| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 265188 | A. Building<br>B. Wing | 08/25/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Spring Valley Health & Rehabilitation Center | 2915 South Fremont Ave<br>Springfield, MO 65804 |

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|---|---|
| F 0554<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Allow residents to self-administer drugs if determined clinically appropriate.<br><br>(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 0554<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure the right to self-administer medications if the interdisciplinary team has determined that this practice is clinically appropriate when staff failed to assess for, care plan regarding, and obtain a physician's order for self-administration and bedside storage one medications for three residents (Resident #37, #148, and #31). The facility census was 149. Review of the facility policy titled Bedside Medication Storage, dated December 2017, showed the following information:-Bedside medication storage is permitted for residents who wish to self-administer medications, upon the written order of the prescriber, and once self-administration skills have been assessed and deemed appropriate in the judgment of the facility's interdisciplinary resident assessment team;-A written order for the bedside storage of medication is present in the resident's medical record;-Bedside storage of medications is indicated on the resident Medication Administration Record (MAR) and in the care plan for the appropriate medications;-For residents who self-administer medications, for bedside storage to occur the manner of storage must prevent access by other residents, lockable drawers or cabinets were required only if unlocked storage was deemed inappropriate, and facility management should have acopy of the key in addition to the resident;-The medications provided to the resident for bedside storage are kept in the containers dispensed by the provider pharmacy, or in the original container if a nonprescription medication;-The resident is instructed in the proper use of bedside medications, including what the medication is for, how it is to be used, how often it may be used, proper cleaning of inhalers where applicable, proper storage of the medication;-All nurses and aides are required to report to the charge nurse on duty any medications found at the bedside not authorized for bedside storage and to give unauthorized medications to the charge nurse for return to the family or responsible party.Review of the facility policy titled Medication Administration - General Guidelines, dated December 2017, showed the following:-Residents are allowed to self-administer medications when specifically authorized by the attending physician and in accordance with procedures for self-administration of medications.1. Review of Resident # 37's face sheet (brief look at resident information) showed the following information:-re-admission date of 08/04/25;-Diagnoses included ocular hypertension (a condition where the pressure inside the eye is consistently higher than normal).Review of the resident's comprehensive Minimum Data Set (MDS - a federally mandated assessment tool filled out by facility staff), dated 08/20/25, showed the following information:-Vision impairment;-Required partial to moderate assistance from staff for mobility;-Diagnoses include cataracts (clouding of the normally clear lens of the eye), glaucoma(a group of eye conditions that can cause blindness), and/or macular degeneration (an eye disease that causes vision loss).Review of the resident's care plan, dated 08/25/25, showed the following information:-The resident had cataracts and glaucoma;-Arrange consultation with eye care practitioner as required;-Review medications for side effects that affect vision;-Tell the resident where you are placing their items and be consistent.(Staff did not care plan related to the resident ability to maintain at bedside and self-administer medications.) Review of the resident's August 2025 Physician Order Sheet (POS) showed no order to maintain the drops at bedside and self-administer the drops.Review of the resident's record show no documented self-administrator assessment for the resident. Observation and Interview on 08/22/25, at 8:54 A.M., showed Certified Medication Technician (CMT) H said the resident kept his/her eye drops in his/her room. Upon entering the resident's room, two bottles of eye drops were observed on the resident's bedside table. The bottles had prescription labels identifying one bottle as prednisolone acetate 1 % (a topical corticosteroid ophthalmic suspension used for treating inflammatory eye conditions) and Systane (an over-the-counter lubricant eye drop used to relieve dryness, burning, and irritation in the eyes).2. Review of Resident #148's face sheet showed the following:-admission date of 11/24/21;-Diagnoses included chronic pain syndrome (persistent pain interferes with daily life), suicidal ideations, and anxiety disorder.Review of the resident's care plan, last updated 03/27/25, showed the following:-Resident had depression and anxiety with a history of suicidal ideations;-Staff should monitor, document, report as needed any risk for harm to self: suicidal plan, past attempt at suicide, and risky actions including stockpiling pills;-Staff should administer medications as ordered and monitor and document for side effects and effectiveness.(Staff did not care plan regarding the resident self-administering medications or having medications at bed side.) Review of the resident POS, current as of 08/25/25, showed the following:-An order, dated 01/11/22, to monitor side effects of all medications;-An order, dated 11/24/23, for acetaminophen tablet 325 mg, give 2 tablets by mouth every |

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| F 0561<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to promote and facilitate each resident's right of self-determination when staff failed to provide timely bathing, in the form the resident preferred, for four residents (Resident #20, Resident #37 and Resident #113) out of a sample of nine resident. The facility census was 149.<br><br>Review of the facility's policy titled, ADL (activities of daily living) Care Bathing, dated 07/21/22, showed the following:<br><br>-Nursing staff will assist in bathing residents to promote cleanliness and dignity;<br><br>-The charge nurse will be made aware of residents who refuse bathing.<br><br>1. Review of Resident #20’s face sheet showed the following information:<br><br>-admission date of 06/06/24;<br><br>-Diagnoses included nontraumatic intracerebral hemorrhage (type of stroke when bleeding occurs on the brain), encephalopathy (condition that affects the brain’s function leading to various issues), hemiplegia (paralysis of one or both sides of the body), and depression (persistent feelings of sadness).<br><br>Review of the resident’s quarterly Minimum Data Set (MDS – a federally mandated assessment completed by facility staff), dated 08/06/25, showed the following:<br><br>-Moderately impaired cognition;<br><br>-Dependent upon staff for showers.<br><br>During interviews on 08/17/25, at 4:56 P.M., on 08/20/25, at 9:35 A.M., and on 08/21/25, at 3:20 P.M., the resident said the following:<br><br>-He/she was not receiving showers. He/she didn’t know how long it had been since he/she received a shower. He/she had received some bed baths, but he/she would prefer a shower;<br><br>-He/she feels yucky when he/she does not get regular showers;<br><br>-He/she had not refused a bed bath, there have been times when the resident didn’t understand the staff giving a bed bath when he/she would like a shower;<br><br>-He/she would rather the staff give him/her a shower instead of receiving a bed bath from a family member.<br><br>Review of the resident’s July 2025 Shower Sheets showed the following:<br><br>(continued on next page) |

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| F 0561<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | -On 07/24/25, the resident received a bed bath;<br><br>-On 07/29/25, the resident’s family provided a bed bath;<br><br>-On 07/31/25, staff noted the resident refused a bed bath.<br><br>Review of the resident’s August 2025 Shower Sheets showed the following:<br><br>-On 08/05/25, the resident’s family member provided a bed bath (seven days after the last document bed bath);<br><br>-On 08/08/25, staff noted dryness over much of the resident’s body, Staff noted the resident’s head was washed, but did not indicate there was a shower;<br><br>-On 08/11/25, the resident’s family member provided a bed bath;<br><br>-On 08/14/25, staff noted resident bathed. Staff did not specify if it was a shower or bed bath;<br><br>-On 08/18/25, the resident’s family member provided a bed bath.<br><br>During an interview on 08/22/25, at 11:10 A.M., Certified Nurse’s Aide (CNA) I said he/she didn’t know if the resident was getting showers. He/she had not been at the facility when the resident had been given a shower. He/she had not given the resident a shower.<br><br>During an interview on 08/22/25, at 12:22 P.M., Licensed Practical Nurse (LPN B) the resident or his/her parents have complained about showers. He/she believed the resident had received a bed bath, as the shower hurts his/her back. He/she didn’t know if the resident was offered a shower.<br><br>During an interview on 08/22/25, at 2:22 P.M., Director of Nursing (DON) said the resident used to receive a bed bath. He/she didn’t know if that had changed. He/she would assume staff are offering him/her a shower.<br><br>2. Review of Resident #37’s face sheet showed the following information:<br><br>-admission date of 08/04/25;<br><br>-Diagnoses included fracture to lower left leg.<br><br>Review of the resident’s entry MDS, dated [DATE], showed the following:<br><br>-Moderately impaired cognition;<br><br>-Substantial with showers.<br><br>Review of the resident’s care plan, dated 08/18/25, showed the following:<br><br>-Resident had ADL self-care performance deficit related to activity intolerance, impaired balance, limited mobility and pain;<br><br>(continued on next page) |

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| F 0561<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | -Staff to offer bathing/showering two times per week and as necessary;<br><br>-Staff to offer sponge bath when a full bath or shower cannot be tolerated.<br><br>During interviews 08/18/25, at 9:40 A.M., and on 08/21/25, at 8:12 A.M., the resident said the following:<br><br>-He/she admitted on [DATE], and he/she has received one sponge bath on 08/08/25 and 08/20/25;<br><br>-He/she can’t have a full shower but would like a couple of sponge baths per week.<br><br>Review of the resident’s August 2025 Shower Sheets showed the following:<br><br>-On 08/08/25, staff signed off on the shower review sheet, but did not specify what type of shower was provided;<br><br>-On 08/15/25, (seven days after the previous shower/bed bath), staff noted the resident refused a shower. The unit manager signed off as the charge nurse. (Staff did not document if a bed bath was offered.);<br><br>-On 08/17/25, staff noted the resident refused a shower. The unit manager signed off as the charge nurse. (Staff did not document if a bed bath was offered.);<br><br>-On 08/20/25, staff noted resident had a shower, but didn’t specify the type.<br><br>During an interview on 08/22/25, at 12:22 P.M., LPN B said he/she believed the resident was receiving showers, as far as he/she knew. The resident hadn’t complained to him/her about not receiving showers;<br><br>During an interview on 08/22/25, at 2:22 P.M., the DON said the resident received bed baths due to his/her leg cast.<br><br>3. Review of Resident #113’s face sheet showed the following information:<br><br>-admission date of 02/19/21;<br><br>-Diagnoses included altered mental status.<br><br>Review of the resident’s quarterly MDS, dated [DATE], showed the following:<br><br>-Moderately impaired cognition;<br><br>-Substantial assistance with showers.<br><br>During interviews on 08/18/25, at 1:18 P.M., and on 08/21/25, at 10:44 A.M., the resident said the following:<br><br>-The resident has a calendar where he/she kept track of showers;<br><br>(continued on next page) |

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| F 0561<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | -He/she showed the surveyor his/her calendar and he/she had one day in July where he/she was provided a shower, and it was 07/10/25;<br><br>-He/she had no days marked in August. He/she said he/she had not received a shower in August;<br><br>-He/she feels dirty. He/she would like two showers per week, it doesn’t matter the day;<br><br>-He/she had not refused any showers, but there have been a couple of times he/she wanted to participate in activities, and he/she came back to his/her room immediately after the activity to wait for a shower and never got one;<br><br>-He/she has asked for showers several times and they don’t have time.<br><br>Review of the resident’s July 2025 and August 2025 Shower Sheets showed the following:<br><br>-On 07/18/25, staff noted the received a shower;<br><br>-On 07/23/25, staff noted the resident received a shower (a five day gap);<br><br>-On 07/29/25, staff noted the resident received a shower (a six day gap);<br><br>-On 08/09/25, staff noted the resident received a shower (an 11 day gap);<br><br>-On 08/12/25, staff noted the resident received a shower;<br><br>-On 08/17/25, staff noted the the resident received a shower (a five day gap).<br><br>During an interview on 08/22/25, at 11:10 A.M., CNA I said he/she imagined the resident had been given a shower, but he/she had not seen the resident take one and he/she had not given the resident a shower.<br><br>During an interview on 08/22/25, at 12:22 P.M., LPN B said the resident was receiving showers.<br><br>During an interview on 08/22/25, at 2:22 P.M., DON said the resident was receiving showers as he/she requests them.<br><br>4. Review of Resident # 39’s face sheet showed the following:<br><br>-admission date of 11/21/23;<br><br>-Diagnoses included cerebral infarction (stroke), hemiplegia and hemiparesis (weakness or paralysis on one side of the body) following cerebral infarction affecting left non-dominant side, and cognitive communication deficit (condition where a person experiences difficulties with various aspects of communication due to underlying cognitive impairments).<br><br>Review of the resident’s quarterly MDS, dated [DATE], showed the following:<br><br>-Cognitively intact;<br><br>(continued on next page) |

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| F 0561<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | -Dependent on staff for bathing.<br><br>Review of the resident’s care plan, updated 07/28/25, showed the following:<br><br>-Resident had an ADL self-care performance deficit due to activity intolerance, hemiplegia, and impaired balance;<br><br>-The resident required two staff assistance for bathing.<br><br>Review of the facility’s “Skin Monitoring: Comprehensive CNA Shower Review” forms, showed the following:<br><br>-On 06/18/25, staff documented no new skin issued;<br><br>-On 06/25/25, staff documented no new skin issued (a seven-day gap);<br><br>-On 07/03/25, staff documented arterial wound on coccyx region (small triangular bone at the base of the spinal column) (eight-day gap);<br><br>-On 07/10/25; staff documented resident received a bed bath and hair was washed (seven day gap);<br><br>-On 07/17/25, staff documented resident refused;<br><br>-On 08/06/25, staff documented resident received a bed bath and hair was washed (20 days after last offered shower);<br><br>-On 08/13/25, staff documented resident received a bed bath and hair was washed (a 7 day gap).<br><br>Review of the resident’s medical record showed staff documented in nursing progress notes on 08/19/25, at 2:23 P.M., that neurosurgery office called and stated that resident needed a shower and the pads in his/her neck brace needed changed and the ones in there now need washed.<br><br>During an interview on 08/20/25, at 11:00 A.M., the resident said he/she would prefer two baths per week. He/she felt dirty without a bath at least that he/she had a shower list laminated in the shower room. Most residents received two showers per week. twice per week.<br><br>During an interview on 08/22/25, at 1:00 P.M., CNA E the resident preferred two bed baths per week. He/she was not aware of him/her going longer than once per week.<br><br>During an interview on 08/25/25, at 11:20 A.M., DON said the resident had no scheduled shower dates attached to his/her room number.<br><br>5. During an interview on 08/22/25, at 11:10 A.M., CNA I said the following:<br><br>-The residents should be offered a shower at least two times per week. He/she believed the residents are receiving showers, but may refuse;<br><br>(continued on next page) |

