STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265362	A. Building B. Wing	02/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Meadow View Health & Rehabilitation	2203 East Mechanic Street Harrisonville, MO 64701

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility failed to retain operable thermometers in all refrigerators and/or freezers to confirm adequate temperature ranges; failed to ensure utensils, beverage dispensers, and food preparation items/equipment were kept in a sanitary condition; failed to maintain plastic and/or rubber cutting boards, plate covers, room trays, and utensils in good condition to avoid food safety hazards (cross-contamination); failed to separate damaged foodstuffs, in accordance with State of Missouri rules and regulations, established national guidelines, and professional standards for food service safety. These deficient practices had the potential to affect all residents, visitors, volunteers, and staff who ate food from the kitchen. The facility's census was 87 residents with a licensed capacity for 120 residents at the time of the survey. Review of the 1999 and 2009 Food and Drug Administration (FDA) Food Code and Missouri Food Codes, showed:-Chapter 4-101.11: Materials that are used in the construction of utensils and food-contact surfaces of equipment may not allow the migration of deleterious substances or impart colors, odors, or tastes to food and under normal use conditions shall be: (A) Safe; (B) Durable, corrosion-resistant, and nonabsorbent; (C) Sufficient in weight and thickness to withstand repeated wear washing; (D) Finished to have a smooth, easily cleanable surface; and (E) Resistant to pitting, chipping, crazing, scratching, scoring, distortion, and decomposition.-Chapter 4-501.12, Surfaces such as cutting blocks and boards that are subject to scratching and scoring shall be resurfaced if they can no longer be effectively cleaned and sanitized or discarded if they are not capable of being resurfaced. Surfaces such as cutting blocks and boards that are subject to scratching and scoring shall be resurfaced if they can no longer be effectively cleaned and sanitized or discarded if they are not capable of being resurfaced.Review of facility policy Food Safety-Director of Food and Nutrition Services' Responsibilities dated 2021 showed:-The director of food and nutrition services would have assured:--Sanitary conditions would be maintained in the food storage, preparation and serving areas.--The director of food and nutrition services or designee would conduct regular inspections to assure proper food handling. -Followed all federal, state, and local requirements.1. Observation on 2/17/26 at 10:59 A.M. and 11:30 A.M., during a kitchen sanitation inspection showed the following:-Refrigeration units A, B, and C had no thermometers inside each unit to verify the temperature reading inside the unit with the thermometers on the outside of the unit that ensured the food inside was being kept at safe temperature for the storage of food. -The red, white, and green cutting boards on a bottom shelf of a shelving unit at the north wall were heavily scored.-There was a 6 pound (lb.) 14 ounce (oz.) can of garbanzo beans dented on the bottom rim and on the other side just above the bottom rim on a large can dispenser rack in the Dry Storage (DS) room.-There was a 50 oz. can of Cream of Mushroom soup that was dented on one side just above the bottom rim on the same dispenser rack in the DS room.-There was a 48 oz can of Chicken and Dumplings that was dented on one side just above its rim on the same dispenser rack in the DS room. -The manual can opener across from the 3-sink area had excessive greasy build-up of unknown debris and paper.During an interview on 2/17/2026 at 11:04 A.M., the [NAME] said:-Temperatures were checked by reading the thermometer on the outside of the refrigeration units.-The staff did not verify temperatures with a (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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	thermometer that was inside the unit.Observation on 2/17/26 between 2:13 P.M. and 2:47 P.M. during the kitchen sanitation inspection showed the following: -Refrigeration units A, B, and C had no thermometers inside each unit to verify the temperature reading inside the unit with the thermometers on the outside of the unit that ensured the food inside was being kept at safe temperature for the storage of food. -The red, white, and green cutting boards on a bottom shelf of a shelving unit at the north wall were heavily scored.-There was a 6 lb. 14 oz. can of garbanzo beans dented on the bottom rim and on the other side just above the bottom rim on a large can dispenser rack in the DS room.-There was a 50 oz. can of Cream of Mushroom soup that was dented on one side just above the bottom rim on the same dispenser rack in the DS room.-There was a 48 oz can of Chicken and Dumplings that was dented on one side just above its rim on the same dispenser rack in the DS room. -The manual can opener across from the 3-sink area had excessive greasy build-up of unknown debris and paper.During an interview on 2/19/26 at 12:46 P.M. the Dietary Manager said the following:-Damaged foodstuffs were to be separated out and returned to their food vendor for a credit or replacement.-The damaged cutting boards should have been replaced with new cutting boards. -Cutting boards should have been replaced when heavily scored. -Damaged food preparation items were to be discarded and replaced.-He/She would expect food to be free of foreign substances.-He/She expected the can opener to be cleaned in the dishwasher after each meal.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to establish and maintain a comprehensive infection prevention and control program designed to help prevent the development and transmission of Legionella (A [NAME] of pathogenic Gram-negative bacteria that includes the species L. pneumophila, causing legionellosis, all illnesses caused by Legionella, including a pneumonia-type illness called Legionnaires' disease and a mild flu-like illness called Pontiac fever) and/or other water-borne pathogens (a bacterium, virus, or other microorganism that can cause disease) that included specific assessments and contents, in accordance with State of Missouri rules and Centers for Disease Control (CDC) and Centers for Medicare and Medicaid Services (CMS) standards and guidelines. This deficient practice had the potential to affect all residents, visitors, volunteers, and staff who resided, visited, used, or worked in the facility, and the facility failed to ensure appropriate hand hygiene was completed during medication pass for four supplemental residents (Resident #30, #21, #45, and #76) out of seven supplemental residents. The facility census was 87 residents with a licensed capacity for 120 residents at the time of the survey. Review of the facility's water-borne pathogen prevention program paperwork from a contracted source, in a binder entitled Legionella - Water Tracking for the Facility, last dated 12/12/25 and provided by the Administrator, showed the following:-There were 10 numbered tabs, unlabeled and not referenced, and no table of contents page.-Tab #4 had nothing there.-Tab #7 had a PowerPoint that was missing the first 14 slides.-There was no facility-specific risk assessment that considered the American Society of Heating, Refrigerating, and Air Conditioning Engineers (ASHRAE) industry standard #188. -There was no completed CDC Legionella Environmental Assessment Form.