STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265866	A. Building B. Wing	04/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Steelville Senior Living	311 N Spring Street Steelville, MO 65565

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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 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician. Based on interview and record review, the facility staff failed to designate a person to serve as the Director of Food and Nutrition Services with the appropriate qualifications, when the facility did not employ a qualified dietitian or other clinically qualified nutrition professional full-time. This failure has the potential to affect all residents. The facility census was 50 with a capacity of 72.1. Review of the facility provided policies showed they did not contain a policy related to the qualifications for the Director of Food and Nutrition Services. Review of the Dietary Manager's (DM) personnel records showed a new hire start date of 01/26/26 and the file did not contain documentation of food service management education, certification or experience. During an interview on 04/23/26 at 11:10 A.M., the DM said when he/she became the DM in late January 2026, facility staff told him/her they would get him/her certified but they did not give a timeline in which that would occur and he/she had not been enrolled in food service training during his/her employment. The DM said he/she never spoke with the current administrator about his/her dietary certification, but he/she spoke with the facility owner two weeks ago about the training and had not heard back from the owner. The DM said he/she never took college courses, food service courses and he/she never served in a kitchen supervisory role. The DM said he/she worked as a cook or dietary aide for almost 15 years, but he/she did not have food service management or supervisory experience. The DM said the facility's dietician comes to the facility monthly and they did not have any other clinically qualified staff employed full-time by the facility. During an interview on 04/23/26 at 3:00 P.M., the administrator said the facility did not have a policy related to qualifications for the DM. The administrator said he/she knew what the DM qualification requirements were, but he/she did not know the current DM did not meet those requirements. The administrator said he/she is responsible to ensure the facility hired qualified staff, but the facility hired the DM before he/she became the administrator a few weeks ago. The administrator said no other staff member met the DM qualifications for the DM position.

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

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. Based on observation and interview, the facility staff failed to ensure the internal temperature of foods placed in hot holding for service to residents remained at least 140 degrees Fahrenheit (F). Facility staff also failed to ensure the internal temperature of hot foods remained at least 120 degrees F upon service to residents who at in their rooms. These failures have the potential to affect all residents. The facility census was 501. Review of the facility's policy titled Food Code Temperatures, dated 02/26, showed staff directed to hold hot foods at 140 degrees F or above. Observation on 04/21/26 at 12:26 P.M., showed hot food items for service at the lunch meal held in the kitchen steam table and an adjacent warming cabinet. Observation showed the internal temperature of the mechanical soft chicken strips in the warming cabinet measured 110 degrees F and the internal temperature of the vegetables on the steam table measured 125 degrees F. During an interview on 04/21/26 at 12:45 P.M., [NAME] Q said he/she prepared the mechanical soft chicken and did not reheat or check the temperature of the chicken after he/she processed it. The cook said the mechanical soft chicken should be held at 135 degrees F and he/she did not reheat or check the temperature of the chicken because he/she had to get the meal out to the residents. Observation on 04/22/26 at 11:40 A.M., showed [NAME] R pureed pork loin and gravy in a food processor and placed the pureed pork in a small steam table pan. [NAME] R noted the internal temperature of the pork as 125 degrees F and then placed the pan of pureed pork in the warming cabinet next to the serving line. During an interview on 04/22/26 at 11:40 A.M., [NAME] R said hot foods should be held at 135 degrees F to 140 degrees F. The cook said he/she knew the temperature of the pureed pork measured 125 degrees F when he/she placed it in the warmer, but he/she did not know how the pureed pork should be reheated. The cook said he/she should follow the recipe to reheat food items but he/she did not because the recipes were not easy to find. Observation on 04/22/26 at 11:48 A.M., showed the internal temperature of the pureed pork in the warming cabinet measured 125 degrees F. Observation also showed the internal temperature of the pureed pork measured 123 degrees F when [NAME] R served it to the resident who received pureed diets. Observation on 04/22/26 at 11:55 A.M., showed the warming cabinet next to the serving line held a pan of mechanical soft pork and the internal temperature of the pork measured 126 degrees F. Observation also showed the internal temperature of the mechanical soft pork measured 122 degrees F when [NAME] R served it to the residents who received mechanical soft diets. 2. Review of the facility's policy titled Food Code Temperatures, dated 02/26, showed the policy did not contain direction to staff on the minimum required temperatures of food at the time of service to the residents. During an interview on 04/21/26 at 10:07 A.M., Resident #20 said he/she eats meals in his/her room and the meals were cold 90% of the time. The resident said he/she had complained to staff about the cold food. During an interview on 04/21/26 at 8:46 A.M., Resident #2 said he/she eats in his/her room and the hot foods on his/her meal trays are not hot when served to him/her. The resident said his/her biscuits and gravy at breakfast were not even warm. The resident said the room trays are delivered covered in plastic wrap and he/she told the staff not to uncover everything because it would get colder. During an interview on 04/21/26 at 11:23 A.M., Resident #50 said he/she eats in his/her room and the food is always cold when he/she gets it. Observation on 04/21/26 at 12:45 P.M. showed lunch meal trays delivered to residents who ate in their rooms. Observation of three sampled room trays showed: -The internal temperature of the ravioli on the first sampled tray measured 115 degrees F and the internal temperature of the vegetables measured 110 degrees F when delivered to the resident;-The internal temperature of the ravioli on the second sampled tray measured 85 degrees F when delivered to the resident.-The internal temperature of the ravioli on the third test tray measured 95 degrees F when delivered to the resident. During an interview on 04/21/26 at 2:29 P.M., Resident #3 said he/she complains to staff sometimes because the food is cold. 3. During an interview on 04/23/26 at 11:10 A.M., the Dietary Manager (DM) said the cook is responsible to serve hot resident foods at 165 (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	degrees F, but he/she did not know how often the cooks checked food temperatures. The DM said he/she had heard complaints from residents about cold food and corporate staff were supposed to provide more plate covers. The DM said he/she did not know when more plate covers were expected to arrive and kitchen staff did not take any other steps to make sure resident food was served hot. During an interview on 04/23/26 at 3:00 P.M., the administrator said the cooks and DM are responsible to serve hot foods at 140 degrees F or above and staff should reheat mechanical soft and pureed foods to 140 degrees before they are served. The administrator said he/she did not know residents received cold food.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview and record review, the facility staff failed to store food in a manner to prevent potential contamination and outdated use. This failure has the potential to affect all residents. The facility census was 50.1. Review of the facility provided policies showed they did not contain a policy related to food labeling, dating or storage. Observation on 04/20/26 at 10:54 A.M., showed the kitchen dry storage area contained: -A half full, undated 22 quart bin of sugar;-An undated 22 quart bin of flour;-An opened and undated bag of cheese snacks;-An opened and undated 12 ounce (oz) bag of heart marshmallows;-An undated 16 oz bag of white marshmallows open to the air;-An undated five pound bag of pancake mix open to the air;-An undated five pound bag of flour open to the air;-An opened and undated 32 oz bag of brown sugar;-An undated 32 oz box of long grain rice open to the air. Observation on 04/20/26 at 11:04 A.M., showed the walk-in refrigerator contained opened and undated bags of shredded lettuce and shredded carrots. Observation on 04/21/26 at 10:50 A.M., showed a plastic scoop stored in an unlabeled and undated container of a brown powder on the lower shelf of the cook's preparation table. Observation on 04/21/26 at 10:52 A.M., showed the walk-in refrigerator contained a large undated container of salad and a plastic zipper bag of cooked sausage, dated 4/23, open to the air. Observation on 04/21/26 10:55 A.M., showed the kitchen dry goods storage area contained:-A plastic scoop stored in an undated bin labeled as thickener;-A box of wheat hot cereal, dated 03/15, open to the air;-A box of long grain rice dated, 01/05/26, open to the air;-A large white plastic bin labeled as chocolate chips open to the air;-A large white plastic bin labeled as cocoa powder open to the air;-A bag of powdered sugar, dated 10/23/25, open to the air-A bag of breadcrumbs, dated 11/06, open to the air;-An opened and undated bag of bag brown sugar;-An opened and undated five pound bag of flour;-An opened and undated bag of heart shaped marshmallows;-A bag of mini marshmallows, dated 11/20, open to the air. During an interview on 04/23/26 at 11:10 A.M., the Dietary Manager (DM) said all cooks and dietary aides are responsible to date food items when they arrive and after they are opened. The DM said all food should be stored sealed and not exposed to the air and scoops should not be stored in food containers. The DM said he/she checks the food storage every day, but he/she did not know why staff did not seal, label and date the food items as required. During an interview on 04/23/26 at 3:00 P.M., the administrator said the DM is responsible to ensure the kitchen staff label and date all food items and all food should be rotated and used or discarded by their use-by dates. The administrator said scoops should never be stored in food containers and he/she did not know about any issues with the food storage.

