STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265677	A. Building B. Wing	08/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Campbell Healthcare & Senior Living	17108 US Highway 62 Campbell, MO 63933

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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 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Encode each resident's assessment data and transmit these data to the State within 7 days of assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to electronically transmit Minimum Data Set (MDS - a federally mandated assessment instrument required to be completed by facility staff) in a timely manner and in accordance with guidelines for three residents (Residents #27, #36 and #51) out of three sampled residents. The facility census was 63.Review of the facility's policy titled, MDS Submission, undated, showed:- It is the policy of this facility to complete and submit all MDS assessments timely, accurately, and in compliance with Centers for Medicare and Medicaid Services (CMS) Resident Assessment Instrument (RAI) Manual standards and Missouri regulatory requirements. Submissions must be completed in the Internet Quality Improvement and Evaluation System (IQIES) and meet Skilled Nursing Facility (SNF) Quality Reporting Program (QRP) deadlines to avoid penalties;- Complete all required MDS assessments;- Submit electronically via iQIES per CMS requirements;- Confirm successful transmission by reviewing validation reports;- Federal SNF QRP MDS submission deadlines occur quarterly;- Review iQIES validation reports;- Correct errors immediately and resubmit;- Document corrections and maintain reports for audit purposes;- The MDS Coordinator oversees submission, validation and corrections;- The Quality Assurance Performance Improvement (QAPI) Committee reviews compliance and trends.1.Review of #27's MDS record showed:- admitted on [DATE];- Quarterly MDS with an assessment reference date (ARD) of 04/01/25, a completion date of 04/02/25, and an accepted/transmitted date of 05/27/25 (41 days late);- Quarterly MDS with an ARD of 07/01/25, a completion date of 07/08/25, and an accepted/transmitted date of 08/21/25 (30 days late). 2.Review of Resident #36's MDS record showed:- admitted on [DATE];- Quarterly MDS with an ARD date of 04/01/25, a completion date of 04/02/25, and an accepted/transmitted date of 04/21/25 (5 days late);- Quarterly MDS ARD date of 07/01/25, a completion date of 07/08/25, and an accepted/transmitted date of 08/21/25 (30 days late). 3.Review of Resident #51's MDS record showed:- admitted on [DATE];- Quarterly MDS ARD date of 4/18/25, a completion date of 04/21/25, and an accepted/transmitted date of 05/27/25 (22 days late);- Quarterly MDS ARD date of 07/18/25, with a completion date of 07/21/25, and an accepted/transmitted date of 08/21/25 (16 days late). During an interview on 08/21/25 at 9:00 A.M., the Administrator said she had hired a new MDS Coordinator this week and he/she was being trained at this time. The facility's MDS's had been completed by a corporate MDS Coordinator and did not know anything about why the MDS's would be submitted late. During an interview on 08/22/25 at 11:23 A.M., the Corporate MDS Coordinator said there had been a glitch in the facility's software program. The company was notified of the software glitch and it was fixed.

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to develop and implement a care plan with specific interventions tailored to meet individual needs for three residents (Residents #5, #51, and #71) out of 16 sampled residents. The facility census was 63. Review of the facility's policy titled, Comprehensive Care Plans, undated, showed: - It is the policy of this facility to ensure that every resident is admitted to the skilled nursing facility has a comprehensive, person-centered care, plan, developed, implemented, and reviewed according to federal and state regulations; - To promote quality of life, safety, and optimal outcomes for each resident; - To involve the resident and/or representative and care decisions; - A comprehensive assessment must be completed within 14 days of admission; - The baseline care plan will be completed within 48 hours of admission; - The comprehensive care plan will be developed within seven days after completion of the comprehensive assessment; - The plan must be individualized and person-centered. It must address clinical needs such as medication, nutrition, activities of daily living (ADLs), safety, skin care, fall prevention, behavior management, pain, psychosocial will be in, and discharge planning; - Contains measurable, objectives and timetables; - The assigned nurse is responsible for initiating care plan interventions; - Residents and/or their legal representatives will be invited to participate in care plan meetings; - Input will be documented and incorporated into the plan; - Care plans must be reviewed and updated quarterly, with a significant change in condition, or upon readmission; - The Director of Nursing (DON) or designee will monitor compliance through audits. 1. Review of Resident #5's medical record showed: - admitted on [DATE]; - admitted to hospice on 07/01/25; (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Diagnoses of chronic kidney disease stage three (moderately damaged kidneys that no longer filter blood as it should), depression (a serious medical illness that negatively affects how you feel, the way you think and how you act), urinary tract infection (UTI – an infection anywhere in the urinary tract), and hypertension (high blood pressure). Review of the resident's Care Plan, revised 08/16/15, showed: - Did not address hospice services with specific interventions. 