STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265797	A. Building B. Wing	09/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ridge Crest Nursing Center	706 South Mitchell Warrensburg, MO 64093

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 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to provide activities that were based on resident preferences and that were meaningful and failed to develop goal directed activity care plans and interventions for two sampled residents (Resident #33 and Resident #21) who were not able to self-direct activities out of 16 sampled residents. The facility census was 46 residents.Review of an undated Activity policy showed the activity department will work with the nursing department to coordinate resident care and needs with scheduled activities. Activity staff should be aware of the resident's safety concerns and transfer needs. The Activity Director is responsible for filling out the activities section of the Minimum Data Set (MDS-a federally mandated assessment tool to be completed by facility staff for care planning) form, assisting with the activity care plan and attending care plan meeting. Activities should be meaningful and individualized to meet the needs of all residents. 1. Review of Resident #33's Face Sheet showed the resident was admitted to the facility on [DATE], with diagnoses including dementia, and stroke with paralysis on the left side. Review of the resident's admission MDS dated [DATE], showed the resident:-Was alert with some confusion.-Did not have any behaviors delusions or wandering.-Activities that were very important to the resident included reading books/magazines/news, animals/pets, going outside, activities with groups, music and favorite activities. Review of the resident's Care Plan dated 7/25/25, showed the resident had impaired cognitive function and impaired thought processes due to dementia, was an elopement risk and wandered, had impaired safety awareness and had a history of attempts to leave the facility unattended. Intervention showed staff would:-Distract the resident from wandering by offering structured activities, food conversation, television, books.-There was no goal directed activity plan or interventions documented in the resident's Care Plan. Review of the resident's Activity Participation Record dated August 2025 showed:-A list of activities during the month included Bingo, Bible study, Games, Crafts, Exercise, Baking, Movie, Talking, Coloring, Resident Counsel, Painting, Nail Care, News, Cards, Laundry, Badminton, Science, Bowling, Hospice, Tie-dye, Shuffleboard, and Racing.-The Participation record showed daily activities the resident was offered or participated in.-The resident's participation record showed staff offered the resident three activities daily from the list.-The resident participated in games on 8/28/25, science on 8/29/25, and bingo on 8/30/25 (a total of 3 activities out of 93 opportunities during the month). All of the other entries showed the resident either refused or was sleeping during the activity.-The participation record did not show the resident received any one to one activities. Observation during the facility tour on 9/2/25 at 10:42 A.M., showed the resident was sitting in his/her wheelchair in the middle of the hallway. The resident said he/she did not know where his/her room was or where he/she was going. Nursing staff who was in the hallway told the resident where his/her room was and assisted the resident to his/her room. At this time there was an activity in the activity room which started at 10:30 A.M. The resident was not encouraged to go to the activity room nor did staff take the resident to the (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265797	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/08/2025
NAME OF PROVIDER OR SUPPLIER Ridge Crest Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 706 South Mitchell Warrensburg, MO 64093	

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	activity. Observation on 9/3/25 at 9:38 A.M., showed the resident was standing in the hallway by the exit door. The resident opened the exit door and the alarm sounded. Facility staff came running immediately toward the resident and brought a wheelchair for the resident. Nursing staff encouraged the resident to sit down and asked the resident cognitive orientation questions (name, place) and the resident said he/she was not feeling good and that his/her head hurt. Nursing staff took the resident back to his/her room. The resident was not provided with an activity. During an interview on 9/3/25 at 10:00 A.M., Certified Nursing Assistant (CNA) A said:-The resident has dementia.-The reside was able to ambulate and also used a wheelchair to mobilize in the facility.-When the resident was out in the facility, he/she did wander and was sometimes exit seeking.-They try to take the resident to or provide activities, but the resident will leave the activity after a few minutes.-He/She did not know if the resident received one to one activity. During an interview on 9/3/25 at 10:19 AM the resident said:-He/She attended activities and had attended an activity yesterday where he/she played games and it was fun.-He/She was not aware of an activity that was going on at 10:30 A.M. in the activity room.-There was no activity calendar in the resident's room. Observation on 9/4/25 at 9:37 A.M., showed the resident was in his/her bed with covers drawn. The resident's eyes were closed and he/she was resting comfortably. The resident remained in bed during the scheduled activity at 10:30 A.M. Observation on 9/4/25 at 12:35 P.M., showed the resident was sitting in his/her wheelchair, in the dining room eating lunch. The resident did not have wandering behavior during the meal. When he/she was finished eating, staff took the resident back to his/her room. There were no scheduled activities until 3:30 P.M. During an interview on 9/4/25 at 1:30 P.M., CNA B said:-They try to prevent the resident from exit seeking and exiting by keeping him/her at the nursing station or involving him/her in an activity.-The resident liked to go outside and sometimes they take him/her outside.-Sometimes the interventions work and sometimes they do not. Observation on 9/4/25 at 1:43 P.M., Certified Medication Technician (CMT) A said:-During the during the day, the resident was usually either in the activity room, they will give him/her snacks or they will take him/her outside.-They try anything to keep the resident busy. 2.Review of Resident #21's Face Sheet showed the resident was admitted on [DATE] with diagnoses including dementia, lack of coordination, cognitive communication deficit, and muscle weakness. Review of the resident's admission MDS assessment dated [DATE], showed the resident:-Was alert with significant confusion.-Needed total care and did not ambulate and used a wheelchair for mobility.-Activities that were somewhat important included going outside, participating in religious services, snacks, animals/pets, group activities and music. Review of the resident's Activity Participation Record dated August 2025 showed:-A list of activities during the month included Bingo, Bible study, Games, Crafts, Exercise, Baking, Movie, Talking, Coloring, Resident Counsel, Painting, Nail Care, News, Cards, Laundry, Badminton, Science, Bowling, Hospice, Tie-dye, Shuffleboard, and Racing.-The Participation record showed daily activities the resident was offered or participated in.-The resident's participation record showed staff offered the resident at least three activities daily from the list.-The resident participated in 20 out of 97 activity opportunities provided during the month. The resident participated in bible study , games, crafts, a movie, talking, nail care, news, science and racing during the month. All of the other entries showed the resident either refused or was sleeping during the activity.-The participation record did not show the resident received one to one activity (nails). Review of the resident's Care Plan updated 9/2/25, showed the resident had impaired cognition, impaired communication and impaired mobility. Interventions for cognition showed staff should:-Incorporate alternative means of communication, such as music, song or visual demonstration.-Incorporate visual prompting and cues and provide reality orientation to focus the (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	resident's attention.-There was no activity goal or interventions in the resident's care plan. Review of the resident's quarterly Activity assessment dated [DATE], showed:-The resident enjoyed coming to activities if he/she was up to it.-One to one activities seemed to work well since he/she enjoyed having conversations.-The resident enjoyed talking to staff and other residents, going outside, reading and puzzle books. The resident was not interested in bible study at this time.-The resident's activity related focuses remained appropriate and current as per the resident's care plan.-The resident's activity goals were met and the interventions had been effective in reaching his/her goals.-The resident participated in activities when at home, wanted to participate in group activities, wanted one to one activities with staff, and liked independent activities.-Activities should be modified due to the resident's cognitive deficit.-Assistance should be provided to get the resident to the activity. Observation on 9/2/25 at 11:41 A.M., showed the resident was in his/her room laying down in a low bed to the floor. He/she was resting with his/her eyes closed without signs or symptoms of discomfort. There were no books, television or music in his/her room and there were minimal belongings in his/her room. There was no activity calendar in resident's the room. Observation on 9/2/25 at 3:04 P.M., showed the resident was laying down in his/her bed that was low to the floor. The resident had his/her eyes closed, resting without signs or symptoms of discomfort. There were no books, music or television in his/her room. Observation on 9/3/25 at 11:20 A.M., showed the resident was in his/ room laying on his/er bed which was low to the floor. The resident was awake but was quiet. The resident had confusion and seemed to have no signs or symptoms of distress. There were no books, music or television in his/her room. Observation on 9/4/25 at 8:30 A.M., showed the resident was up in his/her wheelchair finishing breakfast in the dining room. Nursing staff took the resident to sit in front of the nursing station once he/she was done eating. The resident was not provided with any activity while sitting in front of the nursing station. At this time there were resident's in the activity room in a self-directed activity. Observation on 9/4/25 from 12:40 P.M. to 1:40 P.M. showed the resident was sitting up in his/her wheelchair in front of the nursing station. Observation on 9/4/25 at 2:44 P.M., showed the resident was laying down in his/her bed that was low to the floor. The resident was awake and singing to himself/herself. There was no books, music or television in the resident's room and no indication there was any additional activity provided to the resident while in his/her room. During an interview on 9/4/25 at 2:46 P.M., CNA A said:-The resident sometimes participated in activities like building blocks.-He/She played with blocks with the resident last week.-The resident was recently moved to his/her current room and did not have much in there but he/she thought the resident had a radio.-The resident slept a lot during the day.-He/She was not sure what activities the resident currently participated in.-He/She did not know if the resident had one to one activities. 3. During an interview on 9/5/25 at 11:22 A.M., the Activity Director said:-He/She recently went to the activity training in August. -He/She completed the initial and quarterly activity assessments on the residents.