STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265110	A. Building B. Wing	05/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Moore Few Care Center	901 South Adams Nevada, MO 64772

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 0695 Level of Harm - Actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide respiratory care consistent with standards of practice when staff failed to administer oxygen as ordered, failed to notify the physician of respiratory changes, and failed to create a timely comprehensive care plan that addressed oxygen usage for one residents (Resident #1). The resident went into respiratory distress and was sent to the emergency department. The facility census was 46. Review showed the facility did not provide a policy regarding change of condition procedures. Review showed the facility did not provide a policy regarding physician notification. 1. Review of the Resident #1's face sheet (brief look at resident information) showed the following information: -admission date of [DATE]; -Diagnoses included chronic obstructive pulmonary disease (COPD - a progressive lung disease that makes it difficult to breathe). Review of the resident's admission screening, dated [DATE], showed the following information: -Respiratory rate labored with lung sounds clear to auscultation (the act of listening to the sounds from the lungs, with a stethoscope) bilaterally (LCTAB), and no cough or shortness of breath with lying, sitting, or on exertion. Resident must wear oxygen at 3 liters (L) per minute continuously via nasal cannula. Review of the resident's [DATE] Physician Order Sheet (POS) showed the following: -An order, dated [DATE], for oxygen at 3L per nasal cannula (nc) every shift; -An order, dated [DATE], for opratropium-albuterol (a combination medication use to prevent wheezing, difficulty breathing, chest tightness, and coughing) inhale one vial via nebulizer three times a day related to COPD. Review of the resident's [DATE] Medication Administration Record (MAR) showed on [DATE], staff noted the resident's oxygen was administered at 3L with a night shift oxygen saturation of 88% (with a normal range of 95%- 100%). (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 0695 Level of Harm - Actual harm Residents Affected - Few	Review of the resident's record showed staff did not document physician notification of the reduced oxygen saturation level. Review of the resident's [DATE] MAR showed on [DATE], staff noted the resident's oxygen was administered at 3L with oxygen saturation levels of 90% on day shift and 92% on night shift. Review of the resident's progress note dated [DATE], at 8:59 P.M., showed the resident was on admission charting and was not experiencing any shortness of breath with a oxygen level at 95 % on 2L of oxygen (physician's order was for 3L of oxygen). LCTAB and respirations (rise and fall of the chest) at 22 per minute (with a normal range of 15-18 breaths per minute). Review of the resident's [DATE] MAR showed on [DATE], staff noted the resident's oxygen was administered at 3L with oxygen saturation levels of 95% on day shift and 93% on night shift. Review of the resident's progress note dated [DATE], at 10:25 P.M., showed the resident continued on admission charting and was not experiencing any shortness of breath with a oxygen level at 94% on 4L of oxygen (physician's order was for 3L of oxygen). Lung sounds were diminished (weakened or quieter breath sounds.) No respiration rate obtained. (Staff did not document physician notification of the resident's lung sound change.) Review of the resident's [DATE] MAR showed on [DATE], staff noted the resident's oxygen was administered at 3L with oxygen saturation levels of 91% on day shift and 94% on night shift. Review of the resident's progress note dated [DATE], at 10:24 A.M., showed the resident was adjusting well and gave no medically specific information. Review of the resident's [DATE] MAR showed on [DATE], staff noted the resident's oxygen was administered at 3L with oxygen saturation levels of 93% on day shift and 94% on night shift. Review of the resident's progress note dated [DATE], at 11:22 A.M., showed the resident was not experiencing any shortness of breath with a oxygen level at 93% on 4L of oxygen (physician's order was for 3L of oxygen). Lung sounds were diminished. Respirations at 18 breaths per minute with no edema present. (Staff did not document physician notification of the resident's diminished lung sounds.) Review of the resident's [DATE] MAR showed on [DATE], staff noted the resident's oxygen was administered at 3L with oxygen saturation levels of 93% on day shift and 94% on night shift. Review of the resident's progress note dated [DATE], at 11:00 P.M., showed the resident was experiencing shortness of breath while lying flat with an oxygen level at 94% on 3L of oxygen. Lung sounds were diminished. The resident had a cough with respirations at 20 breaths per minute. (Staff did not document physician notification of the resident's shortness of breath, cough, or diminished lung sounds.) Review of the resident's [DATE] MAR showed on [DATE], staff noted the resident's oxygen was administered at 3L with oxygen saturation levels of 92% on day shift and 93% on night shift. Review of the resident's [DATE] MAR showed on [DATE], staff noted the resident's oxygen was administered at 3L with oxygen saturation levels of 92% on day shift and 96% on night shift. (continued on next page)