-A facility-specific infection prevention program or plan to deal with outbreaks of Legionella and/or other waterborne pathogens was not included. Review of the facility's undated policy titled Handwashing/Hand Hygiene showed:-An alcohol-based hand rub containing at least 62 percent (%) alcohol; or, alternatively, soap and water for the following situations:--Before preparing and handling medications.--Before and after direct contact with residents.--After contact with resident's intact skin.--After removing gloves.-The use of gloves did not replace hand washing/hand hygiene.-Integration of glove use along with routine hand hygiene was recognized as the best practice for preventing healthcare-associated infections. 1. Observation on 2/17/26 between 2:13 P.M. and 2:47 P.M. during the initial Life Safety Code (LSC) kitchen inspection showed there was a sanitizing three-sink area, a chemical dish-washing machine, a hand-washing sink, and a steam table (also referred to as a hot food table, is specifically designed to hold food at steady, safe serving temperatures, and not designed to cook or warm foods from a raw state). Observation on 2/18/26 at 11:58 A.M. and 12:23 P.M. during a facility LSC walk-through inspection with the Director of Maintenance (DOM) and Corporate Maintenance Consultant (CMC) showed the following:-The city municipal water supply entered the facility through two separate main pipes in the basement fire sprinkler riser room (a dedicated space for fire protection equipment), one for their sprinkler system and the second for all other remaining water usage.-The building was equipped with a complete fire sprinkler system with sprinkler heads located throughout the facility.-Two public restrooms were located by the front reception office hall. -A medication room with sink was located behind each of the two separate main nurse's desks.-There were at least 55 resident rooms with private and/or shared bathrooms and sinks throughout the six resident hallways.-There were housekeeping closets with floor mop sinks or ceramic service sinks (mop/service sinks are used in (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	janitorial and maintenance areas to fill and empty mop buckets, clean mops, and dispose of dirty water), boilers, and hot/cold water piping throughout the facility.-There were two commercial clothes washers in the basement laundry area.-There were three Bathhouses with showers in the facility. -There was a Beauty Shop with a sink on the 100 Hall. During an interview on 2/23/26 at 10:02 A.M. the DOM said the following:-The program already existed when he/she was hired.-He/She added the monthly testing to it.-Empty rooms were also checked weekly and faucets ran for a while, though undocumented. During an interview on 2/23/26 at 10:43 A.M. the Administrator said he/she had been educated on Legionella prevention requirements administrator trainings, studying for exams, and by a preceptor that further educated them. 2. Review of Resident #30's admission Record showed he/she admitted to the facility with a diagnosis of Diabetes Mellitus (DM II- a complex disorder of carbohydrate, fat, and protein metabolism that is primarily a result of a deficiency or complete lack of insulin secretion in the pancreas or resistance to insulin). Review of the resident's Order Summary Report dated February 2026 showed:-An order for Voltaren Gel (a topical ointment used to treat pain) one %, apply to both hips topically two times a day.-An order for Cetirizine HCl (used to treat allergy symptoms) 10 milligrams (mg), give one tablet one time a day.-An order for Vitamin D3 (a supplement) Tablet 1000 unit, give three tablets by mouth one time a day.-An order for Celebrex (used to reduce pain, inflammation, swelling, and stiffness) oral capsule 200 mg, take one capsule by mouth one time a day.-An order for Gabapentin (used to treat nerve pain) oral capsule 300 mg, take one capsule by mouth two times a day.-An order for Lisinopril (used to treat high blood pressure) tablet 10 mg, take one tablet by mouth one time a day.-An order for Hydrocodone-Acetaminophen tablet 5-325 mg (used to treat moderate to severe pain), give one tablet by mouth three times a day. Observation on 2/19/26 at 9:42 A.M. of the resident's medication administration completed by Licensed Practical Nurse (LPN) B showed:-He/She did not wash or sanitize his/her hands before starting the task.-Once he/she finished the preparation of the medications, he/she put on gloves.-He/She picked up the resident's medication and walked into the resident's room.-He/She put the Voltaren Gel on the resident's hips and removed his/her gloves.-He/She gave the resident his/her oral medication without washing or sanitizing his/her hands.-He/She exited the resident's room without washing or sanitizing his/her hands. 3. Review of Resident #21's admission Record showed he/she admitted to the facility with a diagnosis of Huntington's Disease (a disorder that causes the progressive breakdown of nerve cells in the brain). Review of the resident's Order Summary Report dated February 2026 showed an order for Acetaminophen (Tylenol- a fever and pain reducer) Extra Strength tablet 500 mg, give one tablet by mouth every six hours as needed for pain. Observation on 2/19/26 at 9:58 A.M. of the resident's medication administration completed by LPN B showed:-He/She did not wash or sanitize his/her hands before starting the task.-He/She prepared the medication and handed it to the resident.-He/She did not wash or sanitize his/her hands after giving the medication to the resident. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	4. Review of Resident #45's admission Record showed he/she admitted to the facility with the following diagnoses:-Chronic Obstructive Pulmonary Disease (COPD- a disease process tat decreases the ability of the lungs to perform ventilation).-Parkinson's Disease (a chronic, progressive disorder that impairs movement and motor control) Review of the resident's Order Summary Report dated February 2026 showed:-An order for Aspirin (commonly used to treat pain or fever) 81 mg, give one tablet by mouth one time a day for heart health.-An order for Cranberry oral tablet (a supplement) 450 mg, give one tablet two times a day.-An order for Amiodarone Hydrochloride (HCl) (used to treat abnormal heart rhythms) oral tablet 100 mg, give one tablet by mouth one time a day.-An order for Carbidopa-Levodopa (used to treat Parkinson's Disease) oral tablet 25-100 mg, give one tablet by mouth three times a day.-An order for Clopidogrel Bisulfate (used to prevent blood clots) tablet, give one tablet one time a day.-An order for Levetiracetam (used to control seizures) oral tablet 750 mg, give one tablet by mouth three times a day.-An order for Metoprolol Succinate Extended Release (ER) (used to treat high blood pressure) 25 mg, give 0.5 tablet by mouth one time a day.-An order for Oxybutynin Chloride ER (primarily used to treat overactive bladder) oral tablet 15 mg, take one tablet by mouth one time a day.-An order for Sertraline (used to treat depression) oral Ttablet 50 mg, give one tablet by mouth one time a day.-An order for Lacosamide (used to treat seizure disorders) tablet 200 mg, give one tablet two times a day. Observation on 2/19/26 at 10:01 A.M. of the resident's medication administration completed by LPN B showed:-He/She did not wash or sanitize his/her hands before starting the task.-He/She prepared all the resident's medications except for the Metoprolol Succinate ER.