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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 ensure staff followed acceptable standards of practice when staff failed to complete neurological checks for two residents (Resident #36 and #38), staff failed to complete post-fall documentation for one resident (Resident #20), and failed to document administration of medications and/or treatments for four residents (Resident #2, #9, #31, and #50) out of 19 sampled residents. The census was 50. 1. Review of the facility policy titled, Falls and Fall Risk, Managing, dated March 2018, showed staff will identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling and to try to minimize complications from falling. A fall is defined as unintentionally coming to rest on the ground, floor or other lower level, but not as a result of an overwhelming external force (e.g., a resident pushes another resident); an episode where a resident lost his/her balance and would have fallen, if not for another person or if he or she had not caught him/herself, is considered a fall. A fall without injury is still a fall, and unless there is evidence suggesting otherwise, when a resident is found on the floor, a fall is considered to have occurred. The staff, with the input of the attending physician, will implement a resident-centered fall prevention plan to reduce the specific risk factor(s) of falls for each resident at risk or with a history of falls. The staff will monitor and document each resident's response to interventions intended to reduce falling or the risks of falling. Review of the facility policy titled, Neurological Assessment, dated October 2010, showed the purpose of this procedure is to provide guidelines for a neurological assessment upon physician order, when following an unwitnessed fall, subsequent to a fall with a suspected head injury, or when indicated by resident condition. When assessing neurological status, always include frequent vital signs, particular attention should be paid to widening pulse pressure (difference between the systolic and diastolic pressures), as this may be indicative of increasing intracranial pressure (ICP). Perform neurological checks with the frequency as ordered or per falls protocol. The following information should be recorded in the resident's medical record: -The date and time the procedure was performed; -The name and title of the individual(s) who performed the procedure; -All assessment data obtained during the procedure; -How the resident tolerated the procedure; -If the resident refused the procedure, the reason(s) why and the intervention taken; -The signature and title of the person recording the data. Notify the physician of any change in a resident's neurological status; notify the supervisor if the resident refuses the procedure; and report other information in accordance with facility policy and professional standards of practice. Review of the facility's Neurological Checks flowsheet in the Electronic Health Record, undated, showed initial neurological check, then every 15 minutes times four; every 30 minutes times four; (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	every hour times four; every eight hours times nine, for a total of 22 opportunities for observations. 2. Review of Resident #36's Quarterly Minimum Data Set (MDS), a federally mandated assessment tool, dated 03/24/26, showed staff assessed the resident did not have falls since prior assessment. Review of the residents' progress notes, dated 04/06/26, showed staff documented an unwitnessed fall. Review the medical record did not contain nine of 22 neurological checks. 3. Review of Resident #38's Quarterly MDS, dated [DATE], showed staff assessed the residents had falls since prior assessment and had two or more falls without injury. Review of the residents' progress notes, dated 09/18/25, showed staff documented an unwitnessed fall without injury. The medical record did not contain documentation of neurological checks completed. Review of the resident's progress notes, dates 10/30/25, showed staff documented a witnessed fall with head involvement. The medical record did not contain 18 of 22 neurological checks. 4. During an interview on 04/23/26 at 2:56 P.M., Registered Nurse (RN) K said neurological checks should be initiated where there is an unwitnessed fall or a fall with head involvement. RN K said the neurological checks should be over three days, with an initial set, then every 15 minutes for the first four, then 30 minutes for an hour, and then every eight hours, and it should be done in the electronic health record. RN K said he/she did not know why they were not done, and it should be passed on in report from nurse to nurse. RN K said if staff know the resident has fallen, they should be able to see an open process in progress, and the Director of Nursing (DON) should oversee to make sure they are done. RN K said it is important to complete neurological checks because the resident could have a serious change in condition or bleeding in their brain. During an interview on 04/23/26 at 4:11 P.M., the Interim DON said when a resident falls staff should get the nurse, the nurse assesses the resident, and information is entered into risk management to be able to track falls and the conditions that were present. The interim DON said neurological checks should be started unless the fall was witnessed, or if there is head involvement, and family and doctor should be notified. He/she said neurological checks are the initial set, then every 15 minutes for one hour, every 30 minutes for two hours, then every hour for four hours, then every 8 hours for 72 hours, and it should be passed on in report that the resident is on fall follow up and when the next neuro check is due. He/she said ultimately the DON is responsible for making sure they are done, and he/she has been trying to reeducate staff because it is important to complete to identify any potential injury that could occur or potential brain bleeding. During an interview on 04/23/26 at 4:45 P.M., the administrator said neurological checks should be done immediately, then every four hours, or the time frame that the policy states, and nurses should be the ones completing the checks. The administrator said the DON oversees to ensure that is done, and they are important to complete to make sure there is no change in condition, like a brain bleed. He/she said the neurological checks should trigger in the Electronic Health Record to be completed once started and should be communicated in report as well. He/she did not know they were not being completed. 5. Review of Resident #20's Quarterly MDS, dated [DATE], showed staff assessed the residents with no falls since prior comprehensive assessment. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the resident's care plan, dated 01/29/26, showed staff documented last fall and intervention on 11/01/24. Review of the resident's Electronic Medical Record (EMR), dated 04/19/26 through 04/22/26, showed it did not contain any documentation of the resident's fall, post-fall evaluation, or post-fall follow up. Observation on 04/20/26 at 12:52 P.M., showed resident awake and in his/her bed. Resident's left knee appears swollen in relation to his/her right knee. There appears to be a slight purplish area above kneecap on left leg. During an interview on 04/20/26 at 12:52 P.M., the resident said he/she fell in his/her bathroom this morning and landed on his/her left knee. The resident said staff assisted him/her up after falling. The resident said the left knee is sore. Observation on 04/21/26 at 10:25 A.M., showed the resident in bed, in his/her room. The resident still had apparent swelling and discoloration to left knee area. During an interview on 04/21/26 at 10:25 A.M., the resident said his/her knee really hurts. Resident said he/she complained to staff last night about his/her knee pain. The resident said staff were present when he/she fell. The resident said he/she doesn't know if staff are going to do anything about his/her knee. During an interview on 04/22/26 at 10:18 A.M., the Director of Nursing (DON) said no one had reported the resident had a fall to him/her and staff should have. The DON said this resident is not a resident that would make something up, if he/she said he/she fell, then he/she fell. During an interview on 04/22/26 at 2:45 P.M., Certified Nurse Aide (CNA) J said he/she was not here when the resident fell, it was 04/20/26. The CNA said he/she reported to the charge nurse this morning, that the resident was in pain. The CNA said he/she just said the resident needed something for pain, he/she did not know all of the details. The CNA said he/she had no clue the resident had a fall. During an interview on 04/22/26 at 2:46 P.M., Certified Medication Technician (CMT) I said 04/20/26, he/she went down to the resident's room to give the resident breathing treatment. The CMT said the resident was out of his/her wheelchair, he/she was on floor in the bathroom. The CMT said he/she went and got Licensed Practical Nurse (LPN) C. The LPN grabbed an aide that came to the room with the LPN, it might have been Nurse Aide (NA) L. The CMT said we put gait belt around the resident and told him/her to reach for bar in front of him/her, to grab why we stood him/her up. The CMT said the resident said his/her knee was hurting him/her, when he/she was on the floor. The CMT said he/she thinks it was the resident's left knee. During an interview on 04/23/26 at 9:59 A.M., the administrator said he/she had no idea there was a fall, until the resident said he/she had one. The administrator said he/she assumes the nurse just did not document it. The nurse was LPN C on 04/20/26, the day of the fall. During an interview on 04/23/26 at 11:40 A.M., LPN C said he/she is not sure, maybe resident had a fall, but he/she doesn't remember. LPN said if a resident had a fall, he/she would absolutely (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	document in nurses' notes, do an incident report, and set of vitals. The LPN said he/she doesn't recall fall being reported to him/her, when there is a fall, he/she would go down there immediately. The LPN said he/she believes the resident's legs were hurting him/her on 04/20/26, and the resident stayed in bed that afternoon. The LPN said he/she would expect staff to notify him/her if a resident fell, staff are not supposed to do anything until they grab the nurse. During an interview on 04/23/26 at 12:23 P.M., NA L said he/she worked on 04/20/26. The NA said he/she recalled the resident having a fall on 04/20/26. The NA said he/she was asked to come to the room by one of the CMT. The NA said the CMT and LPN C went into the resident's room. The NA said the LPN assessed the resident when he/she was in the room. The NA said the resident complained of pain in his/her left knee. The NA said he/she knows the LPN looked at the resident's knee, and said it was swollen, not sure what the LPN did after that. The NA said he/she came back and checked on the resident later, and the resident said he/she wanted to get his/her leg looked at, it was still hurting him/her and was swollen. The NA said he/she also let LPN C know the resident's legs were still hurting. During an interview on 04/23/26 at 4:12 P.M., the DON the charge nurse should have assessed the resident and notified the physician and family, and alert me to the fact of the fall. The DON said normally he/she has the nurses notify him/her if there is a resident fall. The DON said he/she was not notified of the resident's fall. The DON said he/she doesn't think there was anything documented about the resident fall. During an interview on 04/23/26 at 4:45 P.M., the administrator said if a resident has a fall the charge nurse should assess and treat and notify family. The administrator said the nurse should document the fall in the resident's chart. The administrator said he/she doesn't know why the resident's fall was not documented for the resident's fall on 04/20/26. The administrator said the charge nurse should notify the physician and document the notifications in the resident's medical record. 