STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265247	A. Building B. Wing	03/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Kirksville Manor Care Center	1705 East Laharpe Kirksville, MO 63501

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, the facility failed to store, prepare, and serve food in accordance with professional standards for food service safety. Staff failed to ensure food items were sealed, labeled, dated, and stored in sanitary conditions. Staff did not practice proper hand hygiene when handling residents' drinks. The ice machine did not contain an air gap at the drain or backflow prevention device to prevent potential backflow from the drain back into the ice machine. The facility census was 56.1. Review of the facility policy, Food Receiving and Storage, dated 2001, showed the following: -Non-refrigerated foods, disposable dishware and napkins are stored in a designated dry storage unit which is temperature and humidity control, free of insects rodents and kept clean; -Dry foods and goods are handled and stored in a manner that maintains the integrity of the packaging until they are ready to use; -All foods starting refrigerated or freezer are covered, labeled and dated (use by date). Review of the facility policy, Sanitization, dated 2001, showed the following: -The food service area is maintained in a clean and sanitary manner; -All kitchens, kitchen areas and dining areas are kept clean, free from garbage and debris, and protected from rodents and insects. Observation on 03/16/26 from 8:48 A.M. to 9:33 A.M., during the initial kitchen and dietary storage tour of the facility, showed the following:-Under the food preparation counter in the kitchen, the exterior surfaces of the bulk flour, sugar, and salt containers were splattered with food debris and sticky residue;-In the reach-in coolers in the kitchen, a clear container of a tomato-based liquid and a clear container of shredded meat were not labeled or dated. Several unlabeled, undated bowls of frosted cake were uncovered. A package of butter was not securely sealed. A box of sausage patties was unsealed;-In the dry storage room, a large bag of dry noodles sat on the shelf and was not sealed. A soiled apron sat on top of an open box that contained packets of gravy mix. Several stacks of uncovered coffee filters sat on a shelf next to an air conditioner that had a moderate accumulation of dust and debris across the surface of the unit. There was food debris, trash, and dirt on the floor, including under the food storage shelves. A large oil-saturated cardboard box that contained a jug of canola oil sat on the floor;-In the reach-in freezer in the service hall outside the kitchen, the inner bags in boxes of breaded [NAME], cookie dough, and broccoli were not sealed. Observation on 03/17/26 at 10:09 A.M., in the dietary storage room, located across the hall from the staff breakroom, showed the following:-A large bag of navy beans sat on the shelf and was not sealed;-A moderate accumulation of food debris and trash was scattered across the floor, including under the food storage shelves. Observation on 03/16/26 at 9:26 A.M. and on 03/17/26 at 10:36 A.M., of four upright freezers in the vacant dining room (across from room [ROOM NUMBER]), showed the following:-One unlabeled freezer, which contained loaves of bread and packages of frozen raw meat, was rusted across the exterior surface of the door and the inner metal shelves were rusted across 50% of the shelf surfaces;-A second freezer, labeled ?Proteins,' contained various boxes and bags of frozen meat. The bottom shelf was rust-colored and had multiple chipped and broken areas across the surface of the shelf;-A third freezer, labeled ?Vegetables,' contained an unsealed box of corn and other boxes and bags of vegetables. The bottom shelf had reddish-brown residue and bits of food (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	debris across the surface of the shelf;-A fourth freezer, labeled ?Starches,' contained boxes and bags of food items. The bottom shelf had scratches and areas of rust across the surface of the shelf. During an interview on 03/18/26 at 11:52 A.M., the Dietary Manager said he expected food to be stored under sanitary conditions, labeled, dated, and sealed. He had a deep clean schedule for the kitchen, but there had been a lot of new dietary staff and it was difficult to implement the schedule with the new staff. During an interview on 03/18/26 at 1:22 P.M., the Administrator said he expected staff to store, prepare, and serve food in a safe and sanitary manner. 2. Observation on 03/16/26, from 11:45 P.M. to 12:05 P.M., showed the following:-Certified Medication Technician O (CMT) served drinks to residents in the dining room;-He/She did not perform hand hygiene;-With bare hands, CMT O picked up two empty coffee cups, set them on the counter in front of the coffee pot and placed her bare hand on top of the drinking surfaces;-He/She filled the cups with coffee and carried the cups across the dining room by the drinking surface (rim) of the cup instead of by the cup handle and served the beverages to Resident #37 and Resident #60;-He/She did not perform hand hygiene;-With his/her bare hands, he/she picked up two stacked, empty Styrofoam cups, separated them, touched the drinking surface, set them on the counter in front of the tea pitcher, and again, touched the drinking surface with his/her bare hand; -He/She filled the cups with tea and carried the cups across the dining room and served the beverages to Resident #2 and Resident #23. During an interview on 03/17/26 at 9:59 A.M., CMT O said the following:-He/She served several resident's drinks during lunch;-He/She touched the drinking surface with his/her bare hands;-He/She did not wash his/her hands with soap and water or use hand sanitizer when serving drinks to the residents;-He/She should not touch the drinking surface with his/her bare hands. During an interview on 03/17/26 at 8:00 A.M., the Dietary Manager said the following:-Staff should not touch drinking surfaces with their bare hands when serving drinks;-Staff should wash their hands with soap and water or use hand sanitizer before serving a drink to a resident. During an interview on 03/17/26 at 10:21 A.M., the Director of Nursing (DON) said when serving drinks to residents staff should not touch the drinking surface with their hands. Staff should wash their hands with soap and water or use hand sanitizer between every four drinks served. Staff should hold a cup from the bottom to ensure their fingers do not touch the drinking surface. 3. Observation on 03/16/26 at 9:20 A.M., of the facility's ice machine, showed the following:-At the back of the machine, an approximately 3-foot vertical pipe attached to an approximately 1-foot long horizontal pipe connected the ice machine drain directly to the floor drain with no air gap present between the pipe and the floor drain;-At the bottom of the machine, an approximately 2-foot horizontal pipe connected the ice machine drain directly to the floor drain with no air gap present between the pipe and the floor drain. During an interview on 03/16/26 at 4:16 P.M., the Maintenance Supervisor said he expected the ice machine to have an air gap at the drain to prevent potential backflow into the unit. The machine was leased and the company that owned it was responsible for management of the machine, including the connection to the drain. During an interview on 03/18/26 at 11:52 A.M., the Dietary Manager said the facility leased the ice machine, and he was unaware there was no air gap at the drain to prevent backflow of liquid back into the machine.

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F 0567 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to manage his or her financial affairs. Based on observation, interview, and record review, the facility failed to implement policies and procedures to ensure resident trust accounts were not allowed to go into a negative balance for one resident (Resident #53) and failed to deposit residents' personal funds in excess of $50.00 into an interest-bearing account for two residents (Residents #15 and #2). The facility reported holding funds for nine residents. The facility census was 56. Review of the facility's undated policy, Accounting and Records of Resident Funds, showed the following:-The business office maintains a record of all financial transactions involving the resident's personal funds on deposit with the facility;-Individual accounting ledgers are maintained in accordance with generally accepted accounting principles; -The policy did not address negative balance in the resident trust fund account. Review of the facility's undated Resident Trust Account for Personal Funds Agreement showed the following:-Resident may keep up to $50.00 in a petty cash fund at the facility in the Social Services Department;-Resident personal funds over $50.00 will be placed in an interest-bearing bank account. 1. Review of the facility provided ledgers of residents who held money in the resident trust showed the following:-Nine residents held money in the resident trust fund account;-The list did not include Resident #15 and #2. 2. Review of Resident #53's resident fund ledger, dated 12/28/25 through 03/02/26, showed the following:-On 01/06/26, the resident's account balance was $10.11;-On 01/16/26, the resident signed a store receipt in the amount of $43.36;-On 01/16/26, $43.96 was withdrawn from the resident's account. The resident's account balance was -$33.85;-On 01/20/26, $40.00 was deposited into the resident's account;-On 2/16/26, the resident's account balance was $2.82;-On 2/17/26, the resident signed a store receipt in the amount of $13.64;-On 2/17/26, $13.64 was withdrawn from the resident's account. The resident's account balance was -$10.82;-On 03/02/26, $30.00 was deposited into the resident's account. During an interview on 03/17/26 at 12:27 P.M., the resident's guardian said the following:-He/She sent the resident $30.00 per month for his/her spending;-Resident #53 was having a hard time managing his/her money;-He/She had to send extra money after one of the resident's purchases. 3. Observation on 03/18/26 at 12:30 P.M. showed an envelope, labeled with Resident #15's name, was held in a safe in the Social Services Director's office. The envelope contained $66.00 in cash. 4. Observation on 03/18/26 at 12:30 P.M. showed an envelope, labeled with Resident #2's name, was held in a safe in the Social Services Director's office. The envelope contained $72.68 in cash. 5. During an interview on 03/18/26 at 12:30 P.M., the Social Services Director said the following:-She was responsible for the safe keeping and maintenance of the residents' money in the envelopes;-She was unaware there was a $50.00 limit (in the petty cash). During interviews on 03/18/26 at 10:47 A.M. and 5:15 P.M., the Administrator said the following:-He took over maintenance of the resident trust fund account in July 2025;-He authorized Resident #53's purchase in January. He was out of the building a lot and did not know if he knew the resident's balance;-He was the only one with access to the resident trust fund balances;-There should be no negative balances in the resident trust fund;-Staff kept residents' money in envelopes in a safe at the facility for residents who asked the facility to put their money away for safe keeping;-The money in the envelopes was accounted for on the front of the envelopes with entries showing the disbursement and the SSD's signature;-The SSD was responsible for maintaining the money in the envelopes in the safe in her office; -Not all the residents who asked him to safeguard their money was in the resident trust fund account;-He was unsure if the residents could have more than $50.00 in the envelope.

