STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265833	A. Building B. Wing	01/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Grove at Kirkwood, The	711 South Kirkwood Road Kirkwood, MO 63122

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 ensure staff treated residents with dignity and in a respectful manner when staff wore earbuds while providing care for one resident (Residents #11) and one resident reported that staff frequently have earphones in (Resident #44). In addition, the facility failed to ensure all residents were served meals on reusable dishware and utensils instead of Styrofoam. The sample was 21. The facility census was 91.Review of the facility's Resident Rights policy, reviewed 7/1/25, showed the facility shall treat residents with kindness, respect, dignity, and ensure residents rights are being followed. The resident/resident representative will be informed of their rights upon admission. Review of the facility's employee handbook, undated, showed non-negotiable expectations: Use of cell phones for any purpose in any resident care areas including resident rooms, halls, nurse's stations and common areas is strictly prohibited. Cell phones are not to be heard or seen in these areas. This is the same expectation with headphones and/or Bluetooth devices. 1. Review of Resident #11's quarterly Minimum Data Set (MDS), a federally mandated assessment tool completed by facility staff, dated 1/6/25, showed:-Severe cognitive impairment;-Dependent on staff for personal hygiene and toilet hygiene;-Required maximum assistance from staff for dressing lower and upper body;-Diagnoses included dementia, heart disease, and heart failure. Observation on 1/26/26 at 8:26 A.M., showed Licensed Practical Nurse (LPN) Y walked down the 200 hall with earphones in his/her ears, attached to his/her phone. LPN Y entered the resident's room with the earphones in his/her ears. Music could be heard coming from the earphones approximately six feet away. LPN Y changed the resident's brief, dressed the resident, and assisted the resident to the wheelchair while LPN Y had earphones his/her ears, connected to his/her phone, and playing music. During an interview on 1/26/26 at 8:37 A.M., Resident #44 said staff are always on the phone when providing care. You can also see the earbuds in their ears. During an interview on 1/28/26 at 2:16 P.M., Certified Nursing Assistant (CNA) NN said cell phone use was not allowed in any resident care areas or when providing care to the residents. Earphones and earbuds are not allowed to be worn by staff. Staff should not be listening to music on their phones when providing care. During an interview on 1/29/26 at 1:41 P.M., Administrator B and Director of Nursing (DON) C said it was expected that employee cell phones were not seen or used while on duty for any reason. Having music playing through earphones while providing care to a resident was not acceptable. 2. Review of the facility's resident council minutes, dated 11/26/25, showed residents in attendance requested regular plates and bowls at meals, not plastic or Styrofoam. Review of the facility's resident council minutes, dated 12/29/25, showed residents in attendance requested to speak with the Administrator/Executive Directive and owners of the management company. The meeting was adjourned after speaking with the residents about re-scheduling to speak with the owners. During an interview on 1/22/26 at 11:51 A.M., Dietary Aide U said the facility had not had the chemicals required to wash dishes in the dish machine for about two months. During an interview on 1/22/26 at 11:59 A.M., the Dietary (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Manager said the dish machine worked, but it did not have soap or rinse. It had been out for over a month. The new owners did not want to use a particular brand of chemicals because it was too expense, so they needed a new dispenser. Staff were washing dishes by hand. Observation on 1/22/26 at 12:43 P.M., showed the Assistant Dietary Manager plated the residents' food on Styrofoam plates and covered the plates with plastic lids. During an interview on 1/22/26 at 4:19 P.M., Administrator A said corporate ordered a new soap dispenser. They wanted cheaper products for dish machines. There was a monthly fee for the previous supplier, so they were changing the vendor. During an interview on 1/23/26 at 1:12 P.M., CNA V said they were on a tight budget. The residents went from using plastic cups to foam cups. During the resident council meeting on 1/26/26 at 11:20 A.M., five out of five residents, who represented the resident council, said the dishwasher had been broken for at least a month. When the residents started getting plastic cutlery, they knew the dishwasher was broken. They preferred to use normal dishes and silverware. They did not feel like plastic cutlery was homelike. During an interview on 1/28/26 at 10:45 A.M., the Regional Nurse Consultant said the facility ordered from a platform that picked whatever was the cheapest. During an interview on 1/28/26 at 1:43 P.M., Administrator B said he/she was not aware the residents used Styrofoam plates and cups instead of reusable dishware. He/She was not privy to that information, but it was not appropriate to suspend using the dish machine due to not purchasing sanitizer and rinse. He/She was not aware the dish machine was previously not in use. 3. During an interview on 1/28/26 at 1:43 P.M., Administrator B said he/she expected all residents to be treated with dignity and respect. 271280926979122705399268616226837542724850

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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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide reasonable accommodation of individual needs and preferences by failing to ensure call lights were in reach for two residents (Resident #95 and Resident #11) and failing to repair a shower in the 200 hall shower room timely, requiring one resident to go to another shower room that was located further from his/her room (Resident #44). The sample was 21. The census was 91. Review of the facility's Call Lights: Accessibility and Timely Response policy, dated 7/1/25, showed:-The purpose of this policy is to assure the facility is adequately equipped with a call light at each residents' bedside, toilet, and bathing facility to allow residents to call for assistance. Call lights will directly relay to a staff member or centralized location to ensure appropriate response;-All staff will be educated on the proper use of the resident call system, including how the system works and ensuring resident access to the call light;-Each resident will be evaluated for unique needs and preferences to determine any special accommodations that may be needed in order for the resident to utilize the call system;-Staff will ensure the call light is within reach of resident and secured, as needed;-The call system will be accessible to residents while in their bed or other sleeping accommodations within the resident's room. 1. Review of Resident #95's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 11/3/25, showed:-Severe cognitive impairment;-Diagnoses included Alzheimer's disease. Review of the resident's medical record, showed additional diagnoses of osteoarthritis (condition caused by wear and tear of the joints causing loss of range of motion and pain with movement), and insomnia. Review of the resident's care plan, in use during the survey, showed:-Problem: At risk for falls due to gait disturbance, diagnosis of Alzheimer's disease, and periodic poor decision making;-Goal: Resident will be free of falls;-Approach: Encourage the resident to utilize staff assistance with transferring and use of call light for assistance. Observations of the resident in his/her room showed:-On 1/26/26 at 1:29 P.M., the resident seated in his/her recliner. The call button wrapped around the bed rail at the top of the resident's bed. During an interview, the resident said he/she wanted to go to bed but the call button was not within his/her reach; -On 1/16/26 at 4:22 P.M., the resident seated in his/her recliner. The call button wrapped around the bed rail at the top of the resident's bed out of his/her reach;-On 1/27/26 at 9:06 A.M. and 11:12 A.M., the resident seated in his/her recliner. The call button wrapped around the bed rail at the top of the resident's bed out of his/her reach;-On 1/28/26 at 8:39 A.M., the resident seated in his/her recliner. The call button lay under the pillow on the resident's bed out of the resident's reach. During an observation and interview on 1/28/26 at 8:46 A.M., Certified Nurse Assistant (CNA) XX said the resident was able to work his/her call button and was very competent. He/She should have had his/her call light within reach. When the resident wanted to be put to bed, he/she used the call button. During an interview on 1/28/26 at 11:41 A.M., Licensed Practical Nurse (LPN) WW said the resident was able to use his/her call button. The call button should be within his/her reach and accessible to him/her. 2. Review of Resident #11's quarterly MDS, dated [DATE], showed:-Severe cognitive impairment;-Dependent on staff for personal hygiene and toilet hygiene;-Diagnoses included dementia, heart disease, and heart failure. Review of the resident's care plan, in use at the time of survey, showed:-Problem: The resident at risk for falls related to impaired mobility and altered mental status;-Intervention: Keep call light in reach at all times. Observation on 1/22/26 at 8:20 A.M., and on 1/26/26 at 8:26 A.M., showed the resident lay in bed. The call light positioned on the floor, behind the headboard. 3. During an interview on 1/29/26 at 10:15 A.M., CNA PP said call lights were to be positioned within the resident's reach, no matter the (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	resident's cognition status. During an interview on 1/29/26 at 1:43 P.M., Director of Nursing (DON) C said call lights were to be within the resident's reach at all times, no matter what the cognition status. 4. Review of Resident #44's quarterly MDS, dated [DATE], showed:-Cognitively intact;-Dependent on staff for showering and bathing. Review of the resident's medical record, showed diagnoses included arthritis and spinal stenosis (narrowing of the spaces of the spin, causing pain). Observations on 1/22/26 at 9:40 A.M., 1/23/26 at 7:36 A.M. and 12:35 P.M., and 1/26/26 at 8:45 A.M. showed a sign in the 200 hall shower room near in the shower stall that read, Please do not use shower. During an interview on 1/22/26 at 9:30 A.M., the resident said he/she did not have a bathroom in his/her room. The resident said he/she propelled him/herself in his/her wheelchair to the 200 hall shower room to use the bathroom. He/She could not take a shower in the 200 hall shower room because it was broken. It had been broken for over a month. The resident had to go to another shower room located further down the hall. He/She usually could not propel him/herself to the shower room located further away and required assistance from the staff. During an interview on 1/27/26 at 10:12 A.M., Maintenance Associate E said the shower had been broken for about a month. When the shower was turned on, it leaked into the lobby below. During an interview on 1/28/26 at 1:09 P.M., CNA CCC said the shower in the shower room on 200 hall should have been fixed because it was inconvenient for the residents to go further down the hall. During an interview on 1/29/26 at approximately 12:30 P.M., the Maintenance Director said he was aware of the broken shower in the 200 hall shower room. It had been broken for about a month. He had not gotten around to fixing it. During an interview on 1/29/26 at 1:43 P.M., Administrator B said he/she was not aware that the shower on the 200 hall was broken and it should be fixed immediately. The residents should have a shower that is easily accessible to them. 26883552727896

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F 0568 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Properly hold, secure, and manage each resident's personal money which is deposited with the nursing home. Based on interview and record review, the facility failed to implement a process to ensure refundable resident deposits were identified and returned upon discharge. This deficiency had the potential to affect recently discharged residents, which included one resident (Resident #129). The resident sample was 21. The census was 91. Review of the facility's admission agreement under the previous management company, revised on 3/22/23, showed:-To reserve a room, I agree to pay in advance: -A $6,000 interest free security deposit, which is refunded within 45 days after discharge, less balances from Medicare, insurance and hospice companies. The deposit is viewed as an asset by Medicaid and must be applied toward monthly charges to quality for Medicaid. The monthly charge for room and board starts the first day a bed is held in reserve. If the resident passes away before the admission, charges will be assessed for every day the room was held in reserve. Review of the Facility's current admission agreement, received 1/23/26, showed: -Nursing Facility, Financial, and Resource Agreement: -Receipt of Agreement: Resource hereby acknowledges that Resource has received a complete copy of the Agreement, together with all Exhibits thereto;-Disclosure of Income and Resources: Resources hereby represents and warrants that Appendix 1 which is attached to and hereby made a part of this Resource Agreement constitutes a complete, full and accurate list of all the income and other resources of resident which are known to Resource;-Payment from Resident's: Resources hereby agree to pay Facility all charges incurred by resident under the terms of the Agreement only to the extent of the income or resources of Resident;-Limitation: Nothing in this Agreement shall be interpreted to require Resource to make any payment to Facility out of the personal assets of Resource or to incur other financial liability to Facility except as provided in paragraph 3;-Miscellaneous:-Agreement: This agreement contains and merges all agreements, representations and understandings of the parties;-Headings: The headings are for convenience only. They are not a part of and shall not be used to construe this Agreement.-Notices: All notices under this Agreement shall be in writing and shall be deemed given when mailed or delivered in person to a party at the address shown above, or at another address as may be designated in writing by that party;-Missouri Agreement: This Agreement shall be interpreted and enforced under the laws of Missouri without giving effect to its conflicts of law provisions;-No documentation that addressed the previous contract, and previous deposits made under the previous management's contract/agreement. Review of Resident #129's application and invoices, received from family on 1/15/26, showed:-Date of application: 4/2/25;-Payment receipt deposit: $6,000.00; -Room and Board: $7,398.00; -Total due at signing: $13,398.00. Review of the resident's admission Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 7/5/25, showed:-Severe cognitive impairment;-Diagnoses included high blood pressure, non-Alzheimer's dementia, and asthma. Review of the resident's progress notes, showed:-On 10/29/25 at 6:00 P.M., spoke with daughter regarding resident transferring tomorrow and pick up is 10:00 A.M.;-On 10/30/25 at 10:36 A.M., resident was transported via transportation in Broda (reclining) chair via Hoyer pad (mechanical lift) at 10:10 A.M. Report was called to transferring facility at 8:30 A.M. Upon pickup resident denies complaints of pain or discomfort. Resident's daughter followed via personal transportation with resident's medications as well as residents belongings.Review of the resident's invoices, received 1/29/26, showed no documentation of a deposit of $6,000.00.During an interview on 1/28/26 at 12:59 P.M., Regional Nurse Consultant said they had a facility Business Office Manager (BOM), but their last day was yesterday. There is a corporate BOM. The Regional Nurse Consultant was unaware of the contract under the previous management company that required a deposit of $6,000 and the refund of the $6,000 upon being discharged from the facility. As a company, the new management does not (continued on next page)

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F 0568 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	require a deposit. If a resident had a $6,000 deposit and they were discharged from the facility, he would try and get that deposit back to them. They could contact the previous management company. He was not aware of the resident's situation and the attempts to refund the deposit. There was an increase of residents who were discharged , but they were admitting a lot of short-term residents. The Regional Nurse Consultant said they are still under the previous management company until the change in ownership is completed. They are still honoring the original contract. They wanted to make as few changes as possible.During an interview on 1/29/26 at 1:43 P.M., Administrator B said the funds were not turned over during acquisition. They have requested all information from the previous ownership. He/She was not aware of the deposit; however, the corporate BOM was aware. The corporate BOM put in a request to refund the deposit. 2716294

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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, interview and record review, the facility failed to provide a safe, clean, comfortable homelike environment for three residents (Residents #78, #91 and #93). The facility also failed to keep the 200 hall shower room clean and odor free. The sample was 21. The census was 91.Review of the facility's Cleaning Resident's Rooms policy, undated, showed: -Policy: -Resident rooms at the facility are maintained and cleaned on a daily and weekly schedule; -Procedure: -Daily cleaning: -Clean the bathroom; -Dust the furniture, windowsill television and pictures; -Clean chairs, tables, and handrails with disinfection spray; -Clean door know, light switches and telephone with disinfecting spray; -Sweep and mop floors. Review of the facility's Bathroom and Shower Cleaning policy, undated, showed: -Policy: The bathrooms and showers rooms are maintained in a clan and sanitary manner and are cleaned on a daily basis; -Procedure: -Daily cleaning includes: -Emptying waste cans, -Servicing toilet paper holders; - Sweeping and moping floors; -Daily cleaning and sanitizing of toilets includes: -Raise the seat and flush toilet; -With a brush, brush inside the bowl including areas under the rim; -If soiled are around the rim of bowl is not loosed, put on rubber gloves and use cleaning (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	solution to clean by hand; -Wash the outside on the toilet bowl and hinges. 1. Review of Resident #78's annual Minimum Data Set (MDS), federally mandated assessment instrument completed by facility staff dated,12/17/25, showed: -Diagnoses included acute kidney failure, major depressive disorder, and type two diabetes; -Cognitively intact. Observations on 1/22/26 at 11:21 A.M., 1/23/26 at 6:33 A.M., and 1/27/26 at 7:33 A.M., of the resident's room, showed the wall surrounding the windowsill was broken and crumbling, and outside air came through the cracks in the wall. The ceiling tile above the window was stained yellow/orange. During an interview on 1/22/26 at 11:21 A.M., the resident pointed at the window from his/her bed and said he/she could feel cold air coming from the cracked wall. He/She was unable to get out of bed without assistance and was cold due to the draft. He/She would like the stained ceiling tile replaced. During an interview on 1/29/26 at 10:18 A.M., Licensed Practical Nurse (LPN) H said the cracks in the resident's wall were not homelike. He/She expected the resident's wall to be fixed to prevent outside air from coming in the resident's room. During an interview on 1/29/26 at 2:15 P.M., Maintenance Associate E said the resident's window and wall had been in the current condition for at least two months. He/She expected the wall to be in a working condition to prevent drafts from entering the resident's room. During an interview on 1/29/26 at 2:18 P.M., the Plant Operations Manager said he was aware of the wall and window's condition. He said the wall and window should be fixed and there should not be a draft coming into the resident's room. 2. Review of Resident #91's quarterly MDS, dated , 11/3/25, showed: -admission date: 3/18/22; -readmission date: 6/6/23; -Severe cognitive impairment; -Upper/lower extremity: No impairment; -Mobility device: Wheelchair; -Dependent on staff with toileting, bathing, dressing, and transfers; -Substantial/maximal assistance from staff with personal hygiene and dressing; -Supervision or touching assistance only from staff with eating; (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Diagnoses included traumatic brain dysfunction, high blood pressure, dementia, and anxiety disorder. Observation on 1/28/26 at 11:34 A.M., showed the resident's family member showed a time stamped picture, dated for 1/26/26 at 10:13 A.M., on his/her phone. The window was opened in the resident's room, and he/she lay in bed under the cover and his/her feet were not covered. During an interview on 1/28/26 at 11:34 A.M., the resident's family member said the resident lived at the facility for the past five years. The family member was upset because he/she went to visit the resident (on 1/26/26) and found the resident's window opened. It had snowed on that previous Saturday and Sunday (1/24/26 and 1/25/26). On 1/26/26, the resident lay in bed with no socks on, and he/she was shivering and cold to the touch. The resident's tray/plate of food was wrapped with aluminum foil. The plate had mashed potatoes and gravy on it from the night before and was untouched. During an interview on 1/29/26 at 12:30 P.M., Certified Nurses Aide (CNA) XX said he/she had opened the window. He/She did not know if it was opened two minutes or twenty minutes, but he/she apologized to the resident's family member. He/She opened the window because there was a smell in the room, and it was hot. CNA XX understood why the resident's family member was upset. Staff had just cleaned up the resident prior to the family member's visit, and the resident was completely covered with one sheet and two blankets when CNA XX left the room. During an interview on 1/29/26 at 2:14 P.M., Director of Nursing (DON) C, said the resident's family member told him/her about the situation. The resident's window should not have been opened. During an interview via email on 2/5/26 at 12:09 P.M., Regional Nurse Consultant Infection Preventionist (IP) said he did not have a policy that explicitly covered safe and homelike environment. 3. Review of Resident #93's admission MDS, dated [DATE], showed: -Diagnoses included chronic kidney disease, major depressive disorder, and anxiety; -Moderately impaired cognition. Observations on 1/23/26 at 6:35 A.M., 1/26/26 at 8:43 A.M., 1/27/26 at 7:37 A.M., and 1/27/26 at 2:53 P.M., of the resident's room, showed the floors surrounding the bed were dusty and covered with a white power substance. A large wood floor board was missing under the resident's bed. The resident's fall mats were covered with food debris and trash. During an interview on 1/29/26 at 10:18 A.M., LPN H said she expected the floors in the resident's room to be clean and free from debris and trash. During an interview on 1/29/2026 at 2:04 P.M., Administrator B said he/she expected resident rooms to have clean floors. He/She expected the flooring to be intact. During an interview on 1/29/26 at 2:18 P.M., the Plant Operations Manager said he expected the floors in the residents' rooms to be cleaned by housekeeping once a day. He was aware of the flooring missing under the resident's bed. 4. Observations on 1/22/26 at 9:40 A.M., 1/23/26 at 7:36 A.M. and 12:35 P.M., and 1/26/26 at 8:45 (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A.M., showed the second-floor shower room with used briefs in trash cans with no trash liner, toilet riser seats smeared with stool and beneath the toilet riser seats, there was brown matter. There was no toilet paper in the toilet paper dispensary. The floor had puddles of clear liquid near the toilets. The shower room had a strong odor of urine. During an interview on 1/28/26 at 1:30 P.M., Housekeeper T said the shower rooms were cleaned once a day. Staff cleaned the toilets, mopped the floors, refilled the toilet paper, and emptied the trash. During an interview on 1/29/26 at 1:43 P.M., the Administrator B and DON C said the resident's shower room on the second floor should be clean, odor free and with adequate supplies. 2716875 2688456 2681691 2681713