-The MDS Coordinator completed the activity care plan, goals and interventions and he/she followed the resident's activity plan of care.-He/She documented the activity that each resident participated in daily on the activity participation form. -They have three activities per day at 10:00 A.M., 2:00 P.M., and 4:30 P.M.,-Depending on the activity, like bingo, if the activity goes longer the residents don't want to do another activity until later in the evening.-They usually do not have activities after dinner.-Residents who were able to self-direct activities always have accessibility to the activity room and there are coloring sheets, puzzles.-Staff has keys to the activity closet to access board games and other items that are kept locked.-In the activity room they usually have music playing.-He/She said that he/she really has not been completing one to one activity (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	with anyone, but he/she tried to either chat with residents or do nails with residents daily.-He/She did not have a list of residents or schedule for residents who needed more assistance participating in activities, who could not come to activities or who were more appropriate for one to one activities.-Regarding Resident #33, he/she did not do as much as he/she should regarding developing activities for the resident.-Usually, Resident #33 just roams and walks the facility.-He/She could walk with the resident or take him/her outside.-He/She and nursing staff try to get Resident #33 to come to the activity room to participate in activities, but the resident will come in for a few minutes then leave.-Resident #33 liked to sit at the nursing station and he/she liked snacks.-Resident #33 was a farmer but he/she had not gotten him/her any farming related books magazines or things he/she may be interested in-he/she said they have two other residents that were also farmers, and he/she could see if he/she could get the resident to engage with those two residents.-They try to get Resident #21 out more to participate in activities actively or passively.-They don't have any music playing in Resident #21's room, but he/she thought that before the resident moved to his/her current room, he/she did have a radio.-He/She could try to get the resident something to play music in his/her room.-He/She would explore other activities the resident may enjoy to participate in.-He/She would work on improving the activity program for the residents and providing activities for those residents who were not able to come to activities, who were more cognitively impaired or who needed more one to one activity plans.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident’s preferences and goals. Based on observation, interview, and record review, the facility failed to ensure physician's orders were accurately transcribe to include the Intravenous (IV, a way of giving a drug or other fluids through a needle or tube inserted into a vein) infusion rate (flow rate) for IV Vancomycin (antibiotic, used to treat severe bacterial infection) for one sampled resident (Resident #5) out of 16 sampled residents. The facility census was 46 residents.Review of the facility's Medication Order Policy dated 11/2014 showed: -Intravenous orders need to be specify the type of solution, rate of flow and volume to be infused. 1. Review of Resident's #5 admission Record showed the resident readmitted with diagnosis to include Clostridium difficile, (C-Diff is bacterial infection which causes watery or bloody diarrhea). Record review of the quarterly Annual Minimum Data Set (MDS-a federally mandated assessment tool completed by facility staff for care planning) dated 8/15/25 showed he/she:-Was cognitively intact.-He/She was able to understand others and make his/her needs known. Review of the resident's admission Note dated 8/29/25 at 5:06 P.M., showed: -The resident arrived at the facility around 4:30 P.M. from hospital. -He/She was admitted with diagnosis of C-Diff.-He/She returned with a single lumen Peripherally Inserted Central Catheter (PICC, is a thin, flexible tube that is inserted into a vein in the upper arm for IV therapy) line to his/her upper left arm. -He/She was admitted with order for IV vancomycin (antibiotic).-NOTE: No documentation related to the infusion flow rate. Review of the resident's Physician Order Sheet from 8/29/25 to 9/5/25 showed.-Vancomycin HCl Intravenous Solution 750 milligrams/150mililiter (Vancomycin HCl) Use 750 mg intravenously one time a day related to Enterocolitis due to C-Diff for 14 Days (ordered on 8/30/25 at 11:00 A.M. and stop medication on 9/13/25) -NOTE: The order did not have a detail physician order to include the IV infusion rate and how long to run. Review of the resident's Licensed Nurse Medication Record dated 9/1/25 to 9/30/25 showed:-Vancomycin HCl Intravenous Solution 750 mg/150ml (Vancomycin HCl) Use 750 mg intravenously one time a day related to Enterocolitis due to C-Diff be given for 14 Days. To be administered at 12:00 P.M.-NOTE: Did not have a detail physician order to include the IV infusion rate and how long to run. Review of the resident's Nursing Progress Note dated 9/2/25 at 2:12 A.M. showed:-The resident continues IV Vancomycin to treat C- Diff. -NOTE: No documentation related to the IV infusion flow rate. Observation of the resident's on 9/3/25 at 3:03 P.M. showed:-Licensed Practical Nurse (LPN) A entered the resident's room to disconnect the IV therapy and flushed the resident's PICC line. -The resident's antibiotic was still running with 1/4 of bag left. Observation of the resident's IV therapy on 9/4/25 at 2:28 P.M., showed: -The Director of Nursing (DON) obtained the resident bag of IV antibiotic solution.-He/She set the IV pump machine to infuse rate of 120 ml/hour for 75 minutes. -The IV bag had a pharmacy label with the resident name and to administer the medication over 75 minutes. Observation and interview on 9/5/25 at 9:40 A.M., with LPN A showed: -Review of the resident's physician orders did not have a details order to include the IV antibiotic infusion flow rate. -He/She had been administering per the pharmacy label which noted the IV antibiotic bag to infusion rate to run for 75 minutes. (did not have infusion rate on the bag label)-LPN A said he/she would expect the resident physician order to be detail to include IV infusion rate for IV Vancomycin. -He/She had reviewed the resident's hospital discharge order and instruction which did not have detail orders related to infusion rate. During an interview on 9/5/25 at 11:54 A.M., Infection Control Preventionist (ICP) said: -He/She had only audited the resident's physician order one time.-He/She would expect the resident to have comprehensive physician order for IV therapy to include the infusion rate per hour. During an interview on 9/5/25 at 2:18 P.M., DON said:-He/She would expect physician order to be detail and comprehensive. -He/She would expect the resident's physician order for IV antibiotic to (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	include the infusion rate of 120 ml/hr over 75 minutes. -Nursing staff were to document in the resident licensed MAR and in the resident nursing note care task when completed. -The nursing staff and the DON would be responsible for ensure complete physician orders.-The Administrator and DON would complete any audits of the resident medical record to include accurately transcribe physician orders

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, the facility failed to maintain a safe, functional, and sanitary environment by allowing floor tiles to separate creating possible tripping hazards with not easily cleanable cracks and ceilings to crack allowing possible contamination of food and/or drinks underneath. This deficient practice had the potential to affect residents, visitors, volunteers, and staff residing, visiting, using, or working in those locations. Additionally, the facility failed to ensure resident safety by failing to adequately monitor two sampled residents who had wandering and exit seeking behaviors (Resident #33, and #3) and failed to ensure safety during a transfer for one supplemental resident who required staff to use a mechanical lift to transfer (Resident #40) out of 16 sampled residents. The facility had a census of 46 residents with a licensed capacity of 120 residents at the time of the survey.1. Observation on 9/3/25 between 10:57 A.M. and 12:01 P.M. during the facility Life Safety Code (LSC) walk-through inspection with the Director of Maintenance (DOM) and his/her assistant showed:-Inside the double smoke doors at the south entrance of the Main Dining Room (MDR) were approximately (app.) 17 miscolored tiles laid the width of the doorway that did not fit tight in the floor creating cracks between themselves and other pre-existing tiles.-Inside the double smoke doors at the north entrance of the MDR were app. 21 miscolored tiles laid the width of that doorway that did not fit tight in the floor creating cracks between themselves and other pre-existing tiles.-The MDR vaulted popcorn ceiling (a type of ceiling finish that looks like tiny kernels of popcorn on the surface, created with a spray-on or paint-on texture that adds sound-deadening qualities and can hide imperfections) had three patches, each app. 5-inches () x 20, on the east slope where the popcorn was missing and either showed bare ceiling above or had patches of an unknown cracked substance.-At the west end of 200 Hall by an Electrical Closet there were app. 40 miscolored tiles inside the width of the exit door hallway that did not fit tight in the floor creating cracks between themselves and other pre-existing tiles.-The ceiling in the Employee Training Room was cracked and bulging at both sides of a light fixture.-App. 14 mis-colored tiles outside the north Clean Utility door did not fit tight in the floor creating cracks between themselves.-There was an app. 1/4 to 3/8 crack running the length of the ceiling in the Employee Breakroom.-The ceiling by a sprinkler head in the resident room [ROOM NUMBER] bathroom was cracked.-The pavement at the west resident enclosed smoking courtyard had multiple cracks running 9 feet (') or more with a cement patch toward the middle app. 3.5' x 5' that had broken apart edges that created gravel-like pieces. During an interview on 9/3/25 at 11:09 A.M. in the Employee Training Room the DOM said that all the ceiling cracks and patches were from roof leaks that occurred about four years ago. During an interview on 9/4/25 at 12:21 P.M. the DOM said that he/she would expect the facility to be free of any possible contamination of food and have no tripping hazards. During an interview on 9/4/25 at 12:58 P.M. the Administrator said they would expect the facility to have no tripping hazards and be free of any possible contamination of food or drinks. Review of the facility Safe Lifting and Movements policy and procedure dated July 2017, showed:-Staff responsible for direct resident care will be trained in the use of manual and mechanical lifting devices.-Mechanical lifting devices shall be used for heavy lifting, including lifting and moving residents when necessary.-Mechanical lifts shall be made readily available and accessible to staff 24 hours daily. Back up battery packs on remote chargers shall be provided as needed so that lifts can be used 24 hours a day while batteries are being recharged.-All equipment design and use will meet or exceed the guidelines and regulations concerning residents' safety and the use of restraints.-The policy did not address how to use the mechanical lifts. 