STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265348	A. Building B. Wing	02/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Camelot Nursing and Rehabilitation Center	705 Grand Canyon Drive Farmington, MO 63640

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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure residents with orders for psychotropic (medication used to treat mental health conditions by affecting mood, behavior, thoughts and perception) medications were informed about the medication before its use for two residents (Residents #5 and #12) out of five sampled residents. The facility's census was 74.Review of the facility's policy titled, Psychotropic Management, reviewed 07/26/23, showed:- A psychotropic drug is any drug that affects brain activities associated with mental health processes and behavior;- Upon admission, the Licensed Nurse will implement physician order for medication including an approved diagnosis or targeted behavior;- A Psychotropic Medication Consent from resident and/or resident's responsible party;- Complete psychoactive medication review on admission, quarterly, annually, and as needed;- Implement Standardized Behavior Tracking Monitoring Tool. 1. Review of Resident #5's medical record showed:- admitted on [DATE];- Diagnoses of anxiety and depression;Physician's Order Sheet (POS), dated, 02/25/26, showed an order for buspirone (an anti-anxiety medication) five milligrams (mg), one tablet by mouth three times daily for anxiety, dated 09/22/25;- No documentation the resident and/or the representative was informed of risks and benefits of buspirone. 2. Review of Resident #12's medical record showed:- admitted on [DATE];- Diagnosis of bipolar disorder (a mental health condition that causes extreme mood swings);POS, dated 02/25/26, showed:- An order for buspirone, five mg, one tablet by mouth every 12 hours for anxiety, dated 10/09/25;- An order for quetiapine (a drug that affects the brain activities associated with mental processes and behavior), 300 mg by mouth at bedtime for bipolar and depression, dated 12/30/25;- An order for sertraline (an antidepressant), 50 mg by mouth once a day for bipolar and depression, dated 10/09/25;- No documentation the resident or the representative was informed of risks and benefits of buspirone, sertraline, or quetiapine.During an interview on 02/25/26 at 4:30 P.M., the Administrator, Regional Nurse Consultant, Regional Director of Operations, and the Traveling Director of Nursing said they would expect residents and/or residents' representatives to be informed in advance of risks and benefits of proposed care, treatments, treatment alternatives and be able to choose a different option if preferred.

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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	265348	A. Building B. Wing	02/25/2026

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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 0571 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Limit the charges against residents' personal funds for items or services for which payment is made under Medicare or Medicaid. Based on interview and record review, the facility failed to inform of and provide a free basic haircut for two residents (Residents #14 and #75) out of four sampled Medicaid residents. This had the potential to affect all Medicaid residents. The facility's census was 74. Review of the Missouri Department of Social Services, MO Health Net Division State Regulations for Medicaid Reimbursement for Long Term Care Facilities, showed:- 13 CSR 70-10.010 (5) Covered Supplies, Items and Services. All supplies, items and services covered in the per-diem rate must be provided to the resident as necessary. Supplies and services which would otherwise be covered in a per diem rate, but which also are billable to the Title XVIII Medicare program must be billed to that program for facilities participating in the Title XVIII Medicare program. Covered supplies, items and services include, but are not limited to, the following:(K) All routine care items, including disposables and including, but not limited to, those items specified in Appendix A to this rule;- Appendix A showed the following items covered under the per diem rate for Medicaid residents:- Hair Care, Basic (including washing, cuts, sets, brushes, combs, non-legend shampoo).Review of the Appendix A in the facility's admission Packet, provided to all new residents and resident representatives, showed:- The items and services listed below are not included in the basic daily rate, and are not covered by the Medicare and Medicaid/Managed Medicaid Programs: Hairdresser, Barber;- The form did not include information regarding a free basic haircut available to residents who received Medicaid funding.Review of the price list of services posted on the door of the facility's salon showed:Beard trim $5;Hair cut $15;Hair style $15;Perm $35;All over color $35;Highlights $45;The salon price list did not include information regarding a free basic haircut available to residents who received Medicaid funding.1. Review of the facility's Resident Trust Box Log showed:- On 04/26/25, Resident #14 was charged for a haircut.