STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265472	A. Building B. Wing	03/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brent B Tinnin Manor	220 Euel Polk Drive Ellington, MO 63638

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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 0570 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assure the security of all personal funds of residents deposited with the facility. Based on interview and record review, the facility failed to maintain the surety bond (a purchased bond for the security of residents' personal funds) for at least one and one-half times the average monthly balance of the residents' personal funds for the last 12 consecutive months from November 2023 through October 2024. The facility's census was 40. Review of the facility's policy titled, Surety Bond, dated March 2021, showed: - A surety bond is an agreement between the facility, the insurance company, and the resident or the State acting on behalf of the resident, wherein the facility and the insurance company agree to compensate the resident for any loss of the resident's funds that the facility holds, accounts for, safeguards, and manages; - This facility holds a surety bond to guarantee the protection of the residents' funds managed by the facility on behalf of its residents; - All funds (including refundable deposits) entrusted to the facility for a resident are covered by the surety bond; - The purpose of the surety bond is to guarantee that the facility will pay the resident for losses occurring from any failure by the facility; - Inquiries concerning the financial security of personal funds managed by the facility should be referred to the Administrator; - The policy did not address how the surety bond would be calculated. Review of the Residents' Personal Funds Account for the last 12 consecutive months from March 2024 through February 2025, showed: - The facility's approved bond amount equaled $51,000.00; - The average monthly balance of the residents' personal funds equaled $38,481.13; - An average monthly balance of $38,481.13 rounded to the nearest thousand equaled $38,000.00 and at one and one-half times would equal the required bond amount of at least $57,000.00. During an interview on 03/19/25 at 10:30 A.M., the Administrator said she would expect the facility's bond to be sufficient to cover the residents' funds. The previous administration misappropriated (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0570 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	money and therefore, the accounts were not reconciled and were incorrect.

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. Based on interview and record review, the facility failed to properly document notification and obtain a signature of the resident or legal representative for three residents (Residents #2, #36, and #51) out of three sampled residents on the Notice of Medicare Non-Coverage (NOMNC) and the Skilled Nursing Facility Advanced Beneficiary Notice (SNF ABN) forms prior to the facility discharging the resident from Medicare services. The census was 40. Review of facility policy titled, Medicare Advance Beneficiary and Medicare Non-Coverage Notices, revised September 2022, showed: - If the director of admissions or benefits coordinator believes (upon admission or during a resident's stay) that Medicare Part A will not pay for an otherwise covered skilled service(s), the resident or representative is notified in writing why the service(s) may not be covered and of the resident's potential liability for payment of the non-covered service(s); - SNF ABN is issued to the beneficiary before non-covered care items or services are furnished to the beneficiary; - SNF ABN is issued to the beneficiary before items or services to the beneficiary are reduced; - The facility must issue a NOMNC at least two days before the terminated covered care; - The resident or representative is informed that they may choose to receive the skilled services that may not be paid for by Medicare and assume the financial responsibility. 1. Review of Resident #2's medical record showed: - The resident was discharged from skilled services on 11/01/24, with remaining days in the benefit period and remained in the facility; - No documentation of the NOMNC and SNF ABN forms; - The facility failed to issue the NOMNC and SNF ABN forms. 2. Review of Resident #36's medical record showed: - The resident was discharged from skilled services on 11/01/24, with remaining days in the benefit period and remained in the facility; - No documentation of the NOMNC and SNF ABN forms; - The facility failed to issue the NOMNC and SNF ABN forms. 3. Review of Resident #51's medical record showed: - The resident was discharged from skilled services on 11/01/24, with remaining days in the benefit period and discharged from the facility; (continued on next page)

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- The facility failed to notify the resident or the resident's representative of the change to the skilled services; - No documentation of the NOMNC form; - The facility failed to issue the NOMNC form. During an interview on 03/19/25 at 10:05 A.M., the Administrator said she would expect the SNF ABN and NOMNC forms to be provided with the proper notifications conducted and the correct signatures in a timely manner. During an interview on 03/19/25 at 10:19 A.M., the Social Service Designee (SSD) he/she will now be now responsible for the SNF ABN and NOMNC forms in the future. He/She would expect the forms to be completed, the resident's and or the resident resident's representative to be notified, and the signatures to be obtained in timely a manner.

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. Based on interview and record review, the facility failed to follow their policy and procedure to complete Criminal Background Checks (CBC) for four employees (Employees A, B, C, and D) and to check the Employee Disqualification List (EDL - a listing of individuals who have been determined to have abused, neglected, and/or misappropriated funds or property from a resident) prior to the hire date for two employees (Employees A and B) out of five sampled employees . The facility census was 40. Review of the facility's policy titled, Background Screening Investigations, dated March 2019, showed: - Background checks, reference checks, and criminal conviction checks on all potential direct access employees and contractors should be conducted. Background and criminal checks are initiated within two days of an offer of employment and completed prior to employment. Review of the facility policy titled, Hiring and Orientation, undated, showed: - Pre-screening for employment may include license verification, criminal background check, pre-employment physical screening/questionnaire and drug testing. Review of the facility policy titled, Abuse, Neglect, Exploitation and Misappropriation Prevention Program, dated April 2021, showed: - Develop and implement policies and protocols to prevent and identify the above; - Conduct employee background checks. The facility did not provide a policy in regards to checking the EDL. 1. Review of Employee A's personnel file showed: - A hire date of 05/15/24; - No documentation of a CBC completed prior to the hire date; - No documentation of a EDL completed prior to the hire date; - The facility failed to perform the CBC and EDL prior to the hire date. 2. Review of Employee B's personnel file showed: - A hire date of 03/16/24; - The employee's CBC completed after the hire date on 03/20/24; - The employee's EDL completed after the hire date on 03/20/24; - The employee's last EDL completed 05/03/24; (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- The facility failed to perform the CBC and EDL prior to the hire date. 3. Review of Employee C's personnel file showed: - A hire date of 01/21/25; - The employee's CBC completed after the hire date on 01/23/25; - The facility failed to perform the CBC prior to the hire date. 4. Review of Employee D's personnel file showed: - A hire date of 07/05/23; - No documentation of a CBC completed prior to the hire; - The facility failed to perform the CBC prior to the hire date. During an interview on 03/19/25 at 10:45 A.M., the Human Resources (HR) staff said CBC and EDL checks should be done prior to employment and the EDL checks should be done again quarterly. He/She just started in this position and was working to get everything in order. During an interview on 03/19/25 at 10:30 A.M., the Administrator said the CBC and EDL checks should be completed prior to employment and the EDL checked at least quarterly after employment.

