STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265831	A. Building B. Wing	05/07/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Monarch Springs Wellness & Rehabilitation	894 Leland Avenue University City, MO 63130

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview and record review, the facility failed to store and serve food in accordance with professional standards for food service safety. The facility failed to maintain kitchen equipment in a clean condition and failed to ensure that the floors were swept and mopped during three of four days of observation. The facility also failed to ensure that the wash and rinse cycles reached the required temperatures during the dishwashing process on the dishwasher. The census was 53.1. Observations of the kitchen on 5/4/26 at 6:53 A.M., 5/5/26 at 4:45 P.M, and 5/6/26 at 11:36 A.M., showed:-Stove: -Caked-on stains along the front and on the top of the stove; -Caked-on stains and spots on the burners on the stove; along the front;-Oven: -Right side: -Heavy caked-on stains along the front inside doors; -Heavy caked-on stains along the bottom, top, and sides of oven; -Left side: -Caked on matter along the front inside doors; -Caked on matter along the bottom, top, and sides of oven;-Deep fryer: -Dirty grease in the deep fryer; -Heavy caked-on stains along the inside of the fryer;-Floor was noticeably dirty with food crumbs, dirt, and debris. Review of the kitchen daily/after each use cleaning schedule forms showed:-Week of 3/29/26- 4/14/26: -Floor initialed off as been cleaned Monday through Friday; -Range/Grill initialed off as been cleaned Monday through Friday; -Oven (spills) initialed off as been cleaned Monday through Friday; -No responsible party listed for any of the days.-Week of: 4/12/26- 4/18/26: -Floor initialed off as been cleaned Monday through Friday; -Range/Grill initialed off as been cleaned Monday through Friday; -Oven (spills) initialed off as been cleaned Monday through Friday; -No responsible party listed for any of the days.-Week of: 4/19/26- 4/25/26: -Floor initialed off as been cleaned Monday through Friday; -Range/Grill initialed off as been cleaned Monday through Friday; -Oven (spills) initialed off as been cleaned Monday through Friday; -No responsible party listed for any of the days.-Week of: 4/26/26- 4/30/26: -Floor initialed off as been cleaned Monday through Friday; -Range/Grill initialed off as been cleaned Monday through Friday; -Oven (spills) initialed off as been cleaned Monday through Friday; -No responsible party listed for any of the days. 2. Observation of the dishwasher during the dishwashing process, showed the wash cycle to reach 88 degrees and the rinse cycle to reach 104 degrees. Review of the April 2026 dish machine log, showed:-Wash Cycle: The temperatures were logged and initialed at 120 degrees and/or above for 0 out of 90 opportunities;-Sanitizer: The temperatures were logged and initialed at 120 degrees and/or above for 22 out of 90 opportunities. Review of the May 2026 dish machine log, showed:-Wash Cycle: The temperatures were logged and initialed at 120 degrees and/or above for 0 out of 18 opportunities;-Sanitizer: The temperatures were logged and initialed at 120 degrees and/or above for six out of 18 opportunities. Review of the May 2026 dish machine log showed: -For low temperature dish machines: -The wash temperature: > (greater) than 120 degrees (or per manufacturer instruction); -The rinse temperature: > (greater) than 120 degrees (or per manufacturer instruction); -Sanitizer: 50 to 200 PPM (parts per million) (or per manufacturer instruction). 3. During an interview with the Dietary Manager (DM) and [NAME] J on 5/7/26 at 12:20 P.M., [NAME] J said they run the dishwasher a couple of times to get it up to the temperature of where it needs to be. The wash cycle should be at 120 degrees, and the rinse cycle should be at least 115 degrees or above. They had to do a large amount of work with the electrical system, so they are (continued on next page)

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

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

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	installing a booster to make the water temperatures hotter. The DM said it was his expectation that water temperatures should be reaching the required temperatures during the wash and rinse cycles. The grease in the deep fryer was normally changed depending on what they were frying. The grease is drained from the fryer and fryer is cleaned approximately every week and a half. The kitchen appliances and equipment should be clean and in proper working order, and the floor should be swept, cleaned, mopped, and free of debris. General cleaning is done daily to include sweeping and mopping, wiping equipment and appliances down, and cleaning the steam tables upstairs. Deep cleanings were done monthly.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures for flu and pneumonia vaccinations. Based on interview and record review, the facility failed to provide or offer vaccinations for influenza and/or pneumococcal disease for four of five residents sampled for immunization status. The sample was 16. The census was 58.Review of the facility's Pneumococcal Disease Prevention policy, revised 6/2020, showed:-Before offering pneumococcal vaccines, each resident or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization;-The resident or the residence legal representative has the opportunity to refuse immunization, with such refusal being noted in the residence medical record;-The resident's medical record includes documentation that indicates, at a minimum, the following: That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of the pneumococcal polysaccharide vaccine, the informed consent/refusal is to be placed in the resident's medical record, and the resident either received the pneumococcal vaccine or did not receive the vaccination due to medical contraindications or refusal. Review of the facility's Influenza Prevention and Control policy, revised 6/2020, showed:-Influenza season will be defined by the Center for Disease Control (CDC) guidelines;-Residents are offered an influenza immunization during flu use an annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period;-The resident or the resident's legal representative has the opportunity to refuse immunization, with such refusal being noted in the residence medical record;-The resident's medical record includes documentation that indicates at a minimum the following: that the resident or legal representative was provided education regarding the benefits and potential side effects of influenza immunization, that the Influenza Vaccination-Informed Consent/Refusal will be placed in the resident's medical record, and that the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. 1. Review of Resident #2's electronic medical record (EMR), showed:-admission date 9/15/25;-No documentation the resident received or was offered influenza or pneumococcal vaccines. 2. Review of Resident #9's EMR, showed:-admission date 9/22/25;-No documentation the resident received or was offered influenza or pneumococcal vaccines. 3. Review of Resident #40's EMR, showed:-admission date 1/19/26;-No documentation the resident received or was offered influenza or pneumococcal vaccines. 4. Review of Resident #33's EMR, showed:-admission date 12/24/25;-No documentation the resident received or was offered pneumococcal vaccine. 5. During an interview on 5/7/26 at 9:12 A.M., LPN (Licensed Practical Nurse) A said the admitting nurse was expected to check for a resident's immunization records upon the resident's admission. The admitting nurse should offer influenza and pneumococcal vaccines upon a resident's admission and when seasonally appropriate. Immunizations should be documented in the resident's EMR. 6. During interview on 5/7/26 at 1:37 P.M., the Director of Nurses (DON) and Administrator said they expected residents to be offered influenza and pneumococcal vaccinations upon admission, unless documentation of previous immunization is available. Immunizations should be documented in the EMR. Auditing of resident vaccination statuses is the responsibility of the Assistant Director of Nursing (ADON), who also serves as the facility Infection Preventionist (IP).