- On 04/26/25, Resident #75 was charged for a haircut.During an interview on 02/25/26 at 11:50 A.M., Resident #14 said no one told him/her that he/she could get a free basic haircut. He/She would really like that because it would save him/her $15.During an interview on 02/25/26 at 1:18 P.M., Resident #75 said no one told him/her about a basic haircut. That would be great because the residents didn't get much money each month and a haircut was $15. He/She thought he/she had gotten three of them. He/She would have liked to know if the facility offered a free haircut. During an interview on 02/25/26 at 9:59 A.M., the Business Office Manager said they did not provide free basic haircuts or trims, but the nursing assistants would shave and trim resident beards. During an interview on 02/25/26 at 10:54 A.M., the Administrator said if a resident couldn't afford a haircut, the facility would pay the beautician to provide a haircut for them. During an interview on 02/25/26 at 4:30 P.M., the Administrator, Director of Operations, Regional Nurse Consultant, and the Traveling Director of Nursing said that they would expect Medicaid residents to be informed the Medicaid per diem covered the expense of basic haircuts.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. Based on interview and record review, the facility failed to document an accurate Minimum Data Set (MDS - a federally mandated assessment completed by facility staff) for two residents (Residents #8 and #10) out of 18 sampled residents. The facility census was 74.The facility did not provide a policy regarding MDS coding for accuracy.Review of the Resident Assessment Instrument (RAI) Manual, dated October 2025, showed:- J1400: Code 1, yes: if the medical record includes physician documentation: 1) that the resident is terminally ill; or 2) the resident is receiving hospice services;- H0300: Code 9, not rated: if during the seven-day look-back period the resident had an indwelling bladder catheter (a flexible tube inserted into the bladder to continuously drain urine into an external bag) for the entire seven days.1. Review of Resident #8's medical record showed:- admission date of 06/22/22;- Diagnoses of dementia (a decline in mental ability severe enough to interfere with daily life), respiratory failure (a condition where there's not enough oxygen or too much carbon dioxide in the body), and pulmonary fibrosis (a chronic, progressive lung disease where the tissue deep within the lungs becomes scarred, thickened, and stiff);- Resident admitted to hospice on 07/07/25. Review of the resident's MDS assessments showed:- A significant change MDS assessment, dated 07/18/25, with Section J1400 (Does the resident have a condition or chronic disease that may result in a life expectancy of less than 6 months?) coded no;- A quarterly MDS assessment, dated 10/15/25, with Section J1400 (Does the resident have a condition or chronic disease that may result in a life expectancy of less than 6 months?) coded no.2. Review of Resident #10's medical record showed:- admission date of 12/11/25;- Diagnoses of chronic obstructive respiratory disease (COPD - lung and airway diseases that restrict breathing), respiratory failure, and obstructive and reflux uropathy (a blockage in the urinary tract preventing proper urine flow and causing backflow).Review of the resident's Physician's Order Sheet (POS), dated 02/24/26, showed:- An order for catheter care, dated 12/12/25;- An order to change the catheter bag every month and as needed starting on the 11th and ending on the 13th, dated 12/12/25 and discontinued 01/11/26;- An order to change the catheter bag every month and as needed every night shift starting on the 11th and ended on the 13th, dated 01/11/26 and discontinued 01/11/26;- An order to change the catheter bag every month and as needed every night shift every Sunday for catheter maintenance, dated 02/12/26;- An order to record the amount of output from the catheter every shift, dated 12/12/25.Review of the resident's significant change MDS assessment, dated 01/09/26, showed:- H0100A marked yes for indwelling catheter;- H0300 marked always incontinent. During an interview on 02/25/26 at 4:45 P.M., the MDS Coordinator said Section J1400 should be checked yes if someone is on hospice. Section H0300 should be marked not rated if the resident had the catheter for the seven-day lookback period. During an interview on 02/25/26 at 4:30 P.M., the Administrator and Traveling Director of Nursing said they would expect an MDS assessment for a resident on hospice to have section J1400 to be marked yes and they would expect H0300 to be marked not rated for a resident with a catheter.