2. Review of Resident #51's medical record showed: - admitted on [DATE]; - admitted to hospice on 09/24/24; - Diagnosis of protein malnutrition (when the body does not get enough protein and calories). Review of the resident's Care Plan, revised 07/23/25, showed: - Did not address hospice services with specific interventions. 3. Review of Resident #71's August 2025 Physician Order Sheet (POS), showed: - admitted on [DATE]; - An order to check the Wander Guard (a safety system used primarily in memory care units and nursing homes to monitor and protect residents at risk of wandering) every shift, dated 07/24/25. Review of the resident's Smoking Assessment, dated 07/24/25, showed:- A safe smoker. Review of the resident's admission Minimal Data Set (MDS - a federally mandated comprehensive assessment tool used by skill nursing facilities to evaluate the health conditions, treatments and functional abilities of residents), dated 7/29/25, showed:- Not a smoker;- Elopement alarm used daily. Review of the resident's Care Plan, revised 8/15/25, showed:- Did not address smoking with specific interventions;- Did not address the Wander Guard with specific interventions. Observation on 08/19/25 at 10:30 A.M., of the resident showed: - The resident sat outside and smoked at the designated smoking area with staff supervision. Observation on 08/21/25 at 11:15 A.M., of the resident showed: - The resident sat on the side of the bed with a Wander Guard on his/her left ankle. During an interview on 08/22/25 at 2:07 P.M., the Care Plan Coordinator said hospice services should be care planned for Resident #5 and #51 with interventions. He/She would expect smoking with interventions to be on the care plan if a resident was a smoker. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 08/22/25 at 2:26 P.M., the DON said hospice services and smoking should be addressed on a resident's care plan with interventions. During an interview on 08/22/25 at 2:29 P.M., the Administrator said hospice services and smoking should be addressed on a resident's care plan with interventions.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to update and revise care plans with specific interventions tailored to meet individual needs for two residents (Residents #12 and #58) out of 16 sampled residents. The facility census was 63.Review of the facility's policy titled, Revising Care Plans, undated, showed:- It is the policy of this facility to ensure that all comprehensive care plans are reviewed and revised promptly to reflect changes in the resident's condition, treatment, or goals of care;- Care plan revisions are essential to ensure individualized, person-centered, and safe care and to promote accurate, updated interventions that reflect the resident's needs and preferences;- Care plans must be reviewed and revised quarterly, upon a significant change, new physician's orders that impact resident care, after hospitalizations or acute medical events, and upon resident/family request or concerns;- Nurses and other direct care staff must promptly notify the Interdisciplinary Team (IDT - a group of healthcare professionals from diverse fields who work in a coordinated effort toward a common goal for a resident) new pressure injuries, falls, behaviors, infections, or weight changes;- Revised care plans must identify the reason for revision, include updated goals, interventions, and timetables. 1. Review of the Resident #12's medical record showed:- admitted on [DATE];- Diagnoses of Alzheimer's disease (progressive mental deterioration), dementia (a disorder marked by memory loss, personality changes, and impaired reasoning that interferes with daily functioning), history of falls, urinary tract infection (UTI - an infection anywhere in the urinary tract), hypertension (high blood pressure), and unspecified injury to the head.Review of the resident's Incident Progress Notes showed:- On 01/10/25, a fall with no injury;- On 01/29/25, a fall with no injury;- On 02/03/25, a fall with a laceration (cut, tear, or rip in one's skin or other body tissue) to the left eye, a facial fracture, and a subdural hematoma (a buildup of blood on the surface of the brain). Review of the resident's Care Plan, revised 04/04/25, showed:- Not revised and/or updated after multiple reported falls with no interventions put in place for safety measures. 2. Review of the Resident #58's medical record showed:- admitted on [DATE];- Diagnoses of Parkinson's disease (a disease of the central nervous system that affects movement, often including tremors), Alzheimer's disease, bipolar disorder (a mental disorder that causes unusual shifts in mood), UTI, and hypertension.Review of the resident's Incident Progress Notes showed:- On 03/25/25, an unwitnessed fall with no injury;- On 05/09/25, a witnessed fall with no injury;- On 06/06/25, an unwitnessed fall with no injury;- On 06/23/25, an unwitnessed fall with no injury;- On 07/07/25, an unwitnessed fall with no injury;- On 07/30/25, an unwitnessed fall with no injury;- On 08/21/25, an unwitnessed fall with no injury. Review of the resident's Care Plan, revised 05/28/25, showed:- Resident rolled off his/her bed frequently with an intervention to do checks throughout the shift;- No revisions/updates and additional interventions after multiple falls with no additional interventions put in place for safety measures. During an interview on 08/22/25 at 2:37 P.M., the Director of Nursing (DON) said there should be fall interventions in place and the care plan should be updated to ensure safety measures for the residents. During an interview on 08/22/25 at 2:40 A.M., the Administrator said there should be fall interventions in place and the care plan should be updated to ensure safety measures for the residents.