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. Based on observation, interview, and record review, the facility failed to ensure staff provided one (Resident #51) of 16 sampled residents with the appropriate bed rails to assist with repositioning. The census was 53.Review of the facility's Bed Rails policy, revised June 2020, showed:-The assessment of whether to use bed rails should include an evaluation of the alternatives to the use of bed rail that were attempted and how these alternatives failed to meet the resident's needs;-If bed rails are to be used, the assessment Bed Rail Utilization by a licensed nurse and or the IDT (Interdisciplinary team);-The licensed nurse and/or the IDT-restraint reduction committee may refer to the bed rail decision tree during the assessment;-Before installing a bed rail, the facility must: Assess the resident for risk of entrapment from bed rails and;--Ensure the bed's dimensions are appropriate for the resident's size and weight. The manufacturer's recommendations and specifications for installing and maintaining bed rails will be followed;-If a bed rail is used as an enabler, the resident/resident's representative informed consent will be obtained by a licensed nurse or physician;-The resident's plan of care will be updated to reflect the use of bed rails. Review of Resident #51's admission Minimum Dats Set (MDS, a federally mandated assessment instrument completed by staff), dated 3/20/26, showed:-Diagnoses included deep venous thrombosis (blood clots), heart failure, arthritis, malnutrition;-Cognitively intact;-Uses wheelchair;-Impairment to both sides of the upper and lower extremities;-Substantial/maximal assistance required to roll left and right;-Dependent sitting to lying, lying to sitting on side of bed, sit to stand, chair/bed to chair transfer;-Bed rail not used. Review of the resident's care plan, in use during survey, showed:-Focus: Resident needs assistance with Activities of Daily Living (ADLs) related to chronic pain, right above the knee amputation, osteoarthritis, chronic pulmonary edema and congestive heart failure;-Interventions: Bed Mobility: the resident requires (X) staff participation to reposition and turn in bed;-Interventions did not include the number of staff participation to reposition and turn in bed. Review of the resident's Bed Rail Utilization Assessment, dated 4/20/26, showed:-Recommendations: Bed rails are indicated and served as an enabler to promote bed mobility and independence;-Bilateral 1/4 rails. Observation and interview on 5/4/26 at 9:36 A.M., showed the resident in bed. He/She had an above the knee amputation to the right leg. He/She did not have a side rail on the bed. The resident said he/she wanted a side rail to assist with repositioning. During an interview on 5/6/26 at 11:34 A.M., the resident said he/she was supposed to have bed rails. Therapy put in a request and ordered the rail, but he/she did not have bed rails on the bed. During an interview on 5/7/26 at 12:31 P.M., the Maintenance Director said he was told residents in the facility did not use side rails. He had worked for the facility for two years and had not installed a side rail. He was told it was dangerous, and they did not want residents to have the side rails on the bed. He was not aware of side rails installed on any resident beds. During an interview on 5/7/26 at 11:12 A.M., the Director of Rehab said he/she was aware of the resident's assessment, and he/she was able to receive side rails. The assessment was completed by therapy. After the assessment, the side rail was ordered. He/She clarified and said the part needed to be ordered. He/She would have expected the resident to have side rails if the assessment was completed on 4/20/26, but it depended on the type of rail and the type of bed the resident had. During an interview on 5/7/26 at 1:30 P.M., the Administrator said residents were able to have side rails. Once a resident was assessed, they got an order from the physician, had the resident sign the assessment form, and the side rails were installed after. There was no physician order for the resident to have the side rail. Staff had to notify the physician. The Administrator had not been able to put an order in. He was not aware the side rail was ready to be installed. Therapy would give the okay and maintenance would install the bed rail. He would have expected the resident to have the side rails on the bed if the assessment was completed on 4/20/26.

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. Based on interview and record review, the facility failed to follow appropriate discharge procedures for one resident when staff failed to re-admit the resident after returning from the hospital following an immediate discharge (Resident #50). The sample size was 16. The census was 53.Review of the facility's transfer and discharge policy, revised June 2020, showed:-The Facility may transfer or discharge a resident for the following reasons:--The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility;--The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility;--The safety of individuals in the Facility is endangered by the resident's presence;--The health of individuals in the Facility would otherwise be endangered by the resident's presence;--The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. For a resident who becomeseligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid;--The facility ceases to operate;-The facility may not transfer or discharge a resident while the appeal to the notice oftransfer/discharge is pending, unless it is documented that failure to transfer or discharge the resident would endanger the health or safety of the resident or other individuals;-Facility staff will provide the resident with reasonable advance notice of the transfer or discharge before it occurs. Unless exigent circumstances exist, the notice should be provided 30 days prior to the proposed date of transfer/discharge. Situations that may prevent 30 days' notice include:--The resident poses a threat to the health or safety of other individuals at the facility;--The resident's health improves sufficiently to allow for more immediate transfer/discharge;--The resident is experiencing urgent medical needs;--The resident has not resided in the Facility for 30 days;-Cases in which 30 days' notice is not possible, notice of transfer or discharge should be provided to the resident of his/her responsible party as soon as practicable;-Documentation of written or telephone acknowledgement of the resident's transfer by theresident's personal representative may occur after the transfer in an emergency situation;-Documentation relating to resident's transfer/discharge will be maintained in the resident's medical record;-The Facility may use Notice of Transfer/Discharge or another comparable form to provide the resident of his/her personal representative with advance notice of the transfer or discharge. The notice will include the following information: The reason the resident is being transferred/discharged ;-The effective date of the transfer/discharge;-The name, complete address and telephone number to which the resident is beingtransferred;-A statement that the resident has the right to appeal the action to the state, contactinformation for the state entity which receives appeal hearing requests, and information for how to request an appeal;-The name, address, and telephone number of the State Long Term Care Ombudsman;-For residents with intellectual or developmental disabilities, the mailing address andtelephone number of the agency responsible for the protection and advocacy ofdevelopmentally disabled individuals;-For residents with a mental disorder, the mailing address and telephone number of the agency responsible for the protection and advocacy for individuals with mental disorders. Review of the facility's Resident drug and alcohol abuse policy, revised August 2020, showed:-The Facility will admit a resident who has a history of drug and alcohol abuse as long as their primary diagnosis is suitable for skilled care at this Facility;-The Facility has a zero-tolerance policy for the use or possession of illegal drugs (includingmarijuana) or any type of drug apparatus in the Facility or on the grounds of the Facility. All illegal drugs and/or drug paraphernalia will be confiscated from the resident and /or their room;-For the purpose of this policy alcohol is not considered to be an illegal drug;-The only drugs permissible at the Facility and/or on Facility grounds are those for which there is an Attending Physician order. Any alcohol served on Facility grounds will only be provided with Administration's approval and in accordance with an approved activity plan with the resident;-The facility has zero-tolerance policy for (continued on next page)

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	abuse of alcohol in the facility or grounds of the facility;-Any resident found in violation of this policy will be discharged to a more appropriate setting for care;-Violations: Any drugs, drug paraphernalia, or alcohol will be destroyed or handed over to the authorities as required;-If a resident violates this policy, the resident will also be subject to drug screening to test for the presence of any illegal substances in their body;-If the drug screening is positive, the resident will be discharged according to Facility discharge procedures;-If the resident refuses the drug screening, they could be discharged according to the Facility discharge procedures. Review of Resident #50's quarterly Minimum Data Set (MDS, a federally mandated assessment tool completed by facility staff), dated 2/21/26, showed:-Diagnoses included anemia, neurogenic bladder, wound infection, malnutrition and asthma;-Cognitively intact;-Uses wheelchair. Review of the resident's care plan, in use during survey, showed:-Focus: Resident has tested positive for illicit substances Phencyclidine (PCP or angel dust, hallucinogenic drug) while in the facility;-Interventions: Complete a room search for unauthorized or illicit items per facility policy and as indicated;-Encourage resident to participate in counseling or support groups related to substance use;-Resident and belongings will be searched upon returning from leave of absence (LOA) related to history of and current use of PCP use;-Monitor him/her for signs and symptoms of substance use or intoxication;-Perform random urine drug screen as ordered or per facility protocol;-Provide education to him/her regarding the health risks associated with illicit substance use and the potential for discharge if facility policies are not followed;-Focus: Resident has an extensive history of substance use leading to altered mental status, impaired judgement, and safety risks following LOA. Resident will refuse to be sent out to emergency room (ER) and have urine drug screen (UDS) done;-On 3/17/26, ER visit for altered mental status (AMS). UDS positive for PCP;-On 4/3/26, ER visit for AMS. Refused to have UDS done;-On 4/11/26, admitted for AMS. UDS positive for marijuana and PCP. Review of the resident's progress notes, showed:-On 4/14/26 at 1:59 P.M., Administrator, Director of Nursing (DON), and Social Services (SS) had a private discussion with this resident regarding his drug abuse problem. Resident stated he/she was sent out to the hospital most recently for being unresponsive because of the heat. Resident denies taking illicit drugs and stated that no one in the facility is supplying him with illicit drugs. Resident stated that the nurse from the hospital is lying and that he/she did not say that. Resident was informed about having an emergency discharge if he/she is to go out LOA again and return altered and/or suspected to be under the influence of illicit drugs. Resident eventually agreed that he/she has a drug problem and that he/she needs help. Resident is agreeable to receiving help from an alternative detox facility. When asked how PCP is getting in his/her system, resident states that he/she does not know how and suggested that maybe it is because of the cigarettes he/she smokes. Resident denies his/her sibling supplying him/her with PCP and denies mother supplying him/her with PCP. Resident was given opportunity to ask questions or voice concerns to us about his/her plan of care. Resident did not have any further questions and is agreeable to everything stated as far as care planning;-On 4/14/26 4:09 P.M., this resident returned from hospital by emergency medical service (EMS) transferred into bed by EMS staff. Resident able to make all needs known call placed to physician to make aware of resident's return, voicemail box is full at this time. Resident alert and oriented times three, call light in reach. No signs and symptoms of pain or discomfort. Orders being placed in electronic medical record by Assistant Director of Nursing (ADON);-On 4/15/26 at 3:51 P.M., the DON and I went into resident's room and re-educated him/her on the drug and alcohol policy here at the facility. In the acknowledgement form, it states that anymore drug use will result in an immediate discharge with no 30-day notice given. Resident agreed and DON signed the document for him/her. Review of the resident's drug and alcohol abuse policy acknowledgement form, dated 4/15/26, showed:-Statement of Acknowledgement: I acknowledge that I have received and understand the facility Drug and Alcohol Abuse policy, and I agree to abide by the terms of the policy throughout my stay at the facility. You are also agreeing to the understanding that anymore drug use will result in an immediate discharge from facility and you will be not be given a 30-day notice;-Resident's signature (continued on next page)

