoms that occur as medication levels in the body change, leading to periods of improvement (on) and worsening (off)).-Dysphagia oropharyngeal phase (inability or difficulty swallowing)-Unspecified Dementia, moderate with psychotic disturbance (a progressive organic mental disorder characterized by chronic personality disintegration, confusion, disorientation, stupor, deterioration of intellectual capacity and function, and impairment of control of memory, judgment, and impulses).-Paranoid schizophrenia (a form of schizophrenia [a chronic mental illness that interferes with a person's ability to think clearly, to distinguish reality from fantasy, to manage emotions, make decisions, and relate to others] characterized by persistent preoccupation with illogical, absurd, and changeable delusions, usually of a persecutory, grandiose, or jealous nature, accompanied by related hallucinations).-Alzheimer's Disease Unspecified (a slowly progressive disease of the brain that is characterized by impairment of memory and eventually by disturbances in reasoning, planning, language, and perception).Review of the resident's quarterly Minimum Data Set (MDS - a federally mandated assessment tool completed by the facility for care planning) dated 9/29/25 showed: -He/She was not cognitively intact.-He/She needed a wheelchair for mobility.-He/She needed substantial/maximal assistance for feeding.-He/She needed substantial/maximal assistance for all activities of daily living.Observation on 12/2/25 at 12:55 P.M. showed:-The resident was sitting in the community room in his/her wheelchair with other residents. -There was white and brown dried, spilled food debris that was in a dripping formation all over the left side of the resident's arm rest and down the outside of the wheelchair below the resident's arm rest.Observation on 12/2/25 at 2:00 P.M. showed:-The resident was sitting in the community room in his/her wheelchair while other residents and staff worked on the community room Christmas tree. -There was brown and white dried, spilled food debris a dripping formation all over the left side of the resident's arm rest and down the outside of the wheelchair below the resident's arm rest.Observation on 12/2/25 at 2:30 P.M. showed there was brown and white dried, spilled food debris in a dripping formation all over the left side of the resident's arm rest and down the outside of the wheelchair below the resident's arm rest. Observation on 12/3/25 at 9:15 A.M. showed:-The resident was sitting in the community room in his/her wheelchair with other residents. -There was brown and white dried, spilled food debris in a dripping formation all over the left side of the resident's arm rest and down the outside of the wheelchair below the resident's arm rest.Observation on 12/3/25 at 11:04 A.M. showed:-The resident was sitting in the community room in his/her wheelchair with other residents. -There was brown and white dried, spilled food debris in a dripping formation all over the left side of the resident's arm rest and down the outside of the wheelchair below the resident's arm rest. Observation on 12/4/25 at 9:06 A.M. showed:-The resident was sitting in the community room in his/her wheelchair with other residents. -There was brown and white dried, spilled food debris in a dripping formation all over the left side of the resident's arm rest and down the outside of the wheelchair below the resident's arm rest. During an interview on 12/5/25 at 10:30 A.M., Certified Nursing Assistant (CNA) E said:-He/She believed it was night shifts responsibility to clean the residents' wheelchairs.-He/She didn't know what the policy was for cleaning the wheelchairs. -He/She had verbally said something a couple of times to the daytime charge nurses about the wheelchair.-He/She said the resident's wheelchair needed to be (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	scrubbed.-The resident would vomit daily and believed it was always vomit on his/her chair. During an interview on 12/5/25 at 10:45 A.M., Licensed Practical Nurse (LPN) D said: -It was night shifts responsibility to clean the residents' wheelchairs. -There used to be a list staff would put the name of the resident who needed their wheelchair cleaned but didn't know what happened to the list and thought it was just on an as needed basis as to when the wheelchair needed cleaned. -He/She had no idea as to how often the wheelchairs should be cleaned. -The resident vomited every day his/her family would bring food, and he/she would eat too much. -The chair hadn't been cleaned in days. During an interview on 12/5/25 at 1:44 P.M., the Director of Nursing (DON) said: -Night shift was responsible for cleaning the wheelchairs.-Night shift had a schedule to clean all wheelchairs at least once a week and on an as needed basis. -He/She did not know why there was debris on the resident's chair.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **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 one sampled resident (Resident #32) by not providing palm grips to maintain the resident's range of motion and failed to ensure soft (bunny) boots (provide pressure relief to the heel, ankle and lower calf) were worn to prevent skin breakdown for with limited range of motion in upper and lower extremities, who needed total assistance with bed mobility and was at high risk for skin breakdown out of 22 sampled residents. The facility census was 108 residents.1. Review of Resident #32's Face Sheet showed the resident was admitted to the facility with the following diagnoses:-Cerebral Palsy (a brain disorder that appears in infancy or early childhood and permanently affects body movement and muscle coordination).-Cognitive communication deficit.-Dysphagia (a condition that affects your ability to produce and understand spoken language), aphasia (difficulty swallowing).-Hemiplegia (paralysis that affects only one side of your body), and muscle weakness.Review of the resident's Minimum Data Set (MDS-a federally mandated assessment tool to be completed by facility staff for care planning) dated 10/23/25, showed the resident:-Was alert with significant cognitive impairment.-Had upper and lower extremity impairment.-Needed moderate to total assistance with dressing, grooming, bathing and mobility.-Did not receive any restorative treatments or services. Review of the resident's Braden Scale dated 10/18/25, showed score of 11 (a score of 10-12 showed high risk for developing wounds). Review of the resident's Physician's Order Sheet (POS) dated December 2025 showed:-Palm guard (acts as a barrier between fingers and palmar skin to help prevent finger contractures and skin breakdown in the palm) don (to put on) the right hand daily and doff (to remove) at night every shift (ordered 11/3/25).-There were no physician's orders for the resident to wear soft boots (bunny boots).-There was a physician's order dated 4/24/25, to wear bunny boots to (his/her) feet at all times every day and night shift for prevention. This order showed it was discontinued on 11/17/2025.Review of the resident's Care Plan dated 11/8/25, showed the resident was at risk for skin breakdown related to impaired mobility, incontinence and impaired activity of daily living ability (bathing, dressing, toileting, eating, mobility and hygiene). Interventions showed staff would:-Assist to turn and reposition as tolerated (3/20/25).-Check skin during daily care provisions (3/20/25). -Keep skin clean and dry to the extent possible (3/20/25).-Notify the physician and/or responsible party of non-compliance with treatment interventions (3/20/25).-Pressure reduction mattress (3/20/25).-Bunny boots to both feet at all times as tolerated (5/9/25).-Right hand palm guard (5/9/25).Review of the resident's Nursing Note dated 11/11/25 showed:-Second order Restorative Nursing Aide Splinting and Bracing Program Task: If not wearing, already place on the resident's right hand. Resident was able to open (his/her) fingers slightly to allow placement with less pain, 5 times a week.