

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265419	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  06/04/2025
NAME OF PROVIDER OR SUPPLIER  Country View Nursing		STREET ADDRESS, CITY, STATE, ZIP CODE 2106 West Main Bowling Green, MO 63334	

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)
<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on interview and record review, the facility failed to follow professional standards of practice when physician orders for wound care for two residents (Resident #2 and Resident #9) in a review of 12 sampled residents, were not completed as ordered. The facility failed to follow all orders from the outside Wound Care Clinic or add orders to the resident physician order sheets (POS). Additionally, the facility failed to ensure Resident #9 had transportation to the Wound Care Clinic for scheduled appointments. The facility census was 42.</p> <p>Review of the facility policy, following physician's orders, undated, showed the following:</p> <ul style="list-style-type: none"> <li>-The facility was committed to ensuring physician orders were carried out properly;</li> <li>-Nursing staff will follow this policy and Nurse Practice Act in receiving, recording and following physician orders, as well as delegating, communicating and care planning orders;</li> <li>-Transcription of orders such as telephone or fax orders shall be transcribed as given by the physician;</li> <li>-When a physician changes an order that is currently in place, the original order must be discontinued and a new order written to reflect the change;</li> <li>-Orders from consultants and specialists should be reviewed by the primary care physician, unless the primary physician has given previous authorization to accept the specialist or consultants' orders;</li> <li>-The administration of treatments must be signed by the nurse when completed.</li> </ul> <p>1. Review of Resident #2's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument required to be completed by facility staff, dated 1/28/25, showed the following:</p> <ul style="list-style-type: none"> <li>-The resident was cognitively intact;</li> <li>-The resident was at risk for pressure ulcers;</li> <li>-The resident had one Stage II (intact skin with non-blanchable redness of a localized area usually over a bony prominence) pressure ulcer acquired at the facility;</li> </ul> <p>(continued on next page)</p>

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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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-The resident had one Stage III (partial thickness loss of the middle layer of skin presenting as a shallow open ulcer with a red-pink wound bed, without slough) pressure ulcer acquired at the facility.</p> <p>Review of the resident's contracted Wound Care Company's documentation, dated 4/23/25, showed the following:</p> <p>-The resident had a Stage III pressure ulcer on his/her left heel;</p> <p>-The pressure ulcer measured 1.4 centimeters (cm) x 1.0 cm x 0.3 cm;</p> <p>-Orders: use a normal saline cleanse, apply betadine soaked gauze and cover with an absorbent dressing. Apply ace wraps from toes to knee, on in the morning and off at bedtime. Change dressing daily;</p> <p>-The pressure ulcer had improved.</p> <p>-The pressure ulcer was observed by the wound company nurse via telehealth (the provision of healthcare remotely by means of telecommunications technology) with Licensed Practical Nurse (LPN) B.</p> <p>Review of the resident's POS showed no order to apply ace wraps to the resident's left leg from toes to knee, on in the morning and off at bedtime from the wound care company's orders dated 4/23/25.</p> <p>Review of the resident's Treatment Administration Record (TAR), dated April 2025, showed staff did not document an order to apply ace wraps to the resident's left leg from toes to knee, on in the morning and off at bedtime from the wound care company's orders dated 4/23/25.</p> <p>Review of the resident's POS showed an order, dated 5/1/25, to cleanse the resident's left heel with wound cleanser, apply Aquacel AG (a wound dressing that supports the removal of non-viable tissue) and cover with a foam dressing every three days.</p> <p>Review of the resident's contracted Wound Care Company's documentation, dated 5/7/25, showed the following:</p> <p>-The resident had a Stage III pressure ulcer on his/her left heel;</p> <p>-The wound measured 1.5 cm x 1.0 cm x 0.4 cm;</p> <p>-Orders: normal saline cleanse, apply betadine damp gauze, cover with a non-bordered superabsorbent dressing that does not contain an adhesive layer and a superabsorbent bordered adhesive dressing. Apply ace wraps from toes to knee, on in the morning and off at bedtime. Change dressing daily and as needed;</p> <p>-The pressure ulcer had a mild decline.</p> <p>Review of the resident's POS showed no order to apply ace wraps to the resident's left leg from toes to knee, on in the morning and off at bedtime from the wound care company's orders on 5/7/25.</p> <p>(continued on next page)</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the resident's TAR, dated May 2025, showed no order to apply ace wraps to the resident's left leg from toes to knee, on in the morning and off at bedtime from the wound care company's orders on 5/7/25.