STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265419	A. Building B. Wing	01/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Country View Nursing	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)
F 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure one resident (Resident #34), in a review of 17 sampled residents, was free from abuse by staff. Certified Nursing Assistant (CNA) J slapped the resident in the face with a dirty incontinent product, was physically rough with the resident causing the resident pain and discomfort, spoke to the resident in a harsh tone and told the resident he/she could complete tasks that the resident requested help for. CNA J's actions were witnessed by Resident #34's roommate. The interaction made Resident #34 feel unsafe and angry. The facility census was 40. The administrator was notified of the past noncompliance on 01/09/26, which occurred on 01/04/26. On 01/05/26, the facility placed the agency charge nurse and aide on a Do Not Return list (meaning they could not return to the facility for a work assignment) for the allegation of staff to resident abuse. In-servicing of staff on abuse was conducted and the facility began their investigation into the allegation. In-servicing was completed on 01/06/26. This deficiency was corrected on 01/06/26 Review of the facility policy, Abuse, Prevention and Prohibition Policy, revised 2021, showed the following: -Each resident has the right to be free from abuse, corporal punishment, and involuntary seclusion;-Residents must not be subjected to abuse by anyone, including, but not limited to, facility staff, other residents, consultants or volunteers, staff of other agencies serving the resident, family members or legal guardians, friends, or other individuals;-This facility prohibits mistreatment, neglect or abuse of residents;-This presumes that all instances of abuse can cause physical harm, pain or mental anguish;-Abuse means the willful infliction of injury, unreasonable confinement, intimidation or punishment with resulting physical harm, pain or mental anguish;-Mental abuse includes but is not limited to, humiliations, harassment and threats of punishment or deprivation;-Neglect means failure to provide goods and services necessary to avoid physical harm, pain, mental anguish or emotional distress. 1. Review of Resident #34's face sheet showed the following: -He/She was responsible for self;-Diagnoses include unspecified dementia (a clinical term for cognitive decline such as memory loss or thinking problems that could affect daily life), unspecified low back pain, neuralgia and neuritis (sharp, shocking nerve pain and inflammation of the nerve, causing pain, tingling and weakness) and osteoarthritis (a degenerative joint disease causing pain, stiffness, swelling and reduced mobility). Review of the resident's care plan, revised 01/06/25, showed the following: -The resident was at risk for falls, encourage him/her to prepare for bedtime, assist with dressing and toileting prior to going to bed;-The resident had an activities of daily living (ADL) self-care performance deficit and required one assist with undergarment change and peri-care, and one assist with dressing, transfers and toileting. Review of the resident's annual Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 11/02/25, showed the following:-Cognitively intact;-Adequate hearing and clear speech;-No delirium, hallucinations, behaviors or rejection of cares;-Set up or clean up assistance required for toileting hygiene, upper and lower body dressing;-Supervision or touch assistance from staff for sitting to standing transfers and toilet transfers;-Occasional pain that interfered with day-to-day activities. Review of the resident's electronic health record, nursing progress notes, from 01/04/26 through (continued on next page)

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

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F 0600 Level of Harm - Actual harm Residents Affected - Few	01/05/26, showed the following:-On 01/05/26, at 6:39 P.M., charge nurse was directed to do a full skin assessment of the resident. The resident made allegation of abuse toward an agency staff member;-No progress note indicated for the date of the allegation. During an interview on 01/06/26 at 4:04 P.M., the resident said the following: -Last Sunday night at bedtime, he/she asked a staff member to help him/her get ready for bed;-The staff member, someone from an agency that did not work at the facility full time, told him/her do it yourself;-He/She explained he/she needed help with his/her brief change (incontinent product) and the agency staff member said, no, you don't need help;-The resident took his/her brief off, the agency staff member took it and slapped the resident in the face with it;-He/She asked for help and the agency staff member said, for what, you can do it yourself;-He/She did not know the agency staff member's name; agency staff do not wear name tags; when he/she asked the agency staff his/her name, the agency staff member said, for what?;-The agency staff gave a name of a staff member that was working (Nurse Aide NA G), but the resident knew that staff member and he/she was not in the room;-The agency staff member jerked him/her around and it made the resident's shoulder hurt. The agency staff member pulled his/her brief up and pinched the resident;-He/She told the agency staff, don't pinch me and the agency staff said, I'm not; the aide was rude and short in the way he/she spoke to him/her; -The way the agency staff member treated him/her made him/her angry and he/she felt unsafe because of the way he/she was treated;-He/She reported the incident to NA G. During an interview on 01/09/26 at 1:43 P.M., NA G said the following:-He/She was working over his/her regular scheduled shift until 9:00 P.M. on 01/04/26;-Agency staff, Certified Nurse Aide (CNA) J, was assigned to Resident #34's hall and an agency nurse was the charge nurse;-He/She was checking to make sure everyone was ready for bed before he/she left for the night;-Resident #34 said he/she was not feeling very well after the way he/she was treated by the other aide;-Resident #34 said, the other aide was aggressive, and the aide slapped him/her in the face with the resident's brief;-The resident said the other aide was very rough when taking his/her clothes off and jerked him/her around;-NA G reported to the charge nurse what occurred;-When he/she asked the resident who the other aide was, the resident described the staff member as having a big tattoo on his/her arm;-The only staff member working meeting the description was Certified Nurse Aide (CNA) J, the staff assigned to the resident's hall. 2. Review of the facility staffing assignment sheet for the night shift on 01/04/26 showed CNA J was assigned to the resident's hall from 7:00 P.M. thru 7:00 A.M.; review of the facility provided agency staff list, listed CNA J as working for the agency the facility used for staffing. 3. Review of Resident #37's quarterly MDS, dated [DATE], showed the following:-Cognitively intact;-Adequate hearing and vision;-No delusions or hallucinations. During an interview on 01/06/26 at 12:26 P.M., the resident said the following:-There was one person that did not treat his/her roommate, Resident #34, very nice the other night; that person worked for an agency; -The agency aide came in the room and took Resident #34 to the bathroom, and then he/she heard Resident #34 say, stop pinching me, you are pinching me;-The agency staff member said, I'm not pinching you; I'm just trying to care for you;-He/She did not see that part because they were in the bathroom, but the door was open, and he/she could hear the conversation;-The agency aide was really pushing Resident #34's buttons and told the resident he/she wasn't going to help the resident get ready for bed; he/she could do it himself/herself;-Resident #34 asked the agency aide what his/her name was; he/she was not wearing a name tag, and the agency staff said, [NAME] - my name is [NAME];-The resident knew [NAME] and the agency aide was not [NAME];-He/She saw the agency aide smack Resident #34 back and forth in the face with gloves, back and forth a few times, in the resident's room;-The privacy curtain was not pulled because Resident #34 does not like it pulled;-The agency aide was very rude and disrespectful in the way he/she talked to Resident #34 and the tone he/she was using was harsh; the aide was very mean to the resident;-This happened about 8:30 P.M. the other night;-Resident #34 did not deserve to be treated that way;-The whole interaction made him/her feel uncomfortable;-He/She did not report this to anyone because Resident #34 reported it to staff; he/she (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	was asked about it the next day. 4. Review of the facility investigation, Initial Reporting Form, completed by the administrator, dated 01/05/26, showed the following: -Allegation type: abuse, physical;-NA G reported that Resident #34 came to him/her at 9:00 P.M. (on 01/04/26) and said he/she was not feeling very well after an aide left his/her room;-The resident said an aide had slapped his/her face with his/her dirty incontinent product;-The staff member told the resident to take of his/her shirt himself/herself and would not listen to the resident when he/she asked the staff member for help;-The resident said he/she also hit his/her hand on the door when he/she came out of the bathroom;-The resident reported to NA G the staff member was very rough and that his/her body now hurt because of the way he/she was handled;-The resident voiced he/she was pinched, with no bruise noted;-Do Not Return (DNR) of agency CNA J and reached out to the agency used for staffing;During an interview on 01/06/26 at 10:00 A.M and 01/09/26 at 8:53 P.M., the administrator said the following: -CNA J and LPN M, who were working at the time of the allegation, have been placed on the Do Not Return list and will not be back at the facility due to the allegation of abuse and not reporting it to Director of Nursing or himself; -Abuse and neglect training took place 01/05/26 and 01/06/26 for all staff;-The local law enforcement organization (LEO) was contacted and a statement from CNA J was collected by the LEO pertaining to the allegation;-NA G has been educated on the process to report allegations of abuse or neglect. 2707975