-Review of the resident's Nursing Notes showed there was no documentation showing the resident refused to wear the hand splints.Review of the resident's Task form showed:-Restorative Nursing Aide Splinting and Bracing Program Task: If not wearing already place on right hand. Resident was able to open (his/her) fingers slightly to allow placement with less pain, 5 times a week. -There was no documentation showing the resident refused to wear the palm guard.-There was no documentation showing when the palm guard was applied to the resident.Observation on 12/1/25 at 12:20 P.M., showed the resident was lying in bed on a low airloss mattress (a medical-grade mattress designed to prevent and treat wounds by reducing moisture and heat buildup). His/her legs and feet were elevated on pillows, and he/she was not wearing a palm guard on his/her hands or bunny boots on his/her feet. The resident was awake but was not verbalizing. The resident's bunny boots were sitting on his/her tray table across from his/her bed. There was a sign on the wall that said to keep the palm guard in his/her left hand per physician. Observation on 12/2/25 at 10:07 A.M., showed the resident was in his/her bed on a low airloss (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	mattress. The resident's eyes were closed, and he/she was resting comfortably. His/her feet and legs were elevated on pillows. The resident's bunny boots were laying on top of his/her tray table that was beside her bed but not within reach. There was nothing in or on the resident's hands. Observation on 12/3/25 at 9:07 A.M., showed the resident was laying in his/her bed on a low airloss mattress. The resident's bunny boots were on the resident's tray table beside his/her bed, and not within reach. His/her feet were not elevated or on pillows. The resident had nothing in or on his/her hands. The resident's eyes were closed, and he/she was resting comfortably. Observation on 12/3/25 at 10:57 A.M., showed the resident was laying on her left side on his/her low airloss mattress. His/her call light was within reach. His/her bunny boots were on the tray table beside his/her bed. [NAME] did not have anything in or on his/her hands.Observation on 12/3/25 at 12:00 P.M. showed the resident was sitting up in a high-backed wheelchair in the dining room. He/She was dressed for the weather and was wearing a palm guard with a soft lining in his/her right hand. The resident was also wearing his/her bunny boots on both feet while sitting at the assisted dining table.Observation on 12/4/25 at 8:50 A.M., showed the resident was laying in his/her bed turned to the left side on the low airloss mattress. He/She was wearing his/her bunny boots in bed. He/She did not have anything in or on his/her hands.Observation and interview on 12/4/25 at 11:33 A.M., showed the resident was in his/her bed on a low airloss mattress. He/She was wearing bunny boots in bed, but he/she was not wearing a palm guard or anything in/on her hands. The palm guard was laying on the resident's dresser. Family Member A was in the room and said:-Sometimes the staff place the palm grips on the resident and sometimes they do not.-He/She did not know exactly how long the resident was to wear them or when, but therapy would know. -The resident was supposed to wear his/her bunny boots at all times to protect his/her heels, because he/she was in bed so much and was at risk for skin breakdown.-The resident was prone to skin breakdown, which was why they were ordered, and they should not be discontinued.-He/she was not aware they were discontinued. During an interview on 12/4/25 at 12:18 P.M., the Wound Care Nurse said:-The resident was supposed to wear the bunny boots at all times he/she usually had them on when in bed. -Hospice (end of life care) provided the bunny boots.-He/She would check to see if there was a physician's order but there should have been an order for them. -He/She tried to check every week to ensure the hospice orders for equipment they provided was also documented on the resident's POS.During an interview on 12/4/25 at 12:25 P.M., the Rehabilitation Director said:-The resident was supposed to wear the palm grip daily and they were to be put on in the morning and removed in the evening. -The resident would often refuse to wear them, but his/her family members were in the building daily and when they came in, they were able to help to encourage the resident to wear them. -There should be documentation showing whether the resident refused to wear the palm grips, and the Restorative Aide would be responsible for that documentation.During an interview on 12/4/25 at 12:26 P.M., the Restorative Aide said:-He/She was new to the facility and had a list of residents that he/she was responsible for range of motion or applying splints, braces etc. on.-He/She worked with the resident who was supposed to wear palm grip to his/her right hand.-The resident was supposed to wear palm grips in the morning then he/she would remove them.-Most of the time the resident refused to wear the palm grips.-Sometimes he/she would wait until one of the family members came in and they helped to encourage the resident to wear it. -He/She or the family would put it on around lunch time and the resident would wear it 2 to 3 hours then he/she would remove it. -He/She was supposed to document in the resident's medical record if the resident wore the palm grip, but he/she documented it on paper first then transferred it to the medical record later.-He/She documented the resident's refusals on the paper he/she used while performing his/her restorative duties, but this document was not part of the resident's record.-He/She did not remember where in the resident's medical record he/she documented the resident's restorative tasks. During an interview on 12/4/25 at 12:58 P.M., the Wound Nurse said:-The physician's order for the resident's bunny boots was not on the POS and he/she added the order. -The resident's bunny boots were part of his/her care plan. During an interview on (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Jackson Creek Post Acute	3980 South Jackson Drive Independence, MO 64057

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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 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	12/4/25 at 2:29 P.M. Agency Registered Nurse (RN) A said:-Physician's orders for soft bunny boots or hand grips should also be on the resident's POS with the dates they were ordered, and they should also be on the resident's care plan.-Anytime a resident refused any treatment, medication, restorative care or cares, he/she would expect the nursing staff to notify the charge nurse, and it should be documented that the care was refused in the resident's medical record.-If the resident refused restorative care, he/she expected the Restorative Aide to notify the charge nurse.During an interview on 12/5/25 at 11:09 A.M., Unit Manager A said:-The physician's orders should be followed for placing and removing the resident's palm guard. -If the resident refused to allow them to put the palm guard on, they should document that in the resident's medical record and notify the nurse.-Regarding the bunny boots, there should be an order for the bunny boots on the POS and they should have been putting the bunny boots on daily. -The resident usually wore the bunny boots at all times, especially while in bed. -The nurse was responsible to check to ensure the resident is wearing those and the palm grip.-He/She would follow up and complete an in-service on this area.During an interview on 12/5/25 at 1:49 P.M., the Director of Nursing (DON) said:-He/She expected staff to follow the physician's orders for the resident to wear palm grips.-There should have been a physician's order for the resident to wear bunny boots for prevention of skin breakdown.-It was possible the order was discontinued by mistake.