</p> <p>Review of the resident's TAR for May 2025 showed the facility did not discontinue the dressing change order that began on 5/1/25 to cleanse the resident's left heel with wound cleanser, apply Aquacel AG (a wound dressing that supports the removal of non-viable tissue) and cover with a foam dressing every three days after the contracted wound care company gave a new dressing change order on 5/7/25. The facility staff continued to follow the 5/1/25 order on 5/10/25 and 5/13/25 along with the new daily dressing change ordered on 5/7/25.</p> <p>Review of the resident's contracted wound care company's documentation, dated 5/14/25, showed the following:</p> <ul style="list-style-type: none"> <li>-The resident had a Stage III pressure ulcer on his/her left heel;</li> <li>-The pressure ulcer measured 2.5 cm x 2.0 cm x 0.4 cm;</li> <li>-Orders: normal saline cleanse, apply betadine to peri wound, collagen powder to the wound bed, cover with an adhesive silicone bordered dressing. Apply ace wraps from toes to knee, on in the A.M. and off at bedtime. Change dressing every other day and as needed.</li> </ul> <p>Review of the resident's physician order sheet showed no order to apply ace wraps to the resident's left leg from toes to knee, on in the morning and off at bedtime from the wound care company's orders on 5/14/25.</p> <p>Review of the resident's TAR showed staff did not document an order to apply ace wraps to the resident's left leg from toes to knee, on in the morning and off at bedtime from the wound care company's orders on 5/14/25.</p> <p>Review of the resident's contracted wound care company's documentation, dated 5/21/25, showed the following:</p> <ul style="list-style-type: none"> <li>-The resident had a Stage III pressure ulcer on his/her left heel;</li> <li>-The pressure ulcer measured 2.0 cm x 2.0 cm x 0.4 cm with undermining from 12:00 to 6:00 of 1.5 cm;</li> <li>-Orders: normal saline cleanse, apply Santyl (ointment used to help remove dead tissue), calcium alginate (a powder used to absorb drainage to promote healing), 4x4 gauze and wrap with gauze and secure with tape. Apply ace wraps from toes to knee, on in the A.M. and off at bedtime. Change dressing daily and as needed.</li> </ul> <p>Review of the resident's physician order sheet showed no order to apply ace wraps to the resident's left leg from toes to knee, on in the morning and off at bedtime from the wound care company's orders on 5/21/25.</p> <p>(continued on next page)</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the resident's TAR showed no documentation of an order to apply ace wraps to the resident's left leg from toes to knee, on in the morning and off at bedtime from the wound care company's orders on 5/21/25.</p> <p>Review of the resident's contracted wound care company's documentation, dated 5/28/25, showed the following:</p> <ul style="list-style-type: none"> <li>-The resident had a Stage III pressure ulcer on his/her left heel;</li> <li>-The pressure ulcer measured 3 cm x 4.0 cm x 0.3 cm with undermining from 12:00 to 6:00 of 0.5 cm;</li> <li>-Orders: normal saline cleanse, apply Santyl (ointment used to help remove dead tissue), apply calcium alginate (a powder used to absorb drainage to promote healing), apply 4 x 4 gauze, wrap with gauze and secure with tape. Apply ace wraps from toes to knee, on in the morning and off at bedtime. Change dressing daily and as needed.</li> </ul> <p>Review of the resident's physician order sheet showed no orders to apply offloading boots while the resident was in bed or order to apply ace wraps to the resident's left leg from toes to knee, on in the morning and off at bedtime from the wound care company's nurse orders on 5/28/25.</p> <p>Review of the resident's TAR showed staff did not document orders to apply offloading boots while the resident was in bed or order to apply ace wraps to the resident's left leg from toes to knee, on in the morning and off at bedtime from the wound care company's nurse orders on 5/28/25.</p> <p>2. Review of Resident #9's Care Plan, dated 4/1/25, showed the following:</p> <ul style="list-style-type: none"> <li>-The resident had an actual impairment to skin integrity;</li> <li>-The resident had Stage II pressure ulcers to his/her right and left upper back;</li> <li>-The resident had Stage II pressure ulcers to his/her left buttock and left gluteal cleft (a midline groove that separates the buttocks);</li> <li>-The resident had an unstageable pressure ulcer to his/her right buttock;</li> <li>-The resident had a wound vac (vacuum-assisted closure, a device used to promote wound healing by applying controlled negative pressure to the wound bed) to his/her right buttock;</li> <li>-Document location of wound, amount of drainage, peri wound area, pain, swelling, and circumference measurements;</li> <li>-Administer treatments as ordered and monitor for effectiveness.</li> </ul> <p>Review of the resident's quarterly MDS, dated [DATE], showed the following:</p> <ul style="list-style-type: none"> <li>-The resident was cognitively intact;</li> <li>-The resident had diagnoses that included diabetes;</li> </ul> <p>(continued on next page)</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-The resident had two Stage II pressure ulcers upon admission;</p> <p>-The resident had no behaviors and did not reject cares;</p> <p>-The resident was always incontinent of bladder and bowel;</p> <p>-The resident was dependent on staff for transfers, bathing, personal hygiene, turning and repositioning in bed, and ambulation in a wheelchair.</p> <p>Review of the resident's POS showed an order dated 4/30/25 to cleanse the sacral wound, apply Urgoclean AG cut to size of the wound then apply Opti foam daily.