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Grove at Kirkwood, The	711 South Kirkwood Road Kirkwood, MO 63122

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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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. Based on interview and record review, the facility failed to maintain an effective grievance process for residents and family members to voice grievances and prompt the facility to resolve grievances for one resident (Resident #44). In addition, five out of five residents who represent the resident council said the facility failed to properly follow up on grievances. The failure has the potential to affect all residents with grievances. The sample was 21. The census was 91.Review of the facility's Grievance and Missing Property policy, dated 7/1/25, showed:-Policy: Residents and resident representatives have the right to voice concerns or grievances, which affect their lives at the facility, without fear of discrimination or reprisal; All residents, resident representatives, and families also have the right to report missing items or property.-Purpose: To provide an opportunity for residents, resident representatives, and families to present concerns or grievances to the proper authorities at the facility and to receive a response;-Procedure: Grievances may be presented to any staff member. The staff member may resolve the issue immediately. If unable to resolve immediately, follow the grievance procedure; -The Administrator, Grievance Official and department heads will follow up on issues noted; -Grievances may be presented to any staff member who will then report the issue utilizing the grievance form to his/her supervisor and an Interdisciplinary Department Team (IDT) member; -The supervisor will discuss the concerns and grievances and solutions with the appropriate department; -Grievance will be shared with other involved departments as needed; -IDT members are responsible for reviewing the grievance form within 10 working days; Department heads are responsible for reviewing, signing, and forwarding the completed complaint form to the Administrator and Social Service Director (SSD); -Social Service or Grievance Official is responsible for notifying the resident's representative, and Ombudsman (a neutral resident advocate), as appropriate of resolutions. IDT members shall be responsible for notifying the resident of the resolution and indicate on the grievance form. Should resolutions not me satisfactory and or if the grievance re-occur, Social Service or the Grievance Official will notify the Administrator and schedule a meeting with the involved parties. 1. Review of Resident #44's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 1/6/26, showed the resident cognitively intact. During an interview on 1/22/26 at 9:30 A.M., the resident said he/she filed a grievance on 1/5/26 related to the shower room on the 200 hall and has not heard back from the facility regarding a resolution. He/She feels as though no one cares at the facility. Review of the facility's grievance book showed:-A grievance form dated 1/5/26 with the resident's name listed;-A description of an incident that occurred in the 200 hall shower room;-Investigative findings: Blank;-Resolution: Blank;-Results report to: Blank;-Date due: Five days after the date of grievance was filed. 2. During the resident council meeting on 1/26/2026 at 11:20 A.M., five out of five residents who represent the resident council, said very seldom do staff get in contact with the residents when they file a grievance. It takes months to hear back from staff after filing a grievance. Observation on 1/26/26 at approximately 12:00 P.M., showed no grievance forms available for residents and resident representatives in the facility lobby or on the 200 hall. During an interview, the Admissions Coordinator said there used to be grievance forms and a locked box to place the grievance forms in on each floor and in the lobby. She did not know what happened to them. 3. During an interview on 1/28/26 at 1:40 P.M., Licensed Practical Nurse (LPN) BBB said he/she made the Director of Nursing (DON) aware of any concerns that he/she could not take care of. He/She was not familiar with the grievance process. During an interview on 1/29/26 at 10:15 A.M., Certified Nursing Assistant (CNA) PP said he/she just lets the Charge Nurse know about any (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	concerns the residents may have. He/She was not familiar with the grievance process. 4. During an interview on 1/29/26 at approximately 1:00 P.M., the Social Worker said she was named the official Grievance Official on 1/28/26. Administrator A and Administrator B were the previous Grievance Officials. She expected grievances to be thoroughly investigated and to have findings of the investigation within five days. The residents and their families should have free access to grievance forms and a secure box to place them in. The Social Worker was not aware of Resident #44's grievance. 5. During the interview on 1/29/26 at 1:43 P.M., Administrator B said he/she was not aware of Resident #44's grievance. He/She would expect grievances to be acted on immediately and to have a conclusion of the findings reported to the family and their representative within five days. 27164582681713

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F 0620 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Not require residents to give up Medicare or Medicaid benefits, or pay privately as a condition of admission; and must tell residents what care they do not provide. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to update records of residents' personal possessions per facility policy for two sampled residents (Residents #44 and #12). The facility failed to ensure one resident received an admission packet (Resident #124). In addition, the facility failed to ensure that residents were provided an accurate admission agreement that reflected financial terms related to refundable deposits following a change in management (Resident #129). The sample size was 21. The census was 91.Review of the facility's Grievance and Missing Property policy, dated, 7/1/25, showed:-Policy: Residents and their representatives have to right to report missing items or property;-Procedure: Grievances may be presented to any staff member and the staff member may resolve the issue immediately; If unable to resolve immediately, follow the grievance procedure; Supervisory personal will be responsible for notifying the resident and their representative of outcome of missing property investigation. 1 .Review of Resident #44's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated,1/6/26, showed:-admission date 6/3/25;-Cognitively intact. Review of the resident's medical record, showed:-Diagnoses included arthritis and spinal stenosis;-No inventory of personal belongings sheet. Observation on 1/22/26 at 9:30 A.M., showed the resident's room with multiple personal items, including a stereo, pictures, personal hygiene products and clothing in his/her closet. During an interview, the resident said he/she had some clothing missing. He/She told multiple staff members, but no one got back with the resident. He/She was missing an off-white lined quilted vest, flannel night shirt with rose flowers, black pair of pants, and new white turtleneck shirt from Land's End. He/She was never provided an inventory sheet to fill out on admission or any time after. 2. Review of Resident #12's quarterly MDS, dated , 11/18/25, showed:-admission date 4/27/25;-Cognitively intact;-Diagnoses included heart failure, hip fracture, diabetes, and kidney disease. Review of the resident's medical record, showed no inventory of personal belongings sheet. Observation on 1/22/26 at 8:10 A.M., showed the resident's room with multiple clothing items in his/her closet and a chest drawer full of socks and short sleeved t-shirts. During an interview, the resident said he/she had multiple tops missing. The clothing went to laundry, and they never returned. He/She never filled out an inventory sheet of personal belongings. 3. During an interview on 1/26/26 at 11:50 A.M., Certified Medicine Technician (CMT) P said there were paper inventory sheets on each of the halls. On admission and anytime residents had new personal property brought to their rooms, an inventory sheet needed to be filled out and updated. The forms should be given to the nurse so that they could be scanned into the residents' medical record. During an interview on 1/26/26 at 12:40 P.M., the Laundry Supervisor said an inventory of personal belongings sheet should be filled out on every resident. The inventory sheet was located in the resident's medical record or in the resident's room. The Laundry Supervisor had not seen an inventory sheet for Resident #44 or Resident #12 and had been unable to locate the residents' missing clothing. During an interview on 1/29/26 at 1:27 P.M., Administrator B and Director of Nursing (DON) C said they expected staff to fill out inventory sheets on admission and update the sheet when new items were brought in by the resident or their family. They expected staff to try to find the missing clothing and if they were not found, then an investigation would be started. 4. Review of Resident's #124's hospital medical record, dated 1/5/26, showed diagnoses included anxiety, diabetes, and open angle glaucoma (visually impairment).Review of the resident's medical record, showed:-admission date 1/5/26;-No baseline care plan to direct staff on the care needs of the resident. During an interview on 1/22/26 at 9:21 A.M., the resident said he/she (continued on next page)

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F 0620 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	never received a welcome/admission packet. Review of the resident's admission packet, reviewed 1/29/26 at approximately 1:00 P.M., showed it was signed by the resident 1/23/26. During an interview on 1/29/26 at 12:56 P.M., Administer B said admission packets should be given to residents on the day of admission. He/She was unaware why the resident did not receive the admission packet upon admission. The resident was admitted on [DATE]. 5. Review of the facility's admission agreement under the previous management company, revised on 3/22/23, showed:-To reserve a room, I agree to pay in advance:--A $6,000 deposit interest free security deposit, which is refunded within 45 days after discharge, less balances from Medicare, insurance and hospice companies. The deposit is viewed as an asset by Medicaid and must be applied toward monthly charges to qualify for Medicaid. The monthly charge for room and board starts the first day a bed is held in reserve. If the resident passes away before the admission, charges will be assessed for every day the room was held in reserve. Review of the Facility's current admission agreement, received 1/23/26, showed: -Nursing Facility, Financial, and Resource Agreement:---Receipt of Agreement: Resource hereby acknowledges that Resource has received a complete copy of the Agreement, together with all Exhibits thereto;--Disclosure of Income and Resources: Resources hereby represents and warrants that Appendix 1 which is attached to and hereby made a part of this Resource Agreement constitutes a complete, full and accurate list of all the income and other resources of resident which are known to Resource;-Payment from Residents: Resources hereby agree to pay Facility all charges incurred by resident under the terms of the Agreement only to the extent of the income or resources of Resident;-Limitation: Nothing in this Agreement shall be interpreted to require Resource to make any payment to Facility out of the personal assets of Resource or to incur other financial liability to Facility except as provided in paragraph three;-Miscellaneous:-Agreement: This agreement contains and merges all agreements, representations and understandings of the parties;-Notices: All notices under this Agreement shall be in writing and shall be deemed given when mailed or delivered in person to a party at the address shown above, or at another address as may be designated in writing by that party;-No documentation that addressed the previous contract, and previous deposits made under the previous management's contract/agreement. 6. Review of the Resident #129's admission MDS, a federally mandated assessment instrument completed by facility staff, dated 7/5/25, showed:-Severe cognitive impairment;-Diagnoses included hypertension, acid reflux, thyroid disorder, hyperlipidemia, non-Alzheimer's dementia, and asthma. Review of the resident's application and invoices, received from family on 1/15/26, showed:-Date of application: 4/2/25;-Payment receipt deposit: $6,000.00;--Room and Board: $7,398.00;--Total due at signing: $13,398.00. Review of the resident's progress notes, showed:-On 10/29/25 at 6:00 P.M., staff documented spoke with family member regarding resident transferring tomorrow and pick up at 10:00 A.M.;-On 10/20/25 at 10:36 A.M., resident was transported via at 10:10 A.M. Report was called to transferring facility at 8:30 A.M. Resident's daughter followed via personal transportation with resident's medications as well as resident's belongings. Review of the resident's invoices, received 1/29/26, showed no documentation of a deposit refund of $6,000.00. During an interview on 1/28/26 at 12:59 P.M., Regional Nurse Consultant said Business Office Manager's (BOM) last day at the facility was yesterday. There was a Regional BOM. He was unaware of the contract under the previous management company that required a deposit of $6,000 and the refund of the $6,000 upon being discharged from the facility. The new management does not require a deposit. If a resident had a $6,000 deposit and they were discharged from the facility, he would try and get that deposit back to them. They could contact the previous management company. He was not aware of the resident's situation and the attempts to refund the deposit. There was an increase of residents who were discharged , but they were admitting a lot of short-term residents. (continued on next page)

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F 0620 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	They had 10-15 skilled residents and they bumped it up to 30. Regional Nurse Consultant said they are still under the previous management company until the change in ownership was completed. They were still honoring the original contract. They wanted to make as few changes as possible. During an interview on 1/29/26 at 1:43 P.M., Administrator B said the funds were not turned over during acquisition by the new ownership. They have requested all information from the previous ownership. He/She was not aware of the resident's deposit; however, the corporate BOM was aware. The corporate BOM put in a request to refund the deposit. 27162942712809

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure residents had safe discharge plans with arrangements for services/outside resources to assist in transitioning back home, or documented discharge summaries for 2 of 2 residents reviewed for discharges (Residents #124 and #1). The sample 21. The census was 91.Review of the facility's Discharge Planning Policy, dated 7/2025, showed:-An interdisciplinary summary is completed on a resident upon discharge to assure the continuum care needs of the residents are met;-Responsibility Licensed Nurse, Social Services, Therapist, Registered Dietitian/Certified Food Service, Director, and Activities Director;-Guidelines:-A physician's order must be obtained;-Upon notification or impending discharge, the interdisciplinary team (IDT) should be notified to allow staff the opportunity to educate and implement a safe discharge. Social Work (SW) should coordinate the discharge planning process;-If the resident is relocating to another nursing home/assisted living, requested information should be communicated to the new location by SW to provide continuum of care information. May provide to the resident or resident representative, standardized patient assessment data, data on Quality Measures and data on resource use when applicable to the resident's goals of care and treatment preferences;-When the resident is discharged home, with the resident's consent, the resident's community-based physician/practitioners are to be sent a copy of the items identified above except for medication administration records (MARs)/treatment administration records (TARs) and IDT notes. Document in the medical record what information and to whom the information was sent;-If the resident is discharging to a private home, SW should meet with the person accepting responsibility for the resident. Referrals needed should be made to home health, or others based upon the needs of the resident;-Therapy may complete a home assessment to ensure a safe discharge and arrange any assistive equipment needed for home care. Education with the person accepting responsibility for the resident at home should be provided as necessary.-Therapy should identify any needs for care at home. Education with the person accepting responsibility for the resident at home should be provided as necessary. Needed assistive devices should also be arranged. Appropriate referrals for home care should be made and coordinated with Social Services;-Nursing should meet with the person responsible for the resident at home and provide instruction to that person(s) as appropriate in regard to medications and treatments to be continued at home. Referral should be ensured for home care as needed and coordinate same with Social Services. Any unused medications that are currently ordered after discharge may be sent with the resident prior to discharge, according to state regulations.-The Discharge Summary form should be completed with care needs identified and documented as appropriate;-A copy of the Discharge Summary is given to resident/family upon discharge when resident is going home or forwarded to new facility as applicable;-The original is stored in the resident's medical record;-There should be documentation in the nurse's notes regarding resident status at the time of discharge. 1. Review of Resident #124's facility's medical record, showed:-admission on [DATE];-Diagnoses included anxiety, diabetes, and open angle glaucoma (visually impaired);-No baseline care plan to direct staff on the care needs of the resident. During an interview on 1/26/26 at 11:36 A.M., Certified Medical Technician (CMT) R said the resident was being kicked out. The Social Worker (SW) told the resident that it was not in her job description to find the resident a new placement.During an interview on 1/27/26 at 12:49 P.M., the resident said the SW would not place an appeal for the resident, nor would the SW assist with a referral to find a new facility. The SW provided a Notice of Medicare Non-Coverage (NOMNC) form with a discharge date of 1/28/26. During the interview, the resident presented a NOMNC form, which showed it was signed by 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	on 1/26/26 at 2:20 P.M. The resident said he/she was unable to participate in physical therapy due to COVID and a strained the neck.During an interview on 1/27/26 at approximately 1:00 P.M., the SW said she could not help residents file appeals.During an interview on 1/28/26 at 8:30 A.M., the resident said his/her appeal failed. The facility provided him/her with discharge instructions. He/She was concerned with the stairs that lead to the front door of his/her home. He/She was unsure if he/she could make it up the stairs. He/She set up his/her own transportation.During an interview on 1/28/26 at 9:23 AM, Occupational Therapist (OT) Q said the resident's baseline was self-care and needed some help. The resident was not ambulatory. He/She needed moderate assistance with showering. During an interview on 1/28/26 at 9:29 A.M., the Director of Physical and Occupational Therapy (Director of PT/OT) said in her expertise, she was not sure how the resident could get up the steps to his/her home. In reading the evaluation for the resident's home, there are approximately 12+ stairs. When she saw the resident, he/she could only take six or seven steps. The resident did therapy on some days while having COVID, and other days was too sick to participate in therapy. He/She missed two days of therapy. The resident had 15 days of therapy. He/She could walk with one person and a gait belt. He/She would benefit from more therapy. He/She would be unsafe with stairs. His/Her legs were extremely weak. He/She still required assistance with toileting and dressing. The Director of PT/OT did not feel it was safe to discharge the resident back to his/her home. During an interview on 1/28/26 at 1:30 P.M., the Admissions Coordinator said the resident changed his/her discharge plan and his/her new plan was unsafe. They attempted to contact the resident's family member, who would not return phone calls. At 2:56 P.M., the Admissions Coordinator said when they realized the resident would not have 24/7 care at home, they realized it would be an unsafe discharge. The Admissions Coordinator was told staff could not appeal discharges for residents. Review of the resident's medical record, showed he/she was discharged from the facility on 1/28/26.During an interview on 1/29/26 at 12:11 P.M., the SW said she had not received any education or guidance regarding her job duties at the facility. She had experience with discharge planning from working in assisted living facilities (ALFs), but NOMNCs were new to her since they were not done in ALFs. If a resident wanted to appeal their NOMNC or discharge, to her knowledge, she was not allowed to do it for them. She could not recall who informed her of not being able to assist with the appeal. She had never done a home assessment for a resident who is going to be discharged . 2. Review of Resident #11's admission Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 11/24/25, showed:-admission date 11/17/25;-Cognitively intact;-Diagnoses included high blood pressure, peripheral vascular disease, diabetes, hyperlipidemia, depression, and asthma. Review of the resident's Physician Order Sheets, dated December 2025, showed no physician order to discharge the resident from the facility. Review of the resident's progress note, dated 12/20/25, showed resident discharged home with medications. Nurse management aware. Further review of the resident's medical record, showed:-discharge date [DATE];-No documentation of the resident's discharge planning, referrals and/or resources;-No documentation of a discharge summary. 3. During an interview with Administrator B and Director of Nursing (DON) C on 1/29/26 at 1:47 P.M., DON C said he/she expected the SW to assist residents with discharge planning. All services to be provided upon discharge should be documented in the resident's medical record. A discharge summary should be documented in the resident's medical record. 2715118