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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. Based on interview and record review, the facility failed to ensure staff reconciled narcotics (a process that allows one staff to reconcile the exact narcotic inventory on hand with another staff) at each shift change for two out of four medication carts and one out of one medication storage room. This practice had the potential to affect all residents. The facility census was 63.Review of the facility's policy titled, Narcotic Medication Reconciliation Policy and Procedure, undated, showed:- The purpose of this policy is to ensure accurate reconciliation of all narcotic medications when received, transferred, or discontinued in the facility, prevention diversion, loss, or administration errors;- All narcotic medications must be reconciled at key transition points: admission to the facility, receipt from the pharmacy, change of shift counts, discontinuation or destruction of narcotics;- Narcotic reconciliation requires two licensed nurses whenever possible;- All discrepancies must be immediately reported to the Director of Nursing (DON) and Administrator;- Documentation in the narcotic record, Medication Administration Record (MAR) and reconciliation log must be accurate, timely, and complete;- Shift-to-shift count: outgoing and incoming nurses will perform a narcotic count together, counts must match the narcotic control record, and any discrepancies must be resolved before the outgoing nurse leaves;-The DON or designee will conduct narcotic reconciliation, if a problem is reported or randomly;- Results of audits will be reported to the Quality and Performance Improvement (QAPI - a systematic, data-driven, and proactive approach to improving the quality of care and quality of life) committee.1. Review of the 100/200 Hall Medication Cart Narcotic Count Log for Controlled Substances showed:- For 7 A.M. - 7 P.M. shift on 05/04/25 - 5/24/25, the staff missed 13 out of 84 opportunities to reconcile the narcotics;- For 7 A.M. - 7P.M. shift on 05/25/25 - 06/16/25, the staff missed eight out of 92 opportunities to reconcile the narcotics;- For 7 A.M. - 7 P.M. shift on 06/17/25 - 07/08/25, the staff missed three out of 88 opportunities to reconcile the narcotics;- For 7 A.M. - 7 P.M. shift on 07/08/25 - 07/31/25, the staff missed 13 out of 88 opportunities to reconcile the narcotics;- For 7 A.M. - 7 P.M. shift on 07/31/25 - 08/19/25, the staff missed six out of 78 opportunities to reconcile the narcotics.2. Review of the 500 Hall Medication Cart Narcotic Count Log for Controlled Substances showed:- For 7 A.M. - 7 P.M. shift on 05/01/25 - 05/19/25, the staff missed 15 out of 88 opportunities to reconcile the narcotics;- For 7 A.M. - 7 P.M. shift on 05/19/25 - 06/11/25, the staff missed 15 out of 88 opportunities to reconcile the narcotics;- For 7 A.M. - 7 P.M. shift on 06/12/25 - 07/02/25, the staff missed six out of 88 opportunities to reconcile the narcotics;- For 7 A.M. - 7 P.M. shift on 07/04/25 - 07/25/25, the staff missed 11 out of 88 opportunities to reconcile the narcotics;- For 7 A.M. - 7 P.M. shift on 07/26/25 - 08/16/25, the staff missed 22 out of 88 opportunities to reconcile the narcotics;- For 7 A.M. - 7 P.M. shift on 08/17/25 - 08/19/25, the staff missed six out of 10 opportunities to reconcile the narcotics.3. Review of the Medication Room Narcotic Count Log for Controlled Substances showed:- For 7 A.M. - 7 P.M. shift on 04/18/25 - 05/10/25, the staff missed 28 out of 88 opportunities to reconcile the narcotics;- For 7 A.M. - 7 P.M. shift on 05/10/25 - 05/31/25, the staff missed 40 out of 88 opportunities to reconcile the narcotics;- For 7 A.M. - 7 P.M. shift on 05/31/25 - 06/21/25, the staff missed 22 out of 88 opportunities to reconcile the narcotics;- For 7 A.M. - 7 P.M. shift on 06/21/25 - 07/13/25, the staff missed 14 out of 88 opportunities to reconcile the narcotics;- For 7 A.M. - 7 P.M. shift on 07/13/25 - 08/04/25, the staff missed 23 out of 88 opportunities to reconcile the narcotics;- For 7 A.M. - 7 P.M. shift on 08/04/25 - 08/19/25, the staff missed 10 out of 30 opportunities to reconcile the narcotics.During an interview on 08/22/25 at 9:00 A.M., the DON said oncoming and outgoing staff