STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265863	A. Building B. Wing	01/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Tiffany Springs Rehabilitation & Health Care Cente	9191 N Ambassador Drive Kansas City, MO 64154

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 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed promote each resident's right to self-determination when the facility failed to provide services to maintain good grooming and personal hygiene in accordance with resident preferences for two residents (Resident #76 and #92) out of 24 sampled residents. The facility census was 116.Review showed the facility did not provide a policy related to showers.1. Review of Resident #76's Quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 10/30/25, showed:- The resident was cognitively intact;- Required assistance with showering, bathing, and toileting;- Diagnoses included: seizures, diabetes, and heart failure. Review of the Resident's care plan, dated 01/09/26, showed:- The resident preferred a shower on Wednesdays and Saturdays in the evening;- Required two staff participation with bathing;- Staff were required to keep the resident's routine consistent, skin clean, dry, and well moisturized related to fragile skin.Review of the Resident's shower task sheet in the electronic medical record showed staff documented providing six showers over the past 30 days. Showers were provided on a Monday or Friday between the hours of 11:26 A.M. and 2:59 P.M. and not in accordance with the resident's plan of care. During an interview on 01/22/2026 at 7:57 P.M., the Resident said:- He/She didn't get showers that often and it had been almost two weeks since his/her last shower;- The staff tell resident's they can ask for showers, but he/she feels the showers should be scheduled so the staff won't forget to do it;- Going without showers makes him/her feel dirty and he/she does not like feeling that way;- He/She has asked staff to provide a shower and staff have said that they would do it later, but then the staff won't come back to give the shower. He/She doesn't like that.During an interview on 01/22/2026 at 8:04 P.M., the Assistant Director of Nursing (ADON) said:- It was possible that the resident was not getting enough showers because the resident liked to really wash his/her hair, really scrub, and would take a long time in the shower;- He/She had just scheduled the resident for a shower in the morning and not in the evenings.2. Review of Resident #92's Quarterly MDS, dated [DATE], showed:- The resident was cognitively intact;- Dependent on staff with transfers, bathing, and toileting;- Diagnoses included: morbid obesity, diabetes, and respiratory failure. Review of the Resident's care plan, dated 01/16/26, showed:- The resident was totally dependent on staff to provide a bath;- Staff were to provide the resident with a sponge bath when a full bath or shower could not be tolerated;- Staff were to keep the resident's skin clean, dry, and well moisturized related to decreased mobility and incontinence.During an interview on 01/20/2026 at 10:00 A.M., the Resident said:- He/She was lucky to get one bed bath, usually every other week;- He/She doesn't refuse the showers. He/she has trouble remembering things but knows when he/she has not had a shower. It upsets him/her when staff say he/she had already had a shower;Observation on 01/20/2026 at 10:00 A.M., showed the resident lying in bed, his/her hair is greasy and unkempt. A strong smell of foul body odor near the resident.During an interview on 01/22/2026 at 8:30 A.M., ADON B said the resident's shower days had been on Mondays and Thursdays and staff hadn't been able to complete his/her shower on Monday.During an interview on 01/22/2026 at 7:43 P.M., CNA A said:- The facility did not have a shower aide during the day shift; (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 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	there was only one aide on the evening shift;- Staff should chart the showers in the electronic chart when completed;- Staff should notify the charge nurse if the resident refuses a shower.During an interview on 01/22/2026 at 10:42 A.M., RN A said: - The facility used to have a shower aide but not anymore, so aides on each hall have to provide showers and other duties; - The showers are assigned to the aides on each shift, and completion should be documented in the resident's electronic record;- If a resident refuses, the staff should notify the charge nurse who would try to talk to the resident, at least three times;- Sometimes the residents would sign a refusal and sometimes they would not;- Sundays were makeup days for missed showers.During an interview on 01/22/2026 at 8:34 P.M., the Resident said:- He/She thinks his/her last bed bath was about a week ago; does not like missing showers/baths;- He/She would like to get bathed more often;- He/She did not remember when he/she was last bathed and said he/she enjoys a bed bath and it makes his/her body feel good.Observation on 01/22/2026 at 8:34 P.M., showed the resident lay in bed, his/her hair greasy, with a strong foul body odor. During an interview on 01/22/2026 at 8:04 P.M., ADON B said the resident's showers are scheduled based on room number. Preferences should be given and discussed at care plan meetings. Staff should provide care as directed in the plan of care. During an interview on 01/23/26 at 11:37 A.M., the Director of Nursing (DON) said the residents should receive their showers or bed baths twice a week and should have a choice of date, and time. Staff should provide care as directed in the plan of care.

