STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265337	A. Building B. Wing	02/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pacific Care Center	105 South Sixth Street Pacific, MO 63069

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility staff failed to document the stage (classifying a pressure ulcer based on the depth and severity of tissue damage) for one (Resident #52) of three sampled residents with wounds. Staff failed to document the administration of one residents (Resident #23) medication out of three sampled residents. The facility census was 53.1. Review of the facility's Wounds policy, undated, showed all wounds must be measured and documented on weekly (skin tears, surgical, ulcers, blisters, etc). The policy did not contain guidance on the staging of wounds.2. Review of Resident #52's Annual Minimum Date Set (MDS), a federally mandated assessment, dated 02/06/26, showed staff assessed the resident a cognitively impaired and has one or more unhealed pressure ulcer.Review of the resident's care plan, dated 01/22/26, showed the resident is on enhanced barrier precautions (EBP) related to a nephrostomy tube, a feeding tube, and a wound. The resident is at risk for pressure ulcer due to nutrition, moisture, and bedfast/mobility. Review of the resident's physician order sheet (POS), dated February 2026, showed an order to cleanse open area to coccyx with vasine (wound cleansing solution), skin prep to wound, apply santyl (prescription debriding agent to remove dead tissue), and cover with calcium alginate (wound dressing) every night and as needed. Review of the resident's nursing progress notes, dated 01/20/26, showed the resident re-admitted from acute care setting with a small pea sized area just above coccyx. Review of the resident's wound assessments showed the following: - 01/20/26: Sacral wound measurement of 0.7 centimeters (cm) x 0.3 cm x 0.1 cm. The assessment did not contain a stage of the wound;- 01/27/26: The assessment did not contain measurements for the sacral wound or stage of the wound;- 02/03/26: Sacral wound measurement of 3.5 cm x 2.5 cm x 0.2 cm. The assessment did not contain a stage of the wound;- 02/06/26: Sacral wound measurement of 3.6 cm x 3.0 cm and unstageable. During an interview on 02/12/26 at 9:30 A.M., Licensed Practical Nurse (LPN) A said if a resident is not being seen by the wound care clinic, the nursing staff are responsible to measure wounds, and the Director of Nursing (DON) is responsible for staging wounds. LPN A said he/she was not aware the residents wound was not measured on 01/27/26 and the wound was not staged until 02/06/26. During an interview on 02/12/26 at 9:56 A.M., the DON said if a resident is not seeing the wound care clinic, nursing staff are responsible to measure the wound and he/she is responsible to stage the wound. The DON said he/she missed staging the resident's coccyx wound from 01/20/26 to 02/06/26 and the wound should be in staged during that time.During an interview on 02/12/26 at 1:31 P.M., the Administrator said if a resident is not seeing the wound care clinic, the nursing staff are expected to complete wound assessments and said nursing staff and the DON are responsible for staging wounds. The Administrator said he/she was not aware the resident's coccyx wound was not staged from 01/20/26 to 02/06/26. 3.Review of the facility's policy for Medication Administration, undated, showed it is the facility's responsibility to ensure the residents receive their medications timely and as ordered by the resident's physician orders.4. Review of Resident #23's Comprehensive MDS, dated [DATE], showed staff assessed the resident as cognitively impaired and on isolation/quarantine for active infectious disease. The resident admitted on [DATE]. Review of the resident's care plan, dated 01/19/26, showed the resident is on antibiotic for Clostridioides (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
	265337	A. Building B. Wing	02/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pacific Care Center	105 South Sixth Street Pacific, MO 63069

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	difficile (c-diff, a bacterium that causes severe diarrhea, fever, nausea, and abdominal pain by inflaming the colon). Review of the resident's POS, dated January 2026, showed an order for Vancomycin (antibiotic medication to treat severe infections) 125 milligrams (mg) capsule four times a day. Review of the resident's medication administration record (MAR) showed staff did not document they administered the residents Vancomycin as directed on 01/09/26-01/11/26, 01/15/26, 01/19/26, 01/20/26, and 01/22/26. Review of the resident's nurse notes showed the staff did not notify the nurse or the doctor the resident's medications were not administered. During an interview on 02/12/26 at 9:31 A.M., certified medication technician (CMT) C said he/she marks on the MAR the medication is not available due to the drug not available. He/She said he/she noticed the resident's medication is in the cart, but the staff will not give the medication to the resident. CMT said he/she does not know why, he/she marked the resident's medication not available because the resident has the medication. He/She said if the medication is not in the medication cart, we report it to the nurse. He/She said usually the nurse can get the medication that day, if he/she reports it. During an interview on 02/12/26 at 9:54 A.M., LPN A, said if the staff document the medication is not administered, he/she would assume the medication is not in the medication cart. The LPN said most antiobiotics are available. LPN said the CMT should communicate with the nurse if a medication is not available. He/She was not aware the resident did not get is antibiotic. The LPN said the nurse would complete the documentation once the CMT informed the nurse a medication was not available. He/She said if we do not know the medication is not available, we cannot call. He/She said all the nurses should know if a resident's medication is not available and or given timely. During an interview on 02/12/26 at 10:08 A.M., the Director of Nursing (DON) said if the medication is not available, they should contact the nurse, and the nurse will call the pharmacy. The DON said he/she was not aware the resident's medications were unavailable/ not given/ missed. He/She said the CMT will have a book they keep with the medications not available and communicate this with the nurse. He/She said if the resident does not get his antibiotic for C diff, then it will not get rid of the resident's C diff. During an interview on 02/12/26 at 1:29 P.M., the Administrator said he/she expects staff to check the e stat kit, then inform the nurse or the doctor regarding the missed meds. He/she said if the antibiotic is not given then it is not going to do what it is supposed to do. He/She said if the resident's medication is not received for several days, he/she expects the CMT to notify the nurse. He/She said the DON would monitor the MARS at least monthly. He/She said in our morning meetings, we should track the antibiotic daily. The Administrator said he/she was not aware they were not completed, nor the resident's medication was not available or given.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265337	A. Building B. Wing	02/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pacific Care Center	105 South Sixth Street Pacific, MO 63069