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F 0695 Level of Harm - Actual harm Residents Affected - Few	Review of the physician's progress note, dated [DATE], showed the resident was seen by the physician for admission to the facility. The physician did not mention shortness of breath, cough, or diminished lung sounds in the note and no new orders related to shortness of breath, cough, or diminished lung sounds. Review of the resident's progress note dated [DATE], at 10:38 P.M., showed the resident was not experiencing shortness of breath with an oxygen level at 92% on 2L of oxygen (the physician's order was for 3L of oxygen). LCTAB with no cough and respirations at 18 breaths per minute. Review of the resident's progress note dated [DATE], at 7:38 A.M., showed the resident was not experiencing shortness of breath with an oxygen level at 93% on 3 L of oxygen. LCTAB and moist and loose cough present. Respirations at 20 breaths per minute. (Staff did not document physician notification of moist loose cough.) Review of the resident's admission Minimum Data Set (MDS - a federally mandated assessment tool filled out by facility staff), dated [DATE], showed the following information: -Intact cognition; -Required substantial to maximum assistance from staff for mobility; -Required continuous oxygen. Review of the resident's progress note dated [DATE], at 12:02 A.M., showed the resident was not experiencing shortness of breath with an oxygen level at 91% on 3 L of oxygen. LCTAB with no cough. Respirations at 18 breaths per minute. Review of the resident's progress note dated [DATE], at 11:44 P.M., showed the resident was not experiencing shortness of breath with an oxygen level at 92% on 3 L of oxygen with lung sounds diminished and moist/loose cough. Respirations at 22 breaths per minute. (Staff did not document physician notification of the resident's diminished lung sounds and cough.) Review of the resident's progress note dated [DATE], at 9:40 A.M., showed the resident was not experiencing shortness of breath with an oxygen level at 93% on 3 L of oxygen. LCTAB with no cough and respirations at 19 breaths per minute. Review of the resident's progress note dated [DATE], at 1:24 P.M., showed the resident was not experiencing shortness of breath with an oxygen level at 94% on 3 L of oxygen. LCTAB with no cough and respirations at 20 breaths per minute. Review of the resident's progress note dated [DATE], at 12:31 A.M., showed the resident was not experiencing shortness of breath with an oxygen level at 90% on 3L of oxygen. LCTAB with dry non-productive cough present. Respirations at 20 breaths per minute. (Staff did not document physician notification of the resident's cough.) Review of the resident's progress notes, dated [DATE], showed the following: -At 7:41 A.M., the resident tested positive for Covid. Staff notified the physician notified; (continued on next page)

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F 0695 Level of Harm - Actual harm Residents Affected - Few	-At 3:50 P.M., the resident was not experiencing shortness of breath with an oxygen level at 90% on 3L of oxygen. LCTAB with dry non- productive cough present. Respirations at 20 breaths per minute. Review of the resident's progress note dated [DATE], at 11:49 P.M., showed the resident was not experiencing shortness of breath with an oxygen level at 93% on 3L of oxygen. LCTAB with dry non-productive cough present. Respirations at 20 breaths per minute. Review of the resident's progress note dated [DATE], at 8:38 A.M., showed the resident was not experiencing shortness of breath with an oxygen level at 91% on 3L of oxygen. LCTAB with no cough and respirations at 20 breaths per minute. Review of the resident's progress note dated [DATE], at 3:47 P.M., showed no concerns with the resident's oxygen level at 90% on 4L of oxygen (the physician's order was for 3L of oxygen). Review of the resident's progress note dated [DATE], at 12:35 A.M., showed the resident was experiencing shortness of breath with lying flat with an oxygen level at 91% on 3L of oxygen. LCTAB with dry non-productive cough and respirations at 18 breaths per minute. (Staff did not document physician notification of the resident's shortness of breath or cough.) Review of the resident's progress note dated [DATE], at 11:55 P.M., showed the resident was not experiencing shortness of breath with an oxygen level at 94% on 3L of oxygen. LCTAB with moist loose cough and respirations at 20 breaths per minute. (Staff did not document physician notification of the resident's moist loose