STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265840	A. Building B. Wing	01/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Neighborhoods Rehabilitation and Skilled Nursing B	3003 Falling Leaf Court Columbia, MO 65201

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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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	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, facility staff failed to label eye drops and nasal sprays in accordance with professional standards and failed to destroy expired medications for three medication carts and one medication room. The facility census was 88.1. Review of the facility's Medication Storage policy, dated 2025, showed the policy did not contain direction or guidance for labeling or destruction of eye drops or nasal sprays. Review of the facility's Administration of Eye Drops policy, dated 2001, showed the policy directed staff to label new bottles with date opened and follow facility policy or manufacturer's instructions for when to discard and replace the bottle.Review of the facility's Administration of Nasal Spray Administration policy, dated 2025, showed the policy did not contain direction or guidance for labeling or destruction of nasal sprays.2. Observation on 01/20/26 at 9:52 A.M., showed the medication cart on the [NAME] and [NAME] unit contained one opened and undated bottle of Atropine eye drops (used to dilate pupils and treat lazy eye) and six opened and undated bottles of artificial tears (used to treat dry eye, irritation and eye discomfort).During an interview on 01/20/26 at 9:52 A.M., Certified Medication Technician (CMT) E said he/she does not date the bottles when he/she opens them and he/she uses the expiration date on the bottl. The CMT said it is his/her responsibility to ensure medications are not expired prior to administering them. 3. Observation on 01/20/26 at 10:02 A.M., showed the Flat Branch medication cart sat below a cork board on the wall. Observation showed a sign posted on the cork board which read, all vials and miscellaneous items should be dated and discarded after 28 days of opening to include eye drops and any vials that the facility opens. Observation showed the medication cart contained:-One opened and undated bottle of artificial tears;-One opened bottle of artificial tears dated 11/28/25;-One opened and undated bottle of Lantoprost (lowers eye pressure in glaucoma);-Two opened and undated bottles of flucotisone (treats allergies and reduce swelling) nasal spray.During an interview on 01/20/26 at 10:02 A.M., CMT F said eye drops and nasal sprays are good for 30 days. The CMT said he/she knows the drops and sprays need a label but he/she just forgot and did not think about it. The CMT said giving an undated medication could mean the medication is expired and no longer any good. The CMT said it is their responsibility to ensure medication is labeled and dated. 4. Observation on 01/20/26 at 10:15 A.M., showed the medication cart on the [NAME] Station unit contained:-One opened and undated bottle of Olopatadine (used to treat itchy, red and swollen eyes) eye drops;-One opened and undated bottle of azelastine (treats itching, redness and irritation) eye drops;-One opened bottle of artificial tears dated 11/15/25;-One opened bottle of artificial teas dated 07/10/25;-One opened bottle of artificial tears dated 11/28/25;-Three opened and undated bottles of normal saline nasal spray;-One opened and undated bottle of deep sea normal saline nasal spray.During an interview on 01/20/25 at 10:20 A.M., CMT G said eye drops and nasal sprays are only good for 30 day and he/she is responsible to ensure they are dated and not expired but he/she just did not pay attention.5. Observation on 01/20/26 at 10:22 A.M., the refrigerator on the [NAME] Station unit contained:-One opened and undated vial of Lantus (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	insulin;-One opened and undated vial of Aspartate insulin;-One opened and undated bottle of Humalog insulin. Observation showed the manufacturers expiration date on the vial listed as 12/09/25.During an interview on 01/20/26 at 10:30 A.M., Licensed Practical Nurse (LPN) A said insulin is good for 30 days once opened and it is his/her responsibility to ensure the vials are not expired and dated when opened. The LPN said he/she did not know the insulins were not dated and giving expired medication could mean the resident's dose is not effective.6. During an interview on 01/23/26 at 3:50 P.M., the Director of Nursing (DON) said he/she is fairly new to the building but it is his/her responsibility to make daily rounds and he/she checks the cart for expired medications. The DON said if a medication is unopened, the expiration would be based on the manufacturer's date and if it is opened, the medication would be expired after 28 days. The DON said the CMT's are responsible to date the vials/bottles when opened and routinely checked for outdated items and discard them. The DON said giving medication beyond the use by date could make the medication ineffective. The DON said he/she did not know there were expired and/or undated medications on the medication carts. During an interview on 01/23/26 at 4:32 P.M., the administrator said CMT's on each unit are responsible to ensure the carts are reviewed every Wednesday for undated and expired medications. The administrator said he/she is not sure the weekly check is being completed on all the units and he/she does not see the audits. The administrator said a Performance Improvement Plan (PIP) was created and continued, but unfortunately they have had many changes in staff. The administrator said medications should not be used if it has been opened more than 28 days.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility staff to ensure waste containers in food preparation areas remained covered when not in use. Facility staff failed to perform hand hygiene as often as necessary using approved techniques to prevent cross-contamination. Facility staff failed maintain the internal temperature of hot foods held in the steamtable at a minimum of 140 degrees Fahrenheit (dF) to prevent the growth of food-borne pathogen. Facility staff also failed to ensure staff involved in food preparation and service wore effective hair restraints to prevent physical contamination of food and food contact surfaces. These failures had the potential to affect all residents. The facility census was 88.Based on observation, interview and record review, the facility staff to ensure waste containers in food preparation areas remained covered when not in use. Facility staff failed to perform hand hygiene as often as necessary using approved techniques to prevent cross-contamination. Facility staff failed maintain the internal temperature of hot foods held in the steamtable at a minimum of 140 degrees Fahrenheit (dF) to prevent the growth of food-borne pathogen. Facility staff also failed to ensure staff involved in food preparation and service wore effective hair restraints to prevent physical contamination of food and food contact surfaces. These failures have the potential to affect all residents. The facility census was 88. 1. Review of the facility's policy titled Disposal of Garbage and Refuse, dated 2025, showed the policy directed staff to dispose of garbage in refuse containers with plastic liners and lids and to cover the refuse containers when not in use. Observations on 01/20/26 at 12:00 P.M. and 01/23/26 at 8:20 A.M., showed the waste container, contained paper and food waste, in the Flat [NAME] kitchen uncovered and not in use by staff. Observation showed the area did not contain a cover for the waste container. During an interview on 01/23/26 at 8:20 A.M., Dietary Aide (DA) U said he/she did not have a cover for the waste container in the Flat Branch kitchen. The DA said he/she did not work that unit very often, so he/she did not know if the container ever had a cover. Observations on 01/20/26 at 12:10 P.M. and on 01/23/26 at 8:00 A.M., showed the waste container, which contained paper and food waste, in the [NAME] and [NAME] kitchen uncovered and not in use by staff. Observation showed the area did not contain a cover for the waste container. During an interview on 01/23/26 at 8:00 A.M., DA V said he/she did not have a cover for the waste container in the [NAME] and [NAME] kitchen. The DA said there use to be a cover for it, but there had not been one for a while and he/she did not know what happened to the cover. Observations on 01/20/26 at 12:23 P.M. and on 01/23/26 at 8:55 A.M., showed the waste container, which contained paper and food waste, in the Boonslick kitchen uncovered and not in use by staff. Observation showed the area did not contain a cover for the waste container. During an interview on 01/23/26 at 8:55 A.M., DA W said he/she did not have a cover