STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265859	A. Building B. Wing	03/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cotton Point Living Center	609 South Railroad Street Matthews, MO 63867

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 45872 Based on observation, interview and record review, the facility failed to provide a safe, clean and comfortable homelike environment. This deficient practice had the potential to affect all residents in the facility. The facility census was 54. Review of the facility's policy titled, Homelike Environment, revised February 2021, showed: - Residents are provided with a safe, clean, comfortable, homelike environment and encouraged to use their personal belongings to the extent possible; - The facility staff and management maximizes, to the extent possible, the characteristics of the facility that reflect a personalized, homelike setting such as a clean, sanitary and orderly environment. Observations on 03/04/25 at 10:21 A.M., and 03/05/25 at 8:15 A.M., of room [ROOM NUMBER] showed: - A buildup of dust and dirt on the air filter inside the air conditioner unit; - Several long dark markings on the wall near the light switch by the door; - Two areas of exposed sheetrock and peeled paint on the wall near the recliner; - Several long dark markings along the wall next to the bed near the window. Observations on 03/04/25 at 10:24 A.M., and 03/05/25 at 8:21 A.M., of room [ROOM NUMBER] showed: - Several long dark markings with areas of exposed sheetrock and peeled paint on the wall near the door. Observations on 03/04/25 at 10:29 A.M., and 03/05/25 at 8:25 A.M., of room [ROOM NUMBER] showed: - A large area of exposed sheetrock and peeled paint next to the nightstand. Observations on 03/04/25 at 10:51 A.M., and 03/04/25 at 8:32 P.M., of room [ROOM NUMBER] showed: (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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- A buildup of dried food and dirt on the resident's wheelchair cushion, seat, foot pedals, and the sides; - A buildup of dirt and grime on the Hoyer lift next to the bed near the window. Observations on 03/04/25 at 10:59 P.M., and 03/05/25 at 8:42 A.M., of room [ROOM NUMBER] showed: - Long dark markings on the bottom part of the wall next to the bed near the window. Observations on 03/04/25 at 11:09 A.M., and 03/05/25 at 8:53 A.M., of the resident private phone room showed a missing square vent cover on the ceiling near the sprinkler head. Review of February 2025 Resident Council Meeting Minutes showed: - A concern with resident wheelchairs not being cleaned or washed by staff. During an interview on 03/07/25 at 10:03 A.M., the Maintenance Supervisor (MS) said he/she was aware there were a lot of things that needed to be repaired and painted. It was hard at times to keep up with maintenance duties when he/she was verbally told when something needed to be addressed by staff in passing. It would be nice if staff would write down the environmental concerns on the maintenance log to be addressed in a timely manner. During an interview on 03/07/25 10:21 A.M., the Administrator said she was aware the facility had a lot of environmental concerns that needed to be addressed. Staff should be writing down any environmental issues on the maintenance log instead of verbally telling the MS in passing so he/she didin't forget throughout the day.

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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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. 45872 Based on interview and record review, the facility failed to follow their policy and procedure to complete Criminal Background Checks (CBC) for one employee (Employee I) prior to hire and to check the Employee Disqualification List (EDL - a listing of individuals who have been determined to have abused or neglected, misappropriated funds or property from a resident) periodically for six employees (Employees G, I, J, K, L, and M) out of ten sampled employees. The facility census was 54. Review of the facility's policy titled, Employee Disqualification List (EDL), dated February 2022, showed: - At the time of consideration of employment, the designated employee shall access the EDL website and check the EDL; - The designated employee will review the EDL list on the EDL website to make certain the name of the employee has not been placed on the the EDL since the initial checking requirement; - The annual and quarterly information is found on the same website as the individual information; - The annual list is updated each January. - Each quarter, names are added and deleted; - The designated employee should check and print the list each quarter and annually, check it against the current employee list, and file in a folder called EDL quarterly checklist. Review of the facility's policy titled, Criminal Background Checks Policy and Procedure, dated February 2022, showed: - The facility shall perform criminal background checks on all employees hired after August 28, 1997; - After an employment application has been received by Administration and it is determined the applicant will be offered employment, the designated facility employee will complete an online Criminal Background Request; - Print the request for the employee record. In addition, a copy of the disclosure of the applicant's rights under the Fair Credit Reporting Act shall be given to the applicant. Both requirements shall be completed the same day as the decision to hire, and prior to allowing any person contact with a resident. The responsibility for completing this requirement shall remain with the Administrator even if the task shall be delegated to a designee; - The reply for Criminal Background Request will be emailed with a notice that there is no match or that a follow-up is being mailed, which will indicate a criminal history and this applicant shall not be started to work until such time as the Administrator, or designee, shall receive the response and determine whether or not the applicant is to be disqualified; (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- There will be no exceptions to this policy. 