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F 0567 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to manage his or her financial affairs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to implement policies and procedures to ensure resident's trust fund accounts were not allowed to go into a negative balance which affected one resident (Resident #28) and when the facility failed to refund resident funds within 30 days of discharge for six residents (Residents #123, #124, #125, #126, #127, and #128). The facility census was 116. Review of facility policy Resident Trust Fund Policy, revised [DATE], showed:- Refund checks for discharged or expired residents must be completed within 5 business days of the resident discharge. Per state regulations, a completed discharge/trust fund accounting form reflecting discharge date and monies disbursed must be sent to the caseworker within 5 business days.- The Resident Fund bank account must be reconciled monthly immediately upon receipt of the bank statement. - The facility shall require all monies, either spent on behalf of the resident or withdrawn by the resident or his/her legal representative be supported by a receipt and cancelled check or signed voucher on file.- The facility shall refund the balance of the resident's personal funds when a resident is discharged . The amount shall be refunded by the end of the month following the month of discharge or by State/Federal specific guidelines. 1. Review of the facility's business office aging report (report showing outstanding invoices and balances), dated [DATE], showed the following discharged residents had money in the facility's operating account:- Resident #127, discharged [DATE], credit balance $870.42;- Resident #128, discharged [DATE], credit balance $5,683.00;- Resident #126, discharged [DATE], credit balance $2,118.00;- Resident #124, discharged [DATE], credit balance $1,077.00;- Resident #125, discharged [DATE], credit balance $40.00;- Resident #123, discharged [DATE], credit balance $399.00;Review of the facility maintained Resident Trust Fund Statements, showed:- Resident #28 had a negative trust fund balance of $1,891.89 on [DATE];- Resident #28 had a negative trust fund balance of $1,891.89 on [DATE];- Resident #28 had a negative trust fund balance of $1,891.89 on [DATE];Review of the facility maintained Quarterly Statements, dated 3rd and 4th quarters, showed:- Resident #28's trust fund account was debited for room and board for $1,891.89 on [DATE] brining the resident's account balance to negative $1,891.89.- Resident #28 deposited $1,891.89 in the resident trust fund account on [DATE] bringing his/her balance to zero. During an interview on [DATE] at 9:25 A.M., the Business Office Manager (BOM) said:- Resident #28's account went into the negative on August of 2025 because she didn't look at the account to make sure it had funds to pay for room and board. She just issued the check to the corporate account as money owed thereby causing the resident's account balance to go into the negative. In November the facility was able to fix the account balance issue by having the resident deposit funds directly into the account to bring it back to zero. The BOM said that resident accounts in the trust fund should never be negative because that indicates that resident funds are missing from the account affecting all residents.- Resident #127 had money that was owed to insurance which was resolved on [DATE] when the insurance payment posted. A refund for $870.42 is ready to be processed but she was unsure why it had been delayed.- Resident #128 had secondary insurance resolved and processed on [DATE]. His/her refund is in processing but hah not yet posted to the account. This should have been done as soon as the issue was resolved since the resident discharge on [DATE]. - Resident #126 had insurance posting that was delaying his/her refund. This was resolved according to account notes in [DATE]. $2,118.00 needs to be processed and refunded right away to the discharged resident. - Resident #124 requires an accounting adjustment which shows the resident is due $407.00 as of [DATE]. This money should have been processed already to the resident but is still outstanding. - Resident #123 discharged on [DATE] and according to an account reconciliation the resident is owed $99.00 as of [DATE] from an insurance overpayment. - Resident #125 discharged on [DATE] and it shows the resident is owed a refund of $40.00. She was not sure why the refund had not been issued. During an interview on [DATE] at 10:00 A.M., the Administrator (continued on next page)

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F 0567 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	said:- Monies owed to residents should be returned in the timeframe indicated in our facility policies.- Residents should not ever have a negative balance in the Resident Trust Account.