should count the narcotics before leaving or starting their shift. Two (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	signatures for each shift should be in the Narcotic Count Book. The Narcotic Count Book was on every medication cart and in the medication room.During an interview on 08/22/25 at 2:00 P.M., Certified Medication Technician (CMT) K said he/she counted the narcotics before and after each shift. He/She never left the cart without counting the narcotics to make sure there were no discrepancies, and he/she counted with whoever was taking over the cart.During an interview on 08/22/25 at 2:03 P.M., Licensed Practical Nurse (LPN) L said two staff, the outgoing and oncoming staff, count the narcotics and sign in the Narcotic Count Book on the medication cart.During an interview on 08/22/25 at 2:37 P.M., the Administrator said the oncoming and outgoing staff should be counting the cart together and signing the Narcotic Count Book every shift.

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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 store, prepare, distribute, and serve food under sanitary conditions increasing the risk of cross-contamination. This deficient practice had the potential to affect all residents. The facility census was 63. Review of the facility's policy titled, Ice Machine Air Gap (prevents backflow of contaminated water into a potable (drinkable) water system) Compliance, undated, showed:- It is the policy of this facility to ensure that all ice machines used for resident dietary services, hydration, and medical needs are equipped and maintained with a properly installed and maintained air to prevent contamination of potable water supplies;- The purpose is to prevent backflow and contamination of water and ice;- To protect residents, staff, and visitors from foodborne illness or cross-contamination;- All ice machines must be installed with an air gap between the water supply line and the drain line;- The air gap must be at least two times the diameter of the drain line, be visible and accessible for inspection, and prevent direct connection between the potable water and drain system. Review of the facility's policy titled, Kitchen Sanitation and Trash Can Management, undated, showed:- It is the policy of this facility to ensure all kitchen equipment and trash receptacles are kept in a clean, sanitary, and odor-free condition to prevent contamination of food and the spread of infection. All dietary staff are responsible for following sanitation protocols and proper waste handling procedures in compliance per facility standards;- Trash cans in kitchen/food service areas must be covered with tight fitting lids unless actively in use during food preparation;- Staff must wear personal protective equipment (PPE) (gloves, hair/beard covering) when handling trash and during cleaning. Review of the facility's policy titled, Dietary PPE, undated, showed:- It is the policy of this facility that all dietary staff will use appropriate PPE when handling food, cleaning equipment, or performing tasks that pose a risk of contamination. The use of PPE will follow guidelines to ensure resident safety, regulatory compliance, and prevention of foodborne illness;- Hair nets and beard nets are always required when working in food preparation or service areas. 1. Observations on 08/19/25 at 9:08 A.M., 08/20/25 at 9:27 A.M., and 08/21/25 at 2:07 P.M., of the ice machine showed: - Two plastic-like pipes inserted into a round floor opening with a steady flow of water;- No air gap between the plastic-like hoses and the floor opening. 2. Observations on 08/19/25, of Dietary Aide (DA) F showed:- At 9:36 A.M., DA F with visible facial hair on his/her face without a beard covering;- At 10:15 A.M., DA F discarded resident food from the meal trays and cleaned kitchenware without a beard covering; - At 11:16 A.M., DA F placed and sorted out resident menu cards on the food preparation table without a beard covering;- At 11:27 A.M., DA F drank from a beverage bottle while he/she stood in front of the steam table without a beard covering;- At 12:19 P.M., DA F reached into a plastic storage container wearing a blue glove and placed two handfuls of a coleslaw mixture on a serving plate without a beard covering;- At 12:26 P.M., DA F delivered and retrieved resident meal trays in the main dining room without a beard covering. 