STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265352	A. Building B. Wing	05/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Manchester Rehab and Healthcare Center	312 Solley Drive Ballwin, MO 63021

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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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure residents had a safe, homelike environment by failing to ensure residents and staff had access to clean towels for three sampled residents (Resident #34, #36 and #58). Staff also failed to ensure one resident's broken window was fixed (Resident #15), failed to ensure three resident's personal refrigerators had completed temperature logs (Resident #4, #8 and #23) and failed to maintain the hot water at the minimum required temperature of 105 degrees Fahrenheit (F) for three residents (Resident #36, #23 and #55). In addition, staff failed keep the hallway on the Memory Care Unit free from trash. The sample was 19. The census was 74. Review of the facility's housekeeping policy, dated 10/24/22, showed: -Purpose: To ensure the Facility is clean, sanitary, and in good repair at all times so as to promote the health and safety of residents, staff, and visitors; -Policy: All rooms of the facility are kept clean and as free as possible of germs and other contaminating agents at all times, while maintaining a pleasant and homelike atmosphere for our residents; -Procedure: The Housekeeping Department is responsible for completing the daily, weekly, and monthly cleaning procedures. The housekeeping staff's general duties are to: Maintain clean bed and bath linens that are in good condition for residents; sweep and mop, or vacuum, all floors; clean all surfaces in restrooms, showers, and utility rooms; damp-wipe all furniture (except cloth upholstered), counters, windowsills, ledges and doors, wheelchairs, equipment, telephones, lamp bases, light fixtures, and nurses' call lights; clean all mirrors; wash windows as necessary; empty and clean all waste containers. Review of the facility's housekeeping daily cleaning schedule, showed: -Floors: sweep and mop; -Furniture: bed, nightstand, chairs, trash cans; -Bathrooms: toilet, sink, mirror, shower unit, towel racks, and safety bars. 1. Review of Resident #34's medical record, showed diagnoses included heart failure (a reduction in the heart's ability to pump blood to the organs), Chronic Obstructive Pulmonary Disease (COPD, chronic inflammation of the airways in the lungs), Type II Diabetes, Cognitive Communication Deficit, and Presence of Gastrostomy (a surgical appliance inserted into the stomach used to administer (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

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	medication or supplemental nutrition). During interview on 5/21/25 at 10:18 A.M. the resident said he/she received a shower from facility staff as requested, but the aide had to use a blanket to help dry the resident as there was only one clean towel on the hall. 2. Review of Resident #36's quarterly Minimum Data Set (MDS), a federally mandated assessment tool completed by the facility staff, dated 4/11/25, showed: -Diagnoses included epilepsy (seizure disorder), muscle weakness, and quadriplegia (paralysis); -Cognitively intact. During an interview on 5/22/25 at 1:44 P.M., the resident said there was not enough linen in the building. 3. Review of Resident #58's medical record, showed: -Diagnoses included cerebral palsy (congenital disorder of movement, muscle tone, or posture) and muscle weakness; -Cognitively intact. Review of the resident's shower sheet dated 4/29/25, showed Licensed Practical Nurse (LPN) MM signed his/her name on the shower sheet and documented the shower was not completed due to no linen available. 4. Observation of the laundry room on 5/22/25 at 10:22 A.M., showed no clean or dirty towels. Observations of the 300 hallway linen closet and linen cart on 5/22/25, showed: -At 7:06 A.M., no towels or wash cloths. -At 10:15 A.M., two clean towels. No wash cloths; -At 3:10 P.M., two clean towels. No wash cloths. Observation of the 500 hallway linen cart on 5/22/25 at 3:12 P.M., showed no towels or wash cloths. Observations of the 700 hallway linen cart on 5/22/25, showed: -At 7:02 A.M., no clean towels or wash cloths; -At 10: 16 A.M., no clean towels or wash cloths; -At 3:06 P.M., no clean towels or wash cloths. Observation of the 700 hallway linen cart on 5/23/25 at 6:35 A.M., showed no clean towels. