STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265476	A. Building B. Wing	06/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sunrise Nursing & Rehabilitation	600 E Sunrise Drive Raymore, MO 64083

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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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to notify a resident's responsible party when changes to his/her medication orders were changed for one sampled resident (Resident #80) out of 27 sampled residents. The facility census was 134 residents. Review of the facility's Change of Condition Notification policy dated June 2020 showed: -Purpose was to ensure residents and resident representatives are notified of changes in condition in a timely manner. -A change of condition included changes in treatment. -Staff were to document the notification in the resident's medical records. 1. Review of Resident #80's admission Record showed he/she: -Was admitted to the facility on [DATE]. -Had a medical Power of Attorney (POA- a person previously identified to make decisions for an individual in the event of inability to make wishes known). -Had diagnoses that included stroke, dementia (a progressive organic mental disorder characterized by chronic personality disintegration, confusion, disorientation, stupor, deterioration of intellectual capacity and function, and impairment of control of memory, judgment, and impulses), and a state of decline due to chronic medical conditions leading to weight loss, decreased appetite, poor nutrition, and inactivity. Review of the resident's Consultant Pharmacist Recommendation to Physician dated 12/18/24 showed: -The resident had been using Sertraline (an antidepressant) 50 milligrams (mg) every day since 2/2/24. If this therapy was required to prevent future depressive episodes, please document to that effect in your progress notes. -A check mark was next to Change Sertraline therapy as follows: Sertraline 25 mg every day, indicating a positive response to the recommendation. -The form was signed by the primary care provider and dated 12/18/24. (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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the resident's Telephone Order Sheet (TOS) dated 12/29/24 showed: -Telephone order from the resident's physician to discontinue Sertraline 50 mg at bedtime for depression with a reason of Gradual Dose Reduction (GDR). -Telephone order from the resident's physician to start Sertraline 25 mg in the evening for depression, GDR from 50 mg. Review of the resident's electronic medical record dated December 2024 and January 2025 showed no documentation the facility staff notified the resident's responsible party Sertraline was decreased from 50 mg daily to 25 mg daily. Review of the resident's Consultant Pharmacist Recommendation to Physician dated 3/25/25 showed: -The resident had been taking Quetiapine (an atypical antipsychotic used to treat depression) 50 mg twice daily and Rexulti (an atypical antipsychotic that could be used to treat depression) 2 mg daily since 9/2/24. -An X was next to Reduce the dose of Quetiapine to 25 mg twice daily, indicating a positive response to the recommendation. -An X was next to Reduce the dose of Rexulti to 1.5 mg (1 mg tablet + 0.5 mg tablet) daily, indicating a positive response to the recommendation. -The form was singed by the primary care provided but was not dated. Review of the resident's TOS dated 4/3/25 showed: -Discontinue Quetiapine 50 mg twice daily with a reason GDR. -Start Quetiapine 25 mg twice daily for mood/behavior GDR from 50 mg. -Discontinue Rexulti 2 mg daily for agitation with a reason GDR. -Start Rexulti 0.5 mg and start Rexulti 1.5 mg to equal 1.5 mg daily for agitation, GDR from 2 mg. Review of the resident's electronic medical record dated March 2025 and April 2025 showed no documentation the facility staff notified the resident's responsible party Quetiapine was decreased from 50 mg daily to 25 mg daily or Rexulti was decreased from 2 mg to 1.5 mg daily. Review of the resident's Consultant Pharmacist Recommendation to Physician dated 5/20/25 showed: -The resident had been using Mirtazapine (an antidepressant that could be used as an appetite stimulant) 7.5 mg at bedtime since 5/8/24. The resident's weight was 130 pounds (lbs), a 10 lb gain in the last six months. -An X was next to Change Mirtazapine to 7.5 mg every other day at bedtime, indicating a positive response to the recommendation. (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the resident's TOS dated 5/23/25 showed: -Discontinue Mirtazapine 7.5 mg every night for depression. -Start Mirtazapine 7.5 mg every other day for depression GDR from every night at bedtime. Review of the resident's electronic medical record dated May 2025 and June 2025 showed no documentation the facility staff notified the resident's responsible party Mirtazapine was decreased from 7.5 mg every night to 7.5 mg every other night. During an interview on 6/26/25 at 10:59 A.M., Licensed Practical Nurse (LPN) E said: -The Assistant Director of Nursing (ADON) completed the monthly drug reviews. -Any change in medication should be documented in the resident's electronic medical record. During an interview on 6/26/25 at 12:04 P.M., ADON B said: -Monthly Drug Regimen Reviews (Consultant Pharmacist Recommendation to Physician) are reviewed by him/her each month. -He/She would look for physician notes related to recommendations and would document family notification if there were any changes. -Family and/or responsible party's should be notified when there was a change in medication therapy. -Notifications should be documented in the resident's electronic medical record. -He/She could not find any documentation the resident's responsible party was notified of any of the medication changes in December 2024, March 2025, or May 2025. During an interview on 6/26/25 at 1:05 P.M., the Director of Nursing (DON) said: -He/She initially received any pharmacy recommendations, then he/she forwarded the recommendations to the ADON of the unit the resident resided on for follow up. -He/She expected family and/or the resident's responsible party to be notified of any changes in medications. -He/She expected staff to document the notification in the resident's electronic medical record.

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures to prevent abuse, neglect, and theft. Based on interview and record review, the facility failed to ensure a Family Care Safety Registry (FCSR) screening was completed per facility policy for three newly hired employees (Employee #1, #2, and #4) out of 10 newly hired employees. This deficient practice had the potential to affect all residents residing in the facility. The facility census was 134 residents. Review of the facility Background Check Policy dated 2/2025 showed: -Candidates for all staffing positions are subject to background checks. -The Department of Human Resources is responsible for the general administration and implementation of this policy. 1. Review of Employee #1's Employee File showed: -His/Her hire date was 8/28/24. -A FCSR was completed on 9/24/24, one month after the employee was hired. 2. Review of Employee #2's Employee File showed: -His/Her hire date was 7/24/24. -A FCSR was completed on 9/24/24, two months after the employee was hired. 3. Review of Employee #4's Employee File showed: -His/Her hire date was 10/2/24. -No documentation a FCSR was completed for this employee. 4. During an interview on 6/26/25 at 11:39 A.M., the Administrator said: -He/She had no documentation a FCSR was completed on Employee #4. -He/She thought it was missed because the employee had a name change around the time he/she was hired. -He/She was not sure why Employee #1 and Employee #2's FCSR were not completed prior to hire, they were just run late. -He/She would expect all background checks, including the FCSR, to be completed prior to the employee's date of hire. During an interview on 6/26/25 at 12:11 P.M., the Human Resources Director said: -He/She was responsible for completing all FCSR checks prior to the employee's start date. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-He/She submitted the employee's information to a third party vendor to complete the FCSR. The third party vendor would email him/her if no information was found so he/she could update the employee file. -When the checks come through, he/she would update, print, and place in the employee file. -All background checks, including FCSR, should be completed before the staff person started working. -He/She could not find a FCSR for Employee #4. He/She thought there may have been a communication error due to the employee having a name change.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. Based on observation, interview, and record review, the facility failed to ensure that professional standards were met when Certified Medication Technician (CMT) B pre-popped and signed as given prior to administration the medications for three supplemental residents (Resident #6, #56, and #400) out of four supplemental residents. This practice had the potential to affect all residents in the 700 hall. The facility census was 134 residents. Review of the facility's undated policy titled Medication-Administration showed: -The purpose of the policy was to provide practice standards for safe administration of medications for residents in the facility. -The time and dose of the drug or treatment administered to the resident would be recorded in the resident's individual medication record by the person who administered the drug or treatment. -There was no specific policy related to pre-popping medications. 1. Review of Resident #6's admission Record showed that he/she admitted to the facility with a diagnosis of Unspecified Dementia (a progressive organic mental disorder characterized by chronic personality disintegration, confusion, disorientation, stupor, deterioration of intellectual capacity and function, and impairment of control of memory, judgement, and impulses), Unspecified Severity, Without Behavioral Disturbance, Psychotic Disturbance, Mood Disturbance, and Anxiety. Observation on 6/24/25 at 7:59 A.M. of the resident's medication pass completed by CMT B showed: -CMT B removed the resident's medications out of the top drawer of the medication cart. -The resident's medications were in a 30 milliliter (ml) cup and the cup was labeled with the resident's room number and/or last name. -The resident's medications were already marked as administered in the resident's Electronic Medical Record (EMR) prior to the medications being given to the resident. 2. Review of Resident #56's admission Record showed he/she admitted to the facility with a diagnosis of Unspecified Dementia, Unspecified Severity, Without Behavioral Disturbance, Psychotic Disturbance, Mood Disturbance, and Anxiety. Observation on 6/24/25 at 8:03 A.M. of the resident's medication pass completed by CMT B showed: -CMT B checked the resident's blood pressure. -CMT B returned to the medication cart and removed the resident's medications out of the top drawer of the medication cart. -The resident's medications were in a 30 ml cup and the cup was labeled with the resident's room number and/or last name. -The resident's medications were already marked as administered in the resident's EMR prior to the (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	medications being given to the resident. 