STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265347	A. Building B. Wing	01/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Adair Village	1801 North Gaines Drive Clinton, MO 64735

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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 0692 Level of Harm - Actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. Based on observation, interview and record review the facility failed to implement interventions to promote optimal food intake for one resident who the facility identified at risk for weight loss (Resident #2). The resident experienced a severe weight loss of 21.7 pounds or 15.78 % body weight in three months. The facility failed to follow their policy to fully inform the physician, involve the Dietary Manager (DM), and notify the consultant Registered Dietitian (RD) for an assessment related to the weight loss, failed to assess or identify reasons for the weight loss or develop and implement interventions to prevent further weight loss including the provision of assistance and encouragement during meals. The facility census was 57.Review of the facility's policy titled Weight Assessment and Intervention dated 2001, showed the following:-Any weight change of 5% or more since the last weight assessment is retaken the next day for confirmation;-If the weight is verified, nursing will notify the Dietician;-Unless notified of significant weight change the Dietician will review the unit weight record monthly to follow individual weight trends over time; -The threshold for significant unplanned and undesired weight loss will be based on the following criteria [where percentage of body weight loss= (usual weight- actual weight)/(usual/weight) x 100]: One month 5% weight loss is significant; greater than 5% is severe;-If the weight change is desirable, this is documented;-Undesirable weight change is evaluated by the treatment team whether or not the criteria for significant'' weight change has been met. The evaluation includes:-The resident's target weight range (including rationale if different from ideal body weight);-The resident's calorie, protein, and other nutrient needs compared with the resident's current intake;-The physician and the multidisciplinary team identify conditions and medications that may be causing anorexia (eating disorder), weight loss or increasing the risk of weight loss;-Care planning for weight loss or impaired nutrition is a multidisciplinary effort and includes the physician, nursing staff, the dietitian, the consultant pharmacist, and the resident or resident's legal surrogate;-Individualized care plans shall address: The identified causes of weight loss, goals and benchmarks for improvement, time frames and parameters for monitoring and reassessment; -Interventions for undesirable weight loss are based on careful consideration of the following:-Resident choice and preferences;-Nutrition and hydration needs of the resident;-Functional factors that may inhibit independent eating;-Environmental factors that may inhibit appetite or desire to participate in meals;-The use of supplementation and/or feeding tubes (a tube surgically inserted through the abdomen into the stomach to provide hydration, nutrition and medications). Review of Resident #2's medical record showed: -An admission date of 02/11/2025;-Diagnoses included heart disease, kidney disease, dementia, diabetes, high blood pressure and neurologic neglect syndrome (a disabling, often post stroke condition where patients disregard one side of their body or environment. It results from damage of one brain hemisphere. Key signs include eating from only half a plate). Review of the care plan last reviewed on 11/24/2025 showed the following:-Resident was at risk for weight loss related to poor appetite;-Continue 30 milliliter (ml) of TwoCal (supplement drink) three times a day (TID) with medications;-Continue weekly weights for four more weeks;-Determine resident's ability to chew and swallow;-Educate resident/representative regarding nutritional needs and requirements;-Modify diet as appropriate according to resident's food tolerances and preferences;-Regular diet, regular thin liquids;-The resident had unplanned and unexpected weight (continued on next page)

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

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

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F 0692 Level of Harm - Actual harm Residents Affected - Few	loss;-Administer medication as directed to manage pain so resident can focus on meals;-Alert RD if consumption was poor for more than 48 hours;-If weight decline persists, contact physician and dietician immediately;-Monitor and evaluate any weight loss. Determine percentage lost and follow facility protocol for weight loss;-Serve food in small bowls;-Staff to encourage the resident to return to dining room if he/she leaves before finishing meal;-The resident was at risk for visual impairment. The family reports poor vision. Review of the resident's Weight and Vital Signs records, showed staff documented the following:-On 10/01/2025, the resident weighed 137.5 pounds (pounds); -On 11/04/2025, the resident weighed 131 pounds;-On 01/13/2026, the resident weighed 117 pounds which was a 14.91% loss in three months;-On 01/21/2026, the resident weighed 115.8 pounds which was a 15.78% loss in three months.Review of the resident's quarterly Minimum Data Set (MDS), a federally mandated comprehensive assessment instrument, completed by facility staff, dated 11/20/25, showed the following:-Severe cognitive impairment;-Required assistance with bed mobility, transfers, dressing, toileting hygiene and bathing.-The resident required supervision and set up assistance for eating;-The resident was 61 inches tall, weighed 129 pounds and had an unplanned weight loss;-Nutritional approaches included a mechanically altered diet (require change in texture of food or liquids) -Staff failed to identify this weight loss as a significant weight loss in one month. Review of the RD consultant's summary and recommendations, dated 01/09/26, showed the following:-Progress note/weight loss: Weight 121 pounds, Height 61 inches, Body Max Index (BMI, a screening tool that uses height and weight to estimate if an adult is at a healthy weight): 22.9. Loss of 10 pounds (7.6%) x 60 days. Severe weight loss;-Diet was downgraded to mechanical soft (foods are ground, minced, chopped or blended to require minimal chewing) with 30 ml Two Cal TID. History of swelling to the bilateral lower extremities.-RD recommendation included weekly weights, increase Two Cal to 60 ml three times a day and encourage intake and assist as needed. Review of the resident's January 2026 physician orders sheet (POS) showed the following:-On 9/16/2025 an order for a regular diet, mechanical soft texture, regular/thin consistency;-On 10/01/2025 an order for the resident's vitals and weight to be taken monthly;-There was no update to the POS regarding the RD's recommendation on 01/09/2026 for Two Cal supplement to be increased to 60 ml. Review of the resident's January 2026 Medication Administration Record (MAR), showed the following:-TwoCal 30 ml, start date 11/19/25;-The resident refused three times in January;-The MAR did not show the RD's 01/09/26 recommendation to increase the Two Cal to 60 ml. Review of the resident's progress notes showed no Dietary Manager notes.Review of the resident's diet card showed staff did not include any food likes or dislikes or any preferences. Observation and interview on 01/21/26 at 11:28 A.M., showed the staff weighed the resident and documented a weight of 115.8 pounds. When asked if the resident was ready for lunch the resident said his/her favorite food was any flavor of ice cream, but he/she didn't get ice cream very often. The menu showed lunch was pork roast, spinach, mashed potatoes and a dessert (peaches).Observation and interview on 01/21/26 at 11:37 A.M., showed the resident sat at a table in the dining room and said he/she would eat anything. He/She was hungry.Observation of lunch on 01/21/26, showed: -At 11:39 A.M., staff brought a cup of coffee to the resident. The resident drank it;-At 11:44 A.M., staff passed the resident his/her meal tray. The resident was served regular textured food on a regular plate. Staff did not serve the resident's food in bowls. The resident attempted to eat using a fork. The resident was only able to get very small amounts of spinach on the end of the fork. The resident spilled spinach on his/her lap and attempted to take very small bites of the mashed potatoes;-The resident appeared to be frustrated;-At 11:55 A.M., the resident pushed his/her chair back, stood up and walked out of the dining room;-At 11:58 A.M., the resident re-entered the dining room with the Administrator. The Administrator asked the resident if he/she had eaten his/her lunch. Staff spoke up and said the resident had eaten some of his/her lunch meal. The resident sat back down at the dining room table and pushed his/her plate away from him/her. Staff approached and placed peaches in front of resident. The resident took a few small bites of spinach and