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure residents received appropriate activities of daily living (ADL) care to meet their needs, including showers, nail care, and assisting residents out of bed for four residents (Residents #93, Resident #12, Resident #17, and Resident #13). The sample was 21. The census was 91.Review of the facility's ADL policy, dated 7/21/25, showed the nursing staff will assist in bathing the residents to promote cleanliness and dignity. The Charge Nurse will be made aware of residents who refuse bathing. Review of the facility's Oral Hygiene policy, revised 7/1/25, showed the facility will provide oral hygiene to residents as directed by the care plan. Oral care will include cleansing the oral cavity and removing food and debris. This may reduce odors and infection and provide comfort. 1. Review of Resident #93's admission Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 11/8/25, showed:-Diagnoses included chronic kidney disease, major depressive disorder (mood disorder), and anxiety;-Moderately impaired cognition. Review of the resident's medical record, showed the resident did not have a baseline care plan. Observation on 1/22/26 at 8:49 A.M., showed the resident in the dining room finishing up breakfast. The resident's hair appeared oily and stringy. His/Her fingernails were long and jagged. During an interview on 1/22/26 at 9:00 A.M., the resident said he/she had not received a shower yet that week. He/She believed this to be because not enough staff were working. He/She would like his/her nails trimmed. 2. Review of Resident #12's quarterly MDS, dated [DATE], showed:-Cognitively intact;-Dependent on staff for personal hygiene, lower body dressing and putting on and taking off footwear;-Independent with showers and bathing;-Always incontinent of urine and occasionally incontinent of stool;-Diagnosis included heart failure, hip fracture, diabetes, and kidney disease. Review of the resident's care plan, in use at the time of survey, showed:-Problem: ADL functional performance related to the resident's hip fracture;-Approaches: Hands on assist with bathing, dressing, toileting, incontinence care, locomotion with wheelchair, transfers and bed positioning. Observation on 1/22/26 at 8:10 A.M., showed the resident in his/her wheelchair in his/her room. The resident's clothing had food stains and his/her hair appeared frizzy and messy. During an interview, the resident said he/she is supposed to get showers on Wednesdays and Saturdays. Since he/she is incontinent of urine, he/she would like a shower more than once a week because he/she sometimes has an odor. He/She also has visitors and is embarrassed that he/she may have an odor around his/her visitors. He/She requires assistance with showers. He/She cannot complete a shower by him/herself. Review of the resident's shower sheets showed:-Showers documented as completed on 1/3/26, 1/8/26, and 1/28/26;-No shower sheets provided by the facility for the month of December 2025. During an interview 1/26/26 at 8:26 A.M., Licensed Practical Nurse (LPN) Y said the resident requires assistance and supervision with his/her showers. 3. During an interview on 1/29/2026 at 7:08 A.M., Certified Nursing Assistant (CNA) I said he/she expected residents to receive at least two showers or bed baths a week. He/She expected the resident's nails to be clean and trimmed. During an interview on 1/29/26 at 10:22 A.M., LPN H said he/she expected residents to receive at least two showers a week. He/She expected the resident's hair to be washed during the shower. During an interview on 1/29/26 at 9:49 A.M. and at 1:43 P.M., Director of Nursing (DON) C said he/she expected residents to receive two showers or bed baths a week. If the resident refused a shower, the DON was to be notified and he/she would talk with the residents. If the resident still refused, then the shower needed to be rescheduled for the next day. 4. Review of Resident #17's admission MDS, dated [DATE], showed:-Diagnoses included muscle weakness and diabetes;-Cognitively intact. Review of the resident's care plan, in use at the time of the (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	survey, showed the care plan did not include ADL care needs. Observation on 1/27/26 at 1:16 P.M., showed the resident in bed. His/Her toenails on both feet measured approximately an eighth of an inch long and appeared jagged. His/Her front teeth had a whitish-yellow substance caked on them. Observation on 1/28/26 at 1:16 P.M., showed the resident in bed. His/Her toenails on both feet appeared approximately an eighth of an inch long and jagged. His/Her front teeth had a whitish yellow substance caked on them. During an interview, the resident said he/she had asked for help trimming his/her nails and no staff would assist him/her. His/Her children have had to come and help brush his/her teeth because the staff are too busy to assist him/her. During an interview on 1/29/26 at 7:08 A.M., CNA I said nail care should be provided after the resident is showered. Lack of staffing was the reason the resident was not being assisted with oral hygiene. The resident required staff assistance with showers and personal hygiene. 5. During an interview on 1/29/26 at 10:22 A.M., LPN H said CNAs and nurses can trim residents' toenails unless the resident is diabetic, and then only the nurse or podiatrist can trim them. He/She expected CNAs to document on the shower sheet and alert the nurse if the resident needs his/her nails trimmed. He/She expected CNAs to assist residents with oral hygiene. During an interview on 1/29/26 at 9:49 A.M., DON C said he/she expected residents to have clean, trimmed toenails. He/She expected staff to assist residents with oral hygiene. 6. Review of Resident #13's quarterly MDS, dated [DATE], showed:-Cognitively intact;-No rejection of care behavior exhibited;-Substantial to maximum assistance from staff required for rolling from left to right and movement from bed to chair and chair to bed;-Diagnosis included heart disease, kidney disease, and high blood pressure. Review of the resident's medical record, showed no care plan completed. Observation 1/22/26 at 10:00 A.M. and 1/27/26 at 8:55 A.M., showed the resident in bed on his/her back, wearing a green hospital gown. During an interview on 1/27/26 at 8:55 A.M., the resident said he/she would like to get out of bed and wear clothing. He/She was reluctant to ask staff to place him/her in a chair because they leave him/her up in the chair for too long. He/She had a special chair but did not know where it was. Observation on 1/28/26 at approximately 2:00 P.M., showed the resident in bed, wearing a green hospital gown. During an interview, the resident said he/she had not gotten out of bed today and thought he/she was too much work for the staff since he/she required a Hoyer lift (full body mechanical lift). The resident would like to see things outside of his/her four walls. During an interview on 1/28/26 at approximately 2:30 P.M., the Director of Therapy said the resident had no restrictions and staff were to use a Hoyer lift to get the resident out of bed. A special high-back wheelchair had been ordered and was in the resident's room. During an interview on 1/29/26 at 10:05 A.M., CNA BB said the resident was offered to get out of bed, but the resident would refuse. The resident required a Hoyer lift to get out of bed. During an interview on 1/29/26 at 2:14 P.M., the DON said the resident was expected to get out of bed every day and as requested. If the resident refused, then the nurse should be notified. He/She expected refusals of care to be documented in the medical record and on the resident's care plan. 272126227168752703232271336527128092697912270539926883552688456268171327248502724974

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	265833	A. Building B. Wing	01/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Grove at Kirkwood, The	711 South Kirkwood Road Kirkwood, MO 63122

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. Based on observation, interview and record review, the facility failed to ensure wound dressing changes were completed as ordered and as needed for two residents (Residents #12 and #123) and facility staff failed to ensure compression stockings were applied as ordered for one resident (Resident #12). The sample was 21. The census was 91. Review of the facility's Wound Management policy, dated July 2025, showed:-To promote wound healing of various types of wounds, the facility will provide evidence-based treatments in accordance with current standards of practice and physician orders;-Procedure:-Wound Management:--Wound Treatment will be provided in accordance with the physician order;---Cleaning Method;---Type of dressing;---Frequency of dressing change;--Dressing changes may be provided outside of the frequency parameter in certain situations:---Urine, feces, or other bodily fluids have saturated through the dressing;---Dressing is dislodged;---Dressing is soiled;--Wound dressings will be applied in accordance with manufacturer's recommendations. 1. Review of Resident #12's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 11/18/25, showed:-Cognitively intact;-Dependent on staff for lower body dressing and putting on and taking off footwear;-Diagnoses included heart failure, hip fracture, diabetes, and kidney disease. Review of the resident's wound notes from an outside wound company, dated 1/13/26, showed the resident had a non-pressure wound of the left lateral (side) leg and a non-pressure wound to the left anterior (front) leg. Etiology (cause) detail: struck with something. Review of the resident's medical record, showed:-The care plan did not address the resident's wound care;-An order, dated 1/16/26, for left anterior leg, cleanse with wound cleanser or normal saline, apply skin prep around the wound, apply xeroform gauze (a special non-adherent dressing), collagen powder (a treatment that absorbs fluid and increases healing), apply gauze, wrap with Kerlix (specialized wrap) and secure with tape;--Documented as completed on 1/21/26, 1/22/26, 1/24/26, and 1/25/26;--Documented as not completed on 1/23/26 and 1/26/26;-An order, dated 1/16/26, for left lateral leg, cleanse with wound cleaner or normal saline, apply skin prep around the wound, apply xeroform gauze, collagen powder, apply gauze, wrap with Kerlix gauze roll and secure with tape;-An order, dated 12/8/25, for XXL knee high compression stockings, on in morning and off in evening;--Documented as completed 1/22/26 through 1/28/26, morning and evening. Observation on 1/23/26 at 7:35 A.M., showed the resident sat in his/her wheelchair. Licensed Practical Nurse (LPN) JJ removed the resident's left leg dressing that was dated 1/21/26 and the dressings were saturated with serous (clear, yellow) drainage. LPN JJ cleaned the resident's left leg wounds with wound cleanser. The wounds appeared red and the skin around the wounds appeared macerated (wrinkled and red from being moist). LPN JJ applied a Mepilex dressing (a specialized foam dressing) over the left leg wounds. He/She did not use skin prep, xeroform, collagen powder, gauze or kerlix when completing the resident's left leg dressing. He/She did not apply the resident's compression stockings. During an interview, LPN JJ said he/she observed the resident's left sock was saturated with drainage and decided to change it. Observation on 1/26/26 at 8:20 A.M., showed the resident sat in his/her wheelchair. His/Her left leg dressing and sock were saturated with serous drainage. The dressing was dated 1/24/26. He/She did not have on compression stockings. During an interview, the resident said the staff have not been applying the compression stockings for a couple of weeks. Observation on 1/27/26 at 8:55 A.M., showed the resident sat in his/her wheelchair. His/Her left leg dressing was saturated with serous drainage. The dressing was dated 1/24/26. He/She did not have on compression stockings. During an interview, the resident said he/she had to change his/her left sock because it was so wet with drainage. Observation and interview on 1/27/26 at 1:30 P.M., showed the resident sat in his/her wheelchair. His/Her left leg dressing was saturated with serous (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	drainage. The dressing was dated 1/24/26. He/She did not have on compression stockings. The Assistant Director of Nursing (ADON) gathered supplies off the treatment cart. She said the facility did not have collagen powder to apply to the resident's wound. She removed the resident's dressing. The anterior and lateral wounds appeared pink with serous drainage. The skin surrounding the wounds appeared macerated. The ADON said she observed the resident's wounds the week before and thought the skin around the wound looked more red at this time. She completed the resident's left leg treatment without applying the collagen powder. The ADON said nurses were responsible to complete all wound treatments. The facility did not have a treatment or wound nurse. She expected staff to document accurately in the medical record when the treatment was completed. During an interview on 1/28/26 at 1:40 P.M. and on 1/29/26 at 11:55 A.M., LPN KK said the nurses are responsible to complete treatments and dressing changes. LPN KK said the resident should have compression stockings on if there is an active order. During an interview on 1/29/26 at 1:41 P.M., Director of Nurses (DON) C said he/she expected the nurses to follow physician orders and complete the wound treatments as ordered. He/She expected staff to order supplies if they were not available. He/She expected staff to document accurately in the resident's medical record when the treatment was completed. Staff should not document a treatment as completed when it was not administered. He/She expected compression stockings to be on a resident as per physician orders. 2. Review of Resident #123's medical record, showed:-admission date 1/16/26;-Diagnoses included congestive heart failure (heart inability to pump), pneumonia (infection effecting the lungs filling with fluid or pus), glaucoma (impaired vision), and diabetes;-No baseline care plan to direct staff on the care needs of the resident. Review of the electronic physician order sheet (ePOS) and treatment administration record (TAR) for January 2026, showed:-An order, dated 1/22/26, to cleanse skin tear to left lower leg with normal saline, apply xeroform, and dry dressing daily and as needed (PRN);-From 1/22/26 through 1/26/26, staff did not document the treatment as completed. During an interview on 1/22/26 at 11:00 A.M., the resident said he/she had a wound on his/her left leg/ankle. During an interview on 1/23/26 at 12:46 P.M., Certified Nurse Aide (CNA) ZZ said he/she was transferring the resident with Physical Therapist (PT) AA and during the transfer, the resident's leg got caught, causing the wound to the resident's leg/ankle. Observation on 1/26/26 at 2:01 P.M., showed the dressing on the resident's left leg dated 1/22/26. During an interview on 1/29/26 at 1:04 P.M., the Regional Nurse Consultant said nurses are responsible for documenting completion of wound treatments in the resident's electronic medical record. Staff should follow physician orders for completion of wound treatments. 2681713