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F 0568 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Properly hold, secure, and manage each resident's personal money which is deposited with the nursing home. Based on observation, interview, and record review, the facility failed to maintain a system to ensure residents' money was managed in accordance with proper accounting principles when the facility did not reconcile the residents' petty cash each month. The facility also failed to reconcile the resident trust fund bank account monthly to ensure accurate accounting of funds. The facility census was 59. Review of the undated facility policy, Accounting and Records of Resident Funds, showed the following:-The business office maintains a record of all financial transactions involving the residents' personal funds on deposit with the facility;-Individual accounting ledgers are maintained in accordance with generally accepted accounting principles. 1. Review of the facility provided ledgers of residents who held money in the resident trust showed the following:-Nine residents held money in the resident trust fund account;-The list did not include Resident #15;-The list did not include Resident #2;-The list did not include Resident #3;-The list did not include Resident #12;-The list did not include Resident #31;-The list did not include Resident #38. 2. Observation on 03/18/26 at 12:30 P.M. of an envelope, labeled with Resident #15's name, held in the Social Services Department office, showed the following:-The envelope contained $66.00 in cash;-On 10/08/25, the contents of the envelope were verified with staff initials;-There was no monthly reconciliation of the petty cash held in the envelope or documentation of a monthly verification of contents after 10/08/25. 3. Observation on 03/18/26 at 12:30 P.M. of an envelope, labeled with Resident #2's name, held in the Social Services Department office, showed the following:-The envelope contained $72.68 in cash;-On 10/08/25, the contents were verified with staff initials;-There was no monthly reconciliation of the petty cash held in the envelope or documentation of a monthly verification of contents after 10/08/25. 4. Observation on 03/18/26 at 12:30 P.M. of an envelope, labeled with Resident #3's name, held in the Social Services Department office, showed the following:-The envelope contained $16.00 in cash;-On 10/07/25, the contents were verified with staff initials;-There was no monthly reconciliation of the petty cash held in the envelope or documentation of a monthly verification of contents after 10/07/25. 5. Observation on 03/18/26 at 12:30 P.M. of an envelope, labeled with Resident #12's name, held in the Social Services Department office, showed the following:-The envelope contained $50.00 in cash;-On 10/17/25, the contents were verified with staff initials;-There was no monthly reconciliation of the petty cash held in the envelope or documentation of a monthly verification of contents after 10/17/25. 6. Observation on 03/18/26 at 12:30 P.M. of an envelope, labeled with Resident #31's name, held in the Social Services Department office, showed the following:-The envelope contained $30.00 in cash;-On 10/09/25, contents were verified with staff initials;-There was no monthly reconciliation of the petty cash held in the envelope or documentation of a monthly verification of contents after 10/09/25. 7. Observation on 03/18/26 at 12:30 P.M. of an envelope, labeled with Resident #38's name, held in the Social Services Department office, showed the following:-The envelope contained $50.00 in cash;-On 01/19/26, the contents were verified with staff initials;-There was no monthly reconciliation of the petty cash held in the envelope or documentation of a monthly verification of contents after 01/19/26. 8. Observation on 03/18/26 at 12:30 P.M. of an envelope, labeled with Resident #13's name, held in the Social Services Department office, showed the following:-The envelope contained $50.00 in cash;-On 05/05/25, the contents were verified with staff initials;-There was no monthly reconciliation of the petty cash held in the envelope or documentation of a monthly verification of contents after 05/05/25. 9. Observation on 03/18/26 at 12:30 P.M. of an envelope, labeled with Resident #44's name, held in the Social Services Department office, showed the following:-The envelope contained $15.00 in cash;-On 10/08/25, the contents were verified with staff initials;-There was no monthly reconciliation of the petty cash held in the envelope or documentation of a monthly verification of contents after 10/08/25. 10. Observation on 03/18/26 at 12:30 P.M. of an envelope, labeled with Resident #48's name, held in the Social Services Department (continued on next page)

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F 0568 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	office, showed the following:-The envelope contained $0.67 in change;-On 10/08/25, the contents were verified with staff initials;-There was no monthly reconciliation of the petty cash held in the envelope or documentation of a monthly verification of contents after 10/08/25. 11. During an interview on 03/18/26 at 12:30 P.M., the Social Services Director (SSD) said the following:-She was responsible for the safe keeping and maintenance of the resident's money in the envelopes;-She was unaware the money in the envelopes was considered petty cash and needed to be reconciled each month. 12.Review of the Resident Trust Fund ledgers, Resident Trust Fund bank statements and reconciliation form, dated 12/31/25 through 02/28/26, showed the following:-The total amount of the Resident Trust Fund ledgers on 12/31/25 was $7,004.24. The total amount in the Resident Trust Fund bank account was $12,662.58. The facility's reconciliation for the bank account showed the reconciled balance was $12,662.58. The difference between the Resident Trust ledgers and the Resident Trust Fund bank account was $7,004.24-The total amount of the Resident Trust Fund ledgers on 01/31/26 was $4,270.64. The total amount in the Resident Trust Fund bank account was $9,694.12. The facility's reconciliation for the bank account showed the reconciled balance was $9,694.12. The difference between the Resident Trust ledgers and the Resident Trust Fund bank account was $5,423.48;-The total amount of the Resident Trust Fund ledgers on 02/28/26 was $5,129.14. The total amount in the Resident Trust Fund bank account was $10,478.95. The facility's reconciliation for the bank account showed the reconciled balance was $10,478.95. The difference between the Resident Trust ledgers and the Resident Trust Fund bank account was $5,349.81.(The facility did not properly reconcile the resident trust fund bank account monthly to ensure accurate accounting of funds.) 13.During an interview on 03/18/26 at 10:47 A.M. and 5:15 P.M., the Administrator said the following:-He took over maintenance of the resident trust fund account in July 2025;-He was responsible for reconciling the resident trust fund account each month; -There was an approximately $2,000.00 extra in the Resident Trust Fund account. The $2,000.00 had been in the account since before 2022. He tried to find out where the money came from, but he was unable to make that determination; -If the account would have been reconciled properly, he/she would have been able to identify who the $2000.00 belonged to; -He did not have any resident trust fund petty cash in the building;-There was money in envelopes in a safe at the facility was for residents who asked the facility to put their money away for safe keeping;-He did not consider the money in the envelopes to be petty cash;-The money in the envelopes was accounted for on the front of the envelopes with entries showing the disbursement and the SSD's signature;-The SSD was responsible for maintaining the money in the envelopes in the safe in her office;-The resident cash was not reconciled monthly, just when a resident withdrew or deposited money from the envelope.

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F 0584 Level of Harm - Minimal harm or potential for actual harm 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, the facility failed to maintain walls, flooring, resident sleeping rooms, resident restrooms, and shower and toilet rooms to be clean and good repair. The facility census was 56.Observations on 03/16/26 from 10:18 A.M. to 4:23 P.M. and on 03/17/26 from 10:13 A.M. to 3:24 P.M., during the Life Safety Code tour of the facility, showed the following: -In occupied resident room [ROOM NUMBER], ten wooden slats were missing from the closet door; -In occupied resident room [ROOM NUMBER], eight wooden slats were missing from the closet door. The edge of the room door was chipped and a 2-inch piece of plastic was missing from the door covering; -In the bathroom to occupied resident room [ROOM NUMBER], the floor was discolored yellow, and there was brown and black residue around the toilet which had areas of missing caulk; -In occupied resident room [ROOM NUMBER], there were two unfilled holes in the wall above the towel rack by the sink; -In unoccupied resident room [ROOM NUMBER], the sink pulled away from the wall and the cove base along the wall under the sink was off the wall. There was a 2-inch by 4-inch circular area of textured paint that was missing from the ceiling. There were two 1-inch by 2-inch pieces of tile missing from the floor; -In occupied resident room [ROOM NUMBER], one wooden slat was missing from the closet door; -In occupied resident room [ROOM NUMBER], five wooden slats were missing from the closet door; -In the bathroom to occupied resident room [ROOM NUMBER], the floor was discolored yellow and gray in several areas; -In occupied resident room [ROOM NUMBER], a 2-inch by 2-inch section of floor tile was missing; -In the bathroom to occupied resident rooms [ROOM NUMBERS], the floor was discolored brown around the base of the toilet; -In the bathroom to unoccupied resident room [ROOM NUMBER], the floor was discolored gray in several areas. Around the base of the toilet, the caulking was missing and there was a brown residue. A 3-inch section of flooring was missing; -In occupied resident room [ROOM NUMBER], a 2-inch section of cove base was coming loose from the wall; -In the bathroom to occupied resident room [ROOM NUMBER], the floor was discolored with a yellow residue; -In occupied resident room [ROOM NUMBER], there were four 1-inch sections of tile and a 2-inch by 2-inch section of tile missing from the floor. Above the sink, the wall was bulging outward and there was a 6-inch crack in the wall paint; -In the bathroom to occupied resident room [ROOM NUMBER], there was brown residue on the floor and the caulk was missing around the base of the toilet; -In occupied resident room [ROOM NUMBER], the edge of the room door was chipped and there were 2-inch pieces missing from the plastic door covering; -In the bathroom for occupied resident rooms [ROOM NUMBERS], the floor was discolored with a dark brown residue around the base of the toilet which had areas of missing caulk; -In occupied resident room [ROOM NUMBER], a 2-inch by 6-inch section of the protective plastic cover on the room door was missing; -In occupied resident room [ROOM NUMBER], a 4-inch by 12-inch section of floor tile was missing and a 3-inch by 6-inch piece of cove base trim by the closet door was missing; -In the main entryway, the baseboard heater had spots areas of rust; -In the main dining room, a 6-inch by 4-inch area of the ceiling had loose flaking