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F 0688 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to provide restorative nursing services to assist one resident (Resident #9), in a review of 17 sampled residents, to attain or maintain his/her highest level of functioning. Resident #9, who had contractures (shortening and hardening of muscles, tendons, or other tissue, often leading to deformity and rigidity of joints) and a physician order for participation in a Restorative Nursing program six days a week, had not been provided with this service since the order start date of 04/04/25. Resident #9 had a decrease in his/her range of motion abilities and required additional muscle relaxant medication to control his/her contracture pain. The facility census was 40. Review of the facility's policy, Restorative Nursing Services, revised July 2017, showed the following:-Residents will receive restorative nursing care as needed to help promote optimal safety and independence;-Restorative nursing care consists of nursing interventions that may or may not be accompanied by formalized rehabilitative services (e.g., physical, occupational or speech therapies);-Residents may be started on a restorative nursing program upon admission, during the stay, or when discharged from rehabilitative care;-Restorative goals and objectives are individualized and resident-centered, and are outlined in the resident's plan of care;-The resident or representative will be included in determining goals and the plan of care;-Restorative goals may include, but are not limited to, supporting and assisting the resident in: -Adjusting or adapting to changing abilities;-Developing. Maintaining or strengthening his/her physiological and psychological resources; -Maintaining his/her dignity, independence and self-esteem; and -Participating in the development and implementation of his/her plan of care. 1. Review of Resident #9's face sheet showed the following:-The resident had a family member as his/her responsible party;-Diagnoses included stroke, hemiplegia and hemiparesis (hemiplegia is the complete paralysis of one side of the body, while hemiparesis is a partial weakness affecting one side) affecting left non-dominant side; contracture of muscle, and monoplegia (weakness or paralysis affecting only one limb, typically an arm or leg, resulting from damage to the part of the brain or nervous system controlling that limb) of lower limb affecting right dominant side. Review of the resident's Physician Order Recap Report showed orders for the following:-May participate in Restorative Nursing program six days a week with an order start date of 04/04/25;-Tizanidine HCL (short-acting muscle relaxant) tablet 2 milligrams (MG), give one tablet by mouth two times a day for muscle relaxant, start date 03/26/25. Review of the resident's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 04/30/25, showed the following:-Diagnoses included stroke and hemiplegia and hemiparesis;-Dependent on staff for oral hygiene, toilet hygiene, putting on/taking off footwear, personal hygiene, roll left and right, sit to lying, lying to sitting, chair/bed to chair transfer, and tub/shower transfer, upper and lower body dressing;-Dependent on staff for locomotion in wheelchair;-Upper extremity impairment on one side in functional limitations in range of motion (ROM) (the full extent and direction a joint can move, measured in degrees, assessing flexibility and function, crucial for diagnosing issues like stiffness or injury, and improved through exercises (active/passive) to maintain mobility for daily activities);-Lower extremity impairment on both sides in functional limitations in ROM;-Restorative nursing program had been completed for passive range of motion (the extent a joint can move when an external force, like a physical therapist or machine, moves the limb or body part, without the patient using their own muscles to create the motion) (PROM) and training and skill practice with eating and/or swallowing for at least 15 minutes for one day;-Had restorative ROM passive training and skill practice with eating and/or swallowing. Review of the resident's care plan, revised 04/30/25, showed the following:-Focus: The resident had contractures of his/her bilateral upper extremities and bilateral lower extremities;-Goal: The resident will not have any negative effects from his/her contractures through the review date, date initiated (continued on next page)

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F 0688 Level of Harm - Actual harm Residents Affected - Few	10/30/24;-Interventions: He/She was on restorative nursing program six days a week for PROM and eating, date initiated 04/04/25;-He/She was on the restorative program, date initiated 04/24/25;-Range of motion as outlined by therapy, date initiated 10/30/24; -Focus: The resident has pain related to multiple disease processes, revision date 04/30/25;-Goal: The resident will voice a level of comfort through the review date, revised on 04/30/25;-Interventions: Observe and report changes in usual routine, sleep patterns, decrease in functional abilities, decrease ROM, withdrawal or resistance to care, date initiated 11/18/24;-Focus: The resident has an activities of daily living (ADL) self-care performance deficit related to multiple disease processes; date revised on 10/30/24;-Interventions: Restorative program - PROM to left hand and right and left leg; active (the extent to which a person can voluntarily move a joint using their own muscles, without any external help, demonstrating functional movement, muscle strength, coordination, and willingness to move) ROM;-Focus: The resident has limited physical mobility, date revised 04/30/25;-Goal: The resident will remain free of complications related to immobility, including contractures, thrombus formation, skin-breakdown, fall related injury through the next review date, date revised 04/30/25. Review of the resident's medical record from 04/04/25 through 08/05/25, showed no documentation staff completed PROM six days a week for the resident as ordered or as the care plan directed. Review of the resident's quarterly MDS, dated [DATE], showed the following:-Cognitively intact;-Diagnoses included stroke and hemiplegia and hemiparesis;-Dependent on staff for oral hygiene, toilet hygiene, shower/bathe self, upper and lower body dressing, putting on/taking off footwear, personal hygiene, roll left and right, sit to lying, chair/bed to chair transfer, and tub/shower transfer;-Upper extremity impairment on one side in functional limitations in ROM;-Lower extremity impairment on both sides in functional limitations in ROM;-No restorative nursing program documented. Review of the resident's medical record from 08/06/25 through 12/19/25, showed no documentation staff completed PROM six days a week for the resident as ordered or as the care plan directed. Review of the resident's physician progress notes, dated 12/19/25, showed the following:-Chief complaint: The resident wanted a stronger muscle relaxer;-Primary history: Stroke; the resident has muscle spasms and contractures and would like muscle relaxer;-Exam: There is muscle weakness and gait abnormality and limited ROM; neurologically the resident is weak and contracted;-Diagnoses: Flexion contractions (a joint stuck in a bent (flexed) position, unable to straighten fully, caused by structural changes (shortened muscles, tendons, ligaments) from issues like injury, prolonged immobility, or disease, leading to chronic loss of motion, stiffness, and impaired movement, commonly affecting knees, hips, or fingers) and hemiplegia and hemiparesis following a stroke affecting left non-dominant side;-Plan: Flexion contractures: Increase Zanaflex (brand name for tizanidine) (short-acting muscle relaxant) from 2 MG twice daily to 4 mg three times daily as requested by the resident. Review of the resident's progress notes, dated 12/19/25 at 5:46 P.M., showed provider in house today to round on this resident and increased tizanidine 2mg from one tab two times a day (BID) to two tabs three times a day (TID). Review of the resident's Physician Order Recap Report showed the resident had orders for the following:-May participate in Restorative Nursing program six days a week with an order start date of 04/04/25;-Tizanidine hcl tablet 2 mg, give one tablet by mouth two times a day for muscle relaxant, start date 03/26/25, end date 12/19/25;-Tizanidine hcl tablet 2 mg, give two tablets by mouth three times a day for muscle relaxant, start date 12/19/25. Review of the resident's medical record from 12/19/25 through 12/30/25, showed no documentation staff completed PROM six days a week for the resident as ordered or as the care plan directed. Review of the resident's progress notes dated 12/30/25 at 11:15 P.M., showed the following:-Behavior note: Overuse of the call light system, pressing call light three times per hour during bedtime cares, for repositioning and bed comfortability;-Non-pharmacological interventions: Repositioning by nursing staff. Review of the resident's medical record from 12/31/25 through 01/07/25, showed no documentation staff completed PROM six days a week for the resident as ordered or as the care plan directed. Observation on 01/07/26 at 6:20 A.M., 6:50 A.M. and 4:09 P.M., showed the following:-The resident lay (continued on next page)

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F 0688 Level of Harm - Actual harm Residents Affected - Few	on his/her right side in bed;-His/Her left arm was drawn up and his/her left hand was contracted and closed;-The resident's legs were drawn up in the fetal position;-The resident had contractures at the knee, left arm and left hand;-Certified Nurse Aide (CNA) F came into the resident's room and assisted him/her to move; the resident was unable to straighten his/her legs, left arm or hand;-CNA F did not perform any stretches (ROM) exercises for the resident during cares. Observation on 01/07/26 at 4:09 P.M., showed the following:-The resident was in his/her bed;-His/Her left arm was drawn up and his/her left hand was contracted and closed;-The resident's legs were drawn up in the fetal position;-The resident had contractures at the knee, left arm and left hand;-CNA K entered the resident's room to assist the resident up out of bed;-During cares, CNA K did not perform any stretches (ROM) exercises for the resident. During an interview on 01/07/26 at 7:16 A.M. and 7:48 A.M., the resident said the following:-There had been no restorative nursing program for the past two months;-He/She felt he/she could benefit from a restorative program;-He/She felt a lot stiffer in his/her left arm and legs and has had discomfort in his/her left arm since stopping restorative nursing program; -He/She had to be repositioned by staff because he/she was uncomfortable and due to his/her contractures and could not do it him/herself; -He/She felt his/her contractures had gotten worse;-He/She had increased stiffness and soreness and could not roll over without help from staff;-His/Her sleep had been affected, and he/she was unable to stay asleep due to discomfort;-He/She had an increase in agitation and frustration because he/she felt his/her contractures were getting worse due to no restorative nursing program. During an interview on 01/08/26 at 2:42 P.M., the resident's responsible party said the following:-The resident should be getting restorative therapy;-Some of the staff had helped the resident with range of motion exercises in the past and it had helped the resident feel better and he/she was not as stiff and sore. During an interview on 01/09/26 at 6:20 P.M., CNA E said the following:-Currently, there was no restorative nursing program at the facility;-He/She would stretch the resident during his/her shift; -The resident had gotten more tense;-The resident had gotten stiffer and had been more uncomfortable since restorative therapy had stopped. During an interview on 01/09/26 at 3:34 P.M., Licensed Practical Nurse (LPN) B said the following:-The facility used to have a restorative nursing program;-Staff who used to do restorative with the resident said after a few days of working with him/her he/she seemed looser;-The resident has used his/her call light more frequently to be repositioned. During an interview on 01/09/26 at 8:53 P.M., the Director of Nursing (DON) said the following:-There was no restorative nursing program; -Therapy had completed training with the CNAs to train them on range of motion. During an interview on 01/07/26 at 11:29 A.M., the administrator said there was no restorative nursing program at this time. The facility had not had a program in place for the past two months and he was working on getting a restorative nursing program started again, but did not have a start date yet. During an interview on 01/15/26 at 4:10 P.M., the Medical Director said the following:-He is the resident's physician;-He expected staff to follow physician orders;-Staff had not notified him the resident was not getting range of motion;-He would expect the facility to provide restorative nursing services; -Not getting range of motion can cause pain, stiffness or worsening of contractures;-The facility did not make him aware the resident was having more pain, stiffness, or worsening of contractures.