1. Review of Employee G's personnel file showed: - A hire date of 04/09/24; - The last EDL list check was 04/09/24; - The facility did not check a quarterly EDL list check. 2. Review of Employee I's personnel file showed: - A hire date of 12/24/21; - No documentation the CBC was completed before the employee's hire date; - The most recent EDL list check was 09/16/22; - The facility did not check a quarterly or annual EDL list check. 3. Review of Employee J's personnel file showed: - A hire date of 10/02/24; - The last EDL list check was 09/30/24; - The facility did not check a quarterly EDL list check. 4. Review of Employee K's personnel file showed: - A hire date of 08/23/24; -The last EDL list check was 08/19/24; -The facility did not check a quarterly EDL list check. 5. Review of Employee L's personnel file showed: - A hire date of 11/20/24; - The last EDL list check was 11/06/24; - The facility did not check a quarterly EDL list check. 6. Review of Employee M's personnel file showed: - A hire date of 03/07/24; (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- The last EDL list check was 02/15/24; - The facility did not check a quarterly or annual EDL list check. During an interview on 03/07/25 at 4:00 P.M., the Human Resources (HR) staff said he/she was not aware it was required for the facility to check the EDL list except at the time of hire. During an interview on 03/07/25 at 4:38 P.M. the Administrator said the CBC and EDL checks should be completed prior to employment and she thought at least quarterly after employment.

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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 0638 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assure that each resident's assessment is updated at least once every 3 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26904 Based on interview and record review, the facility failed to electronically transmit quarterly Minimum Data Set (MDS) assessments, a federally mandated assessment instrument completed by the facility, in a timely manner and in accordance with the guidelines for two residents (Residents #37 and #40) out of 14 sampled residents and two residents (Residents #38 and #42) outside the sample. The facility's census was 54. Review of the facility's policy titled, Resident Assessments, dated October 2023 showed: - A comprehensive assessment of each resident is completed at intervals designated by Omnibus Budget Reconciliation Act (OBRA) regulations and Protective Payment System (PPS) requirements. Data from the MDS is submitted to the Internet Quality Improvement Evaluation System (iQIES) as required. - OBRA-Required Assessments are federally mandated, and therefore, must be performed for all residents of Medicare and Medicaid certified nursing homes. OBRA assessments include: a. Admission assessment; b. Quarterly assessment; c. Annual assessment; d. Significant change in status assessment; e. Significant correction to prior comprehensive assessment; f. Significant correction to prior quarterly assessment; g. Discharge assessment. - PPS Assessments are conducted (in addition to the OBRA required assessments) for residents for whom the facility receives Medicare Part A Skilled Nursing Facility benefits; - Comprehensive MDS assessments include both the completion of the MDS as well as completion of the Care Area Assessments (CAA) process and care planning. Comprehensive MDS, include admission, annual, and significant changes. - The resident assessment coordinator is responsible for ensuring that the interdisciplinary team conducts timely and appropriate resident assessments. Review of the facility's policy titled, MDS Completion and Submission Timeframes, dated October 2023, showed: - Our facility will conduct and submit resident assessments in accordance with current federal and state submission timeframes; (continued on next page)

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F 0638 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Timeframes for completion and submission of assessments is based on the current requirements published in the Resident Assessment Instrument (RAI) Manual; - Submission of MDS records to the iQIES is electronic. A hard copy of each record submitted is maintained in the resident's clinical record for a period of 15 months from the date submitted. 1. Review of Resident #37's MDS assessments showed: - admitted on [DATE]; - An admission assessment, dated 08/24/24; - A quarterly MDS, dated [DATE]; - The facility did not complete a quarterly MDS for the resident within 92 days of the last MDS. 2. Review of Resident #38's MDS assessments showed: - admitted on [DATE]; - A quarterly MDS, dated [DATE]; - The facility did not complete a quarterly MDS for the resident within 92 days of the last MDS. 3. Review of Resident #40's MDS assessments showed: - admitted on [DATE]; - A quarterly MDS, dated [DATE]; - The facility did not complete a quarterly MDS for the resident within 92 days of the last MDS. 4. Review of Resident #42's MDS assessments showed: - admitted on [DATE]; - A quarterly MDS, dated [DATE]; - The facility did not complete a quarterly MDS for the resident within 92 days of the last MDS. During an interview on 03/06/25 at 10:10 A.M., the MDS Coordinator said he/she just started in the position but was aware there were some MDS assessments that were behind and/or late. During an interview on 03/07/25 at 4:31 P.M., the Administrator said she would expect the MDS's to be completed on time. During an interview on 03/07/25 at 4:35 P.M., the Regional Nurse Consultant said she was told all of the MDS's were up to date.