mashed potatoes and ate two to three small peaches. The resident tried to (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	eat with the fork, but food fell off the fork. The resident was not able to get a lot of food into his/her mouth. The resident pushed the plate away;-No staff approached or encouraged the resident during the meal;-At 12:09 P.M., the resident said he/she was done. The resident ate less than 10% of the meal;-At 12:10 P.M., the staff cleared off the table and the resident's plate. Staff did not document the meal intake or percentage of meal eaten;-At 12:11 P.M., the resident left the dining room.Observations during the survey investigation showed no staff administering the Two Cal 30 ml or 60 ml to the resident. During an interview on 01/22/26 at 1:40 P.M., Certified Medication Technician (CMT) H said he/she worked the 6:00 A.M., to 6:00 P.M., shift. The resident could feed himself/herself and was mostly independent with eating meals. Staff cut up meats and set-up the resident's plate. Staff did not need to sit with the resident during meals. If the resident did not eat one or two meals, then staff needed to sit with resident and encourage eating. Staff usually took the resident to the dining room too early. The resident did not like sitting very long and would get up and leave the dining room. The resident received a supplement for weight loss with breakfast, lunch and dinner, and preferred the chocolate flavor. The resident liked sweets and coffee. If a recommendation was made by the RD, it should have been added to the POS as soon as possible and followed. CMT H said he/she gave the resident his/her Two Cal supplement during the church activity that started at 10:00 A.M. CMT H was not aware the Two Cal supplement had been increased. It was not on the POS or on the MAR. During an interview on 01/22/26 at 2:05 P.M., Certified Nurse Aide (CNA) I said the resident was not alert or oriented. He/she needed to be taken back and forth to the dining room. The resident would go into the dining room and was up and down especially if the meal had not been served yet. Staff encouraged the resident to go back to the dining room to eat. The resident was able to feed himself/herself. CNA I was not sure if the resident had any weight loss. Staff do not sit with the resident. CNA I was not sure if he/she would allow staff to help. The resident did not like sandwiches. The resident's family brought in cookies and other snacks. During an interview on 01/23/26 at 9:42 A.M., Registered Nurse (RN) A said he/she started working there in December 2025. He/she was an RN supervisor. When there was a resident with wight loss the nurse should notify the physician and family. The DM would contact the RD and supplements may be implemented. The resident was alert to self, walked independently and needed some help from staff with activities of daily living. The resident could eat independently. RN A was not aware of any significant weight loss. RN A was not sure how frequently the resident needed to be weighed. Staff did not document any meal intakes. If the RD made any recommendations for residents the DM passed it onto nursing who contacted the physician and family and put in an order on the POS. When staff brought the resident a plate, they should tell him/her what's on the plate. Staff should sit with the resident, who could be easily redirected. Staff should try to keep resident from going to the dining room too soon and closer to meal serve-out. Finger foods may have been a good intervention. All staff should know if a resident was at risk for weight loss or had any kind of weight loss. During an interview on 01/21/26 at 2:10 P.M., and on 01/23/26 at 10:06 A.M., the DM said she had worked for the facility for six years and had been the DM for four years. She did not document any notes unless something significant happened. She added her part in the MDS on a quarterly basis. Dietary cards showed a resident's likes and dislikes and any preferred foods. The resident was alert with dementia and became confused easily. Staff did not document meal or fluid intake for any meals. Staff should document meal intake on any resident at risk for weight loss or had significant weight loss, including the resident. The DM, Social Services, MDS Coordinator, Administrator, DON and Assistant Director of Nursing (ADON) had weekly weight meetings. The resident had been discussed at the meetings, and they had considered giving the resident finger foods, but it was never started. and the resident was discussed. Staff have been watching the resident's weight for quite some time. The e RD saw residents monthly, made recommendations and noted any concerns. When the RD made a recommendation, she took it to the Director of Nursing (DON) to let her know so the physician could add the recommendation to the POS. Residents with weight loss were weighed weekly and observed. The DM said she took the most (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	recent recommendation from the RD who saw the on 01/09/26, and noted the TwoCal should be increased from 30 ml to 60 ml and given TID with medication pass. The recommendation from the RD on 01/09/26 should have been added to the POS and should have been given as ordered. She did not know the recommendation to increase TwoCal was never implemented or added to the POS. Staff should have sat with the resident during meals and assisted the resident. Staff had not been doing this. Staff should have only encouraged the resident to eat meals should have never told the resident he/she didn't have to eat. The DM and other staff watched what the resident ate during meals but did not document intake and have no record of meal intake. The resident liked Oreo cookies and most sweets. During an interview on 01/23/26 at 11:06 A.M., the RD said she was in the facility once a month and as needed. She reviewed new admissions, weight concerns and made any recommendations that were needed. She did not participate in the weekly weight meeting. When she made any recommendation she sent it to the DM, DON and the Administrator. She expects the recommendations to be reviewed, physician notified and if the physician agreed, to get an order and add it to the POS. When a resident had weight loss it was a good practice to document and track meal intake. The resident had had a weight loss, and she had recommended the resident be given food in bowls. They had discussed the resident having some vision issues. She was not sure if the staff told her they stopped using the bowls. She had not seen staff consistently sit with the resident. The resident may need to be moved to a different table. During an interview on 01/23/26 at 12:07 P.M., the Administrator, DON and the ADON the resident was alert to self, but not oriented. The resident could be easily redirected. Staff assisted the resident with what he/she would let them do. They were aware the resident had had weight loss. The DON said it started within the last two to three months. They have weekly weight meetings, and the resident had been identified for weight loss and interventions had been put in place. The resident was placed on TwoCal 30 ml and then recently the dose was increased to 60 ml. The TwoCal should be given during medication pass and should be given three times a day. All staff should know if a resident had a weight loss. The RD's recommendation should have been put in place that day. Nursing should have contacted the physician and added an order to the POS. The physician should have been notified of any change in condition to include a resident with weight loss. Staff should have been sitting with the resident to assist and encourage meal intake. Staff did not document meal intake. Food preference should have been on the meal card. The Administrator and DON were not aware the resident's weight loss was that significant.During an interview on 01/23/26 at 10:39 A.M., the Medical Director said he had been in the position for the last four to five months. He was the resident's facility doctor. He was in the facility twice a week. If a resident had a change in condition, including weight loss, he wanted to be notified. The resident was alert to self, pleasantly confused but could make most of his/her needs known to staff. The resident could feed himself/herself and required staff to assist with most other self-care activities. He was not aware of any weight concerns or weight loss related to the resident. Staff had not notified him of any weight loss or a 20-pound weight loss in three months. He would have documented this in his monthly progress notes and added interventions. He needed to be involved in the weekly weight meetings from now on. When the RD made a recommendation, he should be notified so it could be added to the POS. He was never notified of any of the RDs recommendations. Staff should have documented meal intake, and the resident should be moved to the assist table to ensure he/she was eating. The resident should have a Magic Cup (ice cream like supplement). All staff had to do was tell him. If he didn't know, he could not order any interventions. He could be easily reached, 24 hours a day.