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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 obtain and transcribe a physician order to provide own indwelling foley catheter self-care and failed to ensure to have a nursing assessment completed for the residents ability to perform any or all foley catheter care for one sampled resident (Resident #5) who was at risk for Urinary Tract Infections (UTI - an infection of one or more structures in the urinary system) out of 22 sampled residents. The facility census was 108 residents.The facility Self-Care policy and Catheter Care policy were requested and were not received at the time of exit. 1. Review of Resident #5's admission Face sheet showed the resident admitted to the facility with following diagnoses: -Neuromuscular Dysfunction of the bladder (is nerve damage that keeps the bladder from working properly to include loss of bladder control and retaining urine).-History of UTI.Review of the resident's foley catheter care plan dated 5/16/25 showed: -The resident had a foley catheter due to urinary retention, obstructive uropathy (a blockage in the urinary tract) and history of stroke. --He/she had a history of refusal of catheter care and changes. --Facility staff were to provide catheter care every shift. --Monitor for signs and symptoms of infections and report to his/her physician. -He/she did not have a care plan for providing his/her own catheter care and no nursing assessment was completed to assess the resident's ability and knowledge to perform his/her own catheter care to include emptying the foley catheter drainage bag. Review of the resident's Bladder and Bowel assessment dated [DATE] showed the resident had no documentation he/she was assessed to provide his/her own catheter care. Review of the resident's admission Minimum Data Set (MDS-a federally mandated assessment instrument completed by facility staff for care planning) dated 11/11/25, showed he/she:-Was cognitively intact.-Was able to understand others and make his/her needs known.-Required total assistance from staff for toileting.-admitted with an indwelling catheter. During interview on 12/2/25 at 10:02 A.M., the resident said:-He/she had a foley catheter since 2023.-He/she provided most of his/her own personal care with minimal assistance from care staff. -He/she did complete some of his/her own catheter care to including emptying the catheter drainage bag as needed. -The facility nursing staff monitored his/her catheter site and provided catheter care as needed. -He/she had recently been treated for a UTI.Review of the resident's Physician Order Sheet (POS) active order as of 12/3/25 showed:-Nursing staff and care staff were to provided Foley catheter care with soap and warm water, rinse, pat dry and check for urine output every shift, was ordered on 5/14/25. -Change indwelling foley catheter (s a soft, plastic or rubber tube that is inserted into the bladder to drain the urine) use a 18 French (Fr, a measure of the outer diameter of a catheter) tip with a 10 centimeters (cc) bulb attached to gravity drainage bag, change every month on the 17th and as needed if plugged, leaking or dislodged. Diagnosis of urinary retention and order dated 7/17/25.-NOTE: There was no physician order (PO) for the resident to provide his/her own catheter care to include emptying the drainage bag and personal catheter care. -NOTE: There was no physician order for the licensed staff to assess the resident's ability to provide his/her own catheter care to include emptying the drainage bag. Observation on 12/3/25 at 2:16 P.M., of the resident showed he/she had a foley catheter drainage bag located under his/her wheelchair. During an interview on 12/4/25 at 9:27 A.M., Certified Nursing Assistant (CNA) C said:-The resident tried to complete his/her own catheter care.-The CNA assigned would complete the catheter care to include emptying the catheter drainage bag and document the output of urine. During an interview on 12/4/25 at 9:36 A.M., CNA A and CNA B said: -The resident required assistance with personal care after bowel movements. -The resident normally would empty the catheter bag by himself/herself.-The CNA's tried to encourage the resident to inform staff the amount of output and any concerns he/she had with the catheter. During an interview and record review of the resident POS on 12/4/25 at 9:43 A.M., Agency Registered Nurse (Agency RN) A said:-He/She had worked with the resident in the past (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and the resident had refused care and medications. -The resident's POS showed a physician order for facility nursing staff to provide catheter care every shift. -He/she was not aware the resident provided some of his/her own catheter care. -He/She did not find a physician's order for the resident to perform his/her own catheter care. -The licensed nursing should be providing catheter care every shift and monitoring insertion site every shift for proper placement and signs of infections. During an interview on 12/4/25 at 9:46 A.M., Licensed Practical Nurse (LPN) B said:-He/she was not aware the resident provided his/her own catheter care.-He/she was unsure if a physician's order was required for a resident to provide his/her own catheter care.-Nursing should have completed a self-care assessment if the resident was providing his/her own care. -He/she would have to check with unit manager to get clarification on the facility policy for self-catheter care. During an interview on 12/5/25 at 9:05 A.M., CNA D said: -He/she provided showers for the residents.-The resident provided most of his/her own care with standby assist from care staff. -The resident preferred to complete his/her own personal cares including some catheter care such as emptying the drainage bag. During an interview on 12/5/25 at 9:16 A.M., LPN A said: -The resident provided some of his/her own personal care, due to refusing staff to assist with cares. -The resident did empty his/her own catheter drainage bag, but he/she needed assistance with personal hygiene. -The resident would tell the nurse the amount of urine emptied during the shift. -Staff would check on the resident's catheter every shift. During an interview on 12/5/2025 at 10:00 A.M., Unit Manager A said: -He/she would expect the care staff to be present and assist with the resident's catheter care.-Nursing staff should provide catheter care and monitoring every shift and ensure to document the urine output every shift. During an interview on 12/5/2025 at 1:45 P.M., the Director of Nursing (DON) said: -He/she would expect to have a physician's order, and a nursing assessment completed for the resident who wished to provide any part of his/her own personal catheter care. -He/she would expect nursing staff to have assess the resident for self-care, documented the assessment and any education that had been provided to the resident related to self-catheter care

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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. Based on observation, interview and record review, the facility failed to follow physician's orders for giving the nutritional supplement per the physician's order, and failed to ensure the consumption amount of nutritional supplements were documented for one sampled resident (Resident #32) who was dependent on staff for eating, received nutritional supplements and was a high risk for weight loss out of 22 sampled residents. The facility census was 108 residents.1. Review of Resident #32's Face Sheet showed the resident was admitted to the facility with the following diagnoses:-Cerebral Palsy (a brain disorder that appears in infancy or early childhood and permanently affects body movement and muscle coordination).-Cognitive communication deficit.-Dysphagia (a condition that affects your ability to produce and understand spoken language).-Aphasia (difficulty swallowing).-Hemiplegia (paralysis that affects only one side of your body).-Muscle weakness.Review of the resident's monthly Weight Record showed:-On 7/9/25 the resident weighed 115.8 pounds.-On 8/6/25 the resident weighed 112.0 pounds.-On 9/3/25 the resident weighed 110.4 pounds.-On 10/2/25 the resident weighed 109.0 pounds.-On 11/21/25 the resident weighed 108.2 pounds.-The weight record showed a gradual weight loss over the past three and five months that was not significant weight loss.Review of the resident's Dietary Notes showed:-On 9/22/25 the resident's weight on 9/3/25 was 110.4 pounds, on 8/6 was 112.0 pounds for a 30-day weight loss of 1.4 percent. On 7/9/25 the resident's weight was 115.8 and showed a weight loss of 5 percent in 60 days. He/She was on a regular, mechanical soft-ground meat diet, with thin liquids. He/She was getting Greek Yogurt at breakfast, MedPass supplement, 7 ounces three times daily and magic cup at lunch and dinner. The resident needed assistance eating and sat at the assisted dining table in the dining room. Recommend continue plan of care and continued assistance with eating.-On 10/20/25 the resident was now on Hospice (end of life care). His/her diet was regular, mechanical soft-ground meat diet with thin liquids. He/She received magic cup at noon and in the evening. MedPass supplement, 7 ounces had been ordered three times daily with meals. He/She was to have assistance with his/her meals in the assisted dining area of the dining room. He/She rarely communicated and continued to eat 25 to 50 percent of his/her meals and occasionally more. He/She had family support. Supplement and assistance orders were in place for this Hospice patient.Review of the resident's comprehensive Minimum Data Set (MDS-a federally mandated assessment tool to be completed by facility staff for care planning) dated 10/23/25, showed the resident:-Was alert with significant cognitive impairment.-Had upper and lower extremity impairment and needed moderate to total assistance with dressing, grooming, bathing and mobility.-Needed moderate to extensive assistance with eating.-Had difficulty swallowing.-Had significant weight loss.-Received a mechanically altered diet.-Did not show the resident received supplemental nutrition.Review of the resident's Care Plan, updated on 11/8/25, showed the resident was cognitively incapacitated, was on hospice services and was at risk of rapid decline, altered nutrition and weight loss. The resident preferred to get out of bed for lunch and eat in the assisted dining area when out of bed. Staff was to feed the resident while in bed (at other meals). Interventions showed staff would:-Provide food preferences per resident choice.-Provide nutrition related medications per physician's order.-Provide house supplements as ordered.-Evaluate the need for assistance while eating and drinking as needed.