STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265055	A. Building B. Wing	08/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Kabul Nursing Homes Inc	1000 Main Street Cabool, MO 65689

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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide written information to the resident and/or the resident's representative for the ombudsman (resolves complaints for residents of long term care facilities) contact information, the contact information for the agency responsible for protective and advocacy of individuals with mental disorders, contact information for the protection and advocacy of individuals with development disabilities, and appeal information for two residents (Residents #5 and #10) out of two sampled residents. The facility also failed to provide a discharge summary to the resident which includes a recapitulation of the resident's stay, and a final summary of the resident's status for one resident (Resident #48) out of one sampled resident. The facility's census was 39. Review of the facility's policy titled, Bed Hold Policy, dated 11/08/22, showed: - A written notice of transfer/discharge including bed-hold notice will be given to the resident/responsible party prior to transfer/discharge and a follow up letter will be sent within 24 hours from the time of transfer/discharge, or the first business day thereafter; - If a resident is not admitted to the hospital as an inpatient but is kept for observation up to 24 hours, the resident will not be considered as discharged and the bed hold policy will not apply. Review of the facility's policy titled, Discharge to Hospital or Other Facility, dated 08/13/25, showed: - Order will be received from the attending physician indicating discharge destination; - The charge nurse will complete the Bed Hold Notice and Notice of Transfer or Discharge with the discharging resident and/or the responsible party prior to discharge, make a copy for the resident, business office, and resident medical record; - The charge nurse will print the continuity of care document from the electronic health record and send with the resident. Review of the facility's policy titled, Transfer and Discharge Requirements, dated 08/13/25, showed: - When the facility transfers or discharges a resident under any of the circumstances, the facility will ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider. The resident will also be provided a Notice of Transfer or Discharge; - Documentation will include the basis for the transfer;- (continued on next page)

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

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

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- All other necessary information, including a copy of the resident's discharge summary and any other documentation as applicable, to ensure a safe and effective transition of care. Review of the facility's policy titled, Discharge to Home, dated 08/13/25, showed: - Order will be received from the attending physician indicating the discharge destination, discharge with current medications, any home health services needed, and any equipment needed; - Residents will be provided a notice of transfer or discharge; - Social Service Designee (SSD) will initiate discharge planning, nursing will provide education to the resident regarding medications/treatments; a list of current medications will be provided. 1. Review of Resident #5's medical record showed: - admitted on [DATE]; - Transferred to the hospital on [DATE], with a return anticipated; - No documentation the facility provided the written information to the resident and/or the resident's representative of the ombudsman's contact information, the contact information for the agency responsible for the protective and advocacy of individuals with mental disorders, the contact information for the protection and advocacy of individuals with development disabilities, and the appeal information. 2. Review of Resident #10's medical record showed: - admitted on [DATE]; - Transferred to the hospital on [DATE], with a return anticipated; - No documentation the facility provided the written information to the resident and/or the resident's representative of the ombudsman's contact information, the contact information for the agency responsible for the protective and advocacy of individuals with mental disorders, the contact information for the protection and advocacy of individuals with development disabilities, and the appeal information. 3. Review of Resident #48's medical record showed: - admitted on [DATE]; - discharged home with return not anticipated on 05/14/25; - Discharge Minimum Data Set (MDS – a federally mandated assessment to be completed by the facility), dated 05/14/25, showed an unplanned discharge and return not anticipated; - Nurse's Note, dated 05/14/25, the resident discharged home with all medications and belongings. Left facility with a family member; (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- No documentation the facility provided the written information to the resident and/or the resident's representative of the discharge summary to include the recapitulation of the stay and a final summary of the resident's status. During an interview on 08/13/25 at 11:45 A.M., Medical Records said the discharge paperwork should include all the required information. During an interview on 08/12/25 at 3:30 P.M., the Administrator said the discharge paperwork did not include all the required information, but it should. The facility did not provide discharge/transfer paperwork for residents when sent to the hospital, only when an actual discharge was issued. During an interview on 08/13/25 at 2:00 P.M., Medical Records said the correct discharge paperwork didn't get completed for Resident #48 because the resident left before expected.