paint. Two areas of the ceiling, measuring 2-foot by 12-foot and 2-foot by 3-foot, were discolored brown. A 2-foot by 2-foot ceiling vent had a moderate accumulation of dust; -In the staff restroom by the Victorian [NAME] nurses' station, there was a heavy accumulation of dust on the 8-inch by 8-inch ceiling vent; -In the women's restroom by the kitchen, there was no tile on the floor which was discolored gray around the edges of the room. There was a dark brown discoloration by the base of the toilet; -In the janitor closet, a heavy accumulation of dust was visible on a 6-inch by 6-inch ceiling vent; -In the beauty shop, a 2-inch by 6-inch section of floor tile was missing; -In the Victorian [NAME] dining room, a 4-foot by 5-foot section of ceiling was not flush with the rest of the ceiling and drooped down. Two 2-foot circular areas of the ceiling were discolored brown and had cracked and flaking areas of paint; -In the north shower room (Victorian Rose), the floor was (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	discolored with a gray residue and there were yellow dried drips on the floor under the sink. The wall by the sink had various scuffs and marks on the painted surface. Around the toilet, the floor was discolored brown, there was missing caulk around the base of the toilet, and there were gray streaks across the front surface of the toilet. An 8-inch by 8-inch ceiling vent had rusted areas across its surface. The ceiling had an approximately 8-foot long cracked area where the textured ceiling paint was coming loose; -In the south shower room (Victorian Rose), there was a very heavy accumulation of cobwebs and dust on the 6-inch by 6-inch ceiling vent. Observation in the bathroom for occupied resident room [ROOM NUMBER]'s on 03/15/26 at 9:30 A.M. showed the following:-The caulking around the bathroom toilet was missing and/or cracked in areas; -The bathroom floor appeared dirty with a brown and grayish discoloration. Observation in occupied resident room [ROOM NUMBER] on 03/15/26 at 9:45 A.M. showed a large hole in the wall behind the head of the bed. Observation in occupied resident room [ROOM NUMBER] on 03/15/26 at 9:45 A.M. showed the following:-The wall behind the bed was marred;-The bathroom floor had black discoloration behind the toilet;-The floor at the entrance to the room had a brown discoloration. Observation in occupied resident room [ROOM NUMBER] on 03/15/26 at 10:00 A.M. showed the following:-The floor appeared dirty with a brown/black discoloration;-The paint on the wall beside the air conditioning unit had peeled away from the wall; -There was no mattress on the bed next to the window;-The bathroom floor appeared dirty with brown/black discoloration. Observation in the bathroom for occupied resident room [ROOM NUMBER] on 03/15/26 at 10:15 A.M. showed the bathroom floor appeared dirty with black discoloration. Observation in the bathroom for occupied resident room [ROOM NUMBER] on 03/15/26 at 10:15 A.M. showed the floor appeared dirty and the bathroom door was marred. Observation of the bath/shower room on Hummingbird Lane on 03/15/26 at 11:56 A.M. showed the following:-The door was marred;-The door casing to the room was cracked and dirty;-The floor behind the toilet and under the sink appeared dirty with brown/grayish discoloration; -The caulking around the toilet and the wall beside the toilet was missing and/or cracked. Observation on 03/15/26 at 1:25 P.M. in occupied resident room [ROOM NUMBER] showed the following:-A large hole in the wall behind the bed;-The walls beside the bed were marred;-The flooring in the room had a black discoloration. During an interview on 03/18/26 at 10:15 A.M., Housekeeper P said the facility did not have someone who specifically cleaned floors. Housekeeping staff mopped the floors daily, but did not strip the floors. During interviews on 03/16/26 at 11:00 A.M., on 03/17/26 at 10:13 A.M., and on 03/18/26 at 1:22 P.M., the Maintenance Supervisor said the following: -He was the only maintenance staff for the building, and there was no housekeeping supervisor; -He cleaned the main dining room ceiling vent twice per year in the Spring and Fall; -The floors in the facility had not been stripped in about three years; -Staff told him verbally when repairs were needed. During an interview on 03/18/26 at 1:22 P.M., the Administrator said he expected the residents to have a safe and homelike environment. The facility had been without a housekeeping supervisor for approximately one and one-half to two years.

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	265247	A. Building B. Wing	03/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Kirksville Manor Care Center	1705 East Laharpe Kirksville, MO 63501

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to update care plans to reflect current care needs for six residents (Residents #1, #34, #22, #45, #6, and #42), in a review of 18 sampled residents. The facility census was 56. Review of the Resident Assessment Instrument (RAI) Manual, dated October 2025, showed the following:-The RAI and Care Planning as required at 42 CFR 483.21(b), the comprehensive care plan is an interdisciplinary communication tool;-It must include measurable objectives and time frames and must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being;-The care plan must be reviewed and revised periodically, and the services provided or arranged must be consistent with each resident's written plan of care. 1. Review of Resident #1's care plan, dated 11/12/25, showed the following:-The resident had hemodialysis (process for removal of waste and excess water from the blood due to kidney failure) related to acute kidney failure;-He/She had a fistula (connection between an artery and a vein, surgically created for dialysis treatments) located in his/her left arm;-Check and change dressing daily at left arm access site and document. Review of the resident's quarterly Minimum Data Set (MDS), a federally mandated assessment tool to be completed by the facility, dated 01/05/26 showed the following:-His/Her diagnosis included renal insufficiency (partial kidney function failure characterized by less than normal urine excretion);-Required dialysis (process for removal of waste and excess water from the blood due to kidney failure).Review of the resident's physician's orders, dated March 2026, showed the following:-No blood pressure, intravenous access (IV, technique for administering fluids, medications or nutrients directly into a vein) or labs in the right arm;-No lifting over 15 pounds or putting stress on the arm with the access. Observation on 03/16/26 at 1:10 P.M., showed the resident sat in his/her wheelchair. The resident had a Permacath (a flexible tube inserted into a vein) in his/her right upper chest covered with Tegaderm (a transparent dressing). Review of the resident's care plan showed no documentation the care plan was updated to include the resident's Permacath, no lifting over 15 pounds, and no blood pressure, intravenous access or labs in the right arm. During an interview on 03/25/26 at 11:35 A.M., the Care Plan Coordinator said the resident's care plan should reflect he/she had a Permacath for dialysis and not the fistula in the left arm, and added do not take blood pressure, IV's or labs in the right arm, and no lifting over 15 pounds. 2. Review of Resident #34's care plan, dated 10/09/25, showed he/she required assistance from one staff and a wheeled walker for transfers, ambulation, toileting and dressing. Review of the resident's quarterly MDS, dated [DATE], showed he/she required substantial/maximum assistance from staff for sit-to-stand, chair/bed transfers, toilet transfers, and shower transfers. Review of the resident's physicians orders, dated March 2026, showed the following:-Right knee immobilizer (ordered 01/13/26);-Non-weight bearing bilateral lower extremities (ordered 01/13/26);-May transition weight bearing as tolerated to right lower extremity while in knee immobilizer (ordered 01/28/26);-Do not use knee immobilizer when ambulating (ordered 01/28/26). Observation on 03/16/26 at 2:50 P.M., showed Certified Nurse Assistant (CNA) K and CNA C transferred the resident with a mechanical lift from the wheelchair to bed. The resident had a knee immobilizer on his/her right knee. Review of the resident's care plan showed no documentation the care plan was updated to include the right knee immobilizer, non-weight bearing status, transition to weight bearing as tolerated with knee immobilizer, and not to use the knee immobilizer with ambulation. During an interview on 03/16/26 at 2:50 P.M., CNA K said the resident had a fracture in his/her upper leg and was non-weight bearing. The resident wore a knee immobilizer on his/her right knee and transferred with a mechanical lift. A charge nurse communicated these things to him/her a couple of months ago. During an interview on 03/25/26 at 11:35 A.M., the Care Plan Coordinator said the resident's care plan should reflect the use (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	of a mechanical lift, the use of a knee immobilizer, non-weight bearing status, transition to weight bearing as tolerated with knee immobilizer, and do not use knee immobilizer when ambulating. 3. Review of Resident #22's admission MDS, dated [DATE], showed the following:-The resident had a pressure ulcer/injury, a scar over bony prominence, or a non-removable dressing/device;-He/She had one or more unhealed pressure ulcer injuries;-He/She had one stage 3 pressure ulcer (full thickness tissue loss. Subcutaneous fat may be visible, but bone, tendon or muscle is not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling)-One unstageable pressure ulcer (slough and/or eschar known but not stageable due to coverage of wound bed by slough and/or eschar); -He/She had an infection of the foot;-He/She had diabetic foot ulcers (an open wound on the foot);-He/She had an ostomy (a surgically created opening in the abdomen that allows waste or urine to exit the body). Review of the resident's hospital medical records, dated 02/20/26, showed the following:-He/She was admitted to hospital on [DATE] with severe peripheral vascular disease (a circulation disorder) and diabetes with neuropathy (nerve damage caused by long-term high blood sugar);-He/She was seen by wound clinic for progression of his/her chronic ischemic wounds (slow-healing wound caused by reduced blood flow to tissues). Review of the resident's physician's order report, dated March 2026, showed the following:-Cleanse wound to right lateral foot with wound cleanser, pat dry. Apply skin prep to peri wound. Apply Silver sorb (a antimicrobial wound gel) and Silver Alginate (a highly absorbent, antimicrobial wound dressing) to wound bed and cover with foam border gauze dressing every three days (original order dated 02/25/26);-Cleanse wound to genitalia with wound cleanser, pat dry, apply skin prep to peri wound, and apply duoderm (a hydrocolloid dressing) to wound every three days (original order dated 02/25/26);-Urostomy (a surgical procedure creating an opening on the abdomen to divert urine outside the body) to right abdomen (original order dated 02/25/26);-Check and drain urostomy drainage bag every shift (original order dated 02/25/26);-May have diabetic shoes. Review of the resident's smoking assessment, dated 02/25/26, showed the resident smoked tobacco. Review of the resident's care plan, last revised on 03/16/26, showed the following:-No documentation the resident had wounds; -No documentation the resident had a urostomy; -No documentation the resident used diabetic shoes;-No documentation the resident enhanced barrier precautions (EBP) due to presence of a urostomy and wounds;-No documentation the resident smoked tobacco. 