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to follow facility policy for the documentation, notification, review and monitoring of falls and implementation of interventions for two residents (Resident #6 and #5), in a review of 17 sampled residents, who experienced multiple falls. Resident #5 sustained rib fractures due to falls. The facility census was 40. Review of the facility's Fall-Clinical Protocol policy, dated September 2012, showed the following:-As part of the initial assessment, the physician will help identify individuals with a history of falls and risk factors for subsequent falling;a. Staff will ask the resident and the caregiver or family about a history of falling;b. The staff and physician should document in the medical record a history of one or more recent falls;-In addition, the nurse shall assess and document/report the following: Vital signs; recent injury especially fracture or head injury; musculoskeletal function, observing for change in normal range of motion, weight bearing, etc.; change in condition or level of consciousness; neurological status; frequency and number of falls since last physician visit; precipitating factors, details on how fall occurred; all current medications, especially those associated with dizziness or lethargy; and all active diagnoses;-The staff will document risk factors for falling in the resident's record and discuss the resident's fall risk;-The staff will evaluate, and document falls that occur while the individual is in the facility; for example, when and where they happen, any observations of the events, etc.;-Details about where and how the resident fell along with circumstances of the fall will be documented;- Falls should also be identified as witnessed or unwitnessed events;-For an individual who has fallen, staff will attempt to define possible causes within 24 hours of the fall;-If the cause of a fall is unclear, if the fall may have a significant medical cause such as a stroke or an adverse drug reaction (ADR), or if the individual continues to fall despite attempted interventions, a physician will review the situation and help identify contributing causes;-After more than one fall, the physician should review the resident's gait, balance and current medications that may be associated with dizziness or falling;-Based on the preceding assessment, the staff and physician will identify pertinent interventions to try to prevent subsequent falls and to address risks of serious consequences of falling;-The staff and physician will monitor and document the individual's response to interventions intended to reduce falling or the consequences of falling;-If the individual continues to fall, the staff and physician will re-evaluate the situation and consider other possible reasons for the resident's falling (besides those that have already been identified) and will re?evaluate the continued relevance of current interventions;-As needed, the physician will document the presence of uncorrectable risk factors, including reasons why any additional search for causes is unlikely to be helpful. 1.Review of Resident #5's face sheet showed the resident admitted to the facility on [DATE] and had a resident representative. The resident has diagnosis of Alzheimer's disease, radiculopathy (pinched nerve) cervical (neck) region and chronic pain. Review of the resident's Care Plan, dated 10/17/25, showed the following:-Resident had actual/potential for falls;-Resident will not sustain serious injury through the next review;-Be sure call light is within reach and encourage the resident to use it for assistance;-Do not leave the resident in the bathroom unattended;-Ensure personal items are within reach. Review of the resident's Nurses Notes, dated 10/18/25 at 6:42 A.M., showed staff documented notifying the resident's representative of a fall. There was no documentation the resident's physician or administration was notified of a fall and no documentation regarding the details of the fall per facility policy. Review of the resident's Fall risk assessment, dated 10/18/25, showed the resident scored a 28 and was considered a high risk for falls. Review of the resident's Nurses Notes, dated 10/18/25, showed follow up assessment for a fall with no abnormal findings documented at 9:30 P.M., 9:45 P.M., 10:30 P.M., 11:00 P.M., 11:33 P.M. Review of the resident's medical record showed no evidence of an IDT review following the fall on 10/18/25, where the resident's frequency and number (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 0689 Level of Harm - Actual harm Residents Affected - Few	of falls since last physician visit would be evaluated, precipitating factors considered, medications reviewed or attempt to define possible causes of the fall would have been conducted. Further reviewed showed no documentation the resident's care plan was reviewed or updated with new interventions to prevent falls. Review of the resident's Nurses Notes, dated 10/22/25 at 5:40 A.M., showed the resident had an unwitnessed fall. The resident was found on the floor in front of his/her bathroom door. The resident complained of pain in both arms and his/her head. The resident had a large skin tear to his/her left arm right above his/her elbow. Emergency medical services called. Notified the Director of Nursing (DON), resident representative and the nurse practitioner. Review of the resident's Nurses Notes, dated 10/22/25 at 9:34 A.M., showed the resident returned from the emergency room via the resident representative's vehicle. The resident had diagnosis of hematoma (localized collection of clotted or pooled blood outside blood vessels, typically caused by trauma or injury) of the scalp and chest wall contusion (bruise to the chest wall). No new orders. Review of the resident's Care Plan, updated 10/22/25, showed the resident had one unwitnessed fall in the bathroom, no injury (no specific date), and a witnessed fall in the resident's room when he/she took a step and fell to his/her knees then onto his/her shoulder (no specified date). Review showed staff added no new interventions to the care plan to prevent falls. Review of the resident's Nurses Notes, dated 10/25/25, at 5:05 A.M., showed the resident yelled from his/her room. Staff arrived to find him/her in a kneeling position with one knee and one foot on the ground, holding onto his/her walker and leaning over his/her wheelchair. Resident explained he/she was trying to get to the bathroom. Staff reported the resident was having severe pain in left side ribs. Assessed the resident and found bruising to left side abdomen and severe pain on light palpation. The resident screamed when left arm was raised to assess abdominal bruising, then said his/her arm didn't hurt but the arm movement hurt his/her ribs. Physician advised the resident to go to the hospital for chest x-ray. The resident's representative and Director of Nursing notified.Review of the resident's Nurses Notes, dated 10/25/25, at 5:20 A.M., showed staff administered morphine sulfate concentrate (concentrated liquid morphine, medication for pain) 100 milligram (mg)/1 milliliter (ml) 0.25 ml administered for resident complaints of severe pain to left abdomen. Review of the resident's Medication Administration Record dated 10/25/25, at 5:20 A.M., showed the staff administered Morphine Sulfate concentrate 100 mg/ml, 0.25 ml, for pain rated a nine on a one to ten scale (ten being the worst pain). Review of the resident's Nurses Notes, dated 10/25/25 at 1:08 P.M., showed upon further research with the hospital, the resident fractured his/her seventh, eighth and ninth ribs. Review of the resident's emergency room record, dated 10/25/25, showed the resident was treated in the emergency room and three rib fractures were found on x-ray. The medical record showed no evidence of any new intervention or re-evaluation of the resident's care plan following identification of the rib fractures. Review of the resident's admission Minimum Data Set (MDS), a federally mandated assessment completed by staff, dated 10/30/25, showed the following: -Limited range of motion in one upper and one lower extremity;-Utilizes a wheelchair;-Requires partial/moderate assistance from staff for upper body dressing, personal hygiene, chair/bed-to-chair transfer, and toilet transfer;-Requires substantial/maximal assistance from staff for lower body dressing, roll left and right, sit to lying, lying to sitting on side of bed, sit to stand, tub/shower transfer, wheel 50 feet with two turns or wheelchair 150 feet;-Occasionally incontinent of urine;-Scheduled and as needed pain medication, and non-medication intervention for pain;-Pain present, effects sleep occasionally, limits day-to-day occasionally, highest rated, 7 (on a 1-10 scale, 10 being worst pain) in the last five days, -Two non-injury falls, and one injury fall since admission;-Receives antipsychotic, antianxiety, antidepressant and opioid medications (medications that increase the risk of falling);-Receives Hospice care;-No therapy or restorative nursing services. Review of the resident's Care Plan, updated 11/05/25, showed IDT reviewed the fall from 10/22/25, and implemented purposeful rounding. (14 days after the fall and there were no definitions or indications as to what purposeful rounding included). Review of the resident's Nurses Notes, dated 11/10/25 at 3:01 A.M., showed staff found (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	the resident on the floor. The resident said he/she was going to the bathroom. Resident able to move all extremities without pain or discomfort. Resident vitals normal. Notified the resident representative, and neurological checks initiated. There was no documentation to show that the resident's physician or administration was notified as facility policy directed. Review of the resident's Fall risk assessment, dated 11/12/25, showed the resident scored a 31 and was high risk for falls. Review of the resident's medical record showed no evidence of an IDT review for the fall of 11/10/25. Review of the resident's Care Plan, updated 11/17/25, showed motion sensor in place in his/her room; ensure sensor was positioned to correctly pick up the resident's movements. Review of the resident's Nurses Notes, dated 11/28/25 at 2:30 P.M., showed the nurse entered the resident's room to answer his/her call light. The resident was in the fetal position in front of his/her bed with his/her cover on and pillow under his/her head. This nurse asked resident if he/she put him/herself on the floor and the resident said he/she did not remember. Resident said, I don't know how I got here, I just remember grabbing my pillow, so I didn't have to lay my head on the ground. Full head to toe assessment performed, vital signs obtained, neurological checks initiated. Hospice arrived during the assessment and was notified on site, DON notified, physician notified, resident's representative was notified. The resident said he/she turned his/her call light on to alert staff he/she was on the floor. Resident has a small skin tear to the outer left forearm. The resident had a motion detector alarm, but it was facing the door and not the resident, adjusted the monitor. Review of the resident's medical record showed no evidence of an IDT review for the fall of 11/28/25 or that education was provided to staff regarding the proper placement of the motion detector. Further review showed no evidence the resident's care plan was reviewed or updated with new interventions to prevent falls. Review of the resident's Nurses Notes, dated 12/13/25 at 7:11P.M., showed staff assisted the resident to walk from the dining room to the resident's room with a gait belt and a walker. When staff got the resident to the bathroom and turned away from resident, the resident tried to finish taking himself/herself to the toilet and fell between the toilet and the wall. No injuries noted, vital signs and neurological checks were initiated. Notified the resident representative, the on-call physician, the DON and hospice. Review of the resident's Fall risk assessment, dated 12/13/25, showed the resident scored a 27 and was high risk for falls. Review of the resident's Nurses Notes, dated 12/15/25 at 10:30 A.M., showed the nurse and an aide were walking down the resident's hall and noticed the resident trying to reach for his/her wheelchair. The resident reached too far and went down on to his/her knees from his/her bed in front of the wheelchair. The resident said, I was just trying to go to the bathroom. Staff assessed the resident and helped the resident back to his/her chair via a gait belt. DON, hospice and physician notified. No documentation to show staff notified the resident's representative after the fall on 12/15/25. Review of the resident's Fall risk assessment, dated 12/15/25, showed the resident scored a 25 and was high risk for falls. Review of the resident's Nurses Notes, dated 12/17/25 at 4:23 P.M., showed IDT reviewed the unwitnessed fall of 12/13/25. The resident was ambulating from dining hall to bathroom with walker and one staff assist using gait belt. Staff turned around and resident tried to sit down on his/her own and fell. Educated staff on proper gait belt usage. No documentation that the resident's care plan had been reviewed or updated with new interventions after this fall. Review of the resident's Nurses Notes, dated 12/17/25 at 4:28 P.M., showed IDT reviewed the witnessed fall of 12/15/25. It showed the resident attempted to get up on his/her own. The resident's wheelchair was not within reach of resident, the resident then fell onto his/her knees on the fall mat. Educated staff on placing walker and wheelchair at bedside to aide in resident transfers. No documentation that the resident's care plan had been reviewed or updated with new interventions after this fall. Review of the resident's Nurses Notes, dated 12/17/25 at 2:20 A.M. and 6:52 A.M., showed the resident came walking out of his/her room with his/her walker and