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F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Encode each resident's assessment data and transmit these data to the State within 7 days of assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26904 Based on interview and record review, the facility failed to electronically transmit a Minimum Data Set (MDS - a federally mandated assessment instrument completed by the facility staff) in a timely manner and in accordance with guidelines for two residents (Residents #17 and #41) out of 14 sampled residents. The facility's census was 54. Review of the facility's policy titled, MDS Completion and Submission Timeframes, dated October 2023, showed: - Our facility will conduct and submit resident assessments in accordance with current federal and state submission timeframes; - Timeframes for completion and submission of assessments is based on the current requirements published in the Resident Assessment Instrument (RAI) Manual; - Submission of MDS records to the to the Internet Quality Improvement Evaluation System (iQIES) is electronic. A hard copy of each record submitted is maintained in the resident's clinical record for a period of 15 months from the date submitted. 1. Review of Resident #17's MDS record showed: - admitted on [DATE]; - A quarterly MDS, dated [DATE], completed but not transmitted; - The facility did not transmit the MDS within 14 days of the completion date. 2. Review of Resident #41's MDS assessment showed: - admitted on [DATE]; - A quarterly MDS, dated [DATE], completed but not transmitted; - The facility did not transmit the MDS within 14 days of the completion date. During an interview on 03/06/25 at 10:10 A.M., the MDS Coordinator said he/she just started in this position, but was aware there were some MDS assessments that were behind and/or late. During an interview on 03/07/25 at 4:31 P.M., the Administrator said she would expect the MDS's to be submitted on time. During an interview on 03/07/25 at 4:35 P.M., the Regional Nurse Consultant said she was told all of the MDS's were up to date.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted 45872 Based on interview and record review, the facility failed to include an admitting diagnosis of post traumatic stress disorder (PTSD - psychological distress following a traumatic event) with specific interventions on the baseline care plan upon admission for one resident (Resident #158) out of two sampled residents. The facility census was 54. Review of the facility's policy titled, Care Plans - Baseline, revised March 2022, showed: - A baseline plan of care to meet the resident's immediate health and safety needs is developed for each resident within 48 hours of admission; - The baseline care plan includes instructions needed to provide effective, person-centered care of the resident that meets professional standards of quality care and must include the minimum healthcare information necessary to properly care for the resident; - The baseline care plan is used until the staff can conduct the comprehensive assessment and develop interdisciplinary person-centered comprehensive care plan (no later than 21 days after admission); - The baseline care plan is updated as needed to meet the resident's needs until the comprehensive care plan is developed. 1. Review of Resident #158's medical record showed: - An admitted of 02/17/25; - Diagnoses of PTSD, paranoid schizophrenia (a long term mental disorder that causes distrust, affects a person's ability to think, feel, and behave clearly, and sometimes including delusions or hallucinations, schizoaffective disorder (a condition characterized by abnormal thought processes and deregulated emotions), major depression disorder (long-term loss of pleasure or interest in life), irritability, and anger. Review of the resident's Baseline Care Plan, dated 02/18/25, showed: - PTSD with specific interventions not addressed. During an interview on 03/05/25 at 2:19 P.M., the resident said he/she was in the military and witnessed people that were killed. Loud noises triggered the PTSD. During an interview on 03/05/25 at 2:56 P.M., the Social Service Director (SSD) said the resident was asked about his/her PTSD a few days after being admitted to the facility and he/she avoided the question. (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 03/07/25 at 3:42 P.M., the Director of Nursing said if a new resident was admitted to the facility with a PTSD diagnosis, it should be included on the baseline care plan with specific interventions. During an interview on 03/07/25 at 4:42 P.M., the Administrator said if a new resident was admitted to the facility with a diagnosis of PTSD, the resident's baseline care plan should include specific interventions along with other admission diagnoses documented on the admission paperwork.