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| F 0561<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | -When a resident received a shower, it’s documented in the EHR (electronic health record) and on a shower sheet. If the resident refuses staff get a signature on the sheet;<br><br>-Residents should have an option to have a shower or bed bath.<br><br>During an interview on 08/22/25, at 11:24 A.M., CNA K said the following:<br><br>-He/she was not sure if they [NAME] a shower aide for 500 and 600 halls. He/she did not know of a shower schedule;<br><br>-Sometimes the shower aide from 300 and 400 halls will do the 500 and 600 halls;<br><br>-He/she was not sure how often a resident should be offered a shower. He/she washes the residents up when they need it. He/she has offered a shower when he/she she has time;<br><br>-The residents should be given an option of a bed bath or shower;<br><br>-The shower aide completes a shower sheet on each resident, and he/she didn’t know if showers are documented in the EHR;<br><br>-If a resident refused a shower, he/she isn’t sure but thinks maybe they let the nurse know.<br><br>During an interview on 08/22/25, at 1:00 P.M., CNA E said that he/she had a shower list laminated in the shower room. Most residents received two showers per week.<br><br>During an interview on 08/22/25, at 11:35 A.M., Certified Medication Technician (CMT) A said the following:<br><br>-The shower aide for 500 and 600 hall was out and now the CNAs working the floor were giving showers;<br><br>-He/she was not sure how often showers were offered. They should offer a shower first and then a bed bath;<br><br>-CNAs document the showers on shower sheets and he/she didn’t know if they’re documented in the HER;<br><br>-If the resident refused the shower, staff wrote refused on the shower sheet. He/she didn’t know of the nurse was told about the refusal.<br><br>During an interview on 08/22/25, at 12:22 P.M., LPN B said the following:<br><br>-The aides are expected to provide showers to the residents. They should offer showers at least weekly and maybe two times per week;<br><br>-Residents should be offered a shower or a bed bath. If they’re attending activities, they should offer at another time;<br><br>(continued on next page) |

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| F 0561<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | -The showers are documented on a shower sheet, and he/she believed they’re also put into the computer;<br><br>-If a resident refuses, they should put refused on the sheet. He/she doesn’t know that they tell the nurse;<br><br>-He/she had one resident complain and they gave him/her a shower.<br><br>During an interview on 08/22/25, at 2:02 P.M., the Unit Manager/LPN said the following:<br><br>-All CNAs can give residents showers. The CNAs should be offering daily to anyone that wants a shower;<br><br>-The residents should be able to choose whether it’s a shower of bed bath;<br><br>-There is a task in the EHR where the staff select when a shower is provided. They should also be completing shower sheets. If the resident refuses, they should note that and offer another day. They should also let the nurse know when the resident refuses;<br><br>-If the resident is going to an activity, staff should offer a shower later.<br><br>During an interview on 08/22/25, at 2:22 P.M., DON said the following:<br><br>-They do not have a specific shower aide. Any aide can give showers;<br><br>-The residents should be offered showers at last two times per week. Every room comes with two days for showers. This is provided upon admission;<br><br>-He/she has a schedule, which is flexible, with certain rooms scheduled on certain days;<br><br>-Some residents are given a bed bath if therapy makes that suggestion, or the resident prefers a bed bath. He/she would assume aides are offering a shower.<br><br>During an interview on 08/25/25, at 12:30 P.M., the Administrator said the following:<br><br>-He/she wanted every resident to be happy about getting a shower;<br><br>-If a resident refused, they would work hard to get them to take one;<br><br>-Residents should be asked daily if they want a shower;<br><br>-If residents want two per week, they should be getting them and they should have a choice;<br><br>-Any nursing staff can give showers. They don’t have a specific shower aide for 400 and 500 halls since the regular aide is out.<br><br>Complaint #2572207 |

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| F 0584<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure a clean and homelike environment for all residents when staff failed to maintain the cleanliness of the floors, walls, doors, and/or bathrooms for 9 residents (Resident #13, #36, #94, #123, #125, #39, #73, #51, and #141), when staff failed to address odors in the rooms of 5 residents (Resident #13, #123, #125, #141, and #135), when staff failed to a provide a clean over the bed table to one resident (Resident #72), when staff failed to maintain the facility at comfortable temperature in a family dining room and two residents' rooms (Resident #148 and #103), and when staff failed to maintain furniture in good condition in the special care unit. The facility census was 149.<br>1. Review of Resident #13's face sheet showed an admission date of 06/27/25.<br><br>Review of the resident's admission Minimum Data Set (MDS - a federally mandated assessment tool completed by facility staff), dated 07/10/25, showed the resident had severely impaired cognitive skills.<br><br>Observations on 08/19/25, at 9:46 A.M., and on 08/20/25, at 10:27 A.M., of the resident’s room showed the following: -The room had a strong urine odor;-The wall under the window had paint peeled off;-The bathroom floor had brown substances in the corner.<br><br>During an interview on 08/21/25, at 1:09 P.M., the Housekeeping Supervisor acknowledged the resident's bathroom floor had some black substance in the corner and the resident's wall under the window had paint peeled off. He/she did not know how long the resident's wall had areas of peeling paint.<br><br>2. Review of Resident #36's face sheet showed an admission date of 04/15/24.<br><br>Review of the resident's quarterly MDS assessment, dated 07/13/25, showed the resident had severely impaired cognitive skills.<br><br>Observation on 08/18/25, at 2:34 P.M., of the resident’s room showed the resident's bathroom floor contained a brown substance on the caulking around the toilet stool. The bathroom floor felt sticky to the bottom of shoes.<br><br>During an observation on 08/19/25, at 9:46 A.M., a housekeeper had his/her cart and went into the resident's room to clean.<br><br>Observation on 08/19/25, at 9:51 A.M., of the resident’s room, after the housekeeper cleaned the room, showed the following: -The resident's floor under his/her bed contained several ants, two to three pair of shoes, chunks of a black unknown material the size of a half dollar and brown splatters;-The floor under the chair located next to the resident's bed had brown splatters;-The resident's bathroom floor felt sticky to the bottom of shoes.<br><br>(continued on next page) |

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|---|---|---|---|
| | 265188 | A. Building<br>B. Wing | 08/25/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Spring Valley Health & Rehabilitation Center | 2915 South Fremont Ave<br>Springfield, MO 65804 |

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| F 0584<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Observation on 08/19/25, at 10:48 A.M., of the resident’s room showed the following: -The resident sat on his/her bed;-The resident's bathroom floor contained a brown substance on the caulking around the toilet stool;-The bathroom floor felt sticky to the bottom of shoes;-The floor under the resident's bed had a few ants, several pair of shoes, chunks of a black unknown material the size of a half dollar, and brown splatters;-The floor under the chair located next to the resident's bed had brown splatters.<br><br>Observation on 08/20/25, at 10:27 A.M, of the resident’s room showed the following: -The bathroom floor contained a brown substance on the caulking around the toilet stool;-The bathroom floor felt sticky to the bottom of shoes;-The floor under the resident's bed had a few ants, several pair of shoes, approximately three chunks of a black unknown material the size of a half dollar, and brown splatters;-The floor under the chair located next to the resident's bed had brown splatters.<br><br>During an interview on 08/21/25, at 1:09 P.M., the Housekeeping Supervisor said the following:-Staff keep cans of bug spray on supply. The pest control company comes twice per month and treats for ants;-The resident's bathroom floor around the toilet needed cleaned;-The resident's floor under his/her bed and chair should be swept and mopped;-If the mop water is too cold, the mop solution can become sticky. Staff should re-mop the floors if they are sticky. 3. Review of Resident's 94's face sheet showed an admission date of 04/20/24.<br><br>Review of the resident's quarterly MDS assessment, dated 07/13/25, showed the resident had moderately impaired cognitive skills.<br><br>Observations on 08/19/25, at approximately 9:50 A.M., of the resident’s room showed the following: -The resident's bathroom floor contained a brown substance around the base of the toilet stool;-The resident's wall in the bathroom had a black substance on the wall with paint peeled off.<br><br>Observations on 08/20/25, a 10:27 A.M., showed the following: -The resident's bathroom floor contained a brown substance around the base of the toilet stool; -The resident's wall in the bathroom had a black substance on the wall with paint peeled off. During an interview on 08/21/25, at 1:09 P.M., the Housekeeping Supervisor said he/she did not know what the black substance was on the wall.<br><br>During an observation and interview on 08/22/25, at 3:15 P.M., the Maintenance Supervisor said the resident's wall in the bathroom needed cleaned and painted.<br><br>4. Review of Resident #123's face sheet showed an admission date of 08/30/19.<br><br>Review of the resident's quarterly MDS, dated [DATE], showed the resident was cognitively intact.<br><br>Review of Resident #125’s face sheet showed an admission date of 04/07/21.<br><br>Review of the resident's quarterly MDS, dated [DATE], showed the resident was cognitively intact.<br><br>(continued on next page) |

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| F 0584<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During an interview and observation on 08/18/25, at 1:00 P.M., Resident #123 and #125’s room, showed the following:-The room had an unpleasant odor, that can be smelled in the hall before opening the door;-There was a beside commode with no lid with bag full of urine tied into the commode;-There was debris and crumbs on the floor;-The corner of the wall had several areas of to damage dry wall;-The toilet seat was loose and moved when pressure placed on the seat;-When the light switch was turned on the above bed light did not illuminate;-The resident said it had been almost two months since maintenance staff said he/she would fix the above light bulb above his/her bed and the door handle had been broken for several months.<br><br>Review of the Maintenance Log at the 100/200 nurses’ station showed staff wrote the following on the log:-On 07/21/25, Residents #123 and #125 room, staff noted neither overhead light worked when the switch was turned on. Staff did not mark or note that had been completed;-On 08/16/25, staff noted “bathroom needs help.” Staff marked as done on 8/21/25.<br><br>During an interview on 08/21/25, at 1:24 P.M., Housekeeper (HK) DD said he/she noticed the room had an odor. The odor could be smelled in the hallway. He/she sprayed the room with an air freshener which the residents did not like.<br><br>5. Review of Resident #39’s face sheet showed an admission date of 11/21/23.<br><br>Review of the resident's quarterly MDS, dated [DATE], showed the resident was cognitively intact.<br><br>Review of Resident #73’s face sheet showed an admission date of 10/10/18.<br><br>Review of the resident's quarterly MDS, dated [DATE], showed the resident was cognitively intact.-Use of wheelchair;<br><br>Observation on 08/19/25, at 4:00 P.M., of Resident #39’s and #72’s room showed the following:-Bathroom air and heat vent on the wall showed gaping holes above and below the air vent approximately 4 inches tall and the width of the vent approximately 12 inches and approximately 2 inches tall by the width of the vent with no drywall in place;-The inside of the wall was visible and air coming out surrounding the vent could be felt;-Air and heat vent in the resident room on the floor had rust colored damage throughout the vent and the floor vent right side was pulled away from the wall by approximately 2 inches;-The towel rod and toilet paper holder were not attached to the wall.<br><br>6. Review of Resident #72’s face sheet showed an admission date of 06/13/25.<br><br>Review of the resident’s MDS, dated [DATE], showed the resident had severely impaired cognition.<br><br>Observations, on 08/25/25, showed the following:-At 10:05 A.M., the resident was not present in his/her room. The resident’s bed was made, and an adjustable height rolling table was positioned over the bed. The surface of the table was soiled, as was the plate-sized square blue non-slip pad stuck to the table. A full, uncovered mug of ice water was on the table;-At 10:48 A.M., the resident was not present in his/her room. The resident’s bed was made, and an adjustable height rolling table was positioned over the bed. The surface of the table remained soiled, including the blue non-slip pad stuck to the table. A full, uncovered mug of ice water was on the table.<br><br>(continued on next page) |

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| F 0584<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During an interview on 08/25/25, at 11:53 A.M., the Director of Nursing (DON) said staff should clean residents’ bedside tables as needed, especially after a meal. The resident would not be expected to clean his/her own table.<br><br>During an interview on 08/25/25, at 1:06 P.M., the Administrator said a resident’s bedside table should not be left soiled. Staff should ensure the table was cleaned after a meal.<br><br>7. Review of Resident #51’s face sheet showed a readmission date of 11/15/24.<br><br>Review of the resident’s quarterly MDS, dated [DATE], showed the resident had moderately impaired cognition.<br><br>Observation on 08/17/25, at 4:30 P.M, showed a softball-sized jagged hole in the lower part of the hollow core closet door.<br><br>Observation on 08/22/25, at 3:00 P.M., showed the same softball-sized jagged hole in the lower part of the hollow core closet door.<br><br>Observation and interview on 08/25/25, at 10:14 A.M., showed the same softball-sized jagged hole in the lower part of the hollow core closet door. The resident said the large hole was on his/her roommate's side of the closet and said, It doesn't look very good. He/she thought it had been that way for a while.<br><br>Review on 08/25/25, at 11:28 A.M., of the Maintenance Book, showed no documentation regarding the damaged closet door.<br><br>8 .Review of Resident #141's face sheet showed an admission date of 04/26/24.<br><br>Review of the resident's quarterly MDS, dated [DATE], showed the resident was cognitively intact.<br><br>Observation and interview on 08/17/25, at 5:01 P.M., showed the following:-The room had an unpleasant odor, that could be smelled in the hall;-An empty soda box was under the resident’s bed, clothes were on the floor, and the tables had various items on them, including empty bottles;-The floor appeared dirty with brown places and pieces of food on the floor;-The floor had clothes, stuffed animals, and soda on it;-The trashcan was mostly full;-The urinal was half full of urine.<br><br>Observation and interview on 08/21/25, at 11:00 A.M., showed the following:-The room has an unpleasant odor, that could be smelled in the hall;-An empty soda box under the resident’s bed, clothes on the floor, the tables had various items on the, including empty bottles;-The floor appeared dirty with brown places and pieces of food on the floor;-The urinal was fourth of the way full of urine;-The floor had clothes, stuffed animals and soda on it;-The resident’s dogfood bowl had spilled and there was dogfood in the floor.<br><br>During an interview on 08/22/25, at 11:10 A.M., CNA I said he/she felt like the dog was causing most of the odors in the room. When he/she comes in, the urinal is usually full, so that probably adds to the odors.<br><br>(continued on next page) |

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| F 0584<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During an interview on 08/22/25, at 12:22 P.M., Licensed Practical Nurse (LPN B) said he/she had noticed odors in and around the room. He/she had also received complaints from staff about the odors. He/she believed it was a combination of things.<br><br>During an interview on 08/22/25, at 2:02 P.M., LPN A/Unit Manager said he/she had received complaints about the resident’s room. He/she had addressed the complaints with housekeeping who should be cleaning the room and making sure the trash is emptied. Nursing should make sure the urinal in empty.<br><br>During an interview on 08/22/25, at 2:22 P.M., the Director of Nursing (DON) said the resident does not want housekeeping in his/her room. He/she knew there were odors in and around the resident’s room.<br><br>During an interview on 08/25/25, at 12:30 P.M., the Administrator said because of the resident’s size, weight, and food choices, his/her odors can be different. The room has been a challenge as the resident doesn’t want housekeeping in his/her room when he/she is asleep. The staff have taken the dog out because the dog will sometimes pee in the room as the resident doesn’t always take the dog out timely.<br><br>During an interview on 08/25/25, the Housekeeping Supervisor said the resident did not like for his/her room to be cleaned often. Some days the resident will allow him/her to clean, but most days he/she will say no. When the resident refuses he/she will do what he/she can, and try to get a deep clean in the room one time per week. He/she notices odors coming from the resident room.<br><br>9. Review of Resident #135's face sheet showed an admission date of 02/26/25.<br><br>Review of the resident's quarterly MDS assessment, dated 07/30/25, showed the resident had cognitively intact skills.<br><br>Observation on 08/17/25, at 5:30 P.M., showed the resident lay in his/her bed. The resident's room smelled of urine. The hallway just outside the resident's room smelled of urine.<br><br>During an observation and interview on 08/18/25, at 11:00 A.M., the resident lay in his/her bed. The resident said he/she received his/her shower and had no complaints of his/her care. The resident's room smelled of urine. The hallway just outside the resident's room smelled of urine.<br><br>Observations on 08/19/25, at 11:33 A.M., and 2:00 P.M., showed the resident lay in his/her bed. The resident's room smelled of a strong urine odor. The hallway just outside the resident's room smelled of urine.<br><br>During an interview on 08/21/25, at 10:45 A.M., LPN A/Unit Manager said the resident had odors in his/her room and the hall at times.<br><br>During an interview on 08/21/25, at 12:23 P.M., the Director of Nursing (DON) said the following: -The resident's former roommate moved out because the resident smelled;-Staff should monitor for odors on rounds;-Offensive odors is not homelike.<br><br>(continued on next page) |