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	line was blank, but dated 4/15/26;-Handwritten note, resident is unable to sign, but agrees to acknowledgement form;-Signed by DON as witness. Review of the resident's care plan, showed:Focus:-On 4/17/26, behavior discussed with resident and Durable Power of Attorney (DPOA) that if resident leaves this facility and returns under the influence again, or if he/she somehow obtains drugs while in this facility, he/she will be sent out to the hospital with an emergency discharge and will not be able to return;-Interventions: On 4/22/25, may not go on LOA with meds without proper authorization from POA;-On 4/22/26, POA also does not want friend at facility around resident and wants to be notified;-Assess resident immediately upon return from LOA;-Fall precautions will be initiated if altered;-Resident and belongings will be searched for any substance that may have been brought into the facility;-Resident is to be send to the ER for any noted changes in consciousness after returning from LOA;-UDS test upon return back to the facility will be performed for every LOA. Review of the resident's notice of transfer or discharge notice, dated 4/22/26, showed:-You have the right to appeal this proposed transfer or discharge. If you believe you should not have to leave the facility, you may request a hearing with the Missouri Department of Health and Senior Services;-Deadline to appeal: You must submit your request within 30 days of receiving this notice;-If you submit a timely appeal, you will not be transferred or discharged until a hearing is held and a decision is made, unless an emergency transfer is authorized under applicable law;-Reason for transfer or discharge: On 1/15/26, resident read and agreed to the drug and alcohol policy. A staff member signed as witness for him/her;-Resident continues to leave the facility and go into the community;-Resident has returned from the community intoxicated and needs EMS called;-On 3/17/26, resident tested positive for PCP;-Resident received Narcan (lifesaving medication that reverses opioid overdoses) on 4/6/26 after returning to the facility from out in the community;-On 4/10/26, resident left to go to his/her mom's house. On 4/11/26, resident tested positive for PCP while at the hospital;-The resident is a danger to him/herself;-The resident presents a danger to others with drug use at the facility;-Resident's safety cannot be met when he/she leaves the facility and goes into the community;-Based on the details listed above, an immediate and emergent discharge is necessary. Review of the resident's progress notes, showed:-On 4/25/26 at 2:40 P.M., resident requesting to go out of the facility for a couple of hours to get some air. Resident's DPOA contacted. He/She spoke with resident and this nurse and gave permission for resident to leave the facility. DPOA requested facility contact him/her when resident returns;-On 4/25/26 at 7:30 P.M., resident has not returned back to facility. Called placed to DPOA to inform him/her. DPOA thanked this nurse for updating him/her and stated he/she is going to go out and look for the resident. Director of Nursing (DON) updated and informed this nurse if resident does not return to the facility or DPOA has not located him/her by 10:00 P.M., to contact 911. Night nurse here and updated on the above;-On 4/26/26 at 7:00 A.M., upon wound change of resident, resident eyes where noted to be dilated +6 (healthy adult pupils range from 4 to 8mm (millimeter), if pupils remain dilated 6mm+ in bright light or do not respond to light, it may indicate medication side effect, trauma, or neurological issues), resident was originally searched when coming back to the facility due to previous episodes of being positive for illegal substances. Resident belongings were once again searched due to change in condition where it was discovered that resident has in his/her bag in the bottom of the inner lining were four cigars dipped in a wet unknown substance (Fry or PCP, cigarette or cigar dipped in embalming fluid which contains formaldehyde, methanol, and ethanol) with a pungent smell. Vital signs were taken resident blood pressure: 113/66 (normal range 120/80), pulse 88 (normal range 60 to 100), oxygen 98% room air (normal 95 to 100%), temp 98.7 Fahrenheit (F) (97 degrees F to 99 degrees F), resident remained alert and oriented times four, wound change on resident was completed. Resident's Power of Attorney (POA) was contacted. OK to send him/her out for further evaluation. Resident's physician was made aware. Administrator was made aware. Emergency medical services (EMS) and police was contacted and resident was taken to hospital for further evaluation. Police report was given for the illegal substance with the police department. Given previous acts of using (continued on next page)

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	substance, immediate discharge paper work was given to resident;-On 4/26/26 at 10:27 A.M., the social worker from hospital reached out to inform me that this resident will be returning to the facility despite being issued immediate discharge that they never received. It was documented that this resident received immediate discharge paperwork upon departure. This social worker claims that resident has the right to appeal for a 30-day discharge appeal, however he/she was informed that this resident signed immediate discharge paperwork stating if this resident was to leave the facility and return with altered mental status (AMS), he/she will be served an immediate discharge effective immediately and cannot return to this facility. This writer is a witness to this consent issued by this resident as well as the administrator. Another copy of the immediate discharge paperwork has been faxed to the number the social worker has provided me. Social worker stated he/she is still going to try to appeal and send the resident back to the facility anyway, and that he/she doesn't know why the Ombudsman we consulted would tell us this was okay because what we are doing is illegal. Nurse on duty notified that this resident is not to be accepted back to the facility. Administrator notified;-On 4/26/26 at 2:48 P.M., Received update from social worker from hospital and confirmed that they have received the immediate discharge paperwork;-On 4/27/26 at 8:31 A.M., Social Services Designee (SSD) & the Administrator met with DPOA this morning regarding the incident that occurred over the weekend with this resident. Resident remains at hospital at this time. Resident was issued an Emergency Discharge related to violating the Behavioral Contract issued, waiving the right to appeal. (See Administrator's Progress Note of 4/15). The Administrator did advise DPOA that he/she is not willing to except resident back and that he/she has been working with Department of Health and Senior Services (DHSS) and the Ombudsman for guidance to manage this situation resident's behavior continued without regard. DPOA voiced an understanding of this entire situation, stating; I just want to choke him/her. This is the same stuff that caused him/her to be in this wheelchair. DPOA left with the understanding that facility not be accepting resident back and that the hospital social worker is responsible for finding an accepting facility. During an interview on 5/6/26 at 5:34 P.M., Certified Nurse Aide (CNA) C said he/she was familiar with the resident. He/She had a drug problem. He/She went outside the facility and would get high. He/She returned and would run into things with his/her wheelchair. He/She would ride the elevator, attempting to get off the elevator, but would just ride up and down. CNA knew the resident at a prior facility. The resident did the same thing and got kicked out. During an interview on 5/6/26 at 4:54 P.M., the Social Worker (SW) said the resident signed him/herself out and returned high. He/She was sent to the hospital and tested positive for PCP. It happened more than once. His/Her sibling became the resident's DPOA. The resident was not allowed to leave without the DPOA, and the resident's friend was not allowed in the facility because that friend got the resident high. When he/she returned with PCP in his/her system, he/she fell out of the chair, his/her eyes were wide opened, and he/she could not respond to anything. His/Her friend was the one that brought the resident back to the facility by using the resident's joystick on the wheelchair. There were room searches as well. They once found cigars dipped in a substance, which was PCP. The SW tried to find a rehab facility, but the resident required too much care. At one point the resident told the SW that he/she did not know how he/she tested positive for PCP. Toward the end, he/she owned up to drug use. During an interview on 5/7/26 at 8:17 A.M., the Administrator said back in January, the resident went to the hospital for altered mental status and a drug test showed he/she had PCP in his/her system. He/She signed him/herself out and came back under the influence. A week later, there was a facility wide search with police for drugs, and they also went around with a drug and alcohol acknowledgement that was signed by the resident. They sent a referral that month, but no facility would accept him/her. In March 2026, he/she had another AMS and PCP was in his/her system. Early April, it was the same situation. He/She had another AMS and returned to the facility. The Administrator contacted the Ombudsman and DHSS, and they believed there was enough to issue an emergency discharge. The Administrator did not issue the notice on that day, but he contacted the physician and discussed emergency discharge in the future. The resident (continued on next page)