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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** 26904 Based on observation, interview, and record review, the facility failed to obtain and/or follow physician's orders for three residents (Residents #15, #37 and #158) out of five sampled residents and one resident (Resident #2) outside the sample. The facility census was 54. Review of the facility's policy titled, Medication and Treatment Orders, dated July 2016, showed: - Orders for medication and treatments will be consistent with principles of safe and effective order writing; - Medications shall be administered only upon the written order of a person duly licensed and authorized to prescribe such medications in this state; - Only authorized, licensed practitioners, or individuals authorized to take verbal orders from practitioners, shall be allowed to write orders in the medical record; - Drugs and biological orders shall be recorded on the physician's order sheet (POS) in the resident's chart; - Such orders are reviewed by the pharmacy consultant on a monthly basis. 1. Review of Resident #2's medical record showed: - admitted on [DATE]; - Diagnoses of bipolar disorder (a mental disorder that causes unusual shifts in mood) and major depressive disorder (long-term loss of pleasure or interest in life). Review of the resident's February 2025 Physician Order Sheet (POS) showed: - An order for Invega Trinza (an antipsychotic medication) intramuscularly (IM -injection administered into the muscle) 819 milligram (mg)/2.63 millimeter (ml) every three months, starting on the 6th February/May/August/November related to schizophrenia (a long term mental disorder that affects a person's ability to think, feel, or behave clearly, sometimes including delusions or hallucinations), dated 07/06/24. Review of the resident's November 2024 MAR showed: - Invega scheduled for administration on 11/06/24; - The facility failed to administer the medication. Review of the resident's February 2025 MAR showed: - Invega scheduled for administration on 02/06/25; (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- The facility failed to administer the medication. 2. Review of Resident #15's medical record showed: - admitted on [DATE]; - Diagnoses of dementia (a serious medical illness that negatively affects how you feel, the way you think and how you act), chronic obstructive pulmonary disease (COPD - a chronic inflammatory lung disease that causes obstructed airflow from the lungs) and emphysema (a lung disease where the tiny air sacs in the lungs make it hard to breathe). Review of the resident's March 2025 POS showed: - No order for oxygen. Review of the resident's progress note, dated 03/04/25, showed: - Difficulty breathing; - Breathing treatment administered; - Oxygen level at 99% via oxygen concentrator in use at 2 liters (L) per nasal cannula (tubing inserted into the nostrils for supplemental oxygen). Observation on 03/04/25 at 10:21 A.M., showed the resident lay in his/her bed with an oxygen concentrator in use at 2 L per nasal cannula. Observations on 03/04/25 11:01 A.M., and 03/07/25 at 10:11 A.M., showed the resident sat upright in his/her chair with an oxygen concentrator in use at 2 L per nasal cannula. During an interview on 03/04/25 at 11:06 A.M., the resident said he/she had difficulty breathing at times and needed oxygen. During an interview on 03/04/25 at 11:26 A.M., the Director of Nursing (DON) said Resident #15 did not have an oxygen order on his/her current POS. There should be a physician's order for oxygen. During an interview on 03/04/25 at 11:47 A.M., the Administrator said she would expect a resident who required oxygen to have a physician's order on his/her current POS. 3. Review of Resident #37's medical record showed: - admitted on [DATE]; - Diagnoses of hypertension (HTN-high blood pressure), congestive heart failure (CHF- heart muscle weak and cannot pump properly), and atrial fibrillation (a-fib - an irregular, often rapid heart rate causes poor blood flow); - No order for hospice care. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the resident's hospice binder showed: - Resident admitted to hospice on 07/22/24; - Diagnosis of CHF. During an interview on 03/07/25 at 4:22 P.M., Licensed Practical Nurse (LPN) F said the resident did not have an order for hospice until 03/05/25. During an interview on 03/07/25 at 4:35 P.M., the Administrator said any resident on hospice needed an order for the hospice care. 4. Review of Resident #158's medical record showed: - admitted on [DATE]; - Diagnoses of post traumatic stress disorder (PTSD - psychological distress following a traumatic event), paranoid schizophrenia (a long term mental disorder that causes distrust, affects a person's ability to think, feel, and behave clearly, and sometimes including delusions or hallucinations), schizoaffective disorder (a condition characterized by abnormal thought processes and deregulated emotions), major depression disorder, irritability, and anger. Review of the resident's February 2025 POS showed: - An order for Invega Sustenna IM 234 MG/1.5 ml one time a day starting on the 23rd and ending on the 23rd every month for schizoaffective disorder, depressive type dated 02/17/25. Review of the resident's February 2023 MAR showed: - Invega scheduled for administration on 02/23/25; - The facility failed to administer the medication. Review of the resident's progress note, dated 02/27/25, showed: - The resident involved in a resident-to-resident altercation; - No injuries noted for either resident; - Administrator notified of the incident. During an interview on 03/05/25 at 2:30 P.M., the Regional Nurse Consultant said she would expect nursing staff to document when medications were given and to follow the physician's orders. During an interview on 03/07/25 at 4:45 P.M., the Administrator said she would expect nursing staff to follow physician's orders. 45872 (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	48532

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	265859	A. Building B. Wing	03/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cotton Point Living Center	609 South Railroad Street Matthews, MO 63867

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26904 Based on observation, interview, and record review, the facility failed to implement, monitor and modify interventions to maintain acceptable parameters of nutritional status for two residents (Residents #19 and #40) out of four sampled residents. The facility census was 54. Review of the facility's policy titled, Weight Assessment and Intervention, dated March 2022 showed: - Resident weights are monitored for undesirable or unintended weight loss or gain; - Residents are weighed upon admission and at intervals established by the interdisciplinary team; - Any weight change of 5% or more since the last weigh assessment is retaken the next day for confirmation; - Unless notified of significant weight change, the dietitian will review the unit weight record monthly to follow individual weight trends over time; - The threshold for significant unplanned and undesired weight loss will be based on the following criteria: a. one month - 5% weight loss is significant; greater than 5% is severe; b. three months - 7.5% weight loss is significant; greater than 7.5% is severe; c. six months - 10% weight loss is significant; greater than 10% is severe; - If the weight is desirable, this is documented; - An undesirable weight change is evaluated by the treatment team whether or not the criteria for significant weight change has been met; - The physician and the multidisciplinary team identify conditions and medications that may be causing anorexia (reduction in appetite and food intake), weight loss or increasing the risk of weight loss. 1. Review of Resident #19's medical record showed: - admitted on [DATE]; - Diagnoses of anemia (low red blood cells), heart failure (when the heart muscle is weakened and cannot pump blood effectively), hypertension (high blood pressure), anxiety, and depression; - An order for a regular diet, mechanical soft texture, thin liquids, dated 01/09/25; (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- No order for a health shake. Review of the resident's weights showed: - On 11/14/24, 148.0 pounds (lbs.); - On 12/05/24, 145.4 lbs. - On 01/09/25, 140.0 lbs. - On 02/07/25, 136.0 lbs. - On 03/06/25, 138.0 lbs. - From 11/14/24-02/07/25, the resident had a severe weight loss of 8.11% in three months. Review of the resident's RD Nutritional Assessment, dated 12/04/24, showed: - A recommendation to add ice cream two times daily. Review of the resident's RD Assessment and Recommendations, dated 01/09/25, showed: - A health shake/house supplement two times daily. Review of the resident's RD Assessment and Recommendations, dated 02/17/25, showed: - Add a health shake/house supplement two times daily and provide encouragement to improve intake. The facility failed to address the RD recommendations. Observations on 03/05/25 at 12:24 P.M., 03/06/25 at 12:08 P.M., and 03/07/25 at 12:19 P.M., showed the resident with a divided plate and ate 50% of the meal with no assistance. Staff did not encourage the resident to eat his/her meals. Ice cream nor health shakes were provided to the resident. 