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. Based on interview and record review, facility staff failed to provide the services of a Registered Nurse (RN), for at least eight consecutive hours per day, seven days a week. The facility census was 53.1. Review of the facility's policies showed staff did not provide a policy for RN coverage. Review of the facility Payroll Based Journal (PBJ), a method to collect auditable and verifiable staffing data from nursing facilities, report for Fiscal Year 2025, Quarter 4 (July 1 through September 30) showed the facility triggered for no RN hours for Saturdays and Sundays on the following: July 05, 06, 12, 13, 19, 20, 26, and 27th. August 02, 03, 09, 10, 16, 17, 23, 24, 30 and 31st . September 06, 07, and 13th.Review of the facility's RN staff schedule, dated July 2025, showed the facility did not have an RN in the building, for eight consecutive hours on Saturday 07/05, Sunday 7/06, Saturday 07/12, Sunday 07/13, Saturday 07/19, Sunday 07/20, Saturday 07/26 and Sunday 07/27/25. Review of the facility's RN staff schedule, dated August 2025, showed the facility did not have an RN in the building for eight consecutive hours, on Saturday 08/02, Sunday 08/03, Saturday 08/09, Sunday 08/10, Saturday 08/16, Sunday 08/17, Saturday 08/23, Sunday 08/24, Saturday 08/30, and Sunday 08/3/25. Review of the facility's RN staff schedule, dated September 2025, showed the facility did not have an RN in the building for eight consecutive hours on Saturday 09/06, Sunday 09/07, and Saturday 09/13/25. Review of the facility's RN staff schedule, dated October 2025, showed the facility did not have an RN in the building for eight consecutive hours on Saturday 10/04, Sunday 10/05, Saturday 10/11, and Sunday 10/12/25. Review of the facility's RN staff schedule, dated December 2025, showed the facility did not have an RN in the building for eight consecutive hours on Saturday 12/13, Saturday 12/20, Sunday 12/21, Saturday 12/27, and Sunday 12/28/25. Review of the facility's RN staff schedule, dated January 2026, showed the facility did not have an RN in the building for eight consecutive hours on Sunday 01/04, Sunday 01/11, Sunday 01/18/26. Review of the facility's RN staff schedule, dated February 01 thru February 12, 2026, showed the facility did not have an RN in the building for eight consecutive hours on Sunday 02/01, Saturday 02/07/26. During an interview on 02/11/26 at 4:40 P.M., the Human Resource (HR) director said he/she is responsible for schedules and does help with PBJ reporting. The HR said he/she did realize after he/she pulled the schedule information for survey the extent of the days without RN coverage. HR said he/she knew there were some days not covered, they are trying, and it is getting better. The HR said he/she had not thought of the 12hr shift the nurses work being split between two days, which would cause the eight-hour requirement to not be fulfilled. During an interview on 02/12/26 at 1:25 P.M., the Director of Nursing (DON) said HR and the administrator handle staffing. The facility has had some issues with RN coverage. The weekend lacks coverage, but they are actively hiring RN's for the weekend. There are two as needed RN's to utilize. The DON said the importance of having an RN in the building to oversee the nurse duties in the building. During an interview on 02/12/2026 at 1:55 P.M., the Administrator said she is aware of the non-coverage of RN hours. She said there has been some staffing difficulties.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265337	A. Building B. Wing	02/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pacific Care Center	105 South Sixth Street Pacific, MO 63069

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. Based on observation, interview and record review, facility staff failed to ensure a medication error rate of less than five percent (%). Out of 35 opportunities observed, three errors occurred, resulting in a 8.57% error rate, which affected two residents (Resident #11 and #31) of six sampled residents. The facility census was 53. 1.Review of the facility's Medication Errors and Drug Reactions policy, undated, showed staff are directed to report all medication errors immediately to the physician, Director of Nursing (DON) and administrator. The policy did not contain a definition of a medication error. Review of the facility's Medication Administration Guidelines policy, undated, showed it is important that the residents receive their medication on a timely basis. The policy did not contain a definition of a medication error. Review of the facility's Medication Administration policy, undated, showed the policy did not contain a definition of a medication error. 2. Review of Resident #11's physician order sheet (POS), showed an order dated 02/10/26, for Cephalexin (an antibiotic) 500 milligrams (mg) four times a day at 7:00 A.M. to 8:00 A.M., 12:00 P.M. to 1:00 P.M., 5:00 P.M. to 6:00 P.M., and 10:00 P.M. to 11:00 P.M. Observation on 02/11/26 at 7:23 A.M., showed Certified Medication Technician (CMT) B documented Cephalexin as not administered, waiting for the nurse. During an interview on 02/11/26 at 7:23 A.M., CMT B said the medication was not available in the emergency kit and had to tell the nurse. Observation on 02/11/26 at 2:08 P.M., showed the DON verified one tablet of Cephalexin in the emergency supply kit. During an interview on 02/11/26 at 2:08 P.M., the DON said there was not a medication delivery yet and will not be a delivery until after 5:00 P.M. The emergency kit is automatically refilled after a medication is pulled from the supply. He/She does not know why the CMT did not pull the medication for use but should have. He/She said this is considered a medication error since the medication was not given as ordered. 3. Review of Resident #31's POS, dated February 2026, showed the physician ordered Midodrine (medication used to treat low blood pressure when standing) 5 mg daily early morning before breakfast between 5:00 A.M. and 7:00 A.M. and Pantoprazole (reduces stomach acid) 40 mg three times a day between 5:00 A.M. - 7:00 A.M., 11:00 A.M. to 1:00 P.M., and 3:00 P.M. to 5:00 P.M. Observation on 02/11/26 at 7:41 A.M., showed CMT B administered midodrine 5 mg and pantoprazole 40 mg to the resident. During an interview on 02/11/26 at 10:42 A.M., CMT B said he/she frequently has to administer these medications on his/her shift due to the night shift not having enough staff to get it done on time. During an interview on 02/11/26 at 2:08 P.M., the DON said failing to give medication during the ordered time is a medication error. 4. During an interview on 02/11/26 at 2:08 P.M., the DON said staff are expected to follow the seven rights of medication administration (right resident, medication, route, dose, time, reason and documentation). He/She said failing to follow these rights could result in a medication error. The physician should be notified for all medication errors. The DON said he/she is aware there are some medication issues with the night shift pushing off medications the dayshift and is reworking the times to be administering the medications. The CMT's are responsible to ensure medications are ordered timely and to notify the DON and/or the charge nurse if unavailable so a follow up can occur. Staff are expected to report all medication errors to the DON. He/She was not aware of any medication errors.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265337	A. Building B. Wing	02/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pacific Care Center	105 South Sixth Street Pacific, MO 63069