cough.) Review of the resident's progress note dated [DATE], at 9:50 A.M., showed the resident was experiencing shortness of breath with lying flat and with activity with an oxygen level at 92% on 3L of oxygen. LCTAB with moist loose cough and respirations at 20 breaths per minute. (Staff did not document physician notification of the resident's shortness of breath and moist cough.) Review of the resident's care plan, dated of [DATE] (24 days after admission and 11 days after completion of the admission MDS), showed the following: -Required oxygen via nasal cannula at 3L per minute continuously for COPD; -Give aerosol or bronchodilators (medications to help relax the muscles around your breathing airways) as ordered. Monitor and document at side effects and effectiveness; -Monitor for difficulty breathing on exertion; -Monitor/document any signs and symptoms of respiratory infection, fever, chills, increase in sputum (thick mucus coughed up from the lungs), increase in difficulty breathing, increased coughing, and wheezing; -Monitor/document any complications to skin such as cyanosis (a bluish or purplish discoloration of the skin and mucous m a bluish or purplish discoloration of the skin and mucous membranes, primarily caused by a shortage of oxygen in the blood membranes, primarily caused by a shortage of oxygen in the blood) and pallor (pale color of skin). (continued on next page)

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F 0695 Level of Harm - Actual harm Residents Affected - Few	Review of the resident's progress note dated [DATE], at 8:57 P.M., showed the resident was experiencing shortness of breath with lying flat with an oxygen level at 94% on 3L of oxygen. Left lung sounds diminished with moist loose cough and respirations at 20 breaths per minute. (Staff did not document physician notification of the shortness of breath and moist cough.) Review of the resident's progress notes dated [DATE] showed the following: -At 11:38 A.M., staff noted the resident was not experiencing shortness of breath with lying flat with an oxygen level at 96% on 3L of oxygen. LCTAB with no cough noted and respirations at 18 breaths per minute; -At 3:55 P.M., the resident's oxygen dropped to 87% while talking. When the resident would stop talking, oxygen level went up to 93%. (Staff did not document physician notification of the resident's oxygen levels dropping with speaking.) Review of the resident's progress note dated [DATE], at 11:55 P.M.,showed the resident was not experiencing shortness of breath with an oxygen level at 91% on 3L of oxygen. Lung sounds diminished bilaterally with moist loose cough and respirations at 18 breaths per minute. (Staff did not document physician notification of the resident's diminished lung sounds and cough.) Review of the resident's progress notes, dated [DATE], showed the resident continued on Covid monitoring with no complaints of Covid related symptoms. The resident did have a cough that was present before Covid, lung sounds were diminished bilaterally, and oxygen level was 93%. (Staff did not document physician notification of the resident's diminished lung sounds.) Review of the resident's progress notes, dated [DATE] to [DATE], showed staff did not document regarding the resident's shortness of breath, oxygen status, lung sounds, cough, or respirations. Review of the resident's progress note dated [DATE], at 2:18 P.M., showed staff did not document regarding the resident's shortness of breath, oxygen status, lung sounds, cough, or respirations. Review of the resident's progress notes, dated [DATE] through [DATE] , showed staff did not document regarding the resident's shortness of breath, oxygen status, lung sounds, cough, or respirations. Review of the resident's progress note dated [DATE], at 12:20 A.M., showed staff did not document related the resident's shortness of breath, oxygen status, lung sounds, cough, or respirations. Review of the resident's late entry progress notes, dated [DATE], showed the following: -At 2:30 A.M., the nurse, Registered Nurse (RN) B left the resident's room and heard an aide yell out that the resident had passed out. The nurse ran to the resident's room and upon entering noticed the resident was being supported in and upright position on the side of the bed by two aides; -The resident was cyanotic, gasping for air, and his/her tongue was protruding; -The nurse turned the resident's concentrator up to 5L with no improvement in the resident; (continued on next page)