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| F 0584<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | 10. During an interview on 08/21/25, at 9:21 A.M., CNA I said housekeepers mop and sweep daily. Staff check the halls for odors and change a resident if needed.<br><br>During an interview on 08/20/25, at 6:48 P.M., CNA K said staff should report to the housekeepers if there is something on a resident’s floors.<br><br>During an interview on 08/21/25, at 1:24 P.M., HK DD said the following:-Housekeeping clean the residents' rooms every day;-Housekeeping should take out the trash, refill the bathrooms with washcloths, and sweep and mop the floors;-Housekeeping should sweep and mop under the residents' beds;-Staff should report to maintenance of any damage to walls.<br><br>During an interview on 08/21/25, at 1:56 P.M., Registered Nurse (RN) EE said the following: -Staff should check under residents' beds daily for debris and items;-He/she had complaints of odors and sticky floors in the residents' rooms. He/she did not know what housekeeping mopped with but there were several rooms with had sticky floors.<br><br>During an interview on 08/21/25, at 1:09 P.M., the Housekeeping Supervisor said the following:-A housekeeper was on every hall every day;-Housekeeping staff sweep, mop, and disinfectant the sink and toilet every day;-Housekeeping staff should clean under residents’ beds.-He/she walked the halls when he/she arrives on shift and made a list of resident rooms with a stronger odor. He/she informs the charge nurse if it is a task outside of his/her department such as incontinent care.<br><br>During an observation and interview on 08/22/25, at 3:15 P.M., the Maintenance Supervisor said the following: -He/she audited every room to determine what repairs are needed;-Staff should report any damage to him/her and write in the maintenance logbook.<br><br>During an interview on 08/25/25, at 12:29 P.M., the Administrator said the following:-Housekeeping should make sure rooms with odors are clean;-Any person in the building including staff and visitors can inform staff of odors;-The facility did not have a policy for repairs. Staff, family members, vendors or anyone can inform facility staff of a repair that needs addressed. The maintenance logbook is available 24 hours seven days a week for any staff member. Maintenance staff reviews the logbook and implements;-Staff should report any repairs needed and write it in the maintenance log;-The water should be hot for staff to mop the floors. Housekeeping should check the floors and re-mop if the floor are sticky.<br><br>11. Multiple observations on 08/18/25, at 10:18 A.M., through 08/20/25, at 10:27 A.M., during survey showed a recliner in the dementia unit's sunroom that contained a dried brown substance on both arm rests, seat, and down the footrest.<br><br>During an interview on 08/21/25, at 1:09 P.M., the Housekeeping Supervisor said the recliner in the sunroom needed wiped down. During an interview on 08/21/025, at 1:24 P.M., HK DD said the recliner in the sunroom was dirty.<br><br>During an observation and interview on 08/22/25, at 3:15 P.M., the Maintenance Supervisor said the recliner in the sunroom was ”disgusting.”<br><br>During an interview on 08/25/25, at 12:29 P.M., the Administrator said the recliner in the sunroom should be clean.<br><br>(continued on next page) |

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| F 0584<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | 12. Review of Resident #148’s face sheet showed the following:-admission date of 10/13/21;-Diagnosis included anxiety disorder.<br><br>Review of the resident's quarterly MDS, dated [DATE], showed the resident was cognitively intact.<br><br>During an interview and observation on 08/17/25, at 4:30 P.M., of the resident’s room, showed the temperature in the room measured 84.6 degrees Fahrenheit (F). The resident said that it was very warm and without his/her small fan it would be too hot.<br><br>Observation on 08/17/25, at 5:10 P.M., showed the thermostat in the 200-hallway set at 71 degrees F with the temperature reading 82 degrees F.<br><br>13. Observation and interview on 08/17/25, at 5:00 P.M., of Resident #103’s room showed the following: -The resident flushed/red in color and said the following he/she was hot;-The resident said the 300-hall air conditioner unit had been broken for about a month and his/her room gets too warm for comfort;-The facility provided mini-air conditioner units for his/her room, but it does not help much.<br><br>Observation on 08/17/25, at 5:15 P.M., showed the thermostat outside the resident’s room was set to 71 degrees F, but the temperature read 84 degrees F.<br><br>Observation on 08/17/25, at 6:17 P.M., showed the resident’s room temperature measured 84.2 degrees F.<br><br>14. Observation on 08/19/25, at 3:07 P.M., showed the private family dining room’s temperature measured 84.4 degrees F.<br><br>15. Review of the Maintenance Director’s weekly temperature logs showed the following:-On 08/08/25, the highest temperature collected for 300 hall was 78 degrees F;-On 08/15/25, the highest temperature obtained for 300 hall was 77 degrees F.<br><br>16. During an interview on 08/22/25, at 2:22 P.M., the DON said the following:-She believed by regulation, building temperatures should be kept below 80 degrees F;-The facility bought ten mini-air conditioners and fans for the residents for half of 300 hall to keep them comfortable;-The air conditioner has been restored.<br><br>During an interview on 08/25/25, at 12:30 P.M., Administrator said there had been an issue on the 100 hall with the air conditioner but that air conditioner unit had been replaced. The 300 hall had more than one air conditioner and one of the units had been weaker and it had affected a few of the rooms. There was bid out for the air conditioner to be replaced. There was not an air conditioner on the 200-hall broken. No one had shared with her that 200 hall had been hot. She obtained mini-air conditioners for each resident that was in the affected area. She was not aware that any residents were too hot. The air conditioner has been restored.<br><br>Complaint #1534275, #1534276, #2572207, #2590129, and #2591593 |

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| F 0679<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide activities to meet all resident's needs.<br><br>Based on observation, interview, and record review, the facility failed to provide activity programs to meet the needs of all residents when staff failed to provide activities as scheduled on the Special Care Unit (SCU); when staff failed to document routinely offering or completing meaningful activities to with three residents (Resident #13, #17, and #123); and when staff failed to provide preferred independent activities for one resident (Resident #123). The facility census was 149.Review of the facility policy titled Activities, dated 09/14/23, showed the following:-It is the policy of the facility to provide an ongoing program to support residents in their choice of activities based on their comprehensive evaluation, care plan, and preferences. Facility sponsored group, individual, and dependent activities will be designed to meet the interest of and support the physical, mental, and psychosocial well-being of each resident, as well as encourage both independence and interaction within the facility;-Activities may be conducted in several ways including one-on-one programs; person appropriate; activities relevant to the specific needs, interests, culture, background and program of activities; and include a combination of large and small groups, 1:1, and self-directed as the resident desires to attend.<br><br>1. Observations during the survey showed staff provided an activities calendar for the SCU on a large board outside of the dining room.<br><br>Review of the August 2025 Activity Calendar showed a music activity scheduled for 08/18/25 at 3:00 P.M.<br><br>Observation on 08/18/25, at 3:05 P.M. and 3:13 P.M., showed no activities were observed on the unit at that time.<br><br>Review of the August 2025 Activity Calendar showed an activity scheduled for 08/21/25, at 2:00 P.M., for a craft activity. Observation on 08/21/25, at 2:02 P.M., showed no activities offered at that time.<br><br>2. Review of Resident #13's face sheet showed the following:-admission date of 06/27/25;-Diagnoses included hypertension, and bilateral primary osteoarthritis of knee.<br><br>Review of the resident's initial review of activities, dated 07/08/25, showed the following:-The resident refused to answer his/her activities/interests/hobbies;-Current activity participation unknown.<br><br>Review of the resident's admission Minimum Data Set (MDS – a federally mandated assessment completed by facility staff), dated 07/10/25, showed the following:-Severely impaired cognitive skills-No rejection of care;-Not important at all for activities.<br><br>Review of the resident's current care plan, undated, showed the following:-The resident required assistance for meeting emotional, intellectual, physical, and social needs;-One-on-one bedside/in-room visits and activities if unable to attend out of room events;-Invite to scheduled activities.<br><br>Review of the resident's August 2025 Participation Record showed on 08/08/25 through 08/13/25, 08/15/25, 08/18/25, and 08/20/25, staff did not document attendance at or offering of a group, independent, or one-on-one activity.<br><br>(continued on next page) |

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| F 0679<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | 3. Review of Resident #17's face sheet showed the following:-admission date of 10/25/23;-Diagnoses included cognitive communication deficit, schizophrenia (a disorder that affects a person's ability to think, feel, and behave clearly), and bipolar disease (a disorder associated with episodes of mood swings ranging from depressive lows to manic highs).<br><br>Review of the resident's admission MDS assessment, dated 11/06/23, showed the following:-The resident has severely impaired cognitive skills;-No behaviors;-The resident prefers listening to music and participating in favorite activities.<br><br>Review of the resident's care plan, revised 08/14/25, showed the following:-The resident required assistance for meeting emotional, intellectual, physical and social needs related to cognitive deficits;-Assist/escort the resident to activity functions;-Invite the resident to scheduled activities;-Preferred activities are music programs, coffee socials, arts and crafts and cardio drumming.<br><br>Review of the resident's quarterly activities participation review, dated 08/19/25, showed the following:-Staff to provide clear verbal reminders and assist the resident to the location of activities;The resident generally enjoys singing during sing along and musical groups;-The resident enjoys groups with snacks, ice cream, coffee and social time.<br><br>Review of the resident's activity participation record showed on 08/01/25 through 08/10/25, 08/15/25 through 08/17/25, and 08/19/25 staff did not document attendance at or offering of a group, independent, or one-on-one activity.<br><br>4. Review Resident #123’s face sheet showed the following:-admission date of 08/30/19;-Diagnoses included muscle weakness, chronic obstructive pulmonary disease (COPD - group of lung diseases that block airflow and make it difficult to breathe), chronic kidney disease (CKD - kidneys are damaged and can't filter blood the way they should), and congestive heart failure (CHF – condition in which the heart can't pump enough blood to the body's other organs).<br><br>Review of the resident’s care plan, updated 07/25/26, showed the following:-Resident enjoyed activities such as creative being on his/her computer, having friends over, listening to music and watching movies;-Staff should ensure that the activities the resident attended were compatible with physical and mental capabilities;-Staff should establish and record resident’s level of activity involvement and interests;-Staff should thank resident for attendance at activity function.<br><br>Review of the Activities Quarterly Participation Review, dated 04/30/25, showed the following:-Resident preferred independent activities;-Resident’s favorite activities included playing on the computer and talking on the phone.<br><br>Review of the facility provided Activity Participation Form, dated August 2025, showed staff did not document any information.<br><br>During an interview on 08/18/25, at 10:15 A.M., the resident said he/she did not see activity staff for one-to-one visits. He/she said that it would be nice if he/she could get library books at times and even get a library card so he/she could check out books online. He/she said that it would be nice if the staff would tell him/her what was available to residents.<br><br>(continued on next page) |

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| | 265188 | A. Building<br>B. Wing | 08/25/2025 |

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| F 0679<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During an interview on 08/25/25, at 9:10 A.M., Activities Certified Nurse Aide (CNA) F said that he/she visited with residents in their room and asked if need anything and if doing okay. The conversation only lasted about five minutes. There was a log that activities staff document activities attendance including one-to-one visits. He/she opened a 3-ring binder and turned to the resident’s sheet. There was no documentation of visits for the month of August. He/she said he/she forgot to document the dates he/she talked to the resident.<br><br>5. During an interview on 08/21/25, at 1:56 P.M., Registered Nurse (RN) EE said the following: -Staff try to do activities on the SCU, but it is difficult because the residents have attention spans like children;-Activity staff have coffee and conversation, movies, and balloon toss;-He/she did not see any one-on-one activities on the unit;-He/she thinks there should be more activities on the SCU;<br><br>During an interview on 08/22/25, at 8:21 A.M., the Activity Director said the following:-He/she worked at the facility for three weeks;-Activity staff asked the resident's interests upon admission;-Activity staff asked the residents of group and one on one interests;-Activity staff should document activity attendance in the logbook for each hall;-Activity staff should document activity progress notes for residents;-Activity staff did not document on activities other than the activity assessment;-He/she needed to educate the activity staff to document one-on-one activities;-He/she expected activity staff to document one-on-one activities;-The activity program was for quality of life for residents and having something for them to participate in.<br><br>During an interview on 08/22/25, at 8:40 A.M., Certified Nurse Aide (CNA) FF said staff did not instruct him/her to provide any one-on-one activities with the residents on the dementia unit.<br><br>During an interview on 08/22/25, at 8:42 A.M., Certified Medication Technician (CMT) G said he/she did not observe any one-on-one activities with the residents on the dementia unit. The residents ambulate up and down the halls.<br><br>During an interview on 08/22/25, at 9:00 A.M., Activity Staff GG said the following:-Activity staff complete an activity assessment with the residents;-Activity staff ask what the resident likes to do in their spare time;-Activity staff ask the resident of hobbies, if they like to read;-Activity staff document on the activity assessment and give it to the director who enters the information in the computer;-The care plan coordinator develops the care plan;-Activity staff talk with the residents and family members who reside on the dementia unit to determine interests;-It is more difficult for one-on-one activity on the dementia unit due to the residents change every five minutes and some did not converse.<br><br>During an interview on 08/25/25, at 10:40 A.M., the Director of Nursing (DON) said she expected one-on-one activities on the dementia unit and for staff to document activities provided to residents.<br><br>During an interview on 08/25/25, at 12:29 P.M., the Administrator said she expected staff to provide one-on-one and group activities on the SCU. Activities should be provided to all residents, even residents not attending in the activity room.<br><br>Complaint 1534276 |

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| F 0686<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate pressure ulcer care and prevent new ulcers from developing.<br><br>(continued on next page) |