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview, and record review, staff failed to ensure medications were stored in a safe and effective manner, when staff failed to ensure medications were properly labeled and contained in their original package until time of administration for three medication carts of five sampled carts. The facility census was 53.1.Review of the facility's policy, Storage of Medications, undated, showed medications must be store in the container in which they were received and no discontinued, outdated, or deteriorate drugs or biologicals may be retained for use. 2. Observation on 02/09/26 at 10:45 A.M., showed the D medication cart on the B hall contained the following: -19 and a half unidentified loose pills;-Nine unidentified loose capsules;-30 ounces (oz) of active liquid protein (nutritional medical-grade protein supplement) opened and undated;-One medication cup with three unidentified pills; -One small pudding cup opened and undated. 3. Observation on 02/09/26 at 11:35 A.M., showed the C medication cart on the B hall contained 15 and a half unidentified loose pills and one unidentified capsule. Observation on 02/09/2026 at 11:35 A.M., showed the A medication cart on the B hall contained 22 and a half unidentified loose pills and two unidentified capsules. During an interview on 02/09/26 at 11:24 A.M., the Director of Nursing (DON) said Certified Medication Technicians (CMT) who are passing medications on that shift are responsible for maintaining their cart. He/She said it is his/her expectation that carts are monitored and cleaned daily as needed. He/she said he/she was not aware there were so many loose pills in the carts. He/She said he/she is not sure why carts were not clean. During an interview on 02/09/2026 at 11:55 A.M., CMT C said there is not a schedule to clean the medication carts. CMT C said he/she started a couple of months ago and never cleaned the carts. CMT C said when we do a shift change, we count the medications, but we have not cleaned the carts. During an interview on 02/12/2026 at 1:29 P.M., the Administrator said it is the responsibility of the CMT's to maintain medication carts and it is his/her expectation that the CMT's are cleaning the carts at least weekly and that they are following the facility's policy on medication storage. He/She said the concern of having too many loose pills is that medication errors may occur.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265337	A. Building B. Wing	02/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pacific Care Center	105 South Sixth Street Pacific, MO 63069

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 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, facility staff failed to maintain an infection prevention and control program (IPCP) designed to provide a safe, sanitary and comfortable environment to help prevent the development and transmission of communicable diseases and infections, when staff failed to develop and review the (IPCP), policies and procedures annually. Facility staff failed to post Enhanced Barrier Precautions (EBP) signs for one resident (Resident #26) out of six sampled residents and failed to wear Personal Protective Equipment (PPE) for one resident (Resident #52) out of three sampled residents with wounds. Facility staff failed to use transmission-based precautions (TBP) (extra infection-control measures used alongside standard precautions for patients with suspected or confirmed highly contagious diseases, that requires staff to wear PPE for one resident (Resident #23) of one sampled resident. Staff failed to perform appropriate hand hygiene during a medication pass for five of five sampled residents (Resident #27, #11, #24, #31, and #2). The facility census was 53.1.Review of the facility policies showed staff did not provide a written IPCP policy.Review of the facility's IPCP Procedure Manual showed the policies were not dated and had not been reviewed annually. Review of the facility's Antibiotic Stewardship binder, showed staff did not document infection surveillance or antibiotic tracking January through May 2025, and January through February 11, 2026.During an interview on 2/11/26 at 3:20 P.M., the Director of Nursing (DON) said he/she is the facility Infection Preventionist (IP) and he/she is responsible for maintaining the IPCP. He/She said he/she just started at the end of august and has not had time to get the policies and procedures updated. He/She said he/she knows they should be done annually. He/She is not sure why they were not updated previously before he/she started.During an interview on 2/12/26 at 1:29 P.M., the Administrator said the DON is their IP and is responsible for maintaining the IPCP. He/She said the IPCP policies and procedures should be reviewed annually. He/She said he/she does not have the IPCP policies and procedures updated for last year because they just started the process.2. Review of Resident #26's Quarterly Minimum Data Set Assessment (MDS), a federally mandated assessment tool, dated 01/23/26, showed staff assessed the resident as:-Cognitively intact:-Stage one pressure injury not on admission;-Application of treatment/dressing to foot. Review of the resident's care plan, dated 01/22/26, showed the resident was on EBP for wounds and signage will be on door to notify staff of EBP.Review of the resident's Physician Order Sheet (POS), dated 02/08/26, showed an order for left heel open area, cleanse area, skin prep peri-wound, apply calcium alginate (a natural, highly absorbent wound dressing derived from brown seaweed, designed for managing moderate to heavily draining, chronic, or acute wounds), cover once every night shift and as needed for soiling.Observation on 02/09/26 at 12:30 P.M., showed the resident's door did not contain a EBP sign or PPE outside his/her room. Observation showed the resident sat on the bedside with left foot wrapped with a dressing.Observation on 02/10/26 at 9:04 A.M., showed the resident's door did not contain a EBP sign or PPE outside his/her room.Observation 02/10/26 at 2:08 P.M., showed the resident's door did not contain a EBP sign or PPE outside his/her room. Observation on 02/11/26 at 8:14 A.M., showed the resident's door did not contain a EBP sign or PPE outside his/her room.Observation on 2/12/26 at 8:32 A.M., showed the resident's door did not contain a EBP sign or PPE outside his/her room. During an interview on 2/12/26 at 10:08 A.M., the DON said he/she along with housekeeping are responsible for putting up EBP signs. He/She said changes are discussed in morning meeting, housekeeping is made aware and places signs and then it is his/her responsibility to ensure it is completed. He/She said staff should wear PPE before providing care for the resident. He/She said staff should wear gowns and gloves for EBP. He/She said he/she a sign should be placed on this resident's door because he/she has a wound. He/She said he/she is not sure why the sign was not placed on the resident's door and said it might have been overlooked.During an interview on 2/12/26 at 1:29 P.M., the Administrator said the DON is the IP and responsible for ensuring EBP (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265337	A. Building B. Wing	02/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pacific Care Center	105 South Sixth Street Pacific, MO 63069