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observations of the 800 hallway linen cart on 5/22/25 at 6:58 A.M., 10:17 A.M., and 3:04 P.M., showed no towels or wash cloths. Observation of the 800 hallway linen cart on 5/23/25 at 6:36 A.M., showed no clean towels. Observations of the 900 hallway linen cart on 5/22/25, showed: -At 7:00 A.M., no clean towels or wash cloths; -At 10:18 A.M., five clean towels and two wash cloths; -At 3:05 P.M., two clean towels and no wash cloths. Observation of the 900 hallway linen cart on 5/23/25 at 6:37 A.M., showed no clean towels. During an interview on 5/22/25 at 6:55 A.M., Laundry Aide G said he/she was one of two employees in the laundry room. He/She said staff threw away towels a lot. He/She said the evening shift did not always show up, so towels were not cleaned. Laundry Aide G was not able to get to them because resident clothing was a priority. During an interview on 5/22/25 at 10:58 A.M., Nursing Assistant (NA) H said there was a problem with the lack of linen. He/She said on 5/21/25, he/she could not shower any residents until 5:00 P.M., due to the lack of linen in the building. During an interview on 5/22/25 at 11:01 A.M., Certified Nursing Assistant (CNA) E said recently there had been issues with linens not being cleaned on time. During an interview on 5/22/25 at 11:04 A.M., Hospice CNA NN said when he/she came to the building to work with clients, normally it was hard to find clean towels. He/She said sometimes blankets had to be used. During an interview on 5/23/25 at 7:51 A.M., the Administrator said there should be enough linen to ensure all residents received a shower. She said new linen had been ordered. She said the census of residents had gone up and laundry staff were unable to keep up with the demand. 5. Review of Resident #15's quarterly MDS, dated , 4/9/25, showed: -Severe cognitive impairment; -Diagnoses include: cancer, Alzheimer's disease, and depression. Observations of the resident's room on 5/19/25 at 6:19 A.M. and 7:00 A.M., and 5/20/25 at 11:01 A.M., showed a window. One side of the window was boarded with plywood and secured with multiple screws. During an interview on 5/19/25 at 7:00 A.M., the resident said he/she had noticed the window boarded up and thought it didn't look nice. The resident didn't like the way it looked. During an interview on 5/22/25 at approximately 9:00 A.M., Maintenance Assistant Z said the (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	resident's window had been boarded up for about a month. The repair work had to be approved by the corporate office, which they were waiting on. The boarded window was not considered a home like environment. During an interview on 5/22/25 at 9:16 A.M., Housekeeper AA said the resident's window had been boarded up for about three weeks. The room had been occupied by residents since the window was broken. The boarded window was not considered a home like environment. During an interview on 5/22/25 at approximately 11:00 A.M., the Regional Maintenance Director said they were having a contractor come out that day. The glass wasn't the only repair the window needed. The structure of the actual window needed to be repaired. There should not have been residents occupying that room since the window was broken out in April, 2025. The boarded window was not homelike. During an interview on 5/23/25 at 2:06 P.M., the Administrator said the boarded window in the resident's room was not acceptable and was not homelike. She would have expected the residents to be moved out of the room until it was repaired. 6. Review of Resident #4's quarterly MDS, dated [DATE], showed: -Moderate cognitive impairment; -Upper extremity impairment on both sides; -Dependent for transfers and walking; -Diagnoses included stroke. Observation on 5/19/25 at 9:13 A.M., showed a mini refrigerator against the wall in the resident's room. A temperature log on the side of the refrigerator, dated 2025, was blank with no dates filled out. Bologna, cheese slices, cupcakes, and various beverages were observed inside the refrigerator. During an interview, the resident said staff did not check the temperature of his/her refrigerator. Observations on 5/20/25 at 11:11 A.M. and 5/21/25 at 8:43 A.M., showed the refrigerator temperature log was blank. 