3. Observation on 08/20/25 at 8:57 A.M., showed:- A large trash can with no lid with exposed food and trash by the dish machine;- A large trash can with no lid with exposed food and trash by the steam table;- No dietary staff present. 4. Observations on 08/21/25 at 8:09 A.M. and 9:37 A.M., of DA F showed: - DA F with visible facial hair on his/her face without a beard covering;- DA F delivered and retrieved resident meal trays in the main dining room without a beard covering. 5. Observation on 08/21/25 at 3:41 P.M., showed:- A large trash can with no lid with exposed food and trash by the dish machine;- No dietary staff present. During an interview on 08/19/25 at 9:08 A.M., DA G said kitchen staff should wear hair nets and beard covers if needed when working in the kitchen. Trash cans should have lids on them when not in (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	use. During an interview on 08/19/25 at 4:08 P.M., Evening [NAME] I said kitchen staff should wear hair nets and beard covers if needed when working in the kitchen. Trash cans should have lids on them when not in use. During an interview on 08/21/25 at 10:20 A.M., Evening [NAME] J said kitchen staff should wear hair nets and if an employee had facial hair, he/she should wear a beard cover. Trash cans should have lids on them when not in use. During an interview on 08/21/25 at 10:50 A.M., DA F said a beard cover should be always worn when working in the kitchen area and the dining room if a kitchen employee had any kind of facial hair. During an interview on 08/22/25 at 9:11 A.M., the Dietary Manager (DM) said trash cans should have lids on top if staff were not present in the kitchen. Staff should wear hair nets and beard covers for visible facial hair at all times when working in the kitchen. He/She had been informed by the Registered Dietician (RD) about the ice machine needing to have an air gap installed to prevent potential backflow of contaminated water. During an interview on 08/22/25 at 9:11 A.M., the Maintenance Supervisor (MS) said the facility had recently purchased a new ice machine. He/She was made aware the ice machine needed to have an air gap installed and had not gotten around to doing it yet. During an interview on 08/22/25 at 9:15 A.M., the Administrator said kitchen trash cans should have lids placed on top when not in use. If a kitchen employee had facial hair, he/she should wear a beard cover. The ice machine should have an air gap to prevent potential backflow of contaminated water.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to implement enhanced barrier precautions (EBP) when staff performed incontinent care for one resident (Resident #6) and indwelling catheter (a flexible tube inserted into the bladder to drain urine) care for one resident (Resident #13) out of three sampled residents. The facility census was 63. Review of the facility's policy titled, Enhanced Barrier Precautions, last reviewed 07/15/25, showed:- Will follow Centers for Disease Control and Prevention (CDC) guidelines for EBP to reduce the transmission of multidrug-resistant organism (MDRO's) in nursing home settings. EBP will be used for residents with wounds, indwelling medical devices, or other risk factors-regardless of know colonization status;- This policy applies to all direct care staff, including nurses, certified nurse aides (CNA's), therapy staff, and other personnel involved in resident care;- EBP: Use of gloves and gowns during high-contact resident care activities, even when residents are not on contact precautions (infection control measures requiring healthcare workers to wear a gown and gloves to prevent the spread of germs through direct or indirect contact);- EBP is implemented for residents who have risk factors such as: wounds or pressure injuries, indwelling devices (catheters, tracheostomy and feeding tubes), and chronic conditions requiring frequent care;- Gloves and gowns must be worn for high-contact care activities;- Gloves and gowns must be put on before entering the resident's space for care;- Clear signage should indicated when EBP is in use;- Personal protective equipment (PPE) should be stored outside resident rooms in clean, accessible containers or inside the room by the door if it could be a safety issue (ex: on the memory care unit);- All staff will receive annual training on PPE protocols. 