-He/She walked into the resident's room without washing or sanitizing his/her hands.-He/She checked the resident's blood pressure.-He/She then walked out of the resident's room without washing or sanitizing his/her hands.-He/She went back to the medication cart and placed the resident's Metoprolol Succinate ER into the medication cup with the rest of the resident's medications without washing or sanitizing his/her hands.-He/She walked back into the resident's room without washing or sanitizing his/her hands.-He/She gave the resident his/her medications and walked out of the resident's room without washing or sanitizing his/her hands. During an interview on 2/19/26 at 10:05 A.M. LPN B said:-He/She would not have done anything differently.-When asked about hand hygiene, he/she realized that he/she had missed some opportunities for hand hygiene.-He/She would normally sanitize his/her hands during medication administration:--When entering and exiting resident rooms.--Before and after each resident.--After each separate route of medication. 5. Review of Resident #76's admission Record showed he/she admitted to the facility with a diagnosis of DM II. Review of the resident's Order Summary Report dated February 2026 showed:-An order for staff to check the resident's blood glucose (sugar) level as needed.-An order for Lyumjev Kwikpen Subcutaneuos Solution Pen Injector 100 unit/milliliter (ml), inject 18 units subcutaneously before meals and at bedtime for DM II. Observation on 2/20/26 at 11:14 A.M. of the resident's blood sugar check and insulin (a vial hormone produced by the pancreas that regulates blood sugar) administration completed by Registered Nurse (RN) A showed:-He/She had all the supplies prepared and had gloves on when entering the resident's room.-He/She held the supplies in his/her hands as he/she checked the resident's blood sugar level.-Once he/she completed checking the resident's blood sugar he/she set the glucometer (a (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	compact, portable medical device used to measure the amount of sugar in the blood) on the resident's bedside table.-He/She then dug around in his/her pocket with the same gloved hands.-He/She then administered the resident's insulin with the same gloved hands. During an interview on 2/20/26 at 2:02 P.M. RN A said:-He/She would not have done anything differently.-He/She usually wore gloves into resident rooms.-Hand hygiene needed to be completed before and after each resident during medication administration. 6. During an interview on 2/23/26 at 10:12 A.M. Certified Medication Technician (CMT) A said:-Hand hygiene needed to be performed before and after each resident during medication administration.-Hand hygiene needed to be performed in between different routes of medication administration.-Gloves should not be worn into resident rooms.-When gloves were worn into resident rooms, it caused cross contamination and the gloves were no longer clean.-LPN B did not perform hand hygiene appropriately during Resident #30's, Resident #21's, and Resident #45's medication administration.-LPN B should have washed or sanitized his/her hands before starting Resident #30's, Resident #21's, and Resident #45's medication administration.-LPN B should not have worn gloves into Resident #30's room.-LPN B should have washed or sanitized his/her hands after administering Resident #30's Voltaren Gel.-LPN B should have washed or sanitized his/her hands after exiting Resident #30's room.-LPN B should have washed or sanitized his/her hands after completing Resident #21's medication administration.-LPN B should have checked Resident #45's blood pressure first before preparing the medications, so that way he/she didn't have to re-enter and re-exit the room.-LPN B should have washed or sanitized his/her hands before entering Resident #45's room.-LPN B should have washed or sanitized his/her hands after exiting Resident #45's room.-RN A did not perform hand hygiene appropriately during Resident #76's blood sugar check and insulin administration.-RN A should not have worn gloves into Resident #76's room.-RN A should have removed his/her gloves, washed or sanitized his/her hands, and put on new gloves after completing Resident #76's blood sugar check.-RN A should not have continued to wear the same gloves after putting his/her gloved hands in his/her pocket. During an interview on 2/23/26 at 10:34 A.M. LPN C said:-Hand hygiene needed to be performed before and after each resident during medication administration.-Hand hygiene needed to be performed in between different routes of medication administration.-Gloves should not be worn into resident rooms.-When gloves were worn into resident rooms, it caused cross contamination and the gloves were no longer clean.-LPN B did not perform hand hygiene appropriately during Resident #30's, Resident #21's, and Resident #45's medication administration.-LPN B should have washed or sanitized his/her hands before starting Resident #30's, Resident #21's, and Resident #45's medication administration.-LPN B should not have worn gloves into Resident #30's room.-LPN B should have washed or sanitized his/her hands after administering Resident #30's Voltaren Gel.-LPN B should have washed or sanitized his/her hands after exiting Resident #30's room.-LPN B should have washed or sanitized his/her hands after completing Resident #21's medication administration.-LPN B should have checked Resident #45's blood pressure first before preparing the medications, so that way he/she didn't have to re-enter and re-exit the room.-LPN B should have washed or sanitized his/her hands before entering Resident #45's room.-LPN B should have washed or sanitized his/her hands after exiting Resident #45's room.-RN A did not perform hand hygiene appropriately during Resident #76's blood sugar check and insulin administration.-RN A should not have worn gloves into Resident #76's room.-RN A should have removed his/her gloves, washed or sanitized his/her hands, and put on new gloves after completing Resident #76's blood sugar check.-RN A should not have continued to wear the same gloves after putting his/her gloved hands in his/her pocket. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 2/23/26 at 12:39 P.M. the Director of Nursing (DON) said:-Hand hygiene needed to be performed before and after each resident during medication administration.-Hand hygiene needed to be performed in between different routes of medication administration.-Gloves should not be worn into resident rooms.-When gloves were worn into resident rooms, it caused cross contamination and the gloves were no longer clean.-LPN B did not perform hand hygiene appropriately during Resident #30's, Resident #21's, and Resident #45's medication administration.-LPN B should have washed or sanitized his/her hands before starting Resident #30's, Resident #21's, and Resident #45's medication administration.-LPN B should not have worn gloves into Resident #30's room.-LPN B should have washed or sanitized his/her hands after administering Resident #30's Voltaren Gel.-LPN B should have washed or sanitized his/her hands after exiting Resident #30's room.-LPN B should have washed or sanitized his/her hands after completing Resident #21's medication administration.-LPN B should have checked Resident #45's blood pressure first before preparing the medications, so that way he/she didn't have to re-enter and re-exit the room.-LPN B should have washed or sanitized his/her hands before entering Resident #45's room.