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on observation, interview, and record review, the facility failed to ensure staff utilized safe transfer techniques for one resident (Resident #28) out of one sampled resident when staff failed to use a gait belt (an assistive device placed around a person's waist to provide caregivers with a secure grip when lifting or moving) appropriately when lifting and repositioning one resident in wheelchair. The facility census was 39. Review of the facility's policy titled, Transfer Resident With Gait Belt And One - Two Assist, reviewed 01/27/25, showed:- Staff should identify the assistance a resident needs from the care plan and assess the resident for additional assistance prior to beginning a transfer;- Apply gait belt around the resident's waist snugly but not so tight to impair ability to breathe;- Do not lift the resident under the arms;- Position the resident in a chair with the hips all the way back;- Remove the gait belt. 1. Review of Resident #26's medical record showed:- An admission date of 06/04/25;- Diagnoses of unspecified dementia, unspecified severity, with other behavioral disturbance (drastic changes in behavior), essential primary hypertension (high blood pressure), reduced mobility, unspecified hearing loss, type 2 diabetes mellitus (a chronic condition where the body either doesn't produce enough insulin or can't effectively use the insulin it produces, leading to elevated blood sugar levels), and metabolic encephalopathy (a broad category of brain dysfunction caused by underlying medical conditions that disrupt the body's metabolism).Review of the resident's admission Minimum Data Set (MDS - part of a federally mandated process for clinical assessment of all residents in certified nursing homes), dated 07/02/25, showed:- Severely impaired cognition; - Partial/Moderate assistance sit to lying, lying to sitting on side of bed, and sit to stand;- Use of manual wheelchair.Review of the resident's Care Plan, dated 06/26/25, showed: - At risk for injury from falls related to poor safety awareness. Tends to fall a lot, tries to get up without assistance, and combative with care at times. Interventions of monitor the resident and surroundings, avoid allowing the resident to be up in the wheelchair alone in the room, secure the chair alarm while up in the wheelchair propelling in the halls, and keep family involved in communication.Observations on 08/12/25, of the resident's transfer and repositioning showed:- The resident sat in a wheelchair;- At 12:09 P.M., Certified Nurse Assistant (CNA) I and Licensed Practical Nurse (LPN) E each placed one hand under the resident's axillary areas and the other hand under the knees, and lifted the resident to reposition him/her in the wheelchair;- At 12:11 P.M., CNA G stood behind the resident's wheelchair, grabbed the back waistband of the resident's pants, lifted the resident's buttocks off the wheelchair seat, and scooted him/her back in the wheelchair seat. The resident propelled him/herself through the hall and the north dining room, scooted his/her buttocks to the front edge of the wheelchair seat, and 3 inches (in) of the seat cushion hung off the front edge of the wheelchair;- At 12:17 P.M., the resident reclined back in the wheelchair, his/her head rested on the top of the wheelchair seat back, his/her buttocks sat at the front edge of the wheelchair seat, and 3 in of the seat cushion hung off the front edge of the wheelchair seat bent under the resident's legs. CNA H placed his/her right hand behind the resident's left shoulder and pulled the resident forward to sit upright. CNA F wrapped a gait belt around the resident's mid chest area directly under the bottom of the breasts. CNA H and CNA F pulled the resident up with the gait belt;- At 12:21 P.M., LPN E and CNA H each placed one hand under the resident's axillary areas and the other hand under the knees, lifted the resident to reposition him/her in the wheelchair, and 3 in of the seat cushion hung off the front edge of the wheelchair seat bent under the resident's legs;- At 12:23 P.M., LPN E and CNA H wrapped a gait belt under the resident's breasts and pushed the resident to his/her room.During an interview on 08/12/25 at 3:36 P.M., LPN E said the care plan showed how a resident transferred. Staff should not reposition or transfer a resident by holding under the axillary areas and the back of the knees. A gait belt should be used to reposition a resident.During an interview on 8/14/25 at 12:11 P.M., CNA F said that he/she would not pick up any residents by their axillary areas and knees to reposition or scoot them back in a (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	wheelchair with another nursing staff member. He/She would use a gait belt for safety and would position the gait belt just under a resident's breast area.During an interview on 8/14/25 at 12:30 P.M., CNA H said he/she would use a gait belt and position it under a resident's breast area with assistance of another staff member before repositioning a resident.During an interview on 8/14/25 at 12:48 P.M., CNA G said to scoot a resident back in the wheelchair, he/she would hold on to the back of the resident's pants and pull them back in the wheelchair. If another staff member was available, he/she would apply a gait belt under the breast area and both staff would get on each side of the resident and use the gait belt to pull the resident back in the wheelchair seat.During an interview on 08/14/25 at 12:35 P.M., the Administrator and Director of Nursing (DON) said they would expect nursing staff to use proper gait belt procedures for safety of the residents.