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	signs are placed on the doors of residents on EBP. He/She said the resident has a wound and should have a sign placed on his/her door. He/her expectation that signs are placed on the doors of residents who have wounds. He/She said he/she is not sure why the resident did not have a sign on his/her door.3. Review of Resident #52's Annual MDS, dated [DATE], showed the staff assessed the resident as cognitively impaired and has one or more unhealed pressure ulcer. Review of the resident's care plan, dated 01/22/26, showed the resident is on EBP related to a nephrostomy tube, a feeding tube, and a wound. Signage will be on door to notify staff of EBP, and staff will wear appropriate PPE while caring for the resident according to EBP. Review of the resident's POS, dated February 2026, showed an order to cleanse with vasine (wound cleansing solution), skin prep to wound, apply santyl (prescription debriding agent to remove dead tissue), and cover with calcium alginate (wound dressing) every night and as needed for the resident's open area to coccyx (the small bone at the bottom of the spine). Observation on 02/09/26 at 3:14 P.M., showed an EBP sign on the resident's door which instructed staff to put on a gown and gloves prior to providing care or treatments for the resident. Observation on 02/11/26 at 1:52 P.M., showed Licensed Practical Nurse (LPN) A did not wear a gown or gloves when he/she removed the residents wound dressing. During an interview on 02/12/26 at 9:30 A.M., LPA A said he/she should have put on a gown and gloves before touching the resident's wound dressing. LPN A said because he/she was only removing the wound dressing to observe the wound, he/she forgot to put the gown and gloves on and said because he/she touched the wound dressing, he/she should have had a gown and gloves on before doing so.During an interview on 02/12/26 at 1:00 P.M., the DON said he/she expects for staff to follow the EBP guidance and to put on gowns and gloves prior to touching a residents wound dressing.During an interview on 02/12/26 at 1:31 P.M., the Administrator said he/she would expect for staff to follow the EBP guidance before entering a resident's room with a wound and prior to touching the wound dressing. The Administrator said that is important to help prevent infections. 4. Review of the facility's policy for Transmission Based Precautions (TBP), undated, showed:-Contact precautions, staff will implement contact precautions for residents known or suspected to be infected with microorganisms that can be transmitted by direct contact with the resident or indirect contact with environmental surfaces or resident care items in the resident's environment;-Clostridioides difficile (c-diff, a bacterium that causes severe diarrhea, fever, nausea, and abdominal pain by inflaming the colon), and requires contact precautions in place;-Staff will wash their hands after direct or indirect contact with the resident;-Staff will wear gloves (clean, non-sterile) when you enter the room;-Staff will change gloves after an infected contact task (contact with resident);-Staff will remove gloves before you leave the room and perform hand hygiene (handwash with soap and water);-Staff will wear a gown when you perform a task;-Staff will remove the gown and perform hand hygiene before you leave the resident's room;-Staff will clean and disinfect resident care equipment (stethoscope-device use to measure blood pressure reading) after and before use. 5. Review of Resident #23's Comprehensive MDS, dated [DATE], showed staff assessed the resident as cognitively impaired and on isolation/quarantine for active infectious disease. Review of the resident's care plan, dated 01/22/26, showed staff did not document the need for TBP. Review of the resident's nurse's notes showed the following: -On 02/01/06, the resident continues treatment for c-diff, isolation precautions in place for c-diff, isolation precautions in place, staff are to don (put on)/doff (take off) PPE to prevent contamination or injury) with cares;-On 02/07/26, the resident continues treatment for c-diff, PPE is enforced;-On 02/11/26, the resident receives antibiotic treatment for c-diff with isolation precautions in place. The staff documented to don/doff PPE with cares/therapy. 6. Observation on 02/11/26 at 9:50 AM showed the resident's door stood open with TBP sign on the door. CNA H entered the resident's room, touched the bedrail, touched the resident's call light and placed on the resident's bed. The staff left the resident's room, knocked on a separate resident's door. The staff member went to the bottle of sanitizer and applied to his/her hands. The staff entered two more resident's rooms. The staff did not apply PPE before he/she entered the resident's room. CNA H did (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265337	A. Building B. Wing	02/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pacific Care Center	105 South Sixth Street Pacific, MO 63069