-LPN B should have washed or sanitized his/her hands after exiting Resident #45's room.-RN A did not perform hand hygiene appropriately during Resident #76's blood sugar check and insulin administration.-RN A should not have worn gloves into Resident #76's room.-RN A should have removed his/her gloves, washed or sanitized his/her hands, and put on new gloves after completing Resident #76's blood sugar check.-RN A should not have continued to wear the same gloves after putting his/her gloved hands in his/her pocket.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview, and record review, the facility failed to ensure appropriate medication and medical equipment storage in two out of five medication carts and in one out of two medication storage rooms. The facility census was 87 residents. Review of the facility's undated policy titled Storage pf Medications showed:-Drugs and biologicals were stored in the packaging, containers or other dispensing systems in which they are received. -Only the issuing pharmacy was authorized to transfer medications between containers.-Drug containers that had missing, incomplete, improper, or incorrect labels were returned to the pharmacy for proper labeling before storage. -Discontinued, outdated, or deteriorated drugs or biologicals were returned to the dispensing pharmacy or destroyed.Review of the facility's undated policy titled Labeling of Medication Containers showed:-Labels for stock medications included all necessary information such as:--The name and strength of the drug.--The lot and control number.--The expiration date when applicable.--Appropriate accessory and cautionary statements.--Directions for use.-Labels for over-the-counter drugs included all necessary information, such as:--The original label indicating the name, strength and quantity of the medication.--The expiration date when applicable.--Directions for use and appropriate accessory/cautionary statements.-Medications could not be transferred between containers.Review of the facility's undated policy titled Receipt and Storage of Supplies and Equipment showed:-All supplies and equipment must be stored in accordance with the manufacturer's recommendations.-It was the purchasing agent's responsibility to assure that proper storage procedures were maintained.1. Observation on 2/20/26 at 9:46 A.M. of the 400/500 hall nurse cart showed:-12 hemorrhoidal suppositories (a small, bullet-shaped medication designed for insertion into the rectum to treat internal hemorrhoids (a swollen vein or group of veins in the region of the anus) that expired in September 2025.-Seven hemorrhoidal suppositories that expired in December 2025.-One 100 milliliter (ml) bottle of sterile (free from bacteria or other living microorganisms) 0.9 percent (%) normal saline (a salt and water mixture used for many medical purposes) that expired on 1/1/26.-Two wound dressings that expired on 7/24/25.-One wound dressing that expired in May 2022.2. Observation on 2/20/26 at 10:17 A.M. of the 200-hall nurse cart showed:-Three hemorrhoidal suppositories that expired in September 2025.-One Epinephrine pen (Epi Pen- a portable, pre-filled auto-injector used for emergency treatment of severe, life-threatening allergic reactions) that was not stored in its original container with no label on the pen and no expiration date could be found on the pen.-One decannulation plug (a medical device designed to seal or cap the end of a tracheostomy (a surgically created opening (stoma) in the neck leading directly to the windpipe (trachea) to help a person breathe) tube) that expired on 11/20/25.-One bottle of vitamin supplements that expired in July 2025.-One opened spray bottle of hydrogen peroxide topical solution (commonly used as an over the counter (OTC) antiseptic for treating minor cuts, scrapes, and burns preventing infection) with no expiration date.-One urinary drainage bag that was opened and sitting at the bottom of the medication cart, no expiration date could be found, and it was missing a cap.-One tracheostomy inner cannula 5.0 millimeters (mm) with a use by date of 12/16/25.-One enteral (the administration of nutrients or medication directly into the gastrointestinal (GI) tract) funnel transition connector that expired on 7/26/25.3. Observation on 2/20/26 at 10:57 A.M. of the west side medication room showed one bottle of supplements that had a cracked and broken lid.4. During an interview on 2/23/26 at 10:07 A.M. Certified Medication Technician (CMT) A said:-Medication carts were checked once a week.-A pharmacist came to the facility once a month and checked medication carts for expired medications.-Expired medications should not be stored in the medication carts.-Expired supplies should not be stored in the medication carts.-Medications with broken seals or caps needed to be disposed of appropriately.-If he/she were to find expired or mislabeled medication in the medication (continued on next page)

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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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	cart, he/she would dispose of the medication and replace the medication.-If he/she were to find expired medical supplies on the medication cart, he/she would dispose of the supplies and tell the nurse.-All medications needed to be stored in their original container or packaging.-There should have only been one Epi Pen stored in the box and the other pen without a label should have been disposed of.During an interview on 2/23/26 at 10:28 A.M. Licensed Practical Nurse (LPN) C said:-He/She checked his/her medication carts daily to ensure appropriate storage of medications and supplies.-Nurse management did not check the carts regularly.-A pharmacist came to the facility once a month and would inform the Director of Nursing (DON) of all recommendations.-Expired medications should not be stored in the medication carts.-Expired supplies should not be stored in the medication carts.-Medications with broken seals or caps needed to be disposed of appropriately.-If he/she were to find expired or mislabeled medication in the medication cart, he/she would dispose of the medication and replace the medication.-If he/she were to find expired medical supplies on the medication cart, he/she would dispose of the supplies and tell the nurse.-All medications needed to be stored in their original container or packaging.-There should have only been one Epi Pen stored in the box and the other pen without a label should have been disposed of.During an interview on 2/23/26 at 12:32 P.M. the DON said:-A pharmacist came to the facility once a month to check the medication carts.-Nurse management also checked the carts once a month.-When the pharmacist came to the facility, they would only check a couple of carts and not all the carts in the facility.-There was not a check-off list or sheet that would be completed when the medication carts were checked.-Expired medication should not be stored in the medication carts.-Expired medical supplies should not be stored in the medication carts.-He/She expected certified staff to remove and dispose of any expired medication or supplies from the medication carts immediately once they were found.-All expired medications and medical supplies needed to be disposed of appropriately.-All medications need to be stored in their original container.-If certified staff found mislabeled or improperly stored medications in the medication carts, then he/she expected the staff to dispose of the medication.