1.Review of Resident #13's medical record showed: - The resident hospitalized on [DATE] - 07/20/25, with a diagnosis of extended-spectrum beta-lactamase (ESBL - a group of bacteria that produce a specific enzyme which makes them resistant to several common antibiotics) bacteria in the urine; - An order for an indwelling catheter until the resident was seen by the urologist (physician specializing in the urinary tract system), 07/29/25; - EBP due to skin concerns on bilateral (both) legs, dated 06/13/25. Observation 8/21/25 at 10:05 A.M. of the resident's catheter care showed: - EBP signage on the resident's door;- A three-drawer cabinet contained PPE outside the resident's door;- CNA A performed hand hygiene, put on gloves, and did not put on a gown; - CNA A performed the resident's catheter care;- CNA A removed the gloves, performed hand hygiene, and exited the resident's room.During an interview on 8/21/25 at 4:10 P.M., CNA A said he/she should have put a gown on before entering the resident's room due to the resident had a catheter in place and wounds to the resident's legs. 2. Observation on 8/21/25 at 10:35 A.M., of Resident #6's incontinent care showed: - EBP signage on the resident's door; - A three-drawer cabinet of PPE sat right inside the resident's room; - CNA B and CNA C entered the resident's room, did not put on a gown, did not perform hand hygiene, and put on gloves; - CNA B and CNA C removed the resident's urine soaked brief; - CNA B changed gloves and performed hand hygiene; - CNA B cleaned the resident's front peri area; - CNA C did not perform hand hygiene, did not change gloves, and rolled the resident to his/her left side; - CNA B changed gloves and performed hand hygiene; - CNA B cleaned the resident's buttocks, hips, and wiped from front to back; - CNA B changed gloves and performed hand hygiene; - CNA B placed a clean brief under the resident; - CNA C changed gloves, performed hand hygiene, and assisted CNA B with placing the clean brief under the resident; - CNA B and CNA C rolled the resident to his/her back and fastened the brief; - CNA B and CNA C changed gloves and performed hand hygiene; - Licensed Practical Nurse (LPN) D entered the resident's room, did not put on a gown, performed hand hygiene, and put on gloves; - LPN D assessed a new open area to the resident's inner thigh; - LPN D removed the (continued on next page)

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	265677	A. Building B. Wing	08/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Campbell Healthcare & Senior Living	17108 US Highway 62 Campbell, MO 63933

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	gloves, performed hand hygiene, and exited the room; - LPN D entered the resident's room, did not put on a gown, performed hand hygiene, and put on gloves; - CNA B and CNA C assisted LPN D to reposition the resident; - CNA B, CNA C, and LPN D removed the dirty gloves, performed hand hygiene, and exited the resident's room. During an interview on 08/22/25 at 9:05 A.M., CNA C said he/she was not aware of what EBP meant. He/She did know staff should put on PPE before going into residents' rooms that had wounds.During an interview on 08/22/25 at 9:06 A.M., CNA B said he/she just forgot to put the gown on before going into Resident #6's room. Staff should always apply the gown before entering the resident's room.During an interview on 08/22/25 at 9:12 A.M., LPN D said he/she should have put a gown on before entering the resident's room with EBP. The container with the PPE was not outside Resident #6's door and did not see it in the room but should have put a gown on first before going in the room. During an interview on 08/22/25 at 2:03 P.M. the Director of Nursing (DON) said she would expect staff to put on PPE before entering a resident's room that was on EBP. Any resident with an open wound, colostomy, peg tube, or catheter would need to be on EBP. During an interview on 08/22/25 at 2:35 P.M., the Administrator said she would expect the staff to dress out in PPE before entering a resident's rooms that was on EBP.