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	came back around April 11th after being discharged from the hospital. The Administrator, DON, and SW, who was on the phone, spoke to the resident. The resident was informed if he/she went out again and came back under the influence, he/she would receive an emergency discharge. The Administrator re-educated him/her on the drug and alcohol policy. If he/she violated that, he would then forego the appeals process. That was just for this resident. They asked if he/she wanted help and he/she agreed to get help, but no one would accept him/her because of his/her condition. He/She required more care than what they would have provided. On April 25th or 26th, the resident wanted some fresh air, and his/her DPOA said it was okay. The next morning, he/she had AMS. He/She obtained three cigarettes that were dipped in a wet liquid. The police was notified. The resident admitted that he/she dipped it and smoked it. The Administrator said he was out of town on the last day the resident was at the facility, but he made sure the final education and discharge notice was given to the resident. He was also in contact with facility, hospital, and attorney. The Administrator said he stood firm that the resident was a danger to himself. The Administrator said he had not received information regarding the appeal and/or if the hospital filed an appeal. The hospital said they did not have paperwork, so the administrator provided the paperwork to the hospital. The hospital said they would appeal the discharge, and the attorney advised to accept the resident back if he/she returned. During an interview on 5/7/26 at 1:30 P.M., the DON said she spoke to the hospital social worker regarding the emergency discharge. The resident was given the immediate discharge but may not have had it in the hospital. The DON was not aware of the resident's right to return and appeal the discharge until the hospital told her. Intake: 2994401

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to obtain and/or follow physician orders for three residents (Residents #37, #9, and #41). The facility failed to ensure blood pressure parameters were followed prior to medication administration (Resident #37). The facility failed to administer meal supplements (Resident #9) and failed to update dietary orders (Resident #41). The sample size was 16. The census was 53.Review of the facility's Physician Orders policy, revised June 2020, showed:-Policy: The medical records department will verify that physician orders are complete, accurate, and clarified as necessary;-Procedure: Telephone orders: A licensed nurse will transcribe telephone orders with date, time, and signature of the person receiving the order;-Orders will include a description complete enough to ensure clarity of the physician's plan of care;-Physician orders will only include abbreviations that have been approved by the facility;-Whenever possible, the licensed nurse receiving the order will be responsible for documenting and implementing the order;-Medication/treatment orders will be transcribed onto the appropriate resident administration record. Orders pertaining to other health care discipline will be transcribed onto the appropriate communication system for that discipline;-Documentation pertaining to physician orders will be maintained in the resident's medical record. Current month's administration records will be maintained in the Medication Administration Record (MAR)/Treatment Administration Record (TAR). 1. Review of Resident #37's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by the facility staff, dated 3/13/26, showed:-Severe cognitive impairment;-Diagnoses included amenia, heart failure, hypertension (high blood pressure), orthostatic hypotension (sudden drop in blood pressure), diabetes, bipolar disorder (a mental health condition characterized by dramatic shifts in mood), asthma and respiratory failure. Review of the resident's care plan, in use during survey, showed:-Focus: Resident is a moderate risk for falls related to high risk medications, impulsivity, impaired mobility, severe cognitive impairment, and incontinence;-Focus: Resident has congestive heart failure with bilateral edema and uses daily diuretic and is at risk for fluid overload;-Focus: Resident has chronic pain related to polyosteoarthritis (degenerative joint disease), neuropathy (nerve damage) and pain in his/her left shoulder. He/She receives anticonvulsants (anti-seizure) for neuropathy daily;-Interventions: Administer Gabapentin (anticonvulsant) oral capsule 100 milligram (mg) as ordered. Review of the resident's Physician's Orders Sheet (POS), dated May 2026, showed:-An order, dated 4/5/26, Hydrochlorothiazide (diuretic) oral tablet 12.5 mg, give one tablet by mouth in the morning for bilateral edema related to heart failure. Hold if blood pressure is less than 100/60;-An order, dated 4/5/26, Gabapentin oral capsule 100 mg, give one capsule by mouth, two times a day related to type two diabetes. Hold if blood pressure is less than 100/60;-An order, dated 10/24/25, Midodrine (used to treat low blood pressure) hydrochloride (HCl) oral tablet 10 mg, give one tablet my mouth, three times a day related to orthostatic hypotension. Hold if systolic (top number in a blood pressure reading) is greater than or equal to 100 millimeters of mercury (mmHg) (normal is 120 mmHg or less) or diastolic (the bottom number in a blood pressure reading) is greater than or equal to 80 mmHg (normal 60-80 mmHg). Review of the resident's Medication Administration Record (MAR), dated May 2026, showed:-On 5/4/26, staff documented the administration of Hydrochlorothiazide12.5 mg. The resident's blood pressure was documented 89/54;-On 5/4/26 morning medication administration, staff documented the administration of Gabapentin 100 mg. The resident's blood pressure was documented 89/54;-On 5/3/26 morning medication administration, staff documented the administration of Midodrine oral tablet 10 mg. The resident's blood pressure was 130/75;--Afternoon medication administration, showed staff documented the administration of the Midodrine. The resident's blood pressure was 134/71;-On 5/5/26 bedtime medication administration, staff documented the administration of Midodrine. The resident's blood pressure was 125/70;-On 5/6/26 morning medication administration, staff (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	documented the administration of Midodrine. The resident's blood pressure was 111/62;--Afternoon medication administration, staff documented the administration of Midodrine. The resident's blood pressure was 137/67;-On 5/7/26 morning medication administration, staff documented the administration of Midodrine. The resident's blood pressure was 131/83. During an interview on 5/7/26 at 11:12 A.M., Licensed Practical Nurse (LPN) A said the resident's order for Midodrine specified it was either diastolic or systolic number. If either number was greater than what the order specified, the medication should have been held. LPN A was asked if the Midodrine should have been administered on 5/7/26 when the blood pressure was 131/83. LPN A said the Midodrine should have been held. The Certified Medication Technician (CMT) administered the medication. During an interview on 5/7/26 at 1:30 P.M., the Director of Nursing (DON) said she would have expected staff to follow physician's orders. She would have expected the resident's blood pressure to be taken and documented prior to administration. She would have expected staff to follow the blood pressure parameters prior to administering the medications. The DON confirmed staff should have held the Midodrine that morning if the resident's blood pressure was 131/83 and notified the nurse. She would have expected staff to hold the resident's gabapentin and hydrochlorothiazide if the resident's blood pressure was not within parameters. It was important for staff to follow the blood pressure parameters, so the resident did not become hypotensive. 2. Review of Resident #9's progress notes showed a note from the Registered Dietician on 3/27/26 at 9:18 A.M., indicating the resident had stable weekly weights and the recommendation was made to continue the resident's order for 60mL MedPass (a meal supplement used to provide additional calories with meals to patients suffering from malnutrition) three times daily with meals unless weight loss was noted. Review of the resident's quarterly MDS, dated [DATE] showed:-The resident is not cognitively intact;-Medical Diagnoses including: End Stage Renal Disease (ESRD, a chronic condition that impairs the kidneys' ability to filter toxins from the blood), aphasia (a language disorder caused by damage to the brain that impairs the ability to speak, read and write), seizure disorder, and malnutrition (a chronic condition in which the body fails to absorb an adequate amount of nutrients from food products). Review of the resident's progress note, showed a note from the Registered Dietician on 4/30/26 at 1:26 P.M. indicating the resident was noted to have weight loss based on weekly weights and had begun to downtrend after the resident's weekly weights had been increasing. A recommendation was made to increase the resident's MedPass (a high-calorie high-protein nutritional shake) supplement from 60mL three times daily to 120mL three times daily. Review of the resident's physician orders, active through the survey, dated May 2026, showed:-An order for 60mL MedPass 2.0 three times daily with meals entered on 10/8/25 with an end date of 4/30/26;-An order for 120mL MedPass 2.0 three times daily with meals entered on 4/31/26 with a stop date of 5/1/26;-An active order for 120mL MedPass 2.0 three times daily with meals entered on 5/7/26 with no stop date. Observation on 5/4/26 at 7:53 A.M., showed the resident ate breakfast and was assisted by staff. No meal supplement shake was provided to the resident during the breakfast meal. At the conclusion of the meal the resident was wheeled back to his/her room in a Broda chair (a specialized, high-performance mobility device used to provide long-term comfort, pressure relief, and safe positioning for individuals with limited mobility) by staff. No meal supplement shake was provided to the resident after being transferred to his/her room. Observation on 5/5/26 at 12:51 P.M. showed the resident ate lunch and was assisted by staff . No meal supplement shake was provided to the resident during the lunch meal. At the conclusion of the meal the resident was wheeled back to his/her room in a Broda chair by staff. No meal supplement shake was provided to the resident after being transferred to his/her room at the end of the lunch meal. Observation on 5/6/26 at 1:12 P.M. showed the resident ate lunch and was assisted by staff. No meal supplement shake was provided to the resident during the lunch meal. At the conclusion of the meal the resident was wheeled back to his/her room in a Broda chair by staff. No meal supplement shake was provided to the resident after being transferred to his/her room at the end of the lunch meal. During interview on 5/8/26 at 9:06 A.M. CMT B (Certified Medication (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Technician) said he/she was unsure if the resident had experienced weight loss, but knew the resident was to receive meal supplements with all meals. Supplement shakes are provided by the facility CMTs and kept on the medication carts. The Registered Dietician made recommendations monthly, and the Director of Nursing (DON) was responsible for ensuring those orders were transcribed and followed up on. During interview on 5/8/26 at 9:09 A.M. LPN A (Licensed Practical Nurse) said the resident had experienced documented weight loss between 4/7/26 and 4/29/26 and had active orders for 120 mL MedPass 2.0 three times daily with meals. The facility contracted with a Registered Dietician who entered their own orders in and floor nurses were to confirm those orders were accurate and transcribed each month. During interview on 5/8/26 at 1:37 P.M. the facility Administrator and DON said the resident had fluctuating weight loss but were unsure of his/her exact orders for meal supplement shakes. Facility CMTs were responsible for providing meal supplement shakes as they were a physician's order and kept on the medication cart. The facility's Registered Dietician was able to input his/her own orders, and facility nursing staff were responsible for reviewing those orders. The orders were not entered correctly and the resident missed dosages of MedPass. The facility Administrator and DON would have expected orders for meal supplements to be provided as ordered or recommended monthly by the Registered Dietician and entered onto the physician's order correctly. The resident missed dosages of Medpass from 5/1 through 5/7 due to the orders not transcribed correctly. 3. Review of Resident #41's quarterly MDS, dated [DATE], showed:-Severe cognitive impairment;-Diagnoses included non-traumatic brain dysfunction, Alzheimer's disease, and malnutrition;-Supervision or touching assistance with eating;-No signs and symptoms of swallowing disorder. Review of the care plan, in use at the time of survey, showed:-Focus: Resident has nutritional problem related to unplanned weight loss related to severe cognitive impairment, terminal diagnosis, refusal to allow staff to assist with meals, low BMI (body mass index) and variable by mouth intake. Resident requires a mechanically altered diet. Weight loss is expected during end of life stage;-Interventions: Provide and serve diet as ordered. Regular diet, minced and moist texture, thin consistency. Review of the resident's POS, dated May 2026, showed an order, dated 12/30/25, regular diet, minced and moist texture, thin consistency. Observation on 5/5/26 and 5/6/26, showed:-On 5/5/26 at 12:44 P.M., the resident was served spaghetti, vegetables, and garlic bread that was in a pureed consistency;-On 5/6/26 at approximately 5:30 P.M., the resident was served beef tacos, Spanish rice, and refried beans that was in a pureed consistency. During an interview on 5/4/26 at 1:30 P.M., the Administrator said speech therapy assessed the resident and could change the order of their diet. They transcribed the orders. Speech therapy was responsible for changing a resident's diet order in the electronic medical record. He would have expected the diet orders to be accurate and for the care plan to also have reflected a pureed diet.