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F 0695 Level of Harm - Actual harm Residents Affected - Few	-The nurse turned up the residents oxygen concentrator up to 10L with no improvement in the resident; -The resident was placed onto a gurney with assist of four staff members; -Two aides ran the resident to the Emergency Department (ED). Review of the resident's ED documentation, dated [DATE], showed the following information: -The resident was brought into the ED from nursing staff at the facility on campus; -The resident was brought in due to concerns for cardiac and respiratory arrest; -Upon arrival to the ED the resident was gray in color and having difficulty breathing; -Shortly after arrival the resident went into cardiac arrest and cardiopulmonary resuscitation (CPR - cardiopulmonary resuscitation is an emergency procedure that combines chest compressions and rescue breathing to restart a persons breathing and heart beat) was performed; -The resident's family reported the resident had been having respiratory issues three days prior to the incident, with increasing shortness of breath; -The staff at the facility report they found the resident lying on the floor at 2:00 A.M., in the morning; -Assessment includes distress, rapid labored breathing, high heart rate, and gray in color. During an interview on [DATE], at 2:56 P.M., Resident # 2 said the following: -He/she remembered the resident. He/she was on continuous oxygen. Sometimes the resident would have to sit on the side of his/her bed and attempt to catch his/her breath; -Not long before the resident was sent to the ED, the resident had an awful cough. It sounded like water splattering on a tin pan. He/she even asked the staff if he/she should be around the resident because the cough sounded like something contagious; -The resident often complained about his breathing status. During an interview on [DATE], at 3:18 P.M., Certified Nursing Assistant (CNA) A said the following: -On Tuesday, [DATE], he/she was working with the resident on the evening shift. The resident put on his/her call light and asked him/her if the physician was coming. He/she responded and said the physician comes on Sundays. The resident insisted he/she needed to see the physician about his trouble breathing; (continued on next page)

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F 0695 Level of Harm - Actual harm Residents Affected - Few	-The aide reported this to the nurse as well as the resident was having a hard time getting his voice out. He/she was nearly whispering due to lack of air. The nurse wrote it down on a sticky note and put it up on the nurses' desk for when the doctor come in on Sunday; -On [DATE], he/she heard about one of the day shift nurses, Licensed Practical Nurse (LPN) B, tell the resident's family and other staff he/she did not want to send the resident to the ED per his/her request due to pain with breathing. The nurse insisted to the resident's family that the resident was just having anxiety and there was no need to go to the ED; -On the early morning hours of [DATE], he/she took care of the resident. The resident rolled out of bed trying to catch his/her breath. Shortly after that they were having to get him onto a gurney for loosing consciousness; -The resident struggled to breath often, he/she would always have to sit up on the edge of the bed to try to have appropriate positioning for breathing, even with continuous oxygen on; -Aides know how to care for residents by their plans of care. They can be found in the resident rooms. He/she could not recall if the resident had a plan of care. During an interview on [DATE], at 10:57 A.M., CNA C said the following: -The resident often had complaints of pain and inability to breathe; -On the afternoon of [DATE], approximately 2:30 P.M., the resident was gray in color and was complaining of shortness of breath and inability to breathe. He/she reported this to LPN E; -LPN E went and assessed the resident as the resident had family at the facility around 4:00 P.M., who also requested he/she come assess the resident due to his/her breathing and gray color; -While assessing the resident, LPN told the family it's simply anxiety and no reason to go to the ED. The family wanted the resident sent to the ED, but LPN kept insisting it was not needed and eventually the family left the facility; -Anytime a resident shows a change in condition, the physician should be contacted; -The resident was always on continuous oxygen at a rate of 4L; -All care aspects should be care planned. During an interview on [DATE], at 2:17 P.M., Restorative Aide (RA) D said the following: -The resident was often unable to participate in therapy due to his/her pain and or inability to breath. The resident reported the pain was in his/her chest from having trouble to breathe; -The last time he/she tried to work with the resident, he/she helped the resident propel in a wheelchair, and just from that the resident's oxygen level dropped to 72%. He/she did take the resident to the nurse immediately and reported the oxygen level and explained the resident would not be able to participate due to his/her inability to breathe; (continued on next page)