-Offer substitutes for refused fluids and meals.Review of the resident's Dietary Notes showed:-On 11/25/25 Follow up for weight loss. The resident's weight was down 5.6 percent in 90 days. The resident was on Hospice and had leg wounds. He/She moved with difficulty due to pain, so getting in a safe position to eat and drink was challenging for him/her. The resident was monitored for pain. The resident was on a regular, mechanical soft with ground meat/gravy diet with thin liquids. Had Med Pass supplement, 7 ounces with meals three times daily as ordered. Observed the resident drink cranberry juice, without difficulty, through a straw, helped by the nurse. Since 11/22/25 he/she had been eating 0 to 25 percent at meals. Some days he/she ate more. Nursing and Hospice were overseeing his/her care. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Dietician was available as needed. --NOTE: The note did not show whether the med pass supplement was a successful nutritional intervention.Review of the resident's Medication Administration Record (MAR) and Treatment Administration Record (TAR) dated November 2025 showed:-Physician's orders for the resident to receive MedPass (supplement), 7 ounces three times daily at meals.-The MAR showed a checkmark that the MedPass was provided at each meal.-There was no documentation showing how much MedPass the resident consumed at each meal.Review of the resident's Meal Consumption Record dated 11/5/25 to 12/5/25 showed:-The form was to record alternate meal/nourishments provided to the resident.-The task showed staff was to document on the form if the resident consumed 50 percent or less of a meal or refusal.-Options to document daily consumption included the different supplements that could be offered and space to document the percentage consumed, whether the resident refused, whether the resident was not available or was not applicable.-The record showed no data was documented over 30 days (maximum documentation capacity). Review of the resident's Physician's Order Sheet (POS) dated December 2025, showed physician's orders:-Regular diet, mechanical soft texture (foods were soft and meat was ground).-Medpass 7 ounces with meals three times a day (5/29/25).-There were no physician's orders for Magic Cup.Review of the resident's MAR and TAR dated December 2025, showed:-The physician's orders for the resident to receive MedPass, 7 ounces three times daily at meals. -The MARs showed a checkmark showing the med pass was provided at each meal, but there was no documentation showing how much the resident consumed at each meal. Review of the resident's Medical Record showed:-There was no documentation showing how the facility was monitoring the consumption of nutritional supplement. -There was no documentation showing how much of the supplement the resident consumed daily or at each meal.Review on of the resident's Meal Ticket (undated), showed:-The resident was to receive a mechanical soft diet. -It did not show that the resident was to have MedPass 7 ounces three times daily at every meal.Observation on 12/3/25 at 12:00 P.M., showed:-The resident was sitting up in a high-backed wheelchair in the dining room at the assisted dining table. He/She was served mashed potatoes, carrots, ground chicken and a dinner roll with a cranberry juice beverage. -The resident did not receive a MedPass supplement with his/her meal. -Nursing staff was trying to get the resident to eat bites of potatoes and chicken, but the resident would not open his/her mouth for the staff to feed him/her. Staff continued to encourage eating during the meal period. -The resident drank cranberry juice through a straw while assisted by staff but continued to refuse eating. The resident drank all of his/her cranberry juice.-At 12:19 P.M. Certified Nursing Assistant (CNA) C continued to try to feed the resident a chocolate mousse dessert and the resident would not open his/her mouth. CNA C took the resident back to his/her unit.During an interview on 12/3/25 at 12:10 P.M., CNA C said:-The resident did not really eat and had very poor intake at all meals. -If the resident received supplements, it was during the medication pass and the Certified Medication Technician (CMT) or nurse gave it to him/her. -The resident did not receive the supplement with his/her meal.During an interview on 12/3/25 at 12:15 PM CNA F said:-The resident usually did not eat well at any meal. -When his/her sisters visited, they could get him/her to eat a little bit. -The resident would drink the nutritional supplements, but they did not provide the supplement with the resident's meals. -When the resident's sisters visited, they got the supplement from the nurse or CMT and gave it to the resident.Observation on 12/3/25 showed:-At 12:20 P.M. CNA C informed the nurse that the resident had not received his/her nutritional supplement. -At 12:23 P.M., the nurse approached the resident with a banana flavored nutritional supplement and the resident refused to open his/her mouth to drink it. The nurse approached the resident once more and the resident again refused to drink it.Observation and interview on 12/4/25 at 11:33 A.M., showed the resident was lying in his/her bed on a low airloss mattress. There was a container of nutritional supplement on a small dresser with a straw. Family Member A was in the resident's room and said:-The resident had always been a picky eater, but he/she could get him/her to eat at times during his/her visits.-The resident did not eat as much anymore, but he/she would drink the nutritional (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	supplement when it was given to him/her. -Staff were supposed to give the resident the supplement at all three meals. -He/She visited on Tuesday and was able to get the resident to drink a full container of nutritional supplement. -He/She was going to try to get the resident to drink the supplement today while he/she is visiting.During an interview on 12/4/25 at 2:29 P.M., Registered Nurse A (agency) said: -If the physician's order said the resident was to receive nutritional supplement at meals, then he/she should have received it at meals.-Nursing staff should not only document that they provided the supplement, but they should document how much of the supplement the resident was consuming or if the resident refused it.-At this facility, the Certified Medication Technicians (CMT) gave the resident supplements.-The CMT should document on the MAR that he/she gave the supplement, and they should document the amount of supplement the resident drank.-He/She did not know where they were supposed to document the resident consumption in the resident's medical record, but there should be somewhere to document it. Observation on 12/5/25 at 8:20 A.M., showed the resident was lying in bed with his/her eyes closed resting comfortably. There was no one in the room with him/her, and he/she did not have a food tray or supplement in his/her room. Breakfast was being served at this time. During an interview on 12/5/25 at 9:57 A.M., CMT A (agency) said:-He/She gave the resident his/her supplement today, but he/she only drank half of it.-Once he/she offered the supplement using a straw, the resident drank more so he/she documented that the resident drank the supplement on the resident's MAR.-He/She was not able to document how much of the supplement he/she drank. -In the computer system, they could only document if the resident drank the supplement or not. -In other computer systems there was an area to document how much/percentage of supplement the resident drank.During an interview on 12/5/25 at 9:58 A.M., Licensed Practical Nurse (LPN) A said:-The CMT staff give the nutritional supplements.-They documented if they give it or offered it to the resident or if he/she refused it, but they did not document how much of the supplement he/she drank. -The resident was on Hospice and had not been eating any food, though they tried to give the supplement if he/she would accept it.-The resident had not been drinking the supplement either, but they still offered it to him/her.-This week the resident had not been eating or drinking.-The resident had several family members who came in and visited and they tried to get him/her to drink and eat and sometimes they could encourage him/her to eat and drink and other times they could not.During an interview on 12/5/25 at 10:24 A.M., the Registered Dietician said:-His/Her expectation was for staff to document how much of the nutritional supplement the resident drank because he/she needed to know whether it was an effective intervention for this resident and any other residents who received supplements. -The staff seemed to only document that they gave the supplement or not, but it was key to know how much the resident consumed.-Regarding the resident, he/she was on Hospice, and he/she had not been taking food well. -Recently he/she had increasingly not been eating and drinking as much. -His/her family members were concerned, and they tried to encourage him/her to eat and take the supplement, but the resident continued to decline and may be in the process of dying.-He/She did not expect the staff to force the resident to eat/drink.-Even though the resident seemed to be declining, he/she still expected staff to give the resident the supplement as ordered and to document the amount he/she drank if he/she was drinking any of the supplement.During an interview on 12/5/25 at 11:09 A.M., Uniti Manager A said:-He/She expected staff to follow physician's orders regarding providing nutritional supplements. -The CMT was responsible for giving the supplement and documenting whether the resident received it or not.-If the CMT entered a checkmark on the MAR, it meant that they gave the entire supplement. -If the resident did not consume all of the supplement prescribed, they could still show they gave the supplement, but there was a comment section where they could document how much the resident drank.-He/She expected the CMT to notify the nurse that the resident was not drinking all of the supplement, and the nurse should notify the physician. This should also be documented in the resident's progress notes. -The CMT should document the amount the resident received to ensure they were successful in providing the supplement or not and the reason why (maybe he/she did not (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	like the type of supplement).-It was okay that the resident did not receive the supplement at the time of the meal because the resident could receive it before or after mealtime, as long as it was within the parameter of the mealtime.During an interview on 12/5/25 at 1:49 P.M., the Director of Nursing (DON) said:-Nursing staff should follow orders for providing the resident's nutritional supplement. -They were able to add supplemental documentation on the MAR showing what the resident actually drank and not just a checkmark showing that staff gave the supplement.-He/She expected staff to document how much of the supplement the resident consumed. -The option was available in the electronic record.