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. Based on interview and record review, the facility failed to ensure staff completed bed rail assessments and updated care plans, for two residents (Residents #43 and #33) whose beds were equipped with assist rails. The sample was 16. The census was 53. Review of the facility's bed rail policy reviewed June 2020, showed:-Purpose: -To determine the appropriateness of bed rail use for individual residents;-Policy: -Decisions to use or to discontinue the use of a bed rail will be made in the context of an individualized resident assessment using an Interdisciplinary Team (IDT) and will take into account the resident's medical needs, comfort, and freedom of movement.-Procedure: -The Assessment of whether to use bed rails should include an evaluation of the alternatives to the use of bed rail that were attempted and how these alternatives failed to meet the resident's assessed needs; -If bed rails are to be used, the assessment Bed Rail Utilization by a Licensed Nurse and/or the IDT; -The Licensed Nurse and/or the IDT-Restraint Reduction Committee may refer to the Bed Rail Decision Tree during the assessment. -Before installing a bed rail the Facility must: -Assess the resident for risk of entrapment from bed rails; -Ensure the bed's dimensions are appropriate for the resident's size and weight. The manufacturer's recommendations and specifications for installing and maintaining bed rails will be followed; -If a bed rail is used as an enabler, the resident/resident representative's informed consent will be obtained by a Licensed Nurse or the physician; -The resident's plan of care will be updated to reflect the use of bed rails. The plan of care should also include documentation of the type of specific direct monitoring and supervision provided during the use of the bed rails and the identification of how needs will be met during the use of bed rails (e.g., repositioning, hydration, etc.); -Ongoing Monitoring and Supervision: -After installation of bed rails, the IDT will document the review of the use of bed rails at a minimum of quarterly. Re-evaluations should include a discussion of any adverse effects of bed rails and attempts to eliminate the need for the bed rail if it is being used as a restraint; -Maintenance/Designee will assess the bed dimensions no less than quarterly by utilizing Maintenance Inspection Checklist - Resident Rooms. Maintenance will also check bed rails regularly to ensure they are still installed correctly, as rails may shift or loose over time. 1. Review of Resident #43's admission Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 2/9/26, showed:-Intact cognition;-Diagnoses include depression, anxiety disorder, asthma, and malnutrition. Review of the resident's care plan, in use during survey, showed use for assist and/or enabler rail(s) not documented. Review of the resident's medical record, showed the following:-admission date of 1/29/26;-readmission date of 3/6/26;-Additional diagnoses of dystonia (a syndrome of abnormal muscle contraction that produces repetitive involuntary twisting movements and abnormal posturing of the neck, trunk, face, and extremities), hallucinations (are false or distorted sensory experiences that appear to be real perceptions, anemia, and rhabdomyolysis (an acute, fulminating, potentially fatal disease of skeletal muscle that entails destruction of muscle);-No physician order for assist rails for the resident;-No bed rail assessment. Observations of the resident and the resident's room showed:-On 5/4/26 at 9:20A.M., the resident lay in his/her bed awake. Both assist rails were up;-On 5/5/26 at 1:03 P.M., the resident in his/her bed awake, in his/her room, eating lunch. Both assist rails were up;-On 5/6/26 at 12:30 P.M., the resident lay in his/her bed awake. Both assist rails were up. 2. Review of Resident #33's quarterly MDS completed by facility staff, dated 4/13/26, showed:-Intact cognition;-Diagnoses included depression, anxiety disorder, asthma, other orthopedic conditions, and peripheral vascular disease (PVD, poor circulation). Review of the resident's care plan, in use during survey, showed use for assist and/or enabler rail(s) not documented. Review of the resident's medical record, showed the following:-admission date of 12/24/25;-readmission date of 1/23/26.-Additional diagnoses of major depressive disorder, hypothyroidism (the thyroid is not making (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	enough thyroid hormone), and atrial fibrillation (A-Fib, irregular heart rhythm);-No physician order for assist rails for the resident;-No bed rail assessment. Observations of the resident and the resident's room showed:-On 5/4/26 at 8:56 A.M., the resident lay in his/her bed awake. out of the room. Both assist rails were up;-On 5/5/26 at 1:13 P.M., the resident in his/her bed awake, in his/her room, eating lunch. Both assist rails were up;-On 5/6/26 at 5:44P.M., the resident lay in his/her bed awake. Both assist rails were up. 3. During an interview on 5/7/26 at 11:40 A.M., the Director of Nursing (DON) said it was her expectation that bed rail assessments should have been done for any residents with assist rails or bed rails, and there should also be physician orders for the assist rails. They want the rails to be assistive and not restraints because they don't want the rails to restrict the residents' movements. She wasn't sure if the rails had come with the beds when the beds were ordered or if they were installed when the beds came.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure that the physician provided responses to pharmacist recommendations for three sampled residents (Residents #43, #33, and #4). The sample was 16. The census was 53.Review of the facility's Medication Regimen Review policy, effective August 2020, showed:-Purpose: -The consultant pharmacist performs a comprehensive review of each resident's medication regimen and clinical record at least monthly. The medication regimen review (MRR) includes evaluating the resident's response to medication therapy to determine that the resident maintains the highest practicable level of functioning and preventing or minimizing adverse consequences related to medication therapy. The MRR also involves a thorough review of the resident records and may include collaboration with other members of the interdisciplinary team, collaboration with the resident, family members, or other resident representatives. MRR also involves reporting of findings with recommendations for improvement. All findings and recommendations are reported to the Director of Nursing, the Attending Physician, the Medical Director, and the Administrator or in accordance with facility policy; -Policies and procedures developed by the contracted consultant pharmacist services and facility supersede procedures outlined in this policy;-Procedures: -The consultant pharmacist reviews the medication regimen of each resident at least monthly. A more frequent review may be deemed necessary if, for example, the medication regimen is thought to contribute to an acute change in status or adverse consequence or the resident is not expected to stay 30 days; -The findings are phoned, faxed, or e-mailed within 24 hours, or in accordance with facility policy, to the Director of Nursing or designee and are documented and stored with the other consultant pharmacist recommendations in the resident's active record; -The prescriber is notified if needed; -The consultant pharmacist identifies irregularities through a variety of sources including the resident's clinical record, pharmacy records, and other applicable documents. The facility shall make available to the consultant pharmacist all appropriate records. In addition to review pharmacy and clinical records (such as medication administration records (MARs), prescriber's orders, progress notes of prescribers. nurses, and or consultants, the Resident Assessment Instrument (RAI), laboratory and diagnostic test results, and behavior monitoring information), the consultant pharmacist may need to interview the facility staff, the attending physician, and the resident; -Resident-specific irregularities and/or clinically significant risks resulting from or associated with medication are documented in the resident's active record and reported to the Director of Nursing, Medical Director, and/or prescriber as appropriate. -Notification mode is dependent on severity of irregularity and is determined through consultation between consultant pharmacist and the Director of Nursing. -If no irregularities are found, the consultant pharmacist also documents this in the resident's active record and signs and dates such documentation; -If a continuing irregularity is deemed to be clinically insignificant or evidence of a valid clinical reason for rejecting the recommendation is provided, the consultant pharmacist will reconsider whether to report the irregularity again or make a new recommendation on an annual basis; -Recommendations are acted upon and documented by the facility staff and/or the prescriber; -The prescriber accepts and acts upon recommendation or rejects provides an explanation for disagreeing; -If there is a potential for serious harm and the attending physician or prescriber does not concur, or refuses to document an explanation for disagreeing, the Director of Nursing and the consultant pharmacist will contact the medical director. If the attending physician who disagrees is also the medical director, the consultant pharmacist and the Director of Nursing arrange a meeting with the medical director to discuss the issues. All parties must come to agreement or a formal complaint should be initiated according to facility policy. If there is potential for serious harm to the resident, this process must be completed in a manner to ensure no actual harm occurs; -At least monthly, the consultant pharmacist reports any irregularities to the attending (continued on next page)