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide a written copy of the notice of transfer or discharge to the resident and/or the resident's responsible party for five residents (Residents #5, #9, #34, #36, and #45) out of five sampled residents. The facility census was 40. Review of the facility's policy titled, Transfer or Discharge, dated October 2022, showed: - Transfer and discharge includes movement of a resident from a certified bed in the facility to a non-certified bed in another part of the facility, or to a non-certified bed outside the facility; - When residents who are sent emergently to an acute care setting, these scenarios are considered facility-initiated transfers, not discharges, because the resident's return is generally expected; - Resident who are sent emergently to an acute care setting, such as a hospital, are permitted to return to the facility; - Under the following circumstances, the notice is given as soon as it is practicable but before the transfer or discharge: the health and/or safety of individuals in the facility would be endangered due to the clinical or behavioral status of the resident or an immediate transfer or discharge is required by the resident's urgent medical needs; - Notice of transfer is provided to the resident and representative as soon as practicable before the transfer and to the long-term care ombudsman (a resident advocate) when practicable (example a monthly list of residents that includes all notice content requirement); 1. Review of Resident #5's medical record showed: - The resident transferred to the hospital on [DATE]; - No documentation of the written notification with the reason for the hospital transfer provided to the resident and/or the responsible party. 2. Review of Resident #9's medical record showed: - The resident transferred to the hospital on [DATE], 02/08/25, and 03/02/25; - No documentation of the written notifications with the reasons for the hospital transfers provided to the resident and/or the responsible party. 3. Review of Resident #34's medical record showed: - The resident transferred to the hospital on [DATE] and 02/28/25; - No documentation of the written notifications with the reasons for the hospital transfers provided to the resident and/or the responsible party. (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	4. Review of Resident #36's medical record showed: - The resident transferred to the hospital on [DATE] and 02/02/25; - No documentation of the written notifications with the reasons for the hospital transfers provided to the resident and/or the responsible party. 5. Review of Resident #45's medical record showed: - The resident transferred to the hospital on [DATE]; - No documentation of the written notification with the reason for the hospital transfer provided to the resident and/or responsible the party. During an interview on 03/19/25 at 10:05 A.M., the Administrator said she would expect residents and/or the resident's representative to be given a written copy of the notice of the transfer or discharge.

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide written information to the resident and/or the resident's representative of the facility's bed hold policy at the time of the transfer to the hospital for six residents (Residents #2, #5, #9, #34, #36, and #45) out of six sampled residents. The facility's census was 40. Review of the facility's policy titled, Bed Holds and Returns, dated October 2022, showed: - All residents/representatives are provided written information regarding the facility and state bed-hold policies, which addresses holding or reserving a resident's bed during periods of absence at least twice (included in the admission packet, and at the time of transfer, if an emergency, within 24 hours.) 1. Review of Resident #2's medical record showed: - admitted on [DATE]; - The resident transferred to the hospital on [DATE], and returned to the facility on [DATE]; - The resident transferred to the hospital on [DATE], and returned to the facility on [DATE]; - No documentation the resident or the resident's representative was informed in writing of the facility's bed hold policy at the time of the transfer. 2. Review of Resident #5's medical record showed: - admitted on [DATE]; - The resident transferred to the hospital on [DATE], and returned to the facility on [DATE]; - No documentation the resident or the resident's representative was informed in writing of the facility's bed hold policy at the time of the transfer. 3. Review of Resident #9's medical record showed: - admitted on [DATE]; - The resident transferred to the hospital on [DATE], and returned to the facility on [DATE]; - The resident transferred to the hospital on 02/08//25, and returned to the facility on [DATE]; - The resident transferred to the hospital on [DATE], and returned to the facility on [DATE]; - No documentation the resident or the resident's representative was informed in writing of the facility's bed hold policy at the time of the transfer. (continued on next page)

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	4. Review of Resident #34's medical record showed: - admitted on [DATE]; - The resident transferred to the hospital on [DATE], and returned to the facility on [DATE]; - The resident transferred to the hospital on [DATE], and returned to the facility on [DATE]; - No documentation the resident or the resident's representative was informed in writing of the facility's bed hold policy at the time of the transfer. 5. Review of Resident #36's medical record showed: - admitted on [DATE]; - The resident transferred to the hospital on [DATE], and returned to the facility on [DATE]; - The resident transferred to the hospital on [DATE], and returned to the facility on [DATE]; - No documentation the resident or the resident's representative was informed in writing of the facility's bed hold policy at the time of the transfer. 6. Review of Resident #45's medical record showed: - admitted on [DATE]; - The resident transferred to the hospital on [DATE], and did not return; - No documentation the resident or the resident's representative was informed in writing of the facility's bed hold policy at the time of the transfer. During an interview on 03/19/25 at 10:05 A.M., the Administrator said he/she would expect residents and/or the resident's representative to be informed in writing of the facility bed hold policy before a resident was transferred.