7. Review of Resident #8's annual MDS, dated [DATE], showed: -Diagnoses included acute kidney failure, dementia, and type two diabetes mellitus; -Cognitively intact. Observation on 5/19/25 at 5:44 A.M., showed a mini fridge on the resident's night stand. The temperature log, dated 2025, was blank. A cup of pudding and a drink were in the refrigerator. Observation on 5/21/25 at 10:40 A.M., showed the refrigerator temperature log dated 2025 was blank. 8. Review of Resident #23's quarterly MDS, dated [DATE], showed: (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Cognitively intact; -Upper extremity impairment on both sides; -Lower extremity impairment on one side; -Dependent for transfers and walking; -Diagnoses included stroke. Observation on 5/19/25 at 8:49 A.M., showed a mini refrigerator against the wall in the resident's room. A temperature log on the front of the refrigerator, dated 2025, was blank. Cheese, cottage cheese, ranch dressing, fruit cups, and soda were inside the refrigerator. During an interview, the resident said he/she did not know if staff checked the refrigerator temperature. Observation on 5/20/25 at 7:52 A.M. and 5/21/25 at 8:38 A.M., showed the refrigerator temperature log was blank. During an interview on 5/22/25 at 12:48 P.M., Maintenance Assistant Z said the Housekeeping Supervisor was responsible for maintaining the temperature logs for residents' personal refrigerators. He said he was currently overseeing the Housekeeping Supervisor role and had not been taking the temperatures. During an interview on 5/23/25 at 7:51 A.M., the Administrator said the Housekeeping Supervisor was normally responsible to take the temperatures of the residents' personal refrigerators. She said currently Maintenance Assistance Z should be maintaining the temperature logs. She would expect the temperatures to be taken to ensure the residents' food did not spoil. 9. Review of Resident #36's quarterly MDS, dated [DATE], showed: -Diagnoses included epilepsy, muscle weakness, and quadriplegia; -Cognitively intact. Observation and interview on 5/22/25 at 1:44 P.M., showed the resident's bathroom sink water measured a temperature of 67 degrees F. The resident said the cold water was uncomfortable when staff used the water to bathe him/her During an interview on 5/22/25 at 1:45 P.M., Maintenance Assistant Z said the facility had known about the resident's water temperature being cold for a while. He said the facility was in the process of fixing it. Observation on 5/22/25 at 2:56 P.M., showed the bathroom sink water measured a temperature of 97.1 degrees F. Observation on 5/23/25 at 6:49 A.M., showed the bathroom sink water measured a temperature of 69 degrees F. 10. Review of Resident #17's quarterly MDS, dated [DATE], showed: (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Diagnoses included acute respiratory failure, muscle weakness, and depression; -Cognitively intact. Observation and interview on 5/22/25 at 2:00 P.M., showed the water at resident's bathroom sink measured a temperature of 88 degrees F. The resident had no concerns about the water temperature. He/She did not use the sink. Observation on 5/22/25 at 2:59 P.M., showed the bathroom sink water measured a temperature of 102 degrees F. Observation on 5/23/25 at 6:43 A.M., showed the bathroom sink water measured a temperature of 67.1 degrees F. 11. Review of Resident #55's quarterly MDS, dated [DATE], showed: -Diagnoses included COPD, muscle weakness, and chronic respiratory failure; -Cognitively intact. Observation on 5/22/25 at 1:50 P.M., showed the water from the bathroom sink measured a temperature of 93.3 degrees F. Observation on 5/22/25 at 2:54 P.M., showed the water from the bathroom sink measured a temperature of 95 degrees F. During an interview on 5/23/25 at 6:39 A.M., the resident said the water in his/her bathroom was usually cold from the sink. Observation on 5/23/25 at 6:47 A.M., showed the water from the bathroom sink measured a temperature of 74 degrees F. During an interview on 5/23/25 at 7:35 A.M., Licensed Practical Nurse (LPN) X said if the water in a resident's room was too cold staff should tell maintenance. During an interview on 5/23/25 at 11:25 A.M., the Administrator said maintenance staff should be ensuring water temperatures in resident bathrooms are at the required temperature. She would expect nursing staff to inform maintenance if there is a water temperature issue. 