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. Based on interview and record review, the facility failed to provide a Skilled Nursing Facility Advance Beneficiary Notice (SNFABN - form CMS-10055) or a denial letter at the initiation, reduction, or termination of Medicare Part A benefits for two residents (Residents #3 and #5) who remained in the facility. The facility census was 57.Record review of the Centers for Medicare and Medicaid Services Survey and Certification memo (S&C-09-20), dated 1/9/09, showed the following information:-If the skilled nursing facility (SNF) believes on admission or during a resident's stay that Medicare will not pay for skilled nursing or specialized rehabilitative services and the provider believes that an otherwise covered item or service may be denied as not reasonable or necessary, the facility must inform the resident or his/her legal representative in writing why these specific services may not be covered and the beneficiary's potential liability for payment for the non-covered services. The SNF's responsibility to provide notice to the resident can be fulfilled by use of either the SNFABN (form CMS-10055) or one of the five uniform denial letters.-The SNFABN provides an estimated cost of items or services in case the beneficiary had to pay for them his/herself or through other insurance they may have.-If the SNF provides the beneficiary with either the SNFABN or a denial letter at the initiation, reduction, or termination of Medicare Part A benefits, the provider has met its obligation to inform the beneficiary of his/her potential liability for payment and related standard claim appeal rights. 1. Record review of Resident #3's Skilled Nursing Facility Beneficiary Protection Notification Review, completed by staff on 01/22/26, showed the following information:-Med A Skilled Services start date was 12/22/25;-Last covered date was 01/20/26;-The facility/provider initiated the discharge from Medicare Part A Services when the benefit days were not exhausted;-A SNFABN - form CMS-10055 was not provided, and the social service designee (SSD) hand wrote on the form, unaware an ABN was needed as well;-A Notice of Medicare Non-Coverage (NOMNC - form CMS-10123) was provided 01/19/26 by phone to a family representative with a verbal acknowledgement;-Facility staff did not provide the resident or his/her legal representative the SNFABN - form CMS-10055 or alternative denial letter;-The resident remained in the facility after Medicare Part A services ended. 2. Record review of Resident #5's Skilled Nursing Facility Beneficiary Protection Notification Review completed by staff on 01/22/26, showed the following information:-Med A Skilled Services start date was 10/31/25;-Last covered date was 12/11/25;-The facility/provider initiated the discharge from Medicare Part A Services when the benefit days were not exhausted;-A SNFABN - form CMS-10055 was not provided, and the SSD hand wrote on the form, unaware an ABN was needed as well;-A NOMNC - form CMS-10123 was provided 12/08/25 by phone to family member with a verbal acknowledgement;-Facility staff did not provide the resident or his/her legal representative the SNFABN - form CMS-10055 or alternative denial letter. -The resident remained in the facility after Medicare Part A services ended. During an interview on 01/22/26 at 4:50 P.M., the SSD said she has worked for the facility since October 2024. She did not know until today that she should have completed a SNFABN - form CMS-10055 for residents who had therapy. During an interview on 01/23/26 at 12:06 P.M., the administrator said the SSD was responsible for providing residents or legal representatives with the SNFABN - form CMS-10055 or alternative denial letter and NOMNC form. The administrator said she and the SSD did not know the requirement for providing the SNFABN - form CMS-10055 or alternative denial letter for residents remaining in the facility.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 ensure each resident or resident's representative received written notice of transfer and/or discharge when the facility failed to have a process in place to routinely provide transfer letters and notice of bed hold for three sampled residents (Resident #57, #25, #7) transferred to the hospital. The facility census was 57. Review of the facility policy, dated March 2025, titled Transfer or Discharge Notices, showed the following:-Residents or resident representatives are notified of an impending transfer or discharge and the reasons for the move in writing and in a language and manner they understand;-When a resident is sent emergently to an acute care setting, this is considered a transfer, not discharge, because the resident's return is generally expected;-Notice of transfer is provided to the resident and representative as soon as practicable before the transfer;-Notice of Facility Bed-Hold and Return policies are provided to the resident and representative within 24 hours of emergency transfer;-Notices are provided in a form and manner the resident can understand, taking into account the resident's educational level, language, communication barriers, and physical or mental impairments;-Nursing notes will include documentation of appropriate orientation and preparation of the resident prior to transfer or discharge;-The resident and representative are notified in writing of the following information:-The specific reason for the transfer or discharge, including:-The effective date of the transfer or discharge;-The specific location (such as the name of the new provider, description, and/or address if the location is a residence) to which the resident is being transferred or discharged ;-An explanation of the resident's rights to appeal the transfer or discharge to the state, including:-The name, address, email, and telephone number of the entity which receives such appeal hearing requests;-Information about how to obtain an appeal form; and-How to get assistance in completing and submitting the appeal hearing request;-The name, address, and telephone number of the Office of the State Long-term Care Ombudsman (statewide network of individuals who help residents in long-term care facilities maintain and improve their quality of life by helping ensure their rights are preserved and respected);-The Notice of Facility Bed-Hold and policies;-The name, address, email, and telephone number of the agency responsible for the protection and advocacy of residents with intellectual and developmental (or related) disabilities (as applies); and-The name, address, email, and telephone number of the agency responsible for the protection and advocacy of residents with a mental disorder or related disabilities (as applies). Review of the facility policy, dated October 2022, titled Bed-Holds and Returns, showed the following:-Residents and/or representatives are informed in writing of the facility and state bed-hold policies;-All residents and/or 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 absences, hospitalization or therapeutic leave; -Residents, regardless of payer source, are provided written notice about these policies at least twice: notice 1 - well in advance of any transfer, such as admission packet, notice 2 - at the time of transfer if the transfer was an emergency within 24 hours;-Multiple attempts to provide the representative with notice 2 should be documented in cases where staff were unable to reach and notify the representative timely. 