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure orders were in place for self-administration of medication for one sampled resident (Resident #81) and one supplemental resident (Resident #47); and failed to ensure an assessment for self-administration of medication was in place for one supplemental resident (Resident #47) out of 18 sampled residents and seven supplemental residents. The facility census was 87 residents. Review of the facility's policy titled Medication and Treatment Orders dated July 2016 showed:-Orders for medications and treatments would be consistent with principles of safe and effective order writing.-Medications should be administered only upon the written order of a person duly licensed and authorized to prescribe such medications in this state.-Drug and biological orders were to be recorded on the physician's order sheet in the resident's chart.-Orders for medications must include:--Name and strength of the drug.--Number of doses, start and stop date, and/or specific duration of therapy.--Dosage and frequency of administration.--Route of administration.--Clinical condition or symptoms for which the medication was prescribed.--Any interim follow-up requirements.Review of the facility's policy titled Self-Administration of Medications dated March 2025 showed:-As part of the evaluation comprehensive assessment, the interdisciplinary team (IDT) assessed each resident's cognitive and physical abilities to determine whether self-administering medications was safe and clinically appropriate for the resident.-The IDT considered the following factors when determining whether self-administration of medications was safe and appropriate for the resident:--The mediation was appropriate for self-administration.--The resident was able to read and understand medication labels.--The resident could follow directions and tell time to know when to take the medication.--The resident comprehended the medication's purpose, proper dosage, timing, signs of side effects, and when to report these to staff.--The resident has the physical capacity to open medication bottles, remove medications from a container, and to ingest and swallow (or otherwise administer) the medication.--The resident was able to safely and securely store the medication.-If it was deemed safe and appropriate for the resident to self-administer medications, it would be documented in the medical record and the care plan.-The decision that a resident could safely self-administer medications would be re-assessed periodically based on the changes in the resident's medical and/or decision-making status.-For self-administering residents, the nursing staff would determine who was responsible (the resident or the nursing staff) for documenting that medications were taken.-Self-administered medications were stored in safe and secure place, which was not accessible by other residents.-Any medications found at the bedside that were not authorized for self-administration were turned over to the nurse in charge for return to the family or responsible party.1. Review of Resident 47's admission Record showed the resident admitted to the facility with a diagnosis of Chronic Obstructive Pulmonary Disorder (COPD-a disease process that decreases the ability of the lungs to perform ventilation).Review of the resident's quarterly Minimum Data Set (MDS- a federally mandated assessment completed by facility staff for care planning) dated 11/17/25 showed the resident was cognitively intact.Review of the resident's Order Summary Report dated February 2026 showed:-An order for Symbicort Inhalation Aerosol (a prescription combination inhaler used for the long-term daily maintenance treatment of COPD) 80-4.5 micrograms per actuation (mcg/act), inhale two puffs orally two times a day and rinse mouth after use.-An order related to the self-administration of his/her inhaler was not found.Observation on 2/19/26 at 9:16 A.M. of the resident's medication pass showed:-Licensed Practical Nurse (LPN) B handed the resident his/her Symbicort inhaler.-The resident attempted to inhale the medication but administered the medication incorrectly.-The resident did not rinse his/her mouth after attempting to administer the medication.During an interview on 2/19/26 at 12:15 P.M. the resident said:-He/She was normally given the inhaler to administer the medication himself/herself.-He/She had never been assessed to be able to self-administer his/her (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	inhaler.-He/She never rinsed his/her mouth after giving himself/herself the inhaler.Review of the resident's care plan on 2/19/26 showed no focus or intervention related to the self-administration of medications.Review of the resident's Electronic Medical Record (EMR) on 2/19/26 showed no self-administration assessment had been completed or uploaded.2. Review of Resident #81's admission Record showed he/she admitted to the facility with a diagnosis of Fibromyalgia (a chronic disorder characterized by widespread musculoskeletal pain, fatigue, sleep disturbances, and cognitive issues).Review of the resident's quarterly MDS dated [DATE] showed the resident was cognitively intact.Review of the resident's Order Summary Report dated February 2026 showed:-An order for Albuterol Sulfate HFA Inhalation Aerosol Solution (used to treat and prevent breathing problems such as wheezing, coughing, or shortness of breath) 90 mcg/act, inhale two puffs orally every six hours pro re nata (PRN- as needed) for shortness of breath or wheezing.-There was no order for Refresh Relieva (a lubricating eye drop designed to relieve burning, irritation, and discomfort due to dry eyes) eye drops.-There was no order for Refresh Mega-3 (a preservative-free, lubricating eye drop designed to treat moderate-to-severe dry eye symptoms) eye drops.-There was no order in place for the self-administration of eye drops or inhalers.Observation on 2/17/26 at 10:32 A.M. of the resident's room showed:-A box containing Refresh Relieva eye drops on the resident's bedside table.-A box containing Refresh Mega-3 eye drops on the resident's bedside table.Observation on 2/18/26 at 9:32 A.M. of the resident's room showed:-A box containing Refresh Relieva eye drops on the resident's bedside table.-A box containing Refresh Mega-3 eye drops on the resident's bedside table.-An Albuterol-Sulfate inhaler, not in a box or container.Observation on 2/19/26 at 10:20 A.M. of the resident's room showed:-A box containing Refresh Relieva eye drops on the resident's bedside table.-A box containing Refresh Mega-3 eye drops on the resident's bedside table.-An Albuterol-Sulfate inhaler, not in a box or container.Review of the resident's care plan on 2/19/26 showed no focus or intervention related to the self-administration of medications.During an interview on 2/19/26 at 12:03 P.M. the resident said:-He/She had recently been to the eye doctor and the doctor's office had given him/her the eye drops.-He/She had been using both eye drops two times a day.-He/She had recently been to the hospital and had an upper respiratory infection.-He/She had been given the inhaler on 2/17/26 to use as needed.-He/She had been taking the inhaler three to four times a day.-He/She could not remember if he/she had ever been assessed to be able to self-administer eye drops or inhalers.-He/She had not been telling staff when he/she was self-administering the eye drops or inhaler.