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to provide adequate supervision and assistance to prevent the risk of accidental hazards by failing to ensure staff used appropriate techniques during two transfers using a Hoyer lift (mechanical lift) (Residents #7 and #91) and during one assisted transfer without a gait belt (Resident #111). In addition, the facility failed to safely store a topical antiseptic solution by leaving it open in the room of a cognitively impaired resident (Resident #7). The sample was 21. The census was 91.Review of the facility's Total Lift Transfer policy, dated, 7/1/25 showed:-Policy:-The facility will utilize a total lift device on residents who are unable to assist with transfers;-Responsibility: Nursing employees, Nursing administration, Director of Nursing (DON);-Definitions: -Full body lift: A lifting device used to provide safety of resident/employees during transfers;-Procedure:-Position the lift near the receiving surface;-Lock the bed/chair wheels;-Standing next to the resident, press the up button on the lift controls to slowly raise the lift to the height necessary to clear the surface. Maintain contact with the resident to guide/steady the resident during the lift transfer, as necessary;-Standing next to the resident, use the down button on the lift control to slowly lower the resident to the desired surface, guide, steady as necessary;-Lifting from a chair:--Open the legs of the lift using the hand controls;--Safely lower resident to the chair ensuring proper placement;-Mechanical lift care:-Disinfect lift surfaces and allow them to dry. 1. Review of Resident #7's quarterly Minimum Data Set (MDS), federally mandated assessment instrument completed by facility staff, dated 11/3/25, showed:-Mobility device: Wheelchair;-Dependent on staff for transfers;-Diagnoses included dementia, anxiety disorder, and depression. Review of the resident's care plan, in use during the survey, showed:-Problem: The resident required extensive to total assist with activities of daily living (ADLs) due to generalized muscle weakness;-Goal: Resident will maintain current level of function through next review period;-Approach: Hoyer mechanical lift for transfers, extensive to total assist with bed mobility, wheelchair locomotion, dressing, bathing, incontinence care, and grooming. Review of the resident's electronic physician order sheet (ePOS), dated 12/20/25, showed no order for transfers and/or transfer type. Observation on 1/27/26 at 11:13 A.M., showed Certified Nurse Assistant (CNA) MMM and CNA XX assisted the resident to transfer from the bed to his/her wheelchair. The resident lay in bed as CNA MMM gently rolled the resident and then positioned the Hoyer pad underneath him/her. CNA MMM connected the resident's Hoyer pad to the lift. CNA XX operated the Hoyer lift as CNA MMM stood beside the resident. The legs were not opened on the Hoyer lift. No one held or guided the resident while he/she moved from the bed. The legs of the Hoyer remained closed during the movement of the resident. 2. Review of Resident #91's quarterly MDS, dated [DATE], showed:-Severe cognitive impairment;-Mobility device: Wheelchair;-Dependent on staff for transfers;-Diagnoses include traumatic brain dysfunction, hypertension, hyperlipidemia, dementia, and anxiety disorder. Review of the resident's care plan, in use during the survey, showed:-Problem: The resident required staff assistance with ADLs and utilized a Hoyer lift for transfers;-Goal: Resident will maintain current level of function in regard to transfers through next review date;-Approach: Hoyer lift for transfers with two staff members. Review of the resident's (ePOS), dated 1/23/26, showed no order for transfer type. Observation on 1/27/26 at 11:21 A.M., showed the resident in his/her wheelchair, with a Hoyer lift pad underneath his/her body. CNA XX positioned the resident's wheelchair in between the legs of the Hoyer lift, then positioned the Hoyer pad straps onto the Hoyer lift. CNA NNN locked the wheels of the resident's wheelchair and told him/her that they were going up. The resident was lifted up in the Hoyer machine and his/her weight (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	was obtained on the Hoyer lift. After the resident's weight was obtained, CNA NNN moved the Hoyer lift while its legs were closed. CNA XX stood beside the resident with his/her hands up but barely touching the resident. 3. During an interview on 1/28/26 at 12:30 P.M., CNA XX said when he/she does a Hoyer transfer, he/she opens the legs of the Hoyer up once he/she scoots the resident up to do the actual transfer. He/She doesn't ever open the legs up when he/she is doing the actual movement of the Hoyer. When the resident is in the air, he/she closes the legs up, because it is better balance to him/her. During an interview on 1/28/26 at 11:41 A.M., Licensed Practical Nurse (LPN) WW said during a transfer with a Hoyer, the legs should be opened to provide balance. It should always be two people doing the transfer. One person should be guiding the resident, and the other should push the chair and/or wheelchair. During an interview with Administrator B and DON C on 1/28/26 at 3:00 P.M., DON C said the proper way to do a transfer with the Hoyer lift is with two people. The staff should sure the resident is properly hooked up to the Hoyer lift and the legs of the Hoyer should be opened for the base to be more stable. 4. Review of the facility's Gait Belt Transfer policy, dated 7/1/25, showed;-Policy: The facility will utilize a gait belt for residents who require one assist with transfers to promote safety during resident transfers. Review of Resident #11's quarterly MDS, dated [DATE], showed:-Severe cognitive impairment;-Dependent on staff for personal and toilet hygiene;-Requires maximum assistance from staff for dressing lower and upper body, staff for chair to bed and bed to chair transfers;-Diagnoses included dementia, heart disease, and heart failure. Review of the resident's care plan, in use at the time of survey, showed:-Problem: The resident required limited assist with ADL care to meet their needs;-Intervention: Provide assistance with one person with transfers. Observation on 1/26/26 at 8:26 A.M., showed LPN Y entered the resident's room. LPN Y assisted the resident with changing his/her brief and clothing. LPN Y sat the resident on the side of the bed and positioned the resident's wheelchair next to the bed. LPN Y lifted the resident under his/her arms and pulled the resident up off the bed using the resident's pants and pivoted the resident to his/her wheelchair. A gait belt was not used to transfer the resident from his/her bed to his/her wheelchair. Two gait belts were hanging above the resident's bed. During an interview on 1/28/26 at 2:16 P.M., CNA NN said gait belts should be used on all residents requiring assistance with transferring and ambulating. During an interview on 1/29/26 at 10:15 A.M. CNA PP said staff should be using a gait belt on the resident when transferring because he/she did not stand very well. A gait belt was used in case the resident's legs gave out, and they could be safely lowered to the floor or chair. During an interview on 1/29/26 at 2:14 P.M., DON C said he/she expected staff to use a gait belt on all residents that required assistance from staff with walking and transferring from bed to chair. Pulling on the resident's pants to transfer a resident is not acceptable. 5. Review of Resident #7's quarterly MDS, dated [DATE], showed:-Severe cognitive impairment;-Upper/lower extremity: No impairment;-Diagnoses included dementia, anxiety disorder, and depression. Review of the resident's ePOS, dated 1/23/26, showed no order for Dakins (topical antiseptic solution) 0.125% solution. Review of the Safety Data Sheet for Dakin's solution products, undated, showed a warning: Do NOT take internally, for external use only. If swallowed, get medical help or contact Poison Control right away. Observations of the resident's room on 1/27/26, showed:-At 11:16 A.M. and 1:36 P.M., the resident lay in his/her bed. A bottle of Dakins 0.125% solution without a cap sat on the television stand beside the television;-At 5:12 P.M, the not in his/her room. The bottle of Dakins 0.125% solution without a cap sat on the television stand beside the television. Observations of the resident's room on 1/28/26 at 8:32 A.M., showed the resident sat in his/her bed, eating breakfast. The bottle of Dakins 0.125% solution without a cap sat on the television stand beside the television. During an interview with (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Administrator B and DON C on 1/29/26 at 2:14 P.M., DON C said the bottle of Dakins solution should not have been in the resident's room. It would be removed and destroyed. 2722224

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F 0691 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate colostomy, urostomy, or ileostomy care/services for a resident who requires such services. Based on observation, interview and record review, the facility failed to ensure ostomy (medical device used to collect bodily waste) care was provided by staff and physician orders were obtained for ostomy care for one resident who had an ileostomy (surgical procedure that creates an opening (stoma) in the abdominal wall, bringing the end of the small intestine to the surface to divert waste in an external pouch) (Resident #93). The sample was 21. The census was 91. Review of the facility's Pouch Changes - Ileostomy policy, dated 7/1/25, showed:-Policy: It is the policy of this facility to ensure that residents who require colostomy services receive pouch changes consistent with professional standards of practice to minimize occupational exposure and the resident's skin exposure to fecal matter or urine;-Policy Explanation:-Ostomy care will be provided by licensed nurses under the orders of the attending physician. The order should include the type of ostomy, frequency of pouch change, and type of equipment. The nurse will allow the resident to perform as much care as possible in accordance with the resident's goals and preferences. Review of Resident #93's admission Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 11/8/25, showed:-Moderately impaired cognition;-Diagnoses included Chron's disease (inflammatory bowel disease causing chronic inflammation of the gastrointestinal tract), ileostomy status, chronic kidney disease, major depressive disorder, and anxiety;-Had ostomy appliance. Review of the resident's physician order summary (POS), reviewed 1/26/26, showed no orders for ostomy care. Review of the resident's medical record, showed no baseline or comprehensive care plan to direct staff on the resident's care needs. During an interview on 1/22/26 at 8:49 A.M., the resident said he/she felt shaky and did not feel good. He/She was unable to answer specific questions regarding his/her medical needs. During an interview on 1/22/26 at 9:43 A.M., the resident's family member, Family Member UUU, said he/she and another family member had been coming to the facility to assist the resident with ostomy care. Staff were not assisting the resident with emptying his/her ostomy bag, resulting in the resident having to wait for his/her family member to help. He/She informed Director of Nursing (DON) D his/her concerns but had not heard back from any facility staff. During an interview on 1/22/26 at 2:00 P.M., Licensed Practical Nurse (LPN) FFF said today the resident had an unwitnessed fall. LPN FFF was in the hallway with another staff member when they heard a bang come from the resident's room. They went immediately to the resident's room where they found the resident on the floor. The floor around the resident was covered in feces. The resident was holding his/her ostomy bag up, trying to keep feces from coming out more. The resident reported that he/she had been trying to walk to the bathroom to empty his/her ostomy bag. The resident was sent out to the hospital due to shoulder pain after the fall and having an altered cognitive status. LPN FFF had not known the resident had an ostomy bag. During an interview on 1/23/26 at 9:03 A.M., LPN O said he/she was unaware the resident had an ostomy bag. The resident did not have any physician orders for ostomy care. He/She was unaware if the resident was able to care for his/her ostomy him/herself. During an interview on 1/29/26 at 2:00 P.M., DON C said he/she expected staff to assist the resident with his/her colostomy care. He/She expected staff to be informed of the presence of the resident's colostomy. He/She expected for the resident to have a care plan indicating interventions for the resident's ostomy care level needs. He/She expected the resident to have physician orders for ostomy care. He/She expected DON D to have reached out to the resident or the resident's family upon being informed of care concerns. 2661256

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. Based on observation, interview and record review, the facility failed to have sufficient nurse staffing on a 24-hour basis to care for resident's basic needs for three sampled residents (Residents #93, #12, and #17). The facility also failed to ensure sufficient therapy staff to provide speech therapy and restorative therapy. In addition, the facility failed to ensure new staff and/or agency staff were properly oriented. This practice had the potential to affect all residents. The sample was 21. The census was 91.Review of the facility's Facility Assessment, updated 12/18/25, showed:-People involved in completing: Administrator A, Director of Nursing (DON) C, and Director of Maintenance;-Date reviewed with Quality Assurance Performance Improvement (QAPI) committee: 12/18/25;-Number of licensed beds: 117;-Average daily census: 100;-Average weekday admissions by shift: 3-4;-Average weekend admissions by shift: 0-1;-Average weekday discharges by shift: 3-4;-Average weekend discharges by shift: 0-1;-Assistance with activities of daily living monthly average:-Bed mobility sit to lying:--Set up: blank;--Supervision/partial/moderate assistance: blank;--Dependent/max assistance: blank;-Mobility sit to stand:--Set up: blank;--Supervision/partial/moderate assistance: blank;--Dependent/max assistance: blank;-Bathing:--Set up: blank;--Supervision/partial/moderate assistance: blank;--Dependent/max assistance: blank;-Transfer:--Set up: blank;--Supervision/partial/moderate assistance: blank;--Dependent/max assistance: blank;-Eating:--Set up: blank;--Supervision/partial/moderate assistance: blank;--Dependent/max assistance: blank;-Toileting:--Set up: blank;--Supervision/partial/moderate assistance: blank;--Dependent/max assistance: blank;-Other care, describe: blank;-Staff assignments: Describe how you determine and review individual staff assignments for coordination and continuity of care for residents within and across these staff assignments: -The facility meets this requirement by considering census, individual and overall unit acuity, routine/consistent staffing assignments per unit for both licensed nurses and Certified Nursing Assistants (CNAs), and resident preferences for staff assignments. 1. Observation on 1/22/26 at 8:49 A.M., showed Resident #93 in the dining room finishing breakfast. The resident's hair appeared oily and stringy. His/Her fingernails were long and jagged. During an interview on 1/22/26 at 9:00 A.M., the resident said he/she had not received a shower yet that week. He/She believed this to be because not enough staff were working. He/She would like his/her nails trimmed. 2. Observation on 1/22/26 at 8:10 A.M., showed Resident #12 in his/her wheelchair in his/her room. The resident's clothing had food stains and his/her hair appeared frizzy and messy. During an interview, the resident said he/she was supposed to get showers on Wednesdays and Saturdays. Since he/she was incontinent of urine, he/she would like a shower more than once a week because he/she sometimes had an odor. He/She also had visitors and was embarrassed that he/she may have an odor around his/her visitors. He/She required assistance with showers. He/She could not complete a shower by him/herself. Review of the resident's shower sheets showed:-Showers documented as completed on 1/3/26, 1/8/26, and 1/28/26;-No shower sheets provided by the facility for the month of December 2025. 3. Observation on 1/27/26 at 1:16 P.M., showed Resident #17 in bed. His/Her toenails on both feet measured approximately 1/8 inch long and appeared jagged. His/Her front teeth had a whitish-yellow substance caked on them. Observation on 1/28/26 at 1:16 P.M., showed the resident in bed. His/Her toenails on both feet appeared approximately 1/8 inch long and jagged. His/Her front teeth had a whitish yellow substance caked on them. During an interview, the resident said he/she had asked for help trimming his/her nails and no staff would assist him/her. His/Her children have had to come and help brush his/her teeth because the staff were too busy to assist him/her. During an interview on 1/29/26 at 7:08 A.M., CNA I said nail care should be provided after the resident is showered. Lack of staffing was the reason the resident was not being (continued on next page)

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	265833	A. Building B. Wing	01/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Grove at Kirkwood, The	711 South Kirkwood Road Kirkwood, MO 63122

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	assisted with oral hygiene. The resident required staff assistance with showers and personal hygiene. 4. Review of the facility's therapy minutes, dated 9/1/25 through 1/22/26, showed no speech therapy evaluations, speech therapy minutes, or services offered to residents. During an interview on 1/28/26 at 2:22 P.M., the Director of Rehab said there was no speech therapy and they just hired an as needed (PRN) speech therapist. One resident had a speech evaluation via telehealth, but most speech therapists did not feel comfortable doing it via telehealth. The facility did not have a restorative program. There had been no restorative program since he/she started at the facility. During an interview on 1/29/26 at 1:43 P.M., Director of Nursing (DON) C was aware of the lack of therapy and was looking for one therapist. The facility ensured therapy was delivered by completing an assessment, and if they did not have appropriate staff, they would contract a staff member. There was no restorative therapy program. They had a program, but it was not in place. 5. During an interview on 1/26/26 at 8:37 A.M., Licensed Practical Nurse (LPN) LL said he/she was a brand-new nurse who did not receive any orientation. He/She was employed by an agency but became a direct hire by the facility and was unaware of the staffing level being terrible. 6. During an interview on 1/26/26 at 11:13 A.M., LPN GGG said this was his/her first day at the facility. He/She never came here for agency work. He/She should be training with someone but there was no one here. He/She had been solo since 7:00 A.M. this morning. He/She had to familiarize with the residents by reading their charts. If he/she had questions, he/she would refer to another LPN. 7. During an interview on 1/28/26 at 2:39 P.M., LPN Z said since the new management took over, the facility had been short staffed. They recently hired night nurses and more aides. There was only one night nurse before last week. LPN Z and one other nurse were the only nurses on the bottom floor. There was one nurse on the second floor. If the census increased, it would be challenging because residents had critical care needs, such as intravenous medications and wound vacuums (therapeutic device that helps a wound heal faster by removing fluid and bacteria with suction). The admissions LPN did not work the floor, even when short-staffed. The wound nurse quit several weeks ago because they were at the facility for 20 hours. The nurses did not know if they will have relief, so they do not come in. They call management and ask when they can leave. If the nurses leave, management says it is job abandonment. The facility lost so many nurses because they do not know when they can go home. Staff had trouble with pay checks bouncing and the management company took an hour out of his/her paycheck daily. He/She worked 12 hours a day, and they took an hour from him/her. He/She used to work regularly at the facility until he/she was stuck for 23 hours. After that occurred, he/she switched to PRN. Another LPN got stuck overnight. DON D worked the floor more than doing the DON duties. He/She got burned out. Due to all the changes, staff had to keep adjusting to new ideas and new things over and over again. The residents complained about it. After the change in ownership, the company wanted to change the restorative aide to a certified nurse Aide (CNA), but he/she retired and the company got rid of the other restorative aide. 8. During an interview on 1/29/26 at 1:43 P.M., Administrator B said DON C had a daily staffing sheet for nurse hours. He/She did not know if it was tracked. The past weekend was an issue for the Registered Nurses (RNs). The facility used quite a bit of agency staff and spent approximately $20,000 a month on agency staff. They currently had two RNs on staff, who just started working at the facility. Since the change in ownership, there had been three Administrators and two DONs. The Assistant Administrator or Administrator would be responsible for compliance during each transition, as well as corporate staff. Regulatory duties were not handed off between Administrators. They used agency staffing to ensure minimum staffing requirements were met. Administrator B said DON C is currently working on a system for everyone to abide by to ensure continuity of care with frequent staff turnover. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	272126227168752712809271295626883552686162267977926847302683754