4. Review of Resident #45's care plan, last revised on 08/08/24, showed the following: -He/She required assistance of two staff and a wheeled walker for all transfers and toileting (updated 01/19/26);-He/She had a pressure wound on the left heel with a wound vac (updated 08/08/25). Review of the resident's quarterly MDS, dated [DATE], showed the following:-He/She had a stage 4 pressure ulcer (full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present on some parts of the wound bed. Often includes undermining and tunneling);-He/She had a stage 4 pressure ulcer present upon admission/reentry (previous assessment showed no stage four pressure ulcers were documented);-He/She had an infection of the foot;-He/She had required application of nonsurgical dressings (with or without topical medications) other than to feet;-He/She required application of dressings to feet (with or without topical medications);-He/She was dependent on staff with transfers; Review of the resident's wound clinic report, dated 03/06/26, showed the following:-Healed stage 4 pressure ulcer (onset 10/24/25) of the right lateral malleolus (bony prominence on either side of the ankle);-Healed stage 4 pressure ulcer of the lateral right malleolus (onset 10/24/25);-Orders included Cavilon (used to protect intact or damaged skin from moisture, body fluids, adhesives, and friction) to area then place a border foam dressing every two to three days or as needed. Continue to offload to avoid pressure, float heels at all times, and monitor for signs and symptoms of infection. Observation on 03/15/26 at 10:16 A.M. showed a sign on the resident's door showed he/she was on EBP and directed staff to apply PPE (gown and gloves). A storage device hung from the resident's door and contained gowns and gloves. Review of the resident's physician's orders, dated March 2026, showed no orders for a wound vac. Review of the resident's skilled evaluation, dated 03/16/26, (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	showed the following:-He/She had an in-house acquired osteomyelitis to his/her left heel;-He/She had an in-house acquired chronic medical device related pressure ulcer/injury to the right ankle. Observation on 03/16/26 at 3:30 P.M. showed the following:-The resident had dressings on his/her left heel and right ankle;-He/She required use of a Hoyer lift for transfers;-There was not a wound vac attached to the resident's wounds. Review of the resident's care plan on 3/16/26 showed the following: -The care plan did not correctly identify the resident's transfer status. The resident required a Hoyer lift to transfer;-The care plan was not updated to not include the wound vac;-No documentation the resident had a wound on his/her right ankle; -No documentation the resident's required EBP due to presence of wounds. 5. Review of Resident #6's care plan, revised on 02/26/25, showed the following:-Diagnosis of urine retention (when the bladder does not release urine and it builds up);-The resident had a suprapubic catheter (a sterile tube inserted into the bladder through the abdominal wall to drain urine). Review of the resident's MDS, dated [DATE], showed the resident had a urinary catheter (sterile tube inserted into the bladder to drain urine). Review of the resident's physicians' orders, dated March 2026, showed staff was to utilize Enhanced barrier precautions (EBP) every shift for suprapubic catheter. Observation on 03/15/26 at 12:47 P.M., showed the resident sat in his/her wheelchair. A urinary catheter bag hung from the resident's wheelchair. Observation on 03/17/26 at 6:22 A.M. showed the following:-CNA O entered the resident's room and did not put on a gown or face shield;-CNA O obtained a urine collection canister from the resident's bathroom and took it to the resident's bedside;-CNA O emptied the urine of the resident's urinary catheter bag into a urine collection canister and emptied the urine into the resident's toilet;-CNA O did not wear a gown or face shield while emptying the resident's catheter bag. Review of the resident's care plan showed no documentation the care plan was updated to include the resident was on EBP for a urinary catheter. 6. Review of Resident #42's care plan, initiated on 04/17/24, showed the resident had dialysis on Tuesday, Thursday, and Saturday. Review of the resident's quarterly MDS, dated [DATE], showed he/she required dialysis treatments. Review of the resident's physician's orders, dated 03/16/26, showed the following:-He/She required dialysis on Monday, Wednesday, and Fridays (original order dated 02/20/26); -He/She had a Permacath to the right chest for dialysis. Review of the resident's care plan on 03/16/26 showed no documentation staff revised the care plan to reflect the resident had dialysis on Monday, Wednesday and Friday and no documentation to show the resident required enhanced barrier precautions due to having a Permacath. 7. During an interview on 03/18/26 at 9:00 A.M., the Care Plan Coordinator said the following:-Wounds should be part of the resident's care plan;-Care plans should be accurate and reflect the resident's direct care needs;-She was behind on updating care plans because of working patient care. Care plans had not been updated as they should have;-Staff should be able to go to the care plan and know exactly what care needs the resident required and the current care plans are not like that at this time.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure one resident (Resident #26) in a review of 18 sampled and three additional residents (Resident #32, #12 and #8), received the prescribed insulin (a hormone used to treat diabetes by controlling blood sugar levels) dosage when staff failed to prime the insulin pen prior to administration per the manufacturer's guidelines. The facility census was 56. Review of the facility's policy, Insulin Pen, revised 08/15/25, showed the following:-Policy: It is the policy of this facility to use insulin pens in order to improve the accuracy of insulin dosing, provide increased resident comfort, and serve as a teaching aid to prepare residents for self-administration of insulin therapy upon discharge; -Procedure: -Attach pen needle: -Prime the insulin pen: Dial 2 units by turning the dose selector clockwise. With the needle pointing up, push the plunger, and watch to see that at least one drop of insulin appears on the tip of the needle. If not, repeat until at least one drop appears; -Set the insulin dose:-Injecting the insulin: -Inject the needle straight at a 90-degree angle to the skin; -Fully depress plunger until the dosing numbers count back to zero; -While still pressing the plunger, keep the needle in the skin for up to six to ten (6-10) seconds and then remove the needle from the skin; Review of the Lantus Solostar (a prefilled insulin pen) manufacturer's administration guidelines, revised 11/2018, showed the following:-Always perform the safety test before each injection. Performing the safety test ensures that you get an accurate dose by: -Ensuring the pen and needle work properly; -Removing air bubbles; -Select a dose of two (2) units by turning the dosage selector; -Hold the pen with the needle pointing upwards; -Tap the insulin reservoir so that any air bubbles rise up towards the needle; -Press the injection button all the way in. Check if insulin comes out of the needle tip. -You may have to perform the safety test several times before insulin is seen;-If no insulin comes out, check for air bubbles and repeat the safety test two more times to remove them;-If still no insulin comes out, the needle may be blocked. Change the needle and try again;-Inject the dose: -Insert the needle into the skin; -Deliver the dose by pressing the injection button in all the way; -Keep the injection button pressed all the way in. Slowly count to 10 before you withdraw the needle from the skin. This ensures that the full dose will be delivered. Review of the Novolog Flex Pen (a prefilled insulin pen) manufacturer's administration guidelines, dated September 2025, showed the following:-Apply the needle and take off the cap;-The air shot: -To avoid injecting air and to ensure proper dosing, perform an air shot; -Turn the dose selector to select two units; -Hold the Novolog flex pen with the needle pointing up; -Tap the cartridge gently with your finger a few times to get rid of any air bubbles that have collected at the end of the cartridge; -Keep the needle pointed upwards and push the dose selector until it returns to zero; -A drop of insulin should appear at the end of the needle; -With the dose selector at zero, dial up the correct dose of insulin units. Review of the Lispro Kwik Pen (a prefilled insulin pen) package insert showed the following: -Prime- If you do not prime before each injection, you may get too much or too little insulin. Turn the dose knob to select two units, hold the pen with the needle pointed up, tap the cartridge holder gently to collect air bubbles at the top, push the dose knob in until it stops and 0 is seen in the dose window. Hold the dose knob in and count to five slowly. You should see insulin at the tip of the needle. Repeat the priming procedure if you did not see insulin at the tip of the needle;-Turn the dose knob and select the number of units you need to inject and administer the medication. 1. Review of Resident #26's physician order summary, dated March 2026, showed the following:-Blood glucose finger sticks: fasting in the morning. Obtain one time a day;-Lantus (insulin) subcutaneous solution 100 units/milliliter (mL), inject 10 units subcutaneously (beneath the skin) in the morning. Observation on 03/17/26 at 7:07 A.M. showed the following:-Certified Medication Aide (CMT) M applied a needle to the end of the Lantus insulin pen;-CMT M did not prime the needle;-CMT M dialed up 10 units of Lantus;-He/She administered the Lantus into the resident's left upper arm;-He/She held the needle on the resident's arm for six seconds;-He/She did not hold the needle in the resident's (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	arm for 10 seconds as directed by the manufacturer guidelines to ensure the full dose was delivered. 2. Review of Resident #32's physician order summary, dated March 2026, showed the following:-Insulin aspart (Novolog) flex pen subcutaneous solution pen injector 100 units/ml;-Inject as per sliding scale: if 0-150 =0; 151-200 = 1; 201-250 = 2; 251-300 = 3; 301-350 = 3; 351-400 = 5; 401-450 = 5;-Give subcutaneously before meals and at bedtime. Review of the resident's medication administration record (MAR), dated 03/16/26 at 11:00 A.M., showed the resident's blood sugar was 163. Observation on 03/16/26 at 11:12 A.M., showed the following:-CMT M applied a needle to the end of the insulin aspart pen;-CMT M did not prime the needle;-CMT M dialed up one unit of insulin aspart;-He/She administered the insulin aspart into the resident's left arm. 3. Review of Resident #12's physician order summary, dated March 2026, showed the following:-Novolog Flex Pen 100 units/mL;-Inject as per sliding scale if 151-199 = 2; if 200-249 = 4; if 250-299 = 6; if 300-349 = 8; if [PHONE NUMBER] = 10 subcutaneously before meals and at bedtime. Review of the residents' MAR, dated 03/16/26 at 11:00 A.M., showed the resident's blood sugar was 210. Observation on 03/16/26 at 11:20 A.M. showed the following:-CMT M applied a needle to the end of the Novolog flex pen;-CMT M did not prime the needle;-CMT M dialed up four unit of Novolog;-He/She administered the Novolog into the resident's right lower abdomen. Review of the resident's MAR, dated 03/17/26 at 7:30 A.M., showed the resident's blood sugar was 193 (blood sugar reading for insulin administration at 6:50 A.M.) Observation on 03/17/26 at 6:50 A.M., showed the following:-CMT M applied a needle to the end of the insulin Novolog flex pen;-CMT M did not prime the needle;-CMT M dialed up two units of Novolog;-He/She administered the Novolog into the resident's left lower abdomen. During an interview on 03/17/26 at 7:22 A.M., CMT M said the following:-He/She did not prime the needle before administering insulin to Residents #32, #12 or #26;-He/She thought the only time he/she had to prime an insulin pen was when it was initially opened and before the first use;-He/She was not aware he/she needed to prime insulin pens before administering the medication;-When he/she administered insulin from a pen, he/she held the needle to the resident's skin for five to six seconds. 