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	265348	A. Building B. Wing	02/25/2026

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to follow physician's orders for three residents (Residents #6, #10, and #62) and failed to obtain orders for three residents (Residents #10, #15, and #62) out of 18 sampled residents. The facility's census was 74.Review of the facility's policy, Physician's Orders, reviewed 09/28/22, showed: - Physician orders shall be provided by licensed practitioners (Physicians, Nurse Practitioners, and Physician's Assistants) authorized to prescribe orders; - Orders must be recorded in the medical record by the licensed nurse authorized to transcribe such orders; - Physician orders must be documented clearly in the medical record; - Physician orders that are missing required components, are illegible or unclear must be clarified before implementation; - Physician Order Sheets (POS) will be maintained with current Physician orders as new orders are received. Discontinued orders will be marked discontinued with the date, and all new orders will be written in the appropriate area on the POS with the date the order was received; - Physician orders will be transcribed to the appropriate Administration Record; Medication Administration (MAR) or Treatment Administration Record (TAR); - Pharmacist monthly review of the physician's orders will be completed to assure appropriateness, accuracy, and completeness. 1. Review of Resident #6's medical record showed: - admission date of 03/03/25; - Diagnosis of neuromuscular dysfunction of bladder (bladder does not work properly because of a nerve or muscle problem). Review of the resident's POS, dated 02/25/26, showed an order to record the amount of output from the catheter (a flexible, hollow tube inserted into the bladder to drain urine) every shift, monitoring for signs and symptoms of infection every shift for urine output, start date 03/03/25. Review of the resident's TAR, dated January 2026, showed: - Eight opportunities missed out of 31 opportunities for day shift on 01/06/26, 01/08/26, 01/13/26, 01/15/26, 01/22/26, 01/23/26, 01/27/26, and 01/30/26; - 13 opportunities missed out of 31 opportunities for night shift on 01/02/26, 01/03/26, 01/04/26, 01/12/26, 01/15/26, 01/16/26, 01/17/26, 01/21/26, 01/22/26, 01/25/26, 01/26/26, 01/28/26, and 01/30/26. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the resident's TAR, dated 02/01/26 through 02/23/26, showed: - Four opportunities missed out of 23 opportunities for day shift on 02/08/26, 02/15/26, 02/19/26, and 02/21/26; - Nine opportunities missed out of 23 opportunities for night shift on 02/01/26, 02/02/26, 02/05/26, 02/09/26, 02/12/26, 02/13/26, 02/14/26, 02/20/26, and 02/23/26. 2. Review of Resident #10's medical record showed: - admission date of 12/11/25; - Diagnosis of obstructive and reflux uropathy (a blockage in the urinary tract preventing proper urine flow and causing backflow). Review of the resident's POS, dated 02/24/26, showed: - An order for catheter care, dated 12/12/25; - An order to change the catheter bag every month and as needed starting on the 11th and ending on the 13th, dated 12/12/25 and discontinued 01/11/26; - An order to change the catheter bag every month and as needed every night shift starting on the 11th and ended on the 13th, dated 01/11/26 and discontinued 01/11/26; - An order to change the catheter bag every month and as needed every night shift every Sunday for catheter maintenance, dated 02/12/26; - An order to record the amount of output from the catheter every shift, dated 12/12/25; - No orders for the catheter, type and size, or when to flush or change the catheter. Observation on 02/23/26 at 9:23 A.M. showed the resident lay in bed with a Foley (a type of catheter) catheter drainage bag in a privacy bag. Review of the resident's TAR, dated December 2025, showed: - Five opportunities missed out of 31 opportunities for day shift on 12/14/25, 12/17/25, 12/20/25, 12/24/25, and 12/30/25; - Eight opportunities missed out of 31 opportunities for night shift on 12/14/25, 12/17/25, 12/18/25, 12/23/25, 12/24/25, 12/26/25, 12/27/25, and 12/28/25. Review of the resident's TAR, dated January 2026, showed: - One opportunity missed out of 31 opportunities for day shift on 01/12/26; - Seven opportunities missed out of 31 opportunities for night shift on 01/01/26, 01/04/26, 01/07/26, 01/08/26, 01/11/26, 01/24/26, and 01/31/26. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the resident's TAR, dated 02/01/26 through 02/24/26, showed: - One opportunity missed out of 24 opportunities for day shift on 02/03/26; - Four opportunities missed out of 24 opportunities for night shift on 02/01/26, 02/06/26, 02/07/26, and 02/08/26. 3. Review of Resident #15's medical record showed: - admission date of 01/31/26; - Diagnosis of dependency on renal dialysis (process of purifying the blood of a person whose kidneys aren't working normally), end stage renal disease (ESRD - irreversible loss of kidney function, where the kidneys can no longer support life), bladder-neck obstruction (a blockage at the base of the bladder where it connects to the urethra (tube that carries urine from the bladder to the outside of the body) and prevents it from opening properly during urination). Review of the resident's POS, dated 02/24/26, showed: - An order to change the catheter bag monthly, dated 01/31/26; - An order to obtain catheter output each shift, dated 01/31/26; - No orders for the catheter, type and size, catheter care, or when to flush or change the catheter. 4. Review of Resident #62's medical record showed: - An admission date of 12/05/24; - Diagnoses of atrial fibrillation (an irregular heart rhythm that begins in your heart's upper chambers), septic arterial embolism (a vascular obstruction caused by an infected clot originating from a distant infection), and muscle wasting and atrophy (the loss or thinning of muscle tissue). Review of the resident's POS, dated 02/23/26, showed: - An order to obtain daily weights, start date 01/21/26; - An order for daily weights, dated 02/11/26; - An order to refer for a peripherally inserted central catheter (PICC line - a long, thin tube that's inserted through a vein in the arm) placement, dated 02/03/26; - An order for normal saline 75 milliliters (ml) per hour for one liter one time for dehydration, dated 02/03/26; - An order for ceftriaxone solution (antibiotic) two grams (gm) intravenously (IV - the delivery of fluids, medication, or blood directly into a vein) every 24 hours, dated 02/04/26; - An order for vancomycin (antibiotic) 1000 milligrams (mg) intravenously two times a day for septic (continued on next page)

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	265348	A. Building B. Wing	02/25/2026

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	splenic emboli (infected clot) for four weeks, dated 02/03/26 and ending on 03/03/26; - An order for vancomycin 750 mg intravenously two times a day for septic splenic emboli for four weeks, dated 02/09/26 and ending on 03/09/26; - No order for IV or IV flushes; - No order for PICC line, dressing changes, or flushes. Review of the resident's weights, dated 01/20/26 through 02/23/26, showed: - Daily weights not obtained on 01/22/26, 01/23/26, 01/24/26, 01/25/26, 01/29/26, 02/01/26, 02/02/26, 02/03/26, 02/04/26, 02/05/26, 02/06/26, 02/07/26, 02/08/26, 02/09/26, 02/11/26, 02/12/26, 02/13/26, 02/17/26, 02/18/26, 02/20/26, 02/21/26, 02/22/26, and 02/23/26; - 23 missed opportunities out of 35 opportunities to obtain the resident's daily weight. Review of the resident's progress notes, dated 02/04/26 through 02/23/26, showed: - On 02/04/26 at 3:44 A.M., resident had a PICC line placed on 02/04/26. Had IV line in right upper arm, flushed with normal saline (NS) and heparin with no resistance noted; - On 02/04/26 at 2:21 P.M., nurse discontinued resident's peripheral catheter on the resident's right forearm per nurse practitioner order; - On 02/06/26 at 4:51 A.M., resident continued antibiotics vancomycin and ceftriaxone for splenic septic