</p> <p>Review of the facility's Pressure Ulcer Weekly Wound Evaluation, dated 4/30/25, showed the following:</p> <p>-The resident had a Stage II pressure ulcer on the right side of his/her sacrum (lower back above the tailbone) that was present on admission;</p> <p>-The wound bed was moist with 50% eschar tissue (brown, black leathery, scab like tissue) present and macerated peri wound;</p> <p>-The wound had light serous (clear) drainage;</p> <p>-The wound measured 4.5 cm x 2.5 cm x 0.2 cm;</p> <p>-The wound was unchanged;</p> <p>-Orders: cleanse with wound cleanser, apply Urgoclean AG (a wound dressing that supports the removal of slough) and cover with Opti foam (an absorbent adhesive dressing) daily.</p> <p>Review of the resident's TAR, dated 5/2/25, showed no documentation staff completed the treatment to the resident's sacrum as ordered. The date was blank.</p> <p>Review of the resident's POS, dated 5/7/25, showed an order for a wound vac to the sacral wound on Mondays, Wednesdays, and Fridays.</p> <p>Review of the resident's Wound Care Clinic Notes, dated 5/9/25, showed the following:</p> <p>-The resident had a Stage III pressure ulcer on his/her sacrum;</p> <p>-Cleanse pressure ulcer with wound cleanser two times per day for 15 days;</p> <p>-Apply skin prep to peri wound two times per day for 15 days;</p> <p>-Apply DuoDerm (moisture retentive wound dressing) around the pressure ulcer and reddened area on sacrum prior to the application of the wound vac three times a week for 15 days;</p> <p>(continued on next page)</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-Apply Opticell (absorbent dressing to remove drainage) over excoriation near wound two times a day for 15 days;</p> <p>-Change wound vac every Monday, Wednesday, and Friday.</p> <p>Review of the resident's POS showed no documentation of the new orders for the resident's sacrum pressure ulcer from the Wound Care Clinic on 5/9/25.</p> <p>Review of the resident's TAR showed staff did not document new orders for the resident's sacrum from the wound care clinic on 5/9/25.</p> <p>Review of the resident's Wound Care Clinic Notes, dated 5/15/25, showed the following:</p> <p>-Cleanse pressure ulcer with wound cleanser two times per day for 15 days;</p> <p>-Apply skin prep to peri wound two times per day for 15 days;</p> <p>-Apply DuoDerm around the pressure ulcer and reddened area on coccyx prior to the application of the wound vac three times a week for 15 days;</p> <p>-Change wound vac every Monday, Wednesday, and Friday.</p> <p>Review of the resident's POS showed staff did not enter orders for the resident's sacral pressure ulcer from the wound care clinic on 5/15/25.</p> <p>Review of the resident's TAR showed staff did not document new orders for the resident's sacral pressure ulcer from the wound care clinic on 5/15/25.</p> <p>Review of the resident's Wound Care Clinic Notes, dated 5/20/25, showed the following:</p> <p>-Hold wound vac for one week due to skin irritation caused by excessive moisture;</p> <p>-Cleanse pressure ulcer with wound cleanser two times per day;</p> <p>-Apply moisture barrier ointment two times per day;</p> <p>-Pack wound with dry 2x2 gauze two times per day;</p> <p>-Apply an Opti foam dressing over wound two times per day.</p> <p>Review of the resident's POS, dated 5/21/25, showed an order to cleanse the sacral pressure ulcer with wound cleanser, apply a moisture barrier cream, apply gauze and cover with Opti foam two times a day. This order was not the order documented on the wound clinic notes, which listed the pressure ulcer was to be packed with dry 2x2 gauze.</p> <p>Review of the resident's TAR dated May 2025, showed</p> <p>-The resident's wound vac was on hold from 5/21/25 until 5/28/25;</p> <p>(continued on next page)</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-Staff documented the resident was sleeping at 7:00 P.M. on 5/23/25 and 5/24/25 when he/she was scheduled for a dressing change to his/her sacrum. There was no documentation staff changed the resident's dressing on 5/23/25 and 5/24/25.</p> <p>During an interview on 6/17/25 at 11:59 A.M. the resident's spouse said the following:</p> <p>-On 5/23/25 the facility did not have transportation for the resident to get to his/her Wound Care Clinic appointment;</p> <p>-On 5/30/25 the facility did not have transportation for the resident to get to his/her appointment.</p> <p>3. During an interview on 6/2/25 at 3:12 P.M. and 6/4/25 at 11:30 A.M., LPN B said the following:</p> <p>-Resident #2 had telehealth visits every Wednesday with the contracted wound care company;</p> <p>-Resident #2 had a Stage II pressure ulcer on his/her left heel;</p> <p>-Resident #2 had daily dressing changes to his/her left heel;</p> <p>-LPN B took orders for Resident #2 over the phone and entered them on the resident's POS. He/She must have missed the order for the ace wraps;</p> <p>-LPN B thought whoever got the contracted wound company telehealth visit notes from the fax scanned them to the resident's chart. He/She never saw them before they were scanned to the resident's chart;</p> <p>-Since the facility van was unavailable and the sister facility van was not always available to transport residents, some residents miss wound clinic appointments;</p> <p>-Resident #9 did not go to a wound clinic appointment on 5/16, 5/23, 5/30/25 and a few other times because the facility van was out of commission or Medicaid transportation did not pick up the resident;</p> <p>-When residents went to a wound clinic appointment the orders got faxed to the facility the next day. Whichever nurse got the orders off the fax machine would enter the orders into the resident's POS;</p> <p>-Resident #9's orders from the wound care clinic on 5/20/25 were entered by LPN D. LPN B thought LPN D just missed part of the order for packing the pressure ulcer with 2 x 2 gauze and it did not get entered on the POS;</p> <p>-The physician gave new orders that included packing Resident #9's pressure ulcer with 2 x 2 gauze which was left off of the resident's POS in error;</p> <p>-LPN B was not sure if anyone at the facility reviewed orders that were faxed to the facility to ensure they were entered correctly.