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia. Based on observation, interview, and record review, the facility failed to ensure residents diagnosed with dementia (a decline in memory or other thinking skills severe enough to reduce a person's ability to perform everyday activities) had a personalized plan of care to ensure appropriate services to promote the resident's highest level of functioning and psychosocial needs were provided for one resident (Resident #15) out of three sampled residents. The facility census was 39.The facility did not provide a policy regarding dementia care.1. Review of Resident #15's medical record showed:- admission date of 07/02/25;- Diagnoses of vascular dementia (a type of cognitive decline caused by damage to the blood vessels in the brain), moderate, with other behavioral disturbance, and senile degeneration of the brain (progressive decline in cognitive functions associated with old age).Review of the resident's admission Minimum Data Set (MDS - part of a federally mandated process for clinical assessment of all residents in certified nursing homes), dated 07/12/25, showed:- Moderate difficulty hearing and required speaker to increase volume and speak distinctly;- Hearing aides used;- Usually understood with difficulty communicating some words or finishing thoughts but was able if prompted or given time;- Usually understood but missed some part/intent of message but comprehended most conversation;- Severe cognitive impairment.Review of the resident's Care Plan, dated 08/11/25, showed:- Did not address dementia;- Did not address specific problems, interventions, or goals for dementia care.Observations of the resident showed:- On 08/11/25 at 11:07 A.M., the resident lay in bed with his/her eyes closed;- On 08/11/25 at 12:30 P.M., the resident sat in his/her wheelchair at a table in the north side dining room and fed his/herself.- On 08/11/25 at 12:49 P.M., the resident sat in a wheelchair in his/her room and removed his/her sweatpants and a brief wet with urine; - On 08/12/25 at 9:49 A.M., the resident sat in a wheelchair in his/her room, held the television remote in his/her hand, and the television was off. During an interview on 08/14/25 at 1:45 P.M., the Director of Nursing (DON) said a resident's care plan should address dementia. The care plan should show the resident's needs are being met. During an interview on 08/14/25 at 1:45 P.M., the Administrator said the care plan should address the resident's diagnosis and needs.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on interview and record review, the facility failed to establish a system of records for the receipt and disposition of all controlled medications in sufficient detail to enable an accurate reconciliation of the controlled medications to ensure nursing staff signed at the beginning and the end of each shift for two medication carts out of three sampled medication carts. The facility's census was 39.The facility did not provide a policy regarding the reconciliation of narcotics. 1. Review of the North Hall Medication Cart Controlled Medication Package Count Log, dated July 2025, showed: - No documented narcotic quantity for 26 missed opportunities out of 93 opportunities; - No signature and/or initials by the nurse or Certified Medication Technician (CMT) for 46 opportunities out of 186 opportunities. Review of the North Hall Medication Cart Controlled Medication Package Count Log, dated August 2025, showed: - No documented narcotic quantity for eight missed opportunities out of 40 opportunities; - No signature and/or initials by the nurse or CMT for 15 opportunities out of 80 opportunities. 2. Review of the North/South Hall Medication Cart Controlled Medication Package Count Log, dated July 2025, showed: - No documented narcotic quantity for 25 missed opportunities out of 93 opportunities; - No signature and/or initials by the nurse or CMT for 45 opportunities out of 186 opportunities.Review of the North/South Hall Medication Cart Controlled Medication Package Count Log, dated August 2025, showed: - No documented narcotic quantity for six missed opportunities out of 40 opportunities; - No signature and/or initials by the nurse or CMT for 16 opportunities out of 80 opportunities. During an interview on 08/14/25 at 10:00 A.M., CMT D said the narcotic count was completed by the on-coming and off-going nurse and/or CMT at the start and end of the shifts. The narcotic reconciliation sheet should be signed by both staff at that time. During an interview on 08/14/25 at 10:10 A.M., CMT C said he/she did not count the North/South Hall medication cart since coming on shift today and administered medications