emboli. PICC line dressing intact and flushed easily; - On 02/07/26 at 4:52 A.M., had single lumen (tube) PICC line, dressing dry and intact to right upper arm, with no redness or drainage noted. Flushed before and after infusion; - On 02/08/26 at 4:06 A.M., had single lumen PICC line, dressing dry and intact to right upper arm, with no redness or drainage noted. Flushed before and after infusion; - On 02/09/26 at 3:34 A.M., had single lumen PICC line, dressing dry and intact to right upper arm, with no redness or drainage noted. Flushed before and after infusion; - On 02/17/26 at 1:55 A.M., had single lumen PICC line, dressing dry and intact to right upper arm, with no redness or drainage noted. Flushed before and after infusion; - On 02/18/26 at 4:01 A.M., had single lumen PICC line, dressing dry and intact to right upper arm, with no redness or drainage noted. Flushed before and after infusion; - On 02/21/26 at 2:17 A.M., evening dose of vancomycin was administered via single lumen PICC line, dressing dry and intact with no redness or drainage noted. No adverse reaction noted. Flushed before and after infusion; - On 02/22/26 at 3:06 A.M., evening dose of vancomycin was administered via single lumen PICC line, dressing dry and intact with no redness or drainage noted. No adverse reaction noted. Flushed before (continued on next page)

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	265348	A. Building B. Wing	02/25/2026

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and after infusion; - On 02/23/26 at 1:22 A.M., evening dose of vancomycin was administered via single lumen PICC line, dressing dry and intact with no redness or drainage noted. No adverse reaction noted. Flushed before and after infusion. Observations of the resident showed: - On 02/23/26 at 1:02 P.M., the resident with a single lumen PICC line to the right arm with a clear dressing dated 02/13/26; - On 02/24/26 at 11:50 A.M., the resident with a PICC line to the right arm with a clear dressing dated 02/23/26. During an interview on 02/23/26 at 2:05 P.M., Registered Nurse (RN) C and Licensed Practical Nurse (LPN) D said the resident went out to the hospital in December and had his/her gallbladder removed on 12/31/25 and came back to the facility on [DATE]. The resident had the IV from the hospital. He/She only had a PICC line put in while here, not an IV. The resident got a peripheral IV from the hospital because of contrast from a procedure he/she had, then he/she got a liter of fluids here at the facility. Then we discontinued the peripheral IV. Just a few days later, they sent him/her for PICC line placement. During an interview on 02/25/26 at 2:36 P.M., LPN B said residents that had Foley catheters should have a flush order, the size of the catheter, how often to change the catheter, and an order to change the catheter as needed (PRN) and a diagnosis. Catheter care should be documented in the electronic medication administration record (eMAR) under the nurse MAR, and both Certified Nurse Aides (CNAs) and nurses did catheter care. Daily weights were documented by the nurse or restorative aide and were located on the TAR. During an interview on 02/25/26 at 4:10 P.M., RN C said there should be orders for the PICC line, and for flushes, dressing changes, and medication administration. He/She put an order in when he/she changed the dressing, but he/she said staff had been changing the dressing without an order. During an interview on 02/25/26 at 4:30 P.M., the Administrator, Director of Operations, Regional Nurse Consultant, and the Traveling Director of Nursing said they would expect physician orders to be followed. They would expect orders to be in the chart for a catheter, when to change, the size of the balloon, intake and output, and catheter care. They would also expect catheter care to be reflected on the TAR. They would expect a PICC line to have orders, including dressing changes and flushes, and they would expect daily weights to be documented in the resident's chart if they were ordered for daily weights.