for the waste container for the Boonslick kitchen. The DA said he/she could not remember if the waste container ever had a cover, but he/she knew if had not had one in at least two months. Observations on 01/20/26 at 12:31 and on 01/23/26 at 8:45 A.M., showed the waste container, which contained paper and food waste, in the Smithton Village kitchen uncovered and not in use by staff. Observation showed the area did not contain a cover for the waste container. During an interview on 01/23/26 at 8:45 A.M., DA X said he/she did not have a cover for the waste container in the Smithton Village kitchen and he/she did not know if it ever had a cover. Observations on 01/20/26 at 12:45 A.M. and on 01/23/26 at 8:35 A.M., showed the waste container, which contained paper and food waste, in the [NAME] Station kitchen uncovered and not in use by staff. Observation showed the area did not contain a cover for the waste container. During an interview on 01/23/26 at 9:05 A.M., the Dietary Manager (DM) said kitchen waste containers should be covered when not in actual use and staff are trained on this requirement. The DM said there were a couple of the waste container lids that broke and he/she requested maintenance to order replacements, but he/she did not know that status of that (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	order and he/she did not know that all of the waste containers in the unit kitchens did not have covers. During an interview on 01/23/26 at 3:00 P.M., the administrator said kitchen waste containers should have lids and be covered when not in use. The administrator said he/she knew a couple of the lids broke and when they ordered the replacements, they were the wrong lids. The administrator said he/she did not know that the waste containers in all the unit kitchens did not have lids. 2. Review of the facility's policy titled Dietary Employee Personnel Hygiene, dated 2025, showed the policy directed staff to wash their hands prior to beginning work, before they put on gloves, after they remove gloves, and after they engage in other activities that contaminate the hands. Review showed the policy did not provide direction to the staff on the procedure to use when they wash their hands. Observation on 01/20/26 at 12:23 P.M., showed DA W cut a raw onion with gloved hands and then removed his/her gloves. Observation showed when the DA washed his/her hands, he/she placed soap on his/her hands and then rubbed his/her hands together under running water. Observation showed the DA then served prepared foods to residents at the lunch meal. Observations on 01/23/26 at 8:06 A.M., showed DA U entered the kitchen and, without performing hand hygiene, obtained raw eggs from the walk-in refrigerator. Observation showed the DA then lifted the lid of the waste container with his/her bare hand to dispose of trash, put on a hair net and, without performing hand hygiene, transported a cart of prepared food to the Flat Branch kitchen. Observation showed when the DA washed his/her hands upon entry to the Flat Branch kitchen, he/she placed soap on his/her hands and then rubbed his/her hands together under running water, turned the faucet off with a paper towel and then used the same paper towel to dry his/her hands. Observation showed the DA then placed the prepared food items into the steamtable for service to residents at the breakfast meal. Observation on 01/23/26 at 8:20 A.M., showed DA U removed soiled gloves from his/her hands, exited the kitchen to dispose of the soiled gloves and then returned to the kitchen. Observation showed when the DA washed his/her hands, he/she placed soap on his/her hands and then rubbed his/her hands together under running water, turned the faucet off with a paper towel and then used the same paper towel to dry his/her hands. During an interview on 01/23/26 at 8:20 A.M., DA U said staff trained him/her on proper hand hygiene procedures upon hire and staff should preform hand hygiene when they enter the kitchen, before and after glove use, before they handle food, and after they touch anything dirty. The DA said staff should scrub their hands with soap in the water for 30 to 45 seconds, dry their hands with a paper towel and then turn the faucet off with a different paper towel. The DA said staff should not use the same paper towel they used to turn off the faucet to dry their hands because the faucet is dirty and it would just make their hands dirty again. The DA said he/she did not realize that he/she dried his/her hands with the same paper towel he/she used to turn off the faucet. During an interview on 01/23/26 at 9:05 A.M., the DM said staff should perform hand hygiene when they enter the kitchen, before and after glove use, before they handle or serve food, and after they touch anything dirty. The DM said when staff wash their hands, they should scrub their hands with soap out of the running water for 20 to 30 seconds, dry their hands with a paper towel and then use a different paper towel to turn the faucet off. The DM said staff should not use the same paper towel they used to turn off the faucet to dry their hands because the faucet is dirty and it would just make their hands dirty again. The DM said staff are trained on proper hand hygiene procedures upon hire and during in-services as needed. During an interview on 01/23/26 at 3:00 P.M., the administrator said staff should perform hand hygiene when they enter the kitchen, before and after glove use and after they touch anything dirty. The administrator said when staff wash their hands, they should scrub their hands with soap out of the running water for 20 to 30 seconds, dry their hands with a paper towel and then use a different paper towel to turn the faucet off so they do not recontaminate their hands. The administrator said staff are trained on how to properly wash their hands. 3. Review of the facility's policy titled Record of Food Temperatures, dated 2025, showed: -It is the policy of this facility to record food temperatures daily to ensure food is at the proper serving temperature(s) before trays are assembled;-Hot foods will be held at 135 dF;-If the food temperature falls into an unsafe range, (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	immediately follow procedures for reheating previously cooked food;-Potentially hazardous food that is cooked and cooled must be reheated so that all parts of the food reach an internal temperature of 165 dF for at least 15 seconds before holding for hot service;-No food will be served that does not meet the food code standard temperatures;-Food will not be cooked or reheated using the steam table because it does not bring food to the proper temperature within acceptable timeframes. Observation on 01/20/26 at 12:31 P.M., showed DA U served food to residents from the steam table in the Smithton Village kitchen. Observation showed open spaces around the pans of food on the steam table which allowed heat to escape from the steam table. Observation at this time showed the internal temperature of the spaghetti noodles measured 124 dF and the vegetables measured 130 dF. During an interview on 01/20/26 at 12:33 P.M., DA U said hot food held in the steam table should maintain a temperature of 145 dF or higher. The DA said he/she checked the internal temperature of the hot foods when he/she placed them on the steam table and all foods were at least 145 dF. The DA said he/she did not know the temperature of the foods were less than 145 dF and he/she did not realize the open spaces around the pans of food would not keep the food hot enough. Observation on 01/20/26 at 12:45 P.M., showed DA N served food to residents from the steam table in the [NAME] Station kitchen. Observation showed open spaces around the pans of food in the steam table which allowed heat to escape from the steam table. Observation at this time showed the internal temperature of the spaghetti noodles measured 120 dF, the spaghetti sauce measured 130 dF and the vegetables measured 118 dF. Review of the food temperature log located in the [NAME] Station kitchen, showed staff documented the internal temperature of the spaghetti noodles measured 107 dF, the spaghetti sauce measured 168 dF and the vegetables measured 135 dF. During an interview on 01/20/26 at 12:47 P.M., DA N said the internal temperature of hot food held in the steam table should be 140 dF. The DA said he/she checked the internal temperature of the hot foods when he/she placed them on the steam table and documented the temperatures on the food temperature log. The DA said, at that time, the temperature of the spaghetti noodles measured 107 dF so he/she covered them to let them heat up on the steam table. The DA said when he/she rechecked the internal temperature of the noodles they measured 138 dF, but he/she did not document that temperature because he/she had already written down the 107 dF temperature. The DA said when he/she