3. Review of Resident #400's admission Record showed he/she admitted to the facility with a diagnosis of Unspecified Dementia, Unspecified Severity, Without Behavioral Disturbance, Psychotic Disturbance, Mood Disturbance, and Anxiety. Observation on 6/24/25 at 8:06 A.M. of the resident's medication pass completed by CMT B showed: -CMT B returned to the medication cart and removed the resident's medications out of the top drawer of the medication cart. -The resident's medications were in a 30 ml cup and the cup was labeled with the resident's room number and/or last name. -The resident's medications were already marked as administered in the resident's EMR prior to the medications being given to the resident. -The resident began to crush the resident's medications. 4. Observation on 6/24/25 at 8:08 A.M. of the top drawer of the 600/700 hall medication cart showed what appeared to be all of the 700 hall residents' medications pre-popped and placed in 30 ml cups and were labeled with the residents' room numbers and/or last names. During an interview on 6/24/25 at 8:08 A.M. CMT B said that he/she had pre-popped all of the residents' medications prior to beginning his/her 700-hall medication pass. 5. During an interview on 6/24/25 at 8:14 A.M. Assistant Director of Nursing (ADON) A said: -What CMT B did was not acceptable. -Medications should never be pre-popped and need to be signed as given after they are admistered to the resident. During an interview on 6/24/25 at 11:09 A.M. CMT B said: -He/She had marked all of the residents' medications as administered prior to starting the 700-hall medication pass. -He/She usually marked medications such as eye drops and supplements as administered before his/her medication pass because those were the medications that the residents were guaranteed to take. -He/She usually waited to mark blood pressure medications as administered until he/she knew that the resident needed the blood pressure medication. -He/She normally did not pre-pop his/her medications prior to starting his/her medication pass. -He/She did not have a reason as to why he/she decided to pre-pop the medications before the medication pass that day. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Medications should not be pre-popped before starting a medication pass. -Medications should be taken out of their containers or packets at the time of each resident medication administration. During an interview on 6/25/24 at 2:54 P.M. CMT C said: -Medications should never be pre-popped before the start of a medication pass. -If medications were pre-popped, it could lead to medications errors. -Medications should be marked as administered after the medication was given and not before because residents could refuse their medications. During an interview on 6/26/25 at 10:17 A.M. Licensed Practical Nurse (LPN) C said: -Medications should never be pre-popped before the start of a medication pass. -Pre-popping medications could lead to medication errors. -Medications should not be marked as administered prior to administering the medications. -Residents could refuse their medications or could not need a medication based off of their vital signs, which would be why the medications should not be pre-popped or marked as administered prior to giving them. During an interview on 6/26/25 at 1:30 P.M. the Director of Nursing (DON) said: -Medications should never be pre-popped. -There were multiple safety concerns that could lead to negative resident outcomes if medications were pre-popped before medication pass. -Pre-popping medications was against facility policy. -Medications should be taken out of their original containers and packages at the time of administration. -Medications should not be marked as administered prior to the resident getting the medication. -The reason why medications should not be marked as given prior to administering the medications was residents could refuse the medication or simply not be given at all.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on interview and record review, the facility failed to ensure quarterly smoking assessments were completed per facility policy for one sampled resident (Resident #24) out of 27 sampled residents. The facility census was 134 residents. Review of the facility's policy titled Smoking by Residents dated November 2023 showed: -Residents who wanted to smoke would be assessed for their ability to smoke safely prior to being allowed to smoke independently in the designated smoking areas. -Residents who were not able to smoke independently and safely would be accompanied by facility staff while smoking. -All residents who smoked were to be assessed related to smoking safety at the time of admission and then at least quarterly thereafter. 1. Review of Resident #24's admission Record showed that he/she admitted to the facility with the following diagnoses: -Quadriplegia (paralysis of all four limbs). -Tobacco use. Review of the resident's Safe Smoking Evaluation dated 1/3/25 showed: -The resident currently smoked. -The resident was not able to independently light smoking materials safely. -The resident could not extinguish smoking materials completely in an appropriate receptacle. -The resident could not dispose of ashes or other tobacco-related residue appropriately. -The resident required direct supervision while smoking. Review of the resident's annual Minimum Data Set (MDS- a federally mandated assessment instrument completed by facility staff for care planning) dated 4/19/25 showed the resident currently used tobacco. Review of the resident's care plan dated 5/9/25 showed: -The resident smoked and had the following interventions in place. --The resident required a cigarette holder while smoking. --Protective gear was given and demonstrated to the resident. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	--The resident required supervision while smoking. During an interview on 6/25/25 at 2:04 P.M. the resident said: -He/She currently used tobacco. -He/She did not smoke at every designated smoke time. -He/She did not have a normal schedule that he/she followed related to his/her smoking habits. -He/She had to be supervised while smoking and wore an apron. During an interview on 6/26/25 at 10:12 A.M. Licensed Practical Nurse (LPN) C said: -He/She was unsure if the resident currently smoked, but the resident had smoked in the past. -The smoking assessments needed to be completed quarterly. -Nurses could perform the smoking assessments. -The resident should have had another smoking assessment completed by the time of the interview. During an interview on 6/26/25 at 10:57 A.M. Assistant Director of Nursing (ADON) A said: -The resident smoked from time to time. -He/She did the smoking assessments. -The smoking assessments were done upon admission and quarterly thereafter. -The electronic medical charting system that the facility used had been reset at the beginning of the year which could have affected the timing of the smoking assessments. -When the smoking assessments were due, they usually auto-populated, but the staff had been editing the schedules once they realized certain assessments were not showing up on the charting system appropriately. -The resident should have had an additional smoking assessment completed by the time of the interview. During an interview on 6/26/25 at 11:44 A.M. the Director of Nursing (DON) said: -The facility's electronic medical charting system had been updated at the beginning of the year. -All of the residents' assessments needed to be re-triggered in the system due to the update. During an interview on 6/26/25 at 1:30 P.M. the DON said: -He/She was unsure when the resident's last smoking assessment had been completed. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-He/She was unsure if the resident still smoked because he/she had not physically seen the resident smoke in over a year. -The smoking assessments were completed quarterly. -He/She did not think that the resident needed another smoking assessment completed because he/she did not think the resident smoked at that time. -If the resident still smoked then another smoking assessment would need to be completed.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure hand hygiene during catheter (a hollow, partially flexible tube inserted into the bladder to drain urine) care; and failed to ensure the catheter bag was maintained below the level of the bladder for one sampled resident (Resident #37) out of 27 sampled residents. The facility census was 134 residents. Review of the facility undated Catheter Care policy showed: -A resident with a catheter receives care and services to prevent infections to the extent possible. -Wash hands and put on gloves prior to handling the catheter, drainage system or bag. -Position the catheter drainage system and bag utilizing gravity to facilitate drainage. -Always keep the urine collection bag below the level of the bladder. Review of the facility Handwashing/Hand Hygiene policy dated August 2019 showed: -Use an alcohol-based hand rub, or soap and water before and after handling an invasive device, including a urinary catheter. 1. Review of Resident #37's admission Record showed: -He/she was admitted to the facility on [DATE]. -He/she had a diagnosis of neuromuscular dysfunction of bladder (bladder control problems caused by nerve damage affecting the communication between the brain, spinal cord, and bladder). Review of the resident's care plan dated 10/3/23 showed: -He/she had a catheter. -Position the catheter bag below the level of his/her bladder. -He/she refused to have his/her catheter bag lowered. -He/she hung his/her catheter bag off the side of his/her wheelchair. -He/she had been educated on the importance of keeping his/her catheter bag below his/her bladder level. Review of the resident's Physician's Summary Report (POS) dated June 2025 showed catheter care every shift. Observation on 6/19/25 at 1:35 P.M. showed: (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The resident was seated in his/her wheelchair in the main dining room. -His/her catheter bag was attached to the arm of his/her wheelchair above the level of his/her bladder. Observation on 6/23/25 at 12:05 P.M. showed: -The resident was seated in his/her wheelchair in the main dining room. -His/her catheter bag was attached to the arm of his/her wheelchair above the level of his/her bladder. Observation on 6/24/25 at 10:34 A.M. showed: -The resident was seated in his/her wheelchair in the main dining room. -His/her catheter bag was attached to the arm of his/her wheelchair above the level of his/her bladder. -Certified Nursing Assistant (CNA) C completed hand hygiene and put on gloves, placed the resident's catheter bag onto his/her lap and hooked it onto a gait belt around the resident's mid-torso and assisted in transferring the resident to his/her bed and then removed the resident's lower clothing and brief. -Without first removing his/her gloves, washing/sanitizing his/her hands and putting on new gloves, CNA C completed the resident's catheter care and then assisted in putting on a new brief and the resident's lower clothing. During an interview on 6/24/25 at 10:57 A.M. CNA C said: -He/she had not removed his/her gloves, washed his/her hands and put on new gloves just before he/she completed the resident's catheter care. -He/she usually did wash his/her hands and put on gloves right before doing a resident's catheter care. He/she had been nervous because of being watched. -He/she hooked the resident's catheter bag onto the gait belt so that the catheter tubing would not pull on the resident's catheter. -He/she should have hooked the resident's catheter bag onto his/her bedframe so that it would be below his/her bladder. -The resident's catheter bag should be attached low on his/her wheelchair. -The resident always wanted his/her catheter bag hooked on his/her wheelchair arm. During an interview on 6/26/25 Licensed Practical Nurse (LPN) F said: -The resident's catheter bag should always be below the level of his/her bladder. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The resident refused to have his/her catheter anywhere else but hooked on the arm of his/her wheelchair or on top of his/her bed during the day shift. -He/she had spoken to the resident about keeping his/her catheter bag below the level of his/her bladder but had not documented it in the resident's medical record. -Before touching and cleansing the resident's catheter staff were always to remove gloves and perform hand hygiene, then put on clean gloves. -The CNA's should always keep the resident's catheter bag below the level of his/her bladder during all care. Review of requested documentation over a twelve month period of teaching the resident the importance of keeping his/her catheter bag below the level of his/her bladder showed one document dated 6/25/25 showed the Assistant Director of Nursing (ADON) had reeducated the resident on the importance of keeping his/her catheter below the level of his/her bladder. During an interview on 6/26/25 at 1:10 P.M. The Director of Nursing (DON) said: -The resident's catheter bag was to be below the level of his/her bladder at all times. -The licensed nurses should document they had done teaching with the resident regarding the importance of keeping his/her catheter bag below the level of his/her bladder at least once a month. -During catheter care, nursing staff should always complete hand hygiene and put on clean gloves just before cleansing the insertion site and the resident's catheter.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to store nebulizers (a drug delivery device used to administer medication in the form of a mist inhaled into the lungs) and a nasal cannula (a device that gives you additional oxygen (supplemental oxygen or oxygen therapy) through your nose) in a bag for three sampled residents (Resident #48, #41, and #105); and failed to complete a periodic assessment for one sampled resident's (Resident #63) ability to self-administer his/her respiratory care, including tracheostomy (trach - an opening surgically created through the neck into the windpipe; a tube is usually placed through this opening to provide an airway and to remove secretions) out of 27 sampled residents. The facility census was 134 residents. Review of facility policy titled Respiratory Care Policy revised January 2025 showed: -Ensure that residents had comprehensive respiratory care provided to enhance resident safety and promote optimal respiratory health. -Respiratory care included services prescribed by a physician or a non-physician practitioner for the assessment, diagnostic evaluation, treatment, management and of residents with deficiencies and abnormalities. -Ensure proper storage of all respiratory equipment. 1. Review of Resident #48's admission Record showed he/she was admitted to the facility on [DATE]. Review of the resident's care plan dated 5/8/25 showed that the resident's use of a nebulizer was not addressed. Review of the resident's Order Summary Report (OSR) dated June 2025 showed a physician order for DuoNeb 0.5 milligram (mg)-2.5 mg/3 milliliter (ml) (a medication that works by opening your airways and reducing inflammation in your lungs to help you breathe) give one vial every six hours for upper respiratory infection. Observation on 6/22/25 at 12:55 P.M. in the resident's room showed the nebulizer laying on a bedside table not stored in plastic bag, but the plastic bag was next to the nebulizer. Observation on 6/23/25 at 10:13 A.M. in the resident's room showed the nebulizer laying on the resident's bedside table not in a plastic bag. Observation on 6/23/25 at 11:05 A.M. in the resident's room showed the nebulizer not in plastic bag just sitting on the bedside table. 2. Review of Resident #41's admission Record showed he/she was admitted to the facility on [DATE]. Review of the resident's care plan dated 5/22/25 showed: -Supplemental oxygen was not addressed in the care plan. -Whether the resident was compliant or noncompliant with storage of his/her nasal cannula was not (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	addressed. Review of the resident's Order Summary Report dated June 2025 showed an order for oxygen at two to five liters per minute via a nasal cannula as needed to maintain oxygen saturation above 90% and the order was dated 12/15/24. Observation on 6/22/25 at 10:53 A.M. showed the resident's nasal cannula was wrapped around the resident's walker handle no plastic storage bag was visible. Observation on 6/23/25 at 10:30 A.M. showed the resident's nasal cannula was wrapped around the resident's walker handle no plastic storage bag was visible. Observation on 6/24/25 at 11:25 A.M. showed the resident's nasal cannula was wrapped around the resident's walker handle no storage bag was visible. 3. Review of Resident #105's admission Record showed he/she was admitted to the facility on [DATE]. Review of the resident's Order Summary Report dated June 2025 showed: -Order for oxygen at two to five liters per minute via a nasal cannula as needed to maintain oxygen saturation above 90% and the order was dated 2/6/25. - DuoNeb 0.5 mg-2.5 mg/3 ml give one vial four times a day for every six hours for Chronic Obstructive Pulmonary Disease (COPD - a disease process that decreases the ability of the lungs to perform ventilation) or shortness of breath. Review of the resident's care plan dated 6/20/25 showed: -The resident received DuoNeb four times a day. -Did not show whether the resident was compliant or non-compliant with storage of the nebulizer. Observation on 6/22/25 1:36 P.M. showed the resident's nebulizer was not stored in a plastic bag, but laying on the bedside table. Observation on 6/23/25 at 10:45 A.M. showed the resident's nebulizer was not stored in a plastic bag but was on the resident's bedside table. Observation on 6/23/25 at 2:57 P.M. showed the resident's nebulizer was not stored in a plastic bag but was on the resident's bedside table. 4. During an interview on 6/26/25 at 9:00 A.M., Certified Nurse's Aide (CNA) A said: -Nebulizers and nasal cannulas were to be stored in a plastic bag when not in use. -The bag would be dated and changed out weekly. -When one was found not in a plastic bag the item would be replaced and placed in the plastic (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	storage bag. -When a resident was not compliant with the storage of the respiratory item the resident would be educated about the importance of it, and the nurse would be notified so the care plan could then be updated. During an interview on 6/26/25 at 9:04 A.M., Certified Medication Technician (CMT) A said: -Nebulizers and nasal cannulas were to be stored in a plastic bag. -When a nebulizer or nasal cannula was found not in a plastic bag he/she would replace it and place in the plastic bag. -When a resident was noncompliant, with respiratory equipment storage, the resident would have been educated and the nurse notified so the care plan could be updated. During an interview on 6/26/25 at 9:09 A.M. Licensed Practical Nurse (LPN) A said: -Nasal cannulas and nebulizer were to be stored in a dated plastic bag. -When the nebulizer of nasal cannula were not stored in the plastic bag he/she would get a new nasal cannula or nebulizer and place it in the plastic bag. -The Director of Nursing (DON) would be informed that resident was noncompliant on the storage of nasal cannulas or nebulizers and was educated. -The residents care plan would need to be updated. -The DON or Assistant Director of Nursing (ADON) updated the care plan. During an interview on 6/26/25 at 10:50 A.M., LPN B said: -Nasal cannulas and nebulizer would be stored in a dated plastic bag a when not in use. -When a nasal cannula or nebulizer was found not stored in a plastic bag the resident was educated on the importance of this, and the items replaced -The DON and ADON would be notified to have the care plan updated. During an interview on 6/26/25 at 1:05 P.M., the DON said: -It was his/her expectation that nasal cannulas and nebulizers were to be stored in dated plastic bags. -It was his/her expectation that staff would have educated the resident on the importance of storing nasal cannulas of nebulizers in plastic bags when not in use. -When a resident was non-compliant with the storage that he/she would be notified so the care plan would be updated. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	5. Review of Resident #63's respiratory care plan dated 2/27/25 showed: -An original trach and respiratory care plan date of 3/23/22. -Instruction that he/she had physician's orders for him/her to self-administer his/her trach and respiratory care. -Licensed nurses were to monitor him/her for signs/symptoms of respiratory distress. -There was no instruction regarding frequency of assessment and documentation of his/her ability to self-administer his/her trach and respiratory care. Review of the resident's electronic medical record dated 6/1/24 through 6/24/25 showed no documented assessment of the resident's ability to self-administer tracheostomy and respiratory treatments. Observation of the resident on 6/23/25 at 10:24 A.M. showed: -The resident was seated in his/her room. -His/her trach area was clean, and he/she had no signs of respiratory difficulty. Observation on 6/24/25 10:41 A.M. showed: -The resident was seated in his/her room. -Numerous respiratory care items were stored in a plastic bag near his/her sink, in his/her dresser drawers, and on his/her dresser drawers. --All items were orderly and unopened. During an interview on 6/24/25 at 10:41 A.M. the resident said: -He/she had been taking care of his/her trach and respiratory treatments himself/herself for a long time. -He/she had all the supplies he/she needed and was able to do all his/her own trach and respiratory care with the exception that he/she had the licensed nurses fasten his/her trach collar (a soft, padded fabric placed around the neck used to secure a tracheostomy tube in place). -A couple of months ago a licensed nurse watched him/her do his/her trach and respiratory care. -He/she had been taking of his/her trach for a long time; he/she knew what he/she was doing; he/she had not had any problems with his/her trach and had not had any infections. -A licensed nurse came to his/her room at least three to four times a day to see how he/she was doing. -He/she declined for the surveyor to observe him/her complete his/her trach care. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 6/24/25 at 12:14 P.M. LPN G said: -The resident had been taking care of his/her trach and respiratory care for a long time. -He/she had observed that the resident was able to self-administer his/her trach and respiratory care, but he/she had not ever documented his/her observations. During an interview on 6/26/25 at 1:10 P.M. the DON said for residents who self-administered trach/respiratory care there should be a quarterly documented assessment of the resident's ability to self-administer the care completed by a licensed nurse.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure as needed controlled mediation (drug or other substance that was tightly controlled by the government because it may be abused or cause addiction) were signed out on the Controlled Drug Administration Record and in the Nurse's Medication Administration Record (MAR) for two sampled residents (Resident #48 and #113) out of 27 sampled residents. The facility census was 134 residents. Review of facility policy titled Administration Procedures for all Medications revised 8/2020 showed: -After administration, return to the cart, document administration in the MAR or Treatment Administration Record (TAR) and if the mediation was a controlled substance sign out the record. Review of the undated facility policy titled Medication Administration showed: -Medication will be administered by a licensed nurse per the order of an attending physician. -No medication will be used for any resident other than the resident whom it was prescribed. -Medication must be given to the resident by the licensed nurse preparing the medication, or as consistent with state law. -Nursing staff would have kept in mind the seven rights of medication when administering medication: --The right medication. --The right amount. --The right resident. --The right time. --The right route. --The right indication. --The right outcome. -The licensed nurse would chart the drug; time administered and initial his/her name with each medication administration and sign full name and title on each page of the MAR. 1. Review of Resident #48's admission Record showed he/she was admitted to the facility on [DATE] with a diagnosis of chronic (long term) pain. Review of the resident's Quarterly Minimum Data Set (MDS - a federally mandated assessment (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	instrument completed by facility staff for care planning) dated 1/29/25 showed: -The resident was cognitively intact. -The resident was using opioids (a class of natural, semi-synthetic, and synthetic drugs that include both prescription medications and illegal drugs). Review of the resident's care plan dated 5/8/25 showed that the resident had pain and used opioids. Review of the resident's Order Summary Report (OSR) dated June 2025 showed a physician order for Hydrocodone-Acetaminophen (narcotic used to treat pain a controlled substance which had a high risk for addiction and dependence) 5-325 milligram (mg) give one tablet as needed every six hours order was dated 5/20/25. Review of the resident's Nurses' MAR dated June 2025 showed the resident received Hydrocodone-Acetaminophen on: -June 1st at 8:26 P.M. for a pain level of seven out of 10. -June 6th at 9:40 A.M. for a pain level of eight out of 10. -June 7th at 9:51 A.M. for a pain level of eight out of ten. -June 7th at 4:50 P.M. for a pain level of eight out of 10. -June 9th at 12:06 P.M. for a pain level of six out of 10. -June 12th at 8:51 P.M. for a pain level of six out of 10. -June 13th at 11:13 P.M. for a pain level of seven out of 10. -June 22nd at 9:01 P.M. for a pain level of five out 10. -June 23rd at 10:48 P.M. for a pain level of six out of 10. -June 24th at 11:31 P.M. for a pain level of five out 10. Review of the resident's Controlled Drug Administration Record for Hydrocodone-Acetaminophen dated 6/21/25 to 6/25/25 showed: -One tablet was given on 6/21/25 at 9:00 P.M. -One tablet was given on 6/22/25 at 4:00 A.M. -One tablet was given on 6/23/25 at 5:00 A.M. -One tablet was given on 6/24/25 at 8:00 P.M. -One tablet was given on 6/25/25 at 2:00 A.M. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-One tablet was given on 6/25/25 at 2:00 P.M. During an interview on 6/26/25 at 9:09 A.M., Licensed Practical Nurse (LPN) A said: -When giving a controlled medication it needed to be signed out in the Nurse's MAR and the Controlled Drug Administration Record once the medication was given to the resident. -He/She would not give a controlled medication and not sign the Controlled Drug Administration Record and then chart on the Nurse's MAR. -It was his/her expectation that any nurse that gave controlled medication would chart in the Nurse's MAR and sign the Controlled Drug Administration Record. During an interview on 6/26/25 at 10:50 A.M., LPN B said: -When a resident needed pain medication, he/she would have verified that it was time that the medication could be given. -He/She would have assessed the resident for pain. -He/She would have verified the medication. -He/She and sign it out on the Controlled Drug Administration Record under the resident's name and then give the medication and sign it out on the Nurse's MAR in the computer. During an interview on 6/26/25 at 1:05 P.M., Director of Nursing (DON) said: -It was his/her expectation that when controlled medication was given it would be signed out on the Controlled Drug Administration Record and in the computer on the Nurse's MAR. -It was never appropriate to give a controlled substance and not sign it out on the Controlled Drug Administration Record and in the computer on the Nurse's MAR. -The Assistant Director of Nursing (ADON) was to perform audits on the Controlled Drug Administration Record and the Nurse's MAR in the computer to ensure both matched. 2. Review of Resident #113's admission Record showed he/she was admitted to the facility on [DATE] with a diagnosis of arthritis. Review of the resident's Physician Order Sheets dated May 2025 showed a physician order for Hydrocodone-Acetaminophen (a narcotic pain medication) 5-325 milligrams (mg) every 4 hours as needed for pain dated 4/28/25 and discontinued on 5/12/25. Review of the resident's MAR dated May 2025 showed: -Hydrocodone-Acetaminophen 5-325 mg every 4 hours as needed for pain dated 4/28/25 and discontinued on 5/12/25. -No documentation the medication was administered during this month. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the resident's Controlled Drug Administration Record showed: -Hydrocodone-Acetaminophen (Norco) 5-325 mg every 4 hours as needed for pain. -30 tablets were sent to the facility on 4/30/25. -One tablet was removed on 5/22/25. --NOTE: The resident's Norco was discontinued on 5/12/25. The resident did not have a valid order at the time the medication was removed from the medication supply. The medication was not documented on the resident's MAR as being administered on 5/22/25. Review of the resident's Physician Order Sheets dated June 2025 showed Hydrocodone-Acetaminophen 5-325 mg every four hours as needed for pain dated 6/9/25 and discontinued on 6/18/25. Review of the resident's MAR dated June 2025 showed: -Hydrocodone-Acetaminophen 5-325 mg every 4 hours as needed for pain dated 6/9/25 and discontinued on 6/18/25. -One tablet was documented as administered on 6/16/25. Review of the resident's Controlled Drug Administration Record showed: -Hydrocodone-Acetaminophen (Norco) 5-325 mg every 4 hours as needed for pain. -30 tablets were sent to the facility on 4/30/25. -One tablet was removed on 5/26/25 and was written over to show 6/16/25 over the same date. -One tablet was removed on 6/19/25. --NOTE: The resident's Norco was discontinued on 6/18/25. The resident did not have a valid order at the time the medication was removed from the medication supply on 6/19/25. The medication was not documented on the resident's MAR as being administered on 6/19/25. During an interview on 6/26/25 at 11:00 A.M., LPN E said: -If a narcotic was removed from the Controlled Drug Administration Record it should also be documented on the resident's MAR. -Staff should not be able to administer a medication if it was discontinued, the electronic medical record would not show the medication available to document it was administered. -Staff should not administer a medication without a valid physician's order. During an interview on 6/26/26 at 1:08 P.M., the DON said: -Staff should document on the Controlled Drug Administration Record when a narcotic was removed (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	from the supply and document the medication was administered on the resident's MAR. -The MAR and the Controlled Drug Administration Record should match. -Staff should not administer a medication without a valid physician's order.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. Based on observation, interview, and record review, the facility failed to ensure a medication rate under five percent for three sampled residents (Resident #130, #58, and #21) with a medication error rate of 22.58%. The facility census was 134 residents. A policy on insulin pens was requested and not received by the time of exit. Review of the facility Medication Administration policy undated showed: -Medications will be administered per the order of an attending physician or licensed practitioner. -Medications will not be left at the bedside. -The time and dose of the drug or treatment administered to the resident will be recorded in the resident's medication record by the person who administers the medication. A policy for self-administration of medications was requested and not received. Review of https://www.novomedlink.com/diabetes/products/treatments/novolog/dosing-and-administration.html, dated April 2025 showed the following instruction [sometimes called priming the pen] regarding use of insulin aspart (a rapid-acting insulin that helps lower mealtime blood sugar spikes for persons with diabetes) pens: -Attach a new needle to the insulin pen. -Remove the needle cap. -Dial to 2 units on the dose selector. -Press the dose button. -Repeat until you see insulin come from the tip of the needle. -Repeat this process several times until you see insulin come from the end of the needle; if insulin does not come from the tip of the needle, change the needle and repeat the process until you see insulin come from the end of the needle. -Once you see insulin come from the end of the needle, dial and inject the desired dose. 1. Review of Resident #130's Medication Administration Record (MAR) dated June 2025 showed: -The resident had a diagnosis of Diabetes Mellitus (DM II- a complex disorder of carbohydrate, fat, and protein metabolism that is primarily a result of a deficiency or complete lack of insulin (a hormone produced in the pancreas by the islets of Langerhans, which regulates the amount of glucose (sugar) in the blood) secretion in the pancreas or resistance to insulin). -The resident had an order for Humalog Kwikpen Subcutaneous Solution