attempted to run towards the nurse's station; the walker wheels got caught and the resident fell on the floor. The resident grazed his/her head in the doorway near the door frame and landed on his/her right side. The resident said he/she did not know how the fall occurred. The resident complained of 6/10 pain in (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	the right side of his/her body near his/her hip. The resident repeatedly refused any pain medication. Hand grips equal and strong, vital signs normal. Hospice notified and advised not to send the resident to the hospital. The resident's representative was notified of the fall. There was no documentation to show staff notified the resident's physician or administration after the fall on 12/17/25. Review of the resident's Fall risk assessment, dated 12/17/25, showed the resident scored a 31 and was high risk for falls. Review of the resident's medical record showed no evidence of an IDT review following the fall on 12/17/25 or that the resident's care plan was reviewed or updated with new interventions to prevent falls. Review of the resident's Nurses Notes, dated 01/05/26 at 5:15 A.M., showed staff observed the resident on the floor in his/her bathroom. Range of motion normal. Resident assessed with no obvious injuries noted. Staff assisted the resident back to bed with assist of one staff member. Neurological checks initiated per house protocol. No documentation to show staff notified the resident's physician, resident's representative or administration after the fall on 01/05/25. Review of the resident's Fall risk assessment, dated 01/05/25, showed the resident scored a 30 and was high risk for falls. Review of the resident's medical record showed no evidence of an IDT review following the fall on 01/05/26 or that the resident's care plan was reviewed or updated with new interventions to prevent falls. Observation on 01/06/26 at 4:41 P.M., showed the surveyor heard a resident yell and then staff yell for help. Observation showed the resident's door; the resident was on the floor on his/her right side beside the floor matt. The resident said he/she fell to the floor and don't know what happened. The charge nurse and the DON went into the resident's room. During an interview on 01/06/26 at 5:15 P.M., Licensed Practical Nurse (LPN) B said the resident's motion detector did not go off prior to hearing the resident yell for help. Review of the resident's Care Plan showed the IDT reviewed the resident's fall of 01/06/26 and a new intervention of physical therapy and occupation therapy evaluation and treatment as soon as ordered or as needed. Review of the resident's Care Plan, updated 01/07/25, showed the following:-Witnessed falling of resident in the doorway of his/her room [ROOM NUMBER]/17/25;-Assist the resident to the bathroom at least every two hours and as needed, initiated for 12/17/25 fall;-Mat on floor beside the resident's bed when resident is in bed, initiated for 12/17/25 fall.(The interventions were added to the care plan 21 days after the resident's fall). During an interview on 01/07/26 at 11:51 A.M., the resident's representative said the following:-After the surveyor reviewed the list of resident falls with the resident representative, the resident's representative said the facility had not called him/her with notification of each of the resident's falls, he/she said the facility staff had called with a few of the falls but not all of them; -Staff did not call him/her to report the resident's fall on 01/05/26; -He/She expected staff to try to prevent falls; -The facility had not asked him/her about the resident's history of falls and possible interventions to put in place; -The resident was not cognitively able to pull the call light for help;-There was a motion detector above the sink to alert staff when the resident was up and moving;-He/She has been in the resident's room, and it was unplugged and therefore not working. 2. Review of Resident #6's face sheet showed the following:-Diagnoses included anemia (low iron level), dementia, depression and multiple traumatic fractures that included a pelvic fracture;-The resident has a resident representative. Review of the resident's Care Plan, last updated 04/28/25, showed the following:-Resident was high risk for multiple disease processes and recent history of fall with fractures;-Call light within reach and encourage the resident to call for assistance;- Call don't fall sign;-Gripper socks;-Remote motion sensor placed in the resident's room to alert staff when resident was attempting to transfer from bed without assistance (alarmed at the nurses station);-Gripper strips on the resident's floor beside the bed;-Limit the amount of disposable bed pads on the bed to decrease slipping;-Bed in low position when not providing care;-Place one side of the bed against the resident's wall, and a fall matt on the open side of the bed; resident forgets he/she is unable to ambulate without assistance;-Always keep items in reach;-Turn on night light at night;-Purposeful rounding added 04/28/25. The facility has no policy for purposeful rounding. Review of the resident's Nurses Notes, dated 7/23/25 at 4:53 P.M., showed the following:-Certified Nurse Assistants (CNA)s (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	reported at approximately 4:00 P.M., the resident was found in another resident's room on the floor;-The resident was found on the floor on his/her left side and his/her head was on the bottom of the bedside table;-The resident had his/her wheelchair turned the opposite way and was wearing shoes during the fall;-Redness present on left side of the resident's face;-Assessment completed;-Due to the resident's cognitive level, the resident was unable to say how the fall occurred;-The resident said he/she hit his/her head during the fall, the resident said pain was present on the lower back and forehead;-Attempted to turn resident to his/her back and the resident winced and groaned in pain;-Called emergency medical services and the resident was picked up at 4:35 P.M. to be transported to the emergency room;-Notified the resident's power of attorney, physician and Director of Nursing (DON). Review of the resident's Nurses Notes, dated 07/23/25 at 9:45 P.M., showed the nurse took report at 9:45 P.M. from the resident's nurse at the hospital. The hospital nurse reported the resident had a displaced fracture of the right and left iliac crest (portion of the pelvic bone), and his/her sacrum (an additional part of the pelvic bone). The hospital nurse reported their care team had a phone conference with orthopedic surgeons and ultimately decided to transfer him/her to another hospital. Review of the resident's medical record showed no evidence of an IDT review following the resident's fall with fractures on 07/23/25. Review of the resident's care plan, updated 07/30/25, showed recent fall with fractures. There were no new interventions added to the care plan to prevent further falls. Review of the resident's quarterly Minimum Data Set (MDS), a federally mandated assessment completed by staff, dated 07/31/25, showed the following:-Moderate cognitive impairment; -Wandering behavior present one to three days;-Limited range of motion in both upper extremities;-Wheelchair use;-Independent with wheeling 50 feet with two turns;-Requires supervision/touching assistance from staff members to roll left and right, wheel 150 feet; -Requires partial/moderate assistance from staff for to go from sitting to lying flat, sitting on the bed, chair/bed-to-chair transfer-Requires substantial/maximal assistance from staff to shower/bathe, sit to stand, toilet transfer, tub/shower transfer,-Dependent on staff for toileting hygiene, lower body dressing, and putting on/taking off footwear;-Frequently incontinent of bladder and always incontinent of bowel;-Diagnosis of fractures from trauma, osteoporosis (bone disease making bones weak, thin, and brittle by decreasing bone density and mass), dementia, depression and pelvic fractures; -One major injury fall since last assessment; -Receives antidepressant medication. Review of the resident's Nurses Notes, dated 08/01/25 at 5:08 P.M., showed the resident was found on the ground by a neighboring resident who notified nursing staff that he/she had fallen. Resident denies hitting his/her head or having pain. No bruising/ injury noted at this time, vital signs within normal limits, neurological checks initiated. Family was present at time of fall. The DON and physician were notified. Review of the resident's Nurses Notes showed no evidence of an IDT review following the resident's fall on 08/01/25. Review of the resident's Care Plan, last updated 08/06/25, showed a new intervention to provide activities as needed to engage the resident. There was no documentation regarding the fall of 08/01/25 or new interventions specific to fall prevention. Review of the resident's Nurses Notes, dated 08/14/25 at 6:20 P.M., showed staff found the resident on his/her buttocks on the floor in front of bathroom toilet in another resident's room. Resident was alert and showing no sign of distress. Neurological checks were initiated at 6:20 P.M. and vital signs within normal limits. Resident reports no pain currently. All appropriate parties notified. Review of the resident's record showed no evidence of an IDT review following the fall on 08/14/25. Review of the resident's Care Plan showed no reevaluation of the resident's care plan, no revision of current interventions or new interventions added after the fall on 08/14/25. Review of the resident's annual MDS, dated [DATE], showed the following:-Severe cognitive impairment; -No acute mental status change;-Independent with going from lying to sitting on the bed, and wheels 50 feet with two turns;-Requires supervision/touching assistance from staff members to wheel 150 feet; -Requires substantial/maximal assistance from staff to shower/bathe, roll left and right, sit to lying, sit to stand, chair/bed-to-chair transfer, toilet transfer, tub/shower transfer;-Two non-injury falls since last (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	assessment. Review of the resident's Nurses Notes, dated 12/09/25 at 6:59 A.M., showed the following:-At approximately 6:35 A.M., the CNA alerted this nurse that resident was on the floor;-Upon entering the resident's room, the resident was lying on his/her left side towards the bed on the fall mat;-Resident said he/she did not hit his/her head and ended up rolling off bed while sleeping;-Resident noted to have pain in left shoulder rated 5/10, as needed (PRN) Tylenol administered;-Assessment completed;-Notified DON at 6:56 A.M, notified resident representative at 7:00 A.M., and on call physician at 6:45 A.M.-Neurological checks initiated. Review of the resident's fall assessment, dated 12/09/25, showed the resident scored a 30 on his/her fall risk assessment, indicating the resident was high risk according to the assessment. (no fall assessment had been completed with any of the previous falls). Review of the resident's record showed no evidence of an IDT review of the resident's fall on 12/09/25. Review of the resident's Care Plan showed no reevaluation of the resident's care plan, no revision of current interventions or new interventions added after the fall on 12/09/25. Review of the resident's quarterly MDS, dated [DATE], showed the following:-Moderate cognitive impairment;-As needed pain medications and non-medication intervention for pain;-One non-injury fall since last assessment;-New opioid medication. Observation on 01/06/26 at 10:48 A.M., of the resident's room showed remnants of gripper strips (glue residue in strip shape) in the middle of the resident's room and no gripper strips by the resident's bed as directed in the resident's care plan. Observation showed no motion sensor or call don't fall signage in the resident's room as the care plan directed.3. During an interview on 01/09/26 at 7:35 P.M., Certified Nurse Assistant (CNA) E said staff know who has been falling from report and the resident's falls and interventions should be on their care plans. During an interview on 01/09/26, at 6:20 P.M., Licensed Practical Nurse (LPN) B said the following:-He/She worked as a charge nurse;-Interventions in place to prevent falls are expected to be on the care plan;-Staff attempt to determine what caused the fall; that documentation should be documented in the IDT notes; IDT reviews the documentation and updates the care plans; -Resident #5 and Resident #6 have had a lot of falls;-Resident #5 was confused and wandered a lot. The resident was found many times in other residents' rooms on the floor near the bathroom or trying to get into be. The resident was not on a toileting or nap schedule; -Resident #6 was newer to the facility and was confused and forgets he/she needs help; - The motion detector had not been alarming like it should. During an interview on 01/09/26, at 8:53 P.M., the DON said the following:-After a resident falls staff respond to the fall, and the charge nurse will assess and treat the resident for injuries;-The charge nurse should document the fall, and find an intervention to prevent further falls and add it to the care plan;-The charge nurse should notify the DON, resident representative and the resident's physician when a fall happened. If the fall happened in the middle of the night and the resident had no injury, notification could be made the next morning or as soon as possible. During an interview on 01/15/26, at 4:10 P.M., the Medical Director (and Resident #6's physician) said the following:-Staff are expected report to the resident's physician if a resident has a fall;-The physician would review medications, and see if any with side effects could be discontinued; He had not done this for Resident #6 recently;-Nursing should try to identify the root cause of a fall and implement interventions to prevent falls;-Staff are expected to follow policies for fall prevention.