checked the temperature of the vegetables when he/she placed them on the steam table, the internal temperature measured 135 dF and he/she figured they would warm up on the steam table before service. The DA said while he/she knew the internal temperature of hot foods should be 140 dF, he/she served the food items in the steam table anyway because that was as close as they were going to get to the right temperature without him/her running late to serve them. Observation on 01/23/26 at 8:15 A.M., showed DA U check the internal temperatures of the hot food items held in Flat Branch steam table to be served to residents at the breakfast meal. Observation showed the internal temperature of the sausage on the steamtable measured 119 dF, the ground sausage measured 130 dF, and the peppered white gravy measured 125 dF. Observation showed the DA left the food items uncovered on the steam table. During an interview on 01/23/26 at 8:16 A.M., DA U said the internal temperature of hot foods held in the steam table should be at least 140 dF. The DA said he/she still had some time before service so he/she was just going to let the food heat up on the steam table. Observation on 01/23/26 at 8:26 A.M., showed DA U rechecked the internal temperatures of the hot foods held in the steam table. Observation showed the internal temperature of the sausage on the steamtable measured 120 dF, the ground sausage measured 130 dF, and the peppered white gravy measured 125 dF. Observation showed the DA prepared to serve the food items from the steamtable to the residents. During an interview on 01/23/26 at 8:26 A.M., the DA said if the temperature of hot food on the steam table is not at least 140 dF, they should be removed and reheated but he/she did not have time to reheat them because they were waiting for him/her to serve. During an interview on 01/23/26 at 9:05 A.M., the DM said the internal temperature of hot food held in a steam table should be at least 140 dF. The DM said staff are trained on appropriate food (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	temperatures and to check the temperature of the food before they serve it. The DM said staff should not use the steam table to raise the temperature of hot foods to the required temperatures and if the hot food is not at least 140 dF, staff should remove it from the service line and reheat it to an internal temperature of at least 165 dF. The DM said staff are also trained on these requirements and if food is not maintained at the appropriate temperatures there is risk for the growth of bacteria that could cause food-borne illness to the residents. During an interview on 01/23/26 at 3:00 P.M., the administrator said the internal temperature of hot food held in the steam table should be at least 140 dF and staff are trained on proper food temperatures. The administrator said staff are also trained to check the internal temperature of the food before it is served to residents and if it is not at the appropriate temperature, they should remove it to have it reheated and not leave it to reheat on the steam table. 4. Review of the facility's policy titled Dietary Employee Personal Hygiene, dated 2025, showed the policy directed all dietary staff to wear hair restraints, such as a hairnet, hat and/or beard restraint, to prevent hair from contacting food. Observation on 01/23/26 at 8:05 A.M., showed [NAME] Y, who had facial hair, prepared food items in the main kitchen for service to residents at the breakfast meal without the use of a facial hair restraint. Observations on 01/23/26 from 8:06 A.M. to 8:26 A.M., showed DA U had head and facial hair. Observation showed, without the use of head or facial hair restraints, the DA pushed a cart of prepared food into the main kitchen and obtained raw eggs from the walk-in refrigerator. Observation showed the DA then put a hair net on his/her head and, without the use of a facial hair restraint, transported the cart of prepared food to the Flat Branch kitchen, placed the prepared food items into the steamtable and served the food to the residents at the breakfast meal. Observation 01/23/26 at 8:40 A.M., showed DA X, who had facial hair, served food to residents at the breakfast meal in the Smithton Village kitchen. During an interview on 01/23/26 at 9:00 A.M., the DM said all dietary staff are trained to wear hair restraints, including facial hair restraints, and he/she did not know staff did not wear hair restraints as required. During an interview on 01/23/26 at 3:00 P.M., the administrator said anyone who is around the food should wear a hair restraint, including facial hair restraints if they have facial hair, and staff are trained on this requirement.

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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 staff failed to provide Enhanced Barrier Precautions (EBP) during wound care for two (Residents #5 and #15) of five residents who had a wound and one (Resident #5) of two residents who had a catheter. The facility staff failed to provide appropriate hand hygiene between glove changes during the provision of care for one (Residents #5) of six residents. The facility staff failed to ensure the two-step purified protein derivative (PPD) (skin test for tuberculosis (TB)) was completed in accordance with their policy and on file for eight employees (Housekeeper J, Certified Medication Technician (CMT) K, Certified Nurse Aide (CNA) L, Housekeeper M, Dietary Aide (DA) N, Licensed Practical Nurse (LPN) O, Social Service Designee (SSD), and the Assistant Business Office Manager (ABOM) out of ten sampled employees. The facility census was 88.1. Review of facility's Enhanced Barrier Precautions policy, dated 2025, showed:-All staff receive training on EBP upon hire and at least annually and are expected to comply with all designated precautions;-All staff receive training on high risk activities and common organisms that require EBP;-An order for EBP will be obtained for resident with wounds, indwelling medical devices (i.e. central lines, urinary catheters, feeding tubes, and hemodialysis catheters) even if the resident is not known to be infected or colonized with a multi-drug resistant organism;- Gowns and gloves are immediately available near or outside of the resident's room;-High contact resident care activities include dressing, bathing, transferring, providing hygiene, changing linens, assisting with toileting, device care, wound care (any skin opening requiring a dressing).-EBP should be used for the duration of the affected resident's stay in the facility or until resolution of the would or discontinuation of the indwelling medical device that placed them at higher risk. Review of the facility's Hand Hygiene policy, dated 2025, showed:-All staff will perform hand hygiene procedures to prevent the spread of infection to other personnel, residents and visitors. -Staff will perform hand hygiene when indicated, using proper technique consistent with accepted standards of practice;-Hand hygiene will be performed before applying and after removing personal protective equipment (PPE) (including gloves), after handling items potentially contaminated with blood, body fluids, secretions or excretions, when, during resident care, moving from a contaminated body site to a clean body site and before and after handing clean or soiled dressings or linens, etc. 2. Review of Resident #5's, Significant Change of Status (SCS) Minimum Data Set (MDS), a federally mandated assessment tool, dated 12/27/25, showed staff assessed the resident as:-Severe cognitive impairment;-Dependent on staff for toilet hygiene and upper and lower body dressing;-Use of indwelling catheter (tube used to drain the bladder);-Presence of one Stage 3 Pressure ulcer (full thickness loss of skin in which fat is visible in the ulcer) and one Deep Tissue Pressure Injury (intact or non-intact skin with localized area of persistent non-blanchable deep red, maroon, purple discoloration or epidermal separation revealing a dark wound bed or blood-filled blister). Review of the resident's care plan, dated 12/21/25, showed:-Used an indwelling catheter;-At risk for skin breakdown;-The care plan did not contain direction or guidance for EBP or presence of a sacral wound.Observation on 01/23/26 at 5:09 A.M., showed the resident's door contained a sign directed staff to wear a gown and gloves for hygiene, assisting with toileting, catheter care and wound care. CNA H and LPN I entered the resident's room and applied gloves. The CNA cleansed the resident's buttocks and inner folds, removed his/her gloves and applied new gloves. The CNA did not perform hand hygiene before applying clean gloves. The CNA cleansed the resident's inner thighs, catheter site and catheter tubing. CNA H removed his/her gloves and applied new gloves. CNA H did not perform hand hygiene before applying clean gloves. LPN I removed the soiled