Pen-injector 100 unit/milliliter (ml) (insulin Lispro- a fast-acting insulin), inject 12 units subcutaneously before meals for DM (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	II. -Lantus SoloStar Subcutaneous Solution Pen-injector 100 unit/ml (insulin Glargine- a long-acting insulin), inject 20 units subcutaneously one time a day for DM II. -The resident had an order for staff to check the resident's fasting blood sugar (FSBS) using a glucometer (a medical device used to measure the approximate concentration of sugar in the blood). Observation on 6/24/25 at 8:10 A.M. of the resident's insulin administration completed by Certified Medication Technician (CMT) C showed: -He/She gathered the supplies needed to administer the resident's insulin. -He/She placed the needles on the resident's insulin pens. -He/She dialed the resident's Humalog Kwikpen to 12 units. -He/She dialed the resident's Lantus Solostar Subcutaneous Solution Pen-injector to 20 units. -He/She had not primed (this process removes any air bubbles from the needle and insulin cartridge) either pen. -He/She went into the resident's room with the blood sugar testing supplies and the insulin pens. -He/She then checked the resident's blood sugar and administered the resident's insulin. During an interview on 6/25/25 at 2:54 P.M. CMT C said: -He/She had missed a couple of steps during the insulin administration. -He/She had forgotten to prime the insulin pens. -He/She was nervous and that was why he/she had forgotten. -Priming insulin pens was important because it gets the air out of the needles to ensure the resident gets the right amount of insulin. -Insulin pens needed to be primed with two units of insulin. During an interview on 6/26/25 at 10:17 A.M. Licensed Practical Nurse (LPN) C said: -Insulin pens needed to be primed with two units of insulin prior to use. -Priming insulin pens was important because it ensured that the resident received the full dose of insulin. During an interview on 6/26/25 at 11:19 A.M. Assistant Director of Nursing (ADON) A said: -Insulin pens needed to be primed with two units of insulin prior to use. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Priming insulin pens ensured that the resident received the full dose of insulin by getting any air out of the needle During an interview on 6/26/25 at 1:30 P.M. the Director of Nursing (DON) said: -Insulin pens needed to be primed before use. -When an insulin pen is primed, it would ensure that any excess air gets out of the needle. -An insulin pen needed to be primed with two units. -CMT C did not give the insulin to Resident #130 correctly. 2. Review of Resident #58's Physician's Order Summary (POS) dated June 2025 showed: -Biotene Dry Mouth Mouth/Throat Liquid (artificial saliva that moistens and cleans the mouth) (Mouthwashes), give 1 dose by mouth every morning and at bedtime, dated 10/24/24 -Albuterol Sulfate HFA Aerosol Solution (a medication used to treat or prevent breathing difficulties) 108 (90 Base) micrograms (MCG) per actuation (a single dose of medication released from the oral inhalation device), two puffs every day and evening and every six hours as needed for shortness of breath, unsupervised self-administration, dated 3/23/22. -Ketotifen Fumarate Solution (eye drop used to relieve itchy eyes caused by allergies) 0.025 % Instill 1 drop in both eyes one time a day for eye itch relief), dated 7/2/22. -Prednisolone Acetate Suspension 1 % 1 drop in both eyes one time a day every other day for dry eye, dated 7/2/22. Observation on 6/24/25 at 7:55 A.M. showed CMT D prepared and administered 19 medications to the resident but did not prepare or administer the following medications to the resident: -Biotene Dry Mouth Mouth/Throat Liquid. -Albuterol Sulfate HFA Aerosol Solution 108 (90 Base) mcg per actuation two puffs. -Ketotifen Fumarate Solution (eye drops). -Prednisolone Acetate Suspension 1 % eye drops. During an interview on 6/24/25 at 12:41 P.M. CMT D said. -He/she had not administered the resident's Biotine liquid mouth rinse, Albuterol inhaler, Ketotifen Fumarate (eye drops) and Prednisolone eye drops. -The resident always self administered his/her Biotine liquid mouth rinse, Albuterol inhaler, Ketotifen Fumarate (eye drops) and Prednisolone eye drops which he/she kept those meds in his/her room. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 6/24/25 at 12:46 P.M. showed the resident had the following medications in his/her room which he/she kept next to his/her bed in a small purse. -Biotine mouth rinse. -Albuterol Sulfate inhaler. During an interview on 6/24/25 at 12:46 P.M. the resident said: -He/she took his/her own Biotine in the mornings and evenings which he/she kept in his/her room. -He/she had but did not use the Albuterol Sulfate inhaler. as needed once or twice a day which he/she kept in his/her room. -He/she did not have and did not have and did not use Prednisolone eye drops; over one year ago his/her outside of the facility internist physician whom he/she saw outside the facility, at his/her office had told him/her to not use Prednisolone eye drops, which he/she had taken for short term use after eye surgery. -He/she had thrown away his/her Prednisolone eye drops a long time ago. -The CMT's never asked him/her if he/she had taken the medications he/she self-administered and kept in his/her room. During an interview on 6/26/25 12:21 P.M. Licensed Practical Nurse (LPN) F looked at the resident's electronic medical record physician's orders and MAR and said: -The resident did have a physician's order that he/she could self-administer his/her Albuterol inhaler but did not have a physician's order that he/she could keep his/her Albuterol inhaler at his/her bedside. -The resident had no other physician's orders for self-administration of medications other than his/her Albuterol Inhaler. -He/she had been pretty sure the resident had not had any medications in his/her room. -He/she would have to ask the resident if he/she had any medications in his/her room and if he/she had been self-administering any medications. -He/she expected that if the resident had medications in his/her room and was self-administering the medications the CMT's would have to see those orders on the resident's MAR and if those instructions were not on the resident's MAR, he/she expected the CMT would tell him/here so he/she could get clarification of the physician's orders. -If the CMT knew the resident had and self-administered some of his/her medications, the CMT would probably have to ask the resident if he/she had taken those medications; the CMT should not document those medications were administered without asking the resident if he/she had taken the medications the resident self-administered. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/26/25 at 1:10 P.M. the DON said: -For a resident to self-administer his/her own medication there would have to be an assessment of the resident's ability to self-administer those medications. -Assessments of a resident's ability to self-administer medications should be completed quarterly. -There would also have to be physician's orders for the resident to self-administer specific medications and that the resident could keep specific medications at bedside. 3. Review of Resident #21's POS dated June 2024 showed: -Physician's Orders for sliding scale insulin (a method of insulin dosing where the amount of insulin given varies based on a person's blood sugar level at a specific time, typically before meals), including to administer 19 units of insulin aspart (medication used to treat diabetes) including to give 19 units for a pre meal blood sugar of 256. Observation on 6/24/25 at 11:56 A.M. showed: -LPN G wiped the end of the resident's insulin Aspart pen, placed a needle on the end of the pen and without first priming the pen by dialing and expelling two units of insulin dialed the resident's insulin aspart pen to 19 units. -He/she then injected the insulin aspart into the resident's abdomen. During an interview on 6/24/25 at 12:14 P.M. LPN G said: -He/she would not have done anything different when administering the resident's insulin; he/she did the same thing he/she always did when using insulin pens. -He/she did not recall ever hearing anyone say anything about priming insulin pens. -He/she had never seen a policy or any drug reference information that instructed to put the needle on the insulin pen, then dial two units and expel the two units, watching for insulin at the needle tip, then dial the intended insulin dose. During an interview on 6/26/25 at 1:30 P.M. the DON said: -Insulin pens needed to be primed before use. -When an insulin pen is primed, it would ensure that any excess air gets out of the needle. -An insulin pen needed to be primed with two units. -LPN G did not give he insulin to Resident #21 correctly.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview, and record review, the facility failed to ensure appropriate storage and labeling of medications throughout the facility's medication carts and medication rooms which had the potential to affect all residents within the facility; and failed to ensure medications were stored in the medication cart/medication room for one resident (Resident #58) observed during the medication pass. The facility census was 134 residents. Review of the facility's policy titled Storage of Medications dated August 2020 showed: -Medications and biologicals were stored safely, securely, and properly, following manufacturer's recommendations or those of the supplier. -All medications dispensed by the pharmacy were stored in the pharmacy container with the pharmacy label. -Outdated, contaminated, or deteriorated medications and those in containers that were cracked, soiled, or without closures were immediately removed from inventory, disposed of according to procedures for medication disposal. -Expirations dates (beyond-use dates) of dispensed medications should be determined by the pharmacist at the time of dispensing. Review of the facility Medication Administration policy undated showed: -Medications will not be left at the bedside. A policy for self-administration of medications was requested and not received. 1. Observation on 6/24/25 at 8:55 A.M. of the 800-hall medication room showed: -Four soft silicone foam dressing-lite with adhesive border packages that expired on 6/22/25. -Three soft silicone foam dressing with adhesive border packages that expired 6/22/25. -Five humidifier connection tubes that expired on 12/2/24. -Eight female straight catheters that expired on 4/1/25. 2. Observation on 6/24/25 at 10:47 A.M. of the medication room of the 600/700 hall showed: -45 triple anti-biotic ointment packets that expired in May 2025. -One lubricating jelly packet that expired on 5/31/25. -Five sponge swab packages that expired in April 2025. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-26 border gauze packets that expired 1/2/25. -One Foley catheter package that expired on 5/20/25. -Two Foley catheter packages that expired on 4/22/25. -One urinary leg bag-large 900 milliliters (ml) that expired 6/12/22. -One urinary drainage bag- 2000 ml that expired 11/28/24. -One urinary leg bag with built-in cover that expired 6/17/23. -Two urinary medium leg bags with easy-tap that expired in May 2024. During an interview on 6/24/25 at 11:12 A.M. Certified Medication Technician (CMT) B said expired medication supplies should not be stored in medication/treatment carts or rooms. 