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| F 0686<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide care per standards of practice when staff failed to consistently assess and document complete, thorough, and accurate wound tracking of pressure ulcers (localized damage to the skin and/or underlying soft tissue usually over a bony prominence or related to a medical or other device), failed to obtain treatment orders for an identified pressure ulcer in a timely manner, and failed to document wound treatments per physician orders for one resident (Resident #169) who was admitted from the hospital. The facility's census was 149.Review of the facility policy titled Wound Management, dated 11/15/22, showed the following:-To promote wound healing of various types of wounds, the facility will provide evidence-based treatments in accordance with current standards of practice and physician orders;-Wound treatment will be provided in accordance with physician's order: cleansing method, type of dressing, and frequency of dressing change;-Charge nurse will notify physician in the absence of treatment orders;-Treatments will be documented on the Treatment Administration Record (TAR). 1. Review of Resident #169's face sheet (admission data) showed the following:-admission date of 06/10/25;-Diagnoses included pressure ulcer of other site stage 3 (full-thickness loss of skin). Review of the resident's Nursing admission Evaluation and Baseline Care Plan dated 06/10/25, at 3:43 P.M., showed Licensed Practical Nurse (LPN) A/Unit Manager documented the resident admitted from the hospital. Skin had treatment ordered or required.Review of the resident's Physician Order Sheet (POS), dated 06/10/25, showed no order for wound care. Review of the resident's June 2025 TAR showed no orders for wound care added at admission. Review of the resident's Skin Observation Tool dated 06/11/25, at 2:05 P.M., showed LPN A/unit manager documented the following:-Present on admission: Edema (swelling) to bilateral lower extremities with bruising and scabs to bilateral upper extremities;-Open area to left abdominal fold;-Bruising to left shoulder;-Open area to left buttock.(Staff did not document measurements, description of, or treatment orders for the opean area on the resident's buttock.) Review of the resident's admission note dated 06/11/25, at 2:25 P.M., showed LPN A/Unit Manager documented the resident admitted from the hospital. The resident's skin was warm and dry. The resident had scabs and bruising to the resident's bilateral upper extremities. The resident had an open area to his/her right abdominal fold and an open area to his/her left buttock. Review of the resident's POS, dated 06/11/25, showed the following:-An order, dated 06/10/25, for staff to complete Skin Observation Tool form on day shift on Tuesday one time a day, every Tuesday for skin observation.-An order, dated 06/11/25, for wound company consult.(The POS did not show an order for wound care of the resident's open area to buttock.) Review of the resident's wound physician's visit , dated 06/12/25, showed the following:-At the request of the referring provider, a thorough wound care assessment and evaluation was performed;-The resident had wounds on his/her left and right buttock (previously only left buttock documented);-The resident was non ambulatory with bowel incontinence and stage 3 pressure wounds of the bilateral buttocks;-Stage 3 pressure wound of the left buttock measured 8 centimeters (cm) long by 6 cm wide by 0.4 cm in depth, light serosanguinous (a fluid that contains both clear, watery and blood), 50% granulation (red bumpy tissue) tissue, and noted to be present on admission per staff;-Stage 3 pressure wound of the right buttock measured 12 cm long by 7 cm wide by 0.4 cm in depth, light serosanguinous, 50% granulation tissue and noted to be present on admission per staff;-Hydrocolloid paste (wound cream) apply once daily and as needed if saturated, soiled, or dislodged, for 30 days; -General recommendation cleanse wounds with wound cleanser at time of dressing changes. Review of the resident's June 2025 TAR showed staff did not add the wound care, ordered on 06/12/25, for the resident's stage 3 pressure ulcers. Review of the resident' weekly wound observation dated 06/13/25, at 3:15 P.M., showed the wound nurse documented the following:-Stage 3 pressure wound of the resident's left buttock;-The Stage 3 pressure wound was present on admission;-Overall impression: first observation, no reference;-Drainage: small amount serosanguinous;-No odor present;-The resident's left buttock wound measured 8 cm long by 6 cm wide and 0.4 cm in depth;-No inflammation/induration present;-Current treatment plan: Triad (hydrocolloid paste) once daily and as needed. Review of the resident' weekly wound observation dated 06/13/25, at 3:17 P.M., showed the wound nurse documented the following:-Stage 3 pressure wound of the resident's right buttock;-The stage 3 pressure wound was present on admission;-Overall impression: first observation, no reference;-Drainage: small amount serosanguinous;-No odor present;-The right buttock measured 12 cm long by 7 cm wide and 0.4 cm in depth;-No inflammation/induration present;-Current |

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| F 0690<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>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.<br><br>(continued on next page) |

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| F 0690<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Based on record review and interview, the facility failed to ensure all residents with urinary catheters (a tube inserted into the bladder, allowing urine to drain freely), received appropriate treatment for the catheter and prevent urinary tract infections per standards of practice when staff failed to document monitoring of urine output, abnormal urine color, and care of the catheter as ordered for one resident (Resident #169) The Facility census was 149. Review of the facility's policy titled Catheter Care, dated 07/13/22, showed the facility will maintain consistent and adequate hygiene standards for residents with an indwelling catheter to maintain function and prevention of infection or complications. 1. Review of Resident #169's face sheet (admission data) showed the following:-admission date of 06/10/25;-Diagnoses included acute kidney failure. Review of the resident's Nursing admission Evaluation and Baseline Care Plan dated 06/10/25, at 3:43 P.M., showed Licensed Practical Nurse (LPN) A/Unit Manager documented the resident was incontinent of the bladder and had an indwelling catheter. Review of the resident's progress note dated 06/10/25, at 4:12 P.M., showed LPN A/Unit Manager documented the resident admitted from the hospital. The resident had a catheter coude (urinary catheter with a curved or bent tip) size 16 indwelling catheter. Review of the resident's June 2025 Physician Order Sheet (POS) showed the following:-An order, dated 06/11/25, for a size 16 coude indwelling catheter, 10 cubic centimeters (cc) change every month and as needed;-An order, dated 06/11/25, for catheter care every day and night shift;-An order, dated 06/11/25, to change the catheter bag every month and as needed;-An order, dated 06/11/25, for staff to record the amount of urine output every shift, to monitor urine for signs and symptoms of infection every day and night shift. Review of the resident's June 2025 Medication Administration Record (MAR) showed the following:-An order, dated 06/11/25, to record the amount of urine output every shift, to monitor urine for signs and symptoms of infection every day and night shift;-An order, dated 06/11/25, for catheter care every day and night shift;-On 06/14/25, 06/15/25, and 06/16/25, staff did not document the amount of urine output from the resident's catheter or completion of catheter care. Review of the resident's nurse practitioner's progress note, dated 06/16/25, showed the following:-The resident was seen for hematuria (blood in urine);-The resident had Kool-aid colored urine in his/her catheter with no clots present;-Per the urology (physician that specializes in diseases related to the urinary system) consult the resident was a poor candidate for further evaluation;-Recommendation for the resident to continue Foley catheter and change it every 30 days or as needed. Review of the resident's medical record showed show staff did not document regarding the resident's off-color urine in his/her catheter.During an interview on 08/25/25, at 9:45 A.M., Certified Nurse Aide (CNA) K said the following:-Staff should ask the nurse of residents who have a catheter. He/she asked the nurse upon his/her shift of any residents who have a catheter;-Staff should check to ensure a resident's catheter bag is covered and positioned correctly;-Staff should monitor a resident's urine output, write it down, and inform the charge nurse;-Staff should report to the charge nurse if a resident's urine has particles or is cloudy.During an interview on 08/24/25, at 5:00 P.M., Certified Medication Technician (CMT) Z said staff should document input and output of urine. Staff should report to the charge nurse if a resident has blood in their urine. During interviews on 08/21/25, at 10:45 A.M., and on 08/25/25, at 10:11 A.M., LPN A/Unit Manager said the following: -Staff should document observation of the catheter site and color of the urine. -Staff should monitor urine for any discoloration, amount of urine, color, pain or discomfort and report to the charge nurse if any issues;-Staff should document any issues with a resident's catheter;-Staff should document catheter care on the TAR.During an interview on 08/24/25, at 4:46 P.M., LPN B said the following:-Staff should monitor urine output and provide catheter every shift and as need for a resident with a catheter;-Staff should monitor the resident's urine color, amount, and odor, and notify the physician if a resident has issues with their catheter;-Staff should document catheter care on the Treatment Administrator Record (TAR).During an interview on 08/24/25, at 7:20 P.M., Registered Nurse (RN) X said the following:-Staff should monitor a resident's urine output, color of the urine, and odor;-Staff should notify the physician if a resident has issues with their catheter and document it in the resident's medical record; -Staff should document catheter care on the TAR.During an interview on 08/22/25, at 11:08 A.M., the Nurse Practitioner said the following:-The resident had a catheter and had consulted with urology when the resident was in the hospital; -The resident had blood in the bag of his/her catheter. The blood was not frank red blood;-The resident wanted her to take the catheter out;-The urologist was aware of the blood in the resident's urine and wanted no changes. During an interview on 08/25/25, at 9:25 A.M., the Medical Director |

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| F 0692<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide enough food/fluids to maintain a resident's health.<br><br>(continued on next page) |

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| F 0692<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Based on interview and record review, facility staff failed to ensure all residents were offered sufficient meals and fluid intake to maintain proper hydration and health when staff failed to ensure all residents received breakfast, including on dialysis (life-sustaining medical treatment that removes waste, excess fluid, and toxins from the blood when the kidneys can no longer perform their filtering function) days when staff failed to provide breakfast tray one day and failed to provide a sack meal prior to dialysis for one resident (Resident #48). The facility census was 149. 1. Review of Resident #48's face sheet showed the following:-admission date of 02/24/25;-Diagnoses included dependence on renal dialysis (life-sustaining medical treatment that removes waste, excess fluid, and toxins from the blood when the kidneys can no longer perform their filtering function), end stage renal disease (final, permanent stage of chronic kidney disease where the kidneys have lost their ability to function effectively), and type 2 diabetes mellitus (chronic condition that affects the way the body processes blood sugar (glucose)).Review of the resident's quarterly Minimum Data Set (MDS - a federally mandated assessment instrument completed by facility staff), dated 05/30/25, showed the following:-Cognitively intact;-Set up or clean up assistance required for eating.Review of the resident's care plan, updated 07/28/25, showed the following:-Resident had impaired cognitive function or impaired thought processes related to difficulty making decisions as evidenced by intention and disorganized thinking that comes and goes;-Staff should cue, reorient. and supervise as needed;-Resident had potential for malnutrition related to dialysis patient and other multiple comorbidities;-Resident was at risk of dehydration or potential fluid deficit related to history pneumonia infection;-Staff should ensure the resident had access to fluids whenever possible;-Resident would receive adequate nutrition to maintain quality of life;-Staff should refer to dietary card for resident preferences.Review of the resident's dietary card, dated 08/25/25, showed the following:-Regular, low calorie sweetener diet, thin liquids;-Alerts: double protein, one cup milk daily, no orange juice, banana, tomato, or potato.Review of the resident's Dialysis Communication Transfer Forms, showed the following:-For treatment on 08/04/25, time of last meal 08/03/25, at 6:00 P.M.;-For treatment on 08/06/25, time of last meal 08/05/25, at 5:30 P.M.;-For treatment on 08/08/25, time of last meal 08/07/25, at 6:00 P.M.;-For treatment on 08/15/25, time of last meal 08/14/25, at 5:45 P.M.;-For treatment on 08/20/25, time of last meal 08/19/25, at 6:00 P.M. During an interview on 08/21/25, at 9:50 A.M., the resident said he/she did not receive breakfast this day.During an interview on 08/21/25, at 10:00 A.M., Dietary Manager said he/she did not know why the resident did not get breakfast tray. There was an order for breakfast on hold for Monday, Wednesday, and Fridays. The resident should receive breakfast upon return from dialysis. This day was Thursday. The Dietary Manager did not know why the resident did not receive a meal tray. During an interview on 08/21/25, at 10:10 A.M., Registered Nurse (RN) C said he/she did not know why the resident was not provided with a breakfast meal tray. Once he/she was notified by the resident's roommate he/she went to the kitchen, but all breakfast foods were put away. During an interview on 08/21/25, at 12:35 P.M., the resident said there was another day a couple weeks ago that staff also forgot to bring his/her breakfast tray. He/she goes to dialysis on Monday, Wednesday, and Fridays and leaves between 5:00 A.M. and 5:30 A.M. The staff used to bring his/her breakfast tray when he/she returned, but he/she did not get back until almost lunch time, so he/she told them to not bring the breakfast tray those days. On dialysis days he/she was given cookies or crackers before leaving. The resident said it would be nice to have a breakfast sack to go with him/her as dialysis did not provide food and he/she did get hungry.During an interview on 08/22/25, at 9:25 A.M., the Dietary Manager said when a resident has dialysis they just have to ask if want sack lunch. Some of the residents do want a sack lunch, other do not. Some want their meal to be reheated when return. The sack lunch would include deli meat or peanut butter sandwich, fresh fruit and bag chips, along with applesauce or pudding. To ensure all residents get a tray at each meal, each morning, dietary staff gets a census sheet and when they print out the tickets, they go through those to verify all residents are on there. On Thursday, the resident's tray was on the dining room cart. He/she did not know why staff did not take the meal tray to his/her room.During an interview on 08/25/25, at 11:20 A.M., the Director of Nursing (DON) said residents should be provided with meals before dialysis if they want. The nursing staff should let kitchen know and get a sack meal if needed. The resident should be provided with breakfast, and he/she was not aware that he/she did not get breakfast last Thursday. There should be a nutrition assessment with resident preferences. During an interview on 08/25/25, at 12:30 P.M., the Administrator said residents have to talk to the Dietary Manager to get a meal before leaving for dialysis. There is a nutrition assessment done |

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| F 0755<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to provide pharmacy services to meet the needs of each resident when the facility failed to document administration or refusal of medications on the Medication Administration Record (MAR) for two residents (Resident #169 and #200) and when staff failed to follow-up with a provider when one resident (Resident #141) went to an outside appointment and received an order for a medication. The facility census was 149.<br><br>Review of the facility policy titled “ Medication Administration – General Guidelines,” dated December 2017, showed medications are administered as prescribed in accordance with good nursing principles and practices and only by persons legally authorized to do so;<br><br>1. Review of Resident #169's face sheet showed the following:-admission date of 06/10/25;-Diagnoses included acute kidney failure, cognitive communication deficit, Type 2 diabetes mellitus (a group of diseases that result in too much sugar in the blood) with hyperglycemia (high blood sugar levels) and pressure ulcer.<br><br>Review of the resident's Nursing admission Evaluation and Baseline Care Plan dated 06/10/25, at 3:43 P.M., showed Licensed Practical Nurse (LPN) A/Unit Manager documented the following:-The resident admitted from the hospital;-Current medication list provided to the resident and representative;-Physician orders: see current MAR and TAR orders.<br><br>Review of the resident's June 2025 POS showed an order, dated 06/10/25, with a start date of 06/11/25, for apixaban (Eliquis-anticoagulant-blood thinner) tablet 5 milligrams (mg), give one tablet by mouth two times a day for anticoagulant.<br><br>Review of the resident’s June 2025 Medication Administrator Record (MAR) showed the following:-On 06/14/25, at 8:00 A.M. and 4:00 P.M., staff did not document administration of the Eliquis on the MAR;-On 06/15/25, at 08:00 A.M. and 04:00 P.M., staff did not document administration of the Eliquis on the MAR;-On 06/16/25, at 08:00 A.M. and 04:00 P.M. staff did not document administration of the Eliquis on the MAR.<br><br>Review of the resident's June 2025 POS showed an order, dated 06/10/25, for mirtazapine (treats depression) tablet 15 mg, for staff to give by mouth at bedtime for depression.<br><br>Review of the facility's June 2025 MAR showed the following:-On 06/14/25, at 8:00 P.M., staff did not document administration of the mirtazapine tablet on the MAR;-On 06/15/25, at 8:00 P.M., staff did not document administration of the mirtazapine tablet on the MAR;-On 06/16/25, at 8:00 P.M., staff did not document administration of the mirtazapine tablet on the MAR.<br><br>Review of the resident's June 2025 POS showed an order, dated 06/10/25, for oxycodone (treats moderate to severe pain) HCL oral tablet 5 mg, give one tablet by mouth every four hours as need for moderate to severe pain for five days.<br><br>(continued on next page) |