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F 0695 Level of Harm - Actual harm Residents Affected - Few	-All care aspects should be in the care plan, which can be found in resident rooms. During an interview on [DATE], at 3:20 P.M., LPN E said the following: -Symptoms of respiratory distress are elevated respiratory rate, low oxygen level, and change in color; -If a resident has a change of condition, the physian should be called. If a resident exhibited weight gain, shortness of breath, edema, moist cough, and diminished lung sounds the resident should be sent to the ED; -The above mentioned symptoms sound like fluid overload; -The resident exhibited no change of condition a week prior to going to the ED; -Around 4:00 P.M., on [DATE], one of the resident's family members said the resident was having increased shortness of breath. After listening to the residents lungs, he/she changed the residents oxygen tubing to a shorter tube as that could have caused his/her extra shortness of breath; -CNA C reported to him/her that the resident wanted to go to the ED, but the resident's lungs were clear when LPN E listened, so he/she chalked it up to be anxiety; -He/she offered to call the physician and or send the resident out to the ED, to which the resident refused; -The resident's voice was not raspy and he/she was not gray in color; -He/she did not report the resident's complaints to the physician as he/she did not believe it was a problem; -All aspects of care are care planned. During an interview on [DATE], at 9:25 A.M., Registered Nurse (RN) B said the following: -Changing an oxygen administration rate on a resident with COPD can eliminate their drive to breathe. If it is an emergency situation, nursing can turn an oxygen concentrator up to 15L. If staff administer too much oxygen to a resident with COPD it can cause respiratory distress; -If a resident had an acute change of condition, the physician needed to be called. A sticky note is not appropriate; -If he/she noticed a resident exhibited weight gain, shortness of breath, increased pain, a change in lung sounds lung sounds, and a wet cough, he/she would be sending them out to the ED, as that could be fluid overload which is life threatening left untreated; (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Moore Few Care Center	901 South Adams Nevada, MO 64772

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 0695 Level of Harm - Actual harm Residents Affected - Few	During an interview on [DATE], at 12:01 P.M., the Administrator said the following: -She expected staff to notify the DON as well as the physician for any change of condition; -She expected all aspects of care to be in the care plan and to be documented; -The physician should have been contacted. MO00253943

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F 0697 Level of Harm - Actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. Based on observation, interview, and record review, the facility failed to implement and maintain and effective pain management regimen when the facility failed to accurately assess, monitor, address, care plan, and notify the physician of increased and unrelieved pain for one resident (Resident #1) resulting in increased pain. The facility census was 46. Review of the facility policy titled, Pain Management Program, reviewed on 11/17/16, showed the following information: -The facility will assess all resident's on admission, quarterly, and as needed; -Complete pain assessment for all residents. Monitor for persistent as needed (PRN) medication use; -Assess pain presence, frequency, effect on function, and intensity; -Ask resident to rate pain using the pain scale; -Determine if staff assessment for pain is needed; -If staff assessment is needed, review indicators of pain or possible pain; -Based on pain assessment, initiate routine and PRN pain medication regimen or non-medication interventions; -Complete physician notification and reassess PRN. 1. Review of the Resident #1's face sheet (brief look at resident information) showed the following information: -admission date of 03/24/25; -Diagnoses included chronic obstructive pulmonary disease (COPD- a progressive lung disease that makes it difficult to breathe) and peripheral vascular disease (PVD - a circulatory condition where blood vessels outside the heart and brain become narrowed, blocked, or have spasms, leading to reduced blood flow). Review of the resident's March 2025 Physician Order Sheet (POS) showed an order, dated 03/24/25, for pain monitoring. Staff to assess the resident for pain every shift. Review of the resident's admission screening, dated 03/25/25, showed the resident was not experiencing pain at the time of admission. Review of the resident's March 2025 POS showed an order, dated 03/26/25, for acetaminophen 325 milligram (mg), give two tablets by mouth every four hours as needed (PRN) for pain, not to exceed 3000 mg in a 24 hour period. (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	Review of the resident's admission Minimum Data Set (MDS - a federally mandated assessment tool filled out by facility staff), dated 04/06/25, showed the following information: -Intact cognition; -Received scheduled pain medication regimen; -Received PRN pain medications; -The resident rarely had pain, but described his/her pain level at a ten on a scale of one to ten scale, with 