</p> <p>(continued on next page)</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 6/2/25 at 12:48 P.M. and 6/16/25 10:52 A.M. the Director of Nursing said the following:</p> <p>-She expected LPN B's documentation to match Resident #2's contracted wound care company's documentation;</p> <p>-She expected staff to follow treatment orders as directed by the physician.</p> <p>MO254984</p> <p>MO255722</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>Based on interview and record review, the facility failed to ensure one resident (Resident #1), who utilized a wheelchair for mobility and required assistance of one staff member during a facility van transport, was appropriately secured in the facility van when two of the four straps in the van were not functional. At the time of the transport on 5/23/25 at about 8:00 A.M., Transport Staff A said he/she could only attach two of the four straps in the van to the resident's wheelchair (front left and back right), because the other two straps were stuck. During the return transport to the facility, Transport Staff A attached the same two straps to secure the wheelchair in the van and a seat belt to secure the resident. During the return transport one strap came loose while driving through a round-a-bout, the resident's wheelchair tipped backwards, the resident hit his/her head on the van lift platform and slid from the wheelchair to the floor of the van. The Activity Director met the facility van at the round-a-bout and assisted Transport Staff A to transfer the resident back to his/her wheelchair. Neither the Transport nor Activity staff were licensed nurses. Staff returned the resident to the facility using the same two van straps to secure the resident's wheelchair. The resident was assessed upon arrival to the facility and was found to have a bump on his/her head. Transport Staff A continued to transport another resident (Resident #3) who utilized an electric wheelchair, after the accident occurred with Resident #1, when returning the resident from a medical appointment. Staff only secured the resident with the front right and back left straps and a seat belt. The facility census was 42.</p> <p>The Administrator was notified on 6/2/25 at 4:35 P.M. of the Immediate Jeopardy (IJ), which began on 5/23/25. The IJ was removed on 6/2/25, as confirmed by surveyor onsite verification.</p> <p>The facility did not provide a policy regarding the facility transport van or training for staff that transport residents upon request.</p> <p>1. Review of the Resident Council Minutes, dated 3/7/25, showed the residents voiced concerns that the van seatbelts needed to be fixed.</p> <p>Review of the facility Department Response to Issues form, dated 3/7/25 showed the following:</p> <ul style="list-style-type: none"> <li>-Department: Maintenance</li> <li>-The date of the meeting referred to was 3/7/25;</li> <li>-Issue(s) identified by resident council, family council, or resident was not indicated;</li> <li>-Complaint/Issue was blank (not identified);</li> <li>-Plan of action: therapy said seat belts were fine;</li> <li>-Resolved, left blank (no response);</li> <li>-Communicated to resident was blank;</li> <li>-Maintenance department supervisor signed the form on 3/11/25;</li> </ul> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>-Administrator signature line was blank.</p> <p>Review of the Resident Council Minutes, dated 4/4/25, showed the residents voiced concern about the van seatbelt.</p> <p>Review of the facility Department Response to Issues form, dated 4/4/25 showed the following:</p> <ul style="list-style-type: none"> <li>-Department: Maintenance;</li> <li>-The date of the meeting referred to was 4/4/25;</li> <li>-Issue(s) identified by resident council;</li> <li>-Complaint/Issues: seatbelt in the van was broken;</li> <li>-Plan of Action: look at seatbelt;</li> <li>-Resolved was blank (no response);</li> <li>-Communicated to resident was left blank;</li> <li>-Maintenance Department supervisor signed the form on 4/9/25;</li> <li>-Administrator 2 signed the form on 4/9/25.</li> </ul> <p>Review of the Resident Council Minutes, date 5/2/25, showed the following issues for transportation:</p> <ul style="list-style-type: none"> <li>-Not tying/strapping residents down;</li> <li>-One resident's chair went into another resident because of not being strapped down;</li> <li>-Residents said they must hold on so they did not fly out of their wheelchairs.</li> </ul> <p>A Department Response Form from the 5/2/25 meeting was not available from the facility upon request.</p> <p>2. Review of Resident #1's undated Face Sheet showed the resident had diagnoses that included end stage renal disease (the final stage of chronic kidney disease where the kidneys can no longer adequately filter waste and fluid from the blood), dependence on renal dialysis (a machine used that filters the blood, removing waste and excess fluid when kidneys are unable to do so) hemiplegia (the loss of voluntary movement of one side of the body) and hemiparesis (weakness of one entire side of the body) following a stroke affecting his/her right dominant side.