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident when there is a significant change in condition Based on interview and record review, the facility failed to complete a significant change Minimum Data Set (MDS - a federally mandated assessment instrument required to be completed by facility staff) assessment within 14 days of admission to hospice services for one resident (Resident #4) out of one sampled resident. The facility census was 40. The facility did not provide a policy regarding the completion of significant change MDS assessments. 1. Review of Resident #4's medical record showed: - admitted to hospice services on 02/28/25; - No significant change MDS dated on or after 02/28/25; - The facility failed to complete a significant change MDS within 14 days of the resident's admission to hospice. During an interview on 03/19/25 at 1:15 P.M., the Administrator said a significant change MDS should be completed with a significant change, decline, admission to hospice, or an improvement. It should be done as soon as the staff became aware of it. During an interview on 03/19/25 at 1:23 P.M., the MDS Coordinator said the significant change MDS should be completed within 14 days of the change.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident’s preferences and goals. Based on observation, interview, and record review, the facility failed to ensure one resident (Resident #4) had a completed hospice (palliative care for the terminally ill with a life expectancy of six months or less) coordinated plan of care, received the needed care and services in accordance with professional standards of practice by not turning and repositioning, and to follow physician's orders for daily wound care treatments and a wound culture out of one sampled resident receiving hospice services, positioning due to impairment, and wound care and culture. The facility also failed to monitor a valproic acid (an anticonvulsant medication) level for one resident (Resident #3) out of one sampled resident. The facility census was 40. Review of the facility's policy titled, Hospice Program, revised July 2017, showed: - Coordinated care plans for residents receiving hospice services will include the most recent hospice plan of care as well as the care and services provided by our facility (including the responsible provider and discipline assigned to specific tasks) in order to maintain the resident's highest practicable physical, mental and psychosocial well-being; - The coordinated care plan will reflect the resident's goals and wishes, as stated in his/her advance directives and during ongoing communication with the resident or representative, including palliative goals and objectives; palliative interventions; and medical treatment and diagnostic tests; - The coordinated care plan shall be revised and updated as necessary to reflect the resident's current status including, but not limited to diagnosis, problem list; symptom management (pain, nausea, vomiting, etc.); bowel and bladder care; nutrition and hydration needs; oral health; skin integrity; spiritual, activity and psychosocial needs; and mobility; and positioning. Review of the facility's policy titled, Lab and Diagnostic Test Results - Clinical Protocol, revised November 2018, showed: - The staff will process test requisitions and arrange for tests; - When test results are reported to the facility, a nurse will first review the results. If staff who first receive or review lab and diagnostic test results cannot follow the remainder of this procedure for reporting and documenting the results and their implications, another nurse in the facility (supervisor, charge nurse, etc.) should follow or coordinate the procedure. Review of the facility's policy titled, Prevention of Pressure Ulcers, revised April 2020, showed: - The purpose of this procedure is to provide information regarding identification of pressure injury risk factors and interventions for specific risk factors; - Review the resident's care plan and identify the risk factors as well as the interventions designed to reduce or eliminate those considered modifiable; - Reposition resident as indicated on the care plan; - Clean promptly after episodes of incontinence; (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Reposition all residents with or at risk of pressure injuries on an individualized schedule, as determined by the interdisciplinary care team. The facility did not provide a policy regarding ordering labs for medication monitoring. 1. Review of Resident #3's March 2025 Physician Order Sheet (POS): - Diagnosis of epilepsy (a seizure disorder); - An order for Depakote (valproic acid) delayed release 125 milligram (mg) by mouth two times a day related to epilepsy, dated 06/17/24; - An order for Depakote delayed release 500 mg by mouth two times a day related to epilepsy, dated 06/17/24; - An order for Depakote delayed release 250 mg by mouth two times a day related to epilepsy, dated 06/17/24; - No order for a valproic acid level. Review of the resident's Medical Record showed: - Valproic Acid Lab report, dated 01/03/24, with a valproic acid level of 81 micrograms per milliliter (ug/mL) (normal range of 50-100 ug/mL); - No documentation of valproic acid lab values since 01/03/24. Review of the resident's Care Plan, revised 01/15/25, showed: - A focus of seizure disorder with a goal of the resident will maintain lab values within therapeutic range. Interventions included: monitor the resident's labs and report any sub therapeutic or toxic results to the physician. During a phone interview on 03/19/25 at 9:01 A.M., the Nurse Practitioner said lab frequency for valproic acid levels vary based on when the medication was started. If the medication was just started, he/she would expect the level to be checked within one week to 10 days. If the resident was on the medication for a while and the level had been within the normal range, ideally the level should be checked every six months to one year. If the dose was changed, the level would be checked at that time, and again in one week to 10 days. He/She would expect to be notified by the facility of the need for a lab level to be drawn if one had not been completed in the last six months to one year. 2. Review of Resident #4's March 2025 POS showed: - An admission date of 02/10/25; - An order to admit to hospice, diagnoses of protein calorie malnutrition, dated 02/28/25; - An order for two hour turn check. Left to right turns only per wound care, two times a day for wound care, dated 02/24/25; (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- An order for a wound culture to the wound on the right leg to be picked up on the next lab date, dated 02/21/25; - An order to cleanse the sacral wound with facility cleanser, apply Medihoney (a wound dressing) gel, cover with non-bordered foam (a type of dressing), and secure with tape daily, dated 02/12/25; - An order to cleanse the right heel wound with facility cleanser, apply Medihoney gel, cover with non-bordered foam, wrap with Kerlix (sterile gauze), and secure with tape daily, dated 02/12/25; - An order to cleanse the right great toe wound with facility cleanser, apply Medihoney gel, cover with non-bordered foam, wrap with Kerlix, and secure with tape daily, dated 02/12/25. Review of residents admission Minimum Data Set (MDS - a federally mandated assessment instrument completed by the facility staff), 02/18/25, showed: - Moderate cognitive impairment; - Partial/moderate assistance to roll left and right, sit to lying, and lying to sit on side of bed; - Indwelling catheter; - Always incontinent of bowel; - At risk for pressure ulcer (damage to the skin and/or underlying tissue as a result of pressure); - One stage 1 (intact skin with non-blanchable redness) or higher, two stage 3 (full thickness tissue loss) pressure ulcers present on admission, one unstageable (full thickness tissue loss in which actual depth of the ulcer is completely obscured by slough (a type of non-viable tissue that accumulates in wounds) and/or eschar (dark, dead matter that is cast off from the surface of the skin) in the wound bed) pressure ulcer, present on admission; - Other ulcers, wounds, and skin problems, infection of foot, and other open lesion(s) on the foot; - Moisture associated skin damage (MASD); - Skin and ulcer treatments, turning and reposition program, nutrition or hydration interventions, pressure ulcer care, application of non-surgical dressing other than to feet, application of ointments/medications other than to feet, applications of dressing to feet; - Did not receive hospice services. Review of resident's Care Plan, dated 02/20/25, showed: - Osteomyelitis (an infection in a bone) of the right foot; - Pressure ulcer with interventions to check every two hours and turned to the left and right side only. If drainage present, obtain an order for a wound culture and provide the wound care per the treatment order; (continued on next page)

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	265472	A. Building B. Wing	03/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brent B Tinnin Manor	220 Euel Polk Drive Ellington, MO 63638

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Bowel incontinence related to immobility with interventions to check every two hours and assist with toileting as needed, provide bedpan/bedside commode, provide peri care after each incontinent episode; - Stage 2 (partial thickness loss of dermis presenting as a shallow open ulcer with a red pink wound bed, without slough) pressure ulcers to the right heel and coccyx (a small triangular bone at the base of the spinal column). An unstageable wound to the third toe on the right foot related to disease process and immobility with interventions to administer treatments as ordered and monitor for effectiveness; check every two hours and turn left and right sides only; monitor dressing to ensure it is intact and adhering; report loose dressing to the treatment nurse; obtain and monitor lab/diagnostic work as ordered; report results to the physician and follow up as indicated; teach the resident/family the importance of changing positions for prevention of pressure ulcers; and encourage small frequent position changes; - Foley catheter (a tube inserted into the bladder to drain urine) related to neurogenic bladder (condition that results in lack of bladder control due to a brain, spinal cord or nerve problem) with interventions to position the catheter bag and tubing below the level of the bladder and away from the entrance room door, change the catheter on the 17th of every month, and check tubing for kinks every two hours each shift; - Did not address hospice or catheter care. Review of the resident's Hospice Coordinated Plan of Care, dated 02/28/25, showed: - Did not address wounds or wound care; - Did not address Foley catheter care. Review of the resident's Lab Wound Culture Report, dated 02/27/25, showed: - Wound culture with the missing information of no date/time of the collection on the swab and no culture results. During an interview on 03/19/25 at 1:36 P.M., LPN A said Resident #4's wound culture was sent on 02/26/25, but the lab rejected it due to it was missing the date and time information. He/She did not follow up to resend another wound culture sample. Observations of the resident showed: - On 03/16/25 from 12:02 P.M. - 2:59 P.M., the resident lay in bed on his/her back with the head of the bed elevated approximately 40 degrees; a wound dressing, dated 03/14/25, to the right great toe; undated dressing to the right heel with reddish/brown colored substance on the dressing and the fitted sheet under the right foot; both feet pressed against the footboard; Foley catheter bag hung on the bed frame away from the door with a privacy cover in place; and a waffle mattress overlay folded on the floor. The resident lay in the same position for two hours and 57 minutes; - On 03/17/25 from 8:35 A.M. - 2:01 P.M., the resident lay in bed on his/her back with both feet pressed against the footboard. The resident lay in the same position for five hours and 26 minutes; (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- On 03/18/25 at 8:33 A.M., and 11:05 A.M., the resident lay in bed on his/her back; - On 03/19/25 at 10:15 A.M., the resident lay in bed on his/her back with a dressing to the right foot. dated 03/17/25; - On 03/19/25 at 10:24 A.M., the resident lay in bed on his/her back with a dressing to the right foot, dated 03/17/25. The Director of Nursing (DON) observed the date on the wound dressing of 3/17/25. Review of the resident's Wound Care Notes showed: - On 02/17/25, wound #1 right great toe was a stage 3 pressure injury pressure ulcer, status not healed, with 0.8 centimeter (cm) x 1.6 cm, with an area of 1.28 square (sq.) cm (sq) with a moderate amount of serosanguineous (discharge that contains both blood and a clear yellow liquid known as blood serum drainage) drainage; wound # 2 right heel was a stage 3 pressure injury pressure ulcer, status not healed, 1.5 cm x 1.8 cm with an area of 2.7 sq cm and a volume of 0.27 cubic cm, with a scant amount of serosanguineous drainage; wound #3 coccyx was an unstageable pressure injury obscured full-thickness skin and tissue loss, status not healed with 5 cm x 6.5 cm and an area of 32.5 sq cm with moderate amount of serosanguineous drainage. Wound bed had 1-25% granulation (the appearance of the red, bumpy tissue in the wound bed as the wound heals), 76-100% slough (the yellow/white material in the wound bed); - On 02/24/25, wound #1, status not healed, 0.5 cm x 0.4 cm with an area of 0.2 sq cm with a moderate amount of serosanguineous drainage, wound was improving; wound #2, status not healed, 1.5 cm x 1.6 cm x 0.1 cm with an area of 2.4 cm and a volume of 0.24 cubic cm with a scant amount of serosanguineous drainage, wound was improving; wound #3, status not healed, 6 cm x 9.5 cm with an area of 57 sq cm with a moderate amount of serosanguineous drainage, wound bed has 51-75% granulation, 26-50% slough, the wound was deteriorating; - On 03/03/25, wound #1, status not healed, 0.5 cm x 0.7 cm with an area of 0.35 sq cm with a moderate amount of serosanguineous drainage, the wound was deteriorating; wound #2, status not healed, 1.8 cm x 0.7 cm x 0.1 cm with an area of 1.26 sq cm and a volume of 0.126 cubic cm with a scant amount of serosanguineous drainage, the wound was improving; wound #3, status not healed, 8 cm x 8 cm with an area of 64 sq cm with a moderate amount of serosanguineous drainage, wound bed had 51-75% granulation, 26-50% slough, the wound was improving; - On 03/10/25, wound #1, status not healed, 0.5 cm x 0.6 cm with an area of 0.3 sq cm with a moderate amount of serosanguineous drainage, the wound was improving; wound #2, deep tissue pressure injury persistent non-blanchable deep red, maroon or purple discoloration, status not healed, 3.5 cm x 4 cm with an area of 14 sq cm with a scant amount of serosanguineous drainage, wound was improving; wound #3, status not healed, 7 cm x 12 cm with an area of 84 sq cm with a moderate amount of serosanguineous drainage, wound bed had 76-100% granulation, 1-25% slough, the wound was deteriorating; - On 03/17/25, wound #1, status not healed, 0.5 cm x 0.6 cm with an area of 0.3 sq cm with a moderate amount of serosanguineous drainage, there was no change in the wound progression; wound #2, deep tissue pressure injury persistent non-blanchable deep red, maroon or purple discoloration, status not healed, 3 cm x 5 cm with an area of 15 sq cm with a scant amount of serosanguineous drainage, wound was deteriorating; wound #3, status not healed, 13 cm x 12.3 cm with an area of 84 sq cm with a moderate amount of serosanguineous drainage, wound bed had 76-100% granulation, 1-25% slough, the (continued on next page)