1. Review of Resident #57's face sheet showed the following: -admitted on [DATE];-Diagnoses included chronic obstructive pulmonary disease (COPD - common lung disease causing restricted airflow and breathing problems) with acute exacerbation (rapid onset of worsening disease), and encephalopathy (group of conditions that cause brain dysfunction). Review of the resident's Minimum Data Set (MDS - a federally mandated comprehensive assessment completed by facility staff) list in the medical record showed the following:-admitted on [DATE];-discharged with return anticipated on 11/15/25. Review of the resident's nurse progress notes showed staff documented the following:-On 11/15/25 at 8:15 A.M., during breakfast time the Certified Nursing Aide (CNA) alerted the nurse to (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	come and check out the resident as he/she was weak. The resident was on the toilet slumped over and slow to respond but was able to respond and come to. His/her vitals were blood pressure (BP) of 105/72 (normal 120/80), pulse 89 (normal 60 to 100), he/she was able to be reoriented and was alert and oriented times three. The charge nurse came to evaluate the resident as well, and the resident said he/she was ok. At 9:15 A.M., the resident was weak again and assessed; he/she was shaking and very drowsy. He/she was alert and oriented times two but was able to be reoriented to time, but at first he/she said it was 1965. The resident's vital signs were BP 160/85 and pulse 75, oxygen saturation was 93% on 1.5 Liters of oxygen. The charge nurse and physician were alerted, but the resident refused to go to the hospital. He/she stated I'm fine; -On 11/16/25, at 12:36 P.M., the resident was admitted to the hospital. Review of the resident's medical records showed staff did not have documentation regarding a written transfer notice given and/or mailed to the resident and/or resident's representative pertaining to a hospital transfer on 11/15/25. 2. Review of Resident #25's face sheet showed the following: -admitted on [DATE];-Diagnoses included acute and chronic respiratory failure (condition that occurs when the lungs cannot get enough oxygen into the blood or eliminate enough carbon dioxide from the body) with hypoxia (insufficient oxygen at the tissue level), COPD, and hypokalemia (low potassium level in bloodstream). Review of the resident's nurse progress notes showed staff documented the following:-On 11/8/25 at 2:43 P.M., the resident had been de-satting (oxygen levels are dropping) that day, dropping down to low 80's (normal 90 to 100%) while on oxygen, at rest. Confusion observed and resident at times not making sense with sentences. Family here to visit and states they are worried resident may have pneumonia (infection in lungs) due to symptoms. Lungs are diminished throughout with crackles heard to upper lobes. Physician notified and agreed the resident should be assessed at the emergency room. Emergency Medical Services (EMS) arrived at 2:35 P.M. and departed at 2:40 P.M. The Administrator and DON were notified and made aware;-On 11/8/25 at 6:43 P.M., staff received a call from the resident's family that the resident was being admitted to the hospital for pneumonia;-On 11/11/25, at 12:21 P.M., the resident readmitted from hospitalization for pneumonia; acute on chronic respiratory failure with hypoxia and hypercapnia (high levels of carbon dioxide in bloodstream). Resident is alert and oriented times three. Review of the resident's MDS list in the medical record showed the following:-admitted on [DATE];-discharged with return anticipated on 11/8/25;-re-admission on [DATE]. Review of the resident's medical records showed staff did not have documentation regarding a written transfer notice given and/or mailed to the resident and/or resident's representative pertaining to a hospital transfer on 11/08/25. 3. Review of Resident #7's face sheet showed the following: -admitted on [DATE];-Diagnoses included COPD, pneumonia, severe sepsis (infection causing organ damage) with septic shock (critical condition brought on by the sudden drop in blood flow through the body), dementia (progressive or persistent loss of intellectual functioning, especially with impairment of memory and abstract thinking, resulting from disease of the brain). Review of the resident's MDS list in the medical record showed the following:-admitted on [DATE];-discharged with return anticipated on 12/31/25;-re-admitted on [DATE]. Review of the resident's nurse progress notes showed staff documented the following:-On 12/31/25 at 1:23 P.M., the resident complained of not feeling well, resident shaking and light-headed, resident BP 196/100; pulse was 113 but was not stable, oxygen saturation 87% on 3 liters of oxygen via nasal canula. Staff contacted the physician who suggested staff send the resident to the emergency room, the resident agreed and family was notified;-On 01/07/26, at 11:30 A.M., the resident arrived back to facility at 10:55 A.M. via facility transport with a manual wheelchair and oxygen at 2 liters via nasal cannula. The resident had a peripherally inserted central catheter line (PICC - thin, flexible tube that is inserted into a vein in the upper arm and guided into a large vein above the right side of the heart, used when intravenous (IV) treatment is required over a long period) to right upper arm and will receive IV antibiotics (medicine to fight bacterial infection). Review of the resident's medical records showed staff did not have documentation regarding a written transfer notice given and/or mailed to the resident and/or the resident's (continued on next page)

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	265347	A. Building B. Wing	01/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Adair Village	1801 North Gaines Drive Clinton, MO 64735

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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 - Some	representative pertaining to a hospital transfer on 12/31/25. 4. During an interview on 01/22/26 at 12:00 P.M., the Social Service Director said when a resident was sent to the hospital, the nursing staff sends a bed hold with the resident or calls the family. He/she did not mail any information to the family regarding the transfer. He/she talked about the transfer with family by phone call. He/she sent the Ombudsman a monthly list of resident transfers and discharges. He/she had copies of the notices to Ombudsman that showed Resident #57's hospital transfer on 11/15/25, Resident #25's transfer on 11/08/25, and Resident #7's transfer on 12/31/25. During an interview on 01/22/26 at 12:10 P.M., RN A said when sending a resident to the hospital, the nursing staff should send a copy of the resident's face sheet, medication list, and copy of their code status. The nurse should call the doctor and the family. The nurse keeps a copy of the bed hold at the facility and sends a copy with the resident. He/she was not aware of any information or hospital transfer letter to the resident or family. During an interview on 01/22/26 at 12:30 P.M., the MDS Coordinator said he/she did not send any hospital discharge or transfer letter to residents or families. He/she said Social Services sends any letters. During an interview on 01/22/26 at 1:25 P.M., LPN B said when a resident was sent to the hospital, he/she sends a copy of the face sheet, the medication list, code status, and labs if applicable. He/she would talk to the family and tell them of bed hold by phone. He/she was not aware of any written information provided to the resident or family regarding the transfer. During an interview on 01/22/26 at 1:45 P.M., the ADON said with a hospital transfer, staff are to send a copy of the resident's face sheet, orders, vital signs, and code status. Staff are to call the resident's family regarding the transfer and discuss bed hold information by phone. He/She was not aware of any letter sent to family. During an interview on 01/22/26 at 2:00 P.M., the DON said when a resident was sent to the hospital, the nursing staff should notify the responsible party or family of the resident transfer. She was just told that the bed hold and transfer notification should be sent by mail to the family. She was not aware of sending a written notification of transfer. During an interview on 01/23/26 at 12:15 P.M., Administrator said when a resident was sent to the hospital, the nursing staff should complete the bed hold form, give it to the resident, and should notify the responsible party by telephone. She was not aware of the requirement for a written notice of transfer to the hospital.