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|---|---|---|---|
| | 265188 | A. Building<br>B. Wing | 08/25/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Spring Valley Health & Rehabilitation Center | 2915 South Fremont Ave<br>Springfield, MO 65804 |

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| F 0755<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Review of the facility's Medication Machine Report and June 2025 MAR showed the following:-On 06/14/25, at 10:58 P.M. the machine dispensed oxycodone 5 mg tablet two times;-On 06/14/25, staff did not document administration of the oxycodone on the MAR;-On 06/15/25 at 7:21 P.M., the machine dispensed oxycodone 5 mg tablet two times;-On 06/15/25, staff did not document administration of the oxycodone on the MAR.<br><br>Review of the resident's June 2025 POS showed an order, dated 06/10/25, start date of 06/11/25, for pantoprazole sodium (treats gastroesophageal reflux disease) tablet delayed release 40 mg, give 40 mg by mouth two times a day for gastrointestinal (GI).<br><br>Review of the facility's June 2025 MAR showed the following:-On 06/14/25 at 8:00 A.M. and 4:00 P.M., staff did not document administration of the pantoprazole sodium tablet;On 06/15/25, at 8:00 A.M. and 4:00 P.M., staff did not document administration of the pantoprazole sodium tablet;-On 06/16/25, at 8:00 A.M. and 4:00 P.M., staff did not document administration of the pantoprazole sodium tablet.<br><br>Review of the resident's June 2025 POS showed an order, dated 06/10/25, start date of 06/11/25, for potassium chloride (treats low levels of potassium in your body) ER tablet extended release 10 milliequivalent (meq), give one tablet by mouth one time a day for supplement.<br><br>Review of the resident’s June 2025 MAR showed the following:-On 06/14/25, at 8:00 A.M., staff did not document administration of the potassium chloride ER tablet on the MAR;-On 06/15/25, at 8:00 A.M., staff did not document administration of the potassium chloride ER tablet on the MAR;-On 06/16/25, at 08:00 A.M., staff did not document administration of the potassium chloride ER tablet on the MAR.<br><br>Review of the resident's June 2025 POS showed an order, dated 06/10/25, for tizanidine (treats muscle spasms) HCL tablet two mg, one tablet by mouth every eight hours for muscle relaxant.<br><br>Review of the resident’s June 2025 MAR showed the following:-On 06/14/25, at 6:00 A.M., 2:00 P.M., and 10:00 P.M., staff did not document administration of the tizanidine on the MAR;-On 06/15/25, at 6:00 A.M., 2:00 P.M., and 10:00 P.M., staff did not document administration of the tizanidine tablet on the MAR;-On 06/16/25, at 6:00 A.M., 2:00 P.M., and 10:00 P.M., staff did not document administration of the tizanidine tablet on the MAR.<br><br>During interviews on 08/22/25, at 10:02 A.M and 3:00 P.M., and on 08/25/25, at 10:11 A.M., Licensed Practical Nurse (LPN) A/Unit Manager said the following: -Staff should document if the resident refused medications;-He/she was not sure what happened with the resident' medications not documented on the MAR. -Resident was noncompliant with care;-Staff should had notified the physician if the resident refused cares;-The resident refused his/her medications;-Staff should document if a resident refuses medications.<br><br>During interviews on 08/22/25, at 3:50 P.M., and on 08/25/25, at 11:20 A.M., the MDS Coordinator said the following:-Staff did not administer the resident's morning medications on 06/14/25 due to the resident was not in the building;-On 06/15/25, the resident was in the facility and staff administered the medications;-Staff sent the resident out for an evaluation on 06/16/25;-Staff should document on the MAR of medications to show the medication was given.<br><br>(continued on next page) |

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| F 0755<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During an interview on 08/24/25, at 7:20 P.M., Registered Nurse (RN) X said the following:-Staff should document if the resident refused his/her medications;-He/she did not remember the issue with staff not documenting the resident's medications on the MAR for 06/14/25 through 06/16/25.<br><br>During an interview on 08/25/25, at 10:40 A.M., the Director of Nursing (DON) said she did not know what happened with the resident's medication dropping of the MAR.<br><br>2. Review of Resident #141's face sheet showed the following:-admission date of 04/26/24;-Diagnosis of type 2 diabetes (body does not use insulin effectively and morbid obesity (excessive weight).<br><br>Review of the resident's quarterly Minimum Data Set, dated [DATE], showed the following:-Resident was cognitively intact;-No noted skin issues.<br><br>Review of the resident's care plan, updated 01/17/25, showed the following:- Staff will complete skin observations weekly and as needed. Report changes in skin integrity to the nurse;-Administer medications as ordered;-Resident has diabetes. Check all body for breaks in skin and treat promptly.<br><br>Review of the resident's July 2025 POS showed the following:-An order, dated 09/04/24, for Elocon cream (topical corticosteroid used to treat inflammation), every 24 hours as needed for rash, eczema (chronic skin condition characterized by itchy, inflamed red skin);-An appointment, on 07/30/25, with the dermatologist.<br><br>Review of the resident’s progress note, dated 08/04/25, showed the following:-Review of the resident’s systems, noting on dermatological, skin rash due to psoriasis;-Physical exam psoriasis, an order as needed for Elocon cream, daily, recent appointment with dermatology; note not available. No new orders.<br><br>During an interview and observation on 08/17/25, at 5:01 P.M., the resident said he/she saw the dermatologist on 07/30/25. He/she said they sent in a prescription for a diagnosis of psoriasis (inflamed patches of skin with silvery scales). The facility had not applied the cream, and he/she did not believe they had the cream. He/she had told a nurse, and he/she didn’t know if they followed up with the clinic. The spots are uncomfortable and itch. The resident had multiple large, and small red raised spots on his/her arms. The Resident also has multiple spots on his/her legs of a darker color. He/she reported asking several staff to look into the prescription.<br><br>Review of the resident’s August 2025 POS showed an order, dated 08/22/25, for Triamcinolone Acetonide externa cream 0.1% (used to treat various inflammatory skin conditions including psoriasis).<br><br>During an interview on 08/22/25, at 11:35 A.M., Certified Medication Technician (CMT) A said the following;-He/she does nothing with the orders. The nurses put new orders into the resident’s electronic record;-He/she did not apply cream to residents, that was the nurses’ job;-He/she has seen spots on the resident.<br><br>(continued on next page) |

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| F 0755<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During an interview on 08/22/25, at 12:22 P.M., LPN B said the following:-If a resident brings a prescription back from an outside provider, he/she gets it clarified with the facility doctor. Once it’s cleared, he/she would put the order into the electronic record, and it shows on the MAR;-He/she didn’t recall the resident bringing a prescription back from the dermatologist;-The resident did bring it to his/her attention that he/she had been prescribed a medication, and the resident was going to call the dermatologist to follow up. The resident did call and told him/her that a prescription had been sent into the pharmacy;-He/she called the dermatology clinic a couple of times, but didn’t get through. He/she didn’t recall when that was, and he/she didn’t document that in the resident’s progress notes;-If it was sent to the pharmacy, it should have been delivered to the facility. He/she did not follow up with the pharmacy;-He/she did text the resident transport driver and the driver said he/she didn’t know if the resident had a prescription;-He/she said the calls to the dermatologist clinic and the pharmacy should have been documented. During an interview on 08/22/25, at 2:02 P.M., LPN A/Unit manager said the following:-Nurses are responsible for putting in new orders;-If the resident comes back from an outside appointment, the nurse should be following up with the provider, especially if the resident did not bring back paperwork;-He/she was not aware of the resident going to the dermatologist, or getting a prescription for a cream;-He/she would expect the nurse to follow up with the provider to see which prescription was ordered and the pharmacy until they have obtained the prescription. During an interview on 08/22/25, at 2:22 P.M., DON said the following:-If a resident does not bring back paperwork from an outside appointment, the nurse should be following up with the provider to see what was done for the resident;-If the resident was ordered a medication, the nurse should call the outside clinic to see what was ordered, and the pharmacy if needed to ensure the medication is there and follow up until it’s delivered to the facility. During an interview on 08/25/25, at 10:37 A.M., the resident’s physician said the following:-He/she would expect staff to let him/her know if there is an outside order from another provider;-If the resident did not provide paperwork after an appointment, he/she would expect the nurse to follow up with the provider for direction, and to see if there were new orders.<br><br>During an interview on 08/25/25, at 12:30 P.M., the Administrator said staff should follow up with the provider if a resident does not bring paperwork back from the appointment. Staff should see if a medication was prescribed and follow up to get the medication.<br><br>3. Review of Resident 200’s face sheet showed the following information:-admission date of 08/06/25;-Diagnosis included acute post-hemorrhagic anemia (type of anemia (condition characterized by a low level of red blood cells or hemoglobin in the blood) that develops rapidly after a significant and acute loss of blood, such as from an injury, surgery, or internal bleeding, leading to a reduced ability to deliver oxygen to tissues), type 2 diabetes mellitus with hyperglycemia (chronic condition where the body doesn't use insulin effectively (insulin resistance) and/or doesn't produce enough of it, leading to consistently high blood sugar (hyperglycemia) levels), malignant neoplasm (cancer) of the colon (large intestines), and paroxysmal atrial fibrillation (type of irregular heartbeat that occurs in short, intermittent episodes).<br><br>Review of the resident’s POS, current as of 08/11/25, showed an order, dated 08/06/25, for apixaban oral tablet 5 mg (blood thinner medication), give 1 tablet by mouth two times a day for atrial fibrillation.<br><br>(continued on next page) |

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| F 0755<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Review of the resident’s August 2025 MAR showed the following:-On 08/06/25, at 8:00 P.M., staff documented apixaban 5 mg as received; -On 08/07/25, at 8:00 A.M. and 8:00 P.M., staff documented apixaban 5 mg as administered;-On 08/08/25, at 8:00 A.M., staff did not document if medication was given or not given;-On 08/08/25, at 8:00 P.M., staff documented apixaban 5 mg as administered;-On 08/09/25 through 08/11/25, staff did not document if medication was given or not given.<br><br>Review of the resident’s POS, current as of 08/11/25, showed an order, dated 08/06/25, for glipizide oral tablet 10 mg (used to manage blood sugar levels), give 1 tablet by mouth two times a day for diabetes mellitus.<br><br>Review of the August 2025 MAR showed the following:-On 08/06/25, at 5:00 P.M., staff did not document if glipizide was given or not given;-On 08/07/25, at 8:00 A.M. and 5:00 P.M., staff documented the glipizide 20 mg as administered;-On 08/08/25 through 08/11/25, staff did not document if the glipizide was given or not given.<br><br>Review of the resident’s POS, current as of 08/11/25, showed an order, dated 08/06/25, for pantoprazole sodium oral tablet delayed release 40 mg (used to treat and manage conditions caused by excessive stomach acid), give 1 tablet by mouth two times a day for gastroesophageal reflux disease (GERD – type of acid reflux).<br><br>Review of the resident’s August 2025 MAR showed the following:-On 08/06/25, at 5:00 P.M., staff did not document if the pantoprazole was given or not given;-On 08/07/25, at 5:00 A.M. and 5:00 P.M., staff documented the pantoprazole as administered;-On 08/08/25, at 5:00 A.M., staff documented the resident as out of the facility;-On 08/08/25, at 5:00 P.M., staff did not document if the pantoprazole was given or not given;-On 08/09/25, at 5:00 A.M., staff documented the pantoprazole as administered;-On 08/09/25, at 5:00 P.M., through 08/11/25, staff did not document if the pantoprazole was given or not given.<br><br>Review of the resident’s POS, current as of 08/11/25, showed an order, dated 08/06/25, for gabapentin oral capsule 100 mg (used to treat seizures and nerve pain), give 1 capsule by mouth three times a day for nerve pain.<br><br>Review of the resident’s August 2025 MAR showed the following:-On 08/06/25, at 6:00 P.M., staff did not document if the gabapentin was given or not given;-On 08/07/25, at 7:00 A.M., 12:00 P.M. and 6:00 P.M., staff documented the gabapentin 100 mg was administered;-On 08/08/25 through 08/11/25, staff did not document if the gabapentin was given or not given.<br><br>Review of the resident’s POS, current as of 08/11/25, showed an order, dated 08/07/25, for aspirin 81 mg, give one tablet by mouth one time daily for coronary artery disease.<br><br>Review of the resident’s August 2025 MAR showed the following:-On 08/07/25, at 8:00 A.M., staff documented aspirin 81mg as administered;-On 08/08/25 through 08/11/25, staff did not document if the aspirin was given or not given.<br><br>Review of the resident’s POS, current as of 08/11/25, showed an order, dated 08/07/25, for bupropion extended-release tablet 150 mg (used to treat depression), give 1 tablet by mouth one time a day for depression.<br><br>(continued on next page) |