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	265472	A. Building B. Wing	03/19/2025

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	wound was deteriorating; During an interview on 03/16/25 at 2:05 P.M., Resident #4 said hospice came twice a week. Wound dressings were not changed daily, they were usually changed by the hospice nurse. Hospice changed them on Friday (03/14/25). He/She had wounds on his/her bottom, right heel, and right toe. During an interview on 03/18/25 at 2:05 P.M., Licensed Practical Nurse (LPN) A said residents should be checked, and changed, and repositioned at least every two hours. Wound care should be completed per physician's order. During an interview on 03/18/25 at 2:15 P.M., the DON said hospice was with the resident yesterday and should have changed the dressings. The dressings were to be changed at least daily. Hospice staff was not the only one's that did wound care for Resident #4. During an interview on 03/19/25 at 10:24 A.M., the DON said she observed the resident's wound dressing to the right foot, to see when it was last completed. The wound dressing was dated 03/17/25. She said the resident's Medication Administration Record (MAR) showed the dressing was changed on 03/18/25 and 03/19/25. During an interview on 03/19/25 at 1:10 P.M., the DON said the hospice coordinated plan of care should address wound and catheter care, which staff was going to do what, what equipment or care was required, and anything personal to the resident's situation. The facility's care plans should address hospice, wounds, catheters, and should be personalized for each resident. During an interview on 03/19/25 at 1:15 P.M., the Administrator said bed bound residents should be checked and repositioned every two hours and the policy was before and after meals and throughout night. Physician orders should be followed. Care plans should cover wounds, hospice, and oxygen. Hospice coordinated plan of care should cover that too.

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	265472	A. Building B. Wing	03/19/2025

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. Based on observation, interview, and record review, the facility failed to obtain an order for use of a continuous positive airway pressure machine (CPAP - a machine that uses mild air pressure to keep breathing airways open during sleep) and failed to follow physician's order for continuous oxygen for one resident (Resident #4) out of three sampled residents. The facility's census was 40. Review of the facility's policy titled, Oxygen Administrator, revised October 2002, showed: - Verify that there is a physician's order. The facility did not provide a policy regarding CPAP use. 1. Review of Resident #4's medical record showed: - admission date of 02/10/25; - Diagnoses of protein calorie malnutrition and heart failure (heart doesn't pump blood like it should). Review of the resident's Physician's Order Sheet (POS), dated March 2025, showed: - An order for oxygen at 2 liters per minute via nasal cannula (a tube delivering oxygen to a person's nose) continuous, every shift for oxygen, dated 02/13/25; - No order for a CPAP. Review of the residents admission Minimum Data Set (MDS - a federally mandated assessment instrument completed by the facility staff), dated 02/18/25, showed: - Oxygen not used; - CPAP not used. Review of the resident's Care Plan, dated 02/20/25, showed: - Resident had oxygen therapy related to ineffective gas exchange with interventions to change the resident's position every 2 hours to facilitate lung secretion movement and drainage. Resident to wear oxygen at 2 liters per minute via nasal cannula continuously; - Did not address the use of a CPAP machine or the settings. Observations of the resident showed: - On 03/16/25 from 12:02 P.M. - 2:59 P.M. and on 03/17/25 from 8:35 A.M. to 2:01 P.M., the resident lay in bed on his/her back and not wearing the oxygen. The oxygen concentrator sat in the corner to the right of the bed with an undated nasal cannula draped over the top of the oxygen concentrator. A CPAP machine sat on the nightstand to the left of the bed with the mask draped over the nightstand; (continued on next page)

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	265472	A. Building B. Wing	03/19/2025