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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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure residents were free of medication errors greater than 5% when staff failed to prime insulin pens (hormone to help regulate the amount of glucose (type of sugar) in the blood) prior to administration and failed to follow manufacturer's administration instructions for three residents (Resident #8, #44, #4). Three medication errors occurred out of 26 opportunities resulting in an error rate of 11.54%. The facility census was 57. Review of the facility policy titled Administering Medications, dated April 2019, showed the following:-Medications are administered in a safe and timely manner, and as prescribed;-Medications are administered in accordance with prescriber orders, including any required time frames. Review of the facility policy titled Insulin Administration dated March 2025, showed the following:-To provide guidelines for the safe administration of insulin;-The nursing staff have access to specific instructions (from the manufacturer, if appropriate) on all forms of insulin delivery systems prior to their use;-Insulin therapy is individualized based on prognosis, treatment goals, and blood glucose levels. Review of the facility undated policy, titled Insulin Pens, showed the following:-Similar to vials of insulin, insulin pens do not require constant refrigeration once they have been opened; -Each time you use the pen: -Remove the pen cap and clean the top with alcohol; -Attach the needle to the pen. Use a new needle each time; -Prime the pen and then dial up the correct dose; -Double-check the dose before you inject; -Remove the cap and choose a clean site to inject; -Push the button to inject the insulin and wait five to 10 seconds to be sure allof the insulin has been absorbed; -Remove the needle and dispose of it properly. Review of the manufacturer's Instructions for Use for Humalog Kwikpen (brand name for insulin lispro a fast-acting insulin to help prevent and treat high blood sugar from meals), dated July 2023, showed the following:-Prime the pen before each injection;-Priming the pen means removing the air from the needle and cartridge that may collect during normal use and ensures that the pen is working correctly;-If you do not prime before each injection, you may get too much or too little insulin.-To prime your pen, turn the dose knob to select two units;-Hold the pen with the needle pointing up;-Tap the cartridge holder gently to collect air bubbles at the top;-Continue holding the pen with needle pointing up;-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;-Humalog is injected under the skin (subcutaneously) of the stomach area, buttocks, upper legs or upper arms;-Wipe the skin with an alcohol swab and let the skin dry before injecting the dose;-Insert the needle into skin;-Push the dose knob all the way in;-Continue to hold the dose knob in and slowly count to five before removing the needle. 1. Review of Resident #8's face sheet (brief information sheet about the resident) showed the following: -admitted on [DATE];-Diagnoses included: Type 2 diabetes mellitus (chronic condition that affects the way the body processes blood sugar (glucose)) without complications and metabolic encephalopathy (a disease that affects the function or structure of your brain). Review of the resident's quarterly Minimum Data Set (MDS) a federally mandated assessment instrument completed by facility staff, dated 11/17/25, showed the following:-Diagnoses included diabetes mellitus;-Medications received the last seven days included insulin. Review of the resident's care plan, reviewed 11/17/25, showed the following:-Resident had diagnosis of diabetes mellitus;-Staff should administer diabetes medication as ordered by the physician;-Staff should monitor and document signs and symptoms of side effects and effectiveness. Review of the resident's physician's orders showed the following:-An order dated 11/18/26, Humalog Kwikpen subcutaneous solution pen-injector 100 unit/ml (insulin lispro), inject as per sliding scale: if blood sugar 160 to199 give 2 units, if 200 to 249 give 4 units, if 250 to 299 give 6 units, if 300 to 349 give 8 units, if 350 to 399 give 10 units, if over 400 notify the physician, subcutaneously before meals for diabetes mellitus. Observation on 01/21/26 at 11:35 A.M., showed the following:-Licensed Practical Nurse (LPN) G prepared supplies and obtained a blood (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	sample; -Blood glucose was 216;-He/She wiped the resident's left lower abdomen and administered the insulin;-He/She did not hold the needle in the skin for any length of time after pushing the plunger; -The nurse did not prime the pen;-The nurse did not hold the insulin pen in the skin for at least five seconds. 2. Review of Resident #44's face sheet showed the following: -admitted [DATE];-Diagnoses included: cerebrovascular disease (group of conditions that affect blood flow and the blood vessels in the brain), type 2 diabetes mellitus without complications. Review of the resident's quarterly MDS, dated [DATE], showed the following:-Diagnoses included diabetes mellitus;-Medications received the last seven days included insulin. Review of the resident's care plan, reviewed 12/18/25, showed the following:-Resident had diabetes mellitus;-Staff should administer diabetes medications as ordered by the physician;-Staff should monitor and document and side effects and effectiveness. Review of the resident's physician's orders showed the following:-An order dated 09/06/25, insulin lispro subcutaneous solution pen-injector 100 unit/ml (insulin lispro), inject 10 units subcutaneously before meals for diabetes mellitus. Observation on 01/21/26 at 4:15 P.M., showed the following: -LPN G prepared supplies and verified the physician's order;-The nurse turned the insulin pen dial to 10 units;-He/She wiped the resident's left upper arm and administered the insulin;-He/She did not hold the needle in the skin for any length of time after pushing the plunger; -The nurse did not prime the pen;-The nurse did not hold the insulin pen in the skin for at least five seconds. 3. Review of Resident #4's face sheet, showed the following: -admitted on [DATE];-Diagnoses included: stroke, type 2 diabetes mellitus with hyperglycemia (high blood sugar levels), chronic kidney disease stage 3 (CKD, mild to moderate kidney damage). Review of the resident's quarterly MDS, dated [DATE], showed the following:-Diagnoses that included diabetes mellitus (high blood glucose);-Medications received the last seven days included insulin. Review of the resident's care plan, reviewed 12/17/25, showed the following:-Resident had diabetes mellitus;-Staff should administer diabetes medications as ordered by the physician;-Staff should monitor and document side effects and effectiveness;-Staff should obtain fasting blood sugar as ordered by the physician. Review of the resident's physician's orders showed an order dated 10/14/25, insulin lispro subcutaneous solution pen injector 100 unit/ml (insulin lispro), inject 8 units subcutaneously in the evening for diabetes mellitus. Observation on 01/21/26 at 4:40 P.M., showed the following:-LPN G obtained the resident's insulin lispro pen from the medication cart; -He/She then turned the insulin pen dial to 8 units; -LPN G administered the insulin to the resident's left lower abdomen; -LPN G did not hold the pen in the skin for any length of time;-He/She did not prime the pen. 4. During an interview on 01/22/26 at 11:35 A.M., LPN E said when administering insulin using insulin pens, he/she first double checked the order. He/She turned the pen dial to the ordered units and administered it to the resident. Generally, he/she only primed the pens when first opened. LPN E does not prime every time because he/she could see if there was air in the pen. All of the insulin would be administered because there wouldn't be air in the pen. During an interview on 01/22/26 at 12:10 P.M., Registered Nurse A said when administering insulin with an insulin pen he/she turned the dial to two units to prime every time to get insulin into the needle. If the pen was not primed it was possible the correct dose would not be given. After pushing the plunger all the way down staff should hold the pen in the skin for about six seconds. During an interview on 01/22/26 at 1:25 P.M., LPN B said when he/she administered insulin with an insulin pen he/she first checks the orders for correct dose. Then he/she primed the pen with two units and then turned the dial to the ordered dose. The pen should be held for several seconds after administration to ensure the full dose was administered. Insulin pens were primed with every use to ensure no air in the needle and administration of the correct dose. 5. During an interview on 01/22/26 at 1:45 P.M., the Assistant Director of Nursing said nursing staff should prime the insulin pens to take air out of the needle. This should be done every time, not just with new pens. If the pen was not primed the resident might not get the whole dose of insulin. 6. During an interview on 01/22/26 at 2:00 P.M., the Director of Nursing said staff should turn the dial to one or two units to prime the needle, and should be done every time. Once primed staff should turn to the ordered dose and administer. After the plunger was pushed in, (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	staff should hold at least three seconds. If the pen was not primed and the plunger not held, the resident may not get the full dose. 7. During an interview on 01/23/26 at 1:15 P.M., the Administrator said staff should follow physician orders and manufacturer instructions for insulin pens. Staff should have primed the pens every time.