2. Review of Resident #40 medical record showed: - admitted on [DATE]; - Diagnoses of hypertension, gastrointestinal esophageal reflux disease (GERD-a stomach acid being forced back into the throat region), diabetes mellitus (DM- a condition that affects the way the body processes blood sugar), and congestive heart failure (CHF); - An order for a regular diet, regular texture, no concentrated sweet (NCS) for diabetes mellitus, dated 06/05/24; - No order for a health shake. Review of the resident's weights showed: (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- On 10/07/24, 186.6 lbs.; - On 11/04/24, 184.6 lbs.; - On 12/05/24, 183.4 lbs.; - On 01/09/25, 175.4 lbs.; - On 02/07/25, 163.2 lbs.; - On 03/06/25, 166.0 lbs. - From 01/09/25 - 02/07/25, the resident had a severe weight loss of 6.9% in one month; - From 10/07/24 - 03/06/24, the resident had a severe weight loss of 11.3% in six months. Review of the resident's RD Assessment and Recommendations, dated 01/15/25, showed: - Increase the health shake from two times daily to three times daily and to discontinue the low concentrated sweet diet to allow more food choices. Review of the resident's RD Assessment and Recommendations, dated 02/10/25, showed: - Liberalize the diet to a regular diet due to weight loss, increase the health shake to three times daily, and provide encouragement at meals. The facility failed to address the RD recommendations. Observations on 03/06/25 at 12:10 P.M., and on 03/07/25 at 12:16 P.M., showed the resident ate 100% of his/her meal and the ice cream provided with the meal. During an interview on 03/07/25 at 11:00 A.M., the Regional Nurse Consultant said staff weigh the residents. If there was a discrepancy, then the resident was weighed the next day to validate the weight. Nursing was notified and the nursing department would notify the provider of the weight loss. After the RD visited the facility, he/she sent a report to the facility, and the nursing department followed up with the provider with any recommendations. During an interview on 03/07/25 at 3:07 P.M., the Dietary Manager (DM) said he/she received a weight variance report from the RD after his/her facility visit. The DM could look at the residents' medical records after nursing had put the orders in for diet changes and/or supplements. 48532

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 48532 Based on interview and record review, the facility failed to ensure staff reconciled narcotics (a process that allows one staff to reconcile the exact narcotic inventory on hand with another staff) at each shift change for three out of three medication carts. This practice had the potential to affect all residents. The facility census was 54. The facility did not provide a policy on narcotic reconciliation documentation. 1. Review of the 100 Hall Medication Cart Narcotic Count Log for Controlled Substances showed: - For 6 A.M.-6 P.M. shift on 02/03/25-02/24/25, the staff missed 13 out of 44 opportunities to reconcile the narcotic medications; - For 6 A.M.-6 P.M. shift on 02/25/25-03/07/25, the staff missed 6 out of 21 opportunities to reconcile the narcotic medications. 2. Review of the 200 Hall Medication Cart Narcotic Count Log for Controlled Substances showed: - For 6 P.M.-6 A.M. shift on 02/10/25-03/07/25, the staff missed 22 out of 47 opportunities to reconcile the narcotics medications. 3. Review of the 300 Hall Medication Cart Narcotic Count Log for Controlled Substances showed: - For 6 A.M.-6 P.M. shift on 02/15/25-03/07/25, the staff missed 20 out of 42 opportunities to reconcile the narcotic medications. 4. Review of the Medication Room Narcotic Count Log for Controlled Substances showed: - For 6 A.M.-6 P.M. shift on 01/23/25-02/10/25, the staff missed 10 out of 35 opportunities to reconcile the narcotic medications; - For 6 P.M.-6 A.M. shift on 02/10/25-02/27/25, the staff missed 13 out of 35 opportunities to reconcile the narcotic medication; - For 6 A.M.-6 P.M. shift on 02/28/25-03/07/25, the staff missed 4 out of 13 opportunities to reconcile the narcotic medications. During an interview on 03/07/25 at 3:47 P.M., Licensed Practical Nurse (LPN) D said two staff members, the on-coming and off-going staff, count the narcotic medications in the cart or the medication room and signed the narcotic log book. During an interview on 03/07/25 at 4:30 P.M., the Regional Nurse Consultant said the on-coming and off-going staff should count the narcotic medications together and sign the narcotic count log. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 03/07/25 at 4:35 P.M., the Administrator said the on-coming staff and off-going staff should do a narcotic medications reconciliation and sign the narcotic log book.