2. Review of (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #40's Face Sheet showed the resident was admitted to the facility on [DATE] with diagnoses including Parkinson's Disease (a progressive neurodegenerative disorder that affects movement, balance, and coordination), dementia, pain, muscle contracture (a fixed, abnormal shortening of muscle or other soft tissues (like skin, tendons, or ligaments) that restricts normal movement of a joint, often due to scarring, prolonged disuse, or neuromuscular conditions) of upper and lower extremity and history of falling. Review of the resident's quarterly MDS dated [DATE] showed the resident:-Was alert and oriented without cognitive deficits.-Had upper and lower extremity impairment on one side.-Was dependent with all transfers and used a wheelchair for mobility. Observation and interview on 9/4/25 at 9:16 A.M., showed CNA B brought the sit to stand lift (a mechanical hydraulic device that helps a person move from a seated to a standing position and vice versa) into the resident's room. The resident was sitting up in his/her wheelchair. CNA B said he/she was going to transfer the resident into his/her recliner. He/she placed the lift in front of the resident, attached the sling around the resident and hooked it to the lift. He/she noticed the lift did not work and he/she left to get a battery for the lift. He/she came back into the resident's room and put the battery on the lift. CNA B did the following:-He/She lifted the resident into a semi-standing position where the resident's legs were bent, but he/she was still holding onto the lift handles.-CNA B used a gloved hand to pull the resident's pants down, pulled his/her brief aside and used a urinal for the resident to use the bathroom while still semi-standing in the lift.-When the resident was done, CNA B pulled his/her brief back in place, pulled his/her pants up and then lowered the resident down into his/her recliner.-The resident did not show signs of fear or anguish, nor did he/she say he/she was afraid.-CNA B said that he/she assisted the resident to use the urinal while he/she was up in the lift because it was easier for the resident to use the urinal while standing. During an interview on 09/05/2025 2:17 PM with the DON and Administrator both said:-No one should be hanging on to the sit to stand lift while the staff are performing resident cares.-CNA B should have transferred the resident then provided the urinal, not while the resident was still in the sit to stand lift. Review of the facility Wandering and Elopement policy and procedure dated March 2019, showed the facility will identify residents who are at risk of unsafe wandering and strive to prevent harm while maintaining the least restrictive environment for residents. It showed:-If identified at risk for wandering, elopement or other safety issues, the resident's care plan will include strategies and interventions to maintain the resident's safety.-If an employee observed a resident leaving the facility, he/she should attempt to prevent the resident from leaving in a courteous manner, get help from other staff members in the immediate vicinity if necessary and instruct another staff member to inform the charge nurse or Director of Nursing that a resident is attempting to leave the premises.-The policy did not show any interventions regarding supervision to prevent the possibility of elopement. 3 Review of Resident #33's Face Sheet showed the resident was admitted to the facility on [DATE], with diagnoses including dementia, lack of coordination, stroke with paralysis on the left side. Review of the resident's admission Minimum Data Set (MDS-a federally mandated assessment tool to be completed by facility staff for care planning) dated 7/24/25, showed the resident:-Was alert with some confusion.-Did not have any behaviors delusions or wandering.-Had disorganized thoughts, trouble sleeping, trouble concentrating and sleeping.-Was independently mobile. Review of the resident's Care Plan dated 7/25/25, showed the resident had impaired cognitive function and impaired thought processes due to dementia, was an elopement risk and wandered, had impaired safety awareness and had a history of attempts to leave the facility unattended. Intervention showed staff would:-Attempt to redirect the resident away from exits when he/she wants to open doors.-Provide conversation to the topic the resident is showing (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	interest in.-Ensure the safety of the resident and others.-Establish boundaries and limits with the resident.-Reorient the resident to person, place time and situation.-Utilize diversion techniques as needed.-Distract the resident from wandering by offering structured activities, food conversation, television, books.-Identify the resident's pattern of wandering and intervene as appropriate. Observation during the facility tour on 9/2/25 at 10:42 A.M., showed the resident was sitting in his/her wheelchair in the middle of the hallway. The resident said he/she did not know where his/her room was or where he/she was going. Nursing staff who was in the hallway told the resident where his/her room was and assisted the resident to his/her room. Observation on 9/3/25 at 9:38 A.M., showed the resident was standing in the hallway by the exit door. The resident opened the exit door and the alarm sounded. Facility staff came running immediately toward the resident and brought a wheelchair for the resident. Nursing staff encouraged the resident to sit down and asked the resident cognitive orientation questions (name, place) and the resident said he/she was not feeling good and that his/her head hurt. Nursing staff took the resident back to his/her room. During an interview on 9/3/25 at 10:00 A.M., Certified Nursing Assistant (CNA) A said:-The resident has dementia and needed partial assistance with cares.-The reside was able to ambulate and also used a wheelchair to mobilize in the facility.-When the resident was out in the facility, he/she did wander and was sometimes exit seeking.-The resident usually does not actively seek exits unless he/she is anxious or agitated.-The nursing staff will try to distract/redirect him/her by taking the resident to the nursing station and they will also take the resident to his/her room when he gets this way.-The resident set the alarm off this morning and was trying to exit, but staff immediately redirected him/her and took him/her to his/her room.-They received in report this morning that the resident had a difficult time sleeping last night and that may be why he/she was exit seeking this morning.-They were supposed to monitor the resident more frequently when he/she is this way.-They try to take the resident to or provide activities, but the resident will leave the activity. after a few minutes.-He/She did not know if the resident received one to one activities. During an interview on 9/3/25 at 10:19 AM the resident was sitting in his room, he/she said:-He/She did set the alarm off on the door, but it was an accident.-He/She was trying to get some different clothes to wear.-His/Her clothes were in another building. -He/She attended activities and had attended an activity yesterday where he/she played games and it was fun. Observation on 9/4/25 at 1:24 P.M., showed the Director of Nursing (DON) was sitting at the nursing station. The resident ambulated from his/her room, down the hall, to the exit door and opened it, setting off the door alarm. Several staff rushed to the door and asked the resident where he/she was going. The resident was dressed for the weather but was not wearing socks or shoes. The resident said he/she was going home. Nursing staff got his/her wheelchair and asked the resident to sit down and he/she complied. Nursing staff took the resident off of the hall to the nursing station where they provided the resident with a beverage and snack. During an interview on 9/4/25 at 1:30 P.M., Certified Nurse's Aide (CNA) B said:-He/She was the staff working on the hall with the resident today but was in another resident's room at the time the resident tried to get outside. -They try to prevent the resident from exit seeking and exiting by keeping him/her at the nursing station or involving him/her in an activity.-The resident liked to go outside and sometimes they take him/her outside.-Sometimes the interventions work and sometimes they do not.-They had to watch the resident more frequently to keep the resident from getting out of the door.-They do what they can. Observation on 9/4/25 at 1:43 P.M., Certified Medication Technician (CMT) A said:-The resident usually does not go out of the exit door but does wander and exit seek.-They had a routine for the resident during the day to try to keep the resident from wandering/exit seek.-During the during the day, the resident was (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Ridge Crest Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 706 South Mitchell Warrensburg, MO 64093	

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	usually either in the activity room, they will give him/her snacks or they will take him/her outside.-They try anything to keep the resident busy.-Whenever the resident is more agitated, the resident will exit seek and try to go outside.-Today the resident laid down after breakfast and didn't get up until lunch.-He/She did not know why he/she was taken back to his/her room after lunch today.-When the resident is anxious or agitated, they are more attentive to him/her and try to keep him/her occupied.-He/She was more likely to exit seek when he/she was alone or was not being engaged.-They typically have to keep an eye on the resident when he/she was up and mobile. During an interview on 9/5/25 at 2:17 P.M., with the Director of Nursing (DON) and Administrator, the DON said:-They have had in-services on behavior and dementia what it means and what it represents during their employee onboarding education.-They complete more frequent checks on residents that wander and exit seek.-If they see the resident is having increased anxiety or agitation, he/she expected nursing staff to notify the physician for any possible medications/medication changes.-If the resident is in his/her room, then he/she is in a safe place.-If the resident does come out of his/her room, then they will keep him/her in line of sight at all times and provide him/her with coffee or snacks.-He/She saw the resident when he/she was trying to leave on 9/4/25 and ran toward the resident when he/she was headed toward the door but did not get to him/her in time.-The staff was supposed to inform the nurse if they see any behavior in the resident that will trigger him/her to exit seek.-They have tried to take the resident to activities, but he/she usually just leaves.-They try to give him/her snacks and provide other types of activities, he/she likes to tinker.-Regarding residents who wander or are exit seeking, the Administrator said he/she expected staff to keep the resident in their line of sight especially when the resident is exhibiting behaviors. 4. Review of Resident #3 admission Sheet dated 3/11/16 showed diagnosis of unspecified dementia, unspecified severity, with other behavioral disturbances (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). Review of the resident's annual comprehensive MDS dated [DATE], showed: -He/she was severely cognitively impaired. -He/she had behaviors (physical behavioral symptoms directed towards others), occurred 1 to 3 days-He/she had uncleared speech-slurred or mumbled words.-He/she rarely or never understood for being able to express themselves. Review of the resident's Care Plan, initiated 2/25/25, showed:-The resident was at risk of harm from others as evidenced by wandering, approaching peers without permission, decreased cognitive function and history of placing his hands on others. -The resident would be in line of sight, if cooperative with staff while up in a wheelchair and active. -Monitor the residents where abouts while up.