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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 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 all residents were free of significant medication errors when staff failed to prime insulin pens (hormone to help regulate the amount of glucose (type of sugar) in the blood) prior to administration and follow the manufacturer's instructions for administration for three residents during five different observations (Residents #8, #44 and #4). The facility census was 57. Review of the facility policy titled Adverse Consequences and Medication Errors, dated June 2025, showed the following:-The interdisciplinary team monitors medication usage to prevent and detect medication-related problems such as adverse drug reactions (ADRs) and side effects;-A medication error is defined as the preparation or administration of drugs or biological which is not in accordance with physician orders, manufacturer specifications, or accepted professional standards and principles of the professional providing services;-Examples of medication error includes failure to follow manufacturer's instructions and/or accepted professional standards, such as crushing a medication on the do not crush list without an order;-Medication errors are managed according to facility policy. Review of the facility policy titled Insulin Administration dated March 2025, showed the following:-To provide guidelines for the safe administration of insulin;-The nursing staff have access to specific instructions (from the manufacturer, if appropriate) on all forms of insulin delivery systems prior to their use;-Insulin therapy is individualized based on prognosis, treatment goals, and blood glucose levels;-Insulin may be premixed in an insulin pen or syringe;-Injectable insulin comes in concentrations of 100 units per milliliter (ml) of liquid. Review of the facility undated policy, titled Insulin Pens, showed the following:-Similar to vials of insulin, insulin pens do not require constant refrigeration once they have been opened; -Each time you use the pen: -Remove the pen cap and clean the top with alcohol; -Attach the needle to the pen. Use a new needle each time; -Prime the pen and then dial up the correct dose; -Double-check the dose before you inject; -Remove the cap and choose a clean site to inject; -Push the button to inject the insulin and wait five to 10 seconds to be sure allof the insulin has been absorbed; -Remove the needle and dispose of it properly. Review of the manufacturer's Instructions for Use for Humalog Kwikpen (brand name for insulin lispro a fast-acting insulin to help prevent and treat high blood sugar from meals), dated July 2023, showed the following:-Prime the pen before each injection;-Priming the pen means removing the air from the needle and cartridge that may collect during normal use and ensures that the pen is working correctly;-If you do not prime before each injection, you may get too much or too little insulin. -To prime your pen, turn the dose knob to select two units;-Hold the pen with the needle pointing up;-Tap the cartridge holder gently to collect air bubbles at the top;-Continue holding the pen with needle pointing up;-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;-Humalog is injected under the skin (subcutaneously) of the stomach area, buttocks, upper legs or upper arms;-Wipe the skin with an alcohol swab and let the skin dry before injecting the dose;-Insert the needle into skin;-Push the dose knob all the way in;-Continue to hold the dose knob in and slowly count to five before removing the needle. 1. Review of Resident #8's face sheet (brief information sheet about the resident) showed the following: -admitted on [DATE];-Diagnoses included: Type 2 diabetes mellitus (chronic condition that affects the way the body processes blood sugar (glucose)) without complications and metabolic encephalopathy (a disease that affects the function or structure of your brain). Review of the resident's quarterly Minimum Data Set (MDS) a federally mandated assessment instrument completed by facility staff, dated 11/17/25, showed the following:-Diagnoses included diabetes mellitus;-Medications received the last seven days included insulin. Review of the resident's care plan, reviewed 11/17/25, showed the following:-Resident had diagnosis of diabetes mellitus;-Staff should administer diabetes medication as ordered by the physician;-Staff should monitor and document signs and symptoms of side effects and effectiveness. Review of the (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	resident's physician's orders showed the following:-An order dated 11/18/26, Humalog Kwikpen subcutaneous solution pen-injector 100 unit/ml (insulin lispro), inject as per sliding scale: if blood sugar 160 to199 give 2 units, if 200 to 249 give 4 units, if 250 to 299 give 6 units, if 300 to 349 give 8 units, if 350 to 399 give 10 units, if over 400 notify the physician, subcutaneously before meals for diabetes mellitus. Observation on 01/21/26 at 11:35 A.M., showed the following: -Licensed Practical Nurse (LPN) G prepared supplies and obtained a blood sample; -Blood glucose was 216; -He/She wiped the resident's left lower abdomen and administered the insulin;-He/She did not hold the needle in the skin for any length of time after pushing the plunger; -The nurse did not prime the pen;-The nurse did not hold the insulin pen in the skin for at least five seconds.Observation on 01/22/26 at 11:32 A.M., showed LPN E entered the resident's room with an insulin pen. He/She turned the dial to two units and administered the insulin. LPN E did not prime the insulin. 2. Review of Resident #44's face sheet showed the following: -admitted [DATE];-Diagnoses included: cerebrovascular disease (group of conditions that affect blood flow and the blood vessels in the brain), type 2 diabetes mellitus without complications. Review of the resident's quarterly MDS, dated [DATE], showed the following:-Diagnoses included diabetes mellitus;-Medications received the last seven days included insulin. Review of the resident's care plan, reviewed 12/18/25, showed the following:-Resident had diabetes mellitus;-Staff should administer diabetes medications as ordered by the physician;-Staff should monitor and document and side effects and effectiveness. Review of the resident's physician's orders showed the following:-An order dated 09/06/25, insulin lispro subcutaneous solution pen-injector 100 unit/ml (insulin lispro), inject 10 units subcutaneously before meals for diabetes mellitus. Observation on 01/21/26 at 4:15 P.M., showed the following: -LPN G prepared supplies and verified the physician's order;-The nurse turned the insulin pen dial to 10 units;-He/She wiped the resident's left upper arm and administered the insulin;-He/She did not hold the needle in the skin for any length of time after pushing the plunger; -The nurse did not prime the pen;-The nurse did not hold the insulin pen in the skin for at least five seconds.Observation on 01/22/26 at 11:25 A.M., showed LPN E entered the resident room with an insulin pen. He/She turned the dial to 10 units and administered the insulin. LPN E did not prime the pen. 3. Review of Resident #4's face sheet, showed the following: -admitted on [DATE];-Diagnoses included: stroke, type 2 diabetes mellitus with hyperglycemia (high blood sugar levels), chronic kidney disease stage 3 (CKD, mild to moderate kidney damage). Review of the resident's quarterly MDS, dated [DATE], showed the following:-Diagnoses that included diabetes mellitus (high blood glucose);-Medications received the last seven days included insulin. Review of the resident's care plan, reviewed 12/17/25, showed the following:-Resident had diabetes mellitus;-Staff should administer diabetes medications as ordered by the physician;-Staff should monitor and document side effects and effectiveness;-Staff should obtain fasting blood sugar as ordered by the physician. Review of the resident's physician's orders showed an order dated 10/14/25, insulin lispro subcutaneous solution pen injector 100 unit/ml (insulin lispro), inject 8 units subcutaneously in the evening for diabetes mellitus. Observation on 01/21/26 at 4:40 P.M., showed the following:-LPN G obtained the resident's insulin lispro pen from the medication cart; -He/She then turned the insulin pen dial to 8 units; -LPN G administered the insulin to the resident's left lower abdomen; -LPN G did not hold the pen in the skin for any length of time;-He/She did not prime the pen. 4. During an interview on 01/22/26 at 11:35 A.M., LPN E said when administering insulin using insulin pens, he/she first double checked the order. He/She turned the pen dial to the ordered units and administered it to the resident. Generally, he/she only primed the pens when first opened. LPN E does not prime every time because he/she could see if there was air in the pen. All of the insulin would be administered because there wouldn't be air in the pen. During an interview on 01/22/26 at 12:10 P.M., Registered Nurse A said when administering insulin with an insulin pen he/she turned the dial to two units to prime every time to get insulin into the needle. If the pen was not primed it was possible the correct dose would not be given. After pushing the plunger all the way down staff should hold the pen in the skin for about six seconds. During an interview on 01/22/26 at (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1:25 P.M., LPN B said when he/she administered insulin with an insulin pen he/she first checks the orders for correct dose. Then he/she primed the pen with two units and then turned the dial to the ordered dose. The pen should be held for several seconds after administration to ensure the full dose was administered. Insulin pens were primed with every use to ensure no air in the needle and administration of the correct dose. 5. During an interview on 01/22/26 at 1:45 P.M., the Assistant Director of Nursing said nursing staff should prime the insulin pens to take air out of the needle. This should be done every time, not just with new pens. If the pen was not primed the resident might not get the whole dose of insulin. 6. During an interview on 01/22/26 at 2:00 P.M., the Director of Nursing said staff should turn the dial to one or two units to prime the needle, and should be done every time. Once primed staff should turn to the ordered dose and administer. After the plunger was pushed in, staff should hold at least three seconds. If the pen was not primed and the plunger not held, the resident may not get the full dose. 7. During an interview on 01/23/26 at 1:15 P.M., the Administrator said staff should follow physician orders and manufacturer instructions for insulin pens. Staff should have primed the pens every time.