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- On 03/18/25 at 8:33 A.M., the resident lay in bed on his/her back, wearing the CPAP mask, and the CPAP machine on; - On 03/18/25 at 11:05 A.M., the resident lay in bed on his/her back and not wearing the oxygen. The oxygen concentrator sat in the corner to the right of the bed with an undated nasal cannula in a bag on the concentrator. A CPAP machine sat on the nightstand to the left of the bed with the mask draped over the nightstand; - On 03/18/25 at 1:41 P.M., the resident lay in bed and not wearing the oxygen. Certified Medication Technician (CMT) I checked the resident's oxygen saturation which was 88% on room air with the resident's breathing unlabored. CMT I reported to the resident's oxygen saturation to the nurse and the nurse checked the physician orders. The oxygen was placed on the resident via nasal cannula at 2 liters per minute. CMT I rechecked the residents oxygen saturation at 1:45 P.M., and it was 97% on the 2 liters of oxygen. During an interview on 03/18/25 at 2:05 P.M., Licensed Practical Nurse (LPN) A said he/she would follow a physician's order for oxygen. If the order was for continuous oxygen, he/she would expect the oxygen to always be on the resident. The resident should be checked for wearing the oxygen at least once a shift, but should be looked at by staff when walking by rooms, going into rooms, and when providing care. Residents on oxygen should have oxygen saturation checked at least once a shift. Oxygen tubing should be dated and changed weekly, and stored on the machine in a bag when not in use. There should be an order for a CPAP. During an interview on 03/18/25 at 2:15 P.M., the Director of Nursing (DON) said she would expect a physician's orders to be followed. If the order was for continuous oxygen, then oxygen should be on the resident continuously. The resident's oxygen should be monitored during rounds and oxygen saturation should be checked every shift, unless the order specified otherwise, or the resident was having an episode of shortness of breath. There should be a physician's order for CPAP use and the order should show the settings. Oxygen tubing should be changed once a week, and tubing should be dated. The CPAP should be filled with distilled water when needed, cleaned by the nurse, and the mask and tubing should be stored in a bag with the resident's name when not in use. During an interview on 03/19/25 at 1:15 P.M., the Administrator said physician's orders should be followed for oxygen use and should have an order for a CPAP.

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	265472	A. Building B. Wing	03/19/2025

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F 0728 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurse aides who have worked more than 4 months, are trained and competent; and nurse aides who have worked less than 4 months are enrolled in appropriate training. Based on interview and record review, the facility failed to ensure four nurse aides (NAs) (NA B, NA D, NA F and NA G) out of four sampled NAs, completed a nurse aide training program within four months of his/her employment at the facility. The facility's census was 40. Review of the facility's policy titled, Nurse Aide Orientation, revised October 2017, showed: - All newly hired nurse aides must attend an orientation program within their first five days of employment; - The orientation program is not a part of the 75 hour training program and must be completed before the nurse aide begins the training course; - The policy didn't address the time frame the NA must complete the nurse aide training. 1. Review of NA B's personnel file showed: - A hire date of 03/16/24; - NA B completed the nurse aide program, but did not test; - The facility failed to ensure the completion of the program within four months of the hire date. 2. Review of NA D's personnel file showed: - A hire date of 07/05/23; - NA D completed the nurse aide program, but did not test; - The facility failed to ensure the completion of the program within four months of the hire date. 3. Review of NA F's personnel file showed: - A hire date of 10/01/24; - NA F completed the nurse aide program, but did not test; - The facility failed to ensure the completion of the program within four months of the hire date. 4. Review of NA G's personnel file showed: - A hire date of 10/02/24; - NA F completed the nurse aide program, but did not test; - The facility failed to ensure the completion of the program within four months of the hire date. (continued on next page)

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	265472	A. Building B. Wing	03/19/2025

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F 0728 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 03/19/25 at 11:18 A.M., NA G said he/she started working at the facility as a NA at the start of October 2024. He/She didn't start NA classes until January 2025. He/She finished the classes and was waiting to test. During an interview on 03/19/25 at 9:55 A.M., NA D said he/she had started working as a NA a few years ago. He/She didn't start NA classes until January, 2025. He/She finished the classes and was waiting to test. During an interview on 03/19/25 at 11:30 A.M., the Director of Nursing (DON) said NA B, NA D, NA F, and NA G were working in NA positions. During an interview on 03/19/25 at 12:10 P.M., the Administrator said she expected NAs to be certified within four months of hire. The facility had NAs ready to test and the previous administration didn't make that a priority.

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	265472	A. Building B. Wing	03/19/2025

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a plan that describes the process for conducting QAPI and QAA activities. Based on interview and record review, the facility failed to implement a Quality Assurance and Performance Improvement Plan (QAPI - a written plan containing the process that will guide the facility's efforts in assuring care and services are maintained at acceptable levels of performance and continually improved.) The facility census was 40. Review of the facility's policy titled, Quality Assurance and Performance Improvement Program, dated February 2020, showed: - The facility shall develop, implement, and maintain an ongoing, facility-wide, data-driven QAPI program that is focused on indicators of the outcomes of care and quality of life for residents; - The owner and/or governing board of the facility is ultimately responsible for the QAPI program; - The QAPI plan is presented to the state survey agency annually during the recertification survey, and as requested during any other survey. Review showed the facility did not have a QAPI plan implemented containing how they will identify and correct their quality deficiencies, track and measure performance, and establish goals and thresholds for performance measurements. During an interview on 03/19/25 at 12:00 P.M., the Administrator said he just started in January 2025. The facility had the QAPI program shell and policy and procedures in place to follow. He did not have the program up and running yet.

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	265472	A. Building B. Wing	03/19/2025

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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 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. Based on interview and record review, the facility failed to ensure the Quality Assessment and Assurance/Quality Assurance Performance Improvement (QAA/QAPI - a written plan containing the process that will guide the facility's efforts in assuring care and services are maintained at acceptable levels of performance and continually improved) committee developed and implemented an appropriate plan of action to correct identified quality deficiencies. This had the potential to affect all residents in the facility. The facility census was 40. Review of the facility's policy titled, Quality Assurance and Performance Improvement Program, dated February 2020, showed: - The facility shall develop, implement, and maintain an ongoing, facility-wide, data-driven QAPI program that is focused on indicators of the outcomes of care and quality of life for residents; - The owner and/or governing board of the facility is ultimately responsible for the QAPI program; - The QAPI plan is presented to the state survey agency annually during the recertification survey, and as requested during any other survey; The facility did not provide a policy for Performance Improvement Plans (PIPs). Review showed no documentation the facility maintained the minimum required documentation for a QAPI plan or PIPs. During an interview on 03/19/25 at 12:08 P.M., the Administrator said the QAA/QAPI program shell and policy and procedures were in place to follow. The program was not up and running yet. The facility did not have documentation of the QAPI program so no previous PIPs were in place. The Administrator started in January 2025. During an interview on 03/19/25 at 1:20 P.M., the Director of Nursing (DON) said she thought she saw a book with PIPs and but didn't know where it was located.

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	265472	A. Building B. Wing	03/19/2025

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F 0868 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have the Quality Assessment and Assurance group have the required members and meet at least quarterly Based on interview and record review, the facility failed to maintain quarterly Quality Assessment and Assurance/Quality Assurance and Improvement Program (QAA/QAPI - a written plan containing the process that will guide the facility's efforts in assuring care and services are maintained at acceptable levels of performance and continually improved) committee meetings with the required members. The facility census was 40. Review of the facility's policy titled, Quality Assurance and Performance Improvement Program, dated February 2020, showed: - The facility shall develop, implement, and maintain an ongoing, facility-wide, data-driven QAPI program that is focused on indicators of the outcomes of care and quality of life for residents; - The owner and/or governing board of the facility is ultimately responsible for the QAPI program; - The QAPI plan is presented to the state survey agency annually during the recertification survey, and as requested during any other survey; - The QAPI committee reports directly to the administrator; - The QAPI committee oversees implementation of the QAPI plan; - The committee meets monthly to review reports, evaluate data, and monitor QAPI - related activities and make adjustments to the plan; - Did not address who the required committee members should be. Review showed no documentation the facility maintained the minimum required quarterly QAA/QAPI meetings with the required members. During an interview on 03/19/25 at 12:08 P.M., the Administrator said the QAA/QAPI program shell and policy and procedures was in place to follow. The the program was not up and running yet. Therefore, these was no committee to meet until it was implemented. The Administrator started in January 2025.