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Monarch Springs Wellness & Rehabilitation	894 Leland Avenue University City, MO 63130

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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 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	physician, medical director, and director of nursing, at a minimum. 1. Review of Resident #43's admission Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 2/9/26, showed:-Intact cognition;-Diagnoses include depression, anxiety disorder, asthma, and malnutrition. Review of the resident's care plan, in use during survey, showed-Focus: The resident requires antidepressant and hypnotic medication Fluoxetine HCl and Ramelteon for diagnoses of major depressive disorder and insomnia and for sleep;-Goal: The resident will be free from discomfort or adverse reactions related to antidepressant therapy through the review date;-Interventions: Give antidepressant medications ordered by physician. Monitor/document side effects and effectiveness. Antidepressants side effects: Dry mouth, dry eyes, constipation, urinary retention, suicidal ideations. Monitor/document/report to Physician as needed (PRN) ongoing signs and symptoms (s/sx) of depression unaltered by antidepressant meds: Sad, irritable, anger, never satisfied, crying, shame, worthlessness, guilt, suicidal ideations, negative mood/comments, slowed movement, agitation, disrupted sleep, fatigue, lethargy, does not enjoy usual activities, changes in cognition, changes in weight/appetite, fear of being alone or with others, unrealistic fears, attention seeking, concern with body functions, anxiety, constant reassurance. Psychiatric evaluation and treat.-The care plan did not address drug regimen review or monitoring of any medications. Review of the resident's medical record, showed the following:-admission date of 1/29/26;-readmission date of 3/6/26;-Additional diagnoses of dystonia (a syndrome of abnormal muscle contraction that produces repetitive involuntary twisting movements and abnormal posturing of the neck, trunk, face, and extremities), hallucinations (false or distorted sensory experiences that appear to be real perceptions), anemia, and rhabdomyolysis (an acute, fulminating, potentially fatal disease of skeletal muscle that entails destruction of muscle);-A monthly medication review (MMR), dated 3/29/26 showed the resident was taking Diazepam 5 milligrams (mg) (anti-anxiety) medication every eight hours on a PRN basis for anxiety; -Per regulatory guidelines, the duration of treatment with such medications on a PRN basis should be limited to 14 days, however, a new order may be written to extend the duration beyond 14 days if the prescriber believes it is appropriate;-The MMR dated 3/29/26 showed the Pharmacist recommendation to please evaluate the continued need for this medication. If it is to be extended, please document the rationale for the extended time period in the medical record and indicate a specific duration: -Discontinue Order; -Extend for _____ Days. Review of the resident's medical record showed:-No documentation of the physician's rationale for the extended time period for the medication;-No documentation of the physician's response to the MMR, dated 3/29/26. 2. Review of Resident #33's medical record, showed the following:-admission date of 12/24/25;-readmission date of 1/23/26.-Diagnoses included major depressive disorder, hypothyroidism (the thyroid is not making enough thyroid hormone), and atrial fibrillation (A-Fib, irregular heart rhythm). Review of Resident #33's quarterly MDS, dated [DATE], showed:-Intact cognition;-Diagnoses included depression, anxiety disorder, asthma, other orthopedic conditions, and peripheral vascular disease (PVD, poor circulation). Review of the resident's care plan, in use during survey, showed:-Focus: The resident is on anticoagulant therapy Enoxaparin related to unspecified atrial fibrillation;-Goal: The resident will be free from discomfort or adverse reactions related to anticoagulant use through the review date;-Interventions: Labs as ordered. Report abnormal lab results to the Physician. Monitor/document/report to Physician PRN s/sx of anticoagulant complications: blood tinged or frank blood (clearly visible) in urine, black tarry stools, dark or bright red blood in stools, sudden severe headaches, nausea, vomiting, diarrhea, muscle joint pain, lethargy, bruising, blurred vision, shortness of breath (SOB), loss of appetite, sudden changes in mental status, significant or sudden changes in vital signs (v/s). Review medication list for adverse interactions. Avoid use of aspirin or non-steroidal anti-inflammatory drugs (NSAIDS). -Focus: The resident requires anticonvulsants and opioids (a type of pain medication) for acute and chronic pain r/t neuropathy (nerve damage), left knee effusion (excess fluid) and rheumatoid arthritis (RA);-Goal: The resident will not have an interruption in normal activities due to pain through the review date;-Interventions: (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Anticipate the resident's need for pain relief and respond immediately to any complaint of pain or discomfort. Notify physician if interventions are unsuccessful or if current complaint is a significant change from residents past experience of pain. Observe and report changes in usual routine, sleep patterns, decrease in functional abilities, decrease range of motion (ROM), withdrawal or resistance to care. The resident is able to call for assistance when in pain, reposition self, ask for medication, tell you how much pain is experienced, tell you what increases or alleviates pain. -Focus: The resident requires antidepressant medication Lexapro 10 mg and Trazodone 50mg for diagnosis of depression;-Goal: The resident will be free from discomfort or adverse reactions related to antidepressant therapy through the review date;-Interventions: Monitor/document/report to Physician PRN ongoing s/sx of depression unaltered by antidepressant meds: Sad, irritable, anger, never satisfied, crying, shame, worthlessness, guilt, suicidal ideations, neg. mood/comments, slowed movement , agitation, disrupted sleep, fatigue, lethargy, does not enjoy usual activities, changes in cognition, changes in weight/appetite, fear of being alone or with others, unrealistic fears, attention seeking, concern with body functions, anxiety, constant reassurance. -The care plan did not address drug regimen review or monitoring of any medications. Review of the resident's medical record showed:-A monthly MMR, dated 3/29/26, showed the Pharmacist recommendation to consider discontinuing the PRN orders for cyclobenzaprine (muscle relaxer, Flexeril) 10 mg every eight hours and tizanidine (short-acting muscle relaxer) 4 mg every six hours, as neither muscle relaxant has been utilized since his/her admission on [DATE]; this will reduce the risk of central nervous system (CNS) depression and potential polypharmacy. Review of the resident's medical record showed:-No documentation of the physician's response to the MMR, dated 3/29/26. 3. Review of Resident #4'significant change MDS, dated [DATE], showed:-Moderate impaired cognition;-Diagnoses included depression, dementia, stroke, psychotic disorder, anxiety disorder, coronary artery disease (CAD, narrowing or blockage of the arteries and vessels that provide oxygen and nutrients to the heart), Parkinson's disease (a disorder of the brain that leads to tremors, difficulty with walking, movement and coordination), and hyperlipidemia (high cholesterol). Review of the resident's care plan, in use during survey, showed:Focus: The resident requires Duloxetine HCl Oral Capsule Delayed Release Sprinkle 30 mg for diagnosis of major depressive disorder;-Goal: He/She will be/remain free of drug related complications, including movement disorder, discomfort, hypotension, gait disturbance, constipation/impaction or cognitive/behavioral impairment through review date;-Interventions: Administer medications as ordered. Monitor/document for side effects and effectiveness. Discuss with Physician, family regarding ongoing need for use of medication. Educate the resident/family about risks, benefits and the side effects and/or toxic symptoms of psychoactive medication drugs being given. Monitor/record occurrence of target behavior symptoms pacing, wandering, disrobing, inappropriate response to verbal communication, violence/aggression towards staff/others. etc.) and document per facility protocol. Monitor/record/report to Physician PRN side effects and adverse reactions of psychoactive medications: unsteady gait, tardive dyskinesia (abnormal movements due to anti-psychotic medications), EPS (shuffling gait, rigid muscles, shaking), frequent falls, refusal to eat, difficulty swallowing, dry mouth, depression, suicidal ideations, social isolation, blurred vision, diarrhea, fatigue, insomnia, loss of appetite, weight loss, muscle cramps nausea, vomiting, behavior symptoms not usual to the person.-The resident's care plan did not address drug regimen review or monitoring of any medications. Review of the resident's medical record, showed the following:-admission date of 8/23/23;-readmission date of 1/31/26;-A monthly MMR, dated 1/29/26, showed to please note per Center for Medicare & Medicaid Services (CMS) requirements, the use of psychotropic medications are confined to limited duration of use without reassessment of a gradual dose reduction or discontinuation.