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	not wash his/her hands after contact with the resident or upon leaving the resident's room. 7. Observation on 02/11/26 at 10:49 A.M., during morning medication pass, the DON pushed the medication cart to the resident's room. The resident's door stood open with the TBP sign on door. The DON walked in the resident's room. The DON took the resident's blood pressure and gave the resident his/her medications. The DON walked out of the resident's room, placed the blood pressure cuff directly on the medication cart and pushed the medication cart to another resident's room. The DON did not apply PPE prior to entering the resident's room. The DON did not wash his/her hands after he/she provided direct hands-on care to the resident. The DON did not disinfect the medical equipment after he/she used it on the resident. During an interview on 02/12/26 at 1:11 P.M., the DON said during the morning medication pass yesterday, he/she did not apply the gown and gloves. He/She said he/she did not hand wash between the med passes. The DON said he/she did not disinfect the equipment after he/she completed the process with the resident. The DON said we have proper cleaning supplies for C- diff. The DON said he/she could potentially spread C-diff because of the spores. The DON said he/she is responsible to ensure TBP is followed, and he/she monitors TBP practices. 8. During an interview on 02/12/26 at 9:31 A.M., CMT C said regarding c diff, we have precautionary bins, we have the gowns and the masks. CMT said he/she doesn't think we have anyone on C-diff right now. He/She said the resident's been off C-diff precautions for two to three weeks. CMT said he/she did enter the resident's room yesterday without PPE and TBP precautions because she wasn't aware he was still on C-diff precautions. He/She said we had an in-service recently regarding precautions, she said the DON provides the in-services. During an interview on 02/12/26 at 9:54 A.M., LPN A said the DON will place the EBP and TBP signs. LPN said with contact barriers, staff will apply precautions, such as, hand washing, place gown, apply gloves. The LPN said isolation requires the resident's door closed, especially airborne (spores) to prevent the spread. The LPN said he/she expects the staff to apply PPE. The LPN said residents who are on TBP precautions is communicated daily with the staff. He/She said the resident is currently on precautions for C- diff. He/She was part of the infection control tracking until December. LPN said he/she was not aware TBP was not being followed for the resident. During an interview on 02/12/26 at 10:08 A.M., the DON said the resident originally came to the facility with C-diff. He/She said as far as he/she is aware, the resident remains on TBP precautions. The DON said his/her staff should be aware the resident is on precautions. The DON said with contact precautions, you apply gloves and gown. The DON believes the door can stay open. During an interview on 02/12/26 at 10:35 A.M., the DON we would use the contact precaution and take down the EBP. The DON said he/she is responsible to place the EBP and TBP signs outside the resident's rooms. During an interview on 02/12/26 at 1:29 P.M., the Administrator said the DON oversees the infection control program. He/She said the DON is in charge to place the TBP signs, complete the education, verbally, related to infection control with our staff. He/She said staff is expected to wear proper gown, gloves, wash hands ect. He/She said items out of the resident's room, staff should bag the items. Staff is expected to take off their PPE before they come out of the resident's room, so they do not spread the infection to additional rooms. Staff should disinfect equipment used during resident care. He/She is overall responsible to ensure his/her staff follow safe infection control procedures. 9. Review of the facility's Handwashing policy, undated, showed the policy did not contain direction or guidance on when to wash hands.Review of the facility's Hand Cleanser (antiseptic) policy, undated, showed:-Staff are to clean the hands between resident contacts during care and prevent the spread of infection;-Staff are to place a container of antiseptic solution on his/her medication cart or out of resident reach;-Wash his/her hands;-Administer medications or provide care to the resident; -Apply recommended amount of antiseptic cleanser to the palm and rub briskly until the cleaner has evaporated.Review of the Medication Administration policy, undated, showed staff are directed to wash his/her hands before administering medication. 10. Observation on 02/11/26 at 7:15 A.M., showed Certified Medication Technician (CMT) B administered medication to Resident #27, grabbed a soiled gown off the (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265337	A. Building B. Wing	02/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pacific Care Center	105 South Sixth Street Pacific, MO 63069

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	residents' nightstand, took the gown to the soiled linen cart and returned to the medication cart and prepped Resident #11's medication. He/She did not wash his/her hands or use an antiseptic cleanser before administering medication to Resident #27 or #11.Observation on 02/11/26 at 7:23 A.M., showed CMT B administered medication to Resident #11, returned to the medication cart and prepped Resident #24's medication. He/she did not was his/her hands or use an antiseptic cleanser before administering medication to Resident #11 or #24.Observation on 02/11/26 at 7:30 A.M., showed CMT B administered medication to Resident #24, returned to the medication cart and prepped Resident #31's medication. He/She did not wash his/her hands or use an antiseptic cleanser before administering medication to Resident #24 or #31.Observation on 02/11/26 at 7:41 A.M., showed CMT B administered medication to Resident #31 and obtained Resident #2's blood pressure, and return to the medication cart. He/She did not perform hand hygiene before administering Resident #31's medication or before or after taking Resident #2's blood pressure. During an interview on 02/11/26 at 10:42 A.M., CMT B said he/she is supposed to wash or sanitize his/her hands between residents when passing medications to keep from spreading germs. He/She is usually much better at washing or sanitizing but was nervous and forgot. During an interview on 02/11/26 at 2:08 P.M., the DON said he/she expects staff to wash or sanitize between residents during a medication pass. The CMT observed is a part time staff member and should have known to wash or sanitize between residents.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265337	A. Building B. Wing	02/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pacific Care Center	105 South Sixth Street Pacific, MO 63069