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F 0690 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. Based on interview and record review, the facility failed to provide appropriate treatment and services consistent with acceptable standards of practice to prevent and treat urinary tract infections (UTIs) when the facility failed to ensure one resident (Resident #6), went to his/her follow up urology appointments as scheduled and failed to ensure his/her urinary catheter (a sterile tube inserted into the bladder to drain urine) was changed as ordered either at the urology clinic or by facility staff. The resident missed three scheduled appointments. The resident was diagnosed with a UTI which the medical director said could be a result of lack urinary catheter changes. Facility staff identified the resident's catheter was split and unable to be connected to the drainage system and used tape to hold the two pieces together rather than consulting with the urologist or the resident's physician. Further review showed when the two pieces would not connect to ensure a closed drainage system, the facility left the urinary catheter open, unconnected to a collection bag, draining into an incontinent brief which led to risk of infection. The facility identified two residents with an indwelling catheter. The facility census was 39. Review of the facility policy, Urinary Catheter Care, reviewed 02/2021, showed the following: -The purpose of this procedure is to prevent catheter-associated UTIs; -Infection control: -Use standard precautions when handling or manipulating the drainage system;-Maintain clean technique when handling or manipulating the catheter, tubing or drainage bag;-Change catheters and drainage bags based on clinical indications such as infection, obstructions, or when the closed system was compromised. Catheters will be changed per medical practitioner order. Review of the Centers for Disease Control (CDC) Guideline for Prevention of Catheter-Associated Urinary Tract Infections, dated March 25, 2024, showed the following: -Proper techniques for urinary catheter maintenance: -Following aseptic insertion of the urinary catheter, maintain a closed drainage system;-If breaks in aseptic technique, disconnection, or leakage occur, replace the catheter and collecting system using aseptic technique and sterile equipment;-Change catheters and drainage bags based on clinical indications such as infections, obstruction, or when the closed system is compromised. 1. Review of Resident #6's updated face sheet showed his/her diagnoses included neuromuscular dysfunction of bladder (a loss of bladder control caused by nerve damage, resulting in dysfunction of the muscles that store or empty urine). Review of the resident's October 2025 Physician Order Sheet (POS) showed the following: -Change urinary catheter monthly and as needed, one time a day starting on the last day of the month and ending on the last day of month every month; -Indwelling catheter, ensure catheter is patent and draining, document any changes to baseline. Note color and consistency in progress note, every shift for catheter use;-Change urinary catheter monthly and as needed for urinary catheter maintenance. Review of the resident's October 2025 treatment administration record (TAR) showed staff changed the resident's urinary catheter on 10/31/25. Review of the resident's November 2025 POS showed the following: -Change urinary catheter monthly and as needed, one time a day starting on the last day of the month and ending on the last day of month every month;-Indwelling catheter: ensure catheter is patent and draining, document any changes to baseline. Note color and consistency in progress note, every shift for catheter use;-Change urinary catheter monthly and as needed for urinary catheter maintenance. Review of the resident's progress notes, dated 11/03/25 at 3:40 P.M., showed staff documented the wound care nurse had tugged on the resident's catheter when he/she moved the resident's walker. The resident complained of brief pain and a burning sensation; catheter inspected with no issues noted. After the nurse left the room, the resident ambulated independently to the bathroom, the resident alerted nursing staff for assistance and staff noted the resident's catheter had been removed and sat on the bathroom floor. Nursing staff attempted to replace the urinary catheter and was unsuccessful. Staff received an order from the physician to leave the catheter out and try a void trial (see if the resident could pass urine on his/her own). The resident urinated within 30 minutes. Review (continued on next page)

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F 0690 Level of Harm - Actual harm Residents Affected - Few	of the resident's November 2025 POS showed indwelling urinary catheter, ensure catheter is patent and draining, document any changes to baseline. Note color and consistency in progress note, every shift for catheter use (discontinued 11/06/25). Review of the resident's progress notes dated 11/09/25 at 3:35 P.M, showed staff documented the resident was not feeling well, transferred to the local hospital for evaluation, and admitted to the hospital for influenza. Review of the resident's discharge documents from the hospital, dated 11/12/25, showed the following:-Diagnosis for hospitalization was influenza and urinary retention;-While hospitalized , the resident was treated for a urethral stricture (a narrowing of the urethra - the opening that urine passes through - which obstructs urine flow from the bladder) that required dilation (opening) and had a urinary catheter placed;-He/She was to return to the urology clinic in about one month for catheter change (unless the changes would be done by facility staff);-The follow-up urology appointment was scheduled for 12/11/25 at 9:15 A.M. Review of the resident's November 2025 POS showed an order for an indwelling catheter, 20 French 30 milliliter balloon (size of catheter) with an order start date of 11/12/25. (The order did not specify the frequency of catheter changes or additional information related to urinary catheter care). Review of the resident's quarterly Minimum Data Set (MDS), a federally mandated assessment tool completed by facility staff, dated 11/13/25, showed the following:-Cognitively intact;-Supervision or touch assistance for toileting hygiene;-Indwelling catheter present;-Diagnoses included renal insufficiency/renal failure/or end-stage renal disease and neurogenic bladder. Review of the resident's electronic health record (HER), History and Physical, dated 11/21/25, showed the resident was seen as a re-admit, had urinary retention and apparently still needed the urinary catheter and the catheter was replaced at the hospital. Review of the resident's December 2025 POS showed an order for indwelling catheter (The order did not specify the frequency of changes, or any additional information related to urinary catheter care). Review of the resident's care plan, revised on 12/26/25, showed the following:-He/She has a catheter secondary to neuromuscular dysfunction of the bladder and will show no signs or symptoms of urinary infection through review date of 01/30/26;-Catheter care every shift and as needed;-Monitor for signs and symptoms of discomfort on urination and frequency;-Monitor/record/report to physician for any signs or symptoms of UTI. Review of the resident's December 2025 treatment administration record (TAR) showed no documentation staff changed the resident's catheter or completed any type of monitoring of the catheter. Review of the resident's EHR, including progress notes, showed no documentation staff changed the catheter, the resident attended his/her urology appointment scheduled for 12/11/25 at 9:15 A.M. or the reason why the resident missed the urology appointment. Further review showed no documentation staff rescheduled the appointment. Review of the resident's January 2026 POS showed an order for indwelling catheter. (The order did not specify the frequency of changes or additional information related to urinary catheter care). Review of the resident's nursing progress notes, dated 01/12/26 at 3:32 P.M., showed staff documented the resident's urology appointment was cancelled due to the resident having coronavirus disease (Covid- a virus that can be very contagious and spreads quickly). There was no documentation to show staff rescheduled the appointment, changed the resident's catheter or there had been a consultation with the urologist or the resident's physician about changing his/her catheter. Review of the resident's EHR, results section, showed a urine culture with specimen collection date of 01/26/25 and final culture results 01/29/26, that showed a positive UTI, greater than 100,000 CFU/milliliter of Proteus Mirabilis (a rod-shaped bacteria that causes UTIs) (Proteus Mirabilis should not be present in urine). There was no documentation in the record why this urine sample was obtained for testing. Review of the resident's nursing progress notes, dated 01/30/26 at 4:20 P.M., showed staff documented the urine culture final was sent to his/her physician with a new order to add Augmentin (an antibiotic) 875mg every 12 hours for seven days for a diagnosis of UTI. Review of the resident's January 2026 POS showed an order on 01/30/26 for Augmentin 875-125 milligrams, give one tablet by mouth every 12 hours for UTI for seven days. Review of the resident's January 2026 TAR showed no documentation staff changed the resident's (continued on next page)

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	265419	A. Building B. Wing	01/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Country View Nursing	2106 West Main Bowling Green, MO 63334