-The resident has been receiving Duloxetine 30 mg two times a day since 5/2025. An evaluation for gradual dose reduction should be documented at this time. If gradual dose reduction is contraindicated, please review the following and check if appropriate: - _____ The resident's target symptoms returned or worsened after the most recent attempt at tapering dose; (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-_____ Past reduction attempts have resulted in problematic behavior and/or staff inability to provide care; -_____ Past reduction attempts have resulted in psychiatric instability by exacerbating an underlying medical or psychiatric disorder. -_____ Past reduction attempts have caused the resident to pose danger to self or others. Review of the resident's medical record showed:-Nothing marked on the MMR dated 1/29/26 to indicate if an evaluation for the gradual dose reduction and/or if a gradual dose reduction had been completed or not;-No documentation of the physician's response to the MMR, dated 1/29/26. 4. During an interview on 5/7/26 at 11:40 A.M., the Director of Nursing (DON) said she would expect for the Physician to document a response to the Pharmacist recommendation and/or to document a rationale if they decide not to follow the pharmacist's recommendation. She usually did audits to follow up to ensure Physician responses to the monthly medication recommendations were done. It was expected for gradual reductions to be made and/ or evaluated. Once indicated, it was her responsibility to ensure that the gradual dose reductions were evaluated and/or completed. It was also her responsibility to ensure that monthly medication reviews were acted upon.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure residents received medications as ordered by the physician. Concerns were noted when one resident's (Resident #18) blood pressure was not taken prior to the administration of an anti-hypertensive (blood pressure) medication and when one resident's (Resident #10) medication was dropped on the floor and unable to be replaced from the medication cart. The medication error rate was 5.41%, with concerns noted with two of 37 observed medications administered. The sample size was 16. The census was 58.Review of the facility's Medication Administration policy, with no revision or implementation date listed, showed:-Medication will be administered by a licensed nurse per the order of an attending physician or licensed independent practitioner, or as consistent with state law;-Tests and taking vital signs (measurements of a person's bodily function), upon which administration of medications or treatments are conditioned, may be performed as required by state law, and the results recorded;-When administration of the drug is dependent upon vital signs or testing, the vital signs or testing will be completed prior to administration of the medication and recorded in the medical record;-Medications will not be left at the bedside. 1. Review of resident #18's admission MDS (Minimum Data Set, a federally mandated assessment instrument completed by facility staff), dated 5/5/26 showed:-The resident is cognitively intact;-Medical diagnoses including congestive heart failure (a chronic condition in which the ventricles of the heart are unable to pump blood effectively to the body), hypertension (high blood pressure), Urinary Tract Infection (UTI, an infection in the urine causing damage to the kidneys and altered mental status), and Type I Diabetes. Review of the resident's physician orders, active through the survey, dated May 2026, showed an active order for Losartan Potassium Oral Tablet 25 milligrams (mg) (a prescription oral medication used primarily to treat high blood pressure, reduce stroke risk in patients with heart enlargement, and manage kidney disease in type 2 diabetics), with instructions to give one tablet by mouth one time a day related to hypertension. Observation on 5/5/26 at 8:35 A.M., during the morning medication pass, showed CMT (Certified Medication Technician) G entered the resident's room to provide morning medications, including losartan. The medication cup was handed to the resident, who took the medications with water and without issue. CMT G then applied an automatic blood pressure cuff to the resident's left arm to obtain the resident's blood pressure. 2. Review of resident #10's quarterly MDS, dated [DATE] showed:-The resident is cognitively intact;-Med Diagnoses including stroke, hypertension, hemiplegia (loss of motor function and feeling in half of the extremities), malnutrition (a chronic lack of nutritional intake leading to weight loss, weakness, and fatigue), and Chronic Obstructive Pulmonary Disease (COPD, a chronic narrowing of the airways leading to shortness of breath, fatigue, and low blood oxygen levels). Review of Resident #10's active physician orders, dated May 2026, showed an active order for gabapentin 100mg (a prescription medication used to control partial seizures in epilepsy, treat nerve pain, and manage restless legs syndrome) capsules with orders for one tablet to be given three times daily with meals. Observation on 5/5/26 at 8:41 A.M., during the morning med pass, showed CMT G entered the resident's room to provide morning medications, including gabapentin. While taking the administered oral medications the resident dropped the gabapentin capsule on the floor. CMT G retrieved the capsule from the floor and wasted the medication as it was no longer clean per infection control policy. After returning to the cart, CMT G said the medication was not available, as the capsule provided to the resident was the last capsule in the medication card. No additional medication card for gabapentin was found, and none had been indicated as reordered in the system. During the observation, CMT G said the facility CMTs were expected to order a refill of a resident's medication when three days were left on the medication card to avoid missed doses. 3. During an interview on 5/7/26 at 8:31 A.M. RN (Registered Nurse) D said vital signs should be taken prior to the administration of medications that would reduce blood pressure or alter insulin (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	levels. Staff was expected to refill a medication three to four days prior to giving the last dose from a medication card to avoid missed doses due to accident. 4. During an interview on 5/7/26 at 1:37 P.M. the facility Administrator and Director of Nursing (DON) said CMTs were expected to refill a resident's medication three to four days prior to giving the last dose from a medication card to avoid residents missing a dose of a medication due to unforeseen circumstances like dropping a medication on the floor. When administering antihypertensive medications staff should have taken a resident's blood pressure prior to administering the medication to avoid unexpected hypotension.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview, and record review, the facility failed to properly store medications and biologicals in facility medication rooms. Concerns were noted when 17 bags of intravenous antibiotics were noted in one of two facility medication rooms. The sample size was 16. The census was 53.Review of the facility's Storage of Medications policy, revised 9/2018, showed:-Only licensed nurses, pharmacy personnel, and those lawfully authorized to administer medications (such as medication aides) are permitted to access medications. Medication rooms, carts, and medication supplies are locked when they are not attended by persons with authorized access;-Except for those requiring refrigeration or freezing, medications intended for internal use are stored in a medication cart or other designated area;-Outdated, contaminated, or deteriorated medications and those in containers that are cracked, soiled, or without secure closures are immediately removed from inventory, disposed of according to procedures for medication disposal, and reordered from the pharmacy if a current order exists. 1. Observation on 5/7/26 at 7:58 A.M. of the third-floor medication storage room, behind the nurse's station, showed:-Six bags of 100 milliliters (mL) normal saline solution for dilution of 2gm (grams) of intravenous cefepime (a broad-spectrum cephalosporin antibiotic used to treat moderate to severe bacterial infections) prescribed for a resident, expired as of 2/7/26;-Six bags of 100mL normal saline solution for dilution of 2gm of intravenous cefepime prescribed for a resident, expired as of 2/24/26;-Five bags of 200 mL normal saline solution for dilution of 100mg of intravenous vancomycin (powerful glycopeptide antibiotic used to treat severe, resistant gram-positive bacterial infections) prescribed for a resident, expired as of 3/1/26. 2. During an interview on 5/7/26 at 8:27 A.M., CMT (Certified Medication Technician) E said no facility staff member was primarily responsible for ensuring medications were removed or wasted when expired, but each CMT or nurse was expected to remove or waste medications if they were noted as expired. Facility staff was expected to remove or waste medications per policy, and the facility pharmacy partner came a couples times per week to remove or waste medications as necessary. During an interview on 5/7/26 at 8:31 A.M., RN (Registered Nurse) D said no member of the nursing staff routinely went through the third-floor medication room, and most of the facility's stock medications were kept in the second-floor central supply room. Facility administration would expect staff to remove or waste medications if noted during medication administration or seen while in a medication storage room. No one member of the nursing staff was responsible for ensuring medications were wasted per facility policy. The facility had a pharmacy partner that came on a weekly basis to remove and/or waste expired medications. 