6. Review of the facility policy titled, Medication and Treatment Orders, dated July 2016, showed the policy did not address documenting completion of medication and treatment orders in the resident's medical record. 7. Review of Resident # 9's Quarterly MDS, dated [DATE], showed staff assessed the resident cognitively intact and required a feeding tube. Review of resident's Care Plan, dated 04/01/26, showed staff documented resident required tube feeding related to dysphagia, provide local care to gastrostomy tube site as ordered, resident is dependent with tube feeding and water flushes. Review of resident's POS, dated March 2026, showed an order for daily weight on day shift and an order for split drain gauze every day shift. Review of resident's TAR, dated March 2026, showed staff did not document weights on 03/08/26, 03/13/26 and 03/29/26. Review showed staff did not administer the split drain gauze on 03/29/26. Review of resident's POS, dated April 2026, showed an order for daily weight on day shift, an order for split drain gauze every day shift, Eternal Feed order four times a day for flushing Gastrostomy Tube; flush gastrostomy tube with 125 milliliters (ml) before feeding and 125ml after feeding, flush amount can be adjusted per hydration needs and an order for Eternal Feed four times a day to tube feeding; (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	bolus 250ml Glucerna 1.5 feeding four times a day via gastrostomy tube. Review of resident's TAR, dated April 2026, showed staff did not document weights on 04/02/26, 04/03/26, 04/06/26, 04/07/26, 04/10/26, 04/15/26, and 04/21/26 and showed staff did not document they administered the split drain gauze 04/02/26 and 04/06/26. Review of resident's Medication Administration Record (MAR), dated April 2026, showed staff did not document they administered the flushes on 04/02/26 AM and eternal feeding on 04/10/26 and 04/21/26 as ordered. Review of resident's MAR, dated April 2026, showed staff did not document they administered the feeding on: 04/02/26 AM and Midday; 04/10/26 Midday; and 04/21/26 Midday. 9. Review of Resident #31's admission MDS, dated [DATE], showed staff assessed the resident at risk of developing pressure ulcer/injury. Review of resident's POS, dated April 2026, showed an order for bilateral buttocks-clean areas and apply calmoseptine every shift. Review of resident's TAR, dated April 2026, showed staff did not document they administered the treatment on 04/02/26, 04/06/26, 04/07/26, 04/10/26, 04/11/26, 04/15/26, 04/20/26 and 04/21/26 as ordered. 10. Review of Resident #50 POS, dated March and April 2026, showed an order to cleanse open area under abdominal fold with wound cleanser, pat dry, pack with Silver Alginate Gauze (a highly absorbent, antimicrobial wound dressing derived from brown seaweed, designed for moderate to heavily exuding, infected, or high-risk wounds), cover with abdominal pad. Change daily, every day shift for wound care. Review of the resident's TAR, dated March 2026, showed staff are directed to cleanse open area under abdominal fold with wound cleanser, pat dry, pack with Silver Alginate Gauze, cover with abdominal pad. Change daily, every day shift for wound care. Review showed staff did not document they administered the treatment on 03/21/26, 03/10/26, 03/13/26 and 03/24/26 ordered. Review of the resident's TAR, dated April 2026, showed staff are directed to cleanse open area under abdominal fold with wound cleanser, pat dry, pack with Silver Alginate Gauze, cover with abdominal pad. Change daily, every day shift for wound care. Review showed staff did not document they administered the treatment on 04/02/26, 04/04/26, 04/06/26, 04/07/26, 04/15/26 and 04/16/26 as ordered. 11. During an interview on 04/23/26 at 3:03 P.M., RN K said if there are missing signatures on MARs, or TARs, there was no documentation, so either it did not get done, or it was not signed off on, so it did not get done. During an interview on 04/23/26 at 4:12 P.M., the DON said if there are missing signatures on MARs and TARs. The DON said if it was not documented, it was not likely completed for the wound treatments. The DON said he/she should expect staff to proceed as if it was not done, if not documented. (continued on next page)

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Steelville Senior Living	311 N Spring Street Steelville, MO 65565

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 04/23/26 at 4:45 P.M., the administrator said he/she expects staff to sign MARs and TARs. The administrator said the DON is responsible for making sure the MARs and TARs are filled out correctly. The administrator said if there are missing signatures, it is an error.

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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, facility staff failed to provide Activities of Daily Living (ADLs) assistance for seven residents (Resident #2, #11, #50, #1, #31, #15 and #20) out of 19 sampled residents who required assistance with ADLs. The facility Census was 50. 1. Review of the facility's policy titled Activities of Daily Living (ADLs), Supporting, dated March 2018, showed Appropriate care and services will be provided for residents who are unable to carry out ADLs independently, with the consent of the resident and in accordance with the plan of care, including appropriate support and assistance with hygiene, bathing, dressing and grooming. If residents with cognitive impairment or dementia resist care, staff will attempt to identify the underlying cause of the problem and not just assume the resident is refusing or declining care. Approaching the resident in a different way or at a different time or having another staff member speak with the resident may be appropriate. Review of the facility policy titled, Bath, Shower/Tub, dated February 2018, showed the purposes of this procedure is to promote cleanliness, provide comfort to the resident and to observe the condition of the resident's skin. Staff will document: -The date and time the shower/tub bath was performed. -The name and title of the individual(s) who assisted the resident with the shower/tub bath. -All assessment data (e.g., any reddened areas, sores, etc., on the resident's skin) obtained during the shower/tub bath. -How the resident tolerated the shower/tub bath. -If the resident refused the shower/tub bath, the reason(s) why and the intervention taken. -The signature and title of the person recording the data. 2. Review of Resident #2's admission Minimum Data Set (MDS), a federally mandated assessment tool, dated 01/27/26, showed staff assessed the resident as: -Cognitively intact; -Rejection of care-behavior not exhibited; -Very important to choose between a tub bath, shower, bed bath, or sponge bath; -Impairment on both sides of lower extremities; -Substantial/maximal assistance with shower/bath, upper and lower body dressing, and personal hygiene. -Diagnosis of Osteoporosis (a chronic bone disease) and other fracture. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of resident's care plan, dated 03/12/26, showed staff documented resident required substantial/max assistance with bathing/showering, provide sponge bath when a full bath or shower cannot be tolerated; staff failed to document the resident's facial hair preference. Review of Shower sheets from February 2026 through April 2026, showed staff documented the resident received a shower on 03/06/26. Observation on 04/20/26 at 11:15 A.M., showed the resident in bed with upper lip hair and chin hair. Observation on 04/21/26 at 9:00 A.M., showed the resident in bed with upper lip hair and chin hair. During an interview on 04/21/26 at 9:00 A.M., the resident said he/she has only received one shower since he/she was admitted in January. He/She said staff uses wipes in diaper area, but his/her arms, legs, and back don't get washed. He/She said that the staff does not even ask if he/she wants a bed bath. He/She said staff do not offer to shave or use tweezers on his/her facial hair and he/she can't see well enough to do it him/herself. Observation on 04/22/26 at 11:25 A.M., showed the resident in bed with upper lip hair and chin hair. 3. Review of Resident #11's Quarterly MDS, dated [DATE], showed staff assessed the resident as: -Unable to be cognitively assessed; -Short/long-term memory problems; - Rejected care one to three days, but less than daily; - Dependent on staff for oral hygiene, toileting hygiene, shower/bathe self, upper/lower body dressing, and personal hygiene; - Diagnoses of dementia; traumatic brain injury (TBI – a disruption in brain function), Bipolar Disorder (a mental health condition), and schizophrenia (chronic brain disorder). Review of the resident's care plan, dated 12/22/25, showed staff documented resident is dependent on one staff to provide bath/shower, and he/she prefers one shower per week; staff failed to document the resident's facial hair preference and behaviors with showering/bathing. Review of shower sheets from February 2026 through April 2026, showed staff documented the resident received one partial bed bath on March 31, 2026. Observation on 04/20/26 at 11:59 A.M., showed the resident with his/her hair disheveled and knotted in appearance, wearing a long-sleeved gray sweatshirt, with long hairs curled under on his/her chin. Observation on 04/21/26 at 9:22 A.M., showed the resident with his/her hair combed back into messy bun with a disheveled appearance, wearing the same long-sleeved gray sweatshirt, with long hairs curled under on his/her chin. Observation on 04/22/26 at 10:03 A.M., showed the resident walking in the hallway with disheveled hair in a ponytail, with long hairs curled under on his/her chin. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 04/23/26 at 10:00 A.M., the resident was walking in the hallway with disheveled hair and a disarrayed ponytail, with long hairs curled under on his/her chin. During an interview on 04/22/26 at 10:03 A.M., Certified Medication Technician/Certified Nurse Aide (CMT/CNA) G said the resident is combative with cares, clothing changes and showers, and it has to be two people to do his/her showers, and he/she has an as needed medication to take before showers too, and the CMT cannot do it with just one staff. CMT G said the resident gets agitated when staff try to get near his/her face, the resident pushed his/her hand away this morning when trying to clean the resident's face. CMT G said he/she will try to reapproach later, but there is usually only one staff member working on the Special Care Unit (SCU). CMT G said he/she tries to chart behaviors, but he/she cannot really make a note in the charting system, so he/she will pass the information to the charge nurse to chart a more detailed note, and he/she is not sure if that is being done. During an interview on 04/22/26 at 2:58 P.M., Certified Nurse Aide (CNA) J said the resident takes two to three people to do his/her showers, and the resident is fidgety and will fight and be combative, so it is hard to get him/her shaved and showered, although sometimes the resident can be more cooperative. During an interview on 04/23/26 at 10:04 A.M., CMT G said there is a shower room on the SCU, so staff will do those residents showers on the unit, and there is a shower schedule, but it is hard to do them because there is usually only one staff back here, sometimes there is a CMT but they are usually on the unit to pass medications, and it is hard to shower residents with one staff, since there are residents that wander and need to be watched. 4. Review of Resident #50's Quarterly MDS, dated [DATE], showed staff assessed the resident as: -Intact cognition; -Dependent on staff members for bathing and lower body dressing; -Maximal assistance from staff members for bed mobility and transfers. Review of the residents' care plan, dated 04/01/26, showed staff did had not documented the assistance the resident needed with ADLs. Review of shower sheets from February 2026 through April 2026, showed received showers on 02/11/26, 02/25/26, 03/02/26, 03/11/26, 03/23/26 and 04/13/26. Observation on 04/20/26 at 1:17 P.M., showed resident in room. When the door opened a strong, sour odor percolated into the hall. The resident's room filled with body odor and odors came directly from resident. During an interview on 04/21/26 at 11:26 A.M., the resident said he/she does not get enough showers, yesterday was one week from his/her last shower, and it was three weeks in between that one and the one before. The resident said he/she is pretty sure it is supposed to be twice a week, but that has never happened since he/she has been at the facility. The resident said it makes him/her feel gross. The resident said he/she can smell the bad odors he/she has, and it makes him/her not want to leave his/her room. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	5. Review of Resident #1's Annual MDS, dated [DATE], showed staff assessed the resident as: -Cognitively intact; -Very important to choose between a tub bath, shower, bed bath, or sponge bath; -Dependent on staff for shower/bathe self, upper and lower body dressing, and tub/shower transfers; -Partial/Moderate assistance with personal hygiene; -Diagnoses of Alzheimer's, Arthritis, and seizure disorder. Review of resident's care plan, dated 02/17/26, showed staff documented resident is dependent on one staff with bathing/showering, and he/she prefers to bathe one time a week; staff failed to document the resident's facial hair preference. Review of Shower sheets from February 2026 through April 2026, showed staff documented the resident received a shower on 03/02/26 and 03/29/26. Observation on 04/20/26 at 1:53 P.M., showed the resident in bed with several white chin hairs. Observation on 04/21/26 at 10:16 A.M., showed the resident in bed with several white chin hairs. Observation on 04/22/26 at 12:02 P.M., showed the resident in the dining room for lunch with several white chin hairs. During an interview on 04/22/26 at 12:02 P.M., resident said he/she does not remember the last time he/she had a shower but said it has been a while. He/She said staff usually shave him/her in shower. Observation on 04/23/26 at 2:38 P.M., showed the resident in bed with several white chin hairs. 6. Review of Resident #31's admission MDS, dated [DATE], showed staff assessed the resident as: -Cognitively intact; -Very important to choose between a tub bath, shower, bed bath, or sponge bath; -Impairment on one side of upper and lower extremities; -Dependent of staff with shower/bathe, upper and lower body dressing, and personal hygiene; -Diagnosis of Arthritis, Cerebrovascular Accident (interrupted blood flow to the brain), Non-Alzheimer's Dementia, Traumatic Brain Injury (TBI). Review of resident's care plan, dated 03/11/26, showed staff documented resident is dependent on staff with bathing/showering, provide sponge bath when a full bath or shower cannot be tolerated; staff failed to document the resident's facial hair preference. Review of Shower sheets from February 2026 through April 2026, showed staff documented the (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	resident received a shower on 02/26/26 and 03/11/26. Observation on 04/20/26 at 1:58 P.M., showed resident in wheelchair by nurse's station. Residents' hair disheveled and facial hair about 0.5 inches long. Observation on 04/21/26 at 1:08 P.M., showed resident in wheelchair by nurse's station. The resident wore a grey hoodie with hood up and facial hair about 0.5 inches long. During an interview on 04/21/26 at 2:28 P.M., resident said he/she does not remember the last time he/she got a shower. He/She said he/she normally likes to be clean shaven on his/her face, but because he/she has not gotten a shower he/she has not been shaved. Observation on 04/22/26 at 8:51 A.M., showed resident in wheelchair by nurse's station wearing same grey hoodie as yesterday with hood up and facial hair about 0.5 inches long. 7. Review of Resident #15's Quarterly MDS, dated [DATE], showed staff assessed the resident as: -Intact cognition; -Rejection of care one to three days of look back period; -Occasionally incontinent of bladder; -Maximal assistance from staff members for bathing and lower body dressing; -Moderate assistance from staff members for upper body dressing, bed mobility and transfers. Review of the resident's care plan, dated 04/05/26, showed staff documented ADL self-care performance deficit due to fatigue. Resident requires limited assistance by one staff with bathing/showering. The resident prefers one shower per week. Please ensure that the resident gets at least one shower per week. Review of shower sheets from February 2026 through April 2026, showed staff documented the resident refused shower on 02/11/26 and did not receive another shower until 03/03/26. Staff documented the resident received showers on 03/10/26 and 03/11/26. Observation on 04/21/26 at 10:00 A.M., showed the resident in bed with eyes closed. Strong odor of urine can be detected in the room and on the resident's person. Observation on 04/21/26 at 3:21 P.M., showed the resident in his/her wheelchair, in his/her room. The resident's hair appeared oily and clumped together. During an interview on 04/21/26 at 3:21 P.M., the resident said he/she is lucky to get one shower a week. The resident said he/she is happy if he/she can get a shower every week. The resident said he/she does not always get one shower a week, the facility is low staffed. The resident said the facility does not have enough staff to do showers. The resident said it's bad, but he/she can't recall his/her last shower, it has been at least two weeks. The resident said it makes him/her feel gross. 8. Review of Resident #20's Quarterly MDS, dated [DATE], showed staff assessed the resident as: (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Intact cognition; -Rejection of care not exhibited; -Always incontinent of bowel and bladder; -Dependent on staff members for bed mobility, transfers and lower body dressing; -Maximal assistance from staff members for bathing and upper body dressing. Review of the resident's care plan, dated 01/29/26, showed staff documented resident has ADL self-care deficit due to pain from fracture. The resident requires extensive assistance from one staff with bathing/showering. The resident prefers one shower per week. Review of shower sheets from February 2026 through April 2026, showed staff documented the resident received a shower on 02/02/26, 02/16/26, 03/06/26, 03/11/26 and 04/14/26. The resident received two showers a month for the last three months. Observation on 04/21/26 at 10:14 A.M., showed resident in bed, covered up. Mild body odors detected in the room. During an interview on 04/21/26 at 10:14 A.M., the resident said he/she has not had a shower in probably a month, he/she asked staff for shower the other day, and staff said they would see, and the staff never came back. The resident said he/she has been having to give himself/herself bed baths. During an interview on 04/22/26 at 2:45 P.M., CNA J said he/she was put as a shower aide for two weeks and then they told him/her, he/she couldn't do showers anymore, they need him/her on the floor. The CNA said on a good day, the facility is lucky to have two aides on floor. The CNA said it has been a couple weeks since residents got a shower, they get showers at least once a week and never two a week. The CNA said the dates for showers on the shower sheets are absolutely correct, because 3/23/26 was the day he/she was the shower aide. During an