-Redirect the resident when in an area that he/she should not be in. -Provide resident with handheld snacks or suckers to avoid negative interactions with other peers or staff.-Ensure/provide a safe environment.-Resident had a potential to be verbally aggressive.-The resident was an elopement risk/wanderer.-Distract resident from wandering by offering pleasant diversions, structured activities, food, conversation, television, book. Review of Resident #20's quarterly MDS, dated [DATE], showed the resident was cognitively intact. During an observation and interview on 9/2/25 at 11:07 A.M. showed: -Resident #20 was yelling get help and help to get Resident #3 out of his/her room. -Resident #20 said the incident upset him/her because every time Resident #3 comes into his/her room and takes his/her stuff and candy. -Resident #20 said Resident #3 would try to touch him/her and Resident #20 would not let his/her. -Certified Nursing Assistant (CNA) D and therapy assistant from next door came in to redirect Resident #3 out of (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #20's room. During an interview at 9/2/25 at 11:11 A.M. CNA D said the resident wanders the hallway, and staff were to be monitoring and redirecting the resident continually to keep him/her from entering other residents' room. During an observation on 9/2/25 at 2:51 P.M. showed: -The resident wandered into Resident #32's room in his/her wheelchair. -The resident was sitting in his/her wheelchair in Resident #32's room.-The resident had cornered him/herself in between two dressers and the bed. -The resident turned him/herself and opened a drawer on one of the dressers and was going through it.-Resident #32 was standing in his/her room and walked over to Resident #3 and was trying to talk to him/her. -Resident #3 started touching a stuffed animal on top of the smaller dresser and Resident #32 said that was my stuff. -Resident #32 closed the drawer and stood by the bed watching Resident #3.-Resident #3 started moving around in his/her chair again and just kicked the bed and hollered out in pain and knocked something off of the taller dresser.-Resident #32 told Resident #3 to hold still while he/she bent over and picked up the trinket off the floor under Resident #3 wheelchair. -Resident #32 was trying to tell Resident #3 to get out of his/her room and trying to turn him/her around.-Resident #3 tried to open another drawer and Resident #32 said no to Resident #3.-Resident #32 said you need to go over there not here. -Resident #32 was now trapped in the same corner trying to direct Resident #3 out of the room. -Resident #32 was now blocking Resident #3 so he/she would not open anymore dresser drawers.-Resident #32 trying to guide Resident #3 out of the room.-Resident #3 finally got out of the corner and out of the room the resident's room at 3:03 P.M.-Facility staff were not observed in the resident's room or in the hall. Review of Resident #32's comprehensive MDS, dated [DATE], showed facility staff assessed the resident was moderately cognitively impaired. During an interview on 9/2/25 at 3:03 P.M. Resident #32 said:-He/She was okay.-Resident #3 would come into his/her room a lot. During an observation on 9/2/25 at 2:51 P.M. through 3:03 P.M. showed:-There was no nursing staff on the 200 hall.- Two dietary staff walked by but and did not remove Resident #3 from Resident #32's room. Observation on 9/3/25 at 9:55 A.M. showed the resident rolling down the 100 hall in his/her wheelchair and pushed on the side emergency exit door next to the nursing station in between 100 and 200 halls. The door did not open. During an observation on 9/4/25 at 2:17 P.M. showed:-The resident was in common dining room by his/herself and was eating cooked carrots off of Resident #37s tray that was sitting out next to the table that holds dietary supplies and additional food condiments. -The resident stopped eating carrots and rolled over to condiment bin and started putting his/her hands on individual packaged condiments. -Dietary Aide A came out and grabbed the condiment bin from the resident and told the resident that he/she was going to get the resident a snack.-Dietary Aide A came back with a banana and gave it to the resident. -The resident started rolling toward 300 and 400 halls and a nursing staff turned him/her around and pushed him/her back toward the 200 hall. During an interview on 9/4/25 at 2:22 P.M., Dietary Aide A said: -The resident likes to come back to the dining room when lunch was over, and the room was empty and try to steal food off the (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	trays.-The resident was head strong and he/she was afraid he/she was going to get hit when he/she grabbed the condiment bin away from the resident. During an interview on 9/4/25 at 2:23 P.M., the Dietary Manager said:-The resident would come back into the dining room to eat off of other resident's trays.-If the doors were open to the kitchen area the resident would come into the kitchen.-If the resident does come into the kitchen, then he/she would grab the resident a banana and redirect him/her back into the dining room. During an interview on 9/4/25 at 2:30 P.M. Certified Medication Technician (CMT) A said: -If the resident was in the hallway staff would move him/her into another location or sometimes take him/her outside.-He/She would redirect the resident if they would go into another resident's room. -When you approach the resident, you must explain in detail everything that you were going to do.-The resident would go into the dining room and eat off of other residents' trays.-He/She would take the tray away from the resident and get him/her a snack. During an observation on 9/5/25 at 9:31 A.M. showed:-The resident wheeling him/herself from the dining room by his/herself into the 200 hallway and kept trying to open a closet door.-The resident gave up and turned him/herself around and went back into the dining room and towards the 300 and 400 halls. During an interview on 9/5/25 at 9:55 A.M. Licensed Practical Nurse (LPN) A said:-The resident gets caught in the dining room eating off a tray at least once a week. -He/she would grab the resident a snack and redirect him/her back to his/her room. During an interview on 09/05/2025 2:17 PM with the Director of Nursing (DON) and Administrator both said:-Staff would redirect the resident out of other resident rooms.-Staff would use snacks, ball, or games to redirect the resident.-Staff would keep the resident in line of sight so they would always see him/her.-There were snacks at the nurse's desk to provide to the resident.-Staff should be redirecting the resident before he/she gets a chance to eat off other residents' plates.

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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. Based on observation, interview and record review, the facility failed to ensure obtain physician orders for the monitoring and daily care of indwelling Foley catheter (a urinary bladder catheter inserted through urethra) and failed to have documentation monitoring and care of the foley catheter for one sampled resident (Resident #13) out 16 sampled residents, was at risk for Urinary Tack Infections (UTI - an infection of one or more structures in the urinary system). The facility resident census of 46 resident. Review of the facility's Treatment Order Policy dated 7/2016 showed when ordering treatments need to specify the treatment, frequency and duration of the treatment. Received copy of facility Catheter Care, Urinary policy dated 8/2022 showed:-Indwelling foley catheter (is a tube retaining a balloon passed through the urethra into the bladder to drain urine). -Position the catheter drainage bag lower than the bladder at all times to prevent urine from flowing back into the urinary bladder. -Document in the resident medical record to include date and time catheter care was given and name and tile of persons provided the care, character of the urine such as color, clarity and odor noted; assess the skin around the catheter insertion site. 1. Review of Resident #13 admission Record showed the resident admitted with diagnosis of a Flaccid Neuropathic Bladder (is a condition where the bladder muscles are weakened or paralyzed, leading to difficulty or inability to urinate) Review of the resident's Quarterly Minimum Data Set (MDS-a federally mandated assessment tool to be completed by facility staff for care planning) form, dated 7/16/25 showed:-The resident moderately cognitive impaired. -He/She able to make his/her known and understand others most of time. -Requires use of an indwelling foley catheter. -Had diagnosis of neurogenic bladder and instructed uropathy Review of the resident's infection note dated 7/24/25 at 2:22 A.M., showed:The resident continued to be on antibiotic for Urinary tract Infection (UTI, is an infection of one or more structures in the urinary system)-The resident denies any signs or symptoms of adverse reaction. -He/She denies pain at this time and is resting in bed comfortably. Review of the resident's Catheter Care Plan updated on 9/1/25 showed:-The resident has an indwelling catheter related to neurogenic bladder.--Licensed Nurses and Certified Nurse Assistant were to monitor foley catheter and document per facility policy.--The resident prefers dependent drainage bag to be placed onto bed when receiving personal care in bed, due to urethral sensitivity, was updated on 9/3/25. -NOTE: no care plan related how and when to provide perineal and catheter care for the resident. Review of the resident's Physican Order Sheet (POS) dated 9/2025 showed: -The resident Foley Catheter type was a 16 French (FR, size of the catheter) with a 30-milliliter (ml) Balloon. Change foley catheter as needed for clinical indications such as infection, obstruction, or when system is compromised related to diagnosis of Flaccid Neurogenic Bladder.-NOTE: Did not have comprehensive physician order for the ongoing monitoring and daily care for the resident foley catheter. Review of the resident's Treatment Administration Record (TAR) dated 9/1/25 to 9/30/25 showed: -Foley Catheter was a 16 FR/30cc Balloon, change as needed for clinical indications such as infection, obstruction, or when system is compromised related to diagnosis of Flaccid Neurogenic Bladder.-Did not have detail physician order for the care staff to provide ongoing monitoring and daily care for the resident foley catheter. -Did not find documentation of licensed nursing staff provided daily monitoring and assessment and provided daily catheter care. Observation of the resident's on 9/2/25 at 3:00 P.M., showed:-His/Her foley catheter drainage bag was in privacy bag hung on side bed rail. -Resident denied any concern with catheter care and had no current urinary infection at that time. Observation of the resident's catheter care on 9/3/25 at 10:22 A.M. showed:-Certified Medication Technician (CMT) A and Certified Nurse Assistant (CNA) C enter the resident room after they (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	had washed hand, then applied gown and gloves. -When uncovered the resident for care, his/her catheter drainage bag laid on top of bed by the resident's feet. -The CNAs did not lower the bag to kept below the resident bladder during catheter care. -Catheter/perineal care (is the surface area between the thighs extending from the pubic bone to the tail bone) performed by CMT A.-CNA C and CMT A had completed catheter care/peri care with no concern noted. During interview on 9/3/25 at10:45 A.M., CMT A and CNA C said.