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	265472	A. Building B. Wing	03/19/2025

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, interview, and record review, the facility failed to maintain proper infection control practices during catheter (a tube inserted into the bladder to drain urine) care for one resident (Resident #4) out of one sampled resident, wound care for three residents (Residents #4, #19, and #33) out of three sampled residents, and incontinent care for two residents (Resident #4 and #34) out of three sampled residents. The facility failed to ensure proper enhanced barrier precautions (EBP) were utilized for three residents (Residents #4, #19, and #33) and to have dedicated disposable supply items for two residents (Residents #4 and #34) out of three sampled residents on EBP. The facility also failed to correctly screen five residents (Residents #2, #4, #9, #25, and #34) for tuberculosis (TB - an infectious disease characterized by the growth of nodules in the tissues, especially the lungs) out of five sampled residents required by state regulation 19 CSR 20-20.100 . The facility census was 61. The facility did not provide an EBP policy. Review of the facility's policy titled, Catheter Care, Urinary, revised August 2022, showed: - Wash and dry your hands thoroughly; - If using bathing wipes, open the package; - Place the wash basin or wipes on the bedside stand within easy reach.; - Put on gloves; - Use a clean washcloth with warm water and soap (or bathing wipe) to cleanse and rinse the catheter from insertion site to approximately four inches outward; - Secure the catheter with a catheter securement device; - Check the drainage tubing and bag to ensure the catheter is draining properly; - Discard disposable items into designated containers. Remove gloves and discard into designated container. Wash and dry your hands thoroughly. Review of the facility's policy titled Wound Care, revision October 2010, showed: - Use disposable cloth (paper towel is adequate) to establish a clean field on the resident's overbed table. Place all items to be used during the procedure on the clean field; - After completion of the wound care: use the clean field saturated with alcohol to wipe the overbed table; wipe reusable supplies with alcohol as indicated (i.e., outsides of containers that were touched by unclean hands, scissor blades, etc.); return the reusable supplies to resident's drawer in the treatment cart; - Take only the disposable supplies that are necessary for the treatment into the room. Disposable supplies cannot be returned to the cart. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265472	A. Building B. Wing	03/19/2025

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 - Few	Review of the facility's policy titled, Screening Residents for Tuberculosis, revised August 2019, showed: - This facility shall screen all residents for TB infection and disease; - The admitting nurse will screen referrals for admission and readmission for information regarding exposure to or symptoms of TB; - If a potential resident has been exposed to active TB or is at increased risk of TB infection, he/she will be screened for latent tuberculosis infection (LTBI) using tuberculin skin test (TST) or interferon gamma release assay (IGRA); - Screening of new admissions or readmissions for TB infection and disease is in compliance with state regulations; - The facility will conduct an annual risk assessment to determine the risk of exposure; - Residents who have health conditions or take medications that predispose them to developing active TB disease, once infected, are tested regularly according to their exposure risk assessment. 1. Observation on 03/17/25 at 1:43 P.M., of Resident #4's catheter care showed: - EBP signage on the door frame; - Certified Nursing Assistant (CNA) H entered the resident's room, did not put on a gown, did not perform hand hygiene, and put on gloves; - CNA H exited the room, did not remove gloves, did not perform hand hygiene, and retrieved wipes from Resident #34's room with EBP signage on the door frame; - CNA H did not remove the gloves, did not perform hand hygiene, and re-entered the resident's room; - CNA H did not remove the gloves, did not perform hand hygiene, and performed the resident's catheter care; - CNA H removed the gloves, did not perform hand hygiene, and touched the resident's blanket; - CNA H did not perform hand hygiene, exited the resident's room, took the trash to the dirty utility closet, walked to the medication room and touched the door knob, walked back to the resident room, and performed hand hygiene; - CNA H failed to have dedicated disposable supplies for the resident on EBP. During an interview on 03/17/25 at 1:50 P.M., CNA H said hands should be sanitized when entering a resident room, when leaving a room, and when going from dirty to clean care. 2. Observation on 03/17/25 at 1:51 P.M., of Resident #34's incontinent care showed: (continued on next page)

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	265472	A. Building B. Wing	03/19/2025

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- EBP signage on the door frame; - CNA H entered the resident's room, put on gloves, did not perform hand hygiene, and did not put on a gown; - CNA H exited the room, did not remove gloves, did not perform hand hygiene, and retrieved wipes from Resident #4's room with EBP signage on the door frame; - CNA H did not remove the gloves, did not perform hand hygiene, and re-entered the resident's room; - CNA H did not remove the gloves, did not perform hand hygiene, and performed the resident's incontinent care; - CNA H failed to have dedicated disposable supplies for the resident on EBP. 3. Observation on 03/17/25 at 2:01 P.M., of Resident #4's wound care treatment, incontinent care, and catheter care showed: - EBP signage on the door frame; - Licensed Practical Nurse (LPN) A entered the resident's room, did not put on a gown, did not perform hand hygiene, and put on gloves; - CNA G entered the room, did not put on a gown, did not perform hand hygiene, did not put on gloves, and exited the room; - CNA G did not put on a gown, did not perform hand hygiene, did not put on gloves, and entered Resident #34's room;34's room with EBP signage on the door frame; - CNA G retrieved a package of wipes, did not perform hand hygiene, and exited the room; - CNA G re-entered Resident #4's room, did not put on a gown, did not perform hand hygiene, and put on gloves; - LPN A performed the wound care treatment; - LPN A held the resident on his/her side and CNA G cleaned the resident's buttocks, removed the gloves, performed hand hygiene, and put on gloves; - LPN A changed gloves, performed hand hygiene, and rolled the resident to his/her back; - CNA G cleaned the resident's front peri area, changed gloves, performed hand hygiene, and wiped the catheter toward the insertion point during catheter care; - LPN A put a clean brief on the resident, pulled up the blanket, removed the gloves, and performed hand hygiene; - CNA G removed the gloves, did not perform hand hygiene, picked up the trash, took the trash down (continued on next page)

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	265472	A. Building B. Wing	03/19/2025