interview on 04/22/26 at 2:46 P.M., CMT I said residents are not getting showers. The CMT said residents have missed their showers this week, due to staffing issues. During an interview on 04/23/26 at 2:01 P.M., CNA N said the facility doesn't have the staff to provide the care needed, like showers are horrendous. The CNA said it has been upwards to 16 days for residents to get showers. During an interview on 04/23/26 at 2:13 P.M., CNA D said residents get upset needing showers. The residents are not getting showers. The CNA said residents are going a couple of weeks without showers, if not more. The CNA said it probably makes the residents feel awful and neglected, not cared for. During an interview on 04/23/26 at 3:03 P.M., Registered Nurse (RN) K said the reports I have gotten from residents, the biggest thing not getting done is showers. The RN said he/she has noticed the odors walking through the halls. During an interview on 04/23/26 at 4:12 P.M., the Director of Nursing (DON) said he/she is aware of (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the shower issue. The DON said the facility has initiated a Performance Improvement Plan (PIP), because residents had expressed the concern of not getting showers. The DON said even with the PIP, he/she knows it has been a struggle to get residents showers, because we had a lot of call ins last week. The DON said the charge nurse is responsible for making sure the staff know what showers they need to do on their shifts, and the DON is responsible to make sure the staff get those done. The DON said there is not assigned staff for showers on shifts. During an interview on 04/23/26 at 4:45 P.M., the administrator said residents should get showers twice a week per shower schedule. The administrator said he/she is aware the residents are not getting their scheduled showers, because of staffing. The administrator said the charge nurse is responsible to make sure residents get showers on their shifts. The administrator said shower sheets should be filled out when residents get their shower. The administrator said the CNA giving the shower, fills out shower sheet and gives charge nurse. The charge nurse puts all the shower sheets together and then the DON gets them. The administrator said the DON should review the shower sheets. The administrator said the DON is responsible for residents getting showers. 2787106, 2976653, 2989809

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. Based on observation, interview and record review, the facility staff failed to serve food in accordance with the nutritionally calculated recipes and menus to all residents who received regular diets. The facility census was 50.1. Review of the facility's menus dated 04/21/26 (Day 10), showed the menus directed staff to serve the residents on regular diets with 10 ravioli with garlic cream sauce at lunch. Review of the Day 10 recipe for regular textured ravioli with garlic cream sauce showed the recipe directed staff to serve 10 ravioli with garlic cream sauce. Observation on 04/21/26 at 12:30 P.M., showed [NAME] Q served the residents on regular diets with six ravioli (less than directed by the menus). During an interview on 04/21/26 at 12:35 P.M., [NAME] Q said the Dietary Manager (DM) said six ravioli was one serving. The cook said he/she did not check the standardized recipe to verify serving size. During an interview on 04/23/26 at 11:10 A.M., the DM said he/she thought six ravioli was one serving because that was the serving size in the hospital where he/she worked before. The DM said he/she did not know the size of the ravioli being served. The DM said he/she did not review the standardized recipe before instructing [NAME] Q on serving size. The DM said all staff who prepare and serve meals are responsible to follow the standardized recipes and serving sizes. During an interview on 04/23/26 at 3:00 P.M., the administrator said the DM is responsible to ensure all kitchen staff follow the standardized menus and recipes. The administrator said he/she just started a few weeks ago and did not know kitchen staff did not follow the standardized recipes.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on observation, interview, and record review, facility staff failed to use appropriate hand hygiene and glove changes to prevent the spread of bacteria during incontinence care for three residents (Resident's #9, #2, #27 and #30) of four sampled residents. The facility census was 50.1. Review of the facility's policy titled, Handwashing/Hand Hygiene, undated, showed staff are directed as follows: -Use an alcohol-based hand rub containing at least 62% alcohol; or, alternatively, soap and water for the following situations: -Before and after direct contact with residents; -Before donning sterile gloves;-Before moving from a contaminated body site to a clean body site during resident care; -After contact with a resident's intact skin; -After removing gloves;-Hand Hygiene is the final step after removing and disposing of personal protective equipment;-Perform hand hygiene before applying non-sterile gloves;-Perform hand hygiene after removing non-sterile gloves. 2. Observation on 04/21/26 at 12:32 P.M., showed Nurse Aide (NA) L enter Resident #9's room to provide care. The NA applied gloves, removed the resident's blankets, unlatched the brief, and wiped stool from the resident's buttocks. The NA wiped stool from his/her gloves with a wipe and continued to wipe the resident. The NA with the same gloves on, put a clean brief underneath the resident, rolled the resident to his/her back and provided frontal perineal care. The NA removed gloves, did not wash hands, applied new gloves and continued to provide frontal perineal care with stool visibly on the wipes. The NA with the same gloves on latched the resident's clean brief, touched the clean wipe package, and the resident's blankets and pillow. The NA did not perform hand hygiene before he/she left the resident's room. During an interview on 04/23/26 at 12:14 P.M., NA L said gloves should be changed when soiled and after cares. He/She said hand hygiene should be completed before cares, and when gloves are visibly soiled. Gloves should be changed, and hands should be washed before leaving the room, and between dirty to clean cares. The NA said he/she just didn't think about it and was in the middle of it. He/She said he/she should have washed hands before leaving the room to prevent spreading infection when going to soiled utility room. He/She said not changing gloves and doing hand hygiene is a risk for bacteria to transfer and spread of infection. 3. Observation on 04/22/26 at 10:50 A.M., showed Certified Nurse Aide (CNA) M entered Resident #2's room to transfer resident to bed and provide care. The CNA applied gloves, transferred the resident from wheelchair to bed, removed the resident's pants, unlatched the brief, and wiped stool from the buttock. With the same visibly soiled gloves on, the CNA wiped stool from his/her gloves, continued to wipe the resident, and then provided frontal perineal care. The CNA then applied a clean brief to the resident and pushed unused wipes back into the clean package. The CNA removed his/her gloves, and without performing hand hygiene, touched the resident's blanket and bed remote. The CNA left the room, without performing hand hygiene, went to the dirty utility room and went back to the hall to help another resident without performing hand hygiene. During an interview on 04/22/26 at 11:43 A.M., CNA M said gloves should be changed between each resident and when soiled. The CNA said he/she did not remember getting stool on his/her gloves, but he/she believes gloves should be changed between dirty and clean cares. He/She said he/she was not aware hands should be washed with glove changes. He/She said hand washing or sanitizing should be done before providing care and after. He/She said the risk of not changing gloves and washing hands is contaminating clean objects.4. Observation on 04/22/26 at 11:20 A.M., showed NA O entered Resident #27's room to provide incontinence care. The NA wiped bowel from the resident's buttocks, removed the soiled brief and wipes, and with the same soiled gloves on grabbed and placed a clean brief under the resident, rolled the resident, fastened the clean brief, pulled up the resident's clothes, and put his/her gait belt around his/her body. The NA removed the visibly soiled gloves and put on a clean pair without performing hand hygiene, put the soiled brief and wipes in a bag, and then touched the handles on the resident's mechanical chair. The NA took off his/her gloves and left the room without performing hand hygiene. During an interview on 04/22/26 at 11:35 A.M., NA O said he/she is supposed to change (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	gloves during care and should wash hands when completed. The NA said if gloves are super dirty, he/she should change gloves. The NA said that's why he/she changed his/her gloves, when he/she did, because his/her gloves were pretty bad. The NA said he/she didn't change gloves and wash his/her hands when he/she went from dirty to clean, because it slipped his/her mind. The NA said he/she is supposed to wash hands after wiping bowel and before he/she touched the clean brief, again it slipped his/her mind. The NA said he/she should have washed hands before he/she left the room. 5. Observation on 04/23/26 at 9:14 A.M., showed CNA M and CNA N enter Resident #30's room to transfer the resident and provide catheter care. CNA M sanitized hands and applied gown and gloves. CNA N washed hands and applied a gown and gloves. CNA M hooked the resident up to the Hoyer lift and transferred the resident to bed. CNA N placed catheter bag on the side of the bed, removed gloves, did not wash hands, and put on clean gloves. The CNA's removed the resident's Hoyer sling and pants, CNA N performed catheter care and wiped the resident's buttocks. CNA N removed gloves, did not wash hands, and put on clean gloves. CNA M removed gloves, did not wash hands, and put on clean gloves. CNA N applied cream to the resident's perineal area, removed gloves, did not wash hands, and put on clean gloves. The CNA's put a clean brief under the resident and pulled his/her pants up and removed their gloves and gowns. The CNA's put clean gloves without performing hand hygiene and CAN N emptied the resident's catheter bag. During an interview on 04/23/26 at 9:31 A.M., CNA N said gloves changes should be between dirty and clean cares, and when visibly soiled. He/She said he/she should wash hands before resident care, between glove changes, and after resident care. He/She said he/she did not have a reason why he/she did not wash hands between gloves changes. He/She said not washing hands is a risk for spreading infection. 