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted Based on record review and interview, the facility failed to complete a baseline care plan within 48 hours of admission for one resident (Residents #60). The facility census was 57. Review of the facility's policy titled Baseline Care Plans, dated March 2022, showed the following:-A baseline plan of care (gives initial instructions on necessary care until a comprehensive care plan (extremely detailed note that provides information on a patient's past medical history AND current medical history) is established) to meet the resident's immediate health and safety needs is developed for each resident within forty-eight hours of admission;-The baseline care plan includes instructions needed to provide effective, person-centered care of the resident that meet professional standards of quality care and must include the minimum healthcare information necessary to properly care for the resident including, but not limited to the following:-Initial goals based on admission orders and discussion with the resident and representative;-Physician orders;-Dietary orders;-Therapy services;-Social services;The baseline care plan is used until the staff can conduct the comprehensive assessment and develop an interdisciplinary person-centered comprehensive care plan;-The baseline care plan is updated to meet the resident's needs until the comprehensive care plan is developed;-The resident and/or representative are provided with a written summary of the baseline care plan that includes, but is not limited to the following:-The stated goals and objectives of the resident's;-A summary of the resident's medications and dietary instructions;-Any service and treatments to be administered by the facility and personnel acting on behalf of the facility;-Any updated information based on the details of the comprehensive care plan as necessary. Review of Resident #60's face sheet (brief information sheet about the resident) showed the following:-admission date of 01/15/26;-Diagnoses included end stage renal disease (ESRD-a condition in which the kidneys lose the ability to remove waste and balance fluids) and dependence on renal dialysis. Review of the resident's admission Minimum Data Set (MDS - a federally mandated assessment tool completed by facility staff), dated 01/15/26, showed the resident admitted to facility. Review of the resident's baseline care plan, dated 01/19/26, showed the following:-Not completed until 4 days after admission;-Resident on dialysis Monday, Wednesday, and Friday;-Resident can communicate easily with staff;-Resident required supervision or touching assistance with toileting hygiene, dressing, personal hygiene, and transfers;-Resident required partial to moderate assistance with showering;-Resident used a walker;-Resident was cognitively intact. Review of the resident's 48-hour care plan, used in conjunction with the Initial Care Plan and completed within 48 hours of admission, dated 01/20/26, showed the following:-Admitting diagnosis of renal disease;-Participation in treatment for long term care placement;-Dated five days after admission. Review of resident's comprehensive care plan, dated 01/20/26, showed the following:-Resident needs hemodialysis (life-saving medical procedure that filters waste products, toxins, and excess fluids from the blood using an external machine) related to renal failure every Monday, Wednesday and Friday;-Resident will have no signs or symptoms of complications from dialysis through the review date;-Staff should not draw blood or take blood pressure in arm with graft;-Staff should encourage resident to go for the scheduled dialysis appointments;-Staff should monitor labs and report to doctor as needed;-Staff should monitor, document, and report as needed for signs and symptoms of renal insufficiency: changes in level of consciousness, changes in skin turgor, oral mucosa, changes in heart and lung sounds. Review of the resident's medical record in the nursing progress notes showed staff documented the following:-On 01/15/26 at 2:10 P.M., admission summary: Resident arrived by private car and ambulated to room on own. Resident up per self with no assistance, shuffled gait. Resident legally blind, full code. Resident attends dialysis clinic on Monday, Wednesday, and Friday at 5:15 A.M. Resident is on a regular diet and no complaints of pain. No swelling in extremities. Lung sounds clear, bowel sounds active. No concerns voiced or observed at (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	this time. Resident pleasant during assessment. Resident takes medications whole. The resident would like to adhere to a renal diet even though we do not offer special diets;-Dialysis communication forms dated 01/16/26 and 01/19/26 were scanned into the medical record. Review of the resident's Physician Order Sheet (POS), current as of 01/20/26, showed staff did not document an order for dialysis and staff did not have an order regarding assessment of the resident's dialysis site. During an interview on 01/22/26 at 11:50 A.M., the Social Service Director said nursing staff and the MDS Coordinator were responsible for the baseline care plans. During an interview on 01/22/26 at 12:10 P.M., Registered Nurse (RN) A said when a resident was admitted the baseline care plan should be completed within 24 to 48 hours of admission. He/she would not expect the care plan to be started four or five days after admission. He/she said normally, the MDS Coordinator completed the care plans, but the nursing staff can add to the care plans as necessary. During an interview on 01/22/26 at 12:30 P.M., the MDS Coordinator said usually the nursing staff started the baseline care plan for new admissions. The baseline care plan should be done within 48 hours of admission. During an interview on 01/22/26 at 1:25 P.M., Licensed Practical Nurse (LPN) B said baseline care plans should be done right away with the initial resident admission. The baseline care plan should not be started four days after admission. During an interview on 01/22/26 at 1:45 P.M., the Assistant Director of Nurses (ADON) said baseline care plans should be started within 24 hours of admission. It should not be four days before the care plan is started. During an interview on 01/22/26 at 2:00 P.M., the Director of Nurses (DON) said baseline care plans should be done within 24 to 48 hours of resident admission. The baseline care plan should not be started four days after admission. During an interview on 01/23/26 at 12:15 P.M., the Administrator said baseline care plans should done within 24 hours of admission. She would not expect the care plan to be started four days after admission.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. Based on interview and record review, the facility failed to provide sufficient medical documentation to support a new mental health diagnosis of schizophrenia for one resident (Resident #4). The facility census was 57. Review of the facility policy titled Psychotropic Medication Use, dated February 2025, showed the following: -Psychotropic medication management is an interdisciplinary process that involves the resident, family, and/or representative and includes determining adequate indication for use, establishing appropriate dose, adequate monitoring of efficacy and adverse consequences, and determining appropriateness of gradual dose reductions;-When determining whether to initiate, modify, or discontinue medication therapy, the interdisciplinary team conducts and documents an evaluation of the resident. The evaluation includes the resident's physical, behavioral, mental, and psychosocial status, comorbid conditions, expressions or indications of distress, changes in functional status, resident complaints, behaviors and symptoms and the state PASARR (preadmission screening and resident review) evaluation;-Circumstances that warrant an evaluation of the resident's underlying medical condition and medication use include admission or readmission, new or worsening change in condition, or an irregularity identified during the drug regimen review;-A diagnosis alone does not necessarily warrant the use of psychotropic medication; if psychiatric diagnosis is part of the rationale for the use of psychotropic medication, there will be sufficient supporting documentation that the resident meets the criteria for that diagnosis based on the current diagnostic and statistical manual of mental disorders. Review of Resident #4's face sheet (brief information sheet about the resident), showed the following: -admit date of 6/1/23;-admission diagnosis of cerebral infarction due to unspecified occlusion (a critical condition where reduced blood flow causes tissue death in the brain);-Diagnosis of bipolar disorder (chronic mental health condition characterized by extreme mood swings alternating between high energy manic and deeply depressive states);-Diagnosis of schizophrenia (a chronic severe mental health condition causing a disconnect with reality through hallucinations, delusions, and disordered thinking), added on 10/30/25. Review of the resident's quarterly Minimum Data Set (MDS - a federally mandated assessment completed by facility staff), dated 12/05/25, showed the following:-Cognitively impaired;-Utilizes wheelchair for mobility;-Incontinent of bowel and bladder. Review of the resident's care plan, dated 12/17/25, showed the following: -Requires a level two PASRR that is updated as needed;-Uses psychotropic medication, antianxiety, and anti-depressant medication; -Has periods of verbally aggressive behavior. Review of the resident's physician progress note, dated 9/7/25, showed no psychiatric evaluation or documentation to support a new diagnosis of schizophrenia.Review of the resident' physician progress note, dated 10/5/25, showed no psychiatric evaluation or documentation to support a new diagnosis of schizophrenia.Review of the resident's nurse's notes documentation, from 9/21/25 to 10/21/25, showed no documentation by nursing staff of symptoms to support schizophrenia diagnosis. Review of a pharmacy recommendation fax to the physician, dated 10/30/25, showed the following: -The facility requested the physician choose a diagnosis of Huntington's disease (an inherited disorder that causes the progressive breakdown of nerve cells in the brain), schizophrenia, or Turret's syndrome (a nervous system disorder characterized by involuntary, repetitive movements and sounds known as tics) as the indication for resident use of Seroquel (an antipsychotic medication); -The facility indicated the resident is currently on Seroquel but for another diagnosis and would like the physician to use a preferred diagnosis or change the medication order;-The physician response section indicated the physician chose a diagnosis of schizophrenia; the section was not signed. Review of the resident's physician progress note, dated 11/2/25, showed no psychiatric evaluation or documentation to support a new diagnosis of schizophrenia. Review of the resident's nurse's notes documentation, from 10/21/25 to 11/21/25, showed no documentation of symptoms to support a schizophrenia diagnosis and no documentation of the added diagnosis of schizophrenia. Review of the resident's current active physician orders summary showed an order for Quetiapine (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Fumarate Oral Tablet 50 MG (Seroquel), give one tablet by mouth at bedtime related to schizophrenia. During an interview on 1/22/2025 at 11:35 A.M., Registered Nurse (RN) A said the following:-Nursing staff document on resident symptoms and behaviors in the nurses notes every shift;-Any change in behavior or symptoms are reported to the Director of nursing (DON) or Assistant director of nursing (ADON);-The MDS coordinator handles all PASRR issues. During an interview on 1/22/2025 at 11:55 A.M., Licensed Practical Nurse (LPN) E said the following:-Nursing staff chart in the nurses' notes behaviors, symptoms, and changes in condition for every resident, every shift;-PASRR level one and level two for mental health disorders is monitored by the MDS coordinator. During an interview on 1/22/2025 at 1:27 P.M., the ADON said PASRR level one and level two recommendations and mental health diagnosis is handled by the MDS coordinator. During an interview on 1/22/2025 at 1:35 P.M., the MDS coordinator said the following:-He/she ensures a PASRR screen is completed on all residents admitted to the facility;-He/she reviews all diagnoses that would trigger a level two assessment for a resident;-He/she does not know if a new diagnosis for schizophrenia would trigger a review of a previous level two assessment on its own, but it could;-The physician can add new diagnoses based on pharmacy recommendations;-He/she believes Resident #4's diagnosis of schizophrenia was based on a pharmacy recommendation;-He/she would contact the central office medical review unit (COMRU) if a significant change had happened with a resident that triggers a level two screening. During an interview on 1/22/2026 at 3:40 P.M., the resident's physician said the following:-He/she is very familiar with the resident and has been treating the resident for over two years;-Seroquel is necessary for the management of the resident's mood and behavior and he/she does not want any changes made to the resident's current medication as it is clinically contraindicated;-He/she did not recall the added diagnosis of schizophrenia by the facility but would not argue with it as the resident has many schizophrenia-like symptoms. During an interview on 1/22/26 at 2:05 P.M., and on 1/23/26 at 11:54 P.M., the DON said the following:-The facility does not have an in-house psychiatrist team, but they do utilize outpatient services when needed;-All residents with concerns related to psychiatric medication are discussed by the interdisciplinary team;-Resident #4 has schizophrenic tendencies; -Behaviors and symptoms are charted in the nurses' notes; charting is done by exception;-He/she reviews pharmacy recommendations and gives those to the physician for approval; -Documentation of a new mental health diagnosis should include a rationale, physician notification, and documentation of behaviors and symptoms. During an interview on 1/23/2026 at 11:54 A.M., the Administrator said he/she expects staff to document on residents with a new mental health diagnosis.