4. Review of Resident #8's March 2026 physician orders showed the following:-Diagnosis of type I diabetes;-Lispro Kwik Pen Insulin 100 units/mL, inject per sliding scale: if 1-39 = give 1 vial of D50; 40-60 = give 1/2 vial of D50 or a snack; 180-200 = 2 units; 201-250 = 4 units ; 251-300 = 6 units; 301-350 = 8 units; 351-500 = 10; above 450, give 10 units and call physician, subcutaneously before meals and at bedtime. Observation on 03/16/26 at 5:04 P.M., showed the following:-CMT D attached a needle to the resident's Lispro Kwik Pen; -CMT D did not prime the insulin pen;-CMT D dialed up two units of Lispro insulin per the sliding scale insulin instructions, and administered the medication in the resident's left upper arm. During an interview on 03/17/26 at 7:45 A.M., CMT D said the following:-When using an insulin pen, he/she was to prime the needle with two units, then dial up the dose and inject the insulin; -He/She thought he/she primed the insulin pen prior to administering the resident's insulin on 03/16/26 at 5:04 P.M. 5. During interviews on 03/17/26 at 7:39 A.M. and 03/18/26 at 6:00 P.M., the Director of Nursing (DON) said the following:-During insulin administration using an insulin pen, staff needed to prime the needle with two units, administer the insulin and hold the pen on the resident's skin for 6 to 10 seconds;-Staff should follow manufacturer guidelines when administering medications.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to follow current infection control standards for seven residents (Residents #3, #1, #6, #26, #42, #4 and #45), in a review of 18 sampled and three additional residents (Residents #8, #12, and #32). Staff failed to follow enhanced barrier precautions (EBP) by not wearing personal protective equipment (PPE) to prevent infection while providing personal care for Residents #4, #45, #42, #1 and #6, failed to clean a multi-resident use glucometer (machine used to measure blood glucose levels in the blood) and use a barrier during blood glucose finger sticks for Residents #3, #8, #12 and #26, failed to clean insulin pen hubs before attaching a needle for administration of the medication for Residents #12, #26, and #32, and failed to develop a Legionella water management team and conduct meetings to review the monitoring of the facility water system for Legionella. The facility census was 56. Review of the facility's policy for Enhanced Barrier Precautions (EBP), updated on 03/23/24, showed the following:-Enhanced barrier precautions referred to an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employs targeted gown, and gloves use during high contact resident care activities;-All staff receive training on enhanced barrier precautions upon hire and at least annually and are expected to comply with all designated precautions;-All staff receive training on high-risk activities and common organisms that require enhanced barrier precautions;-The facility will have the discretion on how to communicate to staff which residents require the use of EBP, if staff are aware of which residents require the use of EBP prior to providing high-contact care activities;-An order for enhanced barrier precautions will be obtained for residents with any of the following 1)Wounds (e.g., chronic wounds such as pressure ulcers, diabetic foot ulcers, unhealed surgical wounds, and chronic venous stasis ulcers) 2) indwelling medical devices (e.g., central lines, urinary catheters, feeding tubes, tracheostomy/ventilator tubes) 3) even if the resident is not known to be infected or colonized with a MDRO. Infection or colonization with a CDC-targeted MDRO when Contact Precautions do not otherwise apply;-Implementation of Enhanced Barrier Precautions: -Make gowns and gloves available immediately near or outside of the resident's room. Note: face protection may also be needed if performing activity with risk of splash or spray (i.e., wound irrigation, tracheostomy care). -PPE for enhanced barrier precautions is only necessary when performing high-contact care activities and may not need to be donned prior to entering the resident's room;-High-contact resident care activities include: -Dressing; -Bathing; -Transferring; -Providing hygiene; -Changing linens: -Changing briefs or assisting with toileting; -Device care or use: central lines, urinary catheters, feeding tubes, tracheostomy/ventilator tubes; -Wound care: any skin opening requiring a dressing;-Enhanced barrier precautions should be followed outside the resident's room when performing transfers and assisting with bathing in a shared/common shower room and when working with residents in the therapy gym, specifically when anticipating close physical contact while assisting with transfers and mobility;-Enhanced barrier precautions should be used for the duration of the affected resident's stay in the facility or until resolution of the wound or discontinuation of the indwelling medical device that placed them at higher risk. 1. Review of Resident #4's quarterly Minimum Data Set (MDS), a federally mandated assessment to be completed by facility staff, dated 12/22/25, showed the following:-The resident had a feeding tube (a tube surgically inserted into the stomach to provide hydration, nutrition, and medications);-He/She was always incontinent of bowel and bladder;-Dependent on staff with transfers, bathing, and personal hygiene. Review of the resident's care plan, last revised 10/03/25, showed the following:-He/She had a percutaneous endoscopic gastrostomy (PEG tube, surgical insertion of a tube through the abdominal wall into the stomach); -He/She was incontinent of bowel and bladder-Staff was to assist him/her with perineal cleansing as needed and follow standards of practices of care for peri care and infection control protocols;-He/She required two persons assist with Hoyer lift (mechanical lift) for all (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Kirksville Manor Care Center	1705 East Laharpe Kirksville, MO 63501

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	transfers;-He/She required two persons assist for all activities of daily living (ADL). Observation of the resident's room door on 03/15/26 at 9:45 A.M. showed a sign directing staff to use personal protective equipment (PPE) when providing care for the resident as he/she was on EBP. A storage device containing PPE (gowns and gloves) hung from the resident's door. Observation on 03/15/26 at 9:48 A.M. showed the following:-The resident lay in his/her bed;-He/She was incontinent of bowel and bladder.-Certified Nursing Assistant (CNA) E and CNA F entered the resident's room and did not put on gowns;-CNA E and CNA F provided incontinence care then transferred the resident from his/her bed to the wheelchair. Neither staff wore a gown when they provided care for the resident. Observation on 03/16/26 at 3:12 P.M. showed CNA C and CNA K did not wear gowns and transferred the resident with the Hoyer lift from his/her wheelchair to the bed and provided incontinence care. Observations on 03/17/26 at 7:00 A.M. showed the following:-CNA J entered the resident's room to prepare the resident for a shower;-Without wearing a gown, CNA J put an incontinence brief on the resident and put the shower Hoyer lift pad under the resident;-CNA I entered the room, did not put on a gown, and assisted CNA J transfer the resident from the bed to the wheelchair with the Hoyer lift. Observation on 03/17/26 at 7:47 A.M. showed CNA I and CNA J did wear gowns and transferred the resident to his/her bed, assisted the resident to dress, combed the resident's hair, and put dentures in the resident's mouth. During interview on 03/17/26 at 8:05 A.M., CNA J and CNA I said they did not know they needed to wear a gown when providing personal care for the resident. They did not wear a gown when providing care because they had not been instructed to do so. They thought the signs on the doors were for staff who provided direct care to the resident's PEG tube. 2. Review of Resident #45's undated list of diagnoses list showed the following:-Acute osteomyelitis (infection of the bone) left ankle and foot;-Stage 4 pressure ulcer (full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present on some parts of the wound bed. Often includes undermining and tunneling) of the left heel;-Unstageable pressure ulcer (slough and/or eschar known but not stageable due to coverage of wound bed by slough and/or eschar) of the right ankle. Review of the resident's quarterly MDS, dated [DATE], showed the following:-He/She was dependent on staff with toileting, showering, and transfers;-He/She had a stage 4 pressure ulcer;-He/She had an infection of the foot;-He/She was always incontinent of bowel and bladder. Review of the resident's care plan, last revised/reviewed on 11/24/25, showed the following:-He/She had a pressure ulcer on the left heel;-He/She required two staff assist with Hoyer lift for all transfers;-He/She required assist of one with bathing;-He/She was incontinent of bowel and bladder;-He/She required assistance with perineal cleansing when he/she asked for assistance.(There was no documentation to address the resident's need for EBP.) Review of the resident's physician's orders, dated March 2026, showed the following:-He/She had wounds to the left heel which required dressing changes three times a week;-He/She had a wound to the right ankle that required a dressing change every two to three days and as needed. Observation on 03/15/26 at 10:16 A.M. showed a sign on the resident's room door showed the resident was on EBP and directed staff to apply PPE (gown and gloves). A storage device, containing gowns and gloves, hung from the resident's door. Observation on 03/16/26 at 3:30 P.M., showed the following:-CNA G and CNA H entered the resident's room;-Neither CNA G nor CNA H put on a gown;-CNA G and CNA H transferred the resident to bed, put a Hoyer lift sling under the resident, provided incontinence care, and transferred the resident to the shower chair. 