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F 0569 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Notify each resident of certain balances and convey resident funds upon discharge, eviction, or death. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to notify four residents (Resident #16, #23, #75, and #106) when they were within $200.00 of the Social Security Income (SSI) limit ($6,068.80) or when the resident's account was over the SSI limit. This affected four of 24 residents sampled. Facility census was 116. Review of the facility policy, Facility Resident Trust Fund Policy, revised May 2012, showed any individual Resident Trust Account that is nearing the state specified maximum balance will require notification to the Resident/Responsible part via Form letter.1. Review of Resident #16's Quarterly Minimum Data Set (MDS, a federally mandated assessment tool completed by facility staff), dated 12/30/25, showed:- Resident was cognitively intact;- Diagnoses: coronary artery disease, heart failure, kidney disease, diabetes, anxiety disorder, depression, and dementia;Review of the Resident's Monthly Trust Fund Account Balance, showed:- January 2025 $6366.00, which is over the SSI income limit;- February 2025 $6918.00, which is over the SSI income limit;- March 2025 $6932.00, which is over the SSI income limit;- May 2025 $6857.00, which is over the SSI income limit;- June 2025 $6791.00, which is over the SSI income limit;- August 2025 $6725.00, which is over the SSI income limit;2. Review of Resident #23's Annual MDS, dated [DATE], showed:- Resident was cognitively intact;- Diagnoses: coronary artery disease, heart failure, GERD (acid reflux), psychotic disorder, and depression;Review of the Resident's Monthly Trust Fund Account Balance, dated 1/22/25, showed the current account balance $6,263.27, which was over the SSI limit.3. Review of Resident #75's Quarterly MDS, dated [DATE], showed:- Reside was cognitively intact;- Diagnoses: cerebral palsy, anxiety disorder, and depression;Review of Resident's Monthly Trust Fund Account Balance, dated 1/22/25, showed the current account balance was over the SSI limit, $6,114.33.4. Review of Resident #106's Quarterly MDS, dated [DATE], showed:- Resident was cognitively intact;- Diagnoses: anemia, hypertension, kidney disease, and depression;Review of the Resident's Monthly Trust Fund Account Balance, showed:- June 2025 $16,859.00, which is over the SSI limit;- August 2025 $18,027, which is over the SSI limit;During an interview on 1/6/25 at 9:30 A.M., the Business Office Manager (BOM) said:- She had discussions with the residents when they are over the SSI limit but has never sent a formal letter informing them of the requirement to spend down their money. She is working with the families and the residents to reduce the balances, but was not aware she was required to send a letter to the resident or guardian.During an interview on 1/8/25 at 10:10 A.M., the Administrator said residents should be assisted in spending down their funds if they are within $200 of the limit of their SSI income level. A letter is required to be sent to each resident notifying them of this situation.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to provide services or care that adhere to accepted standards of quality when the facility failed to properly manage pain, provide medication as ordered by a physician, failed to notify physician of unavailability of pain medication, failed to obtain medication from emergency medication kit on site for one Resident (Resident #100), and failed to follow physician's orders for Residents #9, #94, #113 and failed to implement Diabetes management for Resident #9. This affected four sampled residents out of 24 sampled. The facility census was 116.Review of the facility's Medication Administration Policy dated May 2019, showed staff to administer all medications to overcome illness and to relieve and prevent symptoms as per physician order.Review of the facility policy titled Ordering Medications Policy dated May 2019, showed refill requests can be faxed, sent via Electronic Health Record system, and/or left on the pharmacy refill voicemail.Review of the facility policy titled, Pain Management Policy dated 2/2025, showed every resident has the right to the assessment and management of pain.There was no facility policy provided regarding Emergency Kit narcotics.1.Review of Resident #100's Quarterly Minimum Data Set (MDS, a federally mandated assessment tool completed by facility staff) dated 1/13/26, showed:-Resident was cognitively intact-He/she required partial to moderate assist with Activities of Daily Living (ADL) including toileting, dressing and grooming;-He/she was on a scheduled pain medication regimen;-He/she was dependent on staff for medication administration;-Diagnoses included heart failure, spinal stenosis, neuropathy (nerve damage causing pain or weakness) and low back pain. Review of resident's care plan dated 7/31/24, showed:-He/she was cognitively intact;-He/she was prescribed opioids (narcotic pain medication);-No care plan for staff interventions regarding monitoring pain management;-He/She had limited physical mobility and was dependent on nursing staff for mobility and transfers. Review of medication administration record on 1/23/26 showed:-The resident had an order for Hydrocodone/Acetaminophen 7.5mg/325mg by mouth four times a day for low back pain.-The facility scheduled the doses for 8 A.M. 12 P.M., 4 P.M., and 8 P.M.