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure physician-ordered prescription medications were received timely from the pharmacy and administered as ordered, for six residents (Residents #66, #10, #52, #93, #131, and #108). The sample was 21. The census was 91.Review of the facility's Ordering Medication policy, undated, showed:-Procedure:--Medication orders are faxed to the pharmacy and written on a medication order form provide by the pharmacy. The entry includes:---Date ordered;---Indication of new or refill order;---New orders should include: name of medication, strength of medication, dosage, time or frequency, route of medication, quantity or duration, and diagnosis or indication of use;---Reorder medication three days in advance to ensure an adequate supply is on hand; ---The refill form is faxed to pharmacy;--- Do not wait until the page is full to send to pharmacy. Send after medication pass is completed;---Check the emergency box supply before if medications are needed prior to regular delivery. Review of the facility's Physician Orders policy, dated 7/1/25, showed:-Policy: To provide guidance and ensure physician orders are transcribed and implemented in accordance with professional standards, state and federal guidelines;-Procedure;-Orders must be recorded in the medical record by the Licensed Nurse authorized to transcribe such orders;-Physician order sheets (POS) will be maintained with current physician orders an new orders are received;-Discontinued orders will be marked as discontinued with the date, and all new orders will be written in the appropriate area on the POS with the dated the order was received;-Physician orders will be transcribed to the appropriate administration record;-Medication will be ordered from the pharmacy to ensure prompt delivery. Medications available from the emergency drug supply (E-kit) or automatic dispensing unit shall be utilized for the first dose until a supply arrives from pharmacy, if available. 1. Review Resident #66's annual Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 12/16/25, showed:-admission date, 12/5/25;-Moderate cognitive impairment. Review of the resident's medical record, showed diagnoses included repeated falls, multiple sclerosis (autoimmune disease that effects spinal cord), muscle weakness, obstructive sleep apnea (sleeping disorder characterized by episodes of paused breathing or shallow breathing during sleep). Review of the resident's electronic POS (ePOS) and electronic medication administration record (eMAR) from the electronic medical record (EMR) 1, dated 12/2025, showed:-An order, dated 12/9/25, for modafinil (wakefulness medication treats excess sleepiness) 100 milligrams (mg.), give three tablets at 8:00 A.M., once daily;--Modafinil 100 mg. documented as drug not available 20 out of 22 opportunities;-An order, dated 12/10/25, for Glatopa (medication used to treat multiple sclerosis) 40 mg. subcutaneously (SQ, given below the skin), every other day, starting Monday, Wednesday, and Friday at 12:30 P.M;--Glatopa 40 mg. injection documented as drug not available 5 out of 10 opportunities. Review of the resident's nurse's note, dated 12/27/25 at 7:26 A.M., showed med tech notified writer that patient had not had his/her medication, modafinil, since he/she was admitted . Call placed to pharmacy and a detailed voicemail was left. Review of the resident's ePOS and eMAR from EMR 2, dated 1/2026, showed:-An order, dated 1/4/26, for Glatopa 40 mg. SQ, every other day, on Monday, Wednesday, Friday;--Glatopa 40 mg. injection documented as not administered 8 out of 9 opportunities; -An order, dated, 1/4/26, modafinil 100 mg, give one tablet; stop date 1/14/26. Review of the resident's nurse's note, dated 1/14/26 at 12:09 P.M., showed modafinil 100 mg. order had been verified by the resident's doctor. Order was updated and changed. Order read modafinil 100mg, give three tabs once a day for sleepiness. During an interview on 1/28/26 at 12:17 P.M., Pharmacist KKK said there were two doses of Glatopa dispensed, which was a week supply of that medication. If modafinil medication was not dispensed or given correctly, it could (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	potentially lead to increased fall risk. Not receiving these two medications as prescribed was a concern/issue that could contribute to increase of falls. During an interview on 1/28/26 at 1:44 P.M., Director of Nursing (DON) C said in EMR 1, the physician order for modafinil 100 mg., three tablets, was correct. The physician order in EMR 2, for modafinil 100 mg., one tablet, was incorrect. Missing these medications could lead to increase falls. 2. Review of Resident #10's admission MDS, dated [DATE], showed:-Diagnoses included muscle weakness and diabetes;-Cognitively intact. Review of the resident's ePOS, dated 1/2026, showed an order, dated 12/18/25, for tramadol (opioid pain medication) oral tablet 50 mg., give one tablet by mouth two times a day related to pain. Review of the resident's eMAR, dated 1/2026, showed:-On 1/2/26 through 1/13/26, tramadol 50 mg., scheduled for 8:00 A.M., not given 6 out of 25 opportunities;-On 1/2/26 through 1/13/26, tramadol 50 mg., scheduled for 8:00 P.M., not given 7 out of 25 opportunities. Review of the resident's progress notes for January 2026, showed on 1/3/26 through 1/13/26, staff documented the resident's tramadol not administered due to being unavailable. During an interview on 1/23/26 at 6:32 A.M., the resident said he/she had not been receiving his/her pain medication routinely. 3. Review of Resident #52's quarterly MDS, dated [DATE], showed:-Diagnoses included acute kidney failure, acute respiratory failure, and muscle weakness;-Cognitively intact. Review of the resident's ePOS, dated 1/2026, showed:-An order, dated 12/24/25, for tramadol oral tablet 50 mg., give one tablet by mouth two times a day related to pain;-An order, dated 12/24/25, for Bion Tears Ophthalmic (dry eye drops) Solution 0.1-0.3 % (Dextran 70-Hypromellose). Instill one drop in both eyes two times a day for dry eyes;-An order, dated 12/25/25, for olopatadine ophthalmic solution 0.2 % (allergy eye drops). Instill one drop in both eyes one time a day for eye allergy. Review of the resident's eMAR, dated 1/2026, showed:-On 1/13/26 through 1/21/26, tramadol 50 mg., scheduled for 8:00 A.M., not given 8 times out of 22 opportunities;-On 1/13/26 through 1/21/26, tramadol 50 mg,, scheduled for 8:00 P.M., not given 4 out of 22 opportunities;-On 1/11/26 through 1/21/26, Bion Tears solution, scheduled for 8:00 A.M., not administered 5 out of 22 opportunities;-On 1/11/26 through 1/21/26, Bion Tears solution, scheduled for 8:00 P.M., not administered 10 out of 22 opportunities;-On 1/1/26 through 1/8/26, olopatadine eye drop solution, scheduled for 6:00 A.M., not administered 21 out of 22 opportunities. Review of the resident's progress notes, showed:-On 1/13/26 through 1/21/26, staff documented the resident's tramadol not administered due to being unavailable;-On 1/11/26 through 1/21/26, staff documented the resident's Bion Tears eye drops not administered due to being unavailable;-On 1/1/26 through 1/18/26, staff documented the resident's olopatadine eye drops not administered due to being unavailable. During an interview on 1/22/26 at 9:14 A.M., the resident said he/she had not been getting his/her eye drops. The nurses tell him/her that they do not have the eyedrops. 4. Review of Resident #93's admission MDS, dated [DATE], showed:-Diagnoses included chronic kidney disease, major depressive disorder, and anxiety;-Moderately impaired cognition. Review of the resident's ePOS in EMR 1, dated 11/2025, showed:-An order, dated 11/26/25, for midodrine tablet, (medication used to treat low blood pressure) 2.5 mg. Take one tablet twice a day at 8:00 A.M. and 5:00 P.M. Special instructions: hold if systolic (top number of blood pressure) blood pressure is greater than 110. Review of the resident's ePOS and ePOS for EMR 2, dated 1/2026, showed:-An order, dated 12/19/25, sodium chloride (normal saline) intravenous (into the veins) solution 0.9 %. Use 2 liters intravenously one time a day, every Monday and Wednesday, for nutrition to infuse over 6 hours;--On 1/14/26 and 1/21/26, sodium chloride intravenous solution 0.9% was blank for all administration opportunities;-No physician order or medication administration documentation for midodrine 2.5 mg. tablet. Observation on 1/27/26 at 7:29 A.M., of the [NAME] Wing medication storage room, showed two bags of sodium chloride, dated 1/7/26, labeled with the resident's name, on (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	top of the refrigerator. During an interview on 1/23/26 at 6:44 A.M., Hospital Nurse JJJ said the day before, the resident arrived to the hospital's emergency room from the facility. When the resident arrived, his/her blood pressure was very low and continued to be low over night. During an interview on 1/23/26 at 1:45 P.M., Pharmacy Representative LLL said the resident's sodium chloride 4000 milliliters (ml.) was filled that day and last filled on 1/8/26 and delivered to the facility on that day. The delivery was a four day supply. During an interview on 1/29/26 at 10:25 A.M., Licensed Practical Nurse (LPN) H said he/she noticed two bags of the resident's sodium chloride placed on top of the medication room refrigerator and was unsure why it was never administered to the resident. During an interview on 1/28/26 at 2:05 P.M., DON C said the resident should have received his/her sodium chloride infusion. When the facility switched EMR companies from EMR 1 to EMR 2, the resident's order for midodrine was not switched over correctly. The resident should have been administered midodrine in January 2026 and was not. 5. Review of Resident #31's medical record, showed:-admission date 10/31/25;-Diagnoses included chronic pain, diabetes, anxiety, high blood pressure, and personal history of healed physical injury. Review of the resident's eMAR, showed:-An order, dated 12/29/25, for atenolol 50 mg., (medication used to treat high blood pressure), give one a day, for high blood pressure;-Atenolol documented as not administered 24 out of 24 opportunities;-An order, dated 1/24/26, for Augmentin 500-125 mg., (antibiotic), give one tablet three times a day, for urinary tract infection, for seven days;-Augmentin documented as not administered on 1/24/26 and 1/25/26 at 8:00 A.M., 2:00 P.M., and 9:00 P.M. doses, and on 1/26/25 at 2:00 P.M. dose. During an interview on 1/26/26 at approximately 8:45 A.M., the resident said he/she had never received his/her atenolol since it was ordered. He/She was recently started on an antibiotic and had not received the antibiotic either. The staff told the resident the antibiotic was on order. 6. Review of Resident #108's medical record, showed:-admission date 5/26/24;-readmission date 8/26/25;-Diagnoses included coronary artery disease, heart failure, diabetes, high cholesterol, anemia, peripheral vascular disease (narrowing of blood vessels in the legs), hypothyroidism, major depressive disorder and chronic kidney disease. Review of the resident's ePOS and eMAR, dated 1/2026, showed:-An order, dated 12/30/25, for atorvastatin calcium (cholesterol medication) 80 mg. oral tablet, give one tablet by mouth at bedtime for cholesterol;-Medication not given 28 out of 28 opportunities;-On 1/1/26 through 1/4/26, documented as medication not available;-An order, dated 12/30/25, for levothyroxine sodium (thyroid medication) 175 micrograms (mcg.) oral tablet, give one tablet by mouth one time a day for thyroid; -Medication not given 22 out of 28 opportunities;-On 1/2/26, documented as medication not available; -An order, dated 12/30/25, for metoprolol tartrate (beta blocker used to treat high blood pressure) 25 mg oral tablet, give 0.5 tablet by mouth two times a day for blood pressure;-Medication not given 46 out of 56 opportunities;-An order, dated 12/30/25, for midodrine hydrochloride (HCl) (blood pressure medication) 5 mg. oral tablet 5 mg, give one tablet by mouth three times a day for hypotension. Special Instructions: Please hold medication if systolic blood pressure is greater than 170; -Medication not given 60 out of 84 opportunities; -On 1/3/26, documented as not given due to morning medications;-An order, dated 12/30/25, for spironolactone (diuretic medication) 25 mg. oral tablet, give one tablet by mouth one time a day for high blood pressure;-Medication not given 26 out of 28 opportunities;-On 1/2/26, 1/3/26, 1/5/26, and 1/10/26, documented as medication not available;-An order, dated 12/30/25, for Eliquis (blood thinner) 5 mg. oral tablet, give one tablet by mouth two times a day for blood clots;-Medication not given 47 out of 56 opportunities;-An order, dated 12/30/25, for clopidogrel bisulfate (antiplatelet medication) 75 mg. oral tablet, give one tablet by mouth one time a day for blood clots;-Medication was not given 23 out of 28 opportunities;-An order, dated 12/30/25, for amiodarone HCl (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	(medication used to treat heart rhythm) 200 mg. oral tablet, give one tablet by mouth one time a day for irregular heart rate.-Medication was not given 22 out of 28 opportunities; Review of the resident's progress notes, dated 1//26 to 1/27/26 showed:-On 1/17/26 at 2:08 P.M., med tech informed writer that he/she was unable to administer the resident's spironolactone due to it not being available. Call placed to the pharmacy and spoke with a staff member. He/She informed facility staff member that the medication was to be delivered on that day, 1/17/26;-No further documentation regarding the resident's missed doses and/or medications not being available. 7. During an interview 1/22/26 at 8:45 A.M., Certified Medication Technician (CMT) W said the facility recently changed over to a new system with ordering medications and is so messed up. Medications were frequently not given because the medications had not been ordered properly. He/She did not get proper training on how the new medication system worked. If a medication wasn't available, the nurse could check the E-kit. 8. During an interview on 1/29/26 at 10:25 A.M., Licensed Practical Nurse (LPN) H said medication should be administered per the physician's order. If a medication was unavailable, the nurse should document this in the resident's medical record and call the physician or pharmacy to obtain a new order. 9. During an interview on 1/29/26 at 2:13 P.M, with Administrator B and DON C, DON C said holes and blank spots on a resident's MAR means the medication was not given. If medication was out or unavailable, the nurse should go to the Pyxis (a locked medication dispensing unit that requires a password) and the medication should be in there. If not, the nurse should call the pharmacy and ask for STAT (urgent) delivery. If the medication is on backorder, the nurse should contact the physician and get a substitute order. DON C said he/she expected medication to be reordered timely and the medication be administered accurately and timely. He/She expected staff to notify the pharmacy and physician after one dose was not given and not wait until multiple doses were missing. 271645827128092686224268498126816 91

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure medication carts were free from personal items and to ensure medications were stored securely and at proper temperatures, resulting in multiple medications being discarded. In addition, the facility failed to ensure medications were appropriately labeled with open dates and/or resident names. Four medication carts were observed, and problems were found with each. The census was 91. Review of the facility's Refrigerator Temperature Monitoring Policy, dated [DATE], showed:-Purpose: To ensure the safe storage of medications, vaccines, biologicals, and other temperatures-sensitive items in compliance with Missouri Department of Health and Senior Services (DHSS), Centers for Disease Control and Prevention (CDC), Centers for Medicare & Medicaid Services (CMS) and applicable regulatory standards;-Scope: This policy applies to all refrigerators used to store medications, vaccines, laboratory specimens and patient-specific items within the facility;-Policy: All refrigerators used for temperatures-sensitives items must maintain temperatures between 36 degrees Fahrenheit (F) and 46 degrees F at all times unless manufactures guidelines specifies otherwise;-Responsibilities:-Staff are responsible monitoring and documenting refrigerator temperatures;-Supervisors/Mangers are responsible for reviewing logs and ensuring corrective actions are completed;-Procedure:-Refrigerator temperatures must be checked and documented at least once daily (or per facility policy);-Temperature must be recorded on the approved temperature log;-Logs must be reviewed according to facility policy (e.g., weekly or monthly);-Out-of-Range Temperatures:-Notify the supervisor or designee immediately;-Document the temperature variance and corrective action taken;-Follow manufacture, pharmacy, or vaccine storage guidance before returning items to use. Review of the facility's Storage Medication policy, undated, showed:-Purpose: Medications and biological are store, securely, and properly following the manufacture or supplies recommendations. The medication supply is accessible only to the licensed nursing personnel, pharmacy, or staff members lawfully authorized to administer medications;-Procedure:-All medications dispensed by pharmacy should be kept in package with label attached;-Medications storage area should be kept clean, well lit, and free of clutter, extreme humidity and temperatures;-Medications requiring refrigeration, or temperature between 36 degrees F and 46 degrees F, are kept in a refrigerator. Medications requiring storage in a cool place are refrigerated unless otherwise on the label;-A thermometer must be kept in the refrigerator containing medications to allow proper temperature monitoring;-The monthly inspection by the consultant Pharmacist and/or Nurse will address all aspects of drug storage and record keeping and will be documented for facility follow-up;-Certain medications or packages types, such as IV (intravenous) solutions, multiple dose injectable vials, ophthalmic (eye medications), nitroglycerin tablets, blood sugar testing solutions and strips, once opened, require an expiration date shorter than the manufacture expiration date to insure medication purity and potency;-When the original seal of a manufacture's container or vial is initially broken, the container or vial will be dated;--The nurse shall place a date opened sticker on the medication and enter the dated opened, and the new date of expiration (Note: the best stickers to affix contain both a date opened and expiration notation line). The expiration date of the vial or container will be 30 days, unless the manufacture recommends another date regulatory/guidelines require a different dating;-The nurse will check the expiration date of each medication before administering it. 1. Observation of the [NAME] Wing medication cart on [DATE] at 6:45 A.M., showed:-Two individually wrapped cupcakes;-An earring;-A personal/portable fan. Observation of the [NAME] Wing medication (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	storage room on [DATE] at 6:45 A.M., showed a mini refrigerator contained a variety of medications for multiple residents. The refrigerator was unplugged. Observation on [DATE] at 6:48 A.M., showed Licensed Practical Nurse (LPN) RRR entered the medication room and plugged the refrigerator back in. The refrigerator temperature gauge showed 65 degrees F and the alarm displayed a message of high temperature alarm (HA). During an interview, Certified Medication Technician) SSS said it was a night shift chore to check the refrigerator. LPN RRR said he/she came in at 3:00 A.M. There was no other nurse when he/she arrived and he/she did not confirm the refrigerator was checked. He/She was unfamiliar with the facility's policy. Observation on [NAME] Wing refrigerator on [DATE] at approximately 6:45 A.M., showed:-7:06 A.M., 62 degrees F, alarm sounding HA;-7:11 A.M., 58 degrees F, no alarm sounding;-7:12 A.M., 57 degrees F, no alarm sounding;-7:14 A.M., 56 degrees F no alarm sounding;-7:15 A.M., 56 degrees F, alarm sounding HA;-7:18 A.M., 55 degrees F, alarm sounding HA. Review of the facility's temperature log for [NAME] Wing, dated [DATE], showed no staff member check on the refrigerator's temperature from [DATE] through [DATE]. During an interview on [DATE] at 8:59 A.M., Director of Nursing (DON) C said everything needs to be pulled from the [NAME] Wing refrigerator and reordered. 2. Observation on the [NAME] Hall nurse cart on [DATE] at 8:40 A.M., showed:-Dry erase markers in the top drawer;-Kwik Pen (insulin) without an open date, and resident name handwritten on the cap;-Solar Star Pen (insulin) without an open date;-Boudreaux's Butt Paste cream tube without an open date or resident name;-Desitin cream without a resident's name or open date. Observation of the [NAME] Hall CMT cart on [DATE] at 8:40 A.M., showed half of a white circular pill in the pill cutter, marked PLI-4, for trazadone 50 milligrams (mg). 3. Observation on the Med A Hall nurse cart on [DATE] at approximately 5:00 P.M., showed:-13 insulin pens with handwritten names and no patient labels;-Betamethasone valerate ointment (topical ointment used to help relieve redness, itching, swelling, or other discomfort caused by skin conditions) without an open date;-Aspercreme (topical cream used to relieve minor pain) without an open date;-A biohazard bag contained 24 urine tubes, expired dated [DATE], and urine culture tubes;-A plastic bag with a sticker labeled refrigerator contained two syringes of glatopa (used to treat multiple sclerosis (autoimmune disease) 40 mg/milliliters (mL). Observation on the Med A Hall CMT cart on [DATE] at approximately 5:00 P.M., showed:-Loperamide (treats diarrhea) blister pack 2 mg without a patient label;-Cetirizine (treats allergies) blister pack contained four pills, without an open date or patient label;-A loose oval, white pill. During an interview on [DATE] at 5:07 P.M., DON C said insulin should have a patient label on the pen and the resident's name should not be handwritten on the caps of the insulin pens. When a resident is discharged , the nurse is primarily responsible for removing the medication no longer used and destroying it.