bed-pad, cleansed the resident's buttocks and inner folds and removed his/her gloves and applied new gloves. LPN I did not perform hand hygiene before applying clean gloves. The staff rolled the resident to his/her left side, a large dressing was removed from a wound on the resident's tailbone area. The LPN cleansed the wound, removed his/her gloves and applied clean (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	gloves. LPN I did not perform hand hygiene before applying clean gloves. The LPN applied a clean dressing and secured with tape. The LPN and the CNA did not wear a gown during wound care or catheter care. During an interview on 01/23/26 at 5:36 A.M., CNA H said he/she was taught about EBP but did not think about it with this resident. He/She was nervous and did not pay attention to the signage that is posted on the door. The aide said he/she knew he/she did not wash his/her hands prior to applying new gloves like he/she should have because he/she was nervous. The aide said if you don't perform hand hygiene, you can spread germs. During an interview on 01/23/26 at 5:42 A.M., LPN I said he/she did hand hygiene as he/she was taught. He/She said he/she did not know what EBP was and he/she did not believe this resident required the EBP during care. The LPN said the signage on the door was outdated and could be removed. 3. Review of Resident #15's admission MDS dated [DATE], showed staff assessed the resident as cognitive with diagnoses of orthopedic condition, wound infection, surgical joint repair, surgical wound care.Review of the resident's Physician Order Set (POS), dated 01/26, showed the following order: -Wound care left upper arm: Cleanse area and apply soaked gauze, cover with dressing pad and secure with kerlix and ACE wraps. Change daily. one time a day for wound care.Observation on 01/22/26 at 09:25 A.M., showed the resident's door did not contain EBP signage or gowns available on the PPE cart.Observation on 01/02/26 at 09:50 A.M., showed LPN A applied a kerlix wrap to the resident's left upper arm wound, removed his/her gown, then wrapped the arm with an ACE bandage. While he/she removed the gown, LPN A said he/she was not going to be in contact with other residents, so he/she did not need it. During an interview on 01/02/26 at 10:00 A.M., the resident said he/she has never seen staff wear gowns during wound care prior to today. During an interview on 01/22/26 at 03:10 P.M., LPN A said EBP is implemented when the resident has an infection or catheter, but it depends on why they have a catheter. He/She said Resident #15 had a PICC line (peripherally inserted central catheter used to deliver intravenous antibiotics) until recently, but PICC lines do not require EBP. LPN A said masks and gloves are helpful but not required. LPN A said he/she receives annual online training for EBP. He/She said there are currently no residents on the unit who needs EBP. He/She said it is the responsibility of the Director of Nursing (DON), Assistant Director of Nursing (ADON) and nursing supervisors to ensure adherence to EBP.4. During an interview on 01/23/26 at 01:55 P.M., the Infection Preventionist said EBP is implemented for residents with wounds, catheters, and intravenous lines. He/She said all staff are aware of who is on EBP protocol and have completed training on EBP and hand hygiene. The IP said signs and PPE carts are distributed by housekeeping after notification by the IP, DON or Admissions. He/She said signs cue staff for proper PPE usage. During an interview on 01/22/26 at 2:11 P.M., Registered Nurse (RN) B said EBP is implemented when a resident has a known pathogen, such as influenza. He/She said it includes air-borne, droplet, contact and bloodborne transmission modes. RN B said if he/she observed staff not complying with EBP, he/she would stop the process, ensure supplies were available and educate the person in the moment. RN B said he/she would not promote the removal of a gown during wound care. He/She said proper hand hygiene includes washing hands before and after providing care, and in between glove changes.During an interview on 01/23/26 at 04:00 P.M., the DON said staff receive online EBP training and are observed by the IP. The DON said EBP PPE includes gloves, gowns, and mask, and a face shield if spray is expected. He/She said the DON and IP ensure signs are posted and PPE carts are available. He/She said hand hygiene is to be performed upon entry, when providing care and when hands become soiled. During an interview on 01/23/26 at 04:20 P.M., the Administrator said facility staff are expected to follow EBP and hand hygiene policies and protocols. The Administrator said the expectations are covered in staff training. He/She said it is the responsibility of the charge nurses and IP to ensure adherence to the policies and ensure supplies are available. 5. Review of the facility's Employee Tuberculosis Testing policy, dated 2025, showed: -All new staff shall receive two Mantoux TB skin tests given two weeks apart (two-step testing);-All initial and follow-up TB tests shall be administered and interpreted (48-72 hours for skin tests) by a trained healthcare provider on (continued on next page)

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	265840	A. Building B. Wing	01/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Neighborhoods Rehabilitation and Skilled Nursing B	3003 Falling Leaf Court Columbia, MO 65201

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	our staff or any licensed physician;-Compliance with initial and subsequent TB screening/testing is required for continued employment with the facility. Review of the Centers for Disease Control, Baseline Tuberculosis Screening and Testing for Health Care Personnel, dated 12/19/23, showed if the Mantoux tuberculin skin test (TST) is used for baseline testing or health care personnel, use the two-step testing. 6. Review of Housekeeper J's employee file showed: -Hire date of: 07/01/25;-First step PPD administered on 07/01/25 and read on 07/03/25;-The file did not contain documentation a second PPD was administered one to three weeks after the first PPD skin test is read. 7. Review of CMT K's employee file showed: -Hire date of: 05/06/25;-First step PPD administered on 05/07/25 and read on 05/10/25;-The file did not contain documentation a second PPD was administered one to three weeks after the first PPD skin test is read. 8. Review of CNA L's employee file showed: -Hire date of: 03/18/25;-First step PPD administered on 03/18/25 and read on 03/29/25;-the file did not contain documentation a second PPD was administered one to three weeks after the first PPD skin test was read. 9. Review of Houskeeper M's employee file showed: -Hire date of: 05/20/25;-First step PPD administered on 05/20/25 and read on 05/23/25;-The file did not contain documentation a second PPD was administered one to three weeks after the first PPD skin test was read. 10. Review of DA N's employee file showed: -Hire date of: 12/16/25;-First step PPD administered on 01/14/26 and read on 01/16/26;-The file did not contain documentation a second PPD was administered one to three weeks after the first PPD skin test was read. 11. Review of LPN O's employee file showed: -Hire date of 12/16/25;-First step PPD administered on 12/10/25 and read on 12/13/25;-The file did not contain documentation a second PPD was administered one to three weeks after the first PPD skin test was read. 12. Review of the SSD's employee file showed: -Hire date of 09/30/25;-First step PPD administered on 09/16/25 and read on 09/19/25;-The file did not contain documentation a second PPD was administered one to three weeks after the first PPD skin test was read. 13. Review of the ABOM's employee file showed: -Hire date of 12/30/25;-First step PPD administered on 12/17/25 and read on 12/19/25;-The file did not contain documentation a second PPD was administered one to three weeks after the first PPD skin test was read. 14. During an interview on 01/23/26 at 1:00 P.M., the Assistant Business Office Manager said he/she handles human resources tasks but does not do anything with the employee TB testing. He/She has only been in the role for eight days and still learning. He/She believes the nurse who works the Flat Branch hallway is responsible for the administration and tracking of the employee TB test.During an interview on 01/23/26 at 1:31 P.M., LPN P said he/she normally works Flat Branch hallway and is responsible to administer the staffs new hire TB test. The tested employee is responsible to return for the test to be read within three days of administration. He/She does not know who ensures the second step is given timely or tracks when it is due.During an interview on 01/23/26 at 3:50 P.M., the DON said the Flat Branch nurse is responsible to initiate and read the PPD skin test on employees. He/She is aware the facility is out of compliance.