12. Observations of the Memory Care Hall on 5/19/25 at 5:07 A.M., at 6:20 A.M. and 6:42 A.M., showed a crumbled pile of white wipe cloths with brown matter and a bag of trash between rooms [ROOM NUMBERS] near the exit door. Snack chip bags, candy wrappers, and clear drinking cups were located on the floor in front of the nurses' station. Multiple staff members walked past the trash and did not pick the trash up off the floor. During an interview on 5/22/25 at 9:16 A.M., Housekeeper AA said he/she saw the trash in the halls when he/she came in the morning of 5/19/25. Cleaning the halls and picking trash off the floor was everyone's job. Trash on the floor was not homelike and he/she would not like trash in his/her house. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 5/23/25 at 12:50 A.M., CNA W said all staff, including nursing staff, could pick up trash off the floor and help maintain a clean comfortable environment for the residents. During an interview on 5/23/25 at 2:06 P.M., the Administrator said she would expect all staff to pick up trash off the floor. Trash on the floor was not homelike. MO00244287 MO00245936 MO00245936 MO00253003

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure residents that required assistance with activities of daily living (ADLs- bathing, dressing and toileting) received necessary services to maintain adequate personal hygiene when staff left three residents soiled for an extended period (Resident's #67, #65 and #17). The facility staff did not provide showers to two residents (Resident #17 and Resident #29). The sample size was 19. The census was 74. Review of the facility's Care and Services policy, revised 10/22/24, showed: -Residents are provided with the necessary care and services to maintain the highest practicable physical, mental, and social well-being level of an environment that enhances quality of life in the scope of a long-term facility; -Care and Services are provided in a manner that consistently enhances self-esteem and worth. Review of the facility's Showering a Resident policy, revised 10/24/22, showed: -A shower or bath is given to the residents to provide cleanliness, comfort and to prevent body odors; -Residents are offered a shower at a minimum of once weekly and given per resident request. 1. Review of Resident #67's, quarterly Minimum Data Set, (MDS, a federally mandated assessment instrument completed by facility staff) dated, 2/18/25, showed: -Severe cognitive impairment; -Dependent on staff for toilet hygiene and toilet transfers; -Requires maximum assist from staff for personal hygiene; -Always incontinent of bowel and bladder; -Diagnoses included: Alzheimer's disease, aphasia (inability to speak), and stroke. Review of the resident's care plan, in use at the time of survey, showed: -Focus: The resident is incontinent of bowel and bladder; -Interventions included: Check the resident every two hours and assist with toileting as needed; Encourage the resident to evacuate his/her bowels if possible; Observe patterns of incontinence and initiate toileting schedule if indicated; Provide perineum care (cleansing of the anal area and genitals) after each incontinent episode. Observation of the resident's room on 5/19/25 at 5:07 A.M., showed the resident's door was open, and he/she lay in bed uncovered on his/ her left side. The resident was a wearing a shirt and a brief. The room had a strong odor of urine and stool. The resident was visibly soiled and saturated; with (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	stool and urine coming out the sides of the brief. The white bed pad underneath the resident was saturated with yellow urine. The resident's call light was clasped to a cord on the wall behind the privacy curtain. The resident could not reach the call light. Observation and interview on 5/19/25 at 5:35 A.M., showed the resident stood in his/her room next to his/her bed. The resident's brief appeared heavy and soiled with stool and urine. The resident's call light was clasped to a cord on the wall behind the privacy curtain out of the resident's reach. Certified Nursing Assistant (CNA) U observed the resident out of bed from the hallway and instructed the resident to go back to bed. A white bed pad located on the resident's bed was saturated with yellow urine. The resident sat on the edge the bed and then laid down. Observation and interview on 5/19/25 at 5:50 A.M., showed the resident lay in bed. CNA U removed the resident's brief. The resident's brief was saturated with stool and urine. The white bed pad underneath the resident was saturated with yellow urine. CNA U provided perineum care to the resident and applied a clean brief. 