3. Observation on 6/25/25 at 10:29 A.M. of medication room three showed: -One PleurX drainage kit (a system that allows patients with recurrent pleural effusions or malignant ascites to drain fluid from their chest or abdomen at home) that expired 12/2/22. -One PleurX drainage kit that expired 11/27/22. -Eight medium foam wound dressing packages that expired in December 2024. -One medium foam wound dressing that expired 7/8/24. -One medium foam wound dressing that expired in October 2023. -One medium black foam wound dressing that expired 6/13/24. -One enteral administration kit that expired 3/1/24. 4. Observation on 6/25/25 at 10:40 A.M. of the 400-hall medication cart showed one bottle of Latanoprost solution 0.005% (used to treat certain kinds of glaucoma (a group of eye diseases that can damage the optic nerve, potentially leading to vision loss and blindness)) not stored in any container and only labeled with a first or last name. 5. During an interview on 6/25/25 at 2:54 P.M. CMT C said: -Expired medical supplies should not be stored in medication/treatment carts or medication rooms. -All medications, including eye drops, needed to be stored in the original container that they came in. -If a medication was found outside of its original container, then the medication needed to be disposed of. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 6/26/25 at 10:30 A.M. Licensed Practical Nurse (LPN) C said: -Expired medical supplies should not be stored in medication/treatment carts. -Expired medical supplies needed to be disposed once they are past the expiration date. -The nurses were responsible for ensuring that expired medications and supplies were destroyed or discarded appropriately. -He/She went through the medication carts and medication rooms periodically to check for expired medications and supplies. -The unit managers with a pharmacist would also go through the medication carts and rooms to ensure proper storage. -He/She was unsure if there was a regular schedule or process in place for going through the medication carts and medication rooms to check for appropriate storage. -Medications needed to be stored in their original container. -Eyedrops usually came in a box or bag, so the eye drops should never be in the cart by themselves. -If a medication was found outside of its original container it needed to be destroyed. During an interview on 6/26/25 at 11:33 A.M. Assistant Director of Nursing (ADON) A said: -Expired medical supplies should not be stored in medication/treatment carts or medication rooms. -Any expired medication or medical supply that was expired needed to be discarded. -The infection control nurse helped to ensure appropriate storage of medications and medical supplies. -He/She went through the medication carts and rooms sometimes to ensure appropriate storage of medications and medical supplies. -There was not a current schedule or process in place to ensure that all medication carts and medication rooms were checked to ensure appropriate storage of medications and medical supplies. -All medications needed to be stored in their original container and have an open date. -Any medication not stored in its original container needed to be destroyed. During an interview on 6/26/25 at 11:44 A.M. the Director of Nursing (DON) said: -Medication carts and medication rooms were audited once a week. -The infection control nurse was responsible for the audit. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-He/She was unsure why there would be so many expired medical supplies because the facility performed full medication room audits. During an interview on 6/26/25 at 1:30 P.M. the DON said: -Expired medications and medical supplies should not be stored in medication/treatment carts or medication rooms. -All medications needed to be stored in their original container and destroyed if found outside of their original container. 6. Review of Resident #58's Physician's Order Summary (POS) dated June 2025 showed: -Biotene Dry Mouth Mouth/Throat Liquid (artificial saliva that moistens and cleans the mouth) (Mouthwashes), give 1 dose by mouth every morning and at bedtime, dated 10/24/24; the order did not include instruction that the resident could self-administer the Biotene and could keep the Biotine at his/her bedside. -Albuterol Sulfate HFA Aerosol Solution (a medication used to treat or prevent breathing difficulties) 108 (90 Base) micrograms (mcg) per actuation (a single dose of medication released from the oral inhalation device), two puffs every day and evening and every six hours as needed for shortness of breath, unsupervised self-administration, and no instruction that the resident could keep his/her Albuterol inhaler at his/her bedside, dated 3/23/22. Observation on 06/24/25 at 7:55 A.M. showed CMT D did not prepare or administer the following medications to the resident: -Biotene Dry Mouth Mouth/Throat Liquid. -Albuterol Sulfate HFA Aerosol Solution (a medication used to treat or prevent breathing difficulties) 108 (90 Base) micrograms (MCG) per actuation (a single dose of medication released from the oral inhalation device), two puffs. During an interview on 6/24/25 at 12:41 P.M. CMT D said. -He/she had not administered the resident's Biotine liquid mouth rinse and Albuterol inhaler. -The resident always administered his/her own Biotine liquid mouth rinse and Albuterol inhaler, which he/she kept those medications in his/her room. Observation on 6/24/25 at 12:46 P.M. showed the resident had the following medications in his/her room which he/she kept next to his/her bed in a small purse. -Biotine mouth rinse. -Albuterol Sulfate inhaler. During an interview on 6/24/25 at 12:46 P.M. the resident said: (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-He/she took his/her own Biotine in the mornings and evenings which he/she kept in his/her room. -He/she used his/her Albuterol inhaler as needed once or twice a day which he/she kept in his/her room. -The CMT's did not keep and did not administer his/her Biotine mouth rinse and his/her Albuterol inhaler. -The CMT's never asked him/her if he/she took the medications he/she kept in his/her room. -The licensed nurses knew he/she kept medication in his/her room and did ask him/her once in a while if he/she had self-administered his/her Biotin mouth wash and Albuterol inhaler. During an interview on 6/26/25 12:21 P.M. Licensed Practical Nurse (LPN) F looked at the resident's electronic medical record physician's orders and Medication Administration Record and said: -The resident did have a physician's order that he/she could self-administer his/her Albuterol inhaler but did not have a physician's order that he/she could keep his/her Albuterol inhaler at his/her bedside. -The resident had no other physician's orders for self-administration of medications other than his/her Albuterol Inhaler. -He/she had been pretty sure the resident had not kept any medications in his/her room. -He/she would have to ask the resident if he/she had any medications in his/her room. -He/she expected that if the resident had medications in his/her room and was self-administering the medications the CMT's would have to see those orders on the resident's MAR and if those instructions were not on the resident's MAR, he/she expected the CMT would tell him/her so he/she could get clarification of the physician's orders. -He/she expected if a CMT was aware that any resident had medication in their room, the CMT would inform him/her. During an interview on 6/26/25 at 1:10 P.M. the Director of Nursing (DON) said: -For a resident to self-administer medication and medications kept at their bedside, there would have to be a quarterly assessment of the resident's ability to self-administer those medications. -Assessments of a resident's ability to self-administer medications should be completed quarterly. -There would also have to be physician's orders for the resident to self-administer specific medications and the resident could keep those specific medications at their bedside.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility failed to maintain plastic cutting boards and plate covers in good condition to avoid food safety hazards (cross-contamination); failed to separate damaged foodstuffs; and failed to store foodstuffs within their recommended acceptable temperature parameters, in accordance with State of Missouri rules and regulations, established national guidelines, and professional standards for food service safety. These deficient practices had the potential to affect all residents, visitors, volunteers, and staff who ate food from the kitchen. The facility's census was 134 residents with a licensed capacity for 156 residents at the time of the survey. 1. Observation on 6/23/25 between 9:51 A.M. and 11:39 A.M. during a kitchen sanitation inspection showed the following: -There was a 6-pound (lb.) 12-ounce (oz.) can of chili con carne on the bottom row of a dispenser rack in the Dry Storage (DS) room that was heavily dented toward its top side. -An open 1-gallon (gal.) jug of teriyaki sauce approximately (app.) 1/8 full on a middle shelf of a baker's rack next to the manual can opener read Refrigerate After Opening on its label. -The red and green cutting boards on a top shelf of a baker's rack at the south wall were heavily scored to the point of plastic flaking off. -Five maroon plastic plate covers on a four-tiered rolling rack outside the meal pass-through window were chipped around their bottom edges. Review of the facility's undated four-week rotating menus used by their Dietary Department showed there were at least two meals during that time with oriental main dishes and several other meals with a vegetable or noodle side dish with which cooks and/or residents may use teriyaki sauce. Observation on 6/24/25 between 10:22 AM and 11:33 A.M. showed the following: -There was a 6-lb. 12-oz. can of chili con carne on the bottom row of a dispenser rack in the DS room that was heavily dented toward its top side. -An open 1-gal. jug of teriyaki sauce app. 1/8 full on a middle shelf of a baker's rack next to the manual can opener read Refrigerate After Opening on its label. -The red and green cutting boards on a top shelf of a baker's rack at the south wall were heavily scored to the point of plastic flaking off. -Five maroon plastic plate covers on a four-tiered rolling rack outside the meal pass-through window were chipped around their bottom edges. During an interview on 6/25/25 at 1:25 P.M. the Dietary Manager said the following: -He/She would expect if a foodstuff read store at a certain temperature on its label that it would be. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sunrise Nursing & Rehabilitation	600 E Sunrise Drive Raymore, MO 64083

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-Damaged foodstuffs were separated out and returned to their food vendor for a credit or replacement. -He/She would expect food to be free of foreign substances. -Damaged food preparation items were discarded and replaced.