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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 maintain proper infection control practices to prevent the development and transmission of infections when staff did not utilize appropriate Personal Protective Equipment (PPE - equipment worn to minimize exposure to hazards that cause serious workplace injuries and illnesses) and Enhanced Barrier Precautions (EBP - an infection control strategy used in nursing homes requiring staff to use gloves and gowns during high-contact activities). The facility also failed to properly handle potentially contaminated sharps, failed to sanitize a glucometer (a small, portable device used to measure the sugar level in blood) per manufacturer's directions, and failed to perform hand hygiene during medication administration and at appropriate times during resident care. This affected three residents (Resident #3, #34, and #62) out of 18 sampled residents and two residents (Resident #9 and #42) outside the sample. The facility census was 74.Review of the facility's policy titled, Enhanced Barrier Precautions, reviewed 05/15/24, showed: - The facility may expand the use of PPE and refer to the use of gowns and gloves during high-contact resident care activities that provides opportunities for transfer of multi-drug resistant organisms (MDROs) to hands and clothing; - The use of gowns and gloves for high-contact resident care activities is indicated when contact precautions do not otherwise apply, for facility residents with wounds or indwelling medical devices regardless of MRDO colonization; - Examples of high-contact resident care activities requiring gown and glove use for EBP include dressing, bathing/showering, transferring, providing hygiene, changing linens, changing briefs, wound care that requires a dressing or device care such as urinary catheters. Review of the facility's policy titled, Hand Hygiene policy, reviewed 04/28/22, showed: - Hand hygiene should be performed before and after providing care; - Before and after performing an aseptic (practices such as hand hygiene, sterilization and barrier use, to prevent the transfer of harmful microorganisms) task; - Contact with blood, body fluids, or contaminated surfaces; - Before and after applying/removing gloves; - After handling soiled linens/items; - Employees may use an alcohol-based hand rub when hands are not visibly soiled. Review of the facility's policy titled, Catheter Care, reviewed 07/13/22, showed: - Gather supplies; - Identify resident and explain procedure; - Provide privacy; (continued on next page)

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	265348	A. Building B. Wing	02/25/2026

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Perform hand hygiene and apply gloves; - Avoid pulling on catheter during cleansing; - Remove gloves and perform hand hygiene; - Apply gloves and reposition resident's clothing/bedding; - Discard contaminated items in designated containers; - Remove gloves and perform hand hygiene. Review of the facility's policy titled, Medication Administration-Preparation and General Guidelines, revised August 2014, showed: - Hands are washed before putting on examination gloves and upon removal for administration of topical (on the skin), ophthalmic (in the eye), injectable, enteral (in the gastrointestinal tract), rectal, and vaginal medications. Review of the facility's policy titled, Blood Glucose Monitoring, undated, showed: - Blood glucose meters measure blood glucose (sugar) concentrations; - The Centers for Disease Control and Prevention (CDC) recommends that, whenever possible, blood glucose meters shouldn't be shared among patients. If a device must be shared, it should be cleaned and disinfected after every use, following the manufacturer's instructions to prevent carry over of blood and infectious agents. If the manufacturer doesn't specify how the device should be cleaned and disinfected, then it shouldn't be shared; - Implementation: verify the practitioner's orders, gather and prepare appropriate equipment, perform hand hygiene and put on gloves, confirm the patient's identity with at least two patient identifiers, provide privacy, explain the procedure, put on gloves, select puncture site, insert the test strip into the blood glucose meter, collect a sample from the fingertip, touch a drop of blood to the test strip, apply firm pressure to puncture site, discard the lancet in a puncture-resistant sharps container, remove the test strip and dispose of properly, remove and discard your gloves, and perform hand hygiene; clean and disinfect the blood glucose meter, following the manufacturer's instructions, perform hand hygiene, document and record, report critical test results to the practitioner. Review of Super Sani-Cloth Manufacturer's Guidelines for Use, on pdihc.com, showed: - Use a wipe to remove visible soil prior to disinfecting; - Unfold a clean wipe and thoroughly wet surface; - Allow treated surface to remain wet for two minutes, allow to air dry; - Do not reuse towelette. Dispose of used towelette in the trash. 1. Observation on 02/23/26 at 2:58 P.M., showed: (continued on next page)