2. Review of Resident #65's, quarterly MDS, dated [DATE], showed: -The resident is rarely understood; -No rejection of care; -Occasionally incontinent of urine and frequently incontinent of bowel; -Requires maximum assist from staff for toileting hygiene; -Diagnoses included Alzheimer's disease. Review of the resident's care plan, in use at the time of survey, showed: -Focus: The resident has ADL deficit; -Intervention: The resident requires one person assist with toilet hygiene; -Focus: The resident has occasional urine incontinence; -Intervention: Clean perineum area after each incontinent episode; Check the resident for urinary incontinence as needed and provide incontinent care. Observation on 5/19/25 at 5:06 A.M., showed the resident lay in bed with his/her eyes closed, covered with a sheet and blanket. The resident's room had a strong odor of stool and urine. Observation on 5/19/25 at 6:04 A.M., showed the resident's door to his/her room was open and the resident was getting out of bed. The resident walked to the doorway wearing a shirt and a soiled brief with loose stool oozing out of the sides onto the floor. The resident's brief appeared heavy and was falling down between the resident's legs. The resident's bed and bed pad were saturated with urine and diarrhea. Graduate Practical Nurse (GPN) DD assisted the resident to walk into the bathroom. CNA U entered the room and provided perineum care, applied a clean brief and clean clothing. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 5/19/25 at approximately 6:15 A.M., CNA U said the last time he/she checked the residents on the hall was several hours ago and changed the residents briefs at approximately 11:00 P.M. Residents should be checked every two and half hours for incontinence and anything else they needed. Observation and interview on 5/23/25 at 8:28 A.M., showed the resident lay in bed. A strong odor of urine and stool was present. Licensed Practical Nurse (LPN) P was changing the resident's lower leg dressing and the resident's lower portion of his/her legs was uncovered. A dark amber ring of urine was on the resident's white fitted sheet. LPN completed the treatment and covered the resident's legs with a blanket and said to the resident, I will get an aide to help you get cleaned up. LPN P left the resident's room. Observation on 5/23/25 at 8:47 A.M., showed the resident lay in bed with his/her eyes closed. A strong odor of urine and stool was preset. A dark amber ring of urine was on the resident's white fitted sheet. Observation and interview on 5/23/25 at 9:35 A.M., showed the resident stood at the side of his/her bed. Nurse Assistant (NA) BB assisted the resident with changing his/her brief. The resident's bed pad, fitted sheet, and brief were saturated with diarrhea and urine. NA BB said he/she checked in on the resident earlier in the morning, but did not physically go into the resident's room and did not pull the covers back to determine if the resident was soiled. NA BB was not aware the resident was so soiled or else he/she would have cleaned the resident earlier. 3. Review of Resident #17's quarterly MDS, dated [DATE], showed: -Cognitively intact; -Frequently incontinent of bowel and bladder; -Dependent on staff for toilet and personal hygiene; -Requires maximum assistance for showering and bathing; -Diagnoses included acute respiratory failure, muscle weakness, and depression. Review of the resident's care plan, dated 4/14/25, showed: -Focus: resident has an ADL self-care performance deficit; -Goal: the resident will maintain current level of function through the review date; -Interventions: check nail length and trim and clean on bath day and as necessary. Report any changes to the nurse. Provide sponge bath when a full bath or shower cannot be tolerated. Monitor, document, and report any changes, any potential for improvement, reasons for self-care deficit, expected course, declines in function; Focus: The resident has bowel and bladder incontinence; Interventions: Check as needed for incontinence and provide incontinent care after each episode. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-The care plan did not include OTC dandruff shampoo and directions for frequency and use. Review on 5/22/25, of the resident's shower sheets, showed: -On 5/6/25, the resident received a shower; -On 5/9/25, the resident received a shower; -On 5/13/25, the resident received a bed bath. Observations on 5/19/25 at 5:39 A.M., and 5/20/25 at 10:57 A.M., showed the resident in bed and awake. A strong odor emitted from the resident. The resident's hair was oily. The resident's face and scalp had white skin flakes and was reddened. During an interview on 5/19/25 at 5:40 A.M., the resident said staff do not shower him/her at least twice a week. He/She said it had been a week since his/her last shower. During an interview on 5/20/25 at 1:20 P.M., the resident's family member said he/she has special Nizoral shampoo for dandruff and psoriasis (condition in which skin cells build up and form scales and itchy dry patches). He/She said the resident does not normally refuse care. During an interview on 5/21/25 at 6:05 P.M., the resident said he/she has special shampoo for his/her scalp, but staff do not shower him/her regularly so his/her head and scalp was itchy. Review of the resident's POS, dated May 2025, showed no order for Nizoral shampoo (used to treat and control flaking, scaling, and itching from dandruff). During an interview on 5/23/25 at 7:33 A.M., LPN X said residents should receive at least two showers or bed baths a week. He/She would expect any skin concerns to be documented on the CNA's shower skin assessments and the nurse's weekly skin assessment. He/She said if a resident had a special shampoo there should be an order, it should be care planned and the resident's hair should be washed regularly. He/She said there currently was no order in the resident's chart for psoriasis shampoo and that was probably why the resident's skin was acting up. Observation and interview on 5/20/25 at 12:48 P.M., showed the resident lay in bed. CNA B and LPN X entered the room and explained to the resident they had to check the resident's skin. CNA B lowered the front part of the resident's brief. The resident had a moderate amount of stool on his/her genital area and groin. CNA B and LPN X rolled the resident to his/her left side and the resident's brief was saturated with urine and soft stool. CNA B and LPN X provided perineum care and applied a clean brief. During an interview on 5/20/25 at 1:20 P.M., the resident said he/she always waited a long time to be cleaned after he/she was incontinent. During an interview on 5/20/25 at 1:25 P.M., CNA B said the last time he/she checked the resident for incontinence was at 9:00 A.M. Residents should be checked for incontinence every two hours and as needed. During an interview on 5/22/25 at 6:55 P.M., LPN T said residents should be checked or taken to the (continued on next page)

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	265352	A. Building B. Wing	05/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Manchester Rehab and Healthcare Center	312 Solley Drive Ballwin, MO 63021

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	restroom every two hours or as needed. Any nursing staff member could assist with providing care to the residents. 4. During an interview on 5/23/25 at 1:00 P.M., the Director of Nursing (DON) said she would expect staff to check residents for incontinence or offer them to use the bathroom every two hours and as needed. Any nursing staff can change the resident. The residents are expected to be cleaned immediately if the staff member was aware that the resident was soiled. 5. Review of Resident #29's quarterly MDS, dated [DATE], showed: -Usually makes self understood; -Moderate cognitive impairment; -Rejection of care behavior not exhibited; -Upper extremity impairment on one side; -Lower extremity impairment on both sides; -Setup or cleanup assistance required for eating; -Dependent on assistance for showering/bathing self and personal hygiene. Review of the the resident's medical record, showed: -Diagnoses included traumatic brain injury, abnormalities of gait and mobility, unsteadiness on feet, generalized muscle weakness, anxiety disorder, depression, post-traumatic stress disorder (PTSD, mental health condition that can develop after a traumatic event), and schizoaffective disorder (mental health condition that includes features of a mood disorder and schizophrenia (serious mental illness that affects how a person thinks, feels, and behaves)); -No documentation of refusals for showering/bathing assistance, hand hygiene, or nail care in April or May 2025. Review of the resident's care plan, in