-The resident's catheter bag should be laid on the bed during care, so does not pull the resident catheter tube when turning the resident. -The catheter drainage bag should be below the bladder in privacy bag after catheter care was completed. -He/She was unsure of the facility policy related to catheter care and placement of the catheter bag during personal cares. During an interview on 9/3/25 at 2:17 P.M., the resident said he/she recently had requested the catheter drainage bag be placed on bed during peri care due to pulling and sensitive of catheter site. Review of the resident's electronic medical record on 9/5/25 at 9:23 A.M., showed CNA's Task section did not have a catheter task to document catheter care was provided for the resident. Review of the resident's POS and TAR on 9/5/25 at 9:40 A.M., with Licensed Practical Nurse (LPN) A showed:-The resident did not have physician order for ongoing monitoring, assessment and care for the resident foley catheter. -LPN A said the resident should have PO to include type catheter care to provide and monitoring required. -Would expect to have documentation by nursing staff in the resident TAR, monitoring and catheter care provided for the resident. -Administrative staff were responsible for auditing the physician order to ensure have a complete comprehensive physician order. During an interview on 9/5/25 at 11:39 A.M., CNA A said he/she would document resident care including catheter care in the resident's Electonic Medical Record. During an interview on 9/5/25 at 11:54 A.M., with Infection Control Preventionist (ICP) said: -He/She had audited the resident's physician order one time after resident readmitted to the facility.-He/She would expect for the resident to have complete comprehensive physician order for nursing staff to provide catheter care and monitoring for infections. -Nursing should ensure to have documentation catheter care and assessment in the resident TAR and nursing notes. During an interview on 9/5/25 at 2:18 P.M., DON and Administrator said:-Best standard of practice he/she would expect the resident's catheter drainage bag remain below the bladder at all times.-The resident requested the foley drainage bag placed on the bed while CNA provide peri care. -The facility had just care planned the resident's request. -He/She would expect physician order to be detail and comprehensive. -He/She would expect the resident's physician order for the foley catheter to include the type of monitoring, catheter care to provide and when.-Nursing staff were to document catheter care and assessment in the resident's TAR and in the resident's nursing notes as completed. -CNA's who provide resident's catheter/peri care would document cares under the CNAs care task section in the resident's electronic medical records. -The nursing staff and the Director of Nursing (DON) would be responsible for ensure complete physician orders.-The Administrator and DON would complete any audits of the resident medical record to include accurately transcription of physician orders.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to follow one sampled resident's nutritional plan for maintaining weight by failing to obtain and provide a physician ordered appetite stimulant in a timely manner and failing to provide a supplemental health shake at breakfast for one sampled resident (Resident #15) who was at risk for weight loss and needed substantial assistance to eat and drink out of 16 residents. The facility census was 46 residents.Review of the facility Nutrition (Impaired)/Unplanned Weight Loss policy and procedure dated September 2012, showed:-The staff and physician will define the resident's nutritional status and identify individuals with weight loss or gain and significant risk for impaired nutrition.-The physician will consider whether any assessment including additional diagnostic testing is indicated to help clarify the severity or consequences of weight loss or impaired nutrition.-The staff and physician will identify any pertinent interventions based on identified causes and overall resident condition, prognosis, and wishes.-The physician will authorize appropriate interventions as indicated.-The physician will limit prescribing of appetite stimulants to situations in which underlying causes cannot be identified or treated, other pertinent interventions have not worked or are not feasible, these medications have a valid indication, and improving appetite and weight is consistent with the individual's condition, prognosis and wishes.-When medical conditions or medication related adverse consequences are causing or contributing to altered nutritional status, the physician and staff will collaborate in adjusting interventions, taking into account the status of those causes and the resident/patient's responses, goals, wishes, prognosis and complications.-The policy did not address following of physician's nutritional orders or Dietician recommendations. 1.Review of Resident #15's Face Sheet showed the resident was admitted on [DATE] with diagnoses including dementia, high blood pressure, cognitive communication deficit, aphasia (a language disorder that affects a person's ability to communicate through speaking, understanding, writing and reading) and insomnia (sleep difficulty). Review of the resident's Minimum Data Set (MDS-a federally mandated assessment tool to be completed by facility staff for care planning) dated 7/1/25 showed the entry tracking record but the assessment was not completed. Review of the resident's Physician's Order Sheet (POS) dated [DATE], showed physician's order for:-Regular diet, Regular texture, Regular/Thin consistency.-Health Shake with meals for nutrition (7/31/25).-House Supplement two times a day 60 milliliters (ml), twice daily with medication pass for nutrition maintenance (7/31/25).-Dronabinol 2.5 milligrams (mg) three times daily for appetite stimulant (9/1/25). -Weekly weights every Friday on the day shift (8/1/25). Review of the resident's Nursing Notes dated 7/1/25 showed:-Nursing staff discussed resident medications with both daughters in the resident's room and discussed the resident's likes and dislikes related to foods.-The resident's daughters stated that on a normal day at the resident's home, he/she ate a good breakfast, big lunch, and a light dinner.-The resident sat in the dining room tonight for evening meal with his/her daughter at his/her side. The resident had difficulty staying on task to eat due to being overstimulated and looking at everyone in the room. The resident's daughters asked that resident may do better if seated toward the windows until he/she gets adjusted to facility. Review of the resident's Care Plan dated 7/1/25 showed the resident had dementia with a self-care performance deficit due to impaired cognitive function and thought process and was at nutritional risk. Interventions showed staff would:-Determine the resident's ability to chew and swallow.-Modify the resident's diet as appropriate according to the resident's food tolerances and preferences.-An update on 8/6/25 showed the resident was at risk foe weight loss and was admitted to Hospice on 7/4/25 due to a diagnosis of senile degeneration of the brain.-There were no updates showing interventions that (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	were implemented to maintain the resident's nutritional status. Review of Dietary Notes showed:-7/31/25 the Registered Dietician (RD) recommended weekly weights, house supplement 60ml twice daily, a health shake with meals, and to assist the resident with meals as needed.-8/29/25 the RD recommended changing the resident's diet to any items or preferences acceptable. staff currently offers substitutes, and family brings in take-out food daily. The resident is on hospice and weight loss with appetite changes are to be expected as natural progression of his/her disease occurs. Review of the resident's Medication Administration Record (MAR) dated August 2025, showed physician's orders for a house supplement 60 ml, twice daily with medication pass (7/31/25). The MAR showed:-House supplement (protein shake) was given twice daily as ordered.-There was no documentation showing health shakes were given with meals (documentation was not on the MAR). Review of the resident's RD assessment dated [DATE] showed:-The RD completed a Significant Change Assessment, reviewed the resident's medications and labs. He/she noted the resident was now on Hospice (end of life care).-The resident's current diet was regular with poor intake of meals and supplements at this time.-The resident did not attend lunch today.-The resident's August weight was 190.6 pounds.-The resident's weight may fluctuate due to diuretic therapy.-Recommend continuing to offer any items/preferences the resident is able to accept/tolerate, encourage intake. The RD will continue to follow as appropriate/requested. Review of the resident's MAR dated [DATE] showed physician's orders for Dronabinol 2.5 mg, give 1 capsule by mouth three times a day for appetite stimulant (Start date 9/1/25), house supplement 60 ml, twice daily with medication pass (7/31/25). The MAR showed:-House supplement was given as ordered-The physician's orders for Dronabinol were not followed on 9/1/25, 9/2/25, or 9/3/25. The attached note showed 'see notes'.-Notes showed on 9/1/25 the medication was not in yet, on 9/2/25 the medication was not in, the charge nurse was notified, they were waiting on pharmacy to deliver the medication, and the charge nurse advised. On 9/3/25 the medication was not in and the charge nurse was notified.-There was no documentation showing health shakes were given at every meal (documentation was not on the MAR). Observation and interview on 9/3/25 at 10:36 A.M., showed the resident was sitting up in his/her recliner and was alert with significant confusion. He/she was in constant movement (sitting up, leaning back, trying to rise from the chair). His/her adult child was giving him/her a protein shake with a straw and the resident was drinking it. He/she said:-The resident stopped eating on his/her own several weeks ago and now needs substantial assistance to eat and drink.-The resident had been losing weight and they were concerned about his/her nutritional status.-The resident was supposed to receive a health shake at meals, but he/she had not seen the facility nursing staff give it to the resident.-When he/she asked the DM about the shake, he/she said that the facility made their own health shakes to give to the residents who have orders for them.-The family has decided to bring in their own protein shakes so they can ensure the resident receives the protein.-They visit the resident almost daily and bring in shakes and meals and also feed the resident at least one meal daily.-He/She did not know if the resident was also supposed to receive an appetite stimulant or other nutritional interventions implemented to maintain his/her weight.-Today he/she did not eat much breakfast so he/she will be here to feed him/her lunch.-It sometimes took a long time to feed the resident, sometimes up to an hour, due to his constant movement and sometimes he/she will not open his/her mouth. Sometimes he/she will eat well and sometimes he/she will not.-The resident was on Hospice services now, but they still want to try to help him/her to maintain his/her weight. During an interview on 9/4/25 at 8:30 A.M., the DM said:-The resident was supposed to receive health shakes at every meal.-They made their own health shakes that were provided with the resident's meals.-The resident was usually fed in his/her room by nursing staff.-He/She was not sure about the resident's current weight, but (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Ridge Crest Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 706 South Mitchell Warrensburg, MO 64093	