-The Resident missed five doses of scheduled medication and was not administered ordered medications on: 1/20/25 at 4 P.M. and 8 P.M. and 1/21/25 at 8 A.M., 12 P.M. and 4 P.M.Review of the medication administration progress notes for the month of January showed that medication was not available or reordered from pharmacy for all missed doses. There was no documentation that the provider had been notified regarding the missed doses of pain medication.Review of the medication administration record for the month of January showed that the resident had an order for Fentanyl Transdermal Patch 72 25mcg/hr. Apply one patch every 72 hours for Chronic pain. Medication was due and not administered on 1/16/26 and 1/19/26 because they were not available. There was no documentation that the physician was notified.Review of medication administration record showed that there was no additional pain medications ordered or administered while resident was out of prescribed pain medication Hydrocodone and Fentanyl.During an Interview on 1/23/26 at 1:30 P.M., the resident said the time period when the pain medications were not administered was a rough few days and he/she had an increase in pain, the facility offered Tylenol, but that did not help to decrease pain level.During an interview on 1/23/26 at 9:30 A.M., LPN C stated that when a medication is missing, they are to document in Medication Administration Record, notify physician, notify pharmacy and document notifications were made in the resident's medical record. During an interview on 1/23/26, the ADON A, said there was a posted list of medications available in the Emergency kit, however, the list is outdated. ADON A was able to pull up Resident #100 in the medication dispensing machine and confirm that Hydrocodone/Acetaminophen 7.5mg/325mg was available to pull for resident use in the Emergency kit. During an interview on 1/23/26 at 1:30 P.M., the Director of Nursing (DON) stated that it is unreasonable for a resident to miss more than one dose of scheduled pain medications and a list of what medications are in the Emergency kit is available to on all nursing (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	units. The resident, prescriber and unit manager should be notified of medication missed if not available. She was not notified of medications not being administered from Emergency kit or not being re-ordered.2.Review of Resident #94's Comprehensive MDS assessment dated [DATE], showed:-Cognitively intact;-Required minimal assist with toileting and upper body dressing related to recent arm fracture and surgical repair;-Had scheduled and as needed pain medications frequently in the prior 5 days;-Required nursing staff to administer inhaled medications.Review of the facility's Medication Administration Policy dated May 2019, showed staff are to read each order entirely and are to know the use and side effects of each medication that is administered to each resident.Observation on 1/23/26 at 9 A.M., showed resident speaking to Certified Med Tech (CMT) B and said he/she had a runny nose and when he/she asked for a nasal spray the day prior, was given Albuterol inhaler. Resident asked CMT B if that would work CMT B replied, it might.Review of medication administration record on 1/22/26, showed that resident had orders for Acetaminophen Tablet 650mg. Give 2 tablets by mouth every 8 hours as needed for fever. There were no orders for Acetaminophen to be given for pain. There were 14 administrations of medications with associated pain scores documented and that the medication was effective for reported pain. The resident had no fevers documented.Review of medication administration record on 1/22/26, showed: Resident had an order for Oxycodone HCL 5MG every 6 hours as needed for severe pain. There were two administrations of Oxycodone with associated pain scores as two out of 10 on the pain scale. (2 being low and 10 being high pain) There were no additional orders for non-narcotic pain medication.Review of physician orders on 1/23/26, showed that resident had an order for ProAir HFA Inhalation Aerosol solution; 2 inhalations inhale orally every 6 hours as needed for Shortness of breath/wheezing. Resident had received 2 doses of this medication, there was no supporting documentation of shortness of breath or wheezing.During an interview on 1/23/26, CMT B, said the resident stated that new symptoms should be reported to nurse or provider when on unit and new orders come from them. CMT B stated that Acetaminophen should only be given for fever as the order is written. CMT B was able to verify the only other as needed medication for pain available to resident was Oxycodone HCL 5MG. CMT B said that the resident does not like the way it makes them feel.3. Review of Resident #9's admission MDS dated [DATE], showed: -Resident cognitively intact;-Required partial to moderate assist with ADL's, toileting, transfers and dressing;-Diagnoses included kidney failure, diabetes, heart failure and failure to thrive.Review of facility's Weight Assessment and Intervention Policy dated 12/24, showed a 5% weight loss in 1 month is significant and greater than 5% is severe.Review of resident's weight record on 1/21/26, showed: Order from physician to obtain a daily weight on resident on 1/4/26. Since admission, 1/2/26, there were four out of 16 weights not documented (01/03/26, 01/07/26, 01/13/26, 1/17/26). There was documented weight loss of 25.3# or 13% in 19 days. There is no documentation of provider notification of weight loss.During an interview on 1/21/26 at 10:00 A.M., the resident said that he/she had not lost that much weight. Resident also reported that facility had not been performing blood glucose monitoring until requested by resident/family.Review of Hospital Referral on 1/21/26, showed: resident had diabetes mellitus; resident had insulin orders and was administered insulin with blood glucose monitoring.Review of Hospital's discharge medication reconciliation showed that insulin was to be stopped.Review of facility records showed resident was admitted on [DATE] and blood glucose monitoring did not begin until 1/16/26 and only after requested by resident.The facility did not have a Diabetes Management, Hypoglycemia (low blood sugar) or Hyperglycemia (high blood sugar) policies.4. Review of resident #113's admission MDS dated [DATE], showed:- Cognitive impairment;- Fracture of left leg with surgical repair;- Incontinent of bowel and bladder;- Partial to moderate assist with bed mobility, transfers and toileting;-Last documented bowel movement was on 1/2/26;-Diagnoses included recent leg fracture with surgical repair, pain and non-Alzheimer's dementia.Review of resident's care plan dated 1/8/26, showed no mention of pain, incontinence, constipation, recent fracture.Review of Physician's orders for the month of January showed:-Milk of Magnesia (MOM) 400mg/5mL. Give (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	30mL by mouth every 23 hours as need for constipation. There was no documentation of MOM being provided to the resident.