10 being the worst pain possible, at the time of the assessment. Review of the resident's pain monitoring assessment, dated 04/08/25, showed the resident had a pain level of 0 out of 10, for both day and night shifts. Review of the resident's April 2025 Medication Administration Record (MAR) showed on 04/08/25, at 8:17 P. M., staff administered two tablets of acetaminophen 325 mg for pain rated 7 out of 10. Staff noted the dose was effective in treating the pain. Review of the resident's progress note dated 04/08/25, at 9:42 P.M., showed staff administered two tablets of acetaminophen 325 mg for bottom pain. Staff noted the dose was effective with a follow-up pain scale of 0 out of 10. (Staff did not document physician notification of the increased pain.) Review of the resident's pain monitoring assessment, dated 04/10/25, showed the resident had a pain level of 6 out of 10 for the day shift and 0 out of 10 for the night shift. Review of the resident's April 2025 MAR showed on 04/10/25, at 11:19 P.M., staff administered two tablets of acetaminophen 325 mg for a pain rated a six out of 10. Staff noted the dose was effective in treating the pain. Review of the resident's progress note dated 04/11/25, at 12:42 A.M., showed staff administered two tablets of acetaminophen 325 mg. Staff did not indicate where the resident's pain was. Staff noted the dose was affective with a follow-up pain scale of 0 out of 10. (Staff did not document physician notification of the increased pain.) Review of the resident's pain monitoring assessment, dated 04/14/25, showed the resident had a pain level of 3 out of 10 for the day shift and 0 out of 10 for the night shift. Review of the resident's MAR and progress notes, dated 04/14/25, showed staff did not document pain interventions taken for the 3 out of 10 pain level. Review of the resident's April 2025 MAR showed on 04/14/25, at 1:22 A.M. and at 11:12 P.M., staff administered two tablets of acetaminophen 325 mg for a pain rated 7 out of 10. Staff noted the dose was effective in treating the pain. (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	Review of the resident's progress notes dated 04/14/25, at 2:36 A.M. and 11:42 P.M., showed the staff administered two tablets of acetaminophen 325 mg for all over pain. Staff noted the doses were effective with a follow-up pain scales of 0 out of 10. (Staff did not document physician notification of the increased pain.) Review of the resident's pain monitoring assessment, dated 04/15/25, showed the resident had a pain level 3 out of 10 for the day shift and 0 out of 10 for the night shift. Review of the resident's MAR and progress notes, dated 04/15/25, showed staff did not document pain interventions implemented for the three out of 10 assessment of pain. Review of the resident's pain monitoring assessment, dated 04/16/25, showed the resident had a pain level of thee out of 10 for the day shift and 0 out of 10 for the night shift. Review of the resident's April 2025 MAR showed on 04/16/25, at 12:22 A.M., staff administered two tablets of acetaminophen 325 mg for a pain rated a 5 out of 10. Staff noted the dose was effective in treating the pain. Review of the resident's progress note dated 04/16/25, at 2:40 A.M., showed the resident was administered two tablets of Acetaminophen 32 5 mg for pain. Staff noted the dose was effective with a follow-up pain scale of one out of 10. Review of the resident's care plan, dated of 04/17/25, showed staff did not care plan related to the resident's pain. Review of the resident's pain monitoring assessment, dated 04/21/25, showed the resident had a pain level of 0 out of 10 for the day shift and 0 out of 10 for the night shift. Review of the resident's April 2025 MAR showed on 04/21/25, at 12:20 A.M., the staff administered two tablets of acetaminophen 325 mg for a pain rated a 0 out of 10. Staff noted the dose was effective in treating the pain. Review of the resident's progress note dated 04/21/25, at 2:41 A.M., showed staff administered two tablets of acetaminophen 325 mg. Staff noted the dose was effective with a follow-up pain scale of 0 out of 10. Review of the resident's pain monitoring assessment, dated 04/23/25, showed the resident had a pain level of 4 out of 10 for the day shift and 2 out of 10 for the night shift. Review of the resident's MAR and progress notes, dated 04/23/25, showed staff did not document pain intervention implement for the 4 or 2 out of 10 pain assessment. Review of the resident's pain monitoring assessment, dated 04/25/25, showed the resident had a pain level of 4 out of 10 for the day shift and 0 out of 10 for the night shift. Review of the resident's MAR and progress notes, dated 04/25/25, showed staff did not document pain intervention implemented for the 4 out of 10 pain assessment. (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	Review of the resident's pain monitoring assessment, dated 04/26/25, showed the resident had a pain level of 0 out of 10 for the day shift and 3 out of 10 for the night