6. During an interview on 04/23/26 at 3:15 P.M., Registered Nurse (RN) K said staff should wash hands upon entering a room, between glove changes, and before leaving the room. He/She said gloves should be changed between dirty and clean cares and wash hands between gloves changes. He/She said staff should not wear the same soiled gloves to apply new brief and touch other items in the room. He/She said hand hygiene and glove changes are to prevent infections and cross contamination. During an interview on 04/23/26 at 4:35 P.M., the Director of Nursing (DON) said he/she expects staff to wash hands upon entering the room, perform care, change gloves after a dirty task, wash hands and reapply gloves and continue clean cares and then wash hands before leaving the room. He/She said it is never okay to use soiled gloves to apply a new brief and adjust blankets. He/She said it's an increased risk of infection to spread. During an interview on 04/23/26 at 5:00 P.M., the administrator said he/she expects staff to wash hands before gloving and between dirty and clean cares and before leaving the room. He/She said not washing hands and glove changes are a risk of infection.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, facility staff failed to provide written information to the resident and/or the resident's representative of the bed hold policy at the time of transfer to the hospital for three residents (Resident #1, #4, and #52) out of 19 residents sampled. The facility census was 50. 1. Review of the facility policy titled Bed-Holds and Returns, dated October 2022, showed residents and/or representatives are informed (in writing) of the facility and state (if applicable) bed-hold policies. All residents/representatives are provided with written information regarding the facility and state bed-hold policies, which address holding or reserving a resident's bed during periods of absence (hospitalization or therapeutic leave). Residents, regardless of payor source, are provided with written notice about these policies at least twice: notice one in the admission packet and notice two at the time of transfer (or, if the transfer was an emergency, within 24 hours). Multiple attempts to provide the resident representative with notice two should be documented in cases where staff were unable to reach and notify the representative timely. The written bed-hold notices provided to the residents/representatives explain in detail: -The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the facility; -The reserve bed payment policy as indicated by the state plan (for Medicaid residents); -The facility policy regarding bed-hold periods; -The facility per-diem rate required to hold a bed (for non-Medicaid residents), or to hold a bed beyond the state bed-hold period (for Medicaid residents), and; -The facility return policy. The requirement that residents be permitted to return to the facility following hospitalization or therapeutic leave applies to all residents regardless of payer source. Residents who seek to return to the facility within the bed-hold period defined in the state plan are allowed to return to their previous room, if available. 2. Review of Resident #1's medical record showed staff documented the resident discharged from the facility to the hospital on [DATE] and returned on 01/27/26. The medical record did not contain documentation staff issued a bed hold upon discharge to the resident or the resident's responsible party. 3. Review of Resident #4's medical record showed staff documented the resident discharged from the facility to the hospital on [DATE] and returned on 08/27/25. Review showed the resident discharged from the facility to the hospital on [DATE] and returned on 09/21/25. Review showed the resident discharged from the facility to the hospital on [DATE] and returned on 10/01/25. The medical record did not contain documentation staff issued a bed hold upon discharge to the resident or the resident's responsible party. 4. Review of Resident #52's medical record showed staff documented the resident discharged from (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the facility to the hospital on [DATE], with return anticipated, resident ended up remaining in the hospital on hospice. The medical record did not contain documentation staff issued a bed hold upon discharge to the resident or the resident's responsible party. 5. During an interview on 04/23/26 at 2:56 P.M., Registered Nurse (RN) K said he/she works for the corporate office as the Minimum Data Set (a federally mandated assessment tool) Nurse and is filling in at the facility as needed on the floor. RN K said typically the nurse would be the one to give the bed hold when a resident is sent out from the facility, the policy is also provided on admission. RN K thinks the Social Services Director (SSD) follows up on the bed holds, and he/she did not know the bed holds were not being done. During an interview on 04/23/26 at 3:30 P.M., the SSD said residents get the bed hold policy on admission, and they should get one when sent out, if they are their own responsible party, when a copy is made with their face sheet when going to the hospital. The SSD said if they are not their own responsible party or have a guardian, they should get the bed hold as soon as possible, and the nurse should be responsible for sending them, since it may happen overnight or on the weekend. During an interview on 04/23/26 at 4:11 P.M., the Interim Director of Nursing (DON) said anytime a resident is sent out to the hospital the nursing staff should be giving the resident the bed hold, and the SSD should follow up to ensure the bed hold is completed. The Interim DON said he/she did not know the bed hold was not being done and had just started to dive in and had not audited yet. During an interview on 04/23/26 at 4:45 P.M., the Administrator said bed holds should be given when the resident exits the building and is in the admission agreement, but the actual one they sign should be given to them by nursing as they are leaving, and the SSD should follow up in a timely manner. He/she did not know they were not being done.

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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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, facility staff failed to document they provided the physician ordered wound treatment for one resident (Resident #2) and failed to ensure one resident (Resident #27) out of seven sampled residents received the necessary treatment and services in accordance with professional standards to promote the prevention of pressure ulcer/injury development when staff failed to provide pressure relief to the resident's heel which resulted in a new pressure ulcer/injury. The facility census was 50.1. Review of the National Pressure Injury Advisory Panels (NPIAP) showed a Stage 1 Pressure Injury is Non-blanchable erythema of intact skin. Intact skin with a localized area of non-blanchable erythema. Color changes do not include purple or maroon discoloration; these may indicate deep tissue pressure injury. 2. Review of the facility's policy titled Prevention of Pressure Injuries, dated April 2020, showed: -Reposition all residents with or at risk of pressure injuries on an individualized schedule, as determined by the interdisciplinary care team;-Choose a frequency for repositioning based on the resident's risk factors and current clinical practice guidelines;-Provide support devices and assistance as needed;-Remind and encourage residents to change positions;-Select appropriate support surfaces based on the resident's risk factors, in accordance with current clinical practice;-Review and select medical devices with consideration to the ability to minimize tissue damage, including size, shape, its application and ability to secure the device;-Monitor regularly for comfort and signs of pressure-related injury;-Evaluate, report and document potential changes in the skin;-Review the interventions and strategies for effectiveness on an ongoing basis. 3.Review of Resident #2's admission MDS, dated [DATE], showed staff assessed the resident as: -Has pressure ulcer/injury, a scar over bony prominence;-Is at risk of developing pressure ulcers/injuries;-Has 1 or more unhealed pressure ulcer/injury;-One stage 1 (an early-stage, localized injury to intact skin, characterized by non-blanchable erythema (redness) that does not turn white when pressed) pressure injury;-Application of nonsurgical dressings, ointments/medications other than to feet.Review of resident's care plan, dated 03/12/26, showed staff documented resident has a stage three (a serious, full-thickness skin injury appearing as a deep, crater-like wound that exposes subcutaneous fat) pressure ulcer to sacrum and to administer treatments as ordered and monitor for effectiveness.Review of resident's Physician's Order Sheet (POS), dated March 2026, showed the physician directed staff to cleanse resident sacrum with wound cleanser, pat dry, apply skin prep to peri wound, cut a fit Calcium Alginate (a water-insoluble, gelatinous, cream-colored substance derived from brown seaweed, commonly used in advanced wound care and food thickening) to wound bed. Cover with bordered gauze dressing every day shift.Review of resident's Treatment Administration Record (TAR), dated March 2026, showed staff did not document they administered the treatment on 03/01/26 and 03/29/26.Review of resident's TAR, dated April 2026, showed staff did not document they administered the treatment on 04/2/26; 04/03/26; 04/06/26; 04/07/26; 04/15/26; and 04/21/26. 