-Bisacodyl Suppository 10MG. Insert 1 suppository rectally every 23 hours as needed for constipation daily if no results from MOM. There is documentation of administration of Suppository on 1/8/26 but no documentation that MOM was administered.Review of nursing progress notes for the month of January showed that resident used their fingers and successfully removed their own fecal impaction in effort to reduce discomfort.During an Interview on 1/22/26 at 11:00 A.M., the resident said that they have had intermittent pain since surgery and when they are immobile is the only time they are pain free. He/she did not believe he/she had constipation problems.During an Interview on 1/23/26 at 1:30 P.M., DON stated that all physician orders should be followed per facility policy and that it would be an expectation for pain to be on the care plan of a resident admitted with pain as a diagnosis.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure dependent residents who were unable to carry out their own activities of daily living (ADLs) received the necessary services to maintain good personal hygiene when staff did not provide complete perineal care for two sampled residents, (Resident #13 and #6). This affected two of 24 sampled residents (Resident #13, and #6). The facility census was 116. Review of the facility's Activities of Daily Living Policy dated, 09/04/25, showed this facility provides each resident with care according to the resident's care plan and the resident's ability to perform activities of daily living including bathing, dressing, grooming and toileting. 1.Review of Resident #13's Quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 12/10/25, showed:-Severe cognitive impairment;-Extensive assistance of two staff members for bed mobility, transfers, toileting and personal hygiene;-Incontinent of bowel and bladder;-Diagnoses included dementia and depression. Review of the resident's undated care plan showed:-ADL self-care deficit;-Incontinent of bowel and bladder;-Assistance of two staff for toileting;-Impaired skin integrity. Observation on 01/22/2026 at 8:03 P.M., showed:-Certified Nurses Aide (CNA) B and CNA D washed their hands and applied gloves;-CNA B and CNA C removed the resident's wet incontinent brief;-CNA B wiped down the left groin, used a new wipe and wiped down the right groin;-CNA B and CNA C turned the resident on his/her side;-CNA B wiped down the middle of the resident's buttocks;-CNA B did not separate and clean all the skin folds;-CNA B did not clean all areas that urine and feces had touched. During an interview on 01/22/2026 at 8:55 P.M CNA B said he/she should have separated and cleaned all areas of the skin where urine or feces has touched. During an interview on 01/22/2026 at 8:55 P.M CNA C said staff should separate and cleanse all areas of the skin where urine or feces has touched. During an interview on 01/22/2026 09:05 P.M., Licensed Practical Nurse (LPN) E said:-Staff should separate and cleanse all skin folds as well as the upper thighs and outer buttocks;-Staff should clean all areas that urine and feces had touched. During an interview on 1/22/26 at 09:10 P.M., the Director of Nursing (DON) said:-She expected staff to separate skin folds and clean all areas urine and feces have touched. During an interview on 1/23/26 at 11:43 A.M., the Administrator said:-She expected the staff to ensure residents were clean and dry;-She expected staff to separate skin folds and clean all areas urine and feces have touched. 2. Review of Resident #6's care plan, showed: Revised 8/29/25 - The resident had bladder incontinence. Assist the resident to the bathroom or offer the bedpan on a routine basis, (upon arising in the morning, before and after meals, at bedtime and as needed). (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Revised 10/26/25 - The resident had an Activities of Daily Living (ADL) Self Care Performance Deficit Disease Process. The resident required set up and supervision for transfers. The resident required one staff participation to use the toilet. Review of the resident's Significant Change in Status MDS, dated [DATE] showed: Cognitive skills intact. Upper extremity impaired on both sides. Lower extremity impaired on one side. Required supervision or touch assistance with transfers. Required partial to moderate assistance with toilet use. Frequently incontinent of bowel and bladder. Diagnoses included high blood pressure, Osteoporosis (abnormal loss of bone density), and bipolar disorder (a mental condition marked by alternating periods of elation and depression). Observation on 1/22/26 at 8:44 P.M., showed: CNA C used the gait bet (a special belt placed around the resident's waist to provide a handle to hold onto during a transfer) and transferred the resident from his/her electric wheelchair to his/her bed. CNA B and CNA C removed the resident's clothes and placed a gown on the resident. CNA B placed the bedpan under the resident. CNA B wiped down one side of the groin. Used a new wipe and wiped across the pubic and area and down the other side of the groin. CNA B wiped down the middle twice with a different wipe each time. CNA B did not separate and clean all the skin folds. CNA B and CNA C turned the resident on his/her side and CNA B removed the bedpan with a moderate amount of amber urine in it. CNA B wiped up one side of the inner buttocks, used a new wipe each time and wiped from front to back twice. CNA B used a new wipe and with the same area of the wipe, wiped up and down both sides of the buttocks then back and forth across the buttocks. CNA B did not clean all areas of the skin where urine had touched. During an interview on 1/22/26 at 9:19 P.M., CNA C said he/she should separate and clean all the skin folds where urine had touched. It should be one wipe, one swipe. Should not wipe back and forth across both sides of the buttocks. During an interview on 1/23/26 at 9:30 P.M., CNA B said he/she should have separated and cleaned all areas of the skin where urine had touched. He/She should have used one wipe for one swipe and not wiped back and forth across the buttocks. During an interview on 1/23/26 at 9:47 A.M., Assistant Director of Nursing (ADON) C said staff should separate and clean all areas of the skin where urine had touched, including the inner thighs. The staff (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	should not wipe back and forth across the resident's buttocks. During an interview on 1/23/26 at 11:37 A.M., the DON said the staff should separate and clean all areas of the skin where urine had touched. Staff should not wipe back and forth across the buttocks.