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F 0690 Level of Harm - Actual harm Residents Affected - Few	catheter or completed any type of monitoring of the catheter. Review of the resident's February 2026 POS showed the following:-An order for indwelling catheter; -An order for Augmentin 875-125 milligrams, give 1 tablet by mouth every 12 hours for UTI for seven days with start date of 1/30/26.(The order did not specify the frequency of changes or additional information related to urinary catheter care). Review of resident's nursing progress notes showed staff documented the following: -On 02/14/26 at 1:50 P.M., the resident's urinary catheter was patent and draining yellow urine at this time, there were no new concerns related to the catheter or his/her output, will continue to monitor;-On 02/14/26 at 2:59 P. M., urinary catheter was split at the attachment to the drainage site. End of catheter was split, and resident said it has been like that for several days. The two ends had been taped together. There was about 600 cubic centimeters (cc's) of yellow urine in the drainage bag, but urine also leaked from the end of the catheter. There was old tape on the end of the connection tubing to the bag. Both ends of the catheter tubing were cleaned, old tape removed, and the drainage bag reconnected to catheter with tape. The resident said he/she was going to the physician on Monday (two days after this date), and they would replace his/her catheter. Urine was now draining in the drainage bag (no documentation staff notified the urologist's office or the resident's physician of the condition of the catheter. Review of the resident's February 2026 TAR showed no documentation staff changed the resident's catheter or completed any type of monitoring of the catheter. Review of the resident's Urology Clinic Note, dated 02/17/26, showed the following:-Resident presented to clinic for first time since previously seen as inpatient and had urethral dilation on 11/11/25;-The resident reported that he/she was unable to follow-up previously due to lack of transportation at the facility, still has the same catheter;-Urethral catheter in place draining clear urine (although no bag is connected to the catheter). Catheter removed; a new catheter placed without difficulty;-The resident's facility was apparently unable to do catheter changes for the resident so the clinic will be doing it for now;-Follow-up in about one month for another change;-Resident agrees with this plan. Review of the resident's March 2026 POS, reviewed on 03/03/26, showed the continued order for indwelling catheter 20 French 30ml balloon. Review of the resident's March 2026 TAR showed no documentation staff changed the resident's catheter or completed any type of monitoring of the catheter. During an interview on 03/03/26 at 4:15 P.M., the resident said the following: -He/She was supposed to have his/her catheter changed every month;-The appointments that he/she had scheduled in November and December did not occur because the arranged transportation service got cancelled;-He/She missed one appointment in December because he/she was counting on family to take him/her, and it did not work out; -He/She missed the next appointment in January due to having Covid; -Before going to urology in February, his/her catheter had not been changed since he/she was in the hospital in November; -Prior to the urology appointment in February, the catheter hose tip that goes to the bag was split in two and the bag was just being taped to the catheter, he/she is not sure how long it had been split but it had been that way for a little while;-He/She wasn't sure if the nurses at the facility could change the catheter or not;-When he/she went to his/her urology appointment in February the bag would not stay connected because of the split, so staff put on an adult brief and he/she went to the appointment with the incontinent brief on and the catheter tubing was left open and was put in the brief to drain the urine into the brief;-His/Her last UTI was about a month ago and he/she has history of UTI's. During an interview on 03/04/26 at 11:39 A.M., medical records staff member said the following:-The resident missed one appointment in November or December because there was a disagreement between the resident and the family member that was going to take him/her to the appointment;-She immediately rescheduled the appointment for the next available date which was January;-In January the resident was in isolation for Covid, and the urology clinic would not see him/her, so that appointment had to be cancelled;-The next available appointment was in February and the resident was able to go to that appointment;-The facility does not have their own transportation but must rely on family or Medicare/Medicaid arranged transportation to transport the residents. During an (continued on next page)

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F 0690 Level of Harm - Actual harm Residents Affected - Few	interview on 03/04/26, at 11:54 A.M., Licensed Practical Nurse (LPN) A said the following:-He/She was not aware the resident had missed urology appointments or procedures related to no transportation;-The resident had a catheter, but the facility was not able to change it, and the resident must go to the urology clinic to have it changed;-Orders should always be completed and include the frequency of administration or treatment time to be completed; for example, urinary catheters should have direction including when to change; -He/She was unaware that he/she did not complete hospital discharge orders from 11/12/25 related to the resident's catheter changes; -Catheters changes are typically monthly and as needed. During an interview on 03/04/26 at 12:41 P.M., the Infection Preventionist (IP) said the following:-She was working as a charge nurse on Saturday, 02/14/26;-The resident had some issues with the connection part of his/her catheter and a urine collection bag would not stay connected due to the end of the urinary tubing being split;-She could see where the catheter had been taped with surgical tape;-She cleaned the end of the urinary tubing and the end of the existing urine collection bag with alcohol and put the urine collection bag connector back in the urinary tubing and the taped the two together with the surgical tape;-She did not change the catheter because the resident was going to the urology clinic on the Monday following her shift; -The resident told her staff at the facility could not change the catheter, so she did not investigate any further as the urine was draining in the bag after taped;-She did not notify the on-call physician, urology clinic or DON about the catheter splitting for further instructions. During an interview on 03/04/26, at 12:21 P.M., the DON said the following: -No residents had missed any appointments that she was aware of;-Any resident with a catheter should have a physician order to address changes and care;-Urinary catheters are changed as ordered by the physician and are individualized, typically orders are to change a urinary catheter monthly;-The resident was supposed to have orders for his/her urinary catheter changes and care and she was waiting on a clarification from the medical director to complete his/her orders;-An order for a 20 Fr 30cc balloon was not a complete order and should have been completed when written or clarified with the physician if clarification was needed;-It was not a professional standard to tape a splitting urinary catheter, the physician should have been notified for further instructions/orders;-If a urinary catheter was taped due to an issue, there could be an increased risk of infection;-She would expect discharge orders from a hospital to be followed;-The resident did not go to his/her appointment in December because it was cancelled by family and did not go to his/her appointment in January due to illness, but did go to his/her appointment in February and had his/her catheter changed at that time;-The resident had not had his/her catheter changed since hospitalization in November;-In January, the facility contacted the urology clinic and the physician and there were no concerns noted as the resident did not have any problems, so the facility was supposed to monitor the resident and keep his/her appointment in February; (There was no documentation in the EHR of this contact with the urology clinic or the resident's physician); -The resident was treated for a UTI at the end of January into February. During an interview on 03/05/26 at 3:22 P.M., a Urology Clinic LPN said the following:-On 02/17/26 the resident came to an appointment at the clinic for a follow-up appointment after a surgical procedure in November; -The resident missed appointments on 12/11/25, 12/29/25, and 01/12/26 due to no transportation or illness; -The resident had orders after hospitalization in November 2025 to return to the clinic in one month to have his/her catheter changed, or it needed to be changed at the facility monthly;-When the resident arrived at the clinic in February for his/her appointment, the urinary catheter was not attached to a drainage bag, it was open to air in an adult brief/incontinent product;-The hub/connecting end of the urinary tubing was also found to have tape wrapped around the end due to it splitting;-The resident should have had his/her catheter changed by either the facility or the clinic monthly as ordered;-Records showed the catheter had not been changed since the November 2025 hospitalization. During an interview on 03/04/26 at 12:53 P.M., the Medical Director said the following:-Residents with a urinary catheter should have an order to change their catheter on a regular basis; he usually orders it to be changed once a month and as needed;-He was aware the (continued on next page)

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F 0690 Level of Harm - Actual harm Residents Affected - Few	resident recently had his/her catheter changed and assumed there was an order for it to be changed;-If a resident missed multiple urology appointments in a row, urology should have been consulted for orders;-If a resident had a catheter split at the end where it connects to the urinary drainage bag, he, or urology, should have been contacted for orders;-The urinary collection bag and the urinary tubing should not have been urinary taped together; this would be a potential risk for increased infection;-The lack of changing a urinary catheter could have increased the resident's risk of obtaining an infection or UTI;-If a resident has specific orders from a specialist, such as urology, to change a catheter in one month or return to the clinic, the catheter should have been changed by either the facility staff or by urology. #2788565

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F 0692 Level of Harm - Actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to follow their policy to address weight loss for two residents, (Resident #5 and #6), in a review of 17 sampled residents. The facility failed to notify the physician of weight loss, assess for root cause, evaluate the care plan, or initiate interventions based on the evaluation to address weight loss. Review of Resident #6's weight records showed the resident lost 7.4 pounds (lbs.) between 10/01/25 and 11/01/25, a 6.32 percent (%) weight loss in one month. Review of Resident #5's record showed the resident lost 6.6.lbs. since 10/18/25 a 5.79 % weight loss in approximately 45 days and a 7 lbs. or 6% weight loss in 30 days (since 10/31/25. The resident weighed 106.0 lbs. on 11/07/25, and lost 9.2 lbs. in one week, a 7.96% weight loss. The facility census was 40. Review of the facility policy, Weight Assessment and Intervention, reviewed 02/2021, showed the following: -Weight Assessment1. The nursing staff will measure resident weights on admission, and weekly for four weeks thereafter. If no weight concerns are noted at this point, weights will be measured monthly;2. Weights will be recorded in the individual's medical record;3. The threshold for significant, unplanned and undesired, weight loss will be based on the following criteria: a. 1 month - 5% weight loss is significant; greater than 5% is severe; b. 3 months - 7.5% weight loss is significant; greater than 7.5% is severe; c. 6 months - 10% weight loss is significant; greater than 10% is severe. Review of the facility policy, Nutrition (Impaired)/Unplanned Weight Loss-Clinical protocol, reviewed 02/2021, showed the following:-Assessment and Recognition:1.The nursing staff will monitor and document the weight and dietary intake of residents in a format which permits readily available comparisons over time;2. As part of the initial assessment, the staff and physician will review the individual's current nutritional status (weight, food/fluid intake, and pertinent laboratory values) and identify individuals with recent weight loss and significant risk for impaired nutrition; for example, high risk residents with acute symptoms such as vomiting, diarrhea, fever and infection, or those taking medications that may be causing or increasing the risk of anorexia or weight loss;3. The threshold for significant unplanned and undesired weight loss will be based on the following criteria: a. 1 month - 5% weight loss is significant; greater than 5% is severe; b. 3 months - 7.5% weight loss is significant; greater than 7.5% is severe; c. 6 months - I0% weight loss is significant; greater than 10% is severe.4. The Physician will consider whether any assessment, including additional diagnostic testing, is indicated to help clarify the severity or consequences of weight loss and/or impaired nutrition. No lab tests are sensitive or specific enough for defining nutritional status that they should be ordered for everyone. Lab tests may be ordered if they are likely to substantially help establish status or prognosis, causes of anorexia or weight loss, or choice of interventions; otherwise, routine ordering to assess or follow nutritional status is not indicated.