</p> <p>Review of the resident's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument required to be completed by facility staff, dated 4/4/25, showed the following:</p> <ul style="list-style-type: none"> <li>-The resident was cognitively intact;</li> </ul> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER  Country View Nursing		STREET ADDRESS, CITY, STATE, ZIP CODE  2106 West Main Bowling Green, MO 63334	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>-The resident did not have any behaviors or rejection of cares;</p> <p>-The resident required partial to moderate assistance of a staff member for chair to bed transfers;</p> <p>-The resident did not have the ability to walk 10 feet due to his/her medical condition.</p> <p>Review of the resident's Care Plan dated, 4/30/25, showed the following:</p> <p>-The resident had limited physical mobility;</p> <p>-Provide supportive care and assistance with mobility as needed;</p> <p>-The resident used a wheelchair for locomotion;</p> <p>-The resident had an activities of daily living self-care performance deficit related to multiple disease processes;</p> <p>-The resident required assistance of one staff member with transfers;</p> <p>-The resident needed dialysis related to end stage renal disease;</p> <p>-The resident had impaired visual function.</p> <p>Review of the resident's Progress Notes, dated 5/23/25, showed the following:</p> <p>-At 8:00 A.M., the resident left the facility via facility van transportation to go to dialysis;</p> <p>-At 12:07 P.M., the resident was picked up by facility transportation from dialysis. The transportation driver went around a round-a-bout and the resident started to go backwards in his/her wheelchair. The seat belt and floor straps were in place and the floor straps came loose. The resident fell back in his/her wheelchair and hit the back of his/her head on the facility van lift bar. Transportation called and notified the facility of the accident, and that transportation needed help to get the resident back in his/her wheelchair to transport the resident back to the facility. The physician was at the facility and gave an order to send the resident to the emergency room (ER). The resident refused to go to the ER. The resident returned to the facility and was assessed by the physician. Acting Director of Nursing (DON) called the corporate DON to notify them of the accident and was awaiting further instructions;</p> <p>-At 12:26 P.M., the resident was assessed by the physician and he/she gave an order for an antibiotic ointment to the scratch/dime size bump to the back or right side of the resident's head for seven days;</p> <p>-At 12:37 P.M., the resident returned from dialysis and a full assessment was completed. The resident was alert and oriented times four (person, place, time, and event), speech was clear, the resident denied a headache, and pupils are equal, round, and reactive to light and accommodation. A small 0.5 inch in length scratch to back side of the head at the top with dime size knot with orders to apply antibiotic ointment daily for seven days;</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>-No open areas to head, face, or neck. No evidence of bruising to upper and lower extremities, no deformities, no dislocations. The resident denied pain to upper and lower extremities.</p> <p>Review of the resident's weekly skin assessment, dated 5/24/25, showed the following:</p> <p>-Staff documented the resident had a new left lower extremity skin discoloration;</p> <p>-Staff documented the resident had a 0.5 inch scratch on the back right side of his/her head due to an accident in the facility van;</p> <p>-Staff obtained a treatment order.</p> <p>Review of the resident's Progress Note, dated 5/27/25, showed at approximately 1:15 P.M. the physician gave an order to send the resident to the hospital.</p> <p>During an interview on 5/29/25 at 9:31 A.M., Licensed Practical Nurse (LPN) H said he/she sent the resident to the emergency room due to a sudden loss of vision.</p> <p>During an interview on 5/29/25 at 9:45 A.M., Administrator L said Resident #1 went to the hospital on 5/27/25 for complaints of a headache and trouble with his/her vision.</p> <p>3. Review of Resident #3's undated Face Sheet showed the resident had diagnoses that included diabetes, chronic kidney disease (CKD) stage four (severe), morbid obesity and bilateral below the knee amputations.</p> <p>Review of the resident's Care Plan, dated 5/2/25, showed the following:</p> <p>-The resident needed dialysis related to CKD;</p> <p>-The resident had limited physical mobility related to bilateral amputation and morbid obesity;</p> <p>-The resident used an electric wheelchair;</p> <p>-The resident had actual and potential for fall and gait/balance problems related to bilateral lower amputation;</p> <p>-The resident had an activities of daily living self-care performance deficit;</p> <p>-The resident required assistance from two staff for transfers with a Hoyer lift (a mechanical machine used to transfer residents from one place to another).</p> <p>Review of the resident's progress notes showed no documentation staff transported the resident by the facility van to and from dialysis on 5/23/25.