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the resident's family also came in regularly to feed the resident, they brought meals in for the resident and they also brought in their own protein shakes. Observation on 9/4/25 from 8:33 A.M. to 8:40 A.M., showed:-The resident was sitting in his/her recliner. There was a breakfast tray sitting beside the resident's recliner with a regular diet of cold cereal, a breakfast sandwich (egg, cheese) with two slices of bacon and a health shake supplement with a glass of juice and milk that was within reach of the resident. There were no straws on the tray or table. The resident was not eating, but was squirming in his/her recliner.-At 8:40 A.M. Certified Nursing Assistant (CNA) B, went into the resident's room, sat down and began feeding the resident cereal. The resident was eating while he/she was being fed and did not attempt to feed himself/herself to try to eat his/her bacon himself/herself.-The resident continued to move around while being fed but did not resist eating. CNA B did not attempt to give the resident any of his/her health shake.-At 8:54 A.M., CNA B finished feeding the resident his/her cereal then he/she took the resident's tray away leaving the milk and juice on the resident's tray table, but not the health shake.-CNA B did not come back to the resident's room but began collecting meal trays from other resident rooms. The resident did not attempt to take a drink from any of the beverages on his/her tray table. Observation on 9/4/25 at 12:49 P.M., showed:-The resident was laying down in his/her bed with the covers pulled up. CNA B was also in the resident's room with his/her meal tray that included the health shake. He/she said he/she was getting ready to try to feed him/her.-CNA B put the head of the resident's bed up and began trying to arouse the resident to get him/her to take a bite of food. The resident kept his/her eyes closed and did not respond to trying to get him/her to eat.-CNAN B took his/her health shake with a straw inside, put it to the resident's mouth and the resident immediately began to drink it. He/she drank all of the shake.-CNA B then again began trying to get the resident to take bites of food. CNA B said:-This was the resident's typical behavior at meals.-They try to get him/her to drink his/her shake if he/she won't eat.-This morning, he/she was able to get the resident to eat his/her cereal, and he/she did not give the resident his/her health shake since he/she ate the cereal.-He/She said, he did not act like he would drink it.-The resident usually drinks with the straw, but the straw probably was not on his/her tray this morning.-He/She did not know where the straws were kept (his/her family puts them away) but the resident drank better with the straws the family provides that the ones they have in the facility.-The resident was supposed to receive a health shake at every meal and his/her family also brought shakes in for the resident that they give to him/her when they visit.-Nursing staff were supposed to try to give the resident the health shakes whether he/she ate his/her meal or not.-It could take anywhere from 10 minutes to 45 minutes to feed the resident and lunch was the meal the resident would eat the most.-At breakfast the resident will not eat much or will not stay awake long enough to eat. During an interview on 9/5/25 at 9:59 A.M., Hospice Licensed Practical Nurse (LPN) said:-They started Hospice services due to the resident's brain degeneration and the resident has had subsequent weight loss due to not eating and has a wound they are trying to heal.-He/She initially lost weight because he/she used to walk and would walk all over the building constantly, but now he/she has forgotten how to walk and is not eating.-The resident's weight is currently 191 pounds and they have ordered 60 ml house shake supplement and he/she was also was supposed to receive health shakes with all meals. They recently implemented an appetite stimulant for the resident.-The resident's family also brought in food and protein shakes and fed the resident when they visit.-He/She usually came in the morning and has observed the meal time-He/she said the resident does not eat well but does drink better than he/she eats. -The facility staff was supposed to follow the orders for nutritional maintenance to try to maintain the resident's weight and help with wound healing. During an interview on (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	9/5/25 at 10:52 A.M., Physician A said:-He/She was the resident's Primary Care Physician and the resident has had some weight loss and they started him on health shake supplements to keep his/her weight up as much as possible.-He/She tried to start an appetite stimulant and initially the family did not want it but they were eventually agreeable.-Nursing staff informed him/her today that the appetite stimulant was ordered but had not come in yet from the pharmacy.-They should have gotten the medication within 24 hours from the pharmacy, but there may have been some issues with the pharmacy.-The charge nurse was going to check on it and get back with him/her today. During an interview on 9/5/25 at 12:45 PM the Director of Nursing (DON) said:-They had an order for an appetite stimulant for the resident but it had not come in from the pharmacy yet.-They still had not received the medication because the medication is a narcotic and it took longer to receive.-In the electronic medical record, if the physician ordered a narcotic medication, sometimes the electronic record did not flag the order which required an extra step to ensure the order goes in.-The physician had to sign to ensure the narcotic was ordered then the pharmacy will send it.-He/She had not checked to ensure the order went through to the physician so he/she could sign off on it and the script then can be routed to the pharmacy to send the medication.-They spoke with the physician today and will have the pharmacy send the medication today. During an interview on 9/5/25 at 2:17 P.M., with the DON and Administrator the DON said:-He/She expected nursing staff to follow the physician's nutritional orders.-Nursing staff should make the attempt to give the resident his/her supplement whether the resident eats his/her meal or not.-The Administrator said the nurse should document in the nursing notes if there is an order for medication that has not been obtained from the pharmacy.-The nurse should document that they notified the physician and the physician should respond within 15 minutes so that a resolution can be made regarding the medication.-They have corrected the issue with the electronic record to ensure physician's narcotic orders were sent and received from the pharmacy timely.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. Based on observation, interview, and record review, the facility failed to follow pre-prepared menus to ensure they met the nutritional needs of residents in accordance with established national guidelines and failed to have a basic ingredient in stock that was called for many of the recipes. These deficient practices potentially affected all residents who ate food from the kitchen. The facility's census was 46 residents with a licensed capacity for 120 residents.Review of the undated Week at a Glance menus for weeks 1 through 4, provided by the Dietary Manager, showed a variety of meals that met the nutritional needs of residents in accordance with established national guidelines. The lunch meal for week 3 that was supposed to be served:-Tuesday was as herb roast beef, brown gravy, roasted carrots, potatoes and onions, and pudding parfait. -Thursday was ham steak, garlic potatoes, buttered carrots, and fruit crumble.-Friday was oven fried fish, cheesy rice, seasoned spinach, and lemon cookie bar.Review of the Resource: Menu Substitution Form showed:-Tuesday the pot roast was substituted with beef stroganoff, and the pudding was substituted with a brownie. -Thursday the ham was substituted with pork.-Friday the fish was substituted with turkey, the spinach was substituted with broccoli, the lemon cookie bar was substituted with chocolate chip cake. During an interview on 9/2/25 at 10:43 A.M. Resident #42 said:-The food budget is too small and limits them on what and how much they can buy. -Dietary never serves what on the menu.-The resident had spoken with the Dietary Manager (DM), and he/she stated he/she can only feed what he/she had.-The resident had spoken with the Administrator, and he/she had stated that the budget was the reason for the food options. Observations on 9/2/25 at 12:20 P.M. showed the resident eating Beef Stroganoff, cooked carrots and a brownie. During interview on 9/4/25 between 9:50 A.M. and 12:00 P.M. the DM said:-The menus were on a 4-week schedule, and they are currently on week 3.-The menus go by seasons and currently on the spring and summer seasons that starts in April and ends in September. -Truck delivery every Tuesday. -The reason for all the substitutions was because the food items were too expensive, out of stock, and the residents were get tired of having the same beef, pork, and chicken all the time. -The dietary vendor was in charge of creating the menu and the representative said he/she would give access to the DM so he/she would be able to change the menu so the residents would have an idea of what would be served, but this hadn't happened yet. -Some foods like, cookies, cakes, and soups were being made in house to save on costs, plus the resident's seemed to like them better.Observations on 9/4/25 at 11:32 A.M. the lunch meal being prepped was for pork chops, buttered carrots, mashed potatoes, and peach cobbler.During an interview on 9/5/25 at 12:43 P.M., the Administrator said:-Corporate was responsible for the dietary budget.-The dietary vendor was responsible for coming up with the menu.-Menu substitution was due to the repetitiveness the resident's get tired of eating the same beef, pork, and chicken. -DM sometimes forgets to order the food.-There was a shopping list on the dietary vendor site, and the DM was educated on how to use. -Price of food had not really been a problem.-The only thing he/she was aware that was changed due to price was the size of the egg they used to get large eggs and now medium.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 the cleanliness inside of the ice machine. This practice potentially affected all 46 residents who had ice in their drinks. The facility census was 46 residents. Review of the facility policy Ice Handling and Cleaning dated 2016 showed:-The ice machine would be wiped down daily with sanitizer.-Ice machine would be emptied quarterly and thoroughly cleaned with an approved sanitizer to remove any settlement or mineral build up in the ice discharge area and floor of the machine.-Ice storage bins shall be drained through an air gap. 1. Observations during the initial walk-through 9/2/25 9:46 A.M., showed the ice machine in the kitchen had a blackish and brownish substance growing inside on the ceiling where the ice comes out. During an interview on 9/4/25 at 9:50 A.M. the Dietary Manager (DM) said:-Maintenance was responsible for maintaining the ice machine. -It was cleaned every 3 to 6 months.During an interview on 9/4/25 at 2:09 P.M. the Maintenance Director (MD) said:-The ice machine company comes out and cleans it every 3 to 4 months.-The Dietary Manager was responsible to call the company. During an interview on 9/5/25 at 10:45 A.M. the DM said the MD may have a schedule of the ice machine being cleaned but he/she did not have it. During an interview on 9/5/25 at 11:29 A.M. the Maintenance Assistant said:-He/She did not know about an ice machine cleaning schedule.-The ice machine was a rental and either the kitchen or Maintenance would call the company to have them come out periodically and clean it. During an interview on 9/5/25 at 11:45 A.M. the MD said there was no schedule that he/she knew of the ice machine being cleaned unless Dietary kept track of it.