3. Review of Resident #42's care plan, last revised on 11/21/25, showed the following:-He/She had end stage renal disease (chronic irreversible kidney failure) and required dialysis three times a week;-He/She required two staff and the Hoyer lift for all transfers;-He/She required extensive assistance of two staff with all ADLs. Review of the resident's quarterly MDS, dated [DATE], showed the following:-His/Her cognition was moderately impaired;-He/She was dependent on staff for showers, toilet hygiene, dressing, oral hygiene, showers, and transfers;-He/She was always incontinent of bowel and bladder;-He/She required dialysis (a treatment that filters waste and excess fluid from the blood). Review of the resident's physician's orders, dated March 2026, showed the following:-He/She (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	required dialysis three times a week;-Permacath (a flexible tube inserted into a large vein for dialysis access) to the right chest for dialysis. During an on 3/16/26 at 2:55 P.M., the resident's representative said staff did not always wear gowns when they provided care. Staff wore gowns when the resident had an infection, but the resident did not currently have an infection. Observation on 03/16/26 at 3:15 P.M., showed a sign for EBP and contact precautions was posted on the resident's room door. PPE (gloves, gowns, and masks) hung on the outside of the door. During an interview on 03/17/26 at 8:10 A.M., CNA C and CNA K said the following:-Staff only wore PPE if they provided care to the area that required PPE/EBP, such as providing direct care to the catheter, wounds, or PEG tube;-Only the nurses wore the PPE because they cared for residents' wounds and PEG tubes; -He/She did not wear PPE a gown or a mask when he/she provided care for residents with wounds or a PEG tube. 4. Review of Resident #1's Care Plan, dated 11/12/25, showed the following:-The resident had hemodialysis (process for removal of waste and excess water from the blood due to kidney failure) related to acute kidney failure (loss of kidney's ability to remove waste);-The resident required assist of one staff and wheeled walker for all transfers;-The resident used a bedside commode for toileting with assist of one staff and wheeled walker;(There was no documentation to address the resident's need for EBP.) Review of the resident's physicians orders, dated March 2026, showed the following:-Diagnoses included dependence on renal dialysis;-Dialysis site- Permacath to right chest. Review of the resident's quarterly MDS, dated [DATE], showed the following:-He/She required substantial help from staff for transfers and dressing;-He/She was dependent on staff for toileting hygiene;-He/She received dialysis. Observation on 03/15/26 at 10:10 A.M., showed an EBP sign on the door directed staff to apply gown and gloves. A storage device containing gowns and gloves hung from the resident's door. Observation on 03/16/26 at 2:13 P.M., showed the following:-CNA K entered the resident's room;-CNA K did not put on a gown, washed his/her hands, put on gloves and applied lotion to the resident's feet;-CNA K did not wear a gown when providing care to the resident. Observation on 03/17/26 at 6:25 A.M., showed the following:-CNA K entered the resident's room; -CNA K did not put on a gown, washed his/her hands, put on gloves, and assisted the resident to sit on the edge of bed, stand with a walker and pivot to sit on the commode;-CNA K assisted the resident with dressing;-CNA K provided the resident with incontinence care;-CNA K assisted the resident to transfer from the commode to the wheelchair;-CNA K did not wear a gown while providing care to the resident. During an interview on 03/17/26 at 5:20 A.M., Nursing Assistant (NA) L said the following:-Staff do not use EBP with the resident;-The resident required assistance with getting in bed, getting to the commode, and with perineal care. 5. Review of Resident #6's quarterly MDS, dated [DATE], showed the following:-He/She was cognitively intact;-He/She had a urinary catheter (a sterile tube inserted into the bladder to drain urine);-He/She was dependent on staff for personal hygiene. Review of the resident's care plan, revised on 02/26/25, showed the following: -The resident has a suprapubic urinary catheter (a sterile tube inserted into the bladder through the abdominal wall to drain urine);-He/She needs staff assistance with one for toileting and personal hygiene;(There was no documentation to address the resident's need for EBP.) Review of the resident's physician orders, dated March 2026, showed the following:-Enhanced Barrier Precautions every shift for suprapubic catheter; -Suprapubic urinary catheter. Observation on 03/17/26 at 6:22 A.M. showed no EBP signage or supplies were on the resident's room door. Observation on 03/17/26 at 6:22 A.M. showed the following:-CNA O entered the resident's room and did not put on a gown; -CNA O rinsed and dried the resident's dentures, applied denture adhesive to the dentures, and handed them to the resident to put in his/her mouth;-CNA O placed a urine collection canister near the resident's catheter bag (a medical device that collects urine draining from the bladder through a catheter). He/She drained the resident's urine from the catheter bag into the empty urine collection canister;-CNA O emptied the canister into the resident's toilet; -CNA O put a hearing aide in the resident's left ear and put slippers on the resident's feet;-CNA O assisted the resident to transfer to the wheelchair;-CNA O did not wear a gown during the residents' (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	personal cares and did not wear a gown and face shield when emptying the resident's catheter bag. During interviews on 03/15/26 at 12:38 P.M. and 1:57 P.M., the resident said the following:-He/She had a catheter;-Staff had to help him/her get dressed, put on his/her shoes and help transfer him/her to the toilet;-Staff never wore a gown when performing his/her personal cares or catheter care. During an interview on 03/17/26 at 9:43 A.M., CNA O said the following:-He/She needed to wear a gown when providing peri care or catheter care for the resident; -He/She did not have to wear a gown during personal cares, only catheter care;-He/She did not perform catheter care (on 03/17/26 at 6:22 A.M.), so he/she did not have to wear a gown. During interviews on 03/17/26 at 9:52 A.M. and 10:36 A.M., Licensed Practical Nurse (LPN) N said the following:-Staff were to wear a gown when they performed catheter care;-Staff should wear a gown when emptying the resident's catheter bag. 6. During an interview on 03/17/26 at 10:09 A.M., the Infection Preventionist (IP) said the following:-Any resident with an indwelling medical device, including a Permacath, PEG tube, supra pubic catheter, chronic wounds, or any other indwelling medical device, required staff to wear PPE during all personal cares;-Staff should wear a gown and eye protection while performing any personal cares;-She was responsible for ensuring EBP signage and EBP supplies were hung on the residents' doors;-The nurses notified her if a resident required EBP signage and supplies on their door;-She was unaware Resident #6 did not have EBP signage or supplies on his/her door.During an interview on 03/17/26 at 10:21 A.M., the Director of Nursing (DON) said the following:-Staff should wear PPE when providing personal cares for any resident with wounds or a medical device; -Medical devices included catheters, feeding tubes, PICC lines, and Permacaths;-The IP was responsible for ensuring EBP signage and supplies were on the residents' doors 7. Review of the facility's undated policy for cleaning of the glucometer, showed to clean the machine by using a soft cloth or tissue to wipe the meter's exterior. If necessary, dip the soft cloth or tissue in a small amount of alcohol. (The policy did not instruct staff to clean the glucometer with an antimicrobial agent after use to prevent the spread of communicable diseases.) Review of the Centers for Disease Control and Prevention website, showed the following:-Proper Protocol: For cleaning blood or other potentially infectious materials, the CDC recommend using an EPA-registered tuberculocidal disinfectant or a 1:10 to 1:100 dilution of bleach and water;-If you are dealing with blood in a professional or healthcare setting, it is recommended to use specialized germicidal wipes (such as Sani-Cloth) or a bleach solution rather than standard consumer disinfecting wipes. Review of the Microdot Minute Wipe manufacturer's instructions for use showed the following:-Disinfecting: To disinfect hard, non-porous surfaces, use one or more wipes, as necessary, to thoroughly wet the surface to be treated. Treated surface must remain visibly wet for one minute to achieve complete disinfection of all pathogens listed on this label;-Allow surfaces to air dry;-Kills Human Immunodeficiency Virus Type 1 (HIV-1, a retrovirus that attacks the human immune system), Hepatitis B Virus (HBV, a contagious virus that causes liver inflammation, and Hepatitis C Virus (HCV, a contagious, bloodborne viral infection that causes liver inflammation). Review of the undated American Health Care Association, Tips for Meeting the Cleaning and Disinfection of Blood Glucose Meter Requirements in Skilled Nursing Facilities, showed the following: -Place barrier under blood glucose meter when in a resident's room or placed on top of medication cart to avoid spread of microorganisms and contamination of surfaces and other equipment or supplies;-Tip: Place clean and dry paper towel(s) under blood glucose meter before placing on resident table or on top of medication cart. Review of the facility's policy, Insulin Pen (a pre-filled pen containing insulin), revised 08/15/25, showed the following procedure for attaching the pen needle:-Remove the pen cap from the insulin pen;-Wipe the rubber seal with an alcohol pad;-Screw the pen needle onto the insulin pen. Review of the Novolog Flex Pen (prefilled insulin pen) manufacturer's administration guidelines, dated September 2025, showed the following: -Pull off the pen cap;-Wipe the rubber stopper with an alcohol swab;-Screw the needle tightly onto your FlexPen. Review of the Lantus Solostar (prefilled insulin pen) manufacturer's administration guidelines, revised 11/2018, showed the following procedure to attach the needle:-Wipe the rubber seal with (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Your program team should establish procedures to confirm, both initially and on an ongoing basis, that the water management program effectively controls the hazardous conditions throughout the building water systems. This step is called validation.;-Document and communicate all the activities of your Water Management Program;-Your written program should include at least the following: -Program team, including names, titles, contact information, and roles on the team -Confirmatory procedures, including verification steps to show that the program is being followed aswritten and validation to show that the program is effective;-Communication: Be sure to communicate with your employees and colleagues about your program on a regular basis and train those responsible for implementing and monitoring the program.-Use this communication as an opportunity to identify strategies for improving the management andefficiency of your water systems. During an interview on 03/16/26 at 5:00 P.M., the Maintenance Director said currently there was no water management team and no water management meetings. During an interview on 03/16/26 at 5:10 P.M., the Infection Preventionist (IP) said she was not part of the water management team and there were no water management meetings. During an interview on 03/16/26 at 5:30 P.M. and 03/25/26 at 12:11 P.M., the Administrator said there was no water management team and there were no water management meetings. He had informal meetings which included the Medical Director and IP but he was not having any formal meetings on a regular basis. He did not share any meeting information at the QAPI meeting.