</p> <p>During an interview on 6/2/25 at 9:59 A.M. the resident said the following:</p> <p>-On 5/23/25, his/her wheelchair was not secured with straps in the van on the way to dialysis;</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>-On 5/23/25, his/her wheelchair was secured with only two straps, the front right, and the back left and no seatbelt on his/her return to the facility from dialysis;</p> <p>-He/She was not sure why only two straps were used;</p> <p>-When the van went around curves his/her chair would sway without the straps in place;</p> <p>-He/She had to use different transportation now because the sister facility's van could not accommodate his/her wheelchair;</p> <p>-He/She did have to use the sister facility van once, but he/she had to squeeze into a smaller wheelchair to get into the van.</p> <p>4. During an interview on 5/29/24 at 8:14 A.M., 3:48 P.M. and 6/2/25 at 3:30 P.M., the Maintenance Director said the following:</p> <p>-He transported residents a few times, but did not like how the straps worked;</p> <p>-If a person knew how to operate the straps they worked fine;</p> <p>-If a person could not get the straps tight it would cause a problem;</p> <p>-In February or March 2025, he spoke with the Regional Director of Clinical Operations about the function of the straps and the need for new straps;</p> <p>-Staff (unsure who) said they could work the straps properly and got them tight;</p> <p>-The Regional Director of Clinical Operations said if there were any more issues with the straps to let him/her know and new ones would be ordered;</p> <p>-The Maintenance Director did not have any work orders on the maintenance log for the facility van;</p> <p>-During a morning meeting after the 3/7/25 resident council meeting the van seatbelt was discussed. The Therapy Director spoke up and said the seatbelt in the van was fine so the Maintenance Director did not make any repairs at that time;</p> <p>-He did not make routine checks of the straps or the seatbelts in the transportation van;</p> <p>-He was not aware if the facility had a manufacturer's manual for the straps or seatbelts for the van at the facility.</p> <p>Review of the facility Maintenance Work Log showed there were no requests for repairs to the transportation van, seatbelts, or straps from 10/15/24 through 5/29/25.</p> <p>During an interview on 5/29/25 at 5 9:14 A.M., Resident #4 said the following:</p> <p>-He/She did not always feel safe when he/she rode in the transportation van;</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>-The straps in the transportation van were loose when he/she was transported;</p> <p>-His/Her wheelchair moved about one quarter of a turn when the driver turned or went around a curve. He/She had to hold on to the seat in front of him/her to keep from moving around;</p> <p>-Transport Driver/CNA/CMT G was the driver for Resident #4 most of the time and asked if the resident was all right when the resident's chair moved around.</p> <p>During an interview on 5/29/25 at 1:17 P.M., Resident #6 said the following:</p> <p>-He/She had an electric wheelchair;</p> <p>-Transport Driver/CNA/CMT G never strapped him/her in the transportation van;</p> <p>-He/She held onto a bar in the transportation van, because he/she was afraid of falling when his/her electric wheelchair would move around during transports;</p> <p>-He/She called the transportation van the death trap.</p> <p>During an interview on 5/29/25 at 1:25 P.M. and 6/2/25 at 1:35 P.M., Transport Driver A said the following:</p> <p>-About two months ago Transport Driver A and Administrator L were told the straps in the van were broken. The two of them looked at the straps and they were not frayed or torn. They could pull the straps tight and thought they were all right;</p> <p>-He/She did not know the straps would come loose until he/she began as a transport driver in May;</p> <p>-He/She did not have training on how to secure the residents' wheelchairs in the transportation van;</p> <p>-The Maintenance Director told him/her the straps could be pulled tight, but they could possibly come loose;</p> <p>-He/She fastened the seatbelt, the front left and back right strap to Resident #1's wheelchair to transport the resident to the facility after dialysis. He/She did not use the other two straps because they were stuck and would not reach the wheelchair;</p> <p>-The front left strap came loose from Resident #1's wheelchair and that is when the resident fell backwards and out of the wheelchair;</p> <p>-He/She called the facility and reported the accident and the Activity Director came and helped him/her get Resident #1 back in his/her wheelchair in the van for the return to the facility;</p> <p>-He/She used the same two straps (front left and back right) to secure Resident #1 in the van for the return to the facility;</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>-The MDS Coordinator's spouse (not a facility employee) came to the facility and looked at the straps, sprayed some lubricant on them and said they would be all right to transport Resident #3 from dialysis back to the facility;</p> <p>-He/She picked up Resident #3 from dialysis and used the seatbelt to secure the resident and the front right and back left straps to secure the resident's wheelchair in the van for the return ride to the facility;</p> <p>-Resident #3's straps came loose during transportation and the resident could undo the straps on his/her own after the van stopped;</p> <p>-He/She always only used two straps to secure the residents;</p> <p>-He/She never put a work order on the maintenance work log because everyone already knew there were problems with the straps.