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F 0568 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 staff failed to obtain written consent from the resident or his/her designee, guardian and conservator, or conservator to manage the personal funds of the resident in the facility resident trust account for four residents (Residents #31, #68, #121 and #122) out of nine sampled residents. Facility staff also failed to maintain a system that assured full, complete, and separate accounting of each resident's personal funds to preclude the commingling of resident funds with facility funds for one resident (Resident #124) out of two sampled residents and ensure timely refunds for five residents (Residents #121, #122, #123, #124, #125) out of six sampled discharged residents. The facility census was 88. 1. Review of the facility's policy titled, Resident Personal Fund, revised 01/05/25, showed: -If the resident chooses to deposit personal funds with the facility, upon written authorization of a resident, the facility must act as a fiduciary of the resident's funds and hold, safeguard, manage, and account for the personal funds of the resident deposited with the facility;-The facility will deposit any resident's personal funds in excess of $50 in an interest-bearing account (or accounts) separate from any of the facility's operating accounts, and will credit all interest earned on resident funds to that account;-The facility will establish and maintain a system that assures a full and complete and separate accounting, according to generally accepted accounting principles, of each resident's personal funds entrusted to the facility on the resident's behalf;-The system will preclude any commingling of resident funds with facility funds or with the funds of any person other than another resident;-Upon the discharge, eviction, or death of a resident with personal funds deposited with the facility, the facility will convey within 30 days the resident's funds and a final account of those funds to the resident, or in the case of death, the individual or probate jurisdiction administering the resident's estate, in accordance with state law. Review of the facility's admission agreement, revised June 2020, showed direction that in order for the facility to manage the resident's personal funds, the resident/designee must provide authorization of such in writing. 2. Review of Resident #31's admission agreement, dated 07/02/19, showed the resident's guardian documented he/she did not authorize the facility to place the resident's personal funds in the possession of the facility. Review of the resident's Resident Trust Transaction History, dated 01/01/25 through 01/23/26, showed $80 of the resident's funds placed in the facility resident trust account to open his/her individual account on 07/30/25. Review showed additional deposits and a withdrawals on the account for the dates of 09/30/25 through 12/31/25 which left the resident with a balance of $231.62 on 12/31/25. Review of the facility's Resident Trust-Current Account Balance Report, dated 01/23/26, showed the resident with a current balance of $231.62. During an interview on 01/23/26 at 1:40 P.M., the Business Office Manager (BOM) said he/she did not have written authorization to manage the resident's personal funds in the facility's resident trust account. The BOM said the resident's guardian just started sending money to the facility for the resident to use for haircuts and gift purchases and he/she did not have any documentation from the resident's guardian authorizing the facility to manage the resident's personal funds and he/she did not know he/she needed to have it in writing. 3. Review of Resident #68's admission agreement, dated 04/29/24, showed the resident documented he/she did not authorize the facility to place the resident's personal funds in the possession of the facility. Review of the resident's Resident Trust Transaction History, dated Review showed an additional deposit to the account on 12/31/25 which left the resident with a balance of $300.01 on 12/31/25. Review of the facility's Resident Trust-Current Account Balance Report, dated 01/23/26, showed the resident with a current balance of $300.01. During an interview on 01/23/26 at 1:40 P.M., the BOM said he/she did not have written authorization to manage the resident's personal funds in the facility's resident trust account and he/she did not know he/she needed to have it in writing. 4. Review of Resident #121's admission agreement, dated 03/09/22, showed the resident documented he/she did not authorize the facility to place his/her personal funds (continued on next page)

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F 0568 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	in the possession of the facility. Review of the resident's Resident Trust Transaction History, dated 01/23/26, showed $221 of the resident's funds placed in the facility resident trust account to open his/her individual account on 06/27/25. Review of the facility's Resident Trust-Current Account Balance Report, dated 01/23/26, showed the resident with a current balance of $221. During an interview on 01/23/26 at 1:40 P.M., the BOM said he/she did not have written authorization to manage the resident's personal funds in the facility's resident trust account and he/she did not know he/she needed to have it in writing. 5. Review of Resident #122's admission agreement, dated 05/17/22, showed the resident's responsible party documented he/she did not authorize the facility to place the resident's personal funds in the possession of the facility. Review of the resident's Resident Trust Transaction History, dated 01/23/26, showed $150 of the resident's funds placed in the facility resident trust account to open his/her individual account on 11/10/22. Review of the facility's Resident Trust-Current Account Balance Report, dated 01/23/26, showed the resident with a current balance of $150. During an interview on 01/23/26 at 1:40 P.M., the BOM said the facility received three of the resident's social security checks in November 2022 and they deposited the resident's personal spending allowance from those social security checks in the facility's resident trust account. The BOM said he/she did not have written authorization to manage the resident's personal funds in the facility's resident trust account and he/she did not know he/she needed to have it in writing. During an interview on 01/23/26 at 1:55 P.M., the administrator said the BOM is responsible for the resident funds and he/she assumed the BOM had been trained on the requirements for the management of resident funds. The administrator said there should be written authorization to manage the personal funds of residents and the written authorization should be received before the holding the funds. The administrator said he/she did not know the BOM managed funds for residents without written authorization. 6. Review of the facility's accounts receivable aging report, dated 01/21/26, showed Resident #124 with a current private pay credit balance of $2,576. Review also showed the resident with a discharge date of 11/11/25. Review of the resident's medical records showed the resident discharged from the facility on 11/11/25. During an interview on 01/23/26 at 11:42 A.M., the BOM said he/she is responsible for the accounting of the facility's operating account and he/she tries to review the accounts receivable aging report twice a month. The BOM said if a resident discharges from the facility, any personal funds that remain should be refunded within 30 days. The BOM said the resident discharged from the facility on 11/11/25 and they were holding the resident's funds until they received payment owed from his/her insurance. The BOM said he/she did not have written authorization to hold the resident's private pay credit balance in the facility's operating account to cover non-payment by third parties and he/she did not know he/she needed written authorization because that is what they had always done. During an interview on 01/23/26 at 1:55 P.M., the administrator said the BOM is responsible for the resident funds and assumed the BOM had been trained on the requirements for the management of resident funds. The administrator said the BOM is to review the facility's accounts receivable monthly and if a resident has a credit balance the BOM should send a refund request to the corporate office. The administrator said the personal funds of residents cannot be held by the facility for non-payment by third parties without written authorization from the resident or his/her responsible party and he/she did not know about the resident's credit balance in the facility's operating account. 7. Review of the facility's Resident Trust-Current Account Balance Report, dated 01/23/26, showed Resident #121 with a current balance of $221. Review of the resident's medical records showed the resident discharged from the facility on 08/07/25. During an interview on 01/23/26 at 11:25 A.M., the BOM said the resident passed away on 08/07/25 and they had not been able to contact the resident's durable power of attorney (DPOA) to refund the money because the DPOA had been out of the country since the resident's passing. The BOM said he/she did not contact anyone else about the resident's personal funds and he/she sent the resident's funds to the state unclaimed property on 12/24/25, so he/she should not have a balance in the resident funds trust account. The BOM said he/she did not have any documentation to the show (continued on next page)