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	265247	A. Building B. Wing	03/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Kirksville Manor Care Center	1705 East Laharpe Kirksville, MO 63501

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, observation, and record review, the facility failed to notify the physician for one resident (Resident #4), in a review of 18 sampled residents, when the resident had a change in condition and abnormal lab results. The facility census was 56. Review of the facility's policy for lab and diagnostic test results, last revised November 2018, showed the following:-When test results are reported to the facility, a nurse will first review the results.-A nurse will identify the urgency of communicating with the attending physician based on physician request, the seriousness of any abnormality, and the individual's current condition.-The reason for getting a test often affects the urgency of acting upon the result;-Nursing staff will consider the following factors to help identify situations requiring prompt physician notification concerning lab or diagnostic test results: -Whether the physician has requested to be notified as soon as a result is received. -Whether the result should be conveyed to a physician regardless of other circumstances (that is, the abnormal result is problematic regardless of any other factors). -Whether the resident/patient's clinical status is unclear, or he/she has signs and symptoms of acute illness or condition change and is not stable or improving, or there are no previous results for comparison.-If the resident has signs and symptoms of acute illness or condition change and he/she is not stable or improving, or there are no previous results for comparison, then the nurse will notify the physician promptly to discuss the situation, including a description of relevant clinical findings as well as the test results.-Direct voice communication with the physician is the preferred means for presenting any results requiring immediate notification, especially when the resident's clinical status is unstable, or current treatment needs review or clarification. 1. Review of the resident's quarterly Minimum Data Set (MDS), a federally mandated assessment to be completed by the facility, dated 12/22/25, showed the following:-His/Her cognition was severely impaired;-He/She had difficulty swallowing;-He/She had a feeding tube (a tube surgically inserted into the stomach to provide hydration, nutrition, and medications). Review of resident's progress notes, dated 02/25/26 at 8:44 P.M., showed the following: -The resident had not been very alert during the shift;-Staff notified the resident's representative and he/she requested labs be obtained on the resident;-Lab orders were obtained from the resident's physician and collected. Review of the resident's vital signs, dated 02/27/26 at 7:17 A.M., showed the resident's oxygen saturation was 87% (normal range between 95-100%) on oxygen delivered via nasal canula. Review of the resident's progress notes, dated 02/27/26, showed no documentation of the resident's condition and no documentation staff notified the resident's physician of the resident's low oxygen saturations when on oxygen at 7:17 A.M. Review of the resident's lab results, collected on 02/26/26, showed the following:-Lab results were reported to the facility on [DATE] at 8:00 A.M.;-Blood urea nitrogen (BUN, a waste product filtered out of the blood by the kidneys. Increased concentrations in the blood may indicate a temporary or chronic decrease in kidney function.) was 38 (normal range 5-23).-Sodium level was 159 (normal range 134-145);-Chloride level was 121 (normal range 98-107);-BUN/Creatinine ratio (indicates urea nitrogen is elevated relative to creatinine, commonly signaling pre-renal issues like dehydration) was 47.5 (normal range 10-20). -White blood cell (WBC) count was 15.7 (normal range 4.8-10.8);-There was a handwritten note on the lab results noting nursing staff faxed the results to the resident's physician on 02/27/26 at 9:00 A.M. Review of the resident's progress notes, dated 02/27/26, showed no documentation related to the resident's condition. Review of the resident's progress note, dated 02/27/26 at 5:00 P.M., showed the following:-The resident's representative arrived at the facility to visit the resident and requested to view the resident's labs;-The resident's representative contacted the resident's physician regarding the lab results and his/her concerns the resident was dehydrated, rapid weight loss, and increased fatigue;-The resident's physician gave orders to send the resident to the hospital for evaluation and treatment due to recent lab results, dehydration, and recent rapid (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	weight loss. During an interview on 03/15/2026 at 12:45 P.M., the resident's representative said he/she was not notified of the resident's decreased oxygen saturation levels. He/She visited the resident on 02/27/26 (after the labs were obtained). He/She noted the resident had decreased level of consciousness and was extremely thirsty. He/She notified the physician of the resident's status and abnormal lab results. The on-call physician said the resident needed sent to the hospital for evaluation and treatment. The resident's primary care physician reached out to him/her and said he/she was made aware of the resident's labs (unaware of when he/she was notified), and the resident needed to go to the hospital. The resident's representative had already had the resident sent to the hospital. Review of the resident's hospital medical records, dated 02/28/26, showed the resident was admitted to the hospital on [DATE] with acute hypoxic respiratory failure (not enough oxygen in the blood) secondary to pneumonia (lung infection), sepsis secondary to multifocal pneumonia, pneumonia, hypernatremia (low sodium levels) secondary to dehydration, metabolic encephalopathy (a serious brain dysfunction caused by systemic illness, organ failure, or chemical imbalances) secondary to sepsis, and electrolyte derangements (occurs when the concentration of essential minerals-like sodium, potassium, and calcium is too high or low in the body, disrupting nerve, muscle, and heart function), moderate to severe dehydration with hypernatremia (elevated sodium level), dry mucous membranes, tachyarrhythmia (an abnormally fast heart rate) likely secondary to sepsis and dehydration. During an interview on 03/18/26 at 4:40 P.M., the Director of Nursing (DON) said staff was to call the resident's physicians with abnormal lab results an hour after faxing the results to ensure the physician was aware of the abnormal lab results that need to be addressed. The nurse should have contacted the resident's physician for orders when he/she noted the abnormal lab results because the resident's condition could change and deteriorate quickly if abnormal labs were not addressed. Complaint 2792589

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide a copy of bed hold policy and written notice of transfer to the resident and/or the resident's representative when three residents (Residents #2, #4, and #56), in a review of 18 sampled residents, were transferred to the hospital. The facility census was 56. Review of the facility's Bed Hold Policy, last revised October 2022, showed the following:-All residents/representatives are provided written information regarding the facility and state bed-hold policies, which address holding or reserving a resident's bed during periods of absence (hospitalization or therapeutic leave). Residents, regardless of payer source, are provided written notice about these policies at least twice, notice well in advance of any transfer (e.g., in the admission packet) and at the time of transfer (or, if the transfer was an emergency, within 24 hours);-The written bed-hold notices provided to the residents/representatives explain in detail the duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the facility, the reserve bed payment policy as indicated by the state plan (for Medicaid residents), the facility policy regarding bed-hold periods, the facility per-diem rate required to hold a bed (for non-Medicaid residents), or to hold a bed beyond the state bed-hold period (for Medicaid residents), and the facility return policy. 1. Review of the Resident #2's face sheet showed the resident had a responsible party. Review of the resident's progress note, dated 03/06/26 at 9:45 A.M., showed the following:-The resident's oxygen saturation (percent of oxygen in the blood) was 87 percent (%) (normal levels 95%-100%);-The resident's respiratory rate (number of breaths per minute) was in the high 20's (normal 12-20); -The facility contacted emergency medical services, and the resident was sent to the emergency room. Review of the resident's medical record showed no documentation the facility provided the resident's representative with the facility's bed hold policy and a written notice of transfer when the resident was transferred to the hospital on [DATE]. Review of the resident's medical record showed the resident returned to the facility from the hospital on [DATE]. During an interview on 03/17/26 at 12:45 P.M., the resident's representative said he/she did not receive a copy of the bed hold policy or a notice of transfer with the resident went to the hospital on [DATE]. 2. Review of the Resident #4's face sheet showed the resident had a responsible party. Review of the resident's hospital records, dated 02/28/26, showed the resident was transferred and admitted to the hospital for dehydration, sepsis (serious condition in which the body responds improperly to an infection.), and failure to thrive (weight or rate of weight gain is significantly lower than expected) on 02/27/26. Review of the resident's progress note, dated 03/03/26 at 3:10 P.M., showed the resident returned to the facility. Review of the resident's medical record showed no documentation the facility provided the resident's representative with the facility's bed hold policy and a written notice of transfer discharge when the resident was transferred to the hospital on [DATE]. During an interview on 03/17/26 at 9:46 A.M., the resident's representative said he/she did not receive a copy of the bed hold policy or a notice of transfer with the resident went to the hospital on [DATE]. 3. Review of the Resident #56's face sheet showed the resident had a responsible party. Review of the resident's progress note, dated 02/25/26 at 10:23 A.M., showed the following:-The wound care nurse thought the resident had an infection and needed to be sent to the hospital; -The facility contacted emergency medical services, and the resident was sent to the emergency room. Review of the resident's medical record showed no documentation the facility provided the resident's representative with the facility's bed hold policy and a written notice of transfer discharge when the resident was transferred to the hospital on [DATE]. Review of the resident's progress note, dated 03/03/26 at 2:15 P.M., showed the resident was readmitted to the facility from the hospital. During an interview on 03/24/26 at 7:38 A.M., the resident's representative said he/she did not receive a copy of the bed hold policy or a notice of transfer with the resident went to the hospital on [DATE]. 4. (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 03/17/26 at 10:47 A.M., Licensed Practical Nurse (LPN) N said the nursing staff were to send a transfer packet with a resident upon transfer to the hospital. He/She did not send a transfer/discharge notice or bed hold policy to a guardian/responsible party. He/She did not know who was responsible for ensuring the resident and/or responsible party received the information. During an interview on 03/17/26 at 3:00 P.M., LPN B said the charge nurse was to complete the transfer/discharge packet which included the bed hold policy and transfer/discharge notices, and place them on the Director of Nursing's (DON) desk when completed, but they didn't always get completed. During an interview on 03/17/26 at 3:14 P.M., the DON said the nurse who initiated a resident transfer was responsible for issuing the transfer/discharge notice and bed hold policy to the resident and/or responsible party.