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure residents were served food that was palatable, safe, and at an appetizing temperature during meal service. This affected 2 of 24 sampled residents (Residents #22 and #95). The facility census was 116.Request for facility policy on cooking and dining food temperatures was not provided for review.1. Review of Resident #22's Quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 11/17/25, showed:- Resident was cognitively intact;- Diagnoses: heart failure, Parkinson's Disease, anxiety disorder, depression, and respiratory failure;During an interview on 1/20/26 at 9:27 A.M., the Resident said the food is cold and this can happen at all meal times. Some of the food is very spicy, he/she normally eats in his/her room. He/she would prefer to have his/her food be hotter than what he/she receives it2. Review of Resident #95's Quarterly MDS, dated [DATE], showed:- He/she was not screened for cognitive ability;- Diagnoses: coronary artery disease, diabetes, and seizure disorder;During an interview on 1/20/26 at 10:49 A.M., the Resident said the food is sometimes cold in the dining room. The food doesn't taste good and makes him/her disappointed, when looking forward to meals is important.During a group interview on 1/21/26 at 10:28 A.M., the Resident Council said:- 13 of 14 residents said that the food was cold at the facility;- Resident #4 said he/she could not eat the chicken yesterday because it was tough and hard;Observation on the 300 hall on 1/22/26 at 1:28 P.M., showed:- Food trays for the hall delivered in an insulated cart by dietary staff;- 1:34 P.M. (6 minutes since delivery) staff started to pass out hall food trays;- 1:50 P.M. The last hall tray is passed (12 of 12 trays) and the test tray is given to the surveyor;Observation of a lunch test tray on 1/22/26 at 1:50 P.M., showed:- Lima Beans temped at 116.0 degrees Fahrenheit;, required serving temperature is 120 degress Fahrenheit. - French Fries temped at 106.0 degrees Fahrenheit, required serving temperature is 120 degress Fahrenheit;- French Fries tasted bland and starchy. The outside texture was gritty. They were dry on the inside and were not crispy;During an interview on 1/23/26 at 8:15 A.M., the Dietary Manager (DM) said his expectation is to serve all residents food that is at a minimum of 120 degrees Fahrenheit. He expects hall trays to be delivered to residents upon delivery to the hall with minimal delay in order to preserve freshness. During an interview on 1/23/26 at 10:15 A.M., the Administrator said:- She would expect food to be served at temperatures that were in accordance with state regulations;- She would expect no more than a five minute delay in serving meals that are delivered to the hall from dietary staff;

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, the facility failed to ensure the bathroom exhaust vents were free of excess dust in residents' rooms. This affected 11 rooms. The facility census was 116.Observation on 1/20/26 starting at 11:17 A.M., showed the bathroom exhaust vents covered in dirt in:- room [ROOM NUMBER];- room [ROOM NUMBER];- room [ROOM NUMBER];- room [ROOM NUMBER];- room [ROOM NUMBER];- room [ROOM NUMBER];- room [ROOM NUMBER];- room [ROOM NUMBER];- room [ROOM NUMBER];- room [ROOM NUMBER];- room [ROOM NUMBER]. During an interview on 1/21/26 at 3:08 P.M., the Maintenance Director said they cleaned the bathroom exhaust vent twice a year. It was last done in July to August in 2025. He thought the maintenance staff may have started and then got called away to other jobs and not completed the task for all exhaust vents, that was why some of them had so much dirt on them.

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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 Based on observation, interview and record review, the facility failed to develop a baseline care plan for one resident (Resident #113), when staff did not care plan pain control. This affected one of 24 sampled residents. The facility census was 116. Review of the facility's Care Plan Policy dated 12/2024, showed: The purpose is to assess strengths, weakness and care needs for each resident that will assist the staff and resident in achieving and maintaining the highest practical level of mental functioning, physical functioning, and wellbeing as possible.1.Review of Resident #113's admission MDS., dated 1/6/26 showed:-Not cognitively intact;-Incontinent of bowel and bladder;-Partial to moderate assistance needed for toileting, toilet hygiene, dressing, transfers and mobility when in bed;-He/She reported frequent pain during the last five days;-Diagnoses included fracture of left lower leg with repair, pain due to internal orthopedic prosthetic devices and cognitive communication deficit. Review of the resident's care plan dated 1/8/26 showed:-He/She was at risk of skin breakdown related to existing pressure injury to coccyx and leg splint;-He/She was dependent on nursing staff for all personal hygiene, grooming, and transfers;-No plan of care regarding incontinence care or toileting programs with staff intervention;-No initiation of a pain management regimen with staff interventions for newly fractured leg;-He/She was dependent on facility staff to assess pain and provide pain management including pain medications. Observation on 1/20/26 at 8:13 A.M., showed the resident yelling from their private room with the door shut, saying I am in pain. The yelling continued for approximately half an hour and could be heard from common areas on the nursing unit.Observation on 01/20/26 at 09:05 A.M., showed a family member in the Resident's room asking staff for the resident to be cleaned up after incontinence.During an Interview on 1/22/26 at 11:00 A.M., the resident said he/she has had intermittent pain since surgery and to not move, was the only time he/she did not feel pain.During an interview on 1/23/26 at 2:30 P.M. the Director of Nursing and Administrator said the/she expected that pain be identified on the resident's care plan if the resident was admitted with pain as a diagnosis.