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement a program that monitors antibiotic use. Based on interview and record review, facility staff failed to implement an Antibiotic Stewardship Program with antibiotic use protocols and a system to monitor and track antibiotic use within the facility. The facility census was 53.1.Review of the facility's policy titled, Antibiotic Stewardship Program (ASP), undated, showed it directed staff as follows:-Infection Preventionist (IP): This person will be the hub of the ASP. They will have the knowledge and expertise to effectively develop, implement, and monitor the ASP;-The IP/designee will be responsible to audit the clinical assessment documentation at the time of the antibiotic prescription'-The IP/designee will be responsible for auditing of the completeness of antibiotic prescribing documentation to include dose, route, state date, end date, days of therapy, and indication;-The IP/designee will track C. difficile (a bacterium that causes severe, often painful, watery diarrhea and intestinal inflammation, usually following antibiotic treatment that disrupts healthy gut flora) and antibiotic-resistant infections. The facility will work with the consultant laboratory personnel to develop a quarterly report of any instances of C. difficile or antibiotic-resistant infections, such as methicillin-resistant Staphylococcus aureus ((MRDA) is a type of staph bacteria that causes infections resistant to many common antibiotics) or E. coli (a bacterium commonly found in the intestines of humans and other animals, some strains of which can cause severe food poisoning).Review of the facility's antibiotic stewardship program showed the following: -Staff did not have a process in place to track and trend antibiotic usage;-Did not contain documentation of an infection/antibiotic control logs for January through May of 2025;-Did not contain documentation of an infection/antibiotic control logs for January through February of 2026.Review of the facility's Infection/Antibiotic control log, dated September 2025, showed 24 antibiotics used, four of the antibiotics did not have documentation of signs and symptoms, five did not have documentation of the site of infection, one did not have documentation of onset of symptoms, three did not have documentation if a culture was done, and three did not have documentation if the pathogen identified. Review of the facility's Infection/Antibiotic control log, dated October 2025, showed 24 antibiotics used, 14 of the antibiotics did not have documentation of signs and symptoms, four did not have documentation of the site of infection, six did not have documentation of onset of symptoms, one did not have documentation if a culture was done, and one did not have documentation if the pathogen identified.Review of the facility's Infection/Antibiotic control log, dated November 2025, showed 12 antibiotics used, eight of the antibiotics did not have documentation of signs and symptoms, three did not have documentation of the site of infection, three did not have documentation if a culture was done, and three did not have if the pathogen was identified. Review of the facility's Infection/Antibiotic control log, dated December 2025, showed seven antibiotics used, seven of the antibiotics did not have documentation of signs and symptoms, one did not have documentation of the site of infection, one did not have documentation if a culture was done, two did not have documentation of if the infection was resolved. During an interview on 02/11/26 at 3:20 P.M., the Director of Nursing (DON) said he/she is the infection preventionist and is responsible for maintaining the antibiotic stewardship program. He/She said he/she started in September and is unsure why it was not completed prior to him/her starting. He/She said he/she was having another nurse come in on Wednesdays to fill out the infection/antibiotics logs but he/she has not done that recently. He/She said he/she looks at antibiotics daily during morning meeting, but he/she does not log/document them or do any trending with them. He/She said he/she knows he/she should be trending the antibiotics because it is important to indicate if any issues need further education or if intervention is needed. He/She said he/she knows the infection/antibiotic logs were not filled out for the last two months. He/she said he/she is trying to catch up.During an interview on 02/12/26 at 1:29 P.M., the administrator said the DON is their IP and is responsible for maintaining the antibiotic stewardship program. He/She said they go over antibiotics in their morning meeting and he/she would expect that the infection/antibiotic logs would be updated at that time. He/She was not (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265337	A. Building B. Wing	02/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pacific Care Center	105 South Sixth Street Pacific, MO 63069

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	aware that the logs and trending were not being done. He/She said he/she is not sure of what the risks are to not having the antibiotic stewardship program maintained and infection trending.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265337	A. Building B. Wing	02/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pacific Care Center	105 South Sixth Street Pacific, MO 63069

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0575 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Post a list of names, addresses, and telephone numbers of all pertinent State agencies and advocacy groups and a statement that the resident may file a complaint with the State Survey Agency. Based on observation, interviews and record review the facility failed to post the required Department of Health and Senior Services (DHSS) hotline information (to report allegations of abuse and neglect), or a list of names, addresses, and phone numbers of the State Survey Agency (SA) in a form and manner accessible to residents and visitors. The facility census was 53.1.Review of the facility's policies did not contain a policy for the required postings.Observation on 2/12/26 at 8:15 A.M., showed staff posted the Elder Abuse Hotline number and contact information in a manner not accessible for all residents and resident representatives. During an interview on 2/12/26 at 8:44 A.M., Resident #44 said he/she was not aware of the number being posted in the building, but he/she found it. During an interview on 2/12/26 at 8:53 A.M., Resident #1 said he/she was not aware of the hotline number or its posted location in the building. During an interview on 2/12/26 at 9:02 A.M., Certified Nurse Aide (CNA) E said he/she was not aware of the hotline number or its posted location in the building.During an interview on 2/12/26 at 9:02 A.M., CNA F said he/she was not aware of the hotline number or its posted location in the building.During an interview on 2/12/26 at 9:06 A.M., Licensed Practical Nurse (LPN) A said he/she was not aware of the hotline number or its posted location in the building. During an interview on 2/12/26 at 1:05 P.M., the Director of Nurse (DON) said the hotline number is in the hall by the main entry. He/She said if a resident asked him/her for the number to the hotline he/she would support them and write it down for them. He/She said he/she knows the hotline is available but said it maybe too high and the font size might be too small for residents to use it discreetly if needed. During an interview on 2/12/26 at 1:57 P.M., the administrator said the hotline number is in the hall of the front office. He/She said he/she knows the sign is available to all residents, staff and family but he/she is not sure if it visible from its location and thinks it should be lowered and the font made larger.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265337	A. Building B. Wing	02/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pacific Care Center	105 South Sixth Street Pacific, MO 63069