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| F 0755<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Review of the resident’s August 2025 MAR showed the following:-On 08/07/25, at 8:00 A.M., staff documented bupropion 150 mg as administered;-On 08/08/25 through 08/11/25, staff did not document if the bupropion was given or not given.<br><br>Review of the resident’s POS, current as of 08/11/25, showed an order, dated 08/07/25, for duloxetine capsule delayed release 30 mg (used to treat depression, anxiety, and some chronic pain), give 1 capsule by mouth one time a day for depression.<br><br>Review of the resident’s August 2025 MAR showed the following:-On 08/07/25, at 8:00 A.M., staff documented the resident received the duloxetine;-On 08/08/25 through 08/11/25, staff did not document if the duloxetine was given or not given.<br><br>Review of the resident’s POS, current as of 08/11/25, showed an order, dated 08/07/25, for ferrous sulfate oral tablet 325 mg (form of mineral iron used to treat and prevent anemia), give 1 tablet by mouth one time a day for anemia.<br><br>Review of the resident’s August 2025 MAR showed the following:-On 08/07/25, at 8:00 A.M., staff documented the resident received the ferrous sulfate;-On 08/08/25 through 08/11/25, staff did not document if the ferrous sulfate was given or not given.<br><br>Review of the resident’s POS, current as of 08/11/25, an order, dated 08/07/25, for metoprolol extended-release tablet 25 mg (used to treat high blood pressure, chest pain, and heart failure), give one-half tablet by mouth one time a day for hypertension (high blood pressure). Hold if systolic blood pressure (first/top number of blood pressure) measured 100 millimeters of Mercury (mm/Hg) or less and notify physician if held for three consecutive doses.<br><br>Review of the resident’s August 2025 MAR showed the following:-On 08/07/25, at 8:00 A.M., staff documented the resident received he metoprolol with a blood pressure reading of 143/64 mm/Hg;-On 08/08/25 through 08/11/25, staff did not document if the metoprolol was given or not given.<br><br>4. During an interview on 08/25/25, at 9:15 A.M., Certified Medication Tech (CMT) AA said staff should document on the MAR any administered medications.<br><br>During an interview on 08/22/25, at 10:00 A.M., CMT D said staff should be documenting medications as administered or not administered with the reason. There should not be blank areas on the MAR.<br><br>During an interview on 08/22/25, at 12:30 P.M., CMT A said staff should be documenting medication as administered or not administered with the reason. There should not be blank areas on the MAR.<br><br>During an interview on 08/22/25, at 12:40 P.M., RN C said staff should be documenting medication as administered or not administered with the reason. There should not be blank areas on the MAR.<br><br>During an interview on 08/25/25, at 11:20 A.M., Director of Nursing (DON) said staff should be documenting medication as administered or not administered with the reason. There should not be blank areas on the MAR. If was not documented it was not done.<br><br>(continued on next page) |

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| F 0755<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During an interview on 08/25/25, at 12:29 P.M., the Administrator said she expected staff to administer resident's medications as ordered and document on the MAR. Staff should be documenting medication as administered or not administered with the reason. There should not be blank areas on the MAR.<br><br>Complaints number #1534273, #1534275, #2572207, and #2585250 |

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| F 0759<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Ensure medication error rates are not 5 percent or greater.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to ensure residents were free of medication errors greater than 5% when the staff failed to administer the correct medication dose for two residents (Resident #109 and #97), when staff administered the wrong medication for one resident (Resident #38), and when staff failed to prime insulin pens prior to administration for two residents (Resident #23 and #132). This resulted in 5 medication errors out of 25 observations opportunities resulting in an error rate of 20%. The facility census was 149.1. Review of the facility policy titled “Medication Administration – General Guidelines,” dated December 2017, showed the following:-Medications are administered as prescribed in accordance with good nursing principles and practices and only by persons legally authorized to do so;-The five rights of medication administration were the right resident, right drug, right dose, right route, and right time. These are applied for each medication being administered. A triple check of these rights is recommended;-Prior to administration of any medication, the medication and dosage schedule on the resident's Medication Administration Record (MAR) are compared with the medication label. If the label and MAR are different and the container has not already been flagged indicating a change in directions, or if there is any other reason to question the dosage or directions, the physician's orders are checked for the correct dosage schedule.-If a medication with a current, active order cannot be located in the medication cart/drawer, other areas of the medication cart, medication room, and facility (e.g., other units) are searched, if possible. If the medication cannot be located after further investigation, the pharmacy is contacted or medication removed from the night box/emergency kit;-Medications are administered in accordance with written orders of the prescriber.<br><br>2. Review of Resident #109’s face sheet showed the following:-admission date of 01/07/25;-Diagnoses included adult failure to thrive (condition characterized by a significant decline in weight, muscle mass, and overall health and function in adults).<br><br>Review of the resident’s quarterly Minimum Data Set (MDS - a federally mandated comprehensive assessment completed by facility staff), dated 08/01/25, showed the resident had severe cognitive impairment.<br><br>Review of the resident’s Physician Order Sheet (POS), current as of 08/25/25, showed an order, dated 01/07/25, for folic acid (man-made B vitamin, also known as folate or vitamin B9, that is essential for cell growth, red blood cell formation, and proper brain health) 1 milligram (mg), give 1 tablet by mouth one time daily for supplement.<br><br>During observation on 08/21/25, at 9:20 A.M., Certified Medication Techn (CMT) D prepared and administered folic acid 800 micrograms (mcg) one tablet to the resident.<br><br>During an interview on 08/22/25, at 9:15 A.M., CMT A if a resident’s order was written for folic acid 1 mg the staff should not administer 800 mcg. He/she said that staff should get clarification from the physician and ask central supply staff to order the 1 mg if not available in the facility.<br><br>(continued on next page) |

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| F 0759<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During an interview on 08/22/25, at 10:00 A.M., CMT D said the order for folic acid 1 mg should have been given as 1 mg. It should not have been given as 800 mcg. Currently the 1 mg dose was not available. He/she had placed an order for the 1 mg dose. He/she said the nurse had contacted the doctor about the 800 mcg dose being available, but did not know the response. He/she said the folic acid dose should have been held until received clarification if could give the 800 mcg that was available.<br><br>3. Review of Resident #38’s face sheet showed the following information:-admission date of 07/28/23;-Diagnoses include diabetes, vitamin d deficiency, high blood pressure, and muscle weakness.<br><br>Review of the resident’s comprehensive MDS, dated [DATE], showed intact cognition.<br><br>Review of the resident’s care plan, dated 08/04/25 showed the following:-Give medications as ordered;-Monitor and record medication side effects and notify physician as needed.<br><br>Review of the resident’s August 2025 POS showed an order, dated 07/28/25, for ferrous sulfate (also known as iron with a higher concentration of elemental iron per dose compared to ferrous gluconate; used to treat iron deficiencies) 325 mg, give one tablet daily.<br><br>Observation on 08/20/25, at 11:53 A.M., showed Registered Nurse (RN) O obtained one tablet of ferrous gluconate (also known as iron, used to treat iron deficiencies.) 27 mg from its bottle in the top of 300 hall’s medication cart. The RN then then administered it to the resident.<br><br>During an interview on 08/22/25, at 10:30 P.M., RN C said staff should not give ferrous gluconate 27 mg if order is ferrous sulfate 325 mg.<br><br>4. Review of Resident #97’s face sheet showed the following information:-admission date of 10/02/24;-Diagnoses included kidney failure, weakness, and iron deficiency.<br><br>Review of the resident’s quarterly MDS assessment, dated 08/01/25, showed the resident had moderate cognitive impairment.<br><br>Review of the resident’s care plan, dated 10/18/24, showed staff to administer medications as ordered. Staff to monitor for and document side effects and effectiveness.<br><br>Review of the resident’s August 2025 POS showed an order, dated 03/08/25, for folic acid 400 mcg one time a day.<br><br>Observation on 08/20/25, at 10:46 A.M., showed RN O obtained one tablet of folic acid 800 mcg from its bottle in the top of 300 hall’s medication cart. The RN then administered the tablet to the resident.<br><br>5. During an interview on 08/22/25, at 9:15 A.M., CMT A said staff should follow physician orders for medication administration and should follow the five rights of medication administration, including the right dose.<br><br>During an interview on 08/22/25, at 10:00 A.M., CMT D said staff should give medications and doses as ordered by the physician.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 265188 | A. Building<br>B. Wing | 08/25/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Spring Valley Health & Rehabilitation Center | 2915 South Fremont Ave<br>Springfield, MO 65804 |

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 0759<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During an interview on 08/22/25, at 10:50 A.M., Director of Nursing (DON) said staff should provide medications as ordered. Staff should provide folic acid in the dose ordered. If there was an order for 1 mg staff should not provide 800 mcg and if there was an order for 400 mcg staff should not give as 800 mcg. Staff should not administer ferrous gluconate if the order was for ferrous sulfate. Staff should notify central supply and the correct items can be ordered if they are out of any over-the-counter supplements.<br><br>During an interview on 08/22/25, at 11:10 A.M., the Administrator said staff should follow physician orders for administering medications. Staff should not administer the incorrect dose or the incorrect medications. If the order was for Folic acid 1 mg or Folic acid 400 mcg, staff should provide as ordered. Staff should not give ferrous gluconate if the order was for ferrous sulfate.<br><br>6. Review of the facility policy titled “Injectable Medication Administration,” dated August 2018, showed prime pen needle per manufacturer guidelines.<br><br>Review of Lilly manufacturer instructions titled “Humalog (insulin lispro – rapid actin insulin) KwikPen – Instructions for Use,” dated March 2020, showed the following:- KwikPen™ is a disposable prefilled pen containing 300 units of insulin;-Multiple doses are in one pen;-Prime the pen before each injection;-Priming the pen means removing the air from the needle and cartridge that may collect during normal use and ensures that the pen is working correctly;-If you do not prime before each injection, you may get too much or too little insulin.<br><br>7. Review of Resident #23’s face sheet showed the following:-admission date of 08/09/24;-Diagnoses included Type 2 diabetes mellitus (chronic condition that affects the way the body processes blood sugar (glucose)) with diabetic polyneuropathy (complication of diabetes that damages the nerves, causing various symptoms and health problems) and hyperglycemia (high blood sugar levels).<br><br>Review of the resident’s quarterly MDS, dated [DATE], showed the following:-Cognitively intact;-Used of insulin seven days of the prior seven days.<br><br>Review of the resident’s care plan, updated 07/21/25, showed the following:-Resident had diabetes mellitus;-He/she was prescribed hyperglycemic medication;-Staff administer diabetes medication as ordered by doctor;-Staff should monitor/document for side effects and effectiveness.<br><br>Review of the resident’s POS, current as of 08/25/25, showed the following:--An order, dated 01/25/25, for Humalog injection solution 100 unit/milliliter (ml), inject 12 unit subcutaneously (applied under the skin) with meals for diabetes mellitus in addition to sliding scale;-An order, dated 01/28/25, for Humalog injection solution 100 unit/ml, inject as per sliding scale (diabetes management method that involves administering a dose of fast-acting insulin based on a person's current blood glucose reading) as follows:-If blood sugar measures 0 to 119 mg/deciliter (dL), then administer no inulin;-If blood sugar measures 120 mg/dL to 160 mg/dL, then administer 3 units of insulin;-If blood sugar measures 161 mg/dL to 200 mg/dL, then administer 5 units of insulin;-If blood sugar measures 201 mg/dL to 240 mg/dL, then administer 8 units of insulin;-If blood sugar measures 241 mg/dL to 280 mg/dL, then administer 12 units of insulin;-If blood sugar measures 281 mg/dL to 320 mg/dL, then administer 16 units of insulin;-If blood sugar measures 321 mg/dL or more, then administer 20 units of insulin and notify physician if blood sugar is 400 mg/dL or greater.<br><br>(continued on next page) |

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| F 0759<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Observation and interview on 08/21/25, at 9:30 A.M., showed the following:-RN C prepared medications for the resident at the nurse’s cart near the resident room;-The resident’s blood glucose reading was 225 mg/dL;-He/she prepared the Humalog KwikPen by removing the top cap, wiped with the rubber stopper with an alcohol wipe, applied the needle, turned the dial to 21 and the returned to 20 units. The nurse did not prime the pen;-The nurse said that he/she did not prime the Humalog pen due to it not being a new pen and the medication would already be at the top of the syringe. He/she said only brand-new pens were primed and if they were not primed the resident may not receive the correct dose;-The nurse entered the resident’s room and wiped the resident’s abdomen with an alcohol wipe and administered Humalog.<br><br>8. Review of Resident #132’s face sheet showed the following information:-admission date of 08/30/24;-Diagnoses include diabetes.<br><br>Review of the resident’s quarterly MDS, dated [DATE], showed the resident was cognitively intact.<br><br>Review of the resident’s care plan, dated 09/17/24, showed staff to administer medications as order and monitor for side effects and effectiveness.<br><br>Review of the resident’s August 2025 POS showed the following orders:-An order, dated 08/29/25, for insulin lispro 100 u/ml, inject 7 units subcutaneously with meals, in addition to the sliding scale;-An order, dated 08/29/25, for insulin lispro 100 u/ml, inject as per sliding scale that follows:-If blood sugar is 0 mg/dL to 119 mg/dL, then do not administer insulin;-If blood sugar is 120 mg/dL to 160 mg/dL, then administer two units of insulin;-If blood sugar is 161 mg/dL to 200 mg/dL, then administer four units of insulin;-If blood sugar is 201 mg/dL to 240 mg/dL, then administer six units of insulin;-If blood sugar is 241 mg/dL to 280 mg/dL, then administer eight units of insulin;-If blood sugar is 281 mg/dL to 320 mg/dL, then administer 11 units of insulin;-If blood sugar is 321 mg/dL or greater, then administer 15 units of insulin and notify the physician if blood sugar is over 400 mg/dL.<br><br>Observation on 08/20/25, at 12:24 P.M., showed RN O obtain the resident’s blood sugar at 148 mg/dL. RN O performed hand hygiene, donned gloves, obtained Humalog and drew up nine units of insulin and administered the insulin to the resident. RN O did not prime the needle prior to administering the insulin.<br><br>9. During an interview on 08/20/25, at 12:50 P.M., RN O said the following:-Staff do not prime insulin pens;-The insulin pens have plungers in them, so there is no need to prime the pen;-If there are bubbles seen in the pen, staff should just watch how they position the pen while administering the insulin;-Even if the resident does get a little bit of air injected, it won't hurt them.<br><br>During an interview on 08/22/25, at 10:30 P.M., RN C said he/she was not aware that insulin pens required primed with each use. He/she thought it was just with new pens.<br><br>During an interview on 08/22/25, at 10:50 A.M., the DON said all insulin pens are required to be primed each time before insulin is administered. Insulin pens should be primed before each use, every pen, every time. This is manufacturer guidelines. The dose would not be correctly administered if not primed.<br><br>(continued on next page) |

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| | 265188 | A. Building<br>B. Wing | 08/25/2025 |

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| Spring Valley Health & Rehabilitation Center | 2915 South Fremont Ave<br>Springfield, MO 65804 |

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| F 0759<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During an interview on 08/22/25, at 11:10 A.M., the Administrator said all insulin pens require priming each time.<br><br>During an interview on 08/22/25, at 11:20 A.M., Corporate Nurse Consultant said that staff should always prime insulin pens with each use.<br><br>Complaint #1534275, #2585250 |