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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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. Based on observation, interview and record review, the facility failed to implement and monitor interventions put into place for one resident with significant unplanned weight loss (Resident #97) to prevent the resident from further weight loss when staff failed to offer Super Cereal (a highly nutritious, calorie-dense food to prevent malnutrition) and a Magic Cup (a high-protein nutritional treat designed to fight malnutrition) and when the staff failed document in the resident's medical record that the prescribed diet had not been consumed. Staff additionally failed to notify the resident's physician and the Registered Dietitian (RD) when the prescribed diet had not been consumed. This affected one of 24 sampled residents. The facility census was 116. Review of the Facility's Nutrition and Unplanned Weight Loss policy dated, December 2024 showed:-The nursing staff will monitor and document the weight and dietary intake of residents;-The threshold for significant unplanned weight loss will be based on the following criteria: 1 month - 5% weight loss is significant; 3 months - 7.5 % weight loss is significant; 6 months - 6% weight loss is significant;-The physician will review possible causes of weight loss and consider supplementation strategies to increase the intake of nutrients and calories;-This strategy may include fortification of foods and providing in between snacks and nutritional supplementation.1. Review of Resident #97's Quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by staff, dated 12/23/25 showed:-Moderate cognitive impairment;-Substantial assistance of staff for all Activities of Daily Living (ADLs);-Weight of 129 pounds (lbs);-No physician prescribed weight loss;-Weight loss of 5% or more;-No difficulty swallowing or chewing; dependent on staff to assist with meal set up;-Diagnoses included Parkinson's Disease, malnutrition and heart failure.Review of the resident's care plan updated on 01/05/26 showed:-Assist of one for ADLs;-Set up help from staff for eating;-At risk of impaired nutrition;-Serve diet as ordered;-Serve supplements as ordered at breakfast and lunch.Review of the resident's Physician's Order Sheet (POS) dated January 2026 showed:-Order start date: 12/13/25, regular diet and add magic cup at lunch;-Order start date: 12/13/25, fortified foods for supplement, super cereal at breakfast.Review of the resident's medical record showed:(lbs);-12/05/25 129.4 pounds (lbs);-10/07/25 133.6 lbs-09/17/25 136.0 lbs;-06/11/25 144.8 lbs;-No record of weights was found for July, August and November of 2025;-June to December 2025 showed a 15.4 pound weight loss or 10.64% in 6 months. Review of the resident's RD note dated 12/11/25 showed:-Encouragement from staff at meals;-Add super cereal with breakfast and ice cream with lunch;-Monitor intake percentages at meals for changes.Observation and interview on 01/20/26 at 01:23 P.M. showed:-Certified Nurse Aide (CNA) A served the resident his/her lunch;-No magic cup or ice cream was served to the resident;-CNA A said the kitchen provided the magic cup and he/she did not know much about it;-CNA A did not get a magic cup for the resident;-CNA A did not tell the nurse or go to the kitchen, the resident did not get a magic cup.Observation and interview on 01/21/26 at 01:17 P.M., showed:-CNA A served the resident his/her lunch;-No magic cup or ice cream was served to the resident;-The resident said he/she was hungry because he/she did not get breakfast that morning.During an interview on 01/21/26 at 08:17 P.M., CNA A said:-The staff filled out the meal tickets for the resident;-The resident told them what he/she wanted to eat;-The resident did not get a breakfast tray this morning;-He/She went to get the resident a snack before lunch;-He/She did not tell the nurse the resident did not get breakfast tray.A review of the resident's breakfast meal ticket dated 01/22/26 showed:-Sugar and coffee creamer were circled on the meal ticket;-Coffee was circled on the meal ticket;-Super Cereal was circled on the meal ticket;-Cornflakes were written on the bottom of the meal ticket.Observation on 01/22/26 at 09:20 A.M., showed:-CNA F served the resident his/her breakfast;-The resident's breakfast tray contained, a 75 ounce (oz) pre-packaged bowl of corn flakes and a pint of milk;-No Super Cereal was served to the resident.During an interview on 1/22/26 at 10:52 A.M., CNA F said:-The staff filled out the menus for the day before;-He/She does not tell the nurse or the kitchen if the resident does not eat;-He/She had never documented that the (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	resident did not eat or did not get what they ordered.During an interview on 1/22/26 at 11:09 A.M., [NAME] A said:-Super cereal is not a bowl of cornflakes;-The resident should have been offered the super cereal;-All diet orders should be followed. During an interview on 1/22/26 at 11:12 A.M., the Dietary Manager said:-The resident had an order for Super Cereal and a magic cup for weight loss;-He did not know why the resident's breakfast ticket had super cereal circled but corn flakes written on it;-If the resident does not want or