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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 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to accurately assess a resident's Percutaneous Endoscopic Gastrostomy tube (PEG tube - a tube that is placed into a patient's stomach as a means of feeding them when they were unable to eat) for proper placement while administering medications; failed to ensure liquid nutrition was received as prescribed daily; failed to label the tube feeding bags accurately according to accepted nursing standards of practice; failed to document and monitor the amount of nutrition and water that was provided daily to ensure physician's orders were followed; facility failed to ensure liquid nutrition was received as prescribed daily; failed to label the tube feeding bags accurately according to accepted nursing standards of practice; failed to document and monitor the amount of nutrition and water that was provided daily to ensure physician's orders were followed; and failed to check for residual fluids in the resident's stomach while administering medications for one sampled resident (Resident #6) out of 22 sampled residents. The facility census was 108 residents. Review of the facility's Enteral Tube Feeding Via Continuous Pump Policy Revised November 2018 showed:-If anything suggested improper tube positioning, do not administer feeding or medications, and notified the charge nurse or physician.-When correct tube placement has been verified, flush tubing with at least 30 milliliters (ml) of warm water (or prescribed amount).-The person that performed the procedure would have recorded verification of tube placement in the residents' medical record. -NOTE: The policy did not explain the procedure on how to verify PEG tube placement. 1. Review of Resident #6's admission Record showed he/she was admitted to the facility with the following diagnoses: -Encounter for surgical aftercare following surgery on the digestive system. -Dysphagia (inability or difficulty swallowing) following cerebral infarction (stroke).-Dysphagia, oropharyngeal (mouth and pharynx) phase. Review of the resident's Comprehensive Minimum Data Set (MDS - a federally mandated assessment instrument completed by facility staff for care planning) dated 10/28/25 showed he/she:-Had severe cognitive impairment.-Had a feeding tube upon admission. -Received over 51 percent (%) of his/her nutrition through tube feeding.-Required total staff assistance for transfers, bed mobility, dressing, and eating.-Required total staff assistance for bathing and toileting. Review of the resident's Medication Administration Record (MAR) and Treatment Administration Record (TAR) dated October 2025 showed:-Check for gastric residual every eight hours from the resident's PEG.-There were no PEG placement checks specified and no directions on how to check for PEG placement. Review of the resident's care plan revised on 11/4/25 showed he/she:-Was dependent on staff for all cares. -Enteral Nutrition/Medications: Resident had a PEG tube and was at risk for enteral nutrition complications related to aspiration pneumonia, clogged tubing, excessive residual, infection, and stoma irritation. With the following interventions:--Check for residual as ordered.--Check for tube placement as ordered.--Check lung sounds for signs and symptoms of fluid overload as needed.-NOTE: The care plan did not specify how to check for PEG tube placement or how often to check for PEG tube placement and for gastric residual. Review of the resident's Order Summary Report (OSR) dated November 2025 showed:-Check for gastric residual every eight hours, if residual was greater than 100 ml, hold feeding and inform the (continued on next page)

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	265820	A. Building B. Wing	12/05/2025

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	resident's physician every shift. -Flush the PEG tube with 30 ml pre and post medication administration. -No direction of how to check placement. -No measurements listed of PEG tube length. Review of the resident's MAR and TAR dated November 2025 showed:-Check for gastric residual every eight hours from the resident's PEG.-There were no PEG placement checks specified and no directions on how to check for PEG placement. Review of the resident's MAR and TAR dated December 2025 showed:-Check for gastric residual every eight hours from the resident's PEG.-There were no PEG placement checks specified and no directions on how to check for PEG placement. Observation on 12/3/24 at 9:31 A.M. showed Licensed Practical Nurse (LPN) A:-Unplugged the tube feeding from the PEG tube and inserted a syringe into the PEG Tube.- Flushed the PEG tube with 30 ml of water. -Poured a medication dissolved in water into the syringe. -Waited for the liquid in the syringe to drain into the PEG tube.-Poured another medication cup of medications mixed with water into the PEG tube.-Poured more water into the medication cup and swirled it around to get all the medication dissolved and poured that in the PEG tube. -Flushed the tube with another 30 ml of water. -Put the cap on the PEG tube. -Did not assess the PEG tube for placement before giving medications. -Did not check residual before giving medications. During an interview on 12/3/25 at 9:43 A.M., LPN A said: -He/She did not assess the PEG tube before giving medications because the tube feeding was running. -He/She did not check residual before giving meds because he/she forgot.-He/She should have assessed the PEG tube placement by listening with a stethoscope on the abdomen and pushing air through the PEG tube using the syringe (auscultation). -When asked if he/she would have verified the PEG tube placement any other way he//she said no just by auscultation. -He/She did not know the PEG tube placement should not be verified by auscultation anymore, that was what he/she was taught in school.-No one at the facility had explained how to correctly assess the PEG tube placement. -He/She did not know facility policy on checking the PEG tube placement. -He/She did not remember seeing anywhere in any resident chart what the external length of tubing should be for the residents PEG tube.-He/She did not know what the length of the PEG tube was supposed to be for the resident. During an interview on 12/3/25 at 12:25 P.M., the Director of Nursing (DON) said:-Staff should have verified placement of a resident's PEG tube by aspiration of gastric contents and length.-The facility policy was to verify placement by length and residual of gastric contents. -He/she expected staff to follow the physician's order on how to assess a PEG tube.-He/she expected the care plan to include how to assess the resident's PEG tube to include length and aspiration of gastric contents.-The unit managers were responsible to ensure staff assessed PEG tubes correctly.-He/She was ultimately responsible to ensure the PEG tube placement was done correctly. -Anytime medications were given by a PEG tube, placement of the PEG tube should have been verified before medications were given even if the tube feed was going before medications were given. -Residual would always be checked before medications were given to ensure that there was not too much residual in the stomach to give the medications.-The PEG tube placement assessment should be done prior to any nurse using the PEG tube. 2. Review of the resident's weight record showed he/she was on weekly weights. The monthly weight showed:-On 10/30/25 he/she weighed 165.0 pounds-On 11/26/25 he/she weighed 165.0 pounds -Documentation showed the resident has had no significant weight loss. Review of the resident's Dietary Notes showed the Registered Dietician (RD) documented:-On (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	11/3/25 the resident was currently on nocturnal continuous feeding of Jevity 1.2. Rate & schedule was 4:00 P.M.to 10: A.M. or 18 hours at a rate of 70 milliliters (ml)/hour. This provided daily: 1260 ml of Jevity 1.2 or 1512 kilocalories (Kcal-the unit used to express the energy value of food), 75.6 grams (g) protein, 1008 ml free water. In addition, he/she was getting 150 ml water flush 4 times daily or 600 ml water daily. The total water he/she was getting was 1608 ml daily. In addition, they would give water with medication. Speech Therapy was working with the resident to try mechanically soft foods and nectar thickened liquids during the 6 hours (between 10:00 A.M. to 4:00 P.M.) he/she was not receiving the Jevity 1.2 continuous feed. Speech therapy was monitoring his/her tolerance to the oral feeding.