shift. Review of the resident's progress notes, dated 04/26/25, showed the following: -At 2:18 P.M., showed the resident was requesting a pain medication other than acetaminophen that his/her levels of pain have been 10 out of 10 in the lower back and the acetaminophen had been ineffective. The nurse contacted the physician and there were no new orders sent. -At 3:24 P.M., the resident was administered 2 tablets of acetaminophen 325 mg. -At, 8:40 P.M., the dose was effective with a follow up pain scale of 3 out of 10. Review of the resident's April 2025 MAR, dated 04/26/25, showed the following: -At 3:24 P.M., staff administered two tablets of acetaminophen 325 mg for a pain rated a 10 out of 10. Staff noted the dose was effective in treating the pain. -At 10:43 P.M., staff administered an additional dose for back pain with a pain rated a 9 out of 10. Staff noted the dose was effective in treating the pain. Review of the resident's pain monitoring assessment, dated 04/27/25, showed the resident had a pain level of 0 out of 10 for the day shift and 0 out of 10 for the night shift. Review of the resident's April 2025 MAR showed on 04/27/25, at 9:49 P.M., staff administered two tablets of acetaminophen 325 mg for back pain with a pain scale of 0 out of 10. Staff noted the dose was effective in treating the pain. Review of the resident's progress notes dated 04/27/25 showed the following: -At 9:49 P.M., staff administered two tablets of acetaminophen 325 mg. -At 1:38 A.M., staff noted the dose was effective with a follow up pain scale of 2 out of 10. Review of the resident's pain monitoring assessment, dated 04/28/25, showed the resident had a pain level of 0 out of 10 for the day shift and 10 out of 10 for the night shift. Review of the resident's April 2025 MAR showed on 04/28/25, at 7:12 P.M., staff administered two tablets of acetaminophen 325 mg for a pain scale of 10 out of 10. Staff noted the dose was effective in treating the pain. Review of the resident's progress note dated 04/28/25, at 7:59 P.M., showed staff administered two tablets of acetaminophen 325 mg. Staff noted the dose was effective with a follow up pain scale of 6 out of 10. (Staff did not document physician notification of the increased pain or steps taken to address the unrelieved pain.) Review of the resident's pain monitoring assessment, dated 04/29/25, showed the resident had a pain level of 2 out of 10 for the day shift and 8 out of 10 for the night shift. (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	Review of the resident's April 2025 MAR showed on 04/29/25, 3:04 P.M., staff administered two tablets of acetaminophen 325 mg for a pain scale of eight out of 10. Staff noted the dose was ineffective. Review of the resident's progress notes, dated 04/29/25, showed the following: -At 3:04 P.M., staff administered two tablets of acetaminophen 325 mg. -At 4:19 P.M., staff noted the dose was ineffective with a follow up pain scale of 6 out of 10. The resident said he/she was still in pain. (Staff did not document physician notification of the pain level or steps taken to address the unrelieved pain.) -At 6:17 P.M., a nurse documented that the resident has had complaints of pain and the PRN acetaminophen was not helping. The resident would like to see the physician when he comes in. (Staff did not document physician notification of the pain level or steps taken to address the unrelieved pain.) Review of the resident's pain monitoring assessment, dated 04/30/25, showed the resident had a pain level of 5 out of 10 for the day shift and 0 out of 10 for the night shift. Review of the resident's April 2025 MAR showed on 04/30/25, at 12:01 A.M., staff administered two tablets of acetaminophen 325 mg for a pain scale rated as 10 out of 10. Staff noted the dose was effective. Review of the resident's progress note dated 04/30/25, at 12:19 A.M., showed staff administered two tablets of acetaminophen 325 mg, The dose was effective with a follow up pain scale of 8 out of 10 (18 minutes after it's administration). Staff noted the resident was complaining of lower back and feet pain. Staff continue to monitor. (Staff did not document physician notification of the pain level or steps taken to address the unrelieved pain.) Review of the resident's pain monitoring assessment, dated 05/01/25, showed the resident had a pain level of 0 out of 10 for the day shift and 0 out of 10 for the night shift. Review of the resident's April 2025 MAR showed on 05/01/25, at 2:12 P.M., staff administered two tablets of acetaminophen 325 mg for a pain rated a five out of 10. Staff noted the dose was effective in treating the pain. Review of the resident's progress note dated 05/01/25, at 5:11 P.M., showed staff administered two tablets of acetaminophen 325 mg. The resident complained of bottom pain and had not been out of bed on this day. Staff noted the dose was effective with a follow-up pain scale of 0 out of 10. Review of the resident's April 2025 MAR showed on 05/01/25, at 8:47 P.M., staff administered two tablets