</p> <p>During an interview on 5/29/25 at 2:28 P.M., the Regional Director of Clinical Operations said the following:</p> <p>-A few months ago, someone said the straps in the van were not working. Transport Driver A and Administrator L assessed the straps and said there was no need to order new straps;</p> <p>-If there were any more issues with the straps or the van, he/she expected staff to enter it on the maintenance work log.</p> <p>During an interview on 5/29/25 at 3:00 P.M. and 6/2/25 at 12:15 P.M., the Activity Director said the following:</p> <p>-If a grievance was brought up in the Resident Council Meeting, he/she wrote them on a Department Response to Issues form and gave it to the appropriate department head;</p> <p>-The department head returned the form to him/her within 48 hours with a resolution and their signature;</p> <p>-He/She then took the form to the administrator to get a signature;</p> <p>-The 5/2/25 Department Response to Issues form he/she filled out with a grievance from residents that reported staff not strapping resident's wheelchairs down was missing. Transport Driver/CNA/CMT G did sign the form, and he/she took it to Administrator L who also signed it;</p> <p>-On 5/23/25, he/she went to assist Transport Driver A when Resident #1 fell backwards and out of the wheelchair in the van;</p> <p>-He/She rode in the van and stood in the back by Resident #1 on the return to the facility.</p> <p>During an interview on 5/29/25 at 3:29 P.M., Transport Driver/CNA/CMT G said the following:</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>-He/She did not remember getting a Department Response to Issues form in May from the Activity Director;</p> <p>-He/She was able to get one side of the straps tighter than the other side. He/She thought it had to do with the wheelchair brakes;</p> <p>-Resident #6 said his/her electric wheelchair did not have to be strapped in the van so Transport Driver/CNA/CMT G did not secure the resident with the straps;</p> <p>-He/She should have secured Resident #6's electric wheelchair with the straps;</p> <p>-Transport Driver/CNA/CMT G assisted Resident #6 and Resident #1 into the van for a transportation (date unknown). Resident #6 was not secured with straps and ran his/her wheelchair into Resident #1 while he/she was adjusting his/her wheelchair. Resident #6 hit Resident #1's chair so hard it took the rubber off of one of Resident #1's wheelchair wheels. Transport Driver/CNA/CMT G had to use a crowbar to get the rubber piece back on the wheelchair.</p> <p>During an interview on 6/2/25 at 10:16 A.M., the MDS Coordinator's spouse said the following:</p> <p>-He/She went to the facility on 5/23/25 after Resident #1 fell in the facility van to check the straps;</p> <p>-He/She had to clean out one of the tracks that held the straps in place before he/she could get the strap locked in the track;</p> <p>-The front two straps' levers would not spring back in a locked position and hold the strap tight. He/She sprayed a lubricant on the levers of the front two straps before they locked correctly;</p> <p>-He/She felt the straps were safe to use and transport residents at that point.</p> <p>During an interview on 6/2/25 at 11:18 A.M., Registered Nurse (RN) J said the following:</p> <p>-On 5/23/25, Transport Driver A called the facility and told him/her Resident #1 fell backwards in the van and hit his/her head;</p> <p>-The Activity Director and the Social Services Director went to meet the van and help the transport driver get the resident back into his/her wheelchair;</p> <p>-When Resident #1 returned to the facility RN J and the Physician assessed the resident;</p> <p>-The resident had a knot on the upper right back of his/her head about the size of a nickel with a small scratch. The physician ordered an antibiotic ointment to the scratch for five days;</p> <p>-He/She was never aware the straps in the van did not work.</p> <p>During an interview on 5/29/25 at 3:24 P.M., the Certified Occupational Therapy Assistant (COTA) I said the therapy department did not assess any part of the facility transportation van.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>During an interview on 6/2/25 at 11:33 A.M., the Director of Rehabilitation said the following:</p> <ul style="list-style-type: none"> <li>-He/She had never assessed the seatbelts in the van;</li> <li>-The function of the seatbelts in the van was not something he/she assessed;</li> <li>-The therapy department only assessed resident's ability to sit and tolerate transport in the van.</li> </ul> <p>During an interview on 5/29/25 at 2:21 P.M., Administrator L said the following:</p> <ul style="list-style-type: none"> <li>-In March 2025 there was discussion about the straps in the transportation van because someone said they were broken;</li> <li>-She and Transport Driver A went to the van and looked at the straps;</li> <li>-The straps were not frayed or broken;</li> <li>-She thought they were fine to continue to use to secure residents during transports;</li> <li>-After Resident #1 fell in the van, the MDS Coordinator's spouse checked out the straps to see if they were defective. The MDS Coordinator's spouse cleaned out the tracks that hold the straps and said he/she could tighten all the straps;</li> <li>-Administrator L called the Regional Director of Clinical Operations and told him/her the straps needed to be replaced;</li> <li>-She did not know the transportation drivers were not trained on how to secure residents in the transportation van with the straps;</li> <li>-She did not think there was anything in place to train transportation drivers on securing residents with the straps in the van;</li> <li>-There was no manufacturer's manual for the straps or seatbelts in the van.