4. Review of Resident #27's Quarterly Minimum Data Set (MDS), a federally mandated assessment tool, dated 04/06/26, showed staff assessed the resident as: -Severe cognitive impairment;-Range of Motion (ROM) to both sides of lower extremities (legs);-Dependent on staff for bed mobility and transfers;-At risk for pressure ulcers/injuries;-Turning/repositioning program.Review of the resident's care plan, dated 03/12/26, showed staff assessed the resident as:-Totally dependent on staff for Activities of Daily Living (ADL) and mobility;-Totally dependent on staff for repositioning and turning in bed;-Totally dependent, with mechanical lift for transferring;-At risk for impaired skin integrity;-Encourage resident to frequently shift weight;-Utilize pressure relieving devices on appropriate surfaces. Review of the resident's Physician Order Summary (POS), dated April 2026, showed an order directed staff to complete skin assessment upon admission and weekly and charge nurse to ensure resident is laid down after meals, if agreeable. Heel protectors and (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	positioning wedges to be used for turning and repositioning. Review of the resident's Nurse Medication Administration Record (MAR), dated April 2026, showed the charge nurses documented they ensured the resident had been laid down after meals with heel protectors on, on 04/20/26, 04/22/2/26 and 04/23/26. The charge nurse did not sign for 04/21/26, after breakfast and lunch.Review of the residents' Weekly Skin Assessments showed: -04/18/26, foot evaluation completed, no skin issues identified;-04/20/26, no skin issues identified;-04/23/26, Issue: #001: New skin Issue. Location: Right heel. Issue type: Pressure ulcer/injury. Progress: New: new wound. Pressure ulcer staging: Stage 1 Pressure ulcer/injury: non-blanchable erythema of intact skin. Wound acquired in-house. Length centimeter (cm): 5 Width (cm): 1.2 Depth (cm): Epithelial: 100%. Surrounding tissue: Intact. New wound identified to right heel. Observation on 04/20/26 at 1:45 P.M., showed the resident sat in mechanical chair, in his/her room. The resident's heel protectors are not on and are in the corner of the resident's room. The resident's heels are pressed firmly against the footrest of the mechanical chair. The footrest is depressed where the resident's heels connect to the footrest. Resident did not have shoes on. Observation on 04/21/26 at 9:51 A.M. through 10:52 A.M., showed the resident in his/her room in his/her mechanical chair. The resident's heel protectors in the corner of room. Observation showed the residents did not have shoes on and his/her heels pressed firmly against the footrest of the mechanical chair. Observation on 04/21/26 at 4:34 P.M., showed resident in his/her room in his/her mechanical chair. The resident wore regular socks on his/her feet and both heels pressed into the footrest of the mechanical chair. Resident's heel protectors on a chair in the corner of room. Observation on 04/22/26 at 8:55 A.M.to 11:20 A.M., showed resident in his/her room in his/her mechanical chair. The resident's heels pressed into the footrest without his/her heel protectors on. Observation showed the heel protectors on a chair. Continuous observation through 11:20 A.M., showed the resident in the same position, unturned or repositioned by staff. Observation on 04/23/26 at 9:46 A.M., showed the Director of Nursing (DON) completed a skin assessment of the resident and observed the resident's right heel with a half dollar sized indention, and the skin over the indention loose from the heel tissue and wrinkled. During an interview on 04/23/26 at 9:51 A.M., the DON said he/she would call the area on the resident's right heel, soft to likely a stage 1. The DON said even if the resident gets agitated when he/she lays down sometimes, he/she sometimes does not, and the staff should at least try to lay the resident down after meals. During an interview on 04/23/26 at 2:01 P.M., Certified Nurse Aide (CNA) N said he/she did not know the resident had orders to lay down between meals, and place heel protectors. The CNA said he/she did know the resident had heel protectors, and they go on when he/she is in bed. The CNA said he/she didn't lay the resident down, because he/she and the other staff were busy and don't always get to do what they are supposed to do. During an interview on 04/23/26 at 2:13 P.M., CNA D said he/she did not know the resident has an order to lay down with heel protectors on between meals. The CNA said he/she did not know the resident is supposed to have heel protectors on, when he/she is in bed. The CNA said when the resident first got to the facility, he/she had heel protectors, to his/her knowledge the last year, staff have not used the heel protectors. The CNA said he/she tries to put a pillow under the resident's feet, to offload pressure, and so his/her feet are not directly on the bar of the chair. During an interview on 04/23/26 at 3:03 P.M., Registered Nurse (RN) K said he/she has assisted at the facility since January, but this is his/her 2nd shift on the floor. The RN said he/she is not aware the resident is supposed to be put in bed between meals. The RN said he/she is not aware the resident had heel protectors. The RN said the DON talked to him/her and said the resident now has an area on his/her heel and he/she will document. During an interview on 04/23/26 at 4:12 P.M., the DON said if something is ordered on the POS staff should complete the order, the aides should have been directed by the charge nurse to lay the resident down. The DON said to lay the resident down in bed between meals and place heel protectors is on the resident's MAR, and the nurses have signed they completed it. The DON said the POS not being followed could be the cause for the pressure ulcer/injury. The DON said he/she is ultimately responsible to make sure the physician's orders are followed. During an (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	interview on 04/23/26 at 4:45 P.M., the administrator said if something is on the resident's POS, the aides need to know, and it should be communicated to the aides by the charge nurse. The administrator said the resident's feet dug into the footrest can cause pressure. The administrator said he/she is aware the resident has a pressure ulcer/injury now and that the wound is facility acquired. The administrator said he/she was not aware the staff did not know the resident is supposed to be placed in bed between meals. The administrator said he/she was not aware some of the staff did not know the resident has heel protectors. During an interview on 04/28/26 at 1:18 P.M., the Nurse Practitioner (NP) said the resident needs to have heel protectors on when in the mechanical chair, or in bed. The NP said not using heel protectors could cause what was seen. The NP said the orders were not followed, and the resident continued to be put in the same position, it would cause a pressure wound. The NP said if the order had been followed, it would have stopped the pressure wound from developing. 2976653

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, facility staff failed to ensure three residents (Residents' #20, #27 and #31) out of four sampled residents were transferred in a manner to prevent accidents with a mechanical lift. The facility Census was 50.1. Review of the facility's mechanical lift manual, dated 10/01/18, showed: -Although the manufacturer recommends that two assistants be used for all lifting preparation, transferring from and transferring to procedures, ourequipment will permit proper operation by one assistant. The use of one assistant is based on the evaluation of the health care professional for each individual case. (This statement in the manual comes with, Warning symbol beside this comment in the guide, which the manufacture states the Warning symbol beside something in the manual indicates a potentially hazardous situation which, if not avoided, could result in death or serious injury.);-When using an adjustable base lift, the legs MUST be in the maximum Opened/Locked position before lifting the patient. This statement in the manual, also comes with Warning symbol beside it.-The legs of the lift must be in the maximum open position for optimum stability and safety. If it is necessary to close the legs of the lift to maneuver the lift under a bed, close the legs of the lift only as long as it takes to position the lift over the patient and lift the patient off the surface of the bed. When the legs of the lift are no longer under the bed, return the legs of the lift to the maximum open position. This statement in the manual, also comes with Warning symbol beside it.-Do not move the patient if the sling is not properly connected to the hooks of the hanger bar. When the sling is elevated a few inches off the stationary surface and before moving the patient, check again to make sure the sling is properly connected to the hooks of the hanger bar. If any attachments are NOT properly in place, lower the patient back to the stationary surface and correct this problem -otherwise, injury or damage may occur. This statement in the manual, also comes with Warning symbol beside it. 2. Review of Resident #20's Significant Change Minimum Data Set (MDS), a federally mandated assessment tool, dated 08/06/24, showed staff assessed the resident as: -Required maximal assistance from staff with bed mobility and transfers;-Hip fracture;-Received surgical wound care.Review of the resident's care plan, revision on 11/1/24, showed staff documented the resident had a fall from a mechanical lift in his/her room. Staff also documented as an intervention, staff were educated on proper mechanical lifting procedure due to fall.Review of the resident's progress notes, dated 11/1/24, showed called to resident's room for a witnessed fall. Upon entry resident was lying on the floor in between the mechanical lift's legs. The resident's left shoulder and head were on top of one of the mechanical lift's legs. The resident's legs were propped up on his/her bed. The resident stated he/she hit his/her head. The resident was moved. The resident was checked for injuries. The resident complained of pain in the left shoulder, left knee, left hip, and lower back. Range of Motion (ROM) normal in all extremities except left leg. The resident could not lay leg flat due to pain. Slid out of mechanical lift pad. During an interview on 04/23/26 at 11:04 A.M., Licensed Practical Nurse (LPN) P Certified Nurse Aide/Certified Medication Technician (CNA/CMT) B was the only CNA/CMT in the building the night the resident fell out of the mechanical lift. The LPN said the CNA called him/her to the resident's room and the CNA was trying to put the resident to bed with a mechanical lift. The CNA had operated the mechanical lift by himself/herself. The LPN said when he/she entered the room, the resident was hanging half on floor, and half his/her body was still in the sling. The LPN said he/she reported the incident to the administrator. The LPN said he/she is pretty sure the CNA knew that he/she had to have two staff, but he/she tried to put the resident to bed by himself/herself. The LPN said he/she is pretty sure the resident's leg was hurting him/her, I thought we did an X-ray after that. The LPN said the CNA could have called him/her in the room to help him/her. The LPN said when he/she entered the room, it looked like one of the straps on the sling was not connected to the mechanical lift. During an interview on 04/23/26 at (continued on next page)