use at the time of survey, showed: -Focus: Resident prefers to eat with his/her hands and prefers to not have his/her food altered for his/her independence; -Interventions: Nursing will provide hand hygiene in between meals and as needed (PRN). Nursing will provide nail care trim/file routine and PRN; -Focus: Resident has an ADL self-care performance deficit. Shower days: Tuesday and Friday evenings; -Interventions included: Check nail length and trim and clean on bath day and PRN. Provide sponge bath when a full bath or shower cannot be tolerated. Total assist with bathing/showering; (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Focus: Resident is resistive to care, taking showers related to confusion at times due to traumatic brain injury; -Interventions included: Allow resident to make decisions about treatment regime to provide sense of control. If possible, negotiate a time for ADLs to that the resident participates in the decision making process and return at the agreed upon time. Review of the facility's shower schedule, undated, showed the resident scheduled for showers on Tuesday and Friday night. Review of the resident's shower sheets for April and May 2025, reviewed on 5/22/25, showed: -An undated shower sheet. No documentation related to the resident's fingernails; -A shower sheet, dated 5/14/25. No documentation related to the resident's fingernails; -No shower sheets for 18 out of 20 opportunities. Observation on 5/19/25 at 9:51 A.M., showed the resident in bed. His/Her fingernails were long and jagged with dark matter underneath the fingernails. Observation on 5/20/25 at 8:00 A.M., showed the resident in bed. His/Her fingernails were long and jagged with dark matter underneath the fingernails. During an interview, the resident was unable to respond verbally and he/she nodded or shook his/her head and used the ok hand gesture to respond to questions. The resident indicated he/she cannot walk. Observations on 5/20/25 at 9:17 A.M., 12:17 P.M., and 1:20 P.M., showed the resident in bed. His/Her fingernails were long and jagged with dark matter underneath the fingernails. During an interview at 1:20 P.M., the resident said his/her hands were dirty and he/she needed assistance from staff to wash them. He/She could not recall the last time his/her hands were washed or when he/she had a shower. Observation on 5/21/25 at 9:18 A.M., showed the resident in bed eating mechanical-soft sausage and scrambled eggs with his/her hands. The resident's fingernails were long and jagged with dark matter underneath the fingernails. During an interview on 5/23/25 at 7:53 A.M., CNA KK said the resident could not walk. He/She ate with his/her hands. He/She needed total assistance from staff for his/her hygiene needs. CNAs should clean the resident's hands after he/she eats as part of routine daily care. CNAs should ensure the resident's fingernails were trimmed and clean. The resident was supposed to get showers and he/she did not have a history of refusing showers. When CNAs provided showers or bed baths, they should document them on shower sheets. If a resident refused a shower or bed bath, staff should offer again and if the resident continued to refuse, it should be reported to the nurse. Refusals should be documented on shower sheets and signed by the resident. Completed shower sheets went to the nurse. During an interview on 5/23/25 at 7:27 A.M., LPN X said residents' fingernails should be cleaned and trimmed. CNAs should trim fingernails and use a washcloth to clean a resident's hands after meals. Staff should follow the shower schedule posted at the nurse's station and document bed baths and (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	showers on shower sheets. If a resident refused their bed bath or shower, staff should offer twice, then report it to the nurse. Resident refusals should be documented on shower sheets. Completed shower sheets were signed by the nurse, then given to the DON. During an interview on 5/23/25 at 8:10 A.M., the DON said the resident could not walk and ate with his/her hands. Staff should clean the resident's hands for him/her, and clean the dark matter out from underneath the resident's fingernails, as he/she cannot do this him/herself. CNAs should trim the resident's fingernails. 