from cart. He/She split the shift with CMT D and should have counted and signed the reconciliation sheet with him/her before taking the keys to the cart. He/She usually counted the narcotics box before taking possession of the cart, and again when passing the cart off to the next nurse or CMT at the shift change. During an interview on 08/14/25 at 10:14 A.M., Licensed Practical Nurse (LPN) A said the narcotics were counted by the on-coming and off-going nurse together and they both signed off the narcotic (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	reconciliation sheet at that time. Since there were two nurses passing medications from the nurse only treatment cart during the day, and only one nurse at night, all three nurses should count together and sign the narcotic reconciliation sheet at shift change. During an interview on 08/14/25 at 10:41 A.M., the Director of Nursing (DON) said everyone should count narcotics for the on-coming and the off-going staff for each shift. Nurses count together, and then a nurse and a CMT, or the on-coming and off-going CMTs count together. The narcotic reconciliation log should be signed off together at that time with the on-coming and off-going staff.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview, and record review, the facility failed to store medications in a safe and effective manner when staff left the medication cart unlocked and unattended. This had the potential to affect all residents. The facility census was 39.Review of the facility's policy, Medication Administration, dated 04/25/24, showed:- Medication will be administered safely and accurately to residents for whom they are prescribed in accordance with current standards of practices;- Medication carts must be kept locked when not in use or in plain sight.1. Observation on 08/14/25 at 11:10 A.M., of the insulin administration for Resident #38 showed:- Licensed Practical Nurse (LPN) A obtained blood sugar reading supplies out of the medication cart, shut the medication cart drawer, and failed to lock the medication cart;- At 11:12 A.M., LPN entered the resident's room with the medication cart facing the hallway, unlocked and unattended. The medication cart sat to the side of the resident's door and out of sight of staff;- LPN A performed the resident's blood sugar reading;- At 11:13 A.M., LPN A exited the room and returned to the unlocked medication cart, obtained the resident's insulin out of the top drawer filled with insulin of the medication cart, left the top drawer of the medication cart open, and failed to lock the medication cart;- At 11:15 A.M., LPN A entered the resident's room with the medication cart facing the hallway with the top insulin drawer opened, unlocked and unattended, and out of the line of sight of staff;- LPN A administered the resident's insulin;- At 11:16 A.M., LPN A exited the resident's room, returned to the opened and unlocked medication cart, and returned the resident's insulin to the opened insulin drawer.2. Observation on 08/14/25 at 11:21 A.M., of the insulin administration for Resident #22 showed:- LPN A obtained the resident's insulin out of the top drawer filled with insulin of the medication cart, left the top drawer of the medication cart open, and failed to lock the medication cart;- LPN A administered the resident's insulin;- At 11:22 A.M., LPN A exited the resident's room, returned to the opened and unlocked medication cart, and returned the resident's insulin to the opened insulin drawer.3. Observation on 08/14/25 at 11:26 A.M., of the insulin administration for Resident #6 showed:- LPN A obtained the resident's insulin out of the top drawer filled with insulin of the medication cart, left the top drawer of the medication cart open, and failed to lock the medication cart;- LPN A administered the resident's insulin;- At 11:27 A.M., LPN A exited the resident's room, returned to the opened and unlocked medication cart, and returned the resident's insulin to the opened insulin drawer. During an interview on 08/14/25 at 12:25 P.M., LPN A said the medication cart should be locked when not being used. During an interview on 08/14/25 at 12:25 P.M., Registered Nurse (RN) B said the medication cart should be locked when not in use and not in the line of sight of the staff. The cart should be in front of the resident door and facing toward the door if left unlocked. During an interview on 08/14/25 at 12:27 P.M., the Director of Nursing (DON) said the medication cart should be locked when not being used or in view of the person using it.During an interview on 08/14/25 at 12:30 P.M., the Administrator said the medication carts should always be locked if not being used.