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. Based on observation, interview and record review, facility staff did not maintain a comfortable and homelike environment, when staff failed to ensure a comfortable sound level for residents when they failed to ensure the keypad for hallway C's entrance and exit door was in working order to prevent a continuous beep sound every time staff enter or exit the hall. The facility census was 53.1.Review of the facility's policies showed the facility did not provide a policy for environment.2. During an interview on 02/09/26 at 3:13 P.M., Resident #44 said the beeping noise is the broken back door that leads to the laundry room. He/She said staff start arriving at 4:00-5:00 A.M He/She said he/she is often woken up by the sound of the beeping door. He/She said staff use that door all day long until 2:30-3:00 P.M He/She said he/she does not like the consistent beeping noise because it wakes him/her and makes him/her feel crazy.Observation on 2/10/26 at 9:06 A.M., showed the secure metal door that led to an outside exit, in C hall, beeped loudly when maintenance personnel held down the metal bar for 15 seconds, before he/she exited the hall. Resident #8 began to yell out from his/her room, while the door beeped.Observation on 2/10/26 at 9:20 A.M., showed the secure metal door that led to an outside exit, in C hall, beeped loudly when the Certified nurse assistant (CNA) held down the metal bar for 15 seconds, before he/she exited the hall. Resident #8 began to yell out from his/her room, while the door beeped.Observation on 2/10/26 at 9:43 A.M., showed the secure metal door that led to an outside exit, in C hall, beeped loudly when laundry aide held down the metal bar for 15 seconds, before he/she exited the hall. Resident #8 began to yell out from his/her room, while the door beeped.During an interview on 02/10/26 at 9:57 A.M., Resident #3 said the loud beeping coming from the door down the hall sounds like a fire alarm at times. He/She believes it is broken. He/She said it wakes him/her up in the mornings and sounds periodically all day long and sometimes at night. He/She said he/she is not sure how long it has been going on like this, but said it bothers everyone.Observation on 2/10/26 at 10:10 A.M., showed the secure metal door that led to an outside exit, in C hall, beeped loudly when laundry personnel held down the metal bar for 15 seconds, before he/she exited the hall.Observation on 2/10/26 at 10:27 A.M., showed the secure metal door that led to an outside exit, in C hall, beeped loudly when maintenance personnel held down the metal bar for 15 seconds, before he/she exited the hall.Observation on 2/10/26 at 10:29 A.M., showed the secure metal door that led to an outside exit, in C hall, beeped loudly when CNA personnel held down the metal bar for 15 seconds, before he/she exited the hall.Observation on 2/10/26 at 10:38 A.M., showed the secure metal door that led to an outside exit, in C hall, beeped loudly when laundry personnel held down the metal bar for 15 seconds, before he/she exited the hall.Observation on 2/10/26 at 10:40 A.M., showed the secure metal door that led to an outside exit, in C hall, beeped loudly when housekeeping personnel held down the metal bar for 15 seconds, before he/she exited the hall.Observation on 2/10/26 at 10:42 A.M., showed the secure metal door that led to an outside exit, in C hall, beeped loudly when housekeeping personnel held down the metal bar for 15 seconds, before he/she exited the hall.Observation on 2/10/26 at 1:26 P.M., showed the secure metal door that led to an outside exit, in C hall, beeped loudly when housekeeping personnel held down the metal bar for 15 seconds, before he/she exited the hall.Observation on 2/11/26 at 9:46 A.M., showed the secure metal door that led to an outside exit, in C hall, beeped loudly when a staff personnel member held down the metal bar for 15 seconds, before he/she exited the hall.Observation on 2/11/26 at 10:03 A.M., showed the secure metal door that led to an outside exit, in C hall, beeped loudly when a staff personnel member held down the metal bar for 15 seconds, before he/she exited the hall.Observation on 2/11/26 at 10:05 A.M., showed the secure metal door that led to an outside exit, in C hall, beeped loudly when a staff personnel member held down the metal bar for 15 seconds, before he/she exited the hall.Observation on 2/11/26 at 10:12 A.M., showed the secure metal door that led to an outside exit, in C hall, beeped loudly when a staff personnel member held down the metal bar for 15 seconds, (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265337	A. Building B. Wing	02/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pacific Care Center	105 South Sixth Street Pacific, MO 63069