6. During an interview on 5/23/25 at 8:10 A.M., the DON said residents should be showered or bathed in accordance with their needs and preferences. Residents want to feel good about themselves and good hygiene helps with this. She expected staff to follow the shower schedule at the nurse's station. If staff could not complete a shower during their shift, it should be passed on to the next shift. Showers and bed baths should be documented on shower sheets. If a resident was out in the hospital during the scheduled shower day, it should be noted on a shower sheet. If a resident refused their shower, staff should come back later to offer again. If the resident continued to refuse, it should be documented on a shower sheet and reported to the nurse, who should chart a note on it. Completed shower sheets were supposed to be reviewed and signed by the nurse. Once signed by the nurse, the shower sheet was given to the DON for review. She had been working with staff ensuring residents received their showers. MO00254289 MO00245476

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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 and interview, the facility failed to ensure food was served at a palatable, safe and appetizing temperature during tray service by failing to maintain the temperature of hot food at least at 120 degrees Fahrenheit (F). This affected five of 19 sampled residents (Residents #17, #36, #38, #50 and #55). The census was 74. Review of the facility's food temperature policy, dated 10/24/22, showed: -Policy: foods prepared and served in the facility will be served at proper temperatures to ensure food safety; -Procedure: if temperatures do not meet the required serving temperatures, reheat the product or chill the product to the proper temperature. -Acceptable food temperatures: meat should be greater than 135 degrees F, potatoes should be greater than 135 degrees F. 1. Review of Resident #17's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 4/23/25, showed: -Cognitively intact; -Diagnoses included acute respiratory failure, muscle weakness and depression. During an interview on 5/19/25 at 5:52 A.M., the resident said food is normally delivered cold. 2. Review of Resident #36's quarterly MDS, dated [DATE], showed: -Cognitively intact; -Diagnoses included epilepsy (seizure disorder), muscle weakness and quadriplegia (paralysis of all four limbs). During an interview on 5/19/25 at 6:57 A.M., the resident said the food is cold most of the time. 3. Review of Resident #38's quarterly MDS, dated [DATE], showed: -Cognitively intact; -Diagnoses included heart failure and anxiety. During an interview on 5/19/25 at 11:17 A.M., the resident said food is cold at all meals. 4. Review of Resident #50's quarterly MDS, dated [DATE], showed: -Cognitively intact; (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Diagnoses included muscle weakness and paraplegia (paralysis of lower portion of the body and of both legs). During an interview on 5/19/25 at 7:24 A.M., the resident said food is normally cold when delivered. 5. Review of Resident #55's quarterly MDS, dated [DATE], showed: -Cognitively intact; -Diagnoses included chronic obstructive pulmonary disease (lung disease), muscle weakness and chronic respiratory failure. During an interview on 5/19/25 at 6:05 A.M., the resident said the food tastes okay, but can be cold. 6. Observation on 5/19/25 at 9:13 A.M., of breakfast on the 300 hallway, showed: -Scrambled eggs measured 99.2 degrees F; -Bacon measured 97.5 degrees F; -Toast was soggy. 7. Observation on 5/21/25 at 1:48 P.M., of lunch on the 800 hallway, showed: -Herbed baked chicken measured 109 degrees F; -Green beans measured 96 degrees F. 8. During an interview on 5/21/25 at 10:30 A.M., the corporate owners said they pulled staff and a Dietary Manager from another facility, due to the Dietary Manager walking out the week before. The facility cook had only been working for four days and had not been trained properly. During an interview on 5/22/25 at 8:19 A.M., Dietary Aide I said food should be delivered to residents at a safe and palatable temperature. During an interview on 5/22/25 at 8:24 A.M., Dietary Aide J said food should be delivered at a safe and palatable temperature. He/She said he/she wouldn't want his/her food to be cold. During an interview on 5/23/25 at 7:49 A.M., the Administrator said she expected staff to serve food to residents at a safe and palatable temperature. The cook is responsible to ensure food is at the appropriate temperature before leaving the kitchen but the current cook was not doing this. MO00244287