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	265348	A. Building B. Wing	02/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Camelot Nursing and Rehabilitation Center	705 Grand Canyon Drive Farmington, MO 63640

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Resident #62 lay in bed and received a nebulizer (machine that converts liquid medication into a fine mist, allowing it to be inhaled into the lungs through a mouthpiece or mask) treatment; - Licensed Practical Nurse (LPN) D in the room with the resident without a gown or gloves; - Registered Nurse (RN) C entered the room without sanitizing or donning a gown or gloves, lay the supplies for antibiotic infusion on the resident's bedside table, knelt at the bedside, held the resident's right hand with his/her bare hand while obtaining a blood pressure reading, then held both of the resident's hands to warm them while attempting to obtain a pulse oximeter (device used to measure blood oxygen saturation) reading from the fingers on both hands; - The Nurse Practitioner (NP) entered the room without donning a gown or gloves, touched the resident's clothing and skin with both hands, and listened to the resident's lungs and heart; - The resident needed assistance with urination, so LPN D and the NP stepped out of the room, and RN C closed the resident's room door to assist the resident in private; - When the resident was finished, RN C opened the door, stepped out in the hall and sanitized his/her hands; - RN C reentered the room, did not don a gown or gloves, removed the pillowcases from the resident's three pillows, removed the urinal containing urine that hung on the side of the resident's trash can, and obtained the extra trash bag from the bottom of the trash can; - RN C, with bare hands, put the extra trash bag into the bag in use in the trash can along with the resident's three pillowcases and hooked the handle of the urinal containing urine back on the side of the trash can with his/her bare right hand and touched the resident's clothed right shoulder with his/her bare right hand while holding the trash bag in his/her left hand and exited the room; - RN C reentered the room, did not sanitize hands or don a gown or gloves, put three new pillowcases on the resident's pillows, touched the pillows and pillowcases to his/her clothing; - RN C touched the resident, obtained gloves from the supplies hanging on the resident's door, donned the gloves without sanitizing his/her hands, did not don a gown, and touched the resident's call light and bedside table with gloved hands; - The resident's roommate propelled him/herself in a wheelchair to the restroom and RN C touched the restroom doorknob, the roommate's wheelchair handles, and the restroom doorknob again; - RN C removed gloves, washed hands, donned clean gloves, touched the restroom doorknob and the roommate's wheelchair handles to back the roommate out of the restroom; - RN C removed gloves, washed hands, donned clean gloves, and did not don a gown; - RN C cleansed the port on the resident's peripherally inserted central catheter (PICC line – a long, thin, flexible tube inserted into a large upper arm vein and advanced toward the heart for long-term intravenous access) with an alcohol swab, flushed with 10 milliliters (ml) of normal saline, started antibiotic, threw trash away, and washed hands. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 02/25/26 at 4:00 P.M., RN C said none of the staff had gowns on when they were caring for Resident #62. They should wear a gown and gloves when a resident had a PICC line. He/She should wash/sanitize hands before and after care and in between glove changes. 2. Observation on 02/24/26 at 9:49 A.M., showed: - RN A obtained a medication from the medication room, crushed the medication in the pill pouch, and emptied the contents into a small cup; - RN A entered Resident #3's room, did not don a gown, and washed his/her hands; - RN A placed a syringe, graduated cylinder, and a cup on a paper towel barrier on top of the resident's night stand; - RN A donned gloves, opened the gastrostomy tube (g-tube - a tube that is surgically inserted through the wall of the abdomen directly into the stomach, and is used to deliver nutrition, fluids and medications) button, and checked placement by injecting air and listening with a stethoscope; - RN A administered medication to the resident via g-tube and flushed with water; - RN A closed the g-tube button, emptied the remaining water out of the cylinder, and lay the cylinder and syringe on the sink without a barrier; - RN A removed gloves and washed his/her hands. During an interview on 02/24/26 at 12:00 P.M., RN A said that he/she should wear a gown when administering