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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** Based on observation, interview, and record review, the facility failed to establish and maintain a comprehensive 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) that included specific assessments and contents, 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; failed to ensure handwashing to prevent cross contamination was performed during wound care for one sampled resident (Resident #22) and with transfers for one supplemental resident (Resident #40) out of 16 sampled residents. The facility census was 46 residents with a licensed capacity for 120 residents at the time of the survey. 1. Observation on 9/2/25 between 10:38 A.M. and 10:51 A.M. during the initial facility Life Safety Code (LSC) kitchen inspection with the Director of Maintenance (DOM) showed there was a three-sink area, a chemical dish-washing machine, a hand-washing sink, an ice machine, and a steam table (also referred to as a hot food table, is specifically designed to hold food at steady, safe serving temperatures, and not designed to cook or warm foods from a raw state). Review of the facility's untitled, undated white binder provided by the DOM showed the following:-There was no facility-specific risk assessment that considered the American Society of Heating, Refrigerating, and Air Conditioning Engineers (ASHRAE) industry standard #188.-No Centers for Disease Control (CDC) toolkit assessment including control measures such as physical controls, temperature management, disinfectant level control, visual inspections, and environmental testing for pathogens was included.-A completed CDC Legionella Environmental Assessment Form was missing.-No schematic, flowchart, or diagram of the facility's water system with a written explanation of the water flow throughout the facility that identified and indicated specific potential risk areas of growth within the building with assessments of each individual area's potential risk level was included. Observation on 9/3/25 between 10:25 A.M. and 11:49 A.M. during the facility LSC walk-through inspection with the DOM and his/her assistant showed:-The municipal water main supply entered the building in the fire sprinkler system riser room (in a nutshell, a fire sprinkler riser room is a dedicated space for fire protection equipment situated on an outside wall at grade with direct exterior access) at the east end of 300 Hall with a sign on the double doors to the hall that read, Main Water Shut Off For Building.-The building was equipped with both a wet and a dry fire sprinkler system with sprinkler heads located throughout the facility. -There were housekeeping closets with floor mop sinks or ceramic service sinks (mop/service sinks are used in janitorial and maintenance areas to fill and empty mop buckets, clean mops, and dispose of dirty water), water heaters, water softeners, and hot/cold water piping throughout the five resident room hallways.-There were at least 50 resident rooms with private and/or shared bathrooms and sinks.-There were commercial clothes washers in the laundry area.-There were four used and unused bathhouses on the facility's middle hall. -There was a Beauty Shop with a sink.-Public restrooms were located on the front administrative office hall. During an interview on 9/3/25 at 10:31 A.M. at the sprinkler riser room the DOM said that was where the facility's water supply came in. Review of the facility's document entitled, Water Management Plan, last dated 4/1/25 and provided by the Administrator, showed the following:-No Centers for Disease Control (CDC) toolkit (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	assessment including control measures such as physical controls, temperature management, disinfectant level control, visual inspections, and environmental testing for pathogens was included.-A completed CDC Legionella Environmental Assessment Form was missing.-Most pages had a footer that read, This Water Management Plan Expires on 4/1/2026. Review of the facility's Emergency Preparedness (EP) manual entitled, Emergency Procedure – Disaster Plan, last reviewed 4/11/25 and provided by the Administrator, showed the following:-Under Tab 11, named, Water Outage, Water Main Break, Utility Outages, there was a generic three-page policy, Legionella Water Management Program, without a:--Facility-specific risk assessment that considered the American Society of Heating, Refrigerating, and Air Conditioning Engineers (ASHRAE) industry standard #188.--Centers for Disease Control (CDC) toolkit assessment including control measures such as physical controls, temperature management, disinfectant level control, visual inspections, and environmental testing for pathogens.--Completed CDC Legionella Environmental Assessment Form.-The last page was an arrowed diagram showing the distribution of the water flow after entering from the front of the building, but there was no accompanying written explanation of that flow throughout the facility that identified and indicated specific potential risk areas of growth within the building with assessments of each individual area's potential risk level. During an interview on 9/4/25 at 12:21 P.M. the DOM said that his/her responsibilities with their Legionella program included going around weekly to flush systems not being used, checking the water's pH (aka, Potential for Hydrogen = a solution's acidity or alkalinity on a scale of 0 to 14, with 7 being neutral) and chloramine levels with test strips, and documenting water temperatures. During an interview on 9/4/25 at 12:58 P.M. the Administrator said the following:-His/Her responsibility regarding the Legionella program was to oversee it.-He/She was educated on its requirements when the issue first came out years ago and with its updates since then; it had kind of evolved. 2. Review of Resident #22's Face Sheet showed the resident was admitted on [DATE] with diagnoses including heart failure, lack of coordination, abnormal gait and mobility, and cognitive communication deficit. Review of the resident's quarterly Minimum Data Set (MDS-a federally mandated assessment tool to be completed by facility staff for care planning) dated 1/28/25 showed the resident:-Was alert and oriented with minimal confusion.-Had limitations on one side of his/her lower extremity.-Needed set up to supervision for activities of daily living (bathing, dressing, eating) and used both walker and wheelchair for mobility.-Had two venous stasis ulcers that were treated with ointments and non-surgical dressings. Review of the resident's Physician's Order Sheet (POS) dated [DATE], showed physician's order for:-Cleanse the resident's left lower extremity with normal saline (salt water), apply moistened hydrofera blue (a foam wound dressing containing properties the promote a moist wound healing environment) dressing to the back of the achilles (the fibrous tendon found in the back of the lower leg), cover with an abdominal pad (ABD pad-a large thick highly absorbent dressing designed for wounds with heavy drainage or for providing padding and protection), wrap with a cotton dressing and ace wrap three times weekly on day shift on Tuesday, Thursday and Saturday (4/23/25). Observation and interview on 9/2/25 at 11:11 A.M., showed there was an enhanced barrier precautions (EBP-an infection control strategy that involves using gowns and gloves during high-contact resident care activities to reduce the spread of multidrug-resistant organisms (MDROs) and other pathogens in healthcare settings, particularly nursing homes) sign on the resident's door with personal protective equipment (PPE-clothing, gear, or equipment worn by an individual to protect against serious injuries, illnesses, or the spread of infection by minimizing exposure to various workplace or environmental hazards) in a container outside of the resident's door. The resident was sitting on his/her bed and was alert and oriented. He/She said:-He/She currently has a wound on his/her left lower leg that came (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	about when he/she was taking medications that caused a skin reaction.-He/She initially had wounds on both legs, but the nursing staff was able to heal the wound on his/her right leg and the wound on his/her left leg had shrunk significantly. -The nurse changed the dressings every week and he/she would be here today to look at it and treat it. Observation and interview on 9/4/25 at 1:53 P.M., showed the resident was sitting up on the side of his/her bed. Licensed Practical Nurse (LPN) and Wound Care Nurse knocked on the resident's door and informed him/her that he/she was coming to provide wound care. The resident said he/she was ready and the Wound Care Nurse put on a gown and brought his/her wound supplies into the resident's room, placing them on a paper towel barrier on the resident's tray table. The resident said his/her dressing was already off of his/her leg. The Wound Care Nurse did the following:-The Wound Care Nurse then washed his/her hands and gloved then laid a barrier across the resident's bed.-The resident laid down placing his/her leg on the barrier. There was an open area on his/her achilles that was an elongated wound about pencil width, approximately one inch in length.-The Wound Care Nurse wiped the area with a cotton swab and wound cleanser.-Without discarding his/her gloves and washing or sanitizing his/her hands, he/she applied pre-moistened hydrothera blue to the wound, then applied the ABD pad and wrapped the resident's leg with a cotton dressing.-The Wound Care Nurse then opened an ace bandage and wrapped the resident's leg from his/her foot to his/her calf.-The Wound Care Nurse then discarded his/her gloves and washed his/her hands, drying them with a paper towel and turning off the water with a paper towel.-He/She bagged the trash, put a new liner in the trash can, then washed his/her hands, removed his/her gown, put it in the trash then left the resident's room. During an interview on 9/4/25 at 2:12 P.M., the Wound Care Nurse said after cleaning the resident's wound he/she should have washed or sanitized his/her hands before applying the new treatment to prevent cross contamination. 3. Review of Resident #40's Face Sheet showed the resident was admitted to the facility on [DATE] with diagnoses including Parkinson's Disease (a progressive neurodegenerative disorder that affects movement, balance, and coordination), dementia, pain, muscle contracture (a fixed, abnormal shortening of muscle or other soft tissues (like skin, tendons, or ligaments) that restricts normal movement of a joint, often due to scarring, prolonged disuse, or neuromuscular conditions) of upper and lower extremity and history of falling. Review of the resident's quarterly MDS dated [DATE] showed the resident:-Was alert and oriented without cognitive deficits.-Had upper and lower extremity impairment on one side.-Was dependent with all transfers and used a wheelchair for mobility. Observation and interview son 9/4/25 at 9:16 A.M., showed Certified Nurse's Aide (CNA) B brought the sit to stand lift (a mechanical hydraulic device that helps a person move from a seated to a standing position and vice versa) into the resident's room. The resident was sitting up in his/her wheelchair. CNA B said he/she was going to transfer the resident into his/her recliner. He/she put a glove on one hand placed the lift in front of the resident, attached the sling around the resident and hooked it to the lift. He/she noticed the lift did not work and he/she left to go get a battery for the lift. He/she came back into the resident's room and put the battery on the lift. CNA B did the following:-Without removing the glove off of his/her right hand, washing or sanitizing his/her hands, he/she lifted the resident into a semi-standing position where the resident's legs were bent, but he/she was still holding onto the lift handles.-CNA B used his/her gloved hand to pull the resident's pants down, pulled his/her brief aside and used a urinal for the resident to use the bathroom while still semi-standing in the lift.-When the resident was done, CNA B pulled his/her brief back in place, pulled his/her pants up and then without sanitizing or washing his/her hands, lowered the resident down into his/her recliner.-CNA B then removed the glove, discarded it, washed his/her hands, re-gloved his/her right hand, poured the contents of the urinal (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265797	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/08/2025