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45872 Based on interview and record review, the facility failed to ensure an appropriate diagnosis for the use of a psychotropic (medications that affect a person's mental status) medication for three residents (Residents #1, #15, and #20) out of five sampled residents. The facility census was 54. Review of the facility's policy titled, Antipsychotic (a medication that affects the brain activities associated with mental processes and behavior) Medication Use, revised July 2022, showed: - Residents will only receive antipsychotic medications when necessary to treat specific conditions for which they are indicated and effective; - The attending physician and other staff will gather and document information to clarify a resident's behavior, mood, function, medical condition, specific symptoms, and risks to the resident and others; - Antipsychotic medications shall generally be used only for the following conditions/diagnoses as documented in the record, consistent with the definitions in the Diagnostic and Statistical Manual of Mental Disorders (current or subsequent editions): a. Schizophrenia (a long term mental disorder that affects a person's ability to think, feel, or behave clearly, sometimes including delusions or hallucinations); b. Schizoaffective disorder (a condition characterized by abnormal thought processes and deregulated emotions); c. Schizophreniform disorder (a mental illness similar to schizophrenia but symptoms last for a shorter period); d. Delusional disorder (a mental disorder marked by false beliefs); e. Mood Disorders (any mental disorder with a disturbance of mood) (e.g. bipolar disorder (a mental disorder that causes unusual shifts in mood), depression with psychotic features (combination of a loss of interest with hallucinations and delusions), and treatment refractory major depression (depression does not respond to standard treatments); f. Psychosis in the absence of dementia (a state where an individual experiences a loss of touch with reality, marked by symptoms like delusions and hallucinations, without dementia); g. Medical illness with psychotic symptoms and/or treatment related psychosis or mania (state of extreme highs such as intense energy and excitement); h. Tourette's Disorder (a neurological disorder that causes people to make sudden, involuntary movements or sounds); (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	i. Huntington's Disease (a genetic progressive brain disorder that causes nerve cells to break down, leading to uncontrolled movements); j. Hiccups (not induced by other medications); or; k. Nausea and vomiting associated with cancer or chemotherapy; - Diagnoses alone do not warrant the use of antipsychotic medication. In addition, to the above criteria, antipsychotic medications will generally only be considered if the following conditions are also met: a. The behavioral symptoms present a danger to the resident or others; and: 1. the symptoms are identified as being due to mania or psychosis (such as auditory, visual, or other hallucinations; delusions, paranoia or grandiosity; or; 2. behavioral interventions have been attempted and included in the plan of care, except in an emergency; - Antipsychotic medications will not be used if the only symptoms are one or more of the following: wandering, poor self-care, restlessness, impaired memory, mild anxiety, insomnia, inattention or indifference to surroundings, sadness or crying alone that is not related to depression or other psychiatric disorders, fidgeting, nervousness, uncooperativeness. 1. Review of Resident #1's March 2025 Physician's Order Sheet (POS) showed: - admitted [DATE]; - Diagnoses of Alzheimer's disease (a disease that destroys memory and other important mental functions), anxiety disorder, major depressive disorder (long-term loss of pleasure or interest in life), and unspecified dementia without psychosis (memory loss where the specific underlying cause cannot be identified); - An order for Seroquel (an antipsychotic medication) 25 milligram (mg) by mouth at bedtime for unspecified dementia, dated, 08/08/24; - The facility did not provide an appropriate diagnosis for the Seroquel. 2. Review of Resident #15's March 2025 POS showed: - admitted [DATE]; - Diagnoses of atherosclerotic heart disease, chronic obstructive pulmonary disease (COPD - a chronic inflammatory lung disease that causes obstructed airflow from the lungs), depression (a disorder marked by memory loss, personality changes, and impaired reasoning that interferes with daily functioning) and dementia; (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- An order for Seroquel 37.5 mg by mouth two times a day for behaviors, dated 06/28/24; - The facility did not provide an appropriate diagnosis for the Seroquel. 3. Review of Resident #20's March 2025 POS showed: - admitted [DATE]; - Diagnoses of major depressive disorder and dementia; - An order for Seroquel 25 mg by mouth two times a day for psychosis, dated 01/03/25; - The facility did not provide an appropriate diagnosis for the Seroquel. During an interview on 03/07/25 at 4:50 P.M., the Regional Nurse Consultant said dementia was not an appropriate diagnosis for Seroquel. During an interview on 03/07/25 at 4:50 P.M., the Administrator said dementia was not an appropriate diagnosis for Seroquel. 48532