does not eat the super cereal the nurse and the RD should be notified;-He was not aware the resident had not been getting the magic cup and the super cereal. During an interview on 01/22/2026 11:22 A.M., Assistant Director of Nursing (ADON) C said:-The nurse, physician and RD should be notified if the resident does not eat;-The resident should be offered the super cereal and the magic cup;-She expected the CNAs to tell the charge nurse if the resident did not eat his/her meal or was not offered his/her ordered diet.During an interview on 1/22/26 at 08:52 P.M., the Director of Nursing (DON) said:-She expects the CNAs to tell the unit manager that the resident did not eat the super cereal, the magic cup and/or the meal;-The super cereal and magic cup must be on the tray and offered to the resident;-The physician and RD should be notified if the resident is not consuming the prescribed diet.During an interview on 1/23/26 at 11:43 A.M., the Administrator said:-She expected the resident to receive his/her diet as ordered by the physician;-The resident is a weight loss and that is why the special diet is ordered;-She expected the CNAs to tell the unit manager that the resident did not eat or did not get the super cereal and magic cup;-She expected the unit manager to tell the physician and the RD.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, interview and record review, the facility failed to maintain an infection prevention and control program designed to provide a safe and sanitary environment when facility staff did not apply Personal Protective Equipment (PPE) when they provided care and treatment for one resident (Resident #13). This affected one of 24 sampled residents (Resident #13). The facility census was 116.Review of the facility's undated, Enhanced Barrier Precautions policy, showed:-Enhanced barrier precautions (EPB) are recommended for residents with any of the following: o Wounds; o Indwelling medical devices; o High contact care activities;-High contact care activities when a gown and gloves should be worn include: o Bathing/showering; o Changing bed linens; o Changing briefs; o Assisting with toileting. 1. Review of Resident #13's Quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 12/10/25, showed:- Severe cognitive impairment;- Extensive assistance of two staff members for bed mobility, transfers, toileting and personal hygiene;- Incontinent of bowel and bladder;- The resident had a wound;- Diagnoses dementia and depression.Review of the resident's undated care plan showed:-Activities of Daily Living (ADL)s self care deficit;-Incontinent of bowel and bladder;-Assistance of two staff for toileting;-Pressure injury to coccyx;-On enhanced barrier precautions due to wound;-Staff will wear gown and gloves when performing high contact resident care.Review of the resident's Physician's Order Sheet (POS) dated January 2026, showed Enhanced Barrier Precautions with providing personal hygiene and toileting.Observation and interview on 01/22/26 at 08:08 A.M., showed:-A sign outside the resident's room that showed the resident was on enhanced barrier precautions;-An isolation cart outside the resident's room;-Certified Nurse Aide (CNA) F and CNA G entered the resident's room;-The resident had a bandage on his/her left buttock;-CNA G uncovered the resident and raised up the resident's gown;-CNA F unfastened the resident's wet brief;-CNA F and CNA G did not put on isolation gowns or gloves before they entered the resident's room and provided care to the resident;-CNA F said the resident was on EBP because he/she had a wound;-CNA F said he/she should have put on a gown and gloves on before he/she entered the resident's room;-CNA F said anytime a resident is on EPB a gown and gloves should be worn when providing peri care;-CNA G said he/she should have put on a gown and gloves on before he/she entered the resident's room;-CNA G said a gown and gloves should be worn when touching bed sheets or the gown of the resident on EPB.Observation and interview on 01/22/2026 at 8:03 P.M., showed:-A sign outside the resident's room that showed the resident was on enhanced barrier precautions;-An isolation cart outside the resident's room;-CNA B and CNA C washed their hands and applied gloves;-CNA B and CNA C removed the resident's wet incontinent brief;-The resident had bandage on his/her left buttock;-CNA B and CNA C provided peri care to the resident;-CNA B and CNA C did not put on isolation gowns before they entered the resident's room and provided care to the resident;-CNA B said the resident was on EBP because he/she had a wound;-CNA B said he/she should have put on a gown on before he/she entered the resident's room;-CNA B said anytime a resident is on EPB a gown and gloves should be worn when providing peri care;-CNA C said he/she should have put on a gown on before he/she entered the resident's room.During an interview on 1/22/26 at 09:10 P.M., the Director of Nursing (DON) said:-She expected staff to put on full Personal Protective Equipment (PPE) when they entered a room with EPB;-The resident had a wound;-A gown and gloves should have been worn when providing cares.During an interview on 12/18/25 at 01:25 P.M. the Administrator said she expected staff to follow the facility protocol when it came to infection control and PPE.