NAME OF PROVIDER OR SUPPLIER Ridge Crest Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 706 South Mitchell Warrensburg, MO 64093	

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

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	into the toilet and flushed it.-CNA B then, without removing his/her glove and washing or sanitizing his/her hands, removed the lift from the resident's room.-CNA B said that he/she assisted the resident to use the urinal while he/she was up in the lift because it was easier for the resident to use the urinal while standing.-He/she did not think there was any concern with only gloving one hand and he/she did not realize he/she needed to wash his/her hands again when he/she re-entered the resident's room.-He/she did not notice that he/she had not washed or sanitized his/her hands after he/she assisted the resident with the urinal.-He/She thought he/she did wash his/her hands before leaving the resident's room. During an Interview on 9/5/25 at 2:17 PM with the DON and Administrator, both said:-Nursing staff should wash their hands upon entering the resident's room, after removing gloves, between dirty to clean tasks and before leaving the resident's room.-The Administrator said the Wound care Nurse said he/she had completed Resident #15's entire treatment without removing his/her gloves or washing his/her hands and he/she knew better than to do that.-CNA B had not followed several protocols for resident cares though he/she had been trained on said protocols.

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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 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure two sampled residents (Residents #4, and #22) were educated on, offered, and/or had the opportunity to decline Influenza vaccinations, failed to document educated on, offered, and/or had the opportunity to decline Pneumococcal vaccinations for two sampled Resident (Resident#4 and #22) out of 16 sampled residents and five supplemental residents. The facility census was 46 residents. Review of the facility's Influenza prevention and control Policy revised 10/2019 showed:-All resident is offered the vaccine unless there is a medical contraindication. Review of the facility's Influenza Vaccine Policy revised 3/2022 showed:-Residents will be offered the Influenza vaccine each year between October 1 and March 31, unless contraindicated or received the vaccine elsewhere during that time. -Prior to the vaccination, the resident or legal representative will be provided information and education regarding the benefits and potential side effects of the influenza vaccine. Provision of such education shall be documented in the resident's medical records.-Those residents that received vaccine, the date of the vaccination, lot number, expiration date, person administering and the site of vaccine will be documented in the resident medical record. -Refusal of the vaccine shall be documented on the informed consent for influenza vaccine and placed in the resident's medical record. Review of the facility's Pneumococcal Vaccine policy revised 10/2019 showed:-All residents will be offered pneumococcal vaccines to aid in preventing pneumococcal infections.-Assessment of pneumococcal vaccine status will be conducted with in five working days of the resident's admission if not conducted prior to admission.-Before receiving a pneumococcal vaccine, the resident or legal representative shall receive information and education regarding the benefits and potential side effects of the pneumococcal vaccine. Provision of such education shall be documented in the resident's medical record. -If refuse the vaccine, appropriate entries will be documented in each resident's medical record indicating the date of the refusal of the vaccine. -For person who receives the vaccine, the date of vaccination. Lot number, expiration date person administering, and the site of vac [NAME] will be documented in the resident medical record.1. Review of Resident #4's admission Record showed he/she was readmitted to the facility on [DATE].Review of the resident's medical record showed no documentation of the resident's influenza and pneumococcal vaccine status or that the resident received education for the risks or benefits of the vaccine since admission to the facility and annually.2. Review of Resident #22's admission Record showed he/she was admitted to the facility on [DATE].Review of the resident's medical record showed no documentation of the resident's influenza and pneumococcal vaccine status or that the resident received education for the risks or benefits of the vaccine since admission to the facility and annually.3. During an interview on 9/5/25 at 11:41 A.M., Licensed Practical Nurse (LPN) A said:-Resident's Immunization should be documented in electronic record under immunization tab. -Wound Nurse and charge nurse would be responsible for ensuring influenza and pneumococcal vaccine status or that the resident received education for the risks and benefits of the vaccines.During Infection Control Surveillance interview on 9/5/25 at 11:54 A.M., the Infection Control Preventionist (ICP)/Administrator said: -Wound Nurse was responsible for tracking and documented vaccines when given or offered, and to document educated provided related to benefits and risk of the specific vaccine. -The facility was not able to locate request documentation of the sampled resident's vaccine status, education provided and documentation of refusal of the vaccines. -He/She would expect the nursing staff and/or assigned staff member to document immunization into the resident electronic medical record as needed. -The facility has not begun offer flu vaccine for 2025 yet. During an interview on 9/5/25 at 11:45 A.M., Director of Nursing (DON) said:-Wound Nurse and (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	ICP would be responsible for tracking and documentation of the resident's vaccine status or refusal.-Wound Nurse and ICP would be responsible to ensure the resident or representative had received education for the risks or benefits of the vaccine at time of administration, as needed.

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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 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure five sampled residents (Residents #4, #5, #7, #22 and #48) a were offered or had documentation of previous COVID-19 (a new disease caused by a novel (new) coronavirus) vaccinations or documentation of refusal of COVID-19 vaccine education provided out of 5 out 5 resident sampled for immunization review. The facility census was 46 residents. Review of the facility's Coronavirus (COVID-19) Vaccine policy dated 11/7/23 showed:-Each resident will have the opportunity to affirm or deny consent to receive the COVID-19 vaccine doses.-The facility will obtain consent for vaccination from each resident or representative.-Document screening and administration of the vaccine in the resident's medical records. 1. Review of Resident #4's admission Record showed he/she was readmitted to the facility on [DATE].Review of the resident's medical record showed no documentation of the resident's COVID-19 vaccine status or that the resident received education for the risks or benefits of the vaccine since admission to the facility. 2. Review of Resident #5's admission Record showed he/she was admitted to the facility on [DATE] and readmitted on [DATE].Review of the resident's medical record showed no documentation of the resident's COVID-19 vaccine status or that the resident received education for the risks or benefits of the vaccine since admission to the facility.3. Review of Resident #7's admission Record showed he/she was admitted to the facility on [DATE].Review of the resident's medical record showed no documentation of the resident's COVID-19 vaccine status or that the resident received education for the risks or benefits of the vaccine since admission to the facility.4. Review of Resident #22's admission Record showed he/she was admitted to the facility on [DATE].Review of the resident's medical record showed no documentation of the resident's COVID-19 vaccine status or that the resident received education for the risks or benefits of the vaccine since admission to the facility.5. Review of Resident #48's admission Record showed he/she was admitted to the facility on [DATE].Review of the resident's medical record showed no documentation of the resident's COVID-19 vaccine status or that the resident received education for the risks or benefits of the vaccine since admission to the facility.6. During an interview on 9/5/25 at 11:41 A.M., Licensed Practical Nurse (LPN) A said:-Resident's Immunization should be documented in electronic record under immunization tab. -Wound Nurse and charge nurse would be responsible for ensuring COVID-19 vaccine status or that the resident received education for the risks or benefits of the COVID vaccine documented upon admission and annually. During the Infection Control Surveillance interview on 9/5/25 at 11:54 A.M., the Infection Control Preventionist (ICP)/Administrator said: -Wound Nurse was responsible for tracking and documented vaccines when given or offered, and to document educated provided related to benefits and risk of the specific vaccine. -The facility was not able to locate request documentation of the sampled residents COVID-19 vaccine status, education provided and documentation of refusal of the vaccine. -He/She would expect the nursing staff and/or assigned staff member to document immunization into the resident electronic medical record as needed. During an interview on 9/5/25 at 11:45 A.M., Director of Nursing (DON) said:-Wound Nurse and ICP would be responsible for tracking and documentation of the resident's COVID-19 vaccine status or refusal.-Wound Nurse and ICP would be responsible to ensure the resident or representative had received education for the risks or benefits of the vaccine at time of admission and annually.