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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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	11:53 A.M., CMT B said he/she was the only person working the night the resident fell out of the mechanical lift. The CMT said he/she was putting the resident in bed with a bariatric sling that was too big, and the resident slipped through one of the holes. The CMT said the resident did not fall, he/she lowered the resident to the floor. The CMT said he/she was the only staff using the mechanical lift for the transfer. The CMT said he/she went to get the nurse, and they got the resident in bed. The CMT said he/she knew he/she was not supposed to do a one-person mechanical lift transfer. The CMT said after the incident, he/she got a verbal warning from the Director of Nursing (DON). The CMT said the resident did not complain of any injury or pain. The CMT said he/she did the mechanical lift transfer with one person, because he/she had 40 residents to get in bed by himself/herself, and he/she is only one person. During an interview on 04/23/26 at 2:13 P.M., CNA D said it takes two staff to complete a mechanical lift transfer. The CNA said he/she would not use one staff member, in case there was a malfunction with the mechanical lift, or something happened where the resident dropped. The CNA said it is not safe to use one staff member for mechanical lift transfers, and he/she has never been told to do it with one staff member. The CNA said he/she has always been told if we need help to get a supervisor. The CNA said if it was just him/her and the nurse on shift, he/she would go get the nurse and ask him/her to help with the transfer. During an interview on 04/23/26 at 3:03 P.M., the Registered Nurse (RN) K said staff should not be doing one-person mechanical lift transfers, it's not safe, the residents could get severely hurt. During an interview on 04/23/26 at 4:12 P.M., the DON said staff should not be doing one-person mechanical lift transfers. The DON said it is the responsibility of the DON to train staff on how to properly perform mechanical lift transfers.During an interview on 04/23/26 at 4:45 P.M., the administrator said two staff should participate in mechanical lift transfers. The administrator said if there is only one staff member, the staff should wait until they get another staff. One-person mechanical lift transfers are unsafe. The administrator said he/she was not aware staff are still doing one-person mechanical lift transfers. The administrator said he/she could not find the investigation, or the training provided to CNA/CMT B after the incident occurred. The administrator said it is the responsibility of the on-shift charge nurse, to ensure aides are not doing one-person mechanical lift transfers. 3. Review of Resident #27's Quarterly MDS, dated [DATE], showed staff assessed the resident as: -Severe cognitive impairment;-Range of Motion impairment to both lower extremities;-Dependent on staff for bed mobility and transfers. Review of the resident's care plan, dated 03/12/26, showed has impaired cognitive function and is totally dependent with mechanical lift for transfers. Observation on 04/22/26 at 11:20 A.M., showed CNA M, Nurse Aide (NA) O and CNA N entered the resident's room to perform a mechanical lift transfer from the resident's mechanical chair to his/her bed. CNA M controlled the mechanical lift and propelled it forward, under the resident's mechanical chair, with base of support all the way closed. CNA M lifted the resident up from the mechanical chair, resident rocked in mechanical lift sling, while CNA N walked around the other side of the resident's bed and the NA pulled the mechanical chair back and out from under the resident. The resident rocked in the sling above the tile floor. CNA M propelled the mechanical lift backwards approximately five feet, resident rocked in sling, other staff did not have hands on resident or sling. With base of support still closed, CNA M performed a 90 degree turn to the right, resident continued to rock, suspended in the air above tile floor. CNA M then propelled the resident forward approximately six feet with base of support still in, until the resident was over the bed. Once over the bed CNA N from the opposite side of the bed, grabbed the sling to prevent the resident from rocking. CNA M lowered the resident to the bed. After perineal care had been performed, CNA M used the mechanical lift to lift the resident. Staff did not have contact with resident, or sling, when CNA pulled mechanical lift backwards away from bed, with resident suspended in air over tile floor, CNA M performed a 90 degree turn with mechanical lift. The resident rocked significantly in the unsecured sling, CNA M let go of the mechanical lift controls and grabbed the sling to stop the resident as he/she rocked side to side. CNA N came around the bed and grabbed the resident until he/she had been lowered into mechanical chair. The base of (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265866	A. Building B. Wing	04/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Steelville Senior Living	311 N Spring Street Steelville, MO 65565

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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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	support had not been opened during either transfer. During an interview on 04/22/26 at 11:44 A.M., CNA N said staff should open the mechanical lift base so the residents will stay steady in the sling. The CNA said he/she does not know why the base of support was not opened during the lifts. The CNA said if the base of support is not open during a transfer with the lift the lift could tip over. The CNA said he/she saw the resident rocking in the sling, he/she came around the bed and tried to secure the resident's feet while he/she rocked and CNA M grabbed the sling to stop the resident as he/she rocked. 4. Review of Resident #31's admission MDS, dated [DATE], showed staff assessed the resident as: -Cognitively intact;-Range of Motion impairment to one side of upper and lower extremities;-Dependent on staff for bed mobility and transfers. Review of the resident's care plan, dated 03/11/26, showed has impaired cognitive functioning and is totally dependent with mechanical lift for transfers. Observation on 04/21/26 at 03:06 A.M., showed CNA D and the DON entered the resident's room to perform a mechanical lift transfer from the resident's wheelchair to his/her bed. CNA D controlled the mechanical lift and propelled it forward, under the resident's wheelchair, with base of support all the way closed. CNA D lifted the resident up from the wheelchair. The DON pulled the wheelchair backwards from underneath the resident. CNA D propelled the mechanical lift backwards approximately four feet while the DON held the resident, or sling. With base of support still closed CNA D performed a 90 degree turn to the right. CNA D then propelled the resident forward in the mechanical lift, approximately four feet, with the base of support still in, until over the bed. CNA D lowered the resident to the bed. The support base had not been opened during any part of the transfer. During an interview on 04/23/26 at 4:12 P.M., the DON said staff should open the legs of the mechanical lift before onloading the weight of the resident, for the distribution of the weight when the resident is up in the air. The DON said with the weight not being distributed, the mechanical lift could tip over. The DON said he/she doesn't know if all the staff have been trained to open the mechanical lift's base of support. During an interview on 04/23/26 at 4:45 P.M., the administrator said staff are supposed to widen the base of support on the mechanical lift, prior to lifting the resident. The administrator said he/she doesn't know if the staff have been trained to open the base of support. The administrator said the DON is responsible to train the staff on opening the base of support on the mechanical lift. The administrator said without the base of support out, the mechanical lift could tip over.

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	265866	A. Building B. Wing	04/23/2026

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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 0881 Level of Harm - Potential for minimal harm Residents Affected - Many	Implement a program that monitors antibiotic use. Based on interview and record review, facility staff failed to implement an Antibiotic Stewardship Program with antibiotic use protocols and a system to monitor and track antibiotic use within the facility. The facility census was 50.1. Review of the facility's policy titled, Antibiotic Stewardship, revised 12/2016, showed the purpose of the antibiotic stewardship program is to monitor the use of antibiotics. The policy did not direct staff on how to track and trend antibiotics in the facility.During an interview on 04/23/26 at 1:43 P.M., the Infection Preventionist (IP) said he/she was hired in November 2025 for the IP position and received his/her certification at the end of December 2025. The IP said the facility has been short staffed since December and he/she has not kept up with the program as he/she has been working on the floor. He/She said he/she should ensure antibiotics have stop dates, tracking and trending antibiotics, and ensuring the antibiotics are effective.During an interview on 04/23/26 at 4:39 P.M., the Director of Nursing (DON) said he/she has not been doing anything with the antibiotic stewardship program. He/She said he/she was not aware the IP was not tracking and trending antibiotics because of being short staffed. He/She said tracking and trending antibiotics is important to make sure antibiotics are being used for the right reasons, ensuring antibiotics are not being overused, and ensuring residents are on the correct antibiotic if a culture and sensitivity is completed.During an interview on 04/23/26 at 5:00 P.M., the administrator said he/she was not aware the IP was not able to complete components of the antibiotic stewardship program. He/She knows the IP has been working a lot of night shifts. He/she said the importance of the antibiotic stewardship program is to avoid antibiotic resistance.