-He/She did not know that he/she needed to inform staff whenever he/she self-administered any medication.Review of the resident's Medication Administration Record (MAR) dated February 2026 showed no documentation related to the administration of his/her albuterol inhaler.3. During an interview on 2/19/26 at 10:10 A.M. LPN B said:-Resident #47 had not taken his/her inhaler correctly.-Resident #47 did not rinse out his/her mouth before smoking.-Resident #47 was not a good candidate to self-administer his/her medication.-An assessment needed to be completed for residents to be able to self-administer medications.-An order needed to be in place for each medication that any resident self-administered.During an interview on 2/23/26 at 9:58 A.M. Certified Medication Technician (CMT) A said:-All medications should have orders, including over the counter (OTC) medications.-If a resident expressed that he/she wanted to self-administer a medication then an assessment needed to be completed by a nurse. -Once the assessment was completed an order needed to be placed in the resident's chart to be able to self-administer the medication.-Each medication that a resident self-administered needed an order for the self-administration.-When a resident self-administered a medication that was kept at the resident's bedside, it was the resident's responsibility to inform the certified staff that he/she had taken the medication.-When a resident informed certified staff that he/she had self-administered their medication, the staff person needed to document the administration in the resident's EMR within 30 minutes.-He/She thought Resident #81 may have gone to the local dollar store to get the eye drops that were not ordered.-Resident #81 should have had an (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	order for the Refresh Relieva and Refresh Mega-3 eye drops.-Resident #47 used to be able to administer his/her inhaler without issue.-He/She was unsure if Resident #47 had an assessment or order to be able to self-administer medication.-If Resident #47 did not have an assessment or order then they would need to be completed.During an interview on 2/23/26 at 10:20 A.M. Licensed Practical Nurse (LPN) C said:-All medications should have orders, including OTC medications.-If a resident expressed that he/she wanted to self-administer a medication then an assessment needed to be completed.-Once the assessment was completed an order needed to be placed in the resident's chart to be able to self-administer the medication.-The assessment would also determine if the resident could keep the medication at the bedside or if the medication needed to be kept in the medication cart.-Each medication that a resident self-administered needed an order for the self-administration.-All residents who could self-administer medication were usually pretty good about telling him/her when they administered the medication.-If the medication was scheduled, then the staff would need to ask the resident if they had taken the medication.-He/She was unsure if Resident #81 had orders for his/her eye drops that were at his/her bedside.-If Resident #81 did not have an order, then an order for the eye drops needed to be in place for the resident to be able to use the eye drops.During an interview on 2/23/26 at 12:25 P.M. the Director of Nursing (DON) said:-All medications should have orders, including OTC medications.-If a resident expressed that he/she wanted to self-administer a medication then an assessment needed to be completed.-Once the assessment was completed an order needed to be placed in the resident's chart to be able to self-administer the medication.-It was the resident's responsibility to tell staff when they self-administered medication.-It was the staff's responsibility to ensure the resident had the supply of the medication and to re-order the medication when needed.-Resident #81 had been educated in the past about telling staff when he/she self-administered medication.-Resident #81 should have orders for all his/her medications.-He/She did not think Resident #81 had a known issue of getting OTC medications at the local stores.-He/She was unsure if the staff were documenting Resident #81's inhaler usage.-He/She was unaware that Resident #81 had not been informing staff when he/she was administering his/her inhaler.-When any medication was administered by staff or self-administered it needed to be documented.-He/She was unaware that Resident #81 had eye drops at his/her bedside that were not currently ordered for the resident.-Resident #47 did not have an assessment or order in place to be able to self-administer the inhaler.-Resident #47 should have had an assessment in place, but he/she did not think the resident was a good candidate to self-administer medication.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. Based on observation, interview, and record review, the facility failed to store a Bilevel Positive Airway Pressure (BiPAP a machine that helps you breathe) mask and a nasal cannula (NC a device that gives you additional oxygen (supplemental oxygen or oxygen therapy) through your nose) in a plastic bag for one sampled resident (Resident #25) out of 18 sampled residents. The facility census was 87 residents. A policy was requested on BiPAP mask storage and NC storage and was not received by the time of exit. 1. Review of Resident #25's admission Record showed he/she was admitted to the facility with the following diagnosis: -Chronic Obstructive Pulmonary Disease (COPD an ongoing lung condition caused by damage to the lungs, and the damage results in swelling and irritation, also called inflammation, inside the airways that limit airflow into and out of the lungs).-Acute and chronic respiratory failure with hypoxia (low oxygen).-Acute and chronic respiratory failure with hypercapnia (elevated carbon dioxide).Review of the resident's Order Summary Report (OSR) dated 9/23/25 showed:-BiPAP was to be placed on at night.-Oxygen at 2 liters per NC continuous and may titrate to keep oxygen saturation levels greater than 89 percent. Review of the resident's care plan dated 10/3/25 showed:-The resident was on continuous oxygen therapy related to ineffective gas exchange and required continuous oxygen therapy.--Storage of the NC was not addressed. -The resident used a BiPAP related to COPD and chronic respiratory failure. --Storage of the BiPAP mask was not addressed. -Resident noncompliance was not addressed. Review of the resident's Quarterly Minimum Data Set (MDS-a federally mandated assessment instrument completed by facility staff for care planning) dated 1/7/26 showed:-The resident was cognitively intact. -Oxygen therapy was not indicated on the assessment. -BiPAP therapy was not indicated on the assessment. Observation on 2/17/26 at 10:05 A.M. of the resident's room showed:-The BiPAP mask was laying on a pile of clothing not stored in plastic bag.-There was no plastic bag on the oxygen concentrator for NC storage. Observation on 2/17/26 at 1:27 P.M. of the resident's room showed:-The BiPAP mask was laying on a pile of clothing not stored in plastic bag.-NC was wrapped around the handles of the resident's wheelchair. -There was no plastic bag on the oxygen concentrator for NC storage. Observation on 2/18/26 at 8:49 A.M. of the resident's room showed:-The BiPAP mask was laying on a pile of clothing not stored in plastic bag.-The NC was wrapped around the handles of the resident's wheelchair. -There was no plastic bag on the oxygen concentrator for NC storage. 