of acetaminophen 325 mg for a pain scale of 10 out of 10. Staff noted the dose was effective. Review of the resident's progress note dated 05/01/25, at 10:29 P.M., showed staff administered two tablets of acetaminophen 325 mg. Staff noted the dose was effective with a follow up pain scale of four out of 10. (Staff did not document physician notification of the continued pain, or steps taken to address the unrelieved pain.) (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	Review of the resident's pain monitoring assessment, dated 05/02/25, showed staff did not document a pain assessment completed. During an interview on 05/09/25, at 3:18 P.M., Certified Nursing Assistant (CNA) A said the following: -The resident did experience a lot of pain. He/she reported that the pain was in his/her chest; -Anytime the resident reported pain, he/she would tell his/her charge nurse immediately; -He/she assumed the pain was related to the resident's diagnosis of COPD and trouble breathing putting pressure on his/her chest; -Several of the nurses would tell him/her it was anxiety related; -Aides can find out about resident diagnoses and required care by viewing the care plan. During an interview on 05/12/25, at 10:57 A.M., CNA C said the following: -The resident did experience a lot of pain, causing him/her to stay in bed a lot. -He/she informed the nurse on duty of the resident's complaints often; -Aides can find out about resident diagnoses and required care by viewing the care plan. During an interview on 05/12/25, at 2:17 P.M., Restorative Aide (RA) D said the following: -The resident participated in therapy for a short while. He/she would refuse to participate related to his/her pain due to complications breathing; -Anytime the resident complained of pain or had care concerns, he/she would report it to the nurse; -All resident care aspects should be care planned. During an interview on 05/12/25, at 9:25 A.M., Registered Nurse (RN) B said the following: -If a resident complained of pain the nurse on duty should go and assess it. If the resident has a PRN medication, it should be given. If the PRN medication does not work, the physician should be notified for something stronger; -Writing a resident's complaints and/or concerns down on a sticky note is not acceptable, especially if a medication is ineffective at treating the resident. The physician should be called; -Pain and any required care should be care planned. During an interview on 05/13/25, at 3:20 P.M., Licensed Practical Nurse (LPN) E said the following: (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	-If a resident complained of pain, he/she would assess the pain level and start with non-pharmacological interventions first. If those interventions were not effective, he/she would administer PRN pain medications; -If PRN pain medications were not effective and the level of pain was a 10 out of 10, he/she would call the physician; -The resident has chronic pain to his/her bottom. He/she was aware of complaints of pain to the chest but believed it was related to anxiety due to breathing complications; -Residents have pain scale documentation on them every shift and will be checked on throughout the day; -He/she never contacted the doctor regarding the resident's pain. It would be written down for the physician to see when he came in on Sundays; -All aspects of care are and should be care planned. During an interview on 05/15/25, at 2:25 P.M., the MDS Nurse said the following: -If a resident complained of pain, the nurse on duty should assess the resident, and administer PRN medications. If the PRN medications are not effective the physician should be called; -All resident care aspects should be care planned. During interviews on 05/12/25, at 11:52 A.M. and 2:50 P.M., the resident's Physician said the following: -He did not see any documentation related to the resident's pain being reported to him; -If any kind of acute change happens with any resident, he wished to and should be notified. During an interview on 05/13/25, at 10:52 A.M., the Director of Nursing (DON) said the following: -If a resident complained of pain, she expected staff to assess it, and use nursing judgement to determine if the pain can be treated without medical intervention. If it cannot be managed in that manner, staff should review the resident's care plan and provide the appropriate intervention; -If all non-pharmacological and pharmacological interventions have been unsuccessful, staff should call the resident's physician; -All aspects of care should be care planned. During an interview on 05/13/25, at 12:01 P.M., the Administrator said the following: -She expected staff to assess residents for pain. If interventions were not effective on reassessment, the physician should be notified for instruction; (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	-She expected the nursing staff to treat pain subjectively and not make their own assumptions on resident complaints; -All aspects of care should be care planned. MO00253943