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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 observation, interview, and record review, the facility failed to provide dialysis (the cleaning of the blood with a machine due to the kidneys not working) services per professional standards of practice when the facility failed to obtain an order for dialysis and routine assessment and monitoring of the dialysis site for one resident who received dialysis (Resident #60). The facility census was 57. The facility did not provide a policy related to dialysis. Review of the facility's undated form titled Dialysis Communication Record, showed the following:-Vital Signs: blood pressure, pulse, respiration, temperature, weight;-Vital signs completed prior to dialysis as ordered by physician, Yes or No;-Shunt site (a surgically created connection between an artery and a vein);-Nurse Signature;-Time left for dialysis. Review of Resident #60's face sheet (brief information sheet about the resident) showed the following:-admission date: 01/15/26;-Diagnoses included end stage renal disease (ESRD, a condition in which the kidneys lose the ability to remove waste and balance fluids), dependence on renal dialysis. Review of the resident's admission Minimum Data Set (MDS) a federally mandated assessment tool completed by facility staff, dated 01/15/26, showed the resident admitted to facility. Review of the resident's medical record, showed the following:-On 01/15/26, at 2:10 P.M., progress note admission summary: Resident arrived by private car and ambulated to room on own. Resident up per self with no assistance, shuffle gait. Resident legally blind, full code. Attended Dialysis Clinic on Monday, Wednesday, and Friday at 5:15 A.M. Resident on regular diet, no complaints of pain. No swelling in extremities. Lung sounds clear, bowel sounds active. No concerns voiced or observed at this time. Resident pleasant during assessment. Resident takes medication whole. The resident would like to adhere to renal diet even though we do not offer special diets;-Dialysis communication forms dated 01/16/26 and 01/19/26 were scanned into the medical record. Review of the resident's baseline care plan, dated 01/19/26, showed the following:-Resident on dialysis Monday, Wednesday, Friday;-Resident can communicate easily with staff;-Resident required supervision or touching assistance with toileting hygiene, dressing, personal hygiene, transfers;-Resident required partial to moderate assistance with showering;-Resident used a walker;-Resident was cognitively intact. Review of the resident's 48-hour care plan, used in conjunction with the Initial Care Plan and completed within 48 hours of admission, dated 01/20/26, showed the following:-Admitting diagnosis of renal disease;-Participation in treatment for long term care placement. Review of resident's comprehensive care plan, dated 01/20/26, showed the following:-Resident needed hemodialysis (dialysis) related to renal failure every Monday, Wednesday and Friday;-Resident will have no signs or symptoms of complications from hemodialysis through the review date;-Staff should not draw blood or take blood pressure in arm with graft (shunt site);-Staff should encourage resident to go for the scheduled dialysis appointments;-Staff should monitor labs and report to doctor as needed;-Staff should monitor, document, report as needed for signs and symptoms of renal insufficiency: changes in level of consciousness, changes in skin turgor, oral mucosa, changes in heart and lung sounds;-No information in care plan related to time of dialysis or which arm was affected. Review of the resident's physician order sheet, current as of 01/20/26, showed staff did not document an order for dialysis and did not have an order regarding assessment of the resident's dialysis site. Observation and interview on 01/19/26 at 3:30 P.M., showed the resident was in his/her room. The resident said he/she left the facility at about 5:00 A.M. for dialysis and did not receive breakfast until after returning from dialysis. During an interview on 01/22/26 at 9:18 A.M., the Regional Nurse Consultant said there was not a specific policy related to dialysis. During an interview on 01/22/26 at 12:10 P.M., Registered Nurse A said any resident that was on dialysis should have an order for when and where the resident went for dialysis. The resident had a new order for checking the bruit (audible, rushing, or whooshing sound heard through a stethoscope over an artery) and thrill (palpable, physical vibration felt on the skin directly over a site of severe turbulent blood flow, such as a fistula (shunt) but did not know if there was an order for when and where the resident went for dialysis. The resident went (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	super early so staff held a breakfast tray for the resident. During an interview on 01/22/26 at 1:25 P.M., Licensed Practical Nurse (LPN) B said there should have been an order for residents that were on dialysis. They had not had a dialysis resident for a while. There was a newer resident who was now on dialysis. LPN B did not know if there was an order or information in the care plan. During an interview on 01/22/26 at 1:45 P.M., the Assistant Director of Nursing said there should have been an order for dialysis. He/She said the order should include to check the shunt site for dialysis. He/She did not know if the resident had an order for dialysis. During an interview on 01/22/26 at 2:00 P.M., the Director of Nursing said there probably should have been an order for dialysis. The facility received the dialysis information from the resident's guardian on admission. During an interview on 01/23/26, at 12:15 P.M., the Administrator said residents who received dialysis should have physician orders. The information should also be on the care plan.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, interview, and record review, the facility failed to establish and maintain a complete infection control program when staff failed to use Enhanced Barrier Precautions (EBP, an infection control intervention designed to reduce transmission of multidrug-resistant organisms (MDRO, microorganism that has developed resistance to one or more classes of antibiotics, making infections caused by it more difficult to treat) in nursing homes) during personal cares for a resident who had a catheter (thin tube that remains in the bladder for continuous urine drainage, often held in place by a small balloon and connected to a collection bag) and failed to complete proper hand hygiene during personal cares for one resident (Resident #9). The census was 57.Review of the facility provided policy titled Enhanced Barrier Precautions, dated March 2024, showed the following:-Enhanced Barrier Precautions (EBP) refers to an infection control intervention designed to reduce the transmission of multi-drug-resistant organisms that employs targeted gown and glove use during high contact resident care;-All staff receive training on EBP upon hire and annually and are expected to comply with all designated precautions;-EBP will be initiated for residents with wounds, indwelling or implanted medical devices (urinary catheters);-High contact resident activities include dressing, bathing, transferring, providing hygiene, changing liens, changing briefs or assisting with toileting. Review of the facility provided policy titled Nursing Services Policy and Procedure Manual for Long Term Care Infection Prevention and Control, dated March 2025, showed the following:-Standard precautions apply to the care of all residents in all situations regardless of suspected or confirmed presence of infectious diseases;-Hand hygiene refers to washing hands with soap (anti-microbial or non anti-microbial) or the use of alcohol-based hand rub (ABHR);-Hand hygiene is performed before and after contact with a resident, before preforming an aseptic (clean) task, before moving from work on a soiled body site to a clean body site on the same resident, after contact with the resident's room, and after removing gloves. Review of resident #9's face sheet (brief information sheet about the resident), showed the following: -admission date of 3/1/22;-Diagnosis of chronic kidney disease (gradual loss of kidney function), Alzheimer's disease, atherosclerotic heart disease (caused by buildup of plaque in the artery walls). Review of the resident's quarterly Minimum Data Set (MDS, a federally mandated assessment completed by facility staff), dated 10/21/25, showed the following: -Severely impaired cognitive skills;-Rarely is able to make self understood;-Dependent on staff for all care. Review of the resident's care plan dated 7/28/25, showed the resident was at risk for infection due to his/her catheter and staff should use enhanced barrier precautions.Review of the resident's physician orders dated 1/22/26, showed the resident had a current order for enhanced barrier precautions due to catheter. Observation of resident care on 1/22/26, at 10:35 A.M., showed the following:-Certified Nurse Aid (CNA) C and CNA D donned gloves (they were not observed washing hands but stated they did) and entered the resident's room, they did not don gowns;-CNA C closed the door while CNA D pulled the curtain to provide privacy for the resident;-CNA C removed the covers from the resident and both CNAs removed the resident's pants and incontinence brief;-The CNAs did not provide catheter care at that time. They assisted the resident to roll to his/her side and placed and new brief and Hoyer lift (mechanical lift) pad under the resident;-CNA C and D then fastened the new brief and pulled up the resident's pants;-CNA D grabbed the resident's catheter bag and placed it in the resident's lap while CNA C began fastening the Hoyer lift pad to the lift;-The resident was lifted over the bed and then placed in his/her wheelchair. The Hoyer lift straps where removed;-CNA D then picked up and placed the catheter bag in the dignity bag attached to the wheel chair;-CNA D picked up the resident's hairbrush and began brushing the resident's hair while CNA C gathered trash and made the resident's bed;-CNA D left the room with the resident and was not observed removing his/her gloves or washing his/her hands; -CNA C removed his/her gloves and washed his/her hands. During an interview on 1/22/26 at 10:45 A.M., CNA C said the following:-He/She was not sure what EBP stands for but he/she knew it meant to wear gowns (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and gloves;-He/She forgot to wear a gown while caring for the resident;-Hand washing should occur before and after touching a resident and every time gloves were changed. During an interview on 1/22/26 at 10:55 A.M., CNA D said the following:-EBP meant he/she needed to wear a gown and gloves while caring for the resident;-Residents with catheters and wounds were on EBP;-He/She forgot to wear a gown while caring for the resident;-He/she washed his/her hands before and after contact with a resident and when entering and exiting a room;-He/she washed his/her hands after taking the to the dining room because they were running late for lunch. During an interview on 1/22/26 at 11:35 A.M., Registered Nurse (RN) A said the following:-EBP was important for infection prevention in residents with indwelling devices and wounds;-Staff should wear a gown and gloves while caring for residents on EBP;-Staff should wash hands before and after any contact with a resident;-Staff should wash hands and change gloves after touching a catheter bag. During an interview on 1/22/26 at 11:55 A.M., Licensed Practical Nurse (LPN) E said the following:-EBP was for resident's with catheters and used along with contact precautions;-The Assistant Director of Nursing (ADON) was in charge of the infection control program, and did staff education on infection control; -Staff should follow EBP;-Staff should wash their hands before and after contact with a resident and during care when going from a dirty to clean area. During an interview on 1/22/26 at 1:27 P.M., the ADON said the following:-EBP was important for infection control and prevention;-He/She expected all staff to wear a gown and gloves while caring for residents on EBP;-Residents on EBP had signs on their doors that instructed staff to wear gowns;-He/She expected all staff to wash hands before and after contact with residents and when going from clean to dirty areas on a resident. Durin an interview on 1/22/26 at 2:05 P.M., the Director of Nursing (DON) said the following:-EBP was for any resident with indwelling devices such as a catheter;-EBP was important to protect compromised residents and prevent infection;-EBP included gowns and gloves;-He/She expected staff to change gloves and hand wash before and after resident contact and when going from clean to dirty while working with a resident. During an interview on 1/23/26 at 12:07 P.M., the Administrator said the following:-He/She expected staff to follow all EBP precautions;-He/She expected staff to wash their hands while caring for residents. -