2. During an interview on 2/20/26 at 12:01 P.M., Certified Medication Technician (CMT) A said: -BiPAP masks and NC were to be stored in a dated plastic bag when not in use. -The plastic bag would be dated and changed out weekly. -When a NC was found not in a plastic bag the NC would be replaced and placed in the plastic storage bag. -When a BiPAP mask was found not stored in a plastic bag the nurse would be notified because the BiPAP mask would need to be cleaned and dried prior to placing in a plastic bag.-Wrapping the NC around the handles of a wheelchair and laying the BiPAP mask on a pile of clothes was not appropriate. -The resident was noncompliant with storage of the NC and BiPAP mask and put them where he/she wanted. -When a resident was not complaint with the storage of the respiratory item the resident would be educated about the importance of it, and the nurse would be notified so the care plan could then be updated. During an interview on 2/20/26 at 12:14 P.M., Registered Nurse (RN) B said:-The NC and BiPAP masks were to be stored in a dated plastic bag when not in use.-When the NC was not stored in the plastic bag, he/she would get a new nasal canula and place it in the plastic bag. -When the BiPAP mask was found not stored correctly it would be cleaned allowed to dry and placed in a plastic bag for storage. -The Director of Nursing (DON) would be informed that resident was noncompliant on the storage of NC and BiPAP masks, so the care plan could be updated for education and noncompliance. -When a resident was not complaint with the storage of the respiratory item the resident would be educated about the importance of it.-The MDS Coordinator updated the care plan. -Wrapping the NC around the handles of a wheelchair and laying the BiPAP mask on a pile of clothes was not appropriate. During an interview on 2/23/2026 at 12:19 (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	P.M., the DON said:-It was his/her expectation that NC and BiPAP masks were stored in dated plastic bags when not being used.-It was his/her expectation that staff would have educated the resident on the importance of storing nasal cannulas and BiPAP masks in plastic bags when not in use.-When a resident was noncompliant with the storage of respiratory items, he/she would be notified so the MDS Coordinator could have updated the care plan. -Wrapping the NC around the handles of a wheelchair and laying the BiPAP mask on a pile of clothes was not appropriate.

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to identify, assess and provide supportive interventions for one sampled residents (Resident #59) with a diagnosis of Post-Traumatic Stress Disorder (PTSD - a mental health condition triggered by a terrifying event - either experiencing it or witnessing it; symptoms may include flashbacks, nightmares and severe anxiety, as well as uncontrollable thoughts about the event), and one sampled resident (Resident #66) who had a positive finding on the trauma/abuse/neglect screening out of 18 sampled residents. The facility census was 87 residents. Review of Trauma-Informed Care Implementation Center (https://www.traumainformedcare.chcs.org/what-is-trauma-informed-care/) copyright 2021 showed:-Trauma-informed care shifts the focus from What's wrong with you? to What happened to you?-A trauma-informed approach to care acknowledges that health care organizations and care teams need to have a complete picture of a patient's life situation - past and present - to provide effective health care services with a healing orientation.-Adopting trauma-informed practices can potentially improve patient engagement, treatment adherence, and health outcomes, as well as provider and staff wellness. It can also help reduce avoidable care and excess costs for both the health care and social service sectors.-Trauma-informed care seeks to:--Realize the widespread impact of trauma and understand paths for recovery.--Recognize the signs and symptoms of trauma in patients, families, and staff.--Integrate knowledge about trauma into policies, procedures, and practices; and--Actively avoid re-traumatization.Review of facility policy titled Trauma Informed Care reviewed April 2025, showed:-To guide staff in appropriate and compassionate care specific to individuals who have had experienced trauma. -Nursing staff were trained on screening tools, trauma assessment and how to identify triggers associated with re-traumatization.-All Staff were guided in evidence-based organizational and interpersonal strategies that supported trauma informed care. -Trauma-informed care was culturally sensitive and person-centered. -Caregivers were taught strategies to help eliminate, mitigate of sensitively, and addressed a resident's triggers. -As part of the comprehensive assessment, identified history of trauma or interpersonal violence when possible.-Identified past trauma of adverse experiences might have involved record review of the used screening tools. 1. Review of Resident #59's admission Record showed the resident admitted to the facility with a diagnosis of PTSD.Review of the resident's Trauma/Abuse/Neglect Screening dated 7/11/25 showed the resident had yes answers to the following:-The resident had a history of abuse and/or neglect.-The resident reported:--Repeated disturbing memories, thoughts, or images of a stressful experience from the past.--Felt very upset when something reminded him/her of a stressful experience from the past.--Avoided activities or situations because they reminded him/her of a stressful experience from the past.--Felt distant or cut off from other people.--Felt irritable or had angry outbursts.-Had factors that increased the resident's vulnerability.-Psychiatric history and/or present mental health diagnosis. -Denial and/or evasiveness. -Depressive illness and/or signs/symptoms of depression/mood distress. -The screening showed a score of six which meant that the resident had trauma-related symptomology.Review of the resident's Trauma/Abuse/Neglect Screening dated 10/10/25 showed the resident had yes answers to the following:-The resident had a history of abuse and/or neglect.-The resident reported:--Repeated disturbing memories, thoughts, or images of a stressful experience from the past.--Felt very upset when something reminded him/her of a stressful experience from the past.--Avoided activities or situations because they reminded him/her of a stressful experience from the past.--Felt distant or cut off from other people.--Felt irritable or had angry outbursts.-Had factors that increased the resident's vulnerability.-Psychiatric history and/or present mental health diagnosis. -Denial and/or evasiveness. -Depressive illness and/or signs/symptoms of depression/mood distress.-The screening showed a score of six which meant that the resident had trauma-related symptomology.Review of the resident's care plan revised on (continued on next page)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1/5/26 showed:-He/She had a diagnosis of PTSD.-PTSD was not addressed in the care plan.-The resident's triggers were not addressed.-The resident's interventions were not addressed.Review of the resident's Trauma/Abuse/Neglect Screening dated 1/12/26 showed the resident had yes answers to the following:-The resident had a history of abuse and/or neglect.-The resident reported:--Repeated disturbing memories, thoughts, or images of a stressful experience from the past.