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| F 0760<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Ensure that residents are free from significant medication errors.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure all residents were free of significant medication errors when staff failed to document administration of insulin to two residents (Resident #5 and #65) and when staff failed to prime insulin pens prior to administration for two residents (Resident #23 and #132). The facility census was 149.<br><br>Review of the facility policy titled “Medication Administration – General Guidelines,” dated December 2017, showed the following:-Medications are administered as prescribed in accordance with good nursing principles and practices and only by persons legally authorized to do so;-The five rights of medication administration were the right resident, right drug, right dose, right route, and right time. These are applied for each medication being administered. A triple check of these rights is recommended;- The medication administration record (MAR) is always employed during medication administration.-Medications are administered in accordance with written orders of the prescriber.<br><br>Review of the facility policy titled “Injectable Medication Administration,” dated August 2018, showed the following:-Check order on the medication administration record to see that an injection is currently ordered and due;-Prime pen needle per manufacturer guidelines;-Check five rights again after dose is prepared and before medication is put away and injection administered.<br><br>1.Review of Resident #5's face sheet (resident's information at a quick glance) showed the following:-admission date of 04/20/24;Diagnoses included Type 2 diabetes (body can’t use insulin properly resulting in high blood sugar levels).<br><br>Review of the resident's care plan, updated 07/22/25, showed the resident had diabetes mellitus. Staff to administer diabetes medication as ordered by the doctor.<br><br>(continued on next page) |

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| | 265188 | A. Building<br>B. Wing | 08/25/2025 |

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| Spring Valley Health & Rehabilitation Center | 2915 South Fremont Ave<br>Springfield, MO 65804 |

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| F 0760<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Review of the resident's quarterly Minimum Data Set (MDS - a federally mandated assessment tool completed by staff), dated 08/20/25, showed the following:-Cognitively intact;-Diagnosis of diabetes. Review of the resident's July 2025 Physician Order Sheet (POS) showed the following:-An order, dated 06/09/25, for admelog soslstar (insulin lispro – rapid acting insulin), subcutaneous (under the skin) solution pen-injector 100 unit/milliliter (ml), inject subcutaneously before meals related to type two diabetes with hyperglycemia as per sliding scale that follows:-If blood sugar level measured 124 milligrams/deciliter (mg/dL) to 150 mg/dL, administer two units of insulin;-If blood sugar level measured 151 mg/dL to 200 mg/dL, administer four units of insulin;-If blood sugar level measured 210 mg/dL to 250 mg/dL, administer six units of insulin;-If blood sugar level measured 251 mg/dL to 300 mg/dL, administer eight units of insulin;-If blood sugar level measured 301 mg/dL to 350 mg/dL, administer 10 units of insulin;-If blood sugar level measured 351 mg/dL to 400 mg/dL, administer 12 units of insulin;-An order, dated 06/13/25, to monitor resident’s blood sugar. Review of the resident’s July 2025 MAR showed the following:-On 07/09/25, at 7:00 A.M., the blood sugar was not checked, and no insulin administered;-On 07/09/25, at 11:30 A.M., the blood sugar was not checked, and no insulin administered;-On 07/09/25, at 4:30 P.M., the blood sugar was not checked, and no insulin administered;-On 07/10/25, at 7:00 A.M., the blood sugar was not checked, and no insulin administered;-On 07/10/25, at 11:30 A.M., the blood sugar was not checked, and no insulin administered;-On 07/10/25, at 4:;30 P.M., the blood sugar was not checked, and no insulin administered;-On 07/11/25, at 7:00 A.M., the blood sugar was not checked, and no insulin administered;-On 07/11/25, at 11:30 A.M., the blood sugar was not checked, and no insulin administered;-On 07/11/25, at 4:30 P.M., the blood sugar was not checked, and no insulin administered;-On 07/24/25, at 7:00 A.M., the blood sugar was not checked, and no insulin administered;-On 07/24/25, at 11:30 A.M., the blood sugar was not checked, and no insulin administered;-On 07/24/25, at 4:30 P.M., the blood sugar was not checked, and no insulin administered;-On 07/25/25, at 7:00 A.M., the blood sugar was not checked, and no insulin administered;-On 07/25/25, at 11:30 A.M., the blood sugar was not checked, and no insulin administered;-On 07/25/25, at 4:30 P.M., the blood sugar was not checked, and no insulin administered;-On 07/26/25, at 11:30 A.M., the blood sugar was not checked, and no insulin administered;-On 07/26/25, at 4:30 P.M., the blood sugar was not checked, and no insulin administered;-On 07/28/25, at 11:30 A.M., the blood sugar was not checked, and no insulin administered;-On 07/28/25, at 4:30 P.M., the blood sugar was not checked, and no insulin administered;-On 07/29/25, at 7:00 A.M., the blood sugar was not checked, and no insulin administered;-On 07/29/25, at 11:30 A.M., the blood sugar was not checked, and no insulin administered;-On 07/29/25, at 4:30 P.M., the blood sugar was not checked, and no insulin administered-On 07/31/25, at 11:30 A.M., the blood sugar was not checked, and no insulin administered;-On 07/31/25, at 4:30 P.M., the blood sugar was not checked, and no insulin administered. Review of the resident's August 2025 POS showed the following:-An order, dated 06/09/25, for admelog soslstar, subcutaneous solution pen-injector 100 unit/milliliter (ml), inject subcutaneously before meals related to type two diabetes with hyperglycemia as per sliding scale that follows:-If blood sugar level measured 124 mg/dL to 150 mg/dL, administer two units of insulin;-If blood sugar level measured 151 mg/dL to 200 mg/dL, administer four units of insulin;-If blood sugar level measured 210 mg/dL to 250 mg/dL, administer six units of insulin;-If blood sugar level measured 251 mg/dL to 300 mg/dL, administer eight units of insulin;-If blood sugar level measured 301 mg/dL to 350 mg/dL, administer 10 units of insulin;-If blood sugar level measured 351 mg/dL to 400 mg/dL, administer 12 units of insulin;-An order, dated 06/13/25, to monitor resident’s blood sugar.<br><br>(continued on next page) |

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|---|---|---|---|
| | 265188 | A. Building<br>B. Wing | 08/25/2025 |

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|---|---|
| F 0760<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Review of the resident August 2025 MAR showed the following:-On 08/01/25, at 7:00 A.M., the blood sugar was not checked, and no insulin administered;-On 08/01/25, at 11:30 A.M., the blood sugar was not checked, and no insulin administered;-On 08/01/25, at 4:30 P.M., the blood sugar was not checked, and no insulin administered;-On 08/02/25, at 7:00 A.M., the blood sugar was not checked, and no insulin administered;-On 08/02/25, at 11:30 A.M., the blood sugar was not checked, and no insulin administered;-On 08/02/25, at 4:30 P.M., the blood sugar was not checked, and no insulin administered;-On 08/03/25, at 7:00 A.M., the blood sugar was not checked, and no insulin administered;-On 08/03/25, at 11:30 A.M., the blood sugar was not checked, and no insulin administered;-On 08/03/25, at 4:30 P.M., the blood sugar was not checked, and no insulin administered.<br><br>2.Review of Resident #65's face sheet showed the following:-admission date of 10/10/23;-Diagnosis included Type 2 diabetes (body can’t use insulin properly resulting in high blood sugar levels.<br><br>Review of the resident's care plan, last updated 05/13/25, showed resident had diabetes mellitus. Staff to administer diabetes medication as ordered by the doctor. Review of the resident's quarterly MDS, dated [DATE], showed the following:-Severally cognitively impaired;-Diagnosis of diabetes. Review of resident's July 2025 POS showed an order, dated 10/31/25, for insulin glargine (long-acting insulin) subcutaneous solution 100 unit/ml, inject 25 units subcutaneously two times a day for diabetes. Review of the resident July 2025 MAR showed the following:-On 07/09/25, at 7:00 A.M., the blood sugar was not checked, and no insulin administered;-On 07/10/25, at 7:00 A.M., the blood sugar was not checked, and no insulin administered;-On 07/11/25, at 7:00 A.M., the blood sugar was not checked, and no insulin administered;-On 07/16/25 at 7:00 P.M., the blood sugar was not checked, and no insulin administered;-On 07/24/25 at 7:00 A.M., the blood sugar was not checked, and no insulin administered;-On 07/24/25 at 7:00 P.M., the blood sugar was not checked, and no insulin administered;-On 07/25/25 at 7:00 A.M., the blood sugar was not checked, and no insulin administered;-On 07/26/25 at 7:00 A.M., the blood sugar was not checked, and no insulin administered. 3. During an interview on 08/22/25, at 11:35 A.M., Certified Medication Technician (CMT) A said the following;-He/she knew which medications to administer by looking at the MAR;-The MAR tells staff when to administer or check the blood sugar of a resident;-He/she didn’t do the blood sugar checks or administer insulin, the nurse did it;-If a medication is not administered, it would be a medication error. During an interview on 08/22/25, at 12:22 P.M., Licensed Practical Nurse (LPN B) said the following:-Staff know which medications to administer by looking at the MAR, which is driven by the physicians’ orders;-When the medication is due, or the blood sugar check, it pops up on the MAR and the staff know to complete that medication or check;-He/she didn’t believe it was an administration issue if the MAR was blank because he/she believed all the blood sugar checks were being completed and the insulin was being administered.<br><br>During an interview on 08/22/25, at 2:02 P.M., LPN A/Unit Manager said the following:-The MARs have the orders for each resident;-He/she would expect staff to administer the medication as ordered;-If the MAR is blank, he/she would have to assume the medication and task was not completed and it would be a medication error;-He/she expected staff to follow the five medication rights.<br><br>During an interview on 08/25/25. at 9:25 A.M., the Medical Director said the following: -Staff should document a resident's blood sugar and administration of insulin;-He was very particular on insulin orders;-Staff should check blood sugars three to four times a day;-If it is not documented, it was not done;-He considers insulin not administered as a significant medication error.<br><br>(continued on next page) |

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| | 265188 | A. Building<br>B. Wing | 08/25/2025 |

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|---|---|
| F 0760<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During an interview on 08/22/25, at 2:22 P.M., the Director of Nursing (DON) said the following:-The staff know who is responsible for which medication as they each have a MAR;-The MAR tells staff what medications or task need to be completed at what time;-The electronic medication record (EMR) pops up the task or medication at that time and the staff should mark off if it’s being administered or why if it’s not;-Some staff go through and check blood sugars, writing them down and come back and put them into the computer and administer insulin as needed when they get to the resident;-If the MAR is blank, it could mean the medication or blood sugar check was missed and that would be a medication error.<br><br>During an interview on 08/25/25, at 12:30 P.M., the Administrator said when residents have an order for insulin, he/she would expect staff to administer the medication as ordered. If checking the blood sugar is required before, they should be checking the blood sugar. Staff should be double checking the MAR to ensure all tasks and medications have been administered.<br><br>4. Review of Lilly manufacturer instructions titled “Humalog (insulin lispro – rapid actin insulin) KwikPen – Instructions for Use,” dated March 2020, showed the following:- KwikPen™ is a disposable prefilled pen containing 300 units of insulin;-Multiple doses are in one pen;-Prime the pen before each injection;-Priming the pen means removing the air from the needle and cartridge that may collect during normal use and ensures that the pen is working correctly;-If you do not prime before each injection, you may get too much or too little insulin.<br><br>5. Review of Resident #23’s face sheet showed the following:-admission date of 08/09/24;-Diagnoses included Type 2 diabetes mellitus (chronic condition that affects the way the body processes blood sugar (glucose)) with diabetic polyneuropathy (complication of diabetes that damages the nerves, causing various symptoms and health problems) and hyperglycemia (high blood sugar levels).<br><br>Review of the resident’s quarterly MDS, dated [DATE], showed the following:-Cognitively intact;-Used of insulin seven days of the prior seven days.<br><br>Review of the resident’s care plan, updated 07/21/25, showed the following:-Resident had diabetes mellitus;-He/she was prescribed hyperglycemic medication;-Staff administer diabetes medication as ordered by doctor;-Staff should monitor/document for side effects and effectiveness.<br><br>Review of the resident’s POS, current as of 08/25/25, showed the following:--An order, dated 01/25/25, for Humalog injection solution 100 unit/milliliter (ml), inject 12 unit subcutaneously (applied under the skin) with meals for diabetes mellitus in addition to sliding scale;-An order, dated 01/28/25, for Humalog injection solution 100 unit/ml, inject as per sliding scale (diabetes management method that involves administering a dose of fast-acting insulin based on a person's current blood glucose reading) as follows:-If blood sugar measures 0 to 119 mg/deciliter (dL), then administer no inulin;-If blood sugar measures 120 mg/dL to 160 mg/dL, then administer 3 units of insulin;-If blood sugar measures 161 mg/dL to 200 mg/dL, then administer 5 units of insulin;-If blood sugar measures 201 mg/dL to 240 mg/dL, then administer 8 units of insulin;-If blood sugar measures 241 mg/dL to 280 mg/dL, then administer 12 units of insulin;-If blood sugar measures 281 mg/dL to 320 mg/dL, then administer 16 units of insulin;-If blood sugar measures 321 mg/dL or more, then administer 20 units of insulin and notify physician if blood sugar is 400 mg/dL or greater.<br><br>(continued on next page) |

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| F 0760<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Observation and interview on 08/21/25, at 9:30 A.M., showed the following:-RN C prepared medications for the resident at the nurse’s cart near the resident room;-The resident’s blood glucose reading was 225 mg/dL;-He/she prepared the Humalog KwikPen by removing the top cap, wiped with the rubber stopper with an alcohol wipe, applied the needle, turned the dial to 21 and the returned to 20 units. The nurse did not prime the pen;-The nurse said that he/she did not prime the Humalog pen due to it not being a new pen and the medication would already be at the top of the syringe. He/she said only brand-new pens were primed and if they were not primed the resident may not receive the correct dose;-The nurse entered the resident’s room and wiped the resident’s abdomen with an alcohol wipe and administered Humalog.<br><br>6. Review of Resident #132’s face sheet showed the following information:-admission date of 08/30/24;-Diagnoses include diabetes.<br><br>Review of the resident’s quarterly MDS, dated [DATE], showed the resident was cognitively intact.<br><br>Review of the resident’s care plan, dated 09/17/24, showed staff to administer medications as order and monitor for side effects and effectiveness.<br><br>Review of the resident’s August 2025 POS showed the following orders:-An order, dated 08/29/25, for insulin lispro 100 u/ml, inject 7 units subcutaneously with meals, in addition to the sliding scale;-An order, dated 08/29/25, for insulin lispro 100 u/ml, inject as per sliding scale that follows:-If blood sugar is 0 mg/dL to 119 mg/dL, then do not administer insulin;-If blood sugar is 120 mg/dL to 160 mg/dL, then administer two units of insulin;-If blood sugar is 161 mg/dL to 200 mg/dL, then administer four units of insulin;-If blood sugar is 201 mg/dL to 240 mg/dL, then administer six units of insulin;-If blood sugar is 241 mg/dL to 280 mg/dL, then administer eight units of insulin;-If blood sugar is 281 mg/dL to 320 mg/dL, then administer 11 units of insulin;-If blood sugar is 321 mg/dL or greater, then administer 15 units of insulin and notify the physician if blood sugar is over 400 mg/dL.<br><br>Observation on 08/20/25, at 12:24 P.M., showed RN O obtain the resident’s blood sugar at 148 mg/dL. RN O performed hand hygiene, donned gloves, obtained Humalog and drew up nine units of insulin and administered the insulin to the resident. RN O did not prime the needle prior to administering the insulin.<br><br>. During an interview on 08/20/25, at 12:50 P.M., RN O said the following:-Staff do not prime insulin pens;-The insulin pens have plungers in them, so there is no need to prime the pen;-If there are bubbles seen in the pen, staff should just watch how they position the pen while administering the insulin;-Even if the resident does get a little bit of air injected, it won't hurt them.<br><br>During an interview on 08/22/25, at 10:30 P.M., RN C said he/she was not aware that insulin pens required primed with each use. He/she thought it was just with new pens.<br><br>During an interview on 08/22/25, at 10:50 A.M., the DON said all insulin pens are required to be primed each time before insulin is administered. Insulin pens should be primed before each use, every pen, every time. This is manufacturer guidelines. The dose would not be correctly administered if not primed.<br><br>(continued on next page) |