-Cause Identification:1. The Physician will review possible causes of anorexia or weight loss with the nursing staff and/or Dietitian before ordering interventions; a. The Dietitian will estimate calorie, nutrient and fluid needs and, with the Physician, will identify whether the resident's current intake is adequate to meet his or her nutritional needs; b. For individuals with recent or rapid weight loss (for example, more than a pound a day), the staff and physician should consider possible fluid and electrolyte imbalance as a cause. Fluid deficits can result in rapid weight loss (1 kg/2.2 pounds lost for each liter of fluid deficit);2. The Physician, with the help of the multi-disciplinary team, will identify conditions and medications that may be causing anorexia, weight loss or increasing the risk of weight loss. For example: a. Cognitive or functional decline; b. Chewing or swallowing abnormalities; c. Pain; d. Medication-related adverse consequences; e. Environmental factors (such as noise or distractions related to dining); f. Increased need for calories and/or protein; g. Poor digestion or absorption; h. Fluid and nutrient loss; and/or i. Inadequate availability of food or fluids;3. The Physician will consider whether any additional diagnostic testing is indicated to help clarify the causes of impaired nutrition. An extensive workup may not be appropriate in some individuals, and (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	knowing the cause may not change the interventions. However, a systematic review for causes based on an individual's history, co-morbidities, risk factors, etc., may be appropriate even if an extensive workup is not;4. The interdisciplinary team (IDT) will document relevant medical observations and conclusions regarding the nature, severity, causes, and consequences of impaired nutritional status, especially in complex situations or where multiple active causes may coexist;-Treatment/Management:1. The staff and physician will identify pertinent interventions based on identified causes and overall resident condition, prognosis, and treatment wishes. Treatment decisions should consider all pertinent confirmation or evidence (e.g., food intake, overall condition and prognosis, etc.), and should not be based solely on lab test results (albumin, cholesterol, etc.);2. The Physician will authorize, and the staff will implement, appropriate, general or cause-specific interventions, as indicated, b. Nutritional needs: The Dietitian and Physician consult to determine the appropriate diet for the resident based on the resident's degree of nutritional impairment, expressed wishes, and underlying causes and conditions. Order for appropriate diet will be obtained from the physician; c. Supplementation: Strategies to increase a resident's intake of nutrients and calories may include fortification of foods, increasing portion sizes at mealtimes, and providing between-meal snacks and/or nutritional supplementation. 1. Review of Resident #6's face sheet showed diagnoses included anemia (low iron level), dementia, depression, and multiple traumatic fractures that included a pelvic fracture. Review of the resident's Physician's Orders, dated 03/30/25, showed med pass supplement (concentrated, liquid nutritional supplement to drink) 60 milliliters (ml) two times a day. Review of the resident's Physician's Orders, dated 07/29/25, showed orders for regular, mechanical soft texture, soft and bite sized, diet. Review of the resident's Care Plan, last updated 08/06/25, showed the following:-Resident has nutritional problem or potential nutritional problem;-Goal: Resident will maintain adequate nutritional status through review date (goal date listed is 10/27/24 which is past);-Provide and serve diet as ordered;-Provide and serve supplements as ordered;-Registered Dietitian to evaluate and make diet change recommendations as needed. Review of the resident's Dietary Notes, dated 09/07/25 at 7:33 A.M., showed the Registered Dietitian documented the following:-Nutrition Progress Note:-Resident's weight is 115 lbs., height is 62 inches;-Diet is Regular;-Resident has supplements ordered: 60 ml med pass two times daily;-The resident's weight remains stable, weight within normal limits; stability and adequate by mouth consumption desired;-Will continue to monitor. Review of the resident's Weight Record, dated 10/01/25 at 3:28 P.M., showed staff documented the resident's weight as 117 lbs. Review of the resident's Dietary Notes, dated 10/12/25 at 9:03 P.M., showed the Registered Dietitian documented the following:-Nutrition Progress Note:-Resident's weight is 117 lbs., height is 62 inches;-Diet is Regular;-Resident has supplements ordered: 60 ml med pass two times daily;-The resident's weight remains stable for 6 months;-Current diet exceeds needs, would continue to monitor;-Weight stability and adequate by mouth consumption is desired, will continue to monitor. Review of the resident's Physician's Orders, dated 10/24/25, showed Depakote (seizure medication) 125 milligrams (mg) two times a day for behavioral disturbance. Review of drugs.com showed Depakote has a warnings that includes: Call your physician at once if the person taking this medicine has signs of liver or pancreas problems, such as: loss of appetite, upper stomach pain (that may spread to your back), ongoing nausea or vomiting, dark urine. Common side effects include loss of appetite, mental depression, nausea, trouble thinking and planning, unusual tiredness or weakness, unusual weight gain or loss. Review of the resident's annual Minimum Data Set (MDS), a federally mandated assessment completed by staff, dated 10/31/25, showed the following:-Severe cognitive impairment; -Independent with eating;-Weight 117 lbs. (would be last weight so weight from 10/01/25). Review of the resident's facility Weight Record, dated 11/01/25 at 2:04 P.M., showed staff documented the resident's weight as 109.6 lbs. On 10/01/2025, the resident weighed 117 lbs.; a 6.32% loss. Review of the resident's medical record, including nurse's notes and physician's notes, showed staff did not document any communication to the physician or the dietitian about the resident's significant weight loss of greater (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	than 5% in 30 days. There was no evidence of updates, reviews, or new interventions in the resident's care plan or the resident's physician orders after the documentation of the 6.32 % weight loss. Review of the resident's Dietary Notes, dated 11/17/25, at 4:53 P.M., showed the Registered Dietitian documented the following:-Resident's weight is 109 lbs., height is 62 inches;-Diet regular;-Resident has supplements ordered: 60 ml med pass two times daily;-Estimated Nutrition Needs 1700 kilocalories (kcal) 80 grams (g) protein and 1700 ml fluid;-Resident's weight indicates slight loss;-Current diet exceeds needs, would continue;-Weight stability and adequate by mouth consumption desired;-Will monitor. Review of the resident's record showed there was no evidence of updates, reviews, or new interventions in the resident's care plan or the resident's physician orders after the resident's weight loss. The Registered Dietitian did not identify the weight loss as significant. Review of the resident's facility Weight Record, dated 12/01/25 at 6:14 P.M., showed staff documented the resident's weight was 110.2 lbs. Review of the resident's Nurses Notes, dated 12/16/25 at 1:55 P.M., showed the IDT team reviewed the resident's weights. The resident had a significant weight loss of 5 % in November, the IDT did not make recommendations at this time. Review of the resident's quarterly MDS, dated [DATE], showed the following:-Moderate cognitive impairment;-110 lbs. 5.9% weight loss in one month (unplanned weight loss was not checked on the resident's MDS);-New Mechanically altered diet. Review of the resident's care plan showed no updates to the resident's nutrition risk since 08/06/25 and there was evidence the care plan was reviewed or revised after the resident's 5.9% weight loss. Observation on 01/06/26 at 1:02 P.M., showed the resident at the dining room table with his/her family member. The family member cued the resident during the meal, and he/she consumed 100 percent (%) of his/her meal. Observation on 01/07/26 from 5:35 P.M. to 6:20 P.M., showed the following:-5:35 P.M the resident in his/her wheelchair at the dining room table;-5:40 P.M., staff served the resident pot roast with carrots and onions in a bowl, salad, roll and mixed fruit;-5:55 P.M., the resident moved his/her food around with his/her fork/spoon, not consuming any food;-No staff cued or encouraged the resident to eat or offered an alternative;-6:20 P.M., the resident left the table in his/her wheelchair; the resident consumed less than 10 % of his/her meal. During an interview on 01/08/26 at 12:15 P.M. and 01/09/26 at 7:35 P.M., Certified Nurse Assistant (CNA) E said the following:-He/She was a full time CNA at the facility;- He/She was not sure which residents at the facility had weight loss;-The resident sometimes just played with his/her food. 2. Review of Resident#5's face sheet showed he/she has a resident representative. Review of the resident's Physician Orders, dated 10/17/25, showed the resident was ordered a regular diet. Review of the resident's Care Plan, dated 10/22/25, showed the following:-Diagnosis of Alzheimer's disease;-Impaired cognitive function/dementia or impaired thought processes;-Review of the care plan did not identify nutritional risk. Review of the resident's admission Minimum Data Set (MDS), a federally mandated assessment completed by staff, dated 10/30/25, showed the following:-Moderate cognitive impairment;-Diagnosis: Alzheimer's, anemia, thyroid disorder and depression;-Set up or clean up assistance from staff for eating;-Weight 115 lbs.;-No weight loss or therapeutic/mechanical diet. Review of the resident's facility Weight Record showed staff documented the following: -On 10/31/25 at 1:55 P.M., the resident weighed 115.2 lbs.; -On 11/07/25 at 4:57 P.M., the resident weighed 106.0 lbs. (a 9.2 lbs. weight loss in one week, which is a 7.96% weight loss in one week Review of the resident's care plan showed no documentation the resident's care plan was updated with interventions regarding nutrition or weight loss. Review of the resident's medical record, including his/her nurses' notes, dietitian notes, physician orders and physician progress notes, showed no identification of the weight loss, notification