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F 0568 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the resident's funds were sent to the state unclaimed property and if a resident's funds are withdrawn from their account, their resident funds trust account should show the withdrawal. The BOM said he/she could not explain why the resident's account did not show his/her funds withdrawn from his/her account. During an interview on 01/23/26 at 1:55 P.M., the administrator said he/she could not provide documentation to show the resident's personal funds were withdrawn from his/her resident funds trust account. The administrator said if a resident's funds are withdrawn from their account, the acceptable accounting practice would be for the withdrawal to be accounted for in their resident funds trust account. 8. Review of the facility's Resident Trust-Current Account Balance Report, dated 01/23/26, showed Resident #122 with a current balance of $150. Review of the resident's medical records showed the resident discharged from the facility on 11/02/22. During an interview on 01/23/26 at 11:38 A.M., the BOM said the resident passed away on 11/02/22. The BOM said the resident's funds were sent to the state unclaimed property in 2023, so he/she should not have a balance in the resident funds trust account. The BOM said he/she did not have any documentation to the show the resident's funds were sent to the state unclaimed property and if a resident's funds are withdrawn from their account, their resident funds trust account should show the withdrawal. The BOM said he/she could not explain why the resident's account did not show his/her funds withdrawn from his/her account. During an interview on 01/23/26 at 1:55 P.M., the administrator said he/she could not provide documentation to show the resident's personal funds were withdrawn from his/her resident funds trust account. The administrator said if a resident's funds are withdrawn from their account, the acceptable accounting practice would be for the withdrawal to be accounted for in their resident funds trust account. 9. Review of the facility's Resident Trust-Current Account Balance Report, dated 01/23/26, showed Resident #123 with a current balance of $3,192.91. Review of the resident's medical records showed the resident discharged from the facility on 11/17/25. During an interview on 01/23/26 at 11:34 A.M., the BOM said the resident passed away on 11/17/25. The BOM said he/she had not refunded the resident's money because the resident still owed the facility his/her Medicaid surplus amount of $2520.68 for November 2025. The BOM said they did not receive the resident's social security checks until after the resident passed away and he/she did not know what he/she was supposed to do with the money, because they did not have written authorization to pay his/her outstanding balance with the funds since the resident always paid his/her bill in person. The BOM said he/she had not contacted anyone about what to do with the resident's personal funds to date. During an interview on 01/23/26 at1:55 P.M., the administrator said personal funds of residents should be refunded within 30 days of a resident's discharge to the facility and they should not hold a resident's personal funds without written authorization from the resident or their responsible party. 10. Review of the facility's Resident Trust-Current Account Balance Report, dated 01/23/26, showed Resident #125 with a current balance of $172.86. Review of the resident's medical records showed the resident discharged from the facility on 09/29/20. During an interview on 01/23/26 at 11:29 A.M., the BOM said the resident discharged from the facility on 09/29/20. The BOM said the resident's personal funds in the resident funds trust account had not been refunded because the resident still owed the facility money and they had turned his/her billing account over to a collection agency, so they were waiting to see what the collection agency would be able to collect. The BOM said he/she did not have written authorization from the resident or their responsible party to hold the resident's personal funds in the resident funds trust account for future facility payment. During an interview on 01/23/26 at1:55 P.M., the administrator said personal funds of residents should be refunded within 30 days of a resident's discharge to the facility and they should not hold a resident's personal funds without written authorization from the resident or their responsible party.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, facility staff failed to develop and implement a person-centered care plan to included behavioral interventions and activity preferences for three of three sampled residents (Resident #2, #5 and #9) who resided on a secured memory care unit. The facility census was 88. 1. Review of the facility's Dementia Care policy, dated 2025, showed individualized, non-pharmacological approaches to care will be utilized, to include meaningful activities aimed at enhancing the resident's well-being. The care plan goals and interventions will be monitored on an ongoing basis for effectiveness and will be reviewed/revised as necessary. Review of the facility's Activity policy, dated 2026, showed it is the policy of the facility to provide an ongoing program to support residents in their choice of activities based on their comprehensive assessment, care plan, and preferences. Special considerations will be made for developing meaningful activities for residents with dementia. Review of the facility's Comprehensive Care Plans policy, dated 2025, showed the comprehensive care plan will describe, at a minimum, the following: services that are to be furnished to attain or maintain the residents highest practicable physical, mental and psychosocial well-being. 2. Review of Resident #2's Significant Change in Status Assessment (SCSA) Minimum Data Set (MDS), a federally mandated assessment tool, dated 11/07/25, showed staff assessed the resident as:-Cognitively impaired;-Did not have behaviors or reject care;-Felt it was somewhat important to listen to music, go outside when the weather was nice and attend religious activities;-Felt it was important to have books or magazines and/or participate in favorite activities;-Felt it was very important to attend group activities;-Diagnosis of Dementia.Review of the resident's nurses' notes, dated 11/01/25 through 01/22/26, showed staff documented the resident had behaviors of confusion, required verbal cues, restless at times, agitation and anxiety.Review of resident's care plan, dated 11/03/25, showed the care plan did not address the resident's need for a secured memory care unit, activity preferences, or behavioral interventions for when the resident had anxiety. Observation on 01/20/26 at 11:00 A.M., showed the resident lived on the secured memory care unit. Observation showed the resident became restless in the television room and attempted to self-transfer from his/her wheelchair to a regular chair and, when unsuccessful, he/she became agitated evidenced by a change in his/her verbal tone and he/she struck the armrest of the wheelchair. Observation showed an unknown staff member unlocked the resident's wheelchair and the resident then self-propelled around the sitting area. 3. Review of Resident #5's SCSA MDS, dated [DATE], showed staff assessed the resident as:-Severely cognitively impaired;-Did not have behaviors or reject care;-Felt it was important to have activities with music, groups of people, participate in favorite activities and religious activities;-Diagnosis of Dementia.Review of the resident's nurses' notes, dated 10/01/25 through 01/22/26, showed staff documented the resident had agitation during an assessment and did not contain documentation of other behaviors. Review of the resident's care plan, dated 12/21/25, showed the care plan did not address the secured memory care unit, activity preferences, or behavioral interventions. Observation on 01/20/25 at 2:24 P.M., showed the resident in bed on the secured memory care unit with his/her eyes closed. Observation on 01/21/25 at 8:46 A.M., showed the resident in bed on the memory care unit with his/her eyes closed. 