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the hall to the dirty utility closet, and performed hand hygiene. During an interview on 03/19/25 at 11:15 A.M., LPN A said hands should be sanitized when walking into a resident room, leaving, in between care, when changing gloves, and when going from dirty to clean tasks. The catheter should be cleaned away from the insertion point. Supplies shouldn't be shared between residents. During an interview on 03/19/25 at 12:00 P.M., CNA G said hands should be sanitized when walking into a resident room, leaving, in between care, when changing gloves, and when going from dirty to clean tasks. The catheter should be cleansed away from insertion point. 4. Observation on 03/18/25 at 2:43 P.M., of Resident #19's wound care showed: - EBP signage on the door frame; - The Director of Nursing (DON) and LPN A did not put on a gown and entered the resident's room with the wound care supplies; - LPN A put the shared wound care supplies, which included a roll of tape and a bottle of wound cleanser, on the bed without a clean barrier; - The DON and LPN A performed hand hygiene and put on gloves; - LPN A performed the wound care treatment; - LPN A removed the gloves and performed hand hygiene; - LPN A picked up the roll of tape and the wound cleanser, did not cleanse them, and put them back into the treatment cart. 5. Observation on 03/18/25 at 2:49 P.M., of Resident #4's wound care treatments showed: - EBP signage on the door frame; - LPN A and CNA H entered the resident's room and did not put on gowns; - CNA H and LPN A performed hand hygiene and put on gloves; - LPN A placed the wound care supplies, which included a container of Medihoney (a type of wound treatment); a roll of tape; and a bottle of wound cleanser, on the unsanitized bedside table and without a clean barrier; - LPN A performed the wound care treatments; - LPN A removed the gloves and performed hand hygiene; - LPN A picked up the Medihoney container, the roll of tape, and the wound cleanser bottle, did not cleanse them, and put them back into the treatment cart. (continued on next page)

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	265472	A. Building B. Wing	03/19/2025

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	6. Observation on 03/18/25 at 3:02 P.M., of Resident #33 wound care treatment showed: - EPB signage on the door frame; - LPN A did not put on a gown and entered the room; - LPN A performed hand hygiene and put on gloves; - LPN A placed the wound care supplies, which included a container of Medihoney; a roll of tape; and a bottle of wound cleanser, on the unsanitized bedside table and without a clean barrier; - LPN A cleansed the wounds and sat the wound cleanser bottle on the floor; - LPN A changed gloves, performed hand hygiene, and used the scissors that lay on the bed without a clean barrier to cut the PolyMem (a type of wound dressing), and placed the scissors back on the bed without a clean barrier; - LPN A performed the wound care treatments; - LPN A removed the gloves, performed hand hygiene, picked up the scissors from the bed without a clean barrier, and put them into his/her clothes pocket; - LPN A picked up the Medihoney container, the roll of tape, and the wound cleanser bottle, did not cleanse them, and put them back into the treatment cart. 7. Review of Resident #2's medical record showed: - admit date of 07/06/24; - TB first step TST, dated 08/20/24, with a result of 0 millimeters (mm) and no read date. 8. Review of Resident #4's medical record showed: - admit date of 02/10/25; - No documentation of an admission TST or screening completed. 9. Review of Resident #9's medical record showed: - admit date of 12/15/22; - No documentation of an annual TST or screening completed. 10. Review of Resident #25's medical record showed: - admission dated of 11/02/22; - No documentation of an annual TST or screening completed. (continued on next page)

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	265472	A. Building B. Wing	03/19/2025

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 - Few	11. Review of Resident #34's medical record showed: - admission dated of 07/18/23; - No documentation of an annual TST or screening completed. During an interview on 03/19/25 at 11:50 P.M., the DON said hands should be sanitized when entering a resident room, leaving, between care, when going from dirty to clean tasks, and between glove changes. Wound supplies should not be placed on a resident bed or bedside table, but on a clean area. Gloves should be changed between care and when going from dirty to clean tasks. Catheters should be cleaned away from the insertion point. A resident should receive a two step TB. One upon admission and the second three weeks later. A TST should be read within 72 hours of administration. EBP should be worn when providing care for a resident with wounds, catheters, and any other indwelling devices. She expected the staff to not share supplies between residents, especially when they were on EBP. During an interview on 03/19/25 at 12:15 P.M., the Administrator said he expected staff to follow policy and procedure regarding infection control, catheter care, administration of TB, and EBP.

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	265472	A. Building B. Wing	03/19/2025

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement a program that monitors antibiotic use. Based on interview and record review, the facility failed to maintain an Infection Prevention and Control Program (IPCP) that included an antibiotic stewardship program to include an infection surveillance program and antibiotic use protocols. The facility failed to identify an appropriate indication for use of an antibiotic for one resident (Resident #19) out of one sampled resident who was currently being treated with an antibiotic. This deficient practice had the potential to affect all residents in the facility. The facility census was 40. Review of the facility's policy titled, Antibiotic Stewardship, revised December 2016, showed: - Antibiotics will be prescribed and administered to the residents under the guidance and the facility's Antibiotic Stewardship Program; - The purpose of the Antibiotic Stewardship Program is to monitor the use of antibiotics in the residents. Review of the Antibiotic Stewardship Program binder showed: - Incomplete documentation related to the appropriate indication of antibiotic use; - Did not include lab reports/findings. Review of the facility's Matrix (a listing of all facility residents), dated 03/17/25, showed: - Five residents currently received antibiotics. 1. Review of Resident #19's Physician Order Sheet, dated March 2025, showed: - An order for doxycycline hyclate (an antibiotic medication) 100 milligram (mg) by mouth one time a day for wound infection for 10 days, start date of 3/12/25; - An order for Flagyl (an antibiotic medication) 500 mg by mouth two times a day every 7 day(s) for diarrhea related to unspecified infectious disease 03/14/2025, start date of 03/07/25. Review of the resident's Nurse's Notes showed: - On 03/10/25 at 10:00 A.M., the resident complained of increased pain and not feeling well overall. Requested to be sent to the emergency department for evaluation. Emergency Medical Services arrived at at the facility to transport the resident to the hospital; - On 03/11/25 at 9:16 A.M., the resident continued to be monitored for antibiotic use related to loose fecal material. The resident had a general complaint of not feeling well; - On 03/12/25 at 9:26 A.M., the resident continued to be monitored for antibiotic use related to loose fecal material and cellulitis (a skin infection). The resident had no signs and symptoms of adverse reaction and no complaints of pain or discomfort; - On 03/12/25 at 9:39 P.M., the resident continued on an antibiotic for wound infection and no (continued on next page)

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	265472	A. Building B. Wing	03/19/2025

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	adverse reactions noted at this time; - On 03/13/25 at 5:35 A.M., the resident continued to be monitored related to the antibiotic use. The wound was weeping (the release of fluids from the tissue) and an odor noted. The resident complained of not feeling well. Redness noted to the thigh and abdomen. Resident continued on Flagyl and doxycycline. The resident had no further complaint of loose fecal material. During an interview on 03/18/25 at 2:50 P.M., the Director of Nursing (DON) said Resident #19 didn't have a stool culture for the Flagyl. The resident took Senna (stool softener) and started having diarrhea. They stopped the Senna and the diarrhea stopped. The Flagyl order came from the medical director for the diarrhea. The resident was started on doxycycline from the hospital for a wound infection on the leg. They did not have a would culture or the hospital records to show if one was completed. During an interview on 03/19/25 at 12:20 P.M., the Administrator said he would expect the facility to follow policy and procedures for an ICPC. Cultures and labs should be done as ordered and as expected with standard practice. Hospital records should be followed up on.