medications to a resident with a g-tube. 3. Observations on 02/24/26 from 11:30 A.M. to 12:12 P.M., showed: - At 11:30 A.M., RN A gathered a glucometer, lancet, test strip, and alcohol wipe from the nurse cart and lay the supplies on top of his/her computer on top of the nurse cart without a barrier; - RN A entered Resident #9's room with the supplies and placed them on a paper towel barrier; - RN A washed his/her hands, donned gloves, and obtained the fingerstick blood glucose reading; - RN A removed gloves, carried the used lancet in his/her bare hand to the nurse cart, and placed in the sharps container; - RN A wiped the glucometer with a purple top Sani Cloth wipe and did not wrap the glucometer to properly sanitize; - At 11:39 A.M., RN A gathered the same glucometer, lancet, test strip and alcohol wipe from the nurse cart and lay the supplies on top of the nurse cart without a barrier; - RN A entered Resident #42's room with the supplies and placed them on a paper towel barrier; - RN A washed hands, donned gloves, and obtained the fingerstick blood glucose reading; (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- RN A removed gloves, carried the used lancet in his/her bare hand to the nurse cart, and placed in the sharps container; - RN A wiped the glucometer with a purple top Sani Cloth wipe and did not wrap the glucometer to properly sanitize; - At 12:12 P.M., RN A entered Resident #62's room, did not sanitize or wash hands, donned gloves, and placed a sublingual (under the tongue) medication into the resident's mouth; - RN A removed gloves and washed hands. During an interview on 02/24/26 at 12:15 P.M., RN A said he/she should wear gloves when touching used lancets. He/She just wiped the glucometer off with a Sani-wipe to sanitize it. 4. Observation on 02/24/26 at 1:47 P.M. of Resident #34's suprapubic catheter (a thin, flexible tube inserted through a small incision in lower abdomen, directly into the bladder to drain urine) care showed: - LPN B entered the resident's room, washed hands, donned gloves, and did not don a gown; - LPN B adjusted the resident's wheelchair and foot pedals, moved the bed over, and pulled the curtain; - With the same gloves, LPN B pulled the resident's pants away from the catheter site, and touched the tubing as the resident sat in the wheelchair; - LPN B removed gloves, sanitized hands, donned clean gloves, and flushed the catheter with sterile water; - LPN B soaked gauze in cleanser, cleaned around the catheter site, secured tubing to a leg clamp, removed gloves, sanitized hands, donned clean gloves, cleaned around the catheter tubing and down a few inches, applied a split gauze around the catheter site, removed gloves, and did not sanitize hands; - LPN B donned clean gloves, placed trash in the trash can, adjusted the bed and wheelchair foot pedals, removed gloves and did not perform hand hygiene before leaving the room; - LPN B took the trash bag of soiled towels to the soiled utility and washed hands. During an interview on 02/24/26 at 2:10 P.M., LPN B said he/she forgot to put on a gown and it had just slipped his/her mind. A gown should have been worn because the resident had a catheter. He/She should have sanitized and changed gloves after touching objects in the room and before touching the catheter site. 5. Observation on 02/24/26 at 3:30 P.M., showed: - RN A entered Resident 62's room with antibiotic infusion supplies, obtained gloves, and set the gloves and supplies on the counter by the sink as he/she washed his/her hands; - RN A picked up the gloves and supplies from the counter, sat them on the resident's bedside table, (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and exited the room to get flushes from the medication cart; - RN A reentered the room, set the flushes on the bedside table with the other supplies, did not perform hand hygiene and donned gloves; - RN A swabbed the port with an alcohol swab, hooked up the antibiotic infusion, removed his/her gloves, and washed hands. During an interview on 02/24/26 at 3:39 P.M., RN A said he/she forgot to wear a gown. Staff should wear a gown with anyone with tubes and open areas. He/She normally washed his/her hands before and after, but he/she should have washed his/her hands after getting supplies from the cart and before putting on new gloves. During an interview on 02/25/26 at 4:30 P.M., the Administrator, Regional Director of Operations, Regional Nurse Consultant, and the Traveling Director of Nursing said they would expect staff to wear the proper PPE for EBP, which was gowns and gloves, when dealing with direct care of residents with wounds, catheters, and indwelling intravenous catheters. Staff should perform hand hygiene before donning gloves, before resident care, when going from dirty to clean care, and after care. They would expect staff to wear gloves when handling used lancets and that glucometers should be sanitized per manufacturer's recommendations.