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F 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or get specialized rehabilitative services as required for a resident. Based on interview and record review, the facility failed to provide therapy services as ordered for one resident (Resident #15) who received outside physical therapy (PT) due to inconsistent therapy provided by the facility. The facility also failed to update the resident's medical record to reflect outside therapy services. The facility also failed to offer speech therapy (ST) between 9/1/25 through 1/22/26. In addition, the facility failed to have an active restorative program in accordance with resident needs, placing residents at risk for avoidable decline. The sample was 21. The census was 91. Review of the facility's Therapy Services Policy and Procedures, reviewed 7/1/25, showed:-Policy: It is the policy of the facility to provide therapy services that promote optimal resident function, independence, safety, and quality of life. Therapy services shall be:--Provided under the direction of qualified and licensed therapists;--Based on physician orders and interdisciplinary assessment;--Coordinated with nursing, social services, and dietary departments;--Documented accurately and timely in the medical record;--Evaluated periodically to ensure effectiveness and appropriateness;-Procedure: Referral and Orders;--Therapy services must be initiated upon a written physician order;--Orders may be generated after admission assessment, a change in condition, or upon resident/family request;--Verbal orders must be authenticated by the physician within the required timeframe per facility and state policy;-Evaluation and Plan of Care (POC);--The therapist will perform a comprehensive evaluation within [24-48 hours] of receiving the order;--A written POC shall be developed, including:---Diagnosis and functional limitations;---Measurable goals and expected outcomes;---Treatment frequency, duration, and interventions;---The POC must be approved by the physician before treatment begins;-Treatment Implementation: Therapy sessions are delivered according to the approved POC;--Residents' responses to treatment will be documented after each session;--Any adverse reactions or changes in status will be promptly reported to nursing and the physician;-Reassessment and Progress Reporting: Therapists must complete progress notes and reassessments at least every 7/14/30 days (depending on payer or regulatory requirement);--POC revisions must be updated as needed to reflect progress or decline;-Discharge from Therapy: Therapy services may be discontinued when:--Goals have been met or maximum potential achieved;--The physician or interdisciplinary team determines therapy is no longer beneficial;--The resident refuses or is unable to participate consistently;--A discharge summary must be completed and communicated to the care team;-Documentation: All documentation must:--Be legible, dated, and signed by the therapist or assistant;--Include resident identification, diagnosis, POC, progress notes, and discharge summary;--Be maintained as part of the resident's permanent medical record;--Quality Assurance (QA): The Therapy Director and QA Committee shall review therapy records and outcomes at least quarterly;--Performance indicators include resident satisfaction, therapy completion rates, and falls/mobility outcomes;--Identified deficiencies will be addressed through staff education or process improvement plans;-Compliance: Therapy services must comply with:--CMS Regulations: 42 CFR S483.65 (Specialized Rehabilitative Services);--State licensing standards for rehabilitation staff;--Medicare and Medicaid billing regulations. 1. Review of Resident #15's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 10/24/25, showed:-Moderate cognitive impairment;-Diagnoses included heart failure, coronary artery disease, high blood pressure, multidrug-resistant organism (MDRO, microorganisms that are resistant to one or more classes of antimicrobial agents), anxiety, depression;-Required partial/moderate assistance with rolling to left and right;-Substantial/maximal assistance required with sit to lying, sit to stand, and chair/bed to chair transfer;-Dependent with lying to siting on side of bed, toilet transfers, and tub/shower transfer;-Use of wheelchair and/or scooter;-No documented therapy minutes;-0 days in (continued on next page)

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F 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	restorative nursing program. Review of the resident's care plan, in use during survey, showed:-Problem: Resident has potential for pathological fractures due to osteoporosis;-Goal: Resident will remain free from injury due to osteoporosis;-Approaches included: Diagnostics as ordered. Give resident verbal reminders not to ambulate/transfer without assistance. Medication/supplements as ordered;-Problem: Requires assist with Activities of Daily Living (ADLs) due to chronic debility;-Goal: Resident will maintain current level of function in regards to feeding him/herself;-Interventions included:--No less than two staff members will be present to assist with transfers while using the mechanical lift;--Resident will continue to be educated and assisted with appropriate use of mechanical lift;--Usually dependent with bed mobility. Assist as needed;--Usually dependent with toileting hygiene. Assist as needed;--Usually dependent with dressing, oral hygiene, and bathing. Assist as needed;--Usually need set up and clean up assist for meals;--Wheelchair for mobility. Assist with location as needed;-No documentation of the resident's outside therapy services. Review of the resident's electronic physician order sheet (ePOS), showed:-An order, dated 7/23/25, for PT/occupational therapy (OT)/ST to evaluate and treat as indicated for transfer status, functional decline, and confusion;-An order, dated 8/30/25, to discontinue PT/OT/ST evaluation. Review of the resident's progress note, dated 10/8/25, showed resident left for therapy appointment via facility's transportation with staff member present as escort. Resident left in wheelchair with lunch packed from dietary, all proper protocols followed. Further review of the resident's ePOS, showed:-An order, dated 11/25/25, for PT/OT/ST evaluate and treat as indicated;-An order, dated 1/18/26, to discontinue PT/OT/ST. Review of the resident's progress note, dated 12/9/25, showed writer spoke with resident's family member regarding daily transportation to outside therapy. Advised that at this time we are unable to provide daily transportation to this appointment. Alternatives offered to resident and family member, which were to transfer therapy services in house, family/friends provide transportation to appointment, and/or enroll in therapy provided transportation which is a fee of $15.00 billed by therapy company. Family member stated, ok thanks, I'll take care of it. Nursing leadership and receptionist aware. Review of the resident's physician's progress note, dated 1/20/26, showed resident seen on 1/20/26, present for follow up, patient doing well, patient just returned from outside PT. No sign of distress, getting outside therapy 5x per week. During an interview on 1/26/26 at 1:50 P.M., the resident said he/she did not have consistent PT or ST. He/She could not walk after his/her back surgery. He/She was supposed to have PT, but no one showed up. He/She goes outside to another center for PT Monday through Friday. His/Her family member picks him/her up every day. It has been hard on the family member. During an interview on 1/26/26 at 2:12 P.M., the resident's family member said he/she goes to the therapy clinic five days a week. It is 5 1/2 hours of therapy each day. The resident received therapy at the facility when he/she was first admitted . Resident was admitted in July 2025 and the therapy was good. The resident wanted to be happy. Then he/she did not get what he/she needed for therapy, but the care was still good. Then all of a sudden, everyone got fired or quit. They found out the ownership changed. The resident did not have therapy for three months. He/She had spinal surgery in 2024. His/Her physician said the resident's body was de-conditioning and he/she needed therapy, so they found the day program outside of the facility. He/She started going on 10/8/25, and now the resident is walking with a walker. The family member asked the resident to find out about therapy, but they were told to come to the meeting or we do not know. The family member spoke to everyone about the resident going to day center for therapy, but it is rotating staff now. During an interview on 1/28/26 at 11:00 A.M., the Director of Rehab said the resident never had therapy in the facility since he/she has been the director since September 2025. During an interview on 1/28/26 at 2:05 P.M., the Plant (continued on next page)

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F 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Operations Manager said the facility had a contract with a therapy company until the new ownership came. Therapy continued to happen, but it was light during the transition. Nursing management handled therapy after that the company left. During an interview on 1/28/26 at 2:22 P.M., the Director of Rehab said he/she started after Thanksgiving as director. There were other therapy staff here at the time. There was a full time OT, Certified Occupation Therapy Assistant (COTA) and everyone else was as needed (PRN). There was no ST and they just hired a PRN ST. One resident had a speech evaluation via telehealth, but most speech therapists do not feel comfortable doing it via telehealth. If the resident had orders for all three therapies, PT/OT/ST, they were only getting PT and OT. They had a fulltime PT that recently left and it put them in a bind, but another PT will start in March. There is a contracted Physical Therapy Assistant (PTA) that also just started. The residents receive their PT/OT orders, it is being fulfilled. They receive therapy three times a week. Once they have more staff, it will be five times a week. They do not have a restorative program. There had been no restorative program since he/she started at the facility. During an interview on 1/28/26 at 2:39 P.M., Licensed Practical Nurse (LPN) Z said there was no PT/OT in the beginning of the transition of the new ownership. They did not have a restorative program at this time. They have not had a restorative program since the change in ownership. After the change in ownership, they wanted to change the restorative aide (RA) to Certified Nurse Aide (CNA), but he/she retired and they got rid of the other RA. 2. Review of the facility's therapy minutes, dated 9/1/25 through 1/22/26, showed no ST evaluations, ST minutes or services offered to residents. During an interview on 1/28/26 at 12:20 P.M., the Dietary Manager said ST was supposed to be telehealth and there is a new person starting. 3. During an interview on 1/29/26 at 1:43 P.M., Director of Nursing (DON) C said he/she was aware the resident received therapy outside of the facility. The facility was looking to hire one therapist. The facility ensured therapy was delivered by completing an assessment, and if they do not have appropriate staff, they contracted a staff member. There was no restorative therapy program in place. If a resident received outside therapy services, he/she expected staff to arrange transportation to and from, and set the schedule and arrange it. He/She expected there to be communication between the facility and the outside therapy company. There should be progress notes, proper documentation, and it should be care planned. 265250126464812724850

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Administer the facility in a manner that enables it to use its resources effectively and efficiently. Based on observation, interview and record review, the facility failed to ensure payments were issued or issued in a timely manner, to the facility's food supplier, staffing agency, dietician, and other necessary vendors utilized to provide services for the needs of residents, placing residents at risk for interruption of services and inadequate care. This deficient practice had the potential to affect all residents. The census was 91. Review of the facility's Facility Assessment, undated, showed:-Purpose: The facility assessment is a complete review of internal human and physical resources required by the facility to care for residents competently during day to day (including nights and weekends) and emergency operations. The facility assessment identifies your capabilities as a skilled nursing services provider;-The assessment is not intended as a static tool but is intended to be a living document. It should include the business plan, staffing plan, the types of residents served, and the resources and physical plant required to competently care for the identified population;-Facility resources needed to provide competent resident support and care daily and during emergencies:--Nursing services staff, food and nutrition staff (e.g., Registered Dietician);--Physical environment and building plant needs:---Services, such as barber/beauty;--Facility contracts list included vendors for food and water supplies and oxygen medical supplies. 1. During an interview on 1/23/26 at 8:12 A.M., Certified Nurse Aide (CNA) QQQ said they run out of everything; wipes, towels, plates, etc. Staff try to make do with what they have. Observation and interview on 1/26/26 at 945 A.M., showed Housekeeper F lifted an empty container of the brand P&G Proline 3.78 liter/1 gallon container. During an interview, he/she said the facility stopped purchasing the mop water stuff, so now they use an all purpose cleaner. They used to have a hook up that would pour it out into the bucket. They ran out of the cleaner a while ago, but he/she kept the bottle. Housekeeper K pointed to a bottle that read, Medorra Limpreza All Purpose Cleaner Lavender scent. The facility purchased Medorra Limpreza all purpose cleaner. Without using the hook up, Housekeeper F was not sure how much to use. He/She poured cleaner into the cap and put it into the bucket. He/She said the bottle of the Medorra Limpreza is the last one they have. During an interview on 1/26/26 at 11:35 A.M., the Plant Operations Manager said they had a person in corporate that ordered the supplies. Staff did not have a say of what is approved. They used to have a census of 85, and now it is over 100 so they used more supplies. They dropped all the maintenance vendors. Before the change in ownership, every department had their own budget. He/She used to be able to go to a hardware store, but now it goes to corporate. Sometimes the items ordered did not come at once. During an interview on 1/28/26 at 10:46 A.M., the Regional Nurse Consultant said they ordered supplies from a platform called On-Care. It picked whichever was cheapest. During an interview on 1/28/26 at 2:39 P.M., Licensed Practical Nurse (LPN) Z said they ran out of wipes, paper towels, and tissue. During an interview on 1/29/26 at 10:00 A.M., Central Supply PPP said he/she worked in the building for several years. On 9/1/25, when the new management took over, he/she was given duties of medical records and accounts payable in October 2025. He/She tried to do everything, but it was a lot. Before the management change, there was never a problem. When the new management took over, there was a budget issue, and they went from having supplies to limited supplies. They were told five cases of gloves, which has 10 boxes of gloves to a case, was enough. They ordered them in large and medium. A case of wipes had 12 packs in each case. They ordered 1500 gloves and corporate said it was enough, but they were not looking at the fact they had 10 boxes. They only focused on the 1500 gloves part. He/She tried to add another box, but corporate said no. They said five cases would do. Corporate has been told it was not enough. Administrator A said to copy him/her in the e-mails to corporate, he/she did not have any luck with corporate, either. The (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	quality of the gloves went down. They ordered gloves that ripped once put on. Central Supply PPP did not know about if there were money problems, and did not know what the budget was. He/She had a budget of $4000.00, and now there's no department budget anymore. He/She sent the order out and hoped they received what was ordered. The residents are aware of the issues and they did not like it at all. They complained about the briefs. Before the residents had fit ultra, which was the best. Now they buy fit basic, and the staff ran right through it because urine goes right through the briefs. He/She believed it contributed to odors or residents soiled in the facility. They ordered chucks/liners now, and they never had to order them prior to the management change. There were only four residents using liners at first. The aides told the residents they did not have a supply of briefs, pull-ups, or liners. He/She used to deliver them the briefs for residents to the units, but since he/she had new responsibilities, he/she could not or would fall behind. Before the facility was sold, they stocked up and bought a lot of supplies, so they did not need a lot other than gloves. Personal Protective Equipment (PPE) was in the basement. The face masks, briefs, and face shields are all in the basements. The new company had not completed inventory. They were supposed to do it with the Assistant Director of Nurses, but he/she left. It had not been stable. The had not ordered PPE since 9/1/25. They had ordered only gloves and wipes. During an interview on 1/29/26 at 1:43 P.M., Administrator B said there were extra supplies in the basement, so the Administrator told staff to educate someone on where to find it. He/She expected housekeeping to use appropriate supplies to clean all areas of the facility. He/She expected housekeeping staff to know how much chemicals to use. 2. Review of the facility's resident council minutes, dated 11/26/25, showed residents in attendance requested regular plates and bowls at meals, not plastic or Styrofoam. During an interview on 1/22/26 at 11:51 A.M., Dietary Aide U said the facility had not had the chemicals required to wash dishes in the dish machine for about two months. During an interview on 1/22/26 at 11:59 A.M., the Dietary Manager said the dish machine worked, but it did not have soap or rinse. It had been out for over a month. The new owners did not want to use a particular brand of chemicals because it was too expense, so they needed a new dispenser. Staff were washing dishes by hand. Observation on 1/22/26 at 12:43 P.M., showed the Assistant Dietary Manager plated the residents' food on Styrofoam plates and covered the plates with plastic lids. During an interview on 1/22/26 at 4:19 P.M., Administrator A said corporate ordered a new dispenser. It did not need to be repaired. They wanted cheaper products for dish machine. There was a monthly fee for the previous supplier, so they are changing the vendor. During an interview on 1/23/26 at 1:12 P.M., CNA V said they were on a tight budget. The residents went from having plastic cups to foam cups. During an interview on 1/26/26 at 3:04 P.M., the Dietary Manager said she placed the supply order with corporate. Food orders were based off the menu, so it was ordered weekly. For produce, the Dietary Manager ordered two cases of bananas in the past, and corporate asked, do you really need two? They gave push back on all the ordering. They could order bananas and they used to order grapes, but it was too expensive. They could get honeydew and cantaloupe. At times, they could get two cases, but most of the time, it was only one. Dietary asked for onions and heads of lettuce for burgers, but it was not ordered for them. The Dietary Manager would take the romaine lettuce from the bag and pair it with tomato and pickles for their burgers. Another example is ordering scalloped potatoes, but they will substitute it for hash browns with cheese on it. They used to order beef 81/19 fine, and now they get 73/27 fine raw beef. The 73 means there is more fat than 81. There is loss in protein/nutrients. Last week, she found out the facility owes Vendor A, the food supplier, $51,000.00. A representative from Vendor A informed her last week. They will email corporate and the Administrator. The company that delivered the bread also informed her that they need to be (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	paid. During an interview on 1/27/26 at 4:50 P.M., the Registered Dietician (RD) said he/she was the current dietician and he/she went into the facility once or twice a month. Prior to the new ownership, the dietary budget was high. They fed everyone, including staff for years. Going from that to this budget.now, the residents wanted things on the menu that they could not afford to do. They had a person in corporate that ordered the food. The RD asked corporate to make changes and sometimes he/she did them. The RD was not sure the corporate person that placed orders ever worked in food service. It was hard communicating with them. The RD had never been paid by the facility for services since the new ownership took over. He/She informed Administrator A that he/she needed to be paid. During an interview on 1/28/26 at 1:43 P.M., Administrator B said he/she was not aware the residents used Styrofoam plates and cups instead of reusable dishware. He/She was not privy to that information, but it was not appropriate to suspend using the dish machine due to not purchasing sanitizer and rinse. He/She was not aware the dish machine was previously not in use. During an interview on 2/6/25 at 1232 P.M., representative from Vendor A confirmed the facility had a balance of $65,541.13. A large portion was past due, in the amount of $49,000.00. 3. During an interview on 1/23/26 at 8:12 A.M., CNA QQQ said they tried to call in agency staff, but they didn't show up all the time. It was hard for the facility to accommodate the needs of residents. When he/she started in October 2025, his/her first two paychecks bounced. During an interview on 1/23/26 at 9:03 A.M., LPN O said in December 2025/New Year's, he/she was told the facility would pay him/her for 12 hours instead of 20 hours. He/She had issues getting a paycheck. During an interview on 1/22/26 at 4:19 P.M., Administrator A said the payroll issues were confusing. They switched the time clock in December 2025, but if an employee missed a punch, it would not count the whole time. They fixed it immediately and issued paper checks. During an interview on 1/23/26 at 1:12 P.M., CNA V said he/she worked at the facility for five months. The paychecks were not right and his/her most recent check was incorrect. He/She worked over the weekend and was supposed to receive a $2 differential. Instead of receiving $25/hour (hr), it was $2/hr. He/She spoke to the facility yesterday about the issue, but they did not have an explanation. Staff have asked management for copies of their time, but they give them the run around. CNA V showed his/her paystub, which showed weekend hours were 14.75 hours. The hourly rate showed $2.00. The total amount was $29.50. During an interview on 1/23/26 at 1:23 P.M., CNA EEE said he/she worked at the facility for six months. The most recent check had one shift, which was about eight hours. He/She informed the facility and they said they would either pay them on the next check or cut a check. It had only been the last two checks. When staff asked the facility about it, they tell them it is coming from New York. There was an issue with the time clock. It showed they clocked in an hour later, and he/she had the time fixed when it happened. During an interview on 1/26/26 at 9:30 A.M., a representative from Vendor B, a staffing agency, said after the change in ownership, it was decided agency staffing would not be used; however, after two weeks, they wanted to give it a try until they no longer needed them. They were aware it was a transition change and people were quitting. The contract did not change, only the name of the facility. There are a total of 10 invoices. The company made zero payments. The facility's previous accounts receivable person was someone they had worked with for years and they tried to contact someone. The Administrator at the time told them everything had been approved to send to corporate for payment in an e-mail. This was right before it was decided to stop staffing the facility. Previously, he/she spoke to the facility on the phone and they said a payment would be made. The payment was not made because it was a holiday and then they asked what the minimum payment would be. A Regional Manager complained about the contract and the rates, so the facility received an adjustment of $10,000.00. The Regional Manager texted Vendor B and asked for all (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	invoices, which were given to the facility. After that contact, the Regional Manager had not returned any phone calls and they lost contact with them. They stopped providing staff for the facility in early November 2025. He/She emailed the company on 1/5/26 to get payment. He/She was also privy to other staffing agencies that had not been paid. He/She confirmed the total amount before late fees is approximately $179,000.00. During an interview on 1/28/26 at 2:39 P.M., LPN Z said since the new management took over, they have been short staffed. The wound nurse quit several weeks ago because they were at the facility for 20 hours. The nurses did not know if they would have relief, so they did not come in. They called management and asked when they can leave. If they leave, management will say it is job abandonment. They have lost so many nurses because they did not know when they could go home. They had trouble with pay checks bouncing and they take an hour out of his/her check daily. He/She worked 12 hours and they took an hour from him/her. He/She used to work regularly at the facility until he/she was stuck for 23 hours. After that occurred, he/she switched to as needed (PRN). Another LPN got stuck overnight. Director of Nursing (DON) D worked the floor more than doing the DON duties. He/She got burned out. The residents complain about staffing. 4. During an interview on 1/22/26 at 11:05 P.M., the Beautician said he/she was paid on Friday, but it was not everything owed by the facility. He/She was not paid in December 2025. He/She received $25 per Medicaid resident. He/She was responsible for getting money from private pay residents, but the facility would not help with contacting the residents' families. 5. During an interview on 2/6/26 at 1:44 P.M., a representative from Vendor C, an oxygen supply company, said the facility had a current balance of $789.11. It was well beyond the 60 day term. The last payment made by the facility was 8/26/25, before the new management acquired the facility. They have not made a payment. 6. During an interview on 2/10/26 at 11:35 A.M., a representative from Vendor G, a food vendor, said the facility had an unpaid balance of $8,053.13. It included September 2025 through the end of January 2026. No payment had been made for September 2025 through January 2026. 7. During an interview on 2/10/26 at 1:50 P.M. a representative from Vendor I, a pest control company, said they provided service to the facility twice a month. The facility had two outstanding bills for the months of November 2025, December 2025, and January 2026. The facility owed a balance of $1,050.00. 8. During an interview on 1/28/26 at 2:05 P.M., the Plant Operations Manager said housekeeping and maintenance staff got cut. There were three additional maintenance staff, but now there was one. Everything was ordered from corporate, including the floor cleaner. He was also filling in for housekeeping. Staffing and supplies were an issue. There was so much going on and he was pulled in different directions. The transition has been hard on the residents and families. Some of the residents have been there for years. There are multiple vendors that had not been paid. Pest control and snow removal services did not receive a payment; however, the snow removal service came today. They were paid, but they are waiting for another payment. 9. During an interview on 1/29/26 at 1:43 P.M., Administrator B said the DON had a daily staffing sheet for nurse hours. He/She did not know if it was tracked. The past weekend was the issue for the Registered Nurses (RNs). They use quite a bit of agency staff and spend approximately $20,000.00 a month. They currently have two RNs on staff that just started. Since the change in ownership, there had been three Administrators and two DONs. The Assistant Administrator or Administrator would be responsible for compliance during each transition as well as corporate staff. Regulatory duties were not handed off between Administrators. They used agency staffing to ensure minimum staffing requirements were met. Administrator B said the DON was currently working on a system for everyone to abide by to ensure continuity of care with frequent staff turnover. 10. On 2/5/26 at 10:08 A.M. and 2/6/25 at 11:05 A.M., Department of Health and Senior Services (DHSS) attempted to reach the facility's Corporate (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Business Office Manager. Messages were left requesting returned calls, but the calls were unreturned. 272126227209122684730