--Felt very upset when something reminded him/her of a stressful experience from the past.--Avoided activities or situations because they reminded him/her of a stressful experience from the past.--Felt distant or cut off from other people.--Felt irritable or had angry outbursts.-Had factors that increased the resident's vulnerability.-Psychiatric history and/or present mental health diagnosis. -Denial and/or evasiveness. -Depressive illness and/or signs/symptoms of depression/mood distress. -The screening showed a score of six which meant that the resident had trauma-related symptomology.Review of the resident's Quarterly Minimum Data Set (MDS-a federally mandated assessment instrument completed by facility staff for care planning) dated 1/21/26 showed:-The resident was cognitively intact. -Had PTSD.During an interview on 2/17/26 at 2:10 P.M. the resident said:-He/she had a diagnosis of PTSD.-No staff had asked about what made his/her PTSD worse or better. -He/She did not want to talk about his/her PTSD.2. Review of Resident #66's admission Record showed the resident admitted to the facility with a diagnosis of adult physical abuse suspected and adult sexual abuse suspected.Review of the resident's Trauma/Abuse/Neglect Screening dated 8/13/25 showed the resident had yes answers to the following:-The resident had a history of abuse and/or neglect.-Exposure to any form of trauma. -The resident reported:--Repeated disturbing memories, thoughts, or images of a stressful experience from the past.--Felt very upset when something reminded him/her of a stressful experience from the past.--Avoided activities or situations because they reminded him/her of a stressful experience from the past.--Felt distant or cut off from other people.--Felt irritable or had angry outbursts.-Had factors that increased the resident's vulnerability.-History of substance use/abuse.-Depressive illness and/or signs/symptoms of depression/mood distress. -The screening showed a score of six which meant that the resident had trauma-related symptomology.Review of the resident's Trauma/Abuse/Neglect Screening dated 11/13/25 showed the resident had yes answers to the following:-The resident had a history of abuse and/or neglect.-Exposure to any form of trauma. -The resident reported:--Repeated disturbing memories, thoughts, or images of a stressful experience from the past.--Felt very upset when something reminded him/her of a stressful experience from the past.--Avoided activities or situations because they reminded him/her of a stressful experience from the past.--Felt distant or cut off from other people.--Felt irritable or had angry outbursts.-Had factors that increased the resident's vulnerability.-History of substance use/abuse.-Depressive illness and/or signs/symptoms of depression/mood distress. -The screening showed a score of six which meant that the resident had trauma-related symptomology.Review of the resident's care plan revised on 1/9/26 showed:-He/She had prior trauma related to abuse from men in his/her life. -Recent possible physical abuse from someone in his/her residence, prior to admission. -admitted to hospital with many physical injuries. Resident had admitted tophysical abuse causing injuries, but resident had also given different stories as a reason for injuries that were not abuse related. -The resident's triggers were not addressed.-The resident's interventions were not addressed.Review of the resident's Trauma/Abuse/Neglect Screening dated 2/13/26 showed the resident had yes answers to the following:-The resident had a history of abuse and/or neglect.-Exposure to any form of trauma. -The resident reported:--Repeated disturbing memories, thoughts, or images of a stressful experience from the past.--Felt very upset when something reminded him/her of a stressful experience from the past.--Avoided activities or situations because they reminded him/her of a stressful experience from the past.--Felt distant or cut off from other people.--Felt irritable or had angry outbursts.-Had factors that increased the resident's vulnerability.-History of substance use/abuse.-Depressive illness and/or signs/symptoms of depression/mood distress. -The screening showed a score of six which meant that the resident had (continued on next page)

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	265362	A. Building B. Wing	02/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Meadow View Health & Rehabilitation	2203 East Mechanic Street Harrisonville, MO 64701

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 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	trauma-related symptomology.During an interview on 2/17/2026 at 12:46 P.M. the resident said:-He/she had a history of trauma. -Unsure if he/she had a diagnosis of PTSD.-He/She got anxious when unknown males came around. -He/She preferred to stay in his/her room and avoid crowds. Review of the resident's Quarterly MDS dated [DATE] showed:-The resident was cognitively intact. -No diagnosis of PTSD.3. During an interview on 2/20/26 at 12:01 P.M., Certified Medication Technician (CMT) A said: -He/She was familiar with Resident #59 and Resident #66.-He/She was unsure if either resident had PTSD or past trauma.-He/She did not know what either of the resident's triggers or inventions were.-Neither resident had any behaviors.-He/She would look on the care plan for the triggers and interventions. -He/She would have expected triggers and interventions to be on the care plan.-If the interventions and triggers were not in the care plan, he/she would have informed the nurse. During an interview on 2/20/26 at 12:14 P.M., Registered Nurse (RN) B said:-He/She was familiar with Resident #59 and Resident #66.-Neither resident had any behaviors.-Was unfamiliar with either of the residents' triggers or interventions.-He/She did not know if either resident had a diagnosis of PTSD or had experienced trauma in the past.-Triggers and interventions would be listed in the care plan.-The MDS Coordinator was responsible for care plans. -He/She had not noticed there were no triggers or interventions in either resident's care plan. During an interview on 2/20/26 at 12:30 P.M., the MDS Coordinator said:-He/She knew Resident #59 had a diagnosis of PTSD.-He/She did not know if Resident #66 had a positive trauma/abuse/neglect screening.-Since Resident #59 kept changing his/her story of the PTSD event, he/she was unsure whether to include PTSD in the care plan. -He/She did not know that a PTSD care plan needed to be done for a resident that had a positive trauma/abuse/neglect screening. During an interview on 2/23/2026 at 12:19 P.M., the Director of Nursing (DON) said:-The MDS Coordinator was responsible for the care plan for a resident with PTSD or if a resident had a positive trauma finding.-He/She did not know if Resident #59 had a diagnosis of PTSD.-He/She did not know if Resident #66 had a positive finding on the trauma/abuse/neglect screening. -When a resident had a diagnosis of PTSD there should be triggers and interventions listed in the care plan.-When a resident had a positive finding on the trauma/abuse/neglect screening, there should be a trauma care plan developed with triggers and interventions.-He/She did not know Resident #59's or Resident #66's triggers or interventions. -The information of the resident's triggers and interventions should have been in the care plan. -Care plans were audited by the MDS Coordinator.