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident when there is a significant change in condition **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to complete a significant change in status assessment (SCSA) Minimum Data Set (MDS), a federally mandated assessment instrument required to be completed by facility staff, for two residents (Residents #45 and #34), in a review of 18 sampled residents, within 14 days after the facility determined, or should have determined, there had been a significant change in the resident's physical or mental condition which had an impact on more than one area of the residents' health status and required interdisciplinary review and/or revision of the care plan. The facility census was 56. Review of the Long-Term Care Facility Resident Assessment Instrument (RAI) User's Manual, version 3.0, showed a significant change is a decline or improvement in a resident's status that:-Will not normally resolve itself without intervention by staff or by implementing standard disease-related clinical interventions and is not self-limiting;-Impacts more than one area of the resident's health status;-Requires interdisciplinary review and/or revision to the care plan.-The manual also showed a SCSA was appropriate if there was a consistent pattern of changes, with either two or more areas of decline, or two or more areas of improvement. This may include two changes within a particular domain (e.g., two areas of activities of daily living (ADL) decline or improvement);-Decline in two or more of the following: -Resident's decision-making ability has changed; -Presence of a resident mood item not previously reported by the resident or staff and/or an increase in the symptom frequency (PHQ-2 to 9(C)), e.g., increase in the number of areas where behavioral symptoms are coded as being present and/or the frequency of a symptom increases for items in Section E (Behavior); -Changes in frequency or severity of behavioral symptoms of dementia that indicate progression of the disease process since the last assessment; -Any decline in an ADL physical functioning area (e.g., self-care or mobility) where a resident is newly coded as partial/moderate assistance, substantial/maximal assistance, dependent, resident refused, or the activity was not attempted since last assessment and does not reflect normal fluctuations in that individual's functioning; -Resident's incontinence pattern changes or there was placement of an indwelling catheter; -Emergence of unplanned weight loss problem (5% change in 30 days or 10% change in 180 days); -Emergence of a new pressure ulcer at Stage 2 (partial thickness loss of dermis presenting as a shallow open ulcer with a red-pink wound bed without slough. May also present as an intact or open/ruptured blister) or higher, a new unstageable pressure ulcer/injury (dead tissue is present, the actual base and condition of the ulcer cannot be determined), a new deep tissue injury (purple or maroon localized area of discolored intact skin or blood-filled blister due to damage of underlying soft tissue from pressure and/or shear) or worsening in pressure ulcer status; -Resident begins to use a restraint of any type when it was not used before; and/or -Emergence of a condition/disease in which a resident is judged to be unstable. Review of the facility's policy for Comprehensive Assessments, last revised March 2022, showed the following: -Comprehensive assessments are conducted in accordance with criteria and timeframes established in the Resident Assessment Instrument (RAI) User Manual;-Significant Change in Status Assessment - The SCSA is a comprehensive assessment for a resident that must be completed when the IDT has determined that a resident meets the significant change guidelines for either major improvement or decline. It can be performed at any time after the completion of an admission assessment, and its completion dates (MDS/CAA(s)/care plan) depend on the date that the IDT's determination was made that the resident had a significant change;-A significant change is a major decline or improvement in a resident's status that will not normally resolve itself without intervention by staff or by implementing standard disease-related clinical interventions, the decline is not considered self-limiting, impacts more than one area of the resident's health status, and requires interdisciplinary review and/or revision of the care plan. 1. Review of Resident #45's annual Minimum Data Set (MDS), a federally mandated assessment instrument, dated 04/04/25, showed the following:-He/She required partial/moderate (continued on next page)

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	assistance with showering, upper/lower body dressing, transitioning from sitting to standing positions, toilet transfers, and walking 10 and 50 feet;-He/She did not have any falls;-He/She did not have any wounds;-He/She was frequently incontinent of bladder. Review of resident's fall assessment, dated 06/04/25, showed he/she fell and fractured his/her right hip. Review of the resident's quarterly MDS, dated [DATE], showed the following:-He/She required substantial/maximum assistance with showering, upper/lower body dressing, transitioning from sitting to standing positions, toilet transfers (previous assessment showed he/she required partial/moderate assessment);-Walking did not occur (previous assessment showed he/she required partial/moderate assistance with walking);-He/She was always incontinent of bladder (previous assessment showed he/she was frequently incontinent of bladder);-He/She had a joint replacement (previous assessment showed he/she had not had a joint replacement);-He/She had a surgical wound (previous assessment showed he/she did not have any surgical wounds);-There were no falls documented (the resident fell with major injury (hip fracture) on 06/04/26).(Staff did not complete a comprehensive assessment for a significant change in status when the resident showed a decline in three or more areas since the previous assessment, completed on 04/04/25.) Review of the resident's care plan showed the following:-On 08/02/25, the resident fell;-On 08/08/26, the resident's transfer status changed to a two person assist with Hoyer lift (mechanical lift);-On 08/08/26, update showed the resident had a pressure ulcer on the left heal requiring use of a wound vac (vacuum-assisted closure used to conduct negative pressure wound therapy to promote healing). Review of resident's MDS record showed he/she was discharged to an outside facility on 08/02/25 and returned on 08/08/25. Review of the resident's quarterly MDS, dated [DATE], showed the following:-He/She was dependent on staff assistance with showering, upper/lower body dressing, transitioning from sitting to standing positions, chair to bed, bed to chair, and toilet transfers (previous assessment showed he/she required substantial/maximum assistance);-He/She was always incontinent of bowel and bladder;-He/She had one unstageable pressure ulcer (previous assessment showed the resident did not have any pressure ulcers);-He/She had an infection of the foot (previous assessment showed the resident did not have any infections);-He/She required pressure ulcer injury care (previous assessment showed the resident did not have any pressure ulcer injuries);-He/She used antibiotics in the previous seven-day look back period (previous assessment showed the resident did not require use of antibiotic therapy).(Staff did not complete a comprehensive assessment for a significant change in status when the resident showed a decline in three or more areas since the previous assessment, completed on 07/05/25.) Observation on 03/16/26 at 3:30 P.M. showed the following:-The resident had dressings to left heal and right ankle;-He/She required use of a Hoyer lift for transfers;-He/She was incontinent of bowel and bladder. During an interview on 03/18/26 at 9:00 A.M., the MDS Coordinator said the following:-The resident declined after he/she fell and fractured his/her hip (on 06/04/25). Before the fall, resident could walk but still required assistance. Now the resident was dependent on staff;-After the second fall, the resident returned from the hospital with wounds;-She did not think to do a significant change for the falls, development of wounds and the resident's transfer status requiring a Hoyer lift because they always had to do things for the resident, but she should have completed a significant change for resident's decline in August;-She followed the RAI process when completing significant change assessments. 2. Review of Resident #34's annual MDS, dated [DATE], showed the following:-Occasionally incontinent of bladder; -Partial/moderate assistance with personal hygiene, sit to stand, chair to bed transfers, toilet and shower transfers, and walking 10 feet; Review of the resident's quarterly MDS, dated [DATE], showed the following:-Dependent for toileting hygiene;-Substantial/maximum assistance with sit-to-stand, chair/bed transfers, toilet transfers, shower transfers, and walk 10 feet;-Substantial/maximum assistance with personal hygiene, upper and lower body dressing, roll left and right, sit to lying, lying to sitting on the side of the bed; -Always incontinent of bladder;(The facility did not complete a SCSA when the resident had a decline in his/her continence status and a (continued on next page)

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	decline in his/her ability to perform toileting hygiene, transfers, and ambulation.) Review of the resident's quarterly MDS, dated [DATE], showed the following:-Dependent for upper and lower body dressing, personal hygiene, roll left and right, sit to lying, lying to sitting on the side of the bed(worsened); -Walk 10 feet not attempted due to medical condition (worsened);-Physical and occupational therapy (new).(The facility did not complete a SCSA when the resident required more for upper and lower body dressing, personal hygiene, rolling left and right, sit to lying, lying to sitting on the edge of the bed, and ambulation.) During an interview on 03/25/26 at 11:35 A.M., the MDS Coordinator said the resident would not have needed a significant change MDS with the quarterly MDS completed on 10/10/25, since she recalled the resident only had a change in transfer status. 3. During an interview on 03/18/26 at 5:30 P.M., the Director of Nursing said staff were to follow the RAI process when assessing if a resident required a significant change assessment.