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F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations (including nights and weekends) and emergencies. Based on interview and record review, the facility failed to have a complete and thorough facility-wide assessment to determine what resources are necessary to care for the residents competently during both day-to-day operations and emergencies. The facility assessment did not include a monthly average number of residents who required assistance with activities of daily living. The census was 91. Review of the facility's Facility Assessment, updated 12/18/25, showed:-People involved in completing: Administrator A, Director of Nursing (DON) C, and Director of Maintenance;-Date reviewed with Quality Assurance Performance Improvement (QAPI) committee: 12/18/25;-Number of licensed beds: 117;-Average daily census: 100;-Average weekday admissions by shift: 3-4;-Average weekend admissions by shift: 0-1;-Average weekday discharges by shift: 3-4;-Average weekend discharges by shift: 0-1;-Assistance with activities of daily living monthly average:-Bed mobility sit to lying: --Set up: blank;--Supervision/partial/moderate assistance: blank;--Dependent/max assistance: blank;-Mobility sit to stand: --Set up: blank;--Supervision/partial/moderate assistance: blank;--Dependent/max assistance: blank;-Bathing: --Set up: blank;--Supervision/partial/moderate assistance: blank;--Dependent/max assistance: blank;-Transfer: --Set up: blank;--Supervision/partial/moderate assistance: blank;--Dependent/max assistance: blank;-Eating: --Set up: blank;--Supervision/partial/moderate assistance: blank;--Dependent/max assistance: blank;-Toileting: --Set up: blank;--Supervision/partial/moderate assistance: blank;--Dependent/max assistance: blank;-Other care, describe: blank;-Staff assignments: Describe how you determine and review individual staff assignments for coordination and continuity of care for residents within and across these staff assignments: -The facility meets this requirement by considering census, individual and overall unit acuity, routine/consistent staffing assignments per unit for both licensed nurses and Certified Nursing Assistants (CNAs), and resident preferences for staff assignments.-Describe how you evaluate if your infection prevention and control program includes effective systems for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement, that follow accepted national standards: -Utilize acceptable infection control program, tracking and trending program infections by type, location, and antibiotic used. We provide transmission-based precautions. Annual infection control and handwashing competency training and as needed. Staff and volunteers participate in annual training. Visitors are observed for signs and symptoms of contagious infections. Signage is used to communicate isolation and any other necessary information to visitors and/or vendors. During the course of the survey process, problems were identified which included:-Staffing and training, to include:--No required CNA 12-hour in competencies abuse and neglect and/or dementia care training for 10 out of 10 CNAs who were employed for more than one year;--Insufficient nursing staff available to meet the needs of residents, as evidenced by staff interviews, residents with missed treatments, and residents with missed activities of daily living (ADL) care;-No restorative program or speech therapy;-Infection control practices, to include:--Tuberculosis testing not completed for 5 out of 5 residents sampled;--Residents on enhanced barrier precautions (EBP) did not have signage or a supply of personal protective equipment (PPE);--Housekeeping staff failed to have Environmental Protection Agency (EPA)-registered hospital disinfectant solution to clean floors. During an interview on 1/28/26 at 1:43 P.M., Administrator B said he/she expected the facility assessment to be fully completed with the total numbers of all residents who required assistance. The Administrator is responsible for ensuring the facility assessment is completed.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to follow acceptable infection control standards by not implementing Enhanced Barrier Precautions (EBP, an infection control intervention designed to reduce the transmission of multidrug-resistant organisms (MDROs) that employs targeted gown and glove use during high contact resident care activities) as recommended by the Centers for Disease Control and Prevention (CDC) and as required by the Centers for Medicare and Medicaid Services (CMS) for six residents (Residents #13, #12, #63, #4, #108, and #7). The facility failed to use appropriate infection control practices during perineal care (cleaning of the genitals and rectal area) for four residents (Residents #13, #63, #4, and #11). The facility failed to disinfect a Hoyer lift (mechanical lift) in between use on two residents (Residents #7 and #91). The facility failed to complete a tuberculin test (a test to determine if exposed to tuberculosis (TB, a contagious lung disease)) on five of five sampled residents (Residents #13, #12, #6, #9 and #8). The facility failed to complete a tuberculin test on 9 out of 10 newly hired employees and failed to use a proper disinfecting chemical to clean the floors. The sample was 21. The census was 91. Review of the facility's Incontinent Care policy, dated 7/1/25, showed:-Policy: The facility will provide incontinent care as directed in the plan of care;-Procedure:-Gather supplies;-Perform hand hygiene and apply gloves;-Assist with positioning resident in a safe and comfortable position;-Remove soiled brief and under pad by rolling the brief and under pad;-Cleanse Perineal (genital and rectal area) with perineal cleanser; --Females: Separate labia (part of the female genitalia), cleanse one side and then the other. Cleanse center of labia wiping towards the rectal area. Cleanse perineal area from front to back. Cleanse thighs, rectal area, and buttocks;--Males: Retract foreskin if uncircumcised, cleans the penile tip using a circular motion, starting with the urethra (opening that drains the urine from the body) working outward. Cleanse penile shaft, scrotum, and rectal area, thighs and buttocks;-Use a clean surface are of the cloth for each wipe' Use multiple cloths, if necessary, to maintain, infection control;-Remove soiled gloves, perform hand hygiene and appl clean gloves;-Apply clean brief and clothing;-Discard contaminated items in a plastic liner;-Remove gloves and perform hand hygiene. Review of the facility's EBP policy, dated 7/1/25, showed:-Policy: The facility may expand the use of personal protective equipment (PPE, gowns and gloves) and refer to the use of gowns and gloves during high contact resident care activities that provides opportunities for transfer of MDRO to hands and clothing. The use of gown and gloves for high contact resident care activities is indicated, when contact precautions do not otherwise apply, for facility residents with wounds and or indwelling medical devices regardless of MDRO colonization (presence of bacteria but does not cause and infection), as well as for residents with MDRO infection or colonization;-Steps: Post signage on the door or wall outside of the resident's room indicating the use of EBP, post signage in the resident's room with information on use of EBP and required PPE. PPE should be available inside of the resident's room. Alcohol-based hand rub should be available for hand hygiene .Position a trashcan inside the resident's room near exit for discarding PPE after removal and prior to exiting the resident's room;-Residents with the following: Infection or colonization MDRO, wounds, or and indwelling medical devices such as urinary catheter, (a tube that drains the bladder), central line, (a surgically inserted thin tube inserted into a large blood vessel), tube feeding (a surgically inserted tube in the abdomen that provides liquid nutrition and medications), and tracheostomy (surgically inserted tube into the windpipe to assist with breathing), regardless of MDRO status;-PPE situations: During high contact resident care activities, such as dressing, bathing, transferring, providing hygiene, changing linens, changing briefs and toileting, device care, and (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	wound care, and skin openings requiring a dressing;-PPE required: Gloves and gown prior to high contact care activity. 1. Review of Resident #13's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 1/6/26, showed diagnoses included heart disease, kidney disease, and high blood pressure. Review of the resident's medical record, showed:-An order, dated 12/9/26, for urinary catheter;-No order for EBP. Observation on 1/22/25 at 10:00 A.M., showed on the outside of the resident's door, there was no EBP sign or PPE in the 200 hallway or available in the resident's room. The resident was incontinent of stool and requested to be cleaned. Certified Nurse Aide (CNA) BB and CNA Y performed hand hygiene and applied gloves. CNA BB loosened the resident's brief and rolled the front of the brief between the resident's legs. CNA BB cleansed the resident's genitals and performed urinary catheter care. CNA BB and CNA Y turned the resident to his/her left side. CNA BB cleansed the resident's buttocks and rectal area, removed the resident's soiled brief and bed pad. With the same gloved hands, CNA BB applied a new brief and bed pad. CNA BB pulled back on the privacy curtains with the same gloved hands and adjusted the resident's gown and bedding. CNA Y and CNA BB did not wear isolation gowns while providing direct care. 2. Review of Resident #12's quarterly MDS, dated [DATE], showed diagnoses included heart failure, hip fracture, diabetes, and kidney disease. Review of the resident's medical record, showed:-A physician order, dated 1/16/26, for left anterior leg, cleanse with wound cleaner or normal saline, apply skin prep around the wound, apply xeroform gauze (a special non-adherent dressing), collagen powder (a treatment that absorbs fluid and increases healing), apply gauze, wrap with Kerlix (specialized wrap), and secure with tape;-An order, dated 1/16/26, for left lateral leg, cleanse with wound cleaner or normal saline, apply skin prep around the wound, apply xeroform gauze, collagen powder, apply gauze, wrap with Kerlix gauze roll and secure with tape. Observation on 1/23/26 at 7:35 A.M., showed outside the resident's room, there was no EBP sign posted. There were no PPE supplies outside or inside the resident's room. As the resident was seated his/her wheelchair, Licensed Practical Nurse (LPN) JJ removed the resident's left leg dressings that were dated 1/21/26, and the dressings were saturated with serous (clear, yellow) drainage. LPN JJ cleaned the resident's left leg wounds with wound cleanser. LPN JJ applied a Mepilex dressing (a specialized foam dressing) over the left leg wounds. He/She did not wear an isolation gown while providing direct care. Observation on 1/27/26 at 1:30 P.M., showed outside the resident's room, there was no EBP sign posted. There were no PPE supplies outside or inside the resident's room. The resident sat in his/her wheelchair with his/her left leg dressings saturated with serous drainage. The Assistant Director of Nursing (ADON) gathered supplies off the treatment cart. The ADON removed the resident's dressings and completed the resident's left leg treatments. She did not wear an isolation gown while providing direct care. During an interview, the ADON said she should have worn a gown for the resident's dressing change because the resident is on EBP. She had not seen any gowns in the facility for a while. There should have been a sign posted and PPE supplies outside the resident's room. 3. Review of Resident #63's admission MDS, dated [DATE], showed:-Diagnoses included diabetes, hypertension (high blood pressure), hyperlipidemia (high cholesterol).-Cognitively intact;-Presence of indwelling urinary catheter (a sterile tube inserted into the bladder to drain urine). Review of the resident's POS, dated 1/2026, showed no orders for EBP to be worn during close contact care. Observation on 1/22/26 at 8:28 A.M., showed no EBP sign on the resident's door. Observation on 1/26/26 at 10:55 A.M., showed CNA S walked into the resident's room, put on gloves, and pulled the resident's bed covers down, exposing the resident. He/She rolled the resident to the left side, leaning up against the bed and the resident. He/She wiped the resident from the front to the back. He/She pulled the catheter to the front and out of the brief from the right side. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	He/She attempted to put the catheter in the resident's pant leg while leaning against the resident. He/She did not wear an isolation gown while providing direct care. During an interview on 1/29/26 at 10:31 A.M., LPN H said PPE should be worn during close contact care if a resident has a catheter. Gown and gloves should be worn. During an interview on 1/28/2026 at 2:50 P.M., Director of Nurses (DON) C said gown and gloves should be worn when handling catheters to prevent germs and infection. 4. Review Resident #4's admission MDS, dated [DATE], showed:-Moderate cognitive impairment;-Physical assistance required for hygiene, transfers, and daily care. Review of resident's medical record, showed,-admission date 12/5/25;-Diagnoses included aphasia (inability to comprehend or express self), dementia (memory loss), hemiplegia and hemiparesis (paralysis and weakness), kidney disease, diabetes, anxiety, mood disorder, and hypertension; Review of the resident's electronic physician's order sheet (ePOS), showed:-No orders for EBP;-No orders for urinary catheter care. Review of the resident's medical record, showed no baseline care plan to direct staff on the care needs of the resident or need for maintenance care for catheter care. Observation on 1/22/26 at 2:50 P.M., showed CNA DDD drained the resident's urinary leg bag without wearing PPE while providing direct care. Observation on 1/26/26 at 9:20 A.M., showed CNA DDD did not wear PPE while performing personal care on the resident. He/She did not perform catheter care after cleaning stool from the resident's rectum. During an interview, CNA DDD said he/she guessed he/she should clean a resident's catheter and genitals. 5. Review of Resident #108's quarterly MDS, dated [DATE], showed:-admission date 7/1/25;-Cognitively intact;-Indwelling catheter;-Diagnoses included heart disease, kidney disease, neurogenic bladder (difficulty urinating), obstructive uropathy (difficulty urinating due to a stricture), and depression. Review of the resident's ePOS, dated 1/23/26, showed:-An order, dated 12/30/25, for dressing changes to nephrostomy tubes. Change dressing to right and left nephrostomy tubes on posterior back. Cleanse sites with wound cleanser, apply split gauze to right side and split gauze to left daily. Special Instructions: monitor for redness, swelling, drainage and irritation daily, once a day, one time a day for dressing changes;-An order, dated 12/30/25, for gentamicin sulfate external cream (antibiotic cream) 0.1%, apply to nephrostomy sites topically one time a day for dressing change. Special Instructions: Apply ointment to left and right nephrostomy tube site once daily at night shift. Apply with dressing change;-An order, dated 1/19/26, to flush nephrostomy tube with 10-20 milliliters (ml.) normal saline daily as needed (PRN);-An order, dated 1/26/26, for EBP related to nephrostomy tubes every day and night shift. Observations of the resident's room, showed:-On 1/22/26 at 11:23 A.M., no EBP signage on the door nor any PPE on or outside the door.-On 1/23/26 at 1:05 P.M., no EBP signage on the door nor any PPE on or outside the door.-On 1/23/26 at 2:54 P.M., no EBP signage on the door nor any PPE on or outside the door. Observation on 1/27/26 at 12:30 P.M., showed the resident in his/her wheelchair in his/her room. Employee VVV walked into the room and told the resident that he/she would not like it, but he/she had to change to the dressings on his/her nephrostomy tubes. The staff member put gloves on and proceeded to change the resident's dressings. He/She did not wear an isolation gown while providing direct care. 6. Review of Resident #7's medical record, showed:-Diagnoses included hyperlipidemia (high cholesterol), hypertension (high blood pressure), dementia, malnutrition, anxiety disorder, and depression;-A physician order, dated 12/18/25, for gentamicin sulfate external ointment 0.1%, apply to coccyx wound topically one time a day for wound;-No physician order for EBP. Review of the resident's care plan, in use during the survey, showed resident has pressure ulcers and is at risk for worsening of pressure ulcers due to incontinence and inability to offload and position change; Observations of the resident's room, from 1/22/26 to 1/26/26, showed no EBP signage on the resident's door, or any PPE in or outside the room. 7. During an interview on 1/2826 at 8:07 (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	A.M., LPN OOO said he/she wasn't really exactly sure what or why residents required EBP. He/She thought the PPE supplies were in the basement. During an interview on 1/29/26 at 10:15 A.M., CNA PP said when there was an EBP sign on a resident's door, it meant that staff were to wear gowns and gloves when providing care. He/She had not seen isolation gowns for a couple of weeks. Residents that required EBP were expected to have a sign on their door and PPE supplies readily available. 8. Review of Resident #11's quarterly MDS, dated [DATE], showed:-Severe cognitive impairment;-Dependent on staff for personal and toilet hygiene;-Diagnoses include dementia, heart disease and heart failure. Review of the resident's care plan, in use at the time of survey, showed:-Problem: The resident is incontinent of bowel and bladder at times. The resident has dementia that limits her ability to communicate his/her needs;-Intervention: Provide incontinence care after each incontinent episode. Observation on 1/26/26 at 8:26 A.M., showed LPN Y entered the resident's room, performed hand hygiene and applied gloves. He/She removed the resident's soiled brief and cleaned the resident's perineum. With the same gloved hands, LPN Y applied a new brief, helped the resident get dressed and out of bed, into his/her wheelchair. He/She propelled the resident to the dining room with the same gloved hands. During an interview on 1/29/26 at 10:15 A.M., CNA PP said when providing perineum care, a staff member should remove their gloves and perform hand hygiene. Once that is done, a new pair of gloves should be applied when proving a new brief and bedding. Staff should not be touching the resident or items in their rooms with soiled gloves. 9. Review of Resident #7's quarterly MDS, dated [DATE], showed:-Severe cognitive impairment;-Mobility device: Wheelchair;-Dependent on staff for transfers. Review of the resident's care plan, in use during the survey, showed:-Problem: The resident required extensive to total assist with activities of daily living (ADLs) due to generalized muscle weakness;-Approaches included: Hoyer lift for transfers, extensive to total assist with bed mobility and wheelchair locomotion. Review of Resident #91's quarterly MDS, dated [DATE], showed:-Severe cognitive impairment;-Mobility device: Wheelchair;-Dependent on staff for transfers;-Diagnoses included traumatic brain dysfunction, hypertension, hyperlipidemia, dementia, and anxiety disorder. Review of the resident's care plan, in use during the survey, showed:-Problem: The resident required staff assistance with ADLs and utilized a Hoyer lift for transfers;-Approaches included Hoyer lift for transfers with two staff members. Observations of Residents #7 and #91 on 1/28/26, showed:-At 11:13 A.M., CNA MMM and CNA XX used a Hoyer lift to transfer Resident #7 from the bed to his/her wheelchair;-At 11:18 A.M., immediately following the transfer of Resident #7, CNA XX took the Hoyer lift to Resident #91‘s room;-At 11:21 A.M., CNA NNN and CNA XX used the Hoyer lift to transfer Resident #91 from the bed to the Hoyer lift to weight him/her, then transferred the resident back to his/her bed;-The CNAs did not wipe the Hoyer lift and/or sanitize it in between use on the two residents. During an interview on 1/29/26 at 11:41 A.M., LPN ZZZ said the Hoyer lifts should be cleaned and wiped down in between residents' use. Before the new company took over, this was part of what the infection control nurse had staff doing. Staff should be following proper hand hygiene protocol, and their gloves should be changed when transferring a resident. During an interview on 1/29/26 at 12:30 P.M., CNA XX said the Hoyer lift should have been wiped down in between use on the residents. During an interview with Administrator B and DON C on 1/29/26 at 2:14 P.M., DON C said she expected for the Hoyer lift to have been cleaned and sanitized in between use on the two residents. 10. Review of the facility's Resident Screening for Tuberculosis policy, undated, showed:-Policy: The facility screens residents for TB in accordance with state requirements as part of the facility's overall infection prevention and control program;-Policy explanation and compliance guidelines:-New resident screening: Prior to or at the time of admission, all new residents will receive TB screen and testing and or chest x-ray in accordance (continued on next page)