3. During an interview on 5/8/26 at 1:37 P.M., the facility Administrator and Director of Nursing (DON) said they would have expected staff to waste or remove expired medications. The resident with the expired medication had changes to his/her medication treatment for an infection, including the completion of rounds of antibiotic therapy. Staff was expected to remove or waste expired medications, and the facility pharmacy partner came twice daily to provide medication wasting and removal services.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to follow acceptable standards of practice for infection control when staff failed to use Enhanced Barrier Precautions (EBP, precautions for use during high-contact resident care activities to reduce transmission of multidrug-resistant organisms (MDROs, microorganisms that are resistant to one or more classes of antimicrobial agents) as recommended by the Centers for Disease Control and Prevention (CDC) and as required by the Centers for Medicare and Medicaid Services (CMS) when staff failed to wear a gown and glove while providing direct care to one resident (Resident #9) and by failing to ensure appropriate personal protective equipment (PPE) was easily accessible by the room of one resident (Resident #33) with physician orders for EBP. The sample was 16. The census was 58. Review of the facility's Standard and Enhanced Precautions policy, revised 4/1/24, showed:-EBP should be used for any residents who meet the following criteria, wherever they reside in the facility. The facility has discretion in using EBP for residents who do not have a chronic wound or indwelling medical device and are infected or colonized with a MDRO that is not currently targeted by CDC;-For residents whom EBP are indicated, EBP should be used when performing the following high contact resident care activities: Dressing, bathing/showering, transferring, providing hygiene, changing linens, changing briefs or assisting with toileting, device care or use, and wound care;-EBP are intended to be in place for the duration of a resident's stay in the facility or until resolution of the wound or discontinuation of the indwelling medical device that placed them at high risk. 1. Review of Resident #9's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 4/13/26, showed:-Cognitively impaired;-Diagnoses included presence of a gastrostomy tube (g-tube, a surgical line inserted into the stomach to provide nutrition and medication). Review of the resident's care plan, in use at the time of survey, showed:-Focus: EBP;-Goal: Reduce transmission of pathogens;-Interventions included instructions for direct care staff to utilize gowns and gloves when providing any direct care and to educate the resident of responsible party on the requirements of EBP. Review of the resident's electronic physician order sheet (ePOS), showed no active order for EBP related to the resident's g-tube. Observation on 5/5/26 at 12:51 P.M., showed staff assisted the resident with eating lunch. At the conclusion of the meal, the resident was wheeled back to his/her room in a Broda chair (reclining chair) by CNAs Certified Nurse Aide (CNA) H and CNA I. CNA H and CNA I assisted the resident from the Broda chair into bed and covered him/her with the bed sheets. Neither CNA donned PPE prior to providing direct care to the resident. Observation on 5/6/26 at 8:23 A.M., showed CNA H and CNA I assisted the resident with transferring from the Broda chair to the bed after the breakfast meal. Neither CNA donned PPE prior to providing direct care to the resident. 2. Review of Resident #33's quarterly MDS, dated [DATE], showed:-Cognitively intact;-Diagnoses included depression, anxiety disorder, asthma, other orthopedic conditions, and peripheral vascular disease (PVD, poor circulation). Review of the resident's care plan, in use during survey, showed:-Focus: EBP related to having open active wounds, infectious disease;-Goal: Reduce transmission of pathogens;-Interventions: Staff members will wear clean gowns and gloves while performing high contact resident care activities to include dressing, bathing/showering, transferring, providing hygiene, changing linens, changing briefs or toileting assistance, and/or caring for indwelling medical. Staff to follow standard precautions. Review of the resident's ePOS, dated 3/5/26, showed:-An order, dated 1/23/26, for contact isolation precautions due to vancomycin (an antibiotic)-resistant enterocci (VRE, a bacteria resistant to vancomycin). Resident resides in a single occupancy room with all meals, medications, activities, activities of daily living (ADLs) and therapy provided in room. Residents have active infection with highly transmissible/epidemiological significant pathogens acquired by physical contact/airborne/droplet transmission. The resident must remain in a private room for duration of isolation every shift;-An order, dated 3/17/26, for EBP related (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	to wounds: Staff members will wear a clean gown and gloves while performing high contact resident care activities to include: dressing, bathing/showering, transferring, providing hygiene, changing linens, changing briefs or toileting assistance, and/or caring for indwelling medical devices every shift; -An order, dated 2/5/26, for left lateral (to the side), posterior (to the back) calf venous insufficiency ulcer (ulcer that develops when the veins fail to return blood back toward the heart normally: Cleanse wound with normal saline (NS), pat dry. Apply calcium alginate with silver (provides a moist environment for wound healing), superabsorbent dressing, and wrap with kerlix (gauze bandage) as needed if soiled, dislodged, or saturated;-An order, dated 3/12/26, right anterior (to the front) groin surgical dehiscence (surgical incision opens after surgery) wound: Dressing daily every 24 hours as needed for wound care;-An order, dated 3/12/26, right anterior groin surgical dehiscence wound: Dressing daily every night shift every Tuesday, Thursday, and Saturday for wound care; -An order, dated 4/17/26, right anterior groin surgical dehiscence wound: Cleanse with NS, pat dry, apply calcium alginate and cover with superabsorbent dressing every night shift for wound treatment. Observations of the resident and the resident's room on 5/4/26 at 8:56 A.M., 5/5/26 at 1:13 P.M., and 5/6/26 at 1:01 P.M., showed the resident in his/her room. An EBP sign on the door to the resident's room. No PPE near the door to the resident's room; the resident lay in his/her bed. 3. During an interview on 5/8/26 at 8:12 A.M., CNA F said residents with g-tubes, wounds, colostomies, COVID, or residents who are coming from the hospital are put on EBP. Staff should wear PPE when providing care such as feeding, perineal care, or getting residents up out of bed. When transferring a resident, staff are expected to wear a gown and gloves for personal protection, if the resident is on EBP. 4. During an interview on 5/8/26 at 8:18 A.M., Licensed Practical Nurse (LPN) A said any resident with a g-tube, open wounds, catheters, or tracheostomy should have active EBP orders adhered to by staff. Any resident care involving direct contact by staff requires staff to don PPE, including gown and gloves. 5. During an interview on 5/8/26 at 1:37 P.M., the Director of Nursing (DON) and Administrator said they expected staff to adhere to facility policy and EBP guidelines by using PPE as appropriate for a resident's diagnosis when providing care that includes direct contact with the resident. Staff should wear the PPE provided in the halls when providing direct care. Any resident with EBP orders should have PPE materials at or near the door to the room for staff to access when providing care. The DON would not expect staff to utilize PPE when transferring a resident from the wheelchair to the bed.

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F 0574 Level of Harm - Potential for minimal harm Residents Affected - Many	The resident has the right to receive notices in a format and a language he or she understands. Based on observation, interview and record review, the facility failed to provide accessible information on the location of the State Long-Term Care Ombudsman program or the State Survey Agency hotline number that was readily available to residents in the facility without assistance. The census was 53.Observation on 5/4/26, 5/5/26, 5/6/26, and 5/7/26, showed no posted information for the State Long-Term Care Ombudsman program or the State Survey Agency hotline number in the facility entrances, dining room, and halls of each unit. During a group interview on 5/6/26 at 11:30 A.M., nine out of nine residents said they did not know where the information regarding the State Long-Term Care Ombudsman program and/or the State Survey Agency hotline number was located. During an interview on 5/7/26 at 1:30 P.M., the Administrator said the contact information for the Ombudsman and State Survey Agency information was posted on a sheet of paper across from the elevator. There was a white 8 x11 inch sheet of paper posted observed when exiting the elevator. Observation and interview on 5/7/26 at 2:02 P.M., showed a white sheet of paper across from the first-floor elevator. There were several contact numbers listed on the paper. The Administrator said the Resident's Rights could have been removed from the area, but it was in the admission packet. He would have expected the information to have been posted.