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 45872 Based on observation, interview, and record review, the facility failed to store and distribute food under sanitary conditions, increasing the risk of cross-contamination and food-borne illness. These deficient practices had the potential to affect all residents. The facility census was 54. Review of the facility's policy titled, Refrigerators and Freezers, dated November 2022, showed: - The facility will ensure safe refrigerator and freezer temperatures, and sanitation, and will observe food expiration guidelines; - Monthly tracking sheets for all refrigerators and freezers are posted to record temperatures; - Food service supervisors or designated employees check and record refrigerator and freezer temperatures with first opening and at closing in the evening; - Use by dates are completed with expiration dates on all prepared food in refrigerators; - Expiration dated on unopened food and observed and use by dates are indicated once food is opened. Review of the facility's policy titled, Food Preparation and Service, dated November 2022, showed: - Food and nutrition services employees prepare, distribute, and serve food in a manner that complies with safe food handling practices; - When verifying food temperatures, staff use a thermometer which is both clean, sanitized, and calibrated to ensure accuracy; - Proper hot and cold temperatures are maintained during food distribution and service; - The temperatures of foods held in steam tables are monitored throughout the meal service by food and nutrition service staff; - The policy did not address food temperature tracking sheets for meals served. Review of the facility's policy titled, Sanitation, revised November 2022, showed: - The food service area is maintained in a clean and sanitary manner; - All kitchens, kitchen areas, and dining areas are kept clean, free of garbage and debris, and protected from rodents and insects; - All equipment, food contact services, and utensils are cleaned and sanitized using heat or chemical sanitizing solutions. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 03/04/25 at 9:22 A.M., of the meal time food temperature logs showed: - No food temperature logs for 02/22/25 - 03/04/25, with 42 missed opportunities out of 42 opportunities. Observation on 03/04/25 at 9:22 A.M., of the refrigerator temperature logs showed: - No refrigerator temperature logs for 03/01/25 - 03/04/25, with eight missed opportunities out of eight opportunities. Observation on 03/04/25 at 9:28 A.M., of refrigerator 1 showed: - A bag of opened biscuits undated and not labeled; - Four bags of frozen pancakes undated and not labeled; - A large opened bag of French fries undated. Observations on 03/04/25 at 9:39 A.M., and 03/05/25 at 9:51 A.M., of the dishwasher machine showed a build up of debris, crumbs, and a hard white substance on the top surface. Observation on 03/05/25 at 9:34 A.M., of the refrigerator near the Dietary Manager's (DM) door showed: - A clear container of red jello undated and not labeled; - An opened bag of boiled eggs undated and not sealed; - A bag of shredded cheese opened and undated; - A half-used stick of butter opened, unwrapped, undated, and not sealed. During an interview on 03/05/25 at 10:31 A.M., the DM said the food temperature logs should be checked with each meal. The refrigerator temperature logs should be checked daily. The kitchen equipment should be cleaned daily and as needed. All foods should be labeled, dated, and secured to prevent any type of contamination. During an interview on 03/05/25 at 10:37 A.M., the Registered Dietician (RD) said food temperatures should be checked before each meal. The refrigerator temperatures should be checked and logged daily per policy. The kitchen equipment should be cleaned on a daily basis for sanitary purposes. All foods should be labeled, dated, and secured to prevent any type of contamination. During an interview on 03/05/25 at 10:52 A.M., the Administrator said she would expect kitchen staff to check food temperature logs before serving the food to the residents. Refrigerator temperature logs should be checked every day by the kitchen staff. The kitchen equipment should be clean at all times. All foods should be labeled, dated, and secured to prevent any type of contamination.