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F 0836 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure the facility is licensed under applicable State and local law and operates and provides services in compliance with all applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to follow Federal, State, and Local Laws to ensure the facility van was licensed to ensure legal transport of residents to and from the facility. This failure had the potential to affect all residents who required transportation to and from the facility for appointments. The facility census was 134 residents. A policy related to vehicle maintenance and licensure was requested and not received during survey. 1. During an interview on [DATE] at 12:41 P.M., the Director of Nursing (DON) said: -The facility had two vans in the parking lot. -One van had a sister facility's name on the side that the facility had not used due to the van having mechanical issues. That van had expired tags. -The second van had the facility's name on the side of the van. This was the van they used to transport residents to and from appointments. That van should have current license plates. Observation on [DATE] at 8:45 A.M. showed a van with the facility name parked under the awning in front of the front doors of the facility. The van's engine was running with the van doors open. The license plate on the van expired [DATE]. During an interview on [DATE] at 8:46 A.M. the Administrator said: -The van under the awning in front of the building was waiting to board a resident to take to an appointment. -That was the van the facility used to transport residents. The other van was in the back of the parking lot and had mechanical issues so it was not in use. -He/She did not realize the license plates to the van the facility used were expired. -The van was leased so it was the leasing company's responsibility to ensure the license plates were renewed. -The van was still covered by insurance. -He/She did not think it was a problem to drive a vehicle with expired license plates. -He/She thought the vehicle was still legal to drive despite the expired license plates. Observation on [DATE] at 2:00 P.M. showed the license plates on the second van in the parking lot with the sister facility's name on the side expired [DATE]. During an interview on [DATE] at 12:06 P.M., the facility driver said: (continued on next page)

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F 0836 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-He/She knew the plates on the facility van were expired. -He/She told the other facility driver, who was no longer employed with the facility, around five months ago. -He/She assumed the former driver was taking care of the license issues. -He/She transported residents to and from dialysis, radiation appointments, and other outside appointments in the facility van. -The other van in the parking lot had been out of service for a long time due to it not working.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 2. Review of Resident #12's admission record showed he/she admitted to the facility with the following diagnoses: -Low Back Pain. -Chronic Pain Syndrome (a condition characterized by persistent pain lasting longer than three months, significantly impacting physical, emotional, and social well-being). Review of the resident's Medication Administration Record (MAR) dated June 2025 showed a physician order for Lidocaine Patch 4%, apply to lower back topically in the morning for pain related to Chronic Pain Syndrome. Observation on 6/24/25 at 7:54 A.M. of the resident's Lidocaine 4% patch administration completed by Certified Medication Technician (CMT) B showed: -He/She had put on gloves and unlocked the medication cart without washing or sanitizing his/her hands before putting on the gloves. -He/She removed the Lidocaine 4% patch out of the medication cart and took the patch out of the wrapper. -He/She then labeled the patch with a marker and locked the medication cart. -He/She then knocked on the resident's door and entered the resident's room with the same gloves on and without washing or sanitizing his/her hands. -He/She then walked to the resident's bed and pulled up the resident's top in order to place the patch on the resident's lower back. -He/She then took the rest of the wrapping off of the patch and placed the patch on the resident's lower back. -He/She then exited the resident's room and returned to the medication cart with the same gloves on and without washing or sanitizing his/her hands before exiting the resident's room. During an interview on 6/24/25 at 11:09 A.M. CMT B said he/she would not have done anything differently during his/her administration of the resident's Lidocaine patch. 3. Review of Resident #130's MAR dated June 2025 showed: -The resident had a diagnosis of Diabetes Mellitus (DM II- a complex disorder of carbohydrate, fat, and protein metabolism that is primarily a result of a deficiency or complete lack of insulin secretion in the pancreas or resistance to insulin). -The resident had an order for Humalog Kwikpen Subcutaneous Solution Pen-injector 100 unit/milliliter (ml) (insulin Lispro- a fast-acting insulin), inject 12 units subcutaneously before meals for DM II. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-Lantus SoloStar Subcutaneous Solution Pen-injector 100 unit/ml (insulin Glargine- a long-acting insulin), inject 20 units subcutaneously one time a day for DM II. Observation on 6/24/25 at 8:10 A.M. of the resident's insulin administration completed by CMT C showed: -He/She was gathering the supplies for the blood sugar check and the insulin administration. -He/She placed the needles on the insulin pens without sanitizing the pen. -He/She went into the resident's room. -He/She then set all of the supplies on the resident's countertop without placing a barrier down first. -The supplies remained on the counter without a barrier during the blood sugar test and the insulin administration. -He/She exited the resident's room after administering the insulin. During an interview on 6/25/25 at 2:54 P.M. CMT C said: -He/She had missed a couple of steps when administering the resident's insulin. -He/She forgot to clean the insulin pens before use. -He/She forgot to place a barrier down when placing the blood sugar supplies on the resident's counter. -He/She was nervous and that was why he/she had missed those steps. 4. Review of Resident #24's admission Record showed he/she admitted to the facility with a diagnosis of Pressure Ulcer (an injury to the skin and underlying tissues resulting from prolonged pressure on the skin) of Left Buttock, Stage IV (full thickness tissue loss with exposed bone, tendon, or muscle. Slough or eschar may be present in some parts of the wound bed. Often includes undermining and tunneling). Review of the resident's Physician Order Sheet (POS) dated June 2025 showed a phyaican order for treatment to his/her left ischium, clean with wound cleanser, pat dry, apply calcium alginate (helps in the absorption of wound exudate), and cover with border silicone foam. During an interview on 6/25/25 at 1:36 P.M. Licensed Practical Nurse (LPN) D said: -The resident had been seen by the wound care doctor that morning. -The resident had a new wound and new wound care orders were in place. -The wound care order was to cleanse the area with wound cleanser, apply santyl (a topical enzyme medication used in wound care to remove damaged or dead skin), apply calcium alginate, and cover with (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	border silicone foam. -The santyl was ordered, but had not arrived at the facility, so he/she would not be using santyl during the resident's treatment. Observation on 6/25/25 at 1:38 P.M. of the resident's wound care treatments completed by LPN D showed: -He/She entered the resident's room to start the treatment. -He/She completed the treatment to the resident's left ischium. -He/She then assisted in completing perineal care to the resident. -He/She then washed his/her hands and put on new gloves. -He/She cleansed the new wound to the resident's buttocks and placed the calcium alginate and border foam on the resident's wound area. -He/She then removed his/her gloves and sanitized his/her hands and assisted in the completion of the resident's perineal care. During an interview on 6/25/25 at 1:55 P.M. LPN D said: -He/She had forgotten to change out his/her gloves and perform hand hygiene in between the cleansing of the resident's new wound and putting on the dressing. -There was not a specific reason why he/she had forgotten the glove change and hand hygiene. -Hand hygiene needed to be done when gloves were removed and when completing different tasks during any type of resident care. 5. During an interview on 6/26/25 2:54 P.M. CMT C said: -Hand hygiene needed to be completed after every five residents during medication administration. -Hand hygiene should be performed before and after the use of gloves. -CMT B had not performed appropriate hand hygiene during Resident #12's Lidocaine 4% patch administration. -CMT B should have gathered his/her supplies first, then performed hand hygiene, then put on his/her gloves to get the patch ready. -CMT B should not have worn the gloves into the resident's room. -CMT B should have removed his/her gloves prior to entering the room, sanitized his/her hands upon entering the resident's room, then put new gloves on. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 6/26/25 at 10:15 A.M. LPN C said: -Hand hygiene needed to be performed before and after glove usage. -Hand hygiene needed to be performed when completing different tasks on the same resident during resident care, which included when cleaning a wound and placing a new dressing on a wound. -Hand hygiene should be performed after the completion of any resident care. -Hand hygiene should be performed before and after each resident during medication administration. -CMT B had not performed appropriate hand hygiene during Resident #12's Lidocaine 4% patch administration. -CMT B should have gathered his/her supplies first before putting on the gloves. -CMT B should not have worn gloves into Resident #12's room. -CMT B should have taken all the supplies needed into Resident #12's room and washed his/her hands before putting on new gloves. -CMT B then would have been able to apply Resident #12's Lidocaine 4% patch. -CMT B should have removed his/her gloves and washed/sanitized his/her hands before exiting Resident #12's room. -Insulin pens needed to be sanitized before use. -A barrier needed to be in place during blood sugar checks and insulin administration if supplies were going to be set down anywhere in the resident's room. -CMT C had not performed appropriate infection control measures during Resident #130's blood sugar check and insulin administration. During an interview on 6/26/25 at 11:12 A.M. Assistant Director of Nursing (ADON) A said: -Hand hygiene should be done before and after glove usage. -Hand hygiene needed to be done when performing different tasks during resident care. -LPN D had not performed appropriate hand hygiene during Resident #24's wound care. -LPN D should have removed his/her gloves and washed/sanitized his/her hands after cleansing the wound area. -LPN D should have put on new gloves before putting on the new dressing to Resident #24's wound area. -CMT B had not performed appropriate hand hygiene during Resident #12's Lidocaine 4% patch (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	administration. -Gloves should never be worn into resident rooms. -CMT B should have sanitized/washed his/her hands and entered Resident #12's room with all of the supplies needed. -CMT B should have labeled the patch and then put on gloves, then placed the patch on Resident #12. -CMT B should have washed/sanitized his/her hands before exiting Resident #12's room. -CMT C had not performed appropriate infection control practices during Resident #130's blood sugar check and insulin administration. -CMT C should have cleaned the insulin pens before placing the needles on the pens. -CMT C should have placed a barrier on Resident #130's counter when he/she set the supplies down during Resident #130's blood sugar check and insulin administration. During an interview on 6/26/25 at 1:30 P.M. the Director of Nursing (DON) said: -Hand hygiene should be performed every three to five residents during medication administration. -Hand hygiene should be performed before and after any type of patch was administered. -CMT B had not performed appropriate hand hygiene during Resident #12's Lidocaine 4% patch administration. -Gloves should not be worn into resident rooms. -Hand hygiene should be performed before and after glove usage. -LPN D had not performed appropriate hand hygiene during Resident #24's wound care. -Hand hygiene needed to be completed between each step of the treatment during wound care. -LPN D should have started the dressing change over. -LPN D should have removed his/her gloves after cleansing the wound, washed his/her hands, and put on new gloves before placing the dressing to Resident #24's wound area. -Insulin pens needed to be sanitized before each use. -A barrier needed to be in place during blood sugar checks and insulin administration when setting down supplies in a resident's room. -CMT C had not performed appropriate infection control measures during Resident #130's blood sugar check and insulin administration. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Based on observation, interview, and record review, the facility failed to establish and maintain a comprehensive, facility-specific infection prevention and control program designed to help prevent the development and transmission of Legionella (A [NAME] of pathogenic Gram-negative bacteria that includes the species L. pneumophila, causing legionellosis, all illnesses caused by Legionella, including a pneumonia-type illness called Legionnaires' disease and a mild flu-like illness called Pontiac fever) and/or other water-borne pathogens (a bacterium, virus, or other microorganism that can cause disease), in accordance with State of Missouri rules and Centers for Disease Control (CDC) and Centers for Medicare and Medicaid Services (CMS) standards and guidelines. This deficient practice had the potential to affect all residents, visitors, volunteers, and staff who resided, visited, used, or worked in the facility; the facility failed to ensure appropriate hand hygiene was completed during wound care for one sampled resident (Resident #24); failed to ensure appropriate infection control measures were taken when performing a blood glucose (sugar) test (measures the amount of sugar in the blood) and during insulin (a hormone produces by the pancreas that plays a crucial role in regulating blood sugar levels) for one sampled resident (Resident #130); and failed to ensure appropriate hand hygiene and glove usage was completed during a lidocaine 4% (topical anesthetic) patch administration for one supplemental resident (Resident #12) out of 27 sampled residents and four supplemental residents; and the facility failed to ensure accurate time frames were adhered to for the administration of the two step tuberculosis (TB - a communicable disease that affects especially the lungs, that is characterized by fever, cough, difficulty in breathing, abnormal lung tissue and function) skin tests for four out of five residents sampled for TB testing (Residents #113, #80, #130, and #95) and for two out of 10 sampled staff (Employee #5 and Employee #10). The facility census was 134 residents with a licensed capacity for 152 residents at the time of the survey. Review of the facility's policy titled Administration Procedures for All Medications dated August 2020 showed: -Staff were to cleanse hands using antimicrobial soap and water or facility-approved hand sanitizer before beginning a medication pass, before handing medication, and before contact with a resident. -Staff were to use a barrier such as a clean disposable tray to carry medication containers into the resident's room and to separate the supplies and the over-the-bed table or other surface on which the supplies were placed when medications were administered. -When staff were finished administering medication to each resident, staff were to wash hands with antimicrobial soap and water or use facility-approved hand sanitizer. Review of the facility's policy titled Handwashing/Hand Hygiene dated August 2019 showed: -All personnel were to follow the handwashing/hand hygiene procedures to help prevent the spread of infections to other personnel, residents, and visitors. -Use of an alcohol-based hand rub containing at least 62% alcohol; or, alternatively, soap (antimicrobial or non-antimicrobial) and water for the following situations: --Before and after direct contact with residents. --Before preparing or handling medications. --Before handling clean or soiled dressings. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	--Before moving from a contaminated body site to a clean body site during resident care. --After contact with a resident's intact skin. --After removing gloves. A policy for resident TB testing was requested and not received by the end of survey. Review of the facility's Employee TB Screening and Interpretation of Results policy dated June 2020 showed: -Purpose: To ensure the facility adequately administers and interprets TB results for staff. -The facility will administer and interpret TB skin tests in accordance with recognized guidelines and pertinent regulations. -A qualified nurse or health practitioner interprets the TB skin test 48-72 hours (2-3 days) after administration. 1. Observation on 6/23/25 between 11:05 A.M. and 11:51 A.M. during the initial facility Life Safety Code (LSC) kitchen inspection showed there was a three-sink area, a chemical dish-washing machine, a hand-washing sink, with an ice machine and a steam table (Also referred to as a hot food table, specifically designed to hold food at steady, safe serving temperatures.) in the attached auxiliary kitchenette off the Main Dining Room (MDR). Observation on 6/24/25 between 12:07 P.M. and 3:19 P.M. during the facility LSC walk-through inspection with the Director of Maintenance (DOM) showed the following: -The building was equipped with full fire sprinkler systems with its incoming water supplied by the local water company. -There were three piped fire sprinkler riser rooms (A dedicated space for fire protection equipment) which served the whole facility's systems. -There were some housekeeping closets with a floor mop sink or ceramic service sink (Mop/service sinks were used in janitorial and maintenance areas to fill and empty mop buckets, clean mops, and dispose of dirty water) and water heaters throughout the eight resident room hallways. -There were at least 99 resident rooms with private or shared bathrooms and/or sinks. -There were commercial clothes washers in the laundry area. -There were at least seven bathhouses with toilets throughout the facility. -There was a Beauty Shop with a sink. -There were at least two inoperable water fountains. Review of the facility's 18-page (pg.) policy and procedure entitled Risk Management Plan for (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of his/her Immunization Audit Report dated 6/24/25 showed: -A TB skin test was administered on 6/9/25, five days after admission to the facility, and read on 6/12/25. -A TB skin test was administered on 6/16/25, four days after the first test was resulted, and read on 6/18/25. 9. Review of Resident #95's admission Record showed he/she was admitted to the facility on [DATE] and readmitted on [DATE]. Review of the resident's Electronic Medical Records showed: -No documentation a two step TB test was administered or read upon admission on [DATE]. -A TB skin test was administered on 3/26/24, seven months after admission to the facility, and read on 3/28/24. -A TB skin test was administered on 4/2/24, five days after the first test was resulted, and read on 4/4/24. Review of his/her Immunization Audit Report dated 6/24/25 showed: -No documentation a two step TB test was administered or read upon admission on [DATE]. -A TB skin test was administered on 3/26/24, seven months after admission to the facility, and read on 3/28/24. -A TB skin test was administered on 4/2/24, five days after the first test was resulted, and read on 4/4/24. 10. Review of Employee #5's employee file showed his/her hire date was 10/2/24. -A TB skin test was administered on 9/25/24 and read on 9/27/24. -A TB skin test was administered on 10/3/24, six days after the first test was read, and resulted on 10/5/24 . 11. Review of Employee #10's employee file showed his/her hire date was 4/7/25. -A TB skin test was administered on 4/2/25 and read on 4/4/25. -A TB skin test was administered on 4/10/25, six days after the first test was read, and resulted on 4/12/25. 12. During an interview on 6/26/25 at 12:45 P.M., the Infection Preventionist said: -TB skin tests should be administered within 48 hours from admission. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265476	A. Building B. Wing	06/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sunrise Nursing & Rehabilitation	600 E Sunrise Drive Raymore, MO 64083

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-TB skin test results should be read 48-72 hours after the test was administered. -A second step should be administered no sooner than seven days after the previous test was resulted. During an interview on 6/26/25 at 1:11 P.M., the DON said: -TB skin tests should be administered within 48 hours from admission. -TB skin test results should be read 48-72 hours after the test was administered. -A second step should be administered no sooner than seven days after the previous test was resulted.