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F 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Regularly inspect all bed frames, mattresses, and bed rails (if any) for safety; and all bed rails and mattresses must attach safely to the bed frame. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to conduct inspections of all bed frames, mattresses, and side rails as a part of a regular maintenance program for three residents (Residents #5, #40, and #52) out of three sampled residents and one resident (Resident #43) outside the sample. The facility census was 63. Review of the facility's policy titled, Side Rail Assessment, undated, showed: - It is the policy of this facility that side rails (bed rails) will not be used as restraints and will only be implemented when medically, necessary, functionally, beneficial, on individualized assessment; - Side rails use must comply with regulations, guidance, and resident rights require requirements; - Upon admission, nursing staff must complete a side rail risk/benefit assessment; - Assessment must address medical need (mobility, repositioning aid, transfers); - Resident preference in history; - Cognitive status and entrapment risk; - A physician's order is required for side rail use; - Informed consent must be obtained from the resident/representative, covering the purpose of the side rail, use, and potential benefits, and risks; - Nursing staff check the side rails, each shift for positioning and safety; - Reassess quarterly, with changing condition, or after incidents; - Document tolerance, effectiveness, and any adverse outcomes; - The policy did not address side rails and/or mobility rail (used for repositioning) inspections. 1. Review of Resident #5's medical record showed: - admitted on [DATE]; - Diagnoses of chronic kidney disease stage three (moderately damaged kidneys that no longer filter blood as it should), depression (a serious medical illness that negatively affects how you feel, the way you think and how you act), urinary tract infection (UTI – an infection anywhere in the urinary tract), and hypertension (high blood pressure); - No maintenance inspection for the mobility rail. (continued on next page)

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F 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observations on 08/19/25 at 9:42 A.M., 08/20/25 at 1:42 P.M., and 08/21/25 at 10:41 A.M., of the resident's bed showed: - A U-shaped mobility rail in the upright position on both sides of the resident's bed and moved with minimal effort. During an interview on 08/19/25 at 1:22 P.M., the resident said he/she used the mobility rail for getting up on the side of the bed. The right rail was loose and moved. 2. Review of Resident #40's medical record showed: - admitted on [DATE]; - Diagnoses of chronic obstructive pulmonary disorder (COPD - a group of lung diseases that block airflow and make it difficult to breathe), anxiety (intense, excessive, and persistent worry and fear about everyday situations), diabetes mellitus (a chronic metabolic disorder where the body cannot properly regulate blood sugar levels), dementia (a group of symptoms, that involve impairments in memory, thinking, and problem-solving, along with potential changes in personality and emotion), and upper body weakness; - No maintenance inspection for the mobility rail. Observations on 08/19/25 at 11:30 A.M., 08/20/25 at 8:45 A.M., and 08/21/25 at 9:45 A.M., of the resident's bed showed: - A U-shaped mobility rail in the upright position on both sides of the resident's bed and moved with minimal effort. During an interview on 08/21/25 at 9:47 A.M., the resident said he/she used both mobility rails to try and turn over in bed. 3. Review of Resident #43's medical record showed: - admitted on [DATE]; - Diagnoses of chronic kidney disease stage three, depression, and UTI; - No maintenance inspection for the mobility rail. Observations on 08/19/25 at 9:59 A.M., 08/20/25 at 10:25 A.M., and 08/21/25 at 11:37 A.M., of the resident's bed showed: - A U-shaped mobility rail in the upright position on the right side of the resident's bed and moved with minimal effort. During an interview on 08/19/25 at 10:02 A.M., the resident said he/she used the mobility rail for getting up on the side of the bed and going to the bathroom at night. 4. Review of Resident #52's medical record showed: (continued on next page)

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F 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- admitted on [DATE]; - Diagnoses of diabetes mellitus, chronic pain (long-term pain), and atrial fibrillation (irregular heartbeat, when the upper chambers beat chaotically instead of in a steady rhythm); - No maintenance inspection for the mobility rail. Observations on 08/19/25 at 11:20 A.M., 08/20/25 at 8:40 A.M., and 08/21/25 at 10:47 A.M., of the resident's bed showed: - A U-shaped mobility rail in the upright position on both sides of the resident's bed and moved with minimal effort. During an interview on 08/21/25 at 3:45 P.M., the Assistant Director of Nursing (ADON) said Resident #52 did have mobility rails. The resident had been moved from one hall to another hall, the bed probably had the rails on it, and they were not removed at the time of the resident's move. During an interview on 08/21/25 at 4:25 P.M., the Director of Nursing (DON) said Resident #52's rails had been removed off his/her bed. The DON said it was a mistake for the rails to be on that bed. During an interview on 08/22/25 at 2:15 P.M., the resident said he/she was not sure how often maintenance inspected the mobility rails, but knew nursing monitored them. During an interview on 08/22/25 at 1:32 P.M., the Maintenance Supervisor said he/she inspected the side/mobility rails quarterly and did not have documentation of a monthly inspection. He/She went in the resident rooms during rounds and as needed to adjust and address any issues there might be at the time. During an interview on 08/22/25 at 3:35 P.M., the Administrator said she would expect staff to check the side rails at least monthly per policy.