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| | 265188 | A. Building<br>B. Wing | 08/25/2025 |

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| F 0760<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During an interview on 08/22/25, at 11:10 A.M., the Administrator said all insulin pens require priming each time.<br><br>During an interview on 08/22/25, at 11:20 A.M., Corporate Nurse Consultant said that staff should always prime insulin pens with each use.<br><br>Complaint #1534275, #2585250 |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.<br><br>(continued on next page) |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Based on observation, interview, and record review, the facility failed to ensure all food was protected from possible contamination during storage and preparation when staff failed to ensure the air gap for the ice machine had the required two-inch gap between the drain and the floor, when staff failed to wear a hairnet covering all exposed hair, when staff failed to clean the outside of the appliances, when staff failed to date and label opened food, and when staff failed to keep fans and vents above food items clean. The facility census was 149. Review of the facility's policy titled Nutritional Services Sanitation, dated 03/31/21, showed nutritional services shall ensure a clean and sanitary work environment to promote and protect food safety and to maintain compliance with federal, state and local governing food sanitation and safety.1. Review of the 2013 Missouri Food Code showed an air gap between the water supply inlet and the flood level rim of the plumbing fixture equipment, or nonfood equipment shall be at least twice the diameter of the water supply inlet and may not be less than one inch.Review showed the facility did not provide a policy related to the air gap.During an observation on 08/17/25, at 3:46 P.M., and on 08/19/25, at 11:29 A.M., showed an ice machine located in the kitchen. The plastic drainpipe tubing from the ice machine rested directly on the floor next to the drain area and did not have the required two inch gap. During an interview on 08/22/25, at 8:50 A.M., Dietary Aide (DA) L said he/she doesn't know anything about the drain on ice machine, and whether it should have a gap.During an interview on 08/22/25, at 9:25 A.M., the Dietary Manager (DM) said he/she didn't know anything about the gap on the ice machine drain. He/she didn't know if it was supposed to have a one-inch gap from the drain. During an interview on 08/22/25, at 9:57 A.M., the Administrator said he/she wasn't aware of an issue with the drain outside of the ice machine and that it needed an one inch air gap.2. Review of the facility's policy titled, Nutritional Services Personal Hygiene and Appearance, dated 03/31/21, said hair nets or hair coverings shall be worn while in the kitchen or storage areas. Facial hair, except the eyebrows, shall be covered with a hairnet or beard cover.Review of the 2013 Food Code, issued by the Food and Drug Administration, showed food employees shall wear hair restraints such as hats, hair coverings or nets, beard restraints, and clothing that covers body hair, that are designed and worn to effectively keep their hair from contacting exposed food, clean equipment, utensils, and linens, and unwrapped single-service and single-use articles.Observation on 08/17/25, at 3:46 P.M., showed DA Y in the kitchen folding silverware. DA Y had a mustache, and he/she was not wearing a net to cover. He/she also wore a ball cap, with two to three inches of hair that hung outside of the ball cap with no hair net. During an interview on 08/22/25, at 8:50 A.M., DA L said hair nets should cover all of staff's hair, including facial hair. They should be worn when staff are in the kitchen. If staff are wearing a hat, and hair is hanging out, that should be covered with a hair net. During an interview on 08/22/25, at 9:05 AM., DA M said hair nets should be worn at all times when in the kitchen. It should cover all the hair, facial or if there's hair sticking out of a cap.During an interview on 08/22/25, at 9:16 A.M., DA N said hair nets should be on as soon as staff come through door. The hair nets should cover all hair, including beards, mustache, and any hair hanging out of a ball cap.During an interview on 08/22/25, at 9:25 A.M., the DM said he/she expected staff to wear a hairnet as soon as they pass the line that's set up in the kitchen. The hair net should cover all hair, facial hair if it's over a 1/4 inch. If they have hair coming under a cap, it should be covered as well.During an interview on 08/22/25, at 9:57 A.M., the Administrator said staff should be wearing hair nets in the kitchen and they should cover all hair, including facial hair and any hair outside of the cap.3. Review of the 2013 Missouri Food Codes showed the following information:-Equipment food-contact surfaces and utensils shall be clean to sight and touch;-The food-contact surfaces of cooking equipment and pans shall be kept free of encrusted grease deposits and other soil accumulations;-The physical facilities shall be cleaned as often as necessary to keep them clean. Observations on 08/17/25, at 3:46 P.M., and on 08/19/25, at 11:29 A.M., showed the following:-The front of the stove had multiple pieces of food on the front;-Multiple streaks of white substance were on the front and sides of the stove;-The dehydrator had multiple white streaks down the sides and front. During an interview on 08/22/25, at 8:50 A.M., DA L said appliances are cleaned by the cooks and prep cooks. There should not be grease on or around the appliances. These should be wiped down morning and evening.During an interview on 08/22/25, at 9:05 AM., DA M said the appliances should be cleaned daily.During an interview on 08/22/25, at 9:25 A.M., the DM said appliances should be cleaned daily, wiped down, and there should not be streaks of stuff on them.During an interview on 08/22/25, at 9:57 A.M., the Administrator said the appliances should be wiped down daily. 4. Review of the Missouri Food Code, published 2013, regarding |

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| F 0908<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Keep all essential equipment working safely.<br><br>Based on observation, interview, and record review, the facility failed to maintain equipment in the kitchen in a safe operating condition when three stove knobs were missing. The facility census was 149.Review showed the facility did not provide a policy regarding upkeep of kitchen appliances.1. Observations on 08/17/25, beginning at 3:46 P.M., and on 08/19/25, at 12:36 P.M., showed the cook stove located in the kitchen had three of the seven burner control knobs missing. During an interview on 08/22/25, at 8:50 A.M., Dietary Aide (DA) L said there are knobs missing. He/she didn't know how long they had been missing. He/she was still able to turn the stove burners on and off. The Dietary Manager was aware of the knobs missing.During an interview on 08/22/25, at 9:05 AM., DA M said stove knobs were missing, but they were still able to use them as far as he/she knew. If they have kitchen issues, they let the DM know and she tells maintenance. During an interview on 08/22/25, at 9:25 A.M., the DM said he/she was aware there were stove knobs missing. The staff were still able to turn the stove on. He/she needed to order new ones. During an interview on 08/22/25, at 9:57 A.M., the Administrator said the stove should have all knobs present. |

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| F 0921<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public.<br><br>Based on observation, record review, and interview, the facility failed to provide a sanitary environment for all residents and staff when the floors and walls in the kitchen were not kept clean and free of debris. The facility census was 149.Review of the facility's policy titled Nutritional Services Sanitation, dated 03/31/21, showed nutritional services shall ensure a clean and sanitary work environment to promote and protect food safety and to maintain compliance with federal, state and local governing food sanitation and safety.1. Observations beginning on 08/17/25, at 3:46 P.M., showed the following:-The floors throughout the kitchen had black and white substances in several areas, especially under the sink areas and dishwasher;-There were pieces of food in and around the sink and dishwasher area;-The baseboards in most areas were black with dirt. Observation on 08/17/25, at 3:46 P.M., and on 08/19/25, at 11:29 A.M., showed the following:-The backsplash above the sink to the left when entering the kitchen had a mold looking substance along the section that met the sink, approximately 12 ft. The backsplash had a brown substance on it;-The wall underneath of the sink has large brown splatters in different sections;-The wall under the dishwasher had a black substance present;-The wall behind the stove had grease drops present.During an interview on 08/22/25, at 8:50 A.M., Dietary Aide (DA) L said the floor was swept and mopped each shift, day and evening. The evening cook was supposed to sweep and mop everywhere. The floors should be clean. The walls are cleaned sometimes. Staff have a deep cleaning day two to three times weekly and that is when the walls are done. During an interview on 08/22/25, at 9:05 AM., DA M said the floors are swept and mopped by whichever staff is working. The walls are more of a deep clean job, and those are done on occasion, he/she doesn't know how often. During an interview on 08/22/25, at 9:16 A.M., DA N said the floors were done by housekeeping. He/she was not sure how often. They should be clean. The walls are done weekly by someone. He/she was not aware of dirty walls or mold.During an interview on 08/22/25, at 9:25 A.M., the Dietary Manager (DM) M said the following:-Floors should be swept and mopped during the day and at night. They also have a deep cleaning where maintenance does a power wash. Housekeeping also buffers the floors three times per week;-He/she wouldn't expect there to not be black stuff and food on the floors. They should be clean for the most part;-The walls are cleaned by maintenance. There shouldn't be dirt or mold on the walls.During an interview on 08/22/25, at 9:57 A.M., the Administrator said the floors should be clean. The DM is monitoring the cleaning of the kitchen. He/she wasn't aware of mold long the sink where the backsplash meets. |

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| F 0925<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Make sure there is a pest control program to prevent/deal with mice, insects, or other pests.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, the facility failed to implement and maintain an effective pest control system when multiple flies were located four resident rooms affected five residents (Resident #62, #123, #125, #141 and #147). The facility census was 149.Review showed the facility did not provide a Pest Control Policy.<br><br>1. Review of Resident #62's face sheet (admission data) showed an admission date of 02/28/25.<br><br>Review of the resident's significant change in status Minimum Data Set (MDS-a federally mandated assessment instrument completed by facility staff), dated 07/08/25, showed the resident's cognitive skills intact.<br><br>Observation and interviews on 08/17/25, at 5:35 P.M., showed the resident in bed. The resident's pillow had a black substance on it. A fly landed on the resident's pillow and the resident waved his/her hand at the fly. The resident said the fly was annoying.<br><br>Observation on 08/20/25, at 10:07 A.M., showed the resident in bed. A fly flew around the resident and landed on the resident's pillow.<br><br>Observation on 08/21/25, at 9:35 AM., showed the resident in bed. A fly flew around the resident's room.<br><br>2. Review of Resident #123's face sheet showed an admission date of 08/30/19.<br><br>Review of the resident's quarterly MDS, dated [DATE], showed the resident was cognitively intact.<br><br>Review of Resident #125’s face sheet showed an admission date of 04/07/21.<br><br>Review of the resident's quarterly MDS, dated [DATE], showed the resident was cognitively intact.<br><br>During an interview and observation on 08/18/25, at 1:00 P.M., of Resident #123 and #125’s room showed the following:-The room had an unpleasant odor, that could be smelled in the hall before opening the door;-There were about eight to ten live flies flying in the room;-Two or three gnats were seen flying in the room;-There was a beside commode with no lid with urine in the commode;-There was debris and crumbs on the floor;-A pest control light that was not plugged in to the outlet;-Resident #123 said it had not been plugged in for some time or working to his/her knowledge.<br><br>3. Review of Resident #141's face sheet showed an admission date of 04/26/24.<br><br>Review of the resident's quarterly MDS, dated [DATE], showed the resident was cognitively intact.<br><br>(continued on next page) |

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| F 0925<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Observation and interview on 08/17/25, at 5:01 P.M., showed the following:-The room has an unpleasant odor, that could be smelled in the hall;-An empty soda box under the resident’s bed, clothes on the floor, and the tables had various items on them, including empty bottles;-The floor appeared dirty with brown places and pieces of food on the floor;-The floor had clothes, stuffed animals, and soda present;-The trash can was mostly full;-The urinal was half full of urine;-There was a fly trap on the resident’s triangle bar, hanging above his/her bed. The sticky fly trap that hung down about 16 inches was completely full of flies;-About four or five live flies flying around the room and eight or nine dead flies laying in the window seal;-The resident said housekeeping cleaned his/her room every other day. He/she doesn’t like for housekeeping to move his/her belongings. Observation and interview on 08/21/25, at 11:00 A.M., showed the following:-The room has an unpleasant odor, that can could be smelled in the hall;-An empty soda box was under the resident’s bed, clothes were on the floor, and the tables had various items on them, including empty bottles;-The floor appeared dirty with brown places and pieces of food on the floor;-The urinal was fourth of the way full of urine;-The floor had clothes, stuffed animals and soda;-The resident’s dog food bowl had spilled and there was dogfood in the floor;-About four or five live flies flying around the room and eight or nine dead flies laying in the window seal. During an interview on 08/22/25, at 11:10 A.M., Certified Nurse’s Aide (CNA) I, he/she had noticed some flies in the resident’s room. During an interview on 08/22/25, at 12:22 P.M., Licensed Practical Nurse (LPN) B said he/she had seen flies in and around the resident’s room. He/she didn’t know how often they spray for flies.<br><br>4. Review of Resident #147’s face sheet showed an admission date of 08/07/24.<br><br>Review of the resident’s annual comprehensive MDS, dated [DATE], showed the resident had severely impaired cognition.<br><br>Observation on 08/22/2025, at 1:15 P.M., showed the resident eating lunch in bed. The plate contained cut-up pieces of chicken fried steak, mashed potatoes with gravy, and a sandwich. Beside the plate was an empty ice cream cup. A fly landed on the sandwich twice and continued to fly around the bed and lunch tray. The resident waved his/her hand around to shoo it away several times and said, That's just wrong; go away!<br><br>5. During an interview on 08/21/25, at 9:21 A.M., CNA I said he/she had seen flies on the 500 hall. Staff use fly swatters to kill the flies.<br><br>During an interview on 08/21/25, at 1:09 P.M., the Housekeeping Supervisor said housekeepers do their best to get rid of flies. Staff should have a fly swatter to kill the flies as needed.<br><br>During interviews on 08/22/25, at 12:50 P.M., and on 08/25/25, at 11:09 A.M., the Maintenance Director said he/she checked the logbooks at the nursing stations every day for staff requests. If only one fly was seen he/she would wait for the monthly pest control service. If more issues were identified he/she would quarantine the room if needed and would notify pest control to schedule services sooner. He/she has not received complaints about flies. He/she has a company that comes at least one time per month, or more often as needed.<br><br>(continued on next page) |

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| F 0925<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During an interview on 08/25/25, at 12:29 P.M., the Administrator said staff address flies with the use of fly baits in drains, contacting the pest control company, making sure the doors get shut faster, and making sure screens in resident rooms are intact. She was not aware of an issue with flies. There is an exterminator that comes in as needed to treat whatever is causing an issue.<br><br>Complaint #1534276, #2572207 |