-On 11/13/25 He/She discussed with the Unit Manager and Rehabilitation the resident's tube feeding plan for Saturday and Sunday since therapy was not available to supervise weekend oral feedings when the resident was not on tube feedings. The Registered Dietician showed the resident received Jevity 1.2, at 70ml/hour, given 4:00 P.M.to 11:00 A.M. only and 1or 2 bottles of 237ml Jevity 1.2 could be given as needed if the resident expressed hunger. Jevity 1.2 at 70 ml/hour from 4:00 P.M. to 11:00 A.M. provided: 1330 ml Jevity 1.2, 1596 kcal, 79.8 g protein, 1064 ml water. The resident received an additional 600 ml water from water flushes to total water=1664ml water daily. So far, the resident was tolerating the tube feeding and doing well with therapy's progressive feedings. The RD would continue to follow. The resident's weight on 11/5/25 was 166.8 pounds, up from 165 pounds upon admission on [DATE]. Review of the resident's MAR and TAR dated November 2025 to December 2, 2025, showed:-November and December showed physician's orders for resident to be on nocturnal tube feeding for 8 hours between 9:00 P.M. to 5:00 A.M.-Staff documented when the tube feeding was initiated and removed but the times of initiation and discontinuation varied. -The documentation on the MAR/TAR did not show the residents daily intake or how staff were monitoring whether he/she received the physician ordered daily amount of nutrition. Review of the resident's Fluid Intake record from 11/4/25 to 12/3/25 showed there were options to document the date, time and amount of fluid intake. There were also options to document if the resident refused, if the resident was not available or was not applicable. Documentation showed:-The nursing staff did not document daily fluid intake amounts and the times of documented fluid intake varied.-The nursing staff did not document actual fluid intake amounts on 17 out of 30 days.-On the 13 dates when fluid intake was documented, the fluid intake documentation was more than 600 ml only on 5 days. All other documented fluid intakes were between zero and 400 ml. Review of the resident's medical record showed there was no documentation showing how nursing staff monitored the resident's daily liquid nutrition (tube feeding) amounts. Review of the resident's Physician's Order Sheet (POS) dated December 2025, showed physician's orders for:-Regular diet mechanical soft nectar thickened liquids for dysphasia (11/26/25)-Jevity 1.2 (liquid nutrition) two times a day for nutrition 70 ml/hour from 4:00 p.m. to 10:00 a.m. (11/26/25). Review of the resident's annual Nutritional assessment dated [DATE], showed the resident:-Was alert with aspiration precautions, chewing and swallowing problems, needed assistance with feeding and received tube feeding.-Had no significant weight loss or gain.-The resident's nutritional intake showed he/she was doing well with continuous tube feeding at 70 ml/hour from 4:00 P.M. to 10:00 A.M. along with his/her current diet as ordered. The resident was ready to progress to a regular diet. -The RD recommended reducing the resident's tube feeding to 9:00 P.M. to 5:00 A.M. for 8 hours of Jevity 1.2 continuous feeding at 70 ml/hour. He/She would continue with water flushes of 150 ml four times daily. This tube feeding regimen provided 560 ml of Jevity 1.2, 672 kcal, 448 ml water plus the (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	600ml water flushes-33.6 grams of protein. -He/She would also receive a half cup of cottage cheese and one carton of Greek yogurt for an additional 30 grams of protein.-The new diet order showed regular mechanical soft texture with nectar thickened liquids and Jevity 1.2 continuous feeding at 70 ml/hour with water flushes of 150 ml four times daily. Crushed medications with 30 ml water flush via feeding tube before and after medication administration. Review of the resident's POS dated December 2025 showed a physician's order for:-Jevity 1.2 two times a day for nutrition 70/ml/hour from 9:00 P.M. to 5:00 A.M. (order revised on 12/2/25). Observation on 12/1/25 at 11:08 A.M., showed the resident was laying in his/her bed dressed for the weather with call light within reach. His/her tube feeding machine had both a water and a liquid nutrition bag hanging. The water bag was empty, and the nutrition bag had less than 250 ml of liquid nutrition inside. The date on the bag showed 12/1/25 with no time hung or who hung it. The machine was turned off. The residents' spouse was in the room and said:-The resident had aphasia and received tube feeding from 4:00 P.M., to 10:00 A.M. and then it was turned off.-The resident also was now eating orally and ate a pureed (food is macerated to a baby food consistency) diet and was doing very well so far.-The resident had a stroke that affected his/her right side, and he/she was unable to feed himself/herself and needed to be fed. Observation and interview on 12/2/25 at 11:42 A.M., showed the resident was sitting up in a high-backed wheelchair with tray table in front of him/her with noodles, broccoli and ground meat with gravy. The tube feeding machine was turned off. The nutrition bag showed a date of 12/2/25 and had 450 ml liquid nutrition on the bag. There was no time showing when it was hung or who hung it. The water flush bag showed a date of 12/1/25 and there was 150 ml inside of the bag. The bag did not show the time it was hung or who hung it. The resident's spouse was preparing to feed the resident at this time. He/She said therapy came in to work with the resident this morning so the nurse disconnected the tube feeding and said he/she would reconnect it at 2:00 PM. Observation on 12/3/25 at 9:23 A.M., showed the resident was sitting up in bed. His/her tube feeding was on and running at 70ml/hour. The nutrition bag was dated 12/2/25 without a time hung and had 300 ml of liquid nutrition and the water bag was dated 12/2/25 without a time hung and had 600 ml of water. The resident's spouse said that the resident had biscuits with gravy this morning. Observation on 12/3/25 at 12:27 P.M., showed the resident was not in his/her room. His/her feeding tube machine was off. The liquid nutrition bag showed it was dated 12/2/25 and hang time was 5:00 P.M. It showed there was 300 ml of liquid nutrition inside. The water flush bag showed a date of 12/2/25 and there was 600 ml of water in the bag. The resident was receiving rehabilitation at this time. Observation and interview on 12/4/25 at 8:56 A.M., showed the resident was sitting up in bed with breakfast in front of him/her. His/her tube feeding bag was turned off. The liquid nutrition bag was dated 12/3/25 without the time hung documented or who hung it. There was 500 ml inside. The water flush bag was dated 12/3/25 without a time hung or who hung it documented. There was 1100 ml water inside (full). Family Member B, who was feeding the resident said:-The nurse hung the nutrition and water flush bags last night at 9:00 P.M. and turned them off at 5:00 A.M. this morning. During an interview on 12/4/25 at 9:02 A.M. agency Registered Nurse (RN) A said:-The documentation he/she was given at shift change showed the resident's tube feeding was started at 4:00 P.M. and stopped at 10:00 A.M. -He/She was getting ready to turn the resident's tube feeding off. -He/She had (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	not seen the resident yet, and did not know if the nurse had documented the time the feeding was hung and said he/she had not seen the resident yet. During an interview on 12/4/25 at 9:06 A.M., Unit Manager A said:-They changed the resident's tube feeding order on 12/2/25 for the resident to receive the tube feeding at 70 ml/hour from 9:00 P.M. to 5:00 A.M. with water flushes of 150 ml four times daily.-The resident's prior order showed they were feeding the resident manually four times daily, but after the resident came back from the hospital (on 10/26/25) the order showed continuous tube feeding at 70 ml/hour for 16 hours from 4:00 P.M. to 10:00 A.M. with 150 ml water flushes four times daily.-Once the resident began eating oral food the RD reassessed the resident's tube feeding and it changed to 70 ml/hour tube feeding from 9:00 P.M. to 5:00 A.M. (8 hours) with 150 ml water flush four times daily.-The physician's order was changed to reflect the new order on 12/2/25. During an interview on 12/5/25 at 10:24 A.M., the Registered Dietician said:-He/She expected the nursing staff to follow the nutritional orders for tube feeding and water flushes.-The staff seem to document that they gave the supplement or not, but it was key to know how much the resident consumed. -Regarding the resident, the resident was receiving manual tube feeding four times daily then he/she went to the hospital and came back to the facility (11/26/25) on continuous tube feeding for 16 hours daily from 4:00 PM to 10:00 A.M.-Once they introduced food to the resident and he/she began eating successfully, he/she recommended changing the continuous tube feeding to 8 hours nocturnally so the resident could eat orally during the day.-He/She came into the facility on [DATE] and spoke with the family, resident and Unit Manager and they reduced her tube feedings to 8 hours continuous feeding at 70ml/hr. from 9:00 P.M. to 5:00 A.M. with water flushes four times daily at 150 ml per flush to keep from filling up the resident with liquid nutrition.-When he/she came into the facility on [DATE], the nursing staff said the resident had not received his/her tube feeding overnight on 12/1/25 and that the tube feeding had been started late so they had to run it longer in order for the resident to receive the amount of tube feeding he/she was supposed to receive.