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	before he/she exited the hall.Observation on 2/11/26 at 10:16 A.M., showed the secure metal door that led to an outside exit, in C hall, beeped loudly when a staff personnel member held down the metal bar for 15 seconds, before he/she exited the hall.Observation on 2/11/26 at 10:18 A.M., showed the secure metal door that led to an outside exit, in C hall, beeped loudly when a staff personnel member held down the metal bar for 15 seconds, before he/she exited the hall.Observation on 2/11/26 at 10:24 A.M., showed the secure metal door that led to an outside exit, in C hall, beeped loudly when a staff personnel member held down the metal bar for 15 seconds, before he/she exited the hall.Observation on 2/11/26 at 10:32 A.M., showed the secure metal door that led to an outside exit, in C hall, beeped loudly when a staff personnel member held down the metal bar for 15 seconds, before he/she exited the hall.Observation on 2/11/26 at 10:33 A.M., showed the secure metal door that led to an outside exit, in C hall, beeped loudly when a staff personnel member held down the metal bar for 15 seconds, before he/she exited the hall.Observation on 2/11/26 at 10:35 A.M., showed the secure metal door that led to an outside exit, in C hall, beeped loudly when a staff personnel member held down the metal bar for 15 seconds, before he/she exited the hall. During an interview on 02/12/26 at 11:29 A.M., laundry aide G said metal door down C hall leads to the laundry room and the keypad is broken. He/She said maintenance is aware it has been broken for a couple of weeks. He/She said it beeps for the 15 seconds while staff hold the bar down to open it, then until they put the code in on other side. He/She said the laundry aides arrive by 6:00 A.M. to start their day and leave around 2:30 P.M. He/She said that door is used frequently because it is the only way in or out from the laundry room. During an interview on 02/12/26 at 12:58 P.M., the Director of Nursing (DON) said he/she was not made aware of the broken keypad and the beeping situation down C hall until we arrived. He/She said he/she has been told that the keypad is broken, and they are waiting for a part to come in to fix it. He/She said he/she is unsure how long it has been broken for. He/She said maintenance is in charge of fixing it the door and the administrator is in charge of ensuring it is fixed.During an interview on 02/12/2026 at 1:29 P.M., the administrator said he/she was not aware the keypad to the metal door down C hall was broken, until this week. He/She said it is maintenance responsibility to fix the door. He/She said he/she has a call out to the door company to get the door fixed.During an interview on 02/27/2026 at 8:54 A.M., the maintenance director said he/she was aware the door keypad was broken. He/She said he/she was waiting on invoices to be paid in order for the part to be ordered to fix the door. He/She said when there is an issue, staff fill out and submit a work order on paper to him/her. He/She said he/she doesn't do any work until he/she has the work order. He/She said he/she gets a monthly budget for fixing/maintaining the building. He/She as long as the budget is good, he/she does not need administrative approval to fix items.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265337	A. Building B. Wing	02/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pacific Care Center	105 South Sixth Street Pacific, MO 63069

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. Based on interview and record review, facility staff failed to obtain a contract between the facility and dialysis (the clinical purification of blood by dialysis, as a substitute for the normal function of the kidney) clinic, failed to obtain physician orders to receive dialysis, and failed to obtain physician orders to check the Artery Vein (AV) graft for one (Resident #5) out of one sampled resident who received dialysis services at a dialysis clinic. The facility census was 53.1. Review of the facility's policy titled, Dialysis, Care of a Resident Receiving, undated, showed staff were directed to: -Care for the Artery Vein shunt/fistula/graft (a surgical connection between the artery and vein):-Keep the area clean and dry;-Feel for the thrill sensation daily and document in the resident record, if no thrill notify the physician;-Inspect access for redness, swelling, or warmth;-Avoid excessive pressure on the puncture site after dialysis;-Watch for bleeding after dialysis and monitor for signs of infection. 2. Review of Resident #5's Quarterly Minimum Data Set (MDS), a federally mandated assessment tool, dated 01/09/26, showed staff assessed the resident as: -Cognition intact;-Received dialysis;-Diagnosis of End Stage Renal Disease (ESRD) (the final stages of chronic kidney disease). Review of the resident's medical record showed the record did not contain a contract between the facility and dialysis clinic. Review of the resident's care plan, revised 04/15/25, showed dialysis is every Monday, Wednesday, and Friday. Review of the resident's physician order sheet (POS), dated February 2026, did not contain an order for the resident to receive dialysis and did not contain an order to check the residents Artery Vein graft. Review of the resident's Medication Administration Record (MAR), dated February 2026, showed the MAR did not contain direction for staff to check the residents Artery Vein graft. During an interview on 02/12/26 at 11:14 A.M., the resident said the Artery Vein graft is in his/her left arm and the dialysis clinic covers the sight with band aids after the treatment is completed. The resident said facility staff will sometimes check his/her Artery Vein graft but not all the time. During an interview on 02/12/26 at 10:58 A.M., Licensed Practical Nurse (LPN) A said he/she does not know if the facility has a contract with the resident's dialysis clinic. He/She said the resident should have a physician order to receive dialysis and should have an order to check the residents Artery Vein graft and how often. The LPN said he/she does not recall ever seeing physician orders for the resident's dialysis and believes it's been overlooked. LPN A said the nursing staff are responsible to obtain these orders and he/she did not realize the orders were missing. The LPN said he/she is not sure if staff are checking the residents AV graft daily and not sure if it's been documented in the residents' medical record.During an interview on 02/12/26 at 1:00 P.M., the Director of Nursing (DON) said he/she believes the facility has a contract with the resident's dialysis clinic, but the facility does not have a copy of the contract. The DON said the resident should have a physician order for dialysis and thought there were orders in place that included the name of the dialysis clinic, what days the resident goes to dialysis, directions on checking the residents Artery Vein graft, assessing for thrill, how often to check, and when to contact the physician. The DON said he/she does not know if nursing staff are checking the residents Artery Vein sight daily and documenting those checks because there is no order in place directing them to check. The DON said not having physician orders in place for the resident's dialysis was overlooked and he/she was not aware of it until today. During an interview on 02/12/26 at 1:31 P.M., the administrator said the facility has been trying for a few weeks to obtain a contract from the resident's dialysis clinic, but has not received one. The administrator said he/she would expect for the resident to have physician orders related to the dialysis treatment.