4. Review of Resident #9's admission MDS, dated [DATE], showed staff assessed the resident as:-Cognitively impaired;-Did not have behaviors or reject care;-Felt it was somewhat important to have music and religious act;-Felt it was important to have books or magazines and/or participate in favorite activities but cannot do or no choice to do;-Diagnosis of dementia.Review of the resident's nurses' notes dated,11/01/25 through 01/22/26, showed the resident wandered at night, spit food, yelled out, had chronic confusion and disorganized thinking, required cues, refused care, hallucinated, and behaviors increased when without hearing aids.Review of the resident's care plan, dated (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	11/04/25, showed the care plan did not contain direction for wandering, spitting food, required cueing, hallucinations or use of hearing aids to ease behavioral episodes. Observation on 01/20/25 at 11:42 A.M., showed the resident in his/her wheelchair at the lunch table and he/she would occasionally speak to him/herself.Observation on 01/21/25 at 8:51 A.M., showed the resident in bed with his/her eyes closed. 5. During an interview on 01/23/25 at 10:23 A.M., CNA T said Residents #2, #5, and #9 all reside on the secured memory care unit. He/She said he/she does not know what their behaviors are and staff inform him/her during shift report of any resident behaviors. The CNA said behaviors should be care planned so staff know how to assist the residents when they have behaviors. The CNA said the activities staff comes to the unit and provides activities, but they are not always there. During an interview on 01/23/26 at 11:06 A.M., SSD U said activity assessments are used to develop the care plan and incorporate the residents likes and dislikes. Staff are encouraged to use the information to help residents with behavior management and cognition. He/She is new to the role but is working closely with the Activity Director (AD) to update the care plans. During an interview on 01/23/26 at 11:20 A.M., the AD said he/she has been in the role for three weeks. He/She has been trying to put new things in place and has been working to get some dementia related materials to incorporate into his/her program for those that reside on the memory care unit. The AD said she is not currently updating the care plans because she is still learning. During an interview on 01/23/26 at 3:34 P.M., the MDS nurse said he/she tries to incorporate behaviors into the care plans. He/She said knowing the residents likes and dislikes can help manage difficult behaviors. Behaviors should be care planned with specific interventions. He/She said all team members have access to the care plans and can update it appropriately. He/She said if the MDS coordinator is not informed of important information regarding the resident in between assessments, he/she does not know about it.During an interview on 01/23/26 at 3:50 P.M., the Director of Nursing (DON) said residents with dementia should have a care plan that includes dementia. The care plan should include things that comfort them, specific behaviors and interventions, things that redirect them, activity needs and why they live on a secured unit. The DON said he/she has only been in the role a couple of months and is still trying to get processes together.During an interview on 01/23/26 at 4:32 P.M., the administrator said the Interdisciplinary Team (IDT) is responsible to ensure that care plans are up to date. Dementia care residents that reside on the secured unit should have an indication why they live there in their care plans as well as activity preferences and resident specific behaviors and interventions.

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	265840	A. Building B. Wing	01/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Neighborhoods Rehabilitation and Skilled Nursing B	3003 Falling Leaf Court Columbia, MO 65201

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, facility staff failed to review and revise the comprehensive care plan for three of three sampled residents (Resident #2, #6, and #9) who had falls and failed to update the care plan for one resident (Resident #5) of two sampled residents with pressure ulcers (wound created from pressure). The facility census was 88.Review of the Comprehensive Care Plan policy, dated 2025, showed the comprehensive care plan will include measurable objectives and timeframes to meet the resident's needs as identified in the resident's comprehensive assessment. The objectives will be utilized to monitor the resident's progress. Alternative interventions will be documented, as needed. 1. Review of Resident #2's Significant Change of Status (SCSA) Minimum Data Set (MDS), a federally mandated assessment tool, dated 11/07/25, showed staff assessed the resident as:-Cognitively impaired:-Needed some help with functional cognition;-Had impaired range of motion in one upper and one lower extremity;-Dependent on staff for sit to stand transfers;-Had not fallen since prior assessment;-Diagnosis of stroke.Review of the resident's nurses' notes, dated 01/15/26, showed staff documented the resident fell out of bed at 7:15 P.M., and fell from his/her wheelchair at 10:00 P.M. Review of the resident's care plan, dated 11/29/25, showed the care plan did not contain documentation of a review for the resident's two falls on 01/15/26. 2. Review of Resident #6's Annual MDS dated , 12/01/25, showed staff assessed the resident as:-Cognitively intact;-Diagnoses of progressive neurological disorder and Parkinson's disease;-Had not fallen since admission;-Required substantial maximal assistance with toileting, dressing, hygiene, and mobility.Observation on 01/21/2/25 at 01:55 P.M. showed the resident wore a neck brace and had a forehead laceration. Observation on 01/22/25 at 10:20 A.M., showed Registered Nurse (RN) B cleansed a laceration on the resident's forehead, while the resident wore a neck brace. During an interview on 01/21/25 at 1:55 P.M., the resident said he/she fell and hit his/her head on the bedside table and broke his/her neck on 12/17/25.Review of the resident's care plan, dated 11/25/25, showed the care plan did not contain documentation of a review for the resident's fall or direction for the forehead laceration or neck brace. 3. Review of Resident #9's admission MDS, dated [DATE], showed staff assessed the resident as:-Cognitively impaired;-Had impaired range of motion to one upper extremity;-Dependent on staff for sit to stand transfers;-Had a history of falls prior to admission;-Diagnosis of dementia.Review of the resident's nurse notes', dated 10/28/25 through 01/22/26, showed staff documented the resident fell on [DATE] and 01/19/26. Review of the resident's care plan, dated 11/04/25, showed the care plan did not contain documentation of a review for the resident's falls on 01/17/26 or 01/19/26. 4. Review of Resident #5's SCSA MDS, dated [DATE], showed staff assessed the resident as:-Severely cognitively impaired;-Had a Stage III pressure wound (full-thickness wound with exposed fat);-Had a deep tissue pressure injury (localized damage to soft tissue);-Had a surgical wound;-Received hospice services;-Diagnoses of dementia and anemia.Review of the resident's care plan, dated 12/21/25, showed:-Stage III wound to the right heel;-Surgical wound to the right thigh;-The care plan did not contain documentation of the pressure ulcers located on the resident's left upper arm or tailbone. Observation on 01/23/26 at 5:02 A.M., showed the resident in bed with a stage II pressure (partial thickness loss of skin, shallow) wound to his/her left upper arm and a stage IV pressure (full thickness skin damage exposing bone) wound to his/her tailbone. Observation showed the resident did not have a wound to the right heel or right thigh. 