-He/She was aware that sometimes mistakes occur, but he/she assumed that most of the time his/her recommendations/orders for the tube feeding and flushes were being followed. -The nursing staff do not document the number of flushes the resident receives or the amount of tube feeding the resident receives daily, but he/she has been checking the resident's weights and worked closely with speech therapy regarding the resident's oral intake and the resident was doing okay so far.-He/She expected the nurse who was hanging the formula was documenting the rate, time and amount when the tube feeding was turned off and the bag should show the date and time the feeding was hung. -The resident was to receive 150 ml water flushes every 4 hours which is given automatically while the tube feeding machine was on, but when they turned the machine off, the water flushes were automatically turned off as well, so the staff had to provide those flushes during the time the machine was off. -He/She was not sure that was occurring, and he/she had not seen it documented in the resident's medical record. During an interview on 12/5/25 at 11:09 A.M., Unit Manager A said:-He/She expected staff to follow physician's orders regarding following the resident's tube feeding and water flush orders.-The tube feeding bag should show the residents name, the date, time it was hung and name of the staff that hung the bag for both the feeding and water flush bag. -The nurses had been labeling the bags this way prior to the resident going to the hospital and they had labels that go on the bags.-Prior to 12/2/25, the Jevity was supposed to be hung at 4:00 P.M. and turned off at 10:00 A.M.-On 12/2/25 the nutrition was hung late by the night shift nurse, and the nurse asked if he/she could extend the time of the resident's tube feeding for 2 hours and he/she agreed to this.-The orders for tube feeding and water flushes were changed on 12/2/25 to show they were supposed to start the tube feeding at (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	9:00 P.M. and stop it at 5:00 A.M. (for 8 hours of feeding) with 150 ml water flush 4 times daily. -The tube feeding machine showed how much tube feeding and water flushes the resident had received daily during the time the resident was receiving tube feeding and flushes.-There should be supplemental documentation showing the total amount (how many ml) of the flushes given and the total amount of the feeding the resident received every day in the resident's medical record.-The department heads, nurses and Registered Dietician should be monitoring to ensure the amount of tube feeding and water flushes prescribed was the amount the resident was receiving daily. -The charge nurse should inform the physician if the resident was not receiving the prescribed amount of nutrition/water flushes, or if the resident had a residual and did not receive all of the feeding or flush, he/she was supposed to receive. The nurse should inform the physician and document this in the resident's nursing notes. During an interview on 12/5/25 at 2:00 P.M. the DON said:-The resident's tube feeding nutrition bag and the water flush bag should be labeled with the resident's name, date hung, time hung, and what the physician's order is for the feeding and flush. -The physician's order should match the order on the nutrition and water flush bags.-Any change in physician's orders should be documented on the physician's order sheet and passed along correctly at the shift change.-He/She expected the nurse to document how much nutrition and water was given at the time the nurse turned the feeding tube machine off in the nursing notes in the resident's medical record.-He/She expected to see a nursing note showing whether the resident's tube feeding and or water flush was accepted and any additional information regarding the tube feeding and flush that was pertinent should be in the nursing notes.-If there were any concerns, such as the staff not hanging the bag timely or the resident not receiving all the tube feeding amount or flush amount for whatever reason the tube feeding was not completed or interrupted, the nurse should document an explanation in the nursing notes of why the feeding was not given as ordered.-When administering medications through the tube, the nurse should listen to the resident's bowel sounds, check the tube for placement and ensure the placement was there prior to giving any medication.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. Based on interview and record review, the facility failed to ensure monthly medication regimen reviews (MRR) were reviewed and recommendations were followed within a timely manner for two sampled residents (Resident #15 and #59) out of 22 sampled residents. The facility census was 108 residents.Review of the facility's policy titled Medication Regimen Reviews dated May 2019 showed:-The Consultant Pharmacist performed a MRR for every resident in the facility receiving medication.-MRRs were done upon admission and at least monthly thereafter, or more frequently if indicated.-The goal of the MRR was to promote positive outcomes while minimizing adverse consequences and potential risks associated with medication.-The MRR involved a thorough review of the resident's medical record to prevent, identify, report and resolve medication problems, medication errors and other irregularities.1. Review of Resident #15's admission Record showed he/she was admitted to the facility with the following diagnoses:-Chronic Pain Syndrome (pain that lasts over three months).-Anxiety Disorder (any group of mental conditions characterized by excessive fear of or apprehension about real or perceived threats), Unspecified.Review of the resident's Electronic Medical Record showed:-Pharmacy Recommendations were made in April 2025 and May 2025.-There was no documentation to indicate MRRs were completed from June 2025 through October 2025.Review of the Physician Recommendations dated August 2025 completed by the Consultant Pharmacist showed:-A 14-day stop date needed to be added to the resident's Morphine Sulfate order.-A specific number of days pro re nata (PRN- as needed) use for the resident's Lorazepam order needed to be added to the order or the medication needed to be discontinued.Review of the resident's Treatment Administration Record (TAR) dated August 2025 showed:-The resident's Morphine Sulfate order remained unchanged.-The resident's Lorazepam order remained unchanged.Review of the Physician Recommendations dated September 2025 completed by the Consultant Pharmacist showed:-A 14-day stop date needed to be added to the resident's Morphine Sulfate order.-A specific number of days PRN use for the resident's Lorazepam order needed to be added to the order or the medication needed to be discontinued.Review of the resident's TAR dated September 2025 showed:-The resident's Morphine Sulfate order remained unchanged.-The resident's Lorazepam order remained unchanged.Review of the resident's Consultant Pharmacist Recommendation to Physician dated October 2025 completed by the Consultant Pharmacist showed a specific number of days PRN use for the resident's Lorazepam order needed to be added to the order or the medication needed to be discontinued.Review of the resident's MRRs received on 12/4/25 showed:-No documentation was received for the recommendations made in April 2025.-No documentation was received for the recommendations made in May 2025.-No documentation was received to indicate that an MRR was completed for June 2025.-No documentation was received to indicate that an MRR was completed for July 2025.Review of the resident's Order Summary Report dated December 2025 showed:-An order for Lorazepam (a medication used to treat anxiety) Oral Concentrate two milligrams (mg)/milliliters (ml), give 0.25 ml by mouth every four hours as needed for anxiety, which was ordered on 8/5/25.-An order for Morphine Sulfate (a medication used to treat pain) Oral Solution 20 mg/ml, give 0.25 ml by mouth every four hours as needed for shortness of air (SOA)/pain, which was ordered on 8/5/25.Review of the Resident's Clinical Physician Orders on 12/4/25 at 12:45 P.M. showed:-The resident's Morphine Sulfate order dated 8/5/25 had been discontinued on 12/4/25.-The resident's Lorazepam order dated 8/5/25 had been discontinued on 12/4/25.2. Review of Resident #59's admission Record showed he/she admitted to the facility with the following diagnoses:-Hypertensive Heart (problems with your heart that can develop if you have high blood pressure).-Chronic Kidney Disease (a long-standing kidney disease based on kidney damage or decreased kidney function for three or months) with Heart Failure (a complex clinical syndrome characterized by the heart's inability to pump blood effectively due to structural or functional impairments) and Stage One through Four Chronic Kidney Disease, or (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Unspecified Chronic Kidney Disease.Review of the resident's Electronic Medical Record showed:-Pharmacy Recommendations were made in April 2025 and May 2025.