</li> </ul> <p>During an interview on 6/2/25 at 12:28 P.M., Resident #1's Physician said the following:</p> <ul style="list-style-type: none"> <li>-Resident #1 fell in the facility van and hit his/her head;</li> <li>-The resident refused to go to the hospital for evaluation;</li> <li>-Upon return to the facility the physician assessed the resident's cranial nerves and completed a physical assessment, and the resident was fine. The resident had a small bump and scratch on the back of his/her head;</li> <li>-The Physician was at the facility on 5/27/25 and the resident presented with a change in condition;</li> </ul> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>-The Physician sent Resident #1 to the hospital for evaluation due to her change in condition that could have been from the fall in the van;</p> <p>-The resident's change on 5/27/25 was a big change from 5/23/25. The resident had vision changes that required an evaluation at the hospital;</p> <p>-He/She expected the facility to have a safe and reliable form of transportation for the residents to get to and from appointments.</p> <p>NOTE: At the time of the survey, the violation was determined to be at the immediate jeopardy level J. Based on interview and record review completed during the onsite visit, it was determined the facility had implemented corrective action to remove the IJ violation at the time. A final revisit will be conducted to determine if the facility is in substantial compliance with participation requirements.</p> <p>At the time of exit, the severity of the deficiency was lowered to the D level. This statement does not denote that the facility has complied with State law (Section 198.026.1 RSMo.) requiring that prompt remedial action to be taken to address Class I violation(s).</p> <p>MO254722</p>

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<p>F 0836</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Ensure the facility is licensed under applicable State and local law and operates and provides services in compliance with all applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation and interview, the facility failed to comply with state laws and designate a person as an administrator who was employed in the facility and served in that capacity on a full-time basis. This had the potential to affect all facility residents. The facility census was 42.</p> <p>The facility did not have a policy regarding the administrator or their duties.</p> <p>1. During an interview on [DATE] at 8:30 A.M. and 11:00 A.M., Administrator L said the following:</p> <ul style="list-style-type: none"> <li>-She introduced herself as the facility administrator;</li> <li>-She started as the administrator on [DATE] and fulfilled the duties as acting administrator for the facility;</li> <li>-She had not applied for a temporary emergency license;</li> <li>-Administrator K had her license hanging in the facility.</li> </ul> <p>During an interview on [DATE] at 12:00 P.M., Licensed Practical Nurse (LPN) H said the following:</p> <ul style="list-style-type: none"> <li>-He/She did not remember the last time Administrator K was physically in the building;</li> <li>-Around the first of May the facility was without an administrator for at least one week.</li> </ul> <p>During an interview on [DATE] at 12:26 P.M., the Minimum Data Sheet (MDS) Coordinator/ Registered Nurse (RN) N said Administrator K was the interim administrator and was only in the facility once a week.</p> <p>During an interview on [DATE] at 3:59 P.M. the Director of Nursing (DON) said the following:</p> <ul style="list-style-type: none"> <li>-Administrator M's last day in the facility was [DATE];</li> <li>-Administrator K started as the facility administrator on [DATE];</li> <li>-Administrator K's first day physically in the building was [DATE].</li> </ul> <p>During an interview on [DATE] at 8:37 A.M. Administrator K said the following:</p> <ul style="list-style-type: none"> <li>-Administrator L started as the facility administrator on [DATE] and was going to apply for a temporary emergency license, but had not done so;</li> <li>-She thought the last time she was in the facility was [DATE];</li> </ul> <p>(continued on next page)</p>		

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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)
<p>F 0836</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>-Administrator L was filling in as administrator, but Administrator K's license was the one hanging in the facility.</p> <p>Observation on [DATE] at 12:45 P.M. in the office labeled Administrator, showed a State of Missouri Licensed Nursing Home Administrator License displayed with Administrator K's name that expired [DATE].</p> <p>During an interview on [DATE] at 12:48 P.M. the Regional Director of Clinical Operations said the following:</p> <ul style="list-style-type: none"> <li>-Administrator L acted as the facility administrator;</li> <li>-Administrator L was hired as the administrator, but Administrator K hung her license in the facility on [DATE];</li> <li>-Administrator K worked in the facility on [DATE], [DATE], [DATE], [DATE] and [DATE];</li> <li>-She was aware an administrator had to have a current license and be in the facility full time.</li> </ul>