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	265833	A. Building B. Wing	01/29/2026

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	with state requirements. The preferred method of TB testing shall be conducted as a two-step process unless contraindicated, then a chest x-ray will be performed. All initial and following TB tests shall be administered and interpreted within 48-72 hours, by a trained health care provider on our staff, or any licensed physician-Current resident screening: All residents previously TB tested negative will be rescreened in accordance with state requirements. In the absence of state requirements, rescreening will be completed as per the facility's infection control plane based upon their TB risk assessment. Follow up testing shall be the same type as initial testing for consistency. Review of Resident #13's medical record, showed:-admission date 8/29/25;-No two-step TB test documented as administered;-No TB screening completed. Review of Resident #12's medical record, showed:-admission date 4/27/25;-No two-step TB test documented as administered;-No TB screening completed. Review of Resident #6's medical record showed:-admission date 12/3/25;-No two-step TB test documented as administered;-No TB screening completed. Review of Resident #9's medical record showed:-admission date, 6/1/25;-No two-step TB test documented as administered;-No TB screening completed. Review of Resident #8's medical record showed:-admission date 10/29/25;-No two-step TB test documented as administered;-No TB screening completed. 11. During an interview on 1/29/26 at 12:57 P.M., the Regional Nurse Consultant said he is the facility's Infection Preventionist (IP). He expected staff to remove soiled gloves and perform hand hygiene after providing perineum care. He expected staff to put on clean gloves when placing a clean brief and bedding on a resident. Wearing soiled gloves and touching a resident and a resident's things is unacceptable. He expected catheter care to be completed every time perineum care is done, especially if a resident has had a bowel movement. He expected EBP signs to be on the resident room doors and supplies be readily available. He expected staff to wear PPE when providing direct care to the residents who are on EBP. It is expected for a resident to have a two-step tuberculin test upon admission, and a TB screening tool should be used on the residents that already had TB tests. 12. Review of the facility's Employee Tuberculosis Test policy, revised 7/1/25, showed:-TB screening and testing is conducted in this facility for the purpose of earlyidentification, evaluation, and treatment of employees with latent TB infection (LTBI, positive without symptoms) or TB disease;-Follow state or local requirements regarding TB screening and testing of employees. In the absence of state or local requirements, follow CDC recommendations below;-New Staff Screening: At the time of employment, all new staff shall undergo pre-placement screening for TB, including an individual risk assessment, TB symptom screen, and a TB test;-All new staff shall receive two Mantoux TB Skin Tests given two weeks apart (two-step testing) unless:-A previously positive TB skin test reaction or positive TB blood test is reported, or;--Evidence of completion of adequate therapy for active TB is reported, or;--Two negative TB skin tests within the past twelve months, the more recent within the last three months, can be documented, or;--The employee has previously received the BCG vaccine. In this case, the employee shall be tested using a blood test;-All initial and follow-up TB tests shall be administered and interpreted (48-72 hours for skin tests) by a trained healthcare provider on our staff, or any licensed physician;-No one may interpret his/her own test. Tests shall be interpreted according to current CDC guidelines;-If a designated reader detects redness, swelling, or anything other than an injection-site bruise at the testing site, they must refer the staff member to the Medical Director for a confirmation reading;-If the first test is positive in an employee at low-risk for TB infection, conduct the second test;-New staff with a documented history of a positive TB test, adequate treatment for active TB, or preventive therapy for latent TB infection shall be exempt from further TB testing. A chest radiograph will be required at the time of hire unless, within the last six months, a chest radiograph with no evidence of active pulmonary disease can be (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	documented;-It is the responsibility of any such TB-test exempt staff member to immediately reportsymptoms suggestive of TB (persistent cough, bloody sputum, night sweats, weight loss,anorexia, or fever) to the DON or IP. Review of Employee AAAA's employee file, showed a hire date of 11/5/25. No documentation that a TB test was administered or read prior to his/her hire date, or a chest x-ray was completed. Review of Employee BBBB's employee file, showed a hire date of 11/5/25. No documentation that a TB test was administered or read prior to his/her hire date, or a chest x-ray was completed. Review of Employee CCCC's employee file, showed a hire date of 10/29/25. No documentation that a TB test was administered or read prior to his/her hire date, or a chest x-ray was completed. Review of Employee DDDD's employee file, showed a hire date of 11/24/25. No documentation that a TB test was administered or read prior to his/her hire date, or a chest x-ray was completed. Review of Employee EEEE's employee file, showed a hire date of 12/30/25. No documentation that a TB test was administered or read prior to his/her hire date, or a chest x-ray was completed. Review of Employee FFFF's employee file, showed a hire date of 11/19/25. No documentation that a TB test was administered or read prior to his/her hire date, or a chest x-ray was completed. Review of Employee GGGG's employee file, showed a hire date of 10/16/25. No documentation that a TB test was administered or read prior to his/her hire date, or a chest x-ray was completed. Review of Employee HHHH's employee file, showed a hire date of 9/30/25. No documentation that a TB test was administered or read prior to his/her hire date, or a chest x-ray was completed. Review of Employee IIII's employee file, showed a hire date of 12/5/25. No documentation that a TB test was administered or read prior to his/her hire date, or a chest x-ray was completed. Review of Employee JJJJ's employee file, showed a hire date of 11/26/25. No documentation that a TB test was administered or read prior to his/her hire date, or a chest x-ray was completed. During an interview on 1/29/26 at 1:43 P.M., Administrator B and DON C said Human Resources is responsible for conducting background checks. They expect all employees to have a TB test or submit a chest x-ray. DON C said it is important to test employees to know if they are a carrier of TB, so they do not infect residents. 13. Review of the facility's Cleaning Procedures policy, undated, showed:-Policy: Facility maintains a clean and sanitary environment throughout our building. The Environmental Protection Agency (EPA)-registered hospital disinfectant (disinfecting solution) used is approved by Quality Assurance Committee in accordance with CDC guidelines;-Procedures: Mop buckets: Mop buckets are cleaned after each shift;---Scrub inside and outside of bucket with clean pad, appropriately diluted disinfectant and hot water;--Rinse and dry with cloth. Review of the facility's Cleaning Resident Rooms policy, undated, showed:-Resident rooms at the facility are maintained in a clean and sanitary manner and are cleaned on a daily and weekly schedule. Cleaning procedures are detailed in separate policies;-Daily Cleaning: Equipment needed:--EPA-registered hospital disinfectant (disinfecting spray). Observation and interview on 1/26/26 at 945 A.M., showed Housekeeper F said the facility stopped purchasing the mop water stuff, so now they use an all-purpose cleaner. They used to have a hook up that would pour the cleaner out into a bucket. Housekeeper F lifted an empty container of the brand P&G Proline 3.78 liter/1 gallon container. He/She said they ran out of it a while ago, but he/she kept the bottle. Housekeeper K pointed to a bottle that read, Medorra Limpreza All Purpose Cleaner Lavender scent. The facility purchased Medorra Limpreza all-purpose cleaner. Without using the hook up, Housekeeper F was not sure how much to use. He/She poured cleaner into the cap and put it into the bucket. He/She said bottle of the Medorra Limpreza is the last one they had. During an interview on 1/26/26 at 10:24 A.M., DON C said the facility did not have a Housekeeping Director. During an interview on 1/26/26 at 11:35 A.M., the Plant Operations Manager said staff gave their supply order to corporate and they ordered the supplies. The facility staff did not (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	have a say of what is approved and ordered for them by corporate. During an interview on 1/26/26 at 3:04 P.M., the Dietary Manager said they had a corporate person that ordered supplies for them. During observation and interview on 1/28/26 at 2:19 P.M., Housekeeper T said he/she used the Medorra Limpreza All Purpose Cleaner Lavender scent for the floors. He/She poured enough cleaner to cover the bottom of the bucket. They used to have a hook up that poured water and cleaner out of a hose. He/She liked that set up better. Observation on 1/28/26 at 3:11 P.M., showed a bottle of Medorra Limpreza All Purpose Cleaner Lavender scent. There was no EPA-registered number on the bottle. There was no documentation of EPA approved or hospital grade disinfectant. Review of EPA-approved, certified products on EPA.gov, reviewed 2/6/25, showed no result for Medorra Limpreza All Purpose Cleaner Lavender scent. Review of the Medorra Limpreza official website, reviewed1/28/26, 1/29/26, 2/5/26, and 2/6/26, showed the website had a critical error. The product or EPA registration could not be verified on the website. During an interview on 1/29/26 at 10:00 A.M., Central Supply PPP said he/she worked in the building for several years. On 9/1/25, when the new management took over, he/she was given duties of medical records and accounts payable in October 2025. He/She tried to do everything, but it is a lot. They never had issues with the supplies, but it changed drastically. Before the management change, there was never a problem with supplies. When they took over, there was a budget issue, and the facility went from having supplies to limited supplies. During an interview on 1/29/26 at 1:09 P.M., the Regional Nurse Consultant said housekeeping did their own ordering. They did not have a Housekeeping Director. There was no training for staff on how much floor chemicals to use. During an interview on 1/29/26 at 1:43 P.M., Administrator B said there were extra supplies in the basement, so he/she told staff to educate someone on where to find it. He/She expected housekeeping to use appropriate supplies to clean all areas of the facility. He/She expected housekeeping staff to know how much chemicals to use. 272091227032322712956267987827248 50

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Implement a program that monitors antibiotic use. Based on interview and record review, the facility failed to establish an antibiotic stewardship program that included antibiotic use protocols and a system to monitor antibiotic use. The census was 91. Review of the facility's Antibiotic Stewardship policy, dated, 7/1/25, showed:-Intention: It is the policy of this facility to implement an antibiotic stewardship program as part of the facility's overall infection prevention and control program. The purpose of the program is to optimize the treatment of infections while reducing the adverse events associated with antibiotic use;-Policy: The Medical Director, Director of Nursing (DON), Infection Prevention Control (IPC) Nurse, and Consultant Pharmacist serve as leaders of antibiotic stewardship program and receive support from the Administrator and governing officials at the facility. During an interview on 1/23/26 at 2:19 P.M., Administrator A said the antibiotic stewardship program had not been updated since March 2025. The IPC Nurse recently quit, and the facility just started the program back up on 1/22/26. Administrator A said he/she expected the antibiotic stewardship program to be in place.

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. Based on interview and record review, the facility failed to offer the COVID-19 vaccine for five out of five residents reviewed (Resident # 12, #13, #8, #9, and #6). The census was 91.Review of the facility's COVID Vaccine policy, dated, 7/1/25, showed:-Policy: The facility will offer the COVID vaccine to assist in mitigating the spreads of COVID-19;-Procedure: COVID-19 vaccinations shall be offered to all residents unless such immunization is medically contraindicated; Residents shall be educated on the COVID-19 vaccine they are offered, in a manner they can understand, including the information of the benefits and risks with the Centers for Disease Control and Prevention (CDC) or Food and Drug administration (FDA); Residents shall be offered the opportunity to ask questions about the risk and benefits of the vaccination; The facility shall maintain documentation of COVID-19 vaccine for all residents in the medical record. 1.Review of Resident #12's medical record showed:-Diagnoses that included heart failure and kidney disease;-No documentation that the resident was offered or received the COVID-19 vaccine. 2.Review of Resident #13's medical record showed:-Diagnoses that included asthma and kidney disease;-No documentation that the resident was offered or received the COVID-19 vaccine. 3.Review of Resident #8's medical record showed:-Diagnoses that included diabetes and osteomyelitis (bone infection) of the foot;-No documentation that the resident was offered or received the COVID-19 vaccine. 4.Review of Resident #9's medical record showed:-Diagnoses that included heart failure and stroke;-No documentation that the resident was offered or received the COVID-19 vaccine. 5.Review of Resident #6's medical record showed:-Diagnoses that included stroke, dysphagia (difficulty swallowing) and kidney disease;-No documentation that the resident was offered or received the COVID-19 vaccine. 6. During an interview on 1/29/26 at 12:57 P.M., the Regional Nurse Consultant said he is also the facility's Infection Preventionist (IP). He would expect the COVID-19 vaccinations be offered to the residents on admission or when the resident requests one. Refusals of the vaccines and any education provided is expected to be documented in the resident's medical record. All vaccines administered to the resident are expected to be documented in the resident's medical record.