-There was no documentation to indicate MRRs were completed from June 2025 through October 2025.Review of the resident's MRRs received on 12/4/25 showed:-No documentation was received for the recommendations made in April 2025.-No documentation was received for the recommendations made in May 2025.-No documentation was received to indicate that an MRR was completed for June 2025.-No documentation was received to indicate that an MRR was completed for July 2025.-No documentation was received to indicate that an MRR was completed for August 2025.3. During an interview on 12/5/25 at 9:35 A.M. Licensed Practical Nurse (LPN) D said:-The wound nurse and the unit managers were responsible for the management of the MRRs.-He/She was unsure when the MRRs were completed.-The Director of Nursing (DON) would ensure the recommendations were reviewed and follow-up was completed.-He/She thought there were Pharmacists who came to the building to share pertinent findings with the nurses and nurse management.-The facility changed pharmacies approximately two months prior, which could be a part of the problem.During an interview on 12/5/25 at 9:53 A.M. the wound nurse said:-Unit managers were responsible for completing the MRRs.-He/She was unsure when MRRs were completed.-The facility changed pharmacies about three months ago.-The new pharmacy the facility utilized did not do monthly reviews.-To his/her knowledge the new pharmacy would do the MRRs throughout the month and would send an email with any residents that were completed.-It was very likely that the change in pharmacies contributed to the issues that were found with the MRRs.-At one point in time there was an issue with the previous pharmacy not completing the MRRs.-The DON would be responsible for ensuring that the MRRs were reviewed and completed within a timely manner.During an interview on 12/5/25 at 10:56 A.M. Unit Manager A said:-The unit managers and the wound nurse were responsible for completing the MRRs.-The facility had changed pharmacies around June 2025.-All the recommendations completed by the old pharmacy were sent via email.-The new pharmacy utilized their own website, and the facility would have to log on to the website to get the recommendations.-There had been inconsistencies in the MRRs completion by the pharmacies.-He/She had looked up Resident #15 and Resident #59 and could not find any MRRs that had been completed by the new pharmacy.-He/She was unsure why Resident #15's recommendations were not completed.-Any recommendations that were made by the Consultant Pharmacist needed to be followed up within 24 to 48 hours of receiving the recommendation.During an interview on 12/5/25 at 1:45 P.M. the DON said:-The unit managers were responsible for completing the MRRs.-The facility switched pharmacies in June.-The main difference between the two pharmacies were how the MRRs were provided to the facility.-Unit Manager A would split the recommendations by doctors and then by units so the appropriate unit manager could follow up on the recommendations.-He/She was responsible for ensuring completion of the MRRs.-He/She was unsure why Resident #15 had the same recommendations made multiple months in a row.-There was no back-up system to ensure all MRRs were completed when the facility switched pharmacies.-When the MRRs were completed by the Consultant Pharmacist the facility needed to immediately follow up with any recommendations that were made.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265820	A. Building B. Wing	12/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Jackson Creek Post Acute	3980 South Jackson Drive Independence, MO 64057

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. Based on observation, interview, and record review, the facility failed to provide a choice of food for three days for one sampled resident (Resident #9) out of 22 residents who received room trays. The facility census was 108 residents.Review of the facility's Food and Nutrition Services Policy revised dated 2017 showed:-Each resident is provided with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs, taking into consideration the preferences of each resident. -The multidisciplinary staff, including nursing staff, the attending physician and the dietitian will assess each resident's nutritional needs, food likes, dislikes and eating habits, as well as physical, functional, and psychosocial factors that affect eating and nutritional intake and utilization. -A resident-centered diet and nutrition plan will be based on this assessment.-Reasonable efforts will be made to accommodate resident choices and preferences.-Food and nutrition services staff will inspect food trays to ensure the correct meal is provided to each resident, the food appears palatable and attractive, and it is served at a safe and appetizing temperature.--If an incorrect meal is provided to a resident, or a meal does not appear to be palatable, nursing staff will report it to the Food Service Manager so that a new food tray can be issued. 1. Review of Resident #9's face sheet showed the following diagnoses:-Parkinson's Disease (a chronic nervous disease characterized by a fine slowly spreading tremor, muscle weakness, muscle stiffness and a peculiar gait) without Dyskinesia (involuntary, uncontrolled muscle movements, ranging from fidgeting to writhing, often affecting limbs, face, or tongue) without mention of Fluctuations (the changes in motor and non-motor symptoms that occur as medication levels in the body change, leading to periods of improvement (on) and worsening (off)).Review of the resident's quarterly Minimum Data Set (MDS-a federally mandated assessment tool completed by the facility for care planning), dated 9/24/25, showed:-He/She was cognitively intact.-He/She was dependent on a wheelchair for mobility. -He/She was independent for upper body motions. During an interview on 12/1/25 at 9:47 A.M. the Dietary Manager (DM) said:-The cook and the servers were responsible for checking what was on the meal tickets.-They were in the process of getting a new food software program and at this time the residents that ate in their rooms were not able to order ahead of time but once they got their food, they could refuse any item and get something else. -The residents were supposed to let whoever was passing trays know if they needed something. During an interview on 12/3/25 at 8:48 A.M. the resident said:-He/She did not receive his/her oatmeal or milk this morning, and he/she had told the nursing staff but still did not receive anything. -Not getting items happened frequently in the morning at breakfast time. -He/She had started circling the items on the meal ticket so they could see he/she was not getting them.Observation on 12/3/25 at 8:48 A.M. of the resident's meal ticket showed milk and oatmeal were listed to be served in the morning at breakfast. During an interview on 12/4/25 at 8:47 A.M. the resident said:-He/She did not receive his/her oatmeal or milk this morning, and he/she had told the nursing staff. -He/She had circled the items on the meal ticket again.Observation on 12/4/25 at 8:47 A.M. of the resident's meal ticket showed milk and oatmeal were listed to be served in the morning at breakfast. During an interview on 12/5/25 at 8:51 A.M. the resident said:-He/She did not receive his/her oatmeal or milk this morning, and he/she had told the nursing staff -He/She had items circled the objects on the meal ticket again.Observation on 12/5/25 at 8:51 A.M. of the resident's meal ticket showed milk and oatmeal were listed to be served in the morning at breakfast. During an interview on 12/5/25 at 10:30 A.M., Certified Nursing Assistant (CNA) E said:-If a resident didn't get an item that was on their meal ticket or if they wanted something else the resident would tell whoever was passing out the trays. -The staff was moved around so much, and he/she had not passed trays these last few days in the morning.-The resident had let him/her know in the past that he/she had not received something.-He/She would go to the dining room and let the kitchen staff know and bring the item back to the resident. During an interview on 12/5/25 at 10:45 A.M., Licensed Practical Nurse (LPN) D said:-He/She had delivered trays but had not passed them out the last few days in the (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	morning. -He/She would ask the resident what they wanted.-If he/she noticed a resident hadn't eaten something then he/she would ask why and if they wanted an alternative. -If he/she noticed something wasn't on the tray that was listed on the meal ticket, he/she would ask the resident if they wanted that item or something different.-He/She would go to the kitchen and get the missing item or the additional item for the resident. During an interview on 12/5/25 at 1:44 P.M. the Director of Nursing (DON) said:-The CNA's were supposed to double check the meal tickets before giving the residents their food. -If a resident did not receive something or wanted to make a change the CNA should notify the kitchen and then the CNA would take the item back to the resident's room.