5. During an interview on 01/23/26 at 3:34 P.M., the MDS nurse said staff must tell him/her if changes are needed to the residents' care plans. He/She said a care plan should be updated with a resident change in condition, falls, treatments, acute illnesses and specialized equipment. He/She said it is his/her responsibility to ensure the care plans are accurate, but they can be updated by the nurses or interdisciplinary team (IDT). If a resident falls, documentation is reviewed, and the care plan (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	should be reviewed and updated. He/She is not sure why the care plans were not updated after Residents #2, #6 and #9 had falls, probably overlooked. During an interview on 01/23/26 at 3:50 P.M., the Director of Nursing (DON) said care plans should reasons for treatments, equipment needs, wounds, and falls. The care plan should be updated if there are any changes and as soon as possible. The charge nurse and MDS nurse can update the care plans. The care plans should be reviewed after each fall and updated as needed.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, facility staff failed to provide services to meet professional standards when staff failed to document and obtain orders for catheter use and indication, catheter size and bulb size for catheters on two of two sampled residents (Resident #8 and #111) and failed to document and obtain orders for dialysis to include days of week, location of clinic, and indication for two of two residents (Resident #2 and #5) who received dialysis. The facility census was 88.1. Review of the facility's Catheter Care policy, undated, showed the policy did not contain direction or guidance for contents of a physician order for catheters. 2. Review of Resident #2's Significant Change of Status (SCS) Minimum Data Set (MDS), a federally mandated assessment tool, dated 11/07/25, showed staff assessed the resident as: -Cognitively impaired;-Indwelling catheter;-Diagnosis of Dementia. Review of the residents Physician Order Sheet (POS), dated 01/22/26, showed: -Catheter care every shift, cleansing from proximal to distal for infection prevention;-Empty drainage bag every shift;-Change drainage bag every Sunday on nightshift;-The POS did not contain an order for the size of the catheter, the bulb size of the catheter or the indication for the catheter. Review of the resident's care plan, dated 11/03/25, showed the care plan did not contain direction or guidance for catheter indication, size or bulb size. Observation on 01/20/25 at 11:40 A.M., showed the resident in his/her wheelchair and a catheter drainage bag hung from the bottom of the wheelchair. Observation on 01/21/25 at 8:24 A.M., showed the resident in his/her wheelchair and a catheter drainage bag hung from the bottom of the wheelchair. During an interview on 01/23/26 at 10:50 A.M., Licensed Practical Nurse (LPN) Q said residents who have an indwelling catheter should have an order, which includes why the resident has the catheter and the size and care of the catheter, and it is the responsibility of the nurse who obtained the order to put it into the chart. LPN Q said he/she is not sure why Resident #2 did not have an order for use of a catheter, size or balloon size. LPN Q said the resident has a catheter because he/she has dementia. During an interview on 01/23/26 at 3:50 P.M., the Director of Nursing (DON) said the resident has a catheter for an approved diagnosis of dementia with psychosis. 3. Review of Resident #5's SCS MDS, dated [DATE], showed staff assessed the resident as: -Severely cognitively impaired;-On hospice services;-Indwelling catheter;-Presence of one stage III pressure injury (full thickness skin loss exposing the fat layer);-Dependent on staff for bed mobility;-Diagnosis of dementia; Review of the resident's POS, dated 01/22/26, showed the following orders: -Catheter care every shift, cleansing from proximal to distal for infection prevention;-Empty drainage bag every shift;-Change drainage bag every Sunday on nightshift;-The POS did not contain an order for the size of the catheter, or the bulb size of the catheter or the indication for the catheter. Review of the resident's care plan, dated 12/21/25, showed the care plan did not contain direction of guidance for size of catheter or bulb size. Observation on 01/20/25 at 11:28 A.M., showed the resident in bed with a catheter drainage bag hooked to the side of the bed. Observation on 01/23/25 at 5:02 A.M., showed the resident in bed with a catheter drainage bag hooked to the side of the bed. During an interview on 01/23/26 at 10:50 A.M., LPN Q said residents who have an indwelling catheter should have an order, which includes why the resident has the catheter and the size and care of the catheter, and it is the responsibility of the nurse who obtained the order to put it into the chart. LPN Q said he/she is not sure why Resident #5 did not have an order for use of a catheter, size or balloon size. LPN Q said the resident is on hospice and is allowed to have a catheter. During an interview on 01/23/26 at 3:50 P.M., the DON said the resident has a catheter for hospice and pressure wound to the bottom. 4. During an interview on 01/23/26 at 3:50 P.M., the DON said the nurses are responsible to obtain an order for urinary catheters. The order should include a reason for use, size and bulb size. The DON said he/she did not know Residents #2 and #5 did not have appropriate orders. 5. Review of the facility's Hemodialysis policy, dated 2025, showed the facility will ensure that the physician's orders for dialysis include: (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The type of access for dialysis;-The dialysis schedule;-The nephrologist name and phone number;-The dialysis facility name and phone number. 6. Review of Resident #8's Quarterly MDS, dated [DATE], showed staff assessed the resident as: -Cognitively intact;-On dialysis;-Diagnosis of End Stage Renal Disease (ESRD). Review of the resident's POS, dated 1/22/26 showed orders for the following: -Check dialysis port before and after dialysis twice a day every Monday, Wednesday and Friday;-Take vital signs (VS) pre and post dialysis twice a day every Monday, Wednesday and Friday;-Weigh pre dialysis and post dialysis every dayshift on Tuesday, Thursday, Saturday and Sunday;-Check dialysis port before and after dialysis twice a day every Monday, Wednesday and Friday;-The POS did not contain orders for dialysis to include days of week, location of clinic, and indication for dialysis. During an interview on 01/22/26 at 2:15 P.M., LPN R said he/she was not sure which clinic Resident #8 goes to and could not find it in the medical record. He/She said if there would be an emergency, he/she would have to dig through the chart or ask someone more familiar with the resident to know who to contact. He/She said he/she is informed of what days the resident goes to dialysis in a daily report from the off-going shift. He/She said it would be a good idea to have that information more readily available and does not know who is responsible to ensure the chart contains that information. 7. Review of Resident #111's medical record, showed the resident admitted to the facility on [DATE] and did not have a completed MDS assessment. Review of the resident's baseline care plan, dated 01/14/26, showed the resident received dialysis every Monday, Wednesday and Friday. Review of the resident's POS, dated 01/22/26, showed the following orders: -Dialysis assessment on dialysis days in the afternoon every Monday, Wednesday and Friday;-Dialysis clinic chair time of 6:30 A.M.;-No lab draws or blood pressure on arm with fistula;-Left fistula, if dressing is in place, change as needed when soiled;-Monitor left arm fistula site every shift, assess bruit (sound associated with blood flow) or thrill (vibration felt on the skin associated with blood flow), every shift-The physician orders did not contain orders for indication of dialysis, location of clinic, or name and phone number of nephrologist. During an interview on 01/22/26 at 2:30 P.M., LPN S said dialysis orders are obtained by the admitting nurse when the resident arrives from the hospital and the orders should include days of the week and shunt care, if any. He/She said he/she did not know if the resident had such orders. He/She said the resident goes to dialysis three days a week and knows that because the resident told them. 8. During an interview on 01/23/26 at 3:50 P.M., the DON said residents who undergo dialysis should have appropriate orders that include reason, days of week and location of services and the nurses are responsible to obtain such orders during admission or with a new order. The DON said he/she did not know Residents #8 and #111 did not have appropriate orders.