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	265472	A. Building B. Wing	03/19/2025

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. Based on interview and record review, the facility failed to document pertinent education provided to the resident or the resident's representative regarding benefits, side effects, or warnings of the influenza (a viral respiratory infection) vaccine for four residents (Residents #2, #4, #25, and #34) and for the pneumococcal (an infectious lung disease) vaccine for three residents (Residents #4, #25, and #34) and administered the pneumococcal vaccine to one resident (Resident #2) who refused the vaccine out of five sampled residents. The facility's census was 40. Review of the facility's policy titled, Influenza Vaccine, revised March 2022, showed: - All residents who have no medical contraindications to the vaccine will be offered the influenza vaccine annually to encourage and promote the benefits associated with vaccinations against influenza; - The facility shall provide pertinent information about the significant risks and benefits of vaccines to residents (or residents' legal representatives); - Between October 1st and March 31st each year, the influenza vaccine shall be offered to residents, unless the vaccine is medically contraindicated or the resident has already been immunized; - Residents admitted between October 1st and March 31st shall be offered the vaccine five working days of the resident's admission to the facility; - Prior to the vaccination, the resident (or resident's legal representative) or employee will be provided information and education regarding the benefits and potential side effects of the influenza vaccine. Provision of such education shall be documented in the resident's/employee's medical record; - For those who receive the vaccine, the date of vaccination, lot number, expiration date, person administering, and the site of the vaccination will be documented in the resident's medical record; - A resident's refusal of the vaccine shall be documented on the informed consent for the influenza vaccine and placed in the resident's medical record; - Residents may obtain their influenza vaccines from their personal physicians. Documentation of previous vaccinations should be provided to the facility. Review of the facility's policy titled, Pneumococcal Vaccine, revised March 2022, showed: - All residents are offered pneumococcal vaccines to aid in preventing pneumonia/pneumococcal infections; - Prior to or upon admission, residents are assessed for eligibility to receive the pneumococcal vaccine series, and when indicated, are offered the vaccine series within 30 days of admission to the facility unless medically contraindicated or the resident has already been vaccinated; - Assessments of pneumococcal vaccination status are conducted within five working days of the (continued on next page)

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	265472	A. Building B. Wing	03/19/2025

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	resident's admission if not conducted prior to admission; - Before receiving a pneumococcal vaccine, the resident or legal representative receives information and education regarding the benefits and potential side effects of the pneumococcal vaccine. Provision of such education is documented in the resident's medical record; - Residents/representatives have the right to refuse vaccination. If refused, appropriate information is documented in the resident's medical record indicating the date of the refusal of the pneumococcal vaccination; - For each resident who receives the vaccine, the date of vaccination, lot number, expiration date, person administering, and the site of vaccination are documented in the resident's medical record. 1. Review of Resident #2's medical record showed: - admission date of 07/06/24; - Influenza vaccination administered on 10/27/24; - Refusal of the pneumoccoccal vaccine, dated 01/23/23; - Prevnar 20 (pneumococcal vaccination), administered 01/26/23; - No documentation the facility provided information, education, and received consent for the influenza vaccination; - Facility provided the pneumococcal vaccination after the refusal for the pneumonia vaccine was given. 2. Review of Resident #4's medical record showed: - admission date of 02/10/25; - No documentation the facility provided information and education for the influenza or pneumococcal vaccinations; - No documentation of consent or refusal for the influenza or pneumococcal vaccinations; - No documentation the influenza or the pneumococcal vaccinations were administered or refused. 3. Review of Resident #25's medical record showed: - admission date of 11/09/22; - No documentation the facility provided information and education for the influenza or pneumococcal vaccinations in 2024 and 2025; - No documentation of the consent or refusal for the influenza or pneumococcal vaccinations in 2024 and 2025; (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265472	A. Building B. Wing	03/19/2025

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- No documentation the influenza or the pneumococcal vaccinations were administered in 2024 and 2025. 4. Review of Resident #34's medical record showed: - admission date of 07/18/23; - Influenza vaccination administered on 10/27/24; - No documentation the facility provided information and education for the influenza or pneumococcal vaccinations; - No documentation of consent or refusal for the influenza or pneumococcal vaccinations; - No documentation the pneumococcal vaccinations had been administered or refused. During an interview on 03/19/25 at 1:23 P.M., the Director of Nursing (DON) said vaccinations were offered on admission, annually, and when the facility provided them. The residents and/or resident's representatives received the risks, benefits, education, and consent forms to show acceptance or declination of the vaccinations.

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	265472	A. Building B. Wing	03/19/2025

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. Based on interview and record review, the facility failed to ensure the COVID-19 (an infectious disease caused by a virus that could cause some people to become seriously ill and require medical attention) vaccination was offered, administered, or refused by the resident and/or resident's representative for three residents (Residents #2, #4 and #34) out of five sampled residents. The facility's census was 40. Review of the facility's policy titled, Coronavirus Disease (COVID-19) - Vaccination of Residents, revised May 2023, showed: - Each resident is offered the COVID-19 vaccine unless the immunization is medically contraindicated or the resident is fully vaccinated; - COVID-19 vaccine education, documentation, and reporting are overseen by the infection preventionist (IP) and coordinated by his or her designee; - Before the COVID-19 vaccine is offered, the resident is provided with education regarding the benefits, risk, and potential side effects associated with the vaccine; - Information is provided to the resident in a format and language that is understood by the resident or representative; - Residents must sign a consent to vaccinate form prior to receiving the vaccine; - A vaccine administration record is provided to the resident and a copy is filed in the resident record; - The resident's medical record includes documentation that indicates, at a minimum, the following: the resident or resident representative was provided education regarding the benefits and potential risk associated with COVID-19 vaccine, including the samples of the educational materials used, the date the education took place, and the name of the individual who received the education; signed consent; and each dose of COVID-19 vaccine that was administered to the resident; - If the resident did not receive the COVID-19 vaccine due to medical contraindications, prior vaccination, or refusal, appropriate documentation is made in the residents record. 1. Review of Resident #2's medical record showed: - admission date of 07/06/24; - Diagnoses of metabolic encephalopathy (an alteration of brain function resulting from other internal organ failure), chronic obstructive pulmonary disease (COPD - a chronic inflammatory lung disease that causes obstructed airflow from the lungs), schizophrenia (a long term mental disorder that affects a person's ability to think, feel, or behave clearly, sometimes including delusions or hallucinations), hypertension (high blood pressure), major depressive disorder (MDD - long-term loss of pleasure or interest in life), panic disorder (repeated, unexpected panic attacks and worry constantly (continued on next page)

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	265472	A. Building B. Wing	03/19/2025

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For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	about when the next one might happen), anxiety disorder (persistent worry and fear about everyday situations), and hearing loss; - No documentation the COVID-19 vaccination education was provided; - No documentation the COVID-19 vaccination was administered or refused. 2. Review of Resident #4's medical record showed: - admission date of 02/10/25; - Diagnoses of hematogenous osteomyelitis (a type of bone infection), heart failure (a condition that develops when your heart doesn't pump enough blood for your body's needs), and dementia (a disorder marked by memory loss, personality changes, and impaired reasoning that interferes with daily functioning); - No documentation the COVID-19 vaccination education was provided; - No documentation the COVID-19 vaccination was administered or refused. 3. Review of Resident #34's medical record showed: - admission date of 07/18/23; - Diagnoses of Alzheimer's disease (progressive mental deterioration), cerebral infarction (a stroke), atrial fibrillation (heart beats out of rhythm), and hypertension; - No documentation the COVID-19 vaccination education was provided; - No documentation the COVID-19 vaccination was administered or refused. During an interview on 03/19/25 at 1:23 P.M., the Director of Nursing (DON) said the COVID-19 vaccinations were offered on admission, annually, and/or when the facility provided them. The residents and/or the resident's representatives received the risk and benefits and education and consent forms to show to accept or decline the vaccination.