to the physician, dietitian or resident representative, evaluation, interventions, or updates about the resident's nutrition or weight loss. Review of the resident's facility Weight Record showed staff documented the following:-11/14/25 at 6:30 P.M., the resident weighed 107.8 lbs.;-12/01/25 at 10:19 A.M., the resident weighed 108.2 lbs. (the resident lost 6.6.lbs. since 10/18/25 which is a 5.79 % weight loss in approximately 45 days and a 7 lbs. or 6% weight loss in 30 days (since 10/31/25)). (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	Review of the resident's medical record including Nurses Notes, Physician's Orders, and Dietary notes showed no identification of the resident's weight loss. There were no notifications to the physician or dietitian, and no new orders to address the resident's weight loss on 12/01/25. Review of the resident's Dietary Note, dated 12/18/25 at 8:52 P.M., showed the Registered Dietitian documented:-Resident weighs 108 lbs. and is 64 inches tall;-Regular diet; -Weight stable after slight loss;-Add 60 ml med pass twice a day;-Will continue to monitor. Review of the resident's Dietary Note, dated 12/23/25 at 11:57 A.M., showed staff received a dietary recommendation from the Registered Dietitian, recommending adding Med Pass 60 ml two times daily due to weight loss. Physician notified and new order received. (The first significant weight loss was identified on 11/07/25, the first intervention with the addition of this supplement was 12/23/25). Review of the resident's Physician Orders, dated 12/23/25, showed a new order for Med Pass 60 ml two times a day for weight loss. Review of the resident's care plan showed no documentation staff updated the plan with interventions to address nutrition or weight loss. Review of the resident's medical record, including his/her nurses' notes, dietitian notes, physician orders, and physician progress notes showed no identification, notifications of the physician, resident representative, no evaluation, interventions, or updates about the resident's nutrition or weight loss. Observation on 01/06/26 at 1:20 P.M through 1:40 P.M., showed the resident at 1:20 P.M. in his/her room with a meal tray. At 1:40 P.M., the resident had moved his/her meal away from him/her and had consumed 25%. During an interview on 01/07/26 11:51 A.M., the resident's representative said no one had made him/her aware the resident had lost weight. He/She would expect facility staff to try to find out why the resident lost weight so they could try to stop the weight loss if possible. During an interview on 01/09/26 at 6:20 P.M., Licensed Practical Nurse (LPN B) said the following:-Resident weights are obtained weekly times four weeks after admission and then monthly; -Significant weight loss was reviewed by the IDT team and the charge nurse carried through order requests when received. -He/She was not sure who updated the care plan and speaks to the dietitian;-The charge nurses call the physician and resident representative about weight loss if the IDT team communicate to them. The charge nurse would then document those notifications in the nurses notes;-She knew both Resident #5 and #6 have had weight loss and they were both on Med Pass. He/She was not sure if they have had further weight loss. During an interview on 01/09/26 at 8:53 P.M., the Director of Nursing said the following: -If a resident has a significant weight change, she will ask staff to re-weigh the resident to ensure it was accurate; -Staff are expected to assess the resident; if it's a gain, determine if it was from edema or illness and document in the nurses notes;-If there was weight loss, the facility should try to determine why the resident lost weight (through assessment and investigation) and put an intervention in place to stabilize the resident's weight or assist with gaining the weight back; -The MDS coordinator was in charge of monitoring the weights. The facility did not currently have a MDS coordinator in house and used a Corporate offsite MDS coordinator; -She expected Interventions for weight loss would include supervision while eating, prompting, cueing, snacks, supplements, check for mouth pain, and medications that could cause issues; -The facility used to have an assist table where residents who required more help and cueing would eat; The facility will chart consumptions of meals when staff notice the resident is not eating; she was not sure if this was done for Resident #5 or Resident #6;-When there was weight loss identified, the physician, family and dietician should be notified and the care plan updated;-She was responsible for the IDT meetings. She was not aware of the residents ?weight loss (Resident #5 and #6). During an interview on 01/26/26, at 12:26 P.M., the MDS/Care plan coordinator said she was offsite doing MDS's until the facility can hire and train a new MDS coordinator. She was not in charge of monitoring weights for all residents. During an interview on 01/09/26 at 8:53 P.M., the Corporate Nursing Manager said when there is weight loss identified, staff are expected to notify the physician, family and dietician, and the care plan should be updated with the weight loss and interventions attempted. During an interview on 01/27/26, at 3:06 P.M., the Registered Dietitian said the following:-Unplanned weight loss is considered significant weight loss if (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Country View Nursing	2106 West Main Bowling Green, MO 63334

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F 0692 Level of Harm - Actual harm Residents Affected - Few	the resident loses 5 % one month, 7.5 % in 90 days, or 10 % in six months;-Unplanned significant weight loss can put a resident at risk for malnutrition, wounds, and lean muscle loss;-If a resident has unplanned significant weight loss staff are expected to get a verbal order for a supplement from the physician or something if she was not going to be at the facility within 48 hours-She expected nursing to obtain the resident's weights and if there was an unplanned significant weight loss she would expect nursing staff to contact her of the physician for orders;-She is not sure what the facility policy is for monitoring consumptions, but someone should be paying attention to the resident's eating and consumptions;-She would expect nursing staff and the physician to look at possible causes of weight loss or things that could interfere with weight stability like mouth pain, medication side effects, lack of appetite, or possible swallowing issues to get appropriate referrals if needed; -When unplanned weight loss is found, she would expect the nursing staff to start an intervention like a Med Pass supplement within 48 hours;-She was not involved in the IDT meetings to discuss possible reasons for weight loss. That information would come to her after the IDT meeting to discuss the resident;-She did not know about Resident #5's unplanned significant weight loss until his/her visit at the facility on 12/23/26, and she recommended Med Pass be started. Staff did not contact her before that date about the resident's unplanned significant weight loss;-She would expect them to try a supplement or something prior to three weeks for Resident #5;-Resident #6 has been up and down over the years, he/she was stable for a while. She would expect staff to try monitor the resident at meals to see if the resident needed assistance or cues and assess for other issues that could be causing him/her to lose weight again;-She would want staff to try different things and see if anything would help to stabilize the resident's weight, and document those attempts. During an interview on 01/15/26, at 4:10 P.M. the Medical Director (also Resident #6's primary physician) said the following:-He considered weight loss significant if a resident had a loss of 5% of their body weight in one month, or 10 % in six months;-Significant weight loss can increase the risk of decline in physical abilities, skin issues, weakness, falls, and other systemic issues; When significant weight loss was identified, he expected staff to call/contact the physician, then he would give an order to check the resident's weight more often, like weekly and would order something to help with the weigh' loss, like supplements or medications such as appetite supplements;-He expected staff to check for possible issues including ill-fitting dentures, possible swallowing issues, or if the resident needed assistance or cues with eating;-When on weekly weights, he expected staff to check the weekly weight and if the resident's weight goes down, staff should consult the dietitian and/or him;-When there is a weight loss, medication side effects should be reviewed, dental and swallowing issues considered, level of needed assistance assessed and attempts to find a reason for the weight loss;-If there was a resident with weight loss or a concern, he would expect staff to monitor and document consumptions of meals and supplements;-Finding the root cause of the weight loss like mouth pain, medication side effects, lack of appetite help to address the issue and prevent further weight loss;-Possible interventions for weight loss include weekly weights, snacks, supplements, monitoring consumption, physician review, dietitian review, pharmacist review, possible speech therapy or dental referral;-Resident #6 lost weight, gained some back, and then started losing weight again;-He expects staff to notify him every time a resident loses weight as he may try something new;-He doesn't remember when/if staff told him about weight loss;-If he was told about the weight loss, he would have immediately ordered something to try;-When alerted about the weight loss, he would have looked at the residents' medications, possibly tried Remeron (an antidepressant that stimulates appetite), asked staff to try assisting the resident to eat, added or increased supplements, and possibly other interventions after discussion with staff to see what could be attempted.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to provide a clean, comfortable, safe, and homelike environment by failing to maintain ceilings, walls, railings, floors, doors and toilets, in resident rooms and bathrooms, in good repair. The facility failed to maintain outside gutters and trim in good repair. The facility census was 40. Upon request, the facility did not provide a policy related to maintaining the environment. 1. Observation on 01/06/26 through 01/09/26, during the survey process, showed the following in occupied resident room [ROOM NUMBER]: -Build-up of dirt around the bottom trim, where the wall met the floor, around the room;-Three strips of duct tape, each approximately 6 - 8 inches long, on the bathroom floor, covering cracks or broken tile;-A golf ball size portion of the bathroom floor tile missing;-The bathroom floor tiles had a buildup of dirt;-Anti-skid tape in front of the toilet was worn off in places and curling on the edges;-The door frame going into the bathroom had scrapes in multiple places, exposing the metal underneath;-A gold tack strip covering where the bathroom floor and bedroom floor met. The strip was not flush with the floor and was slightly raised, approximately 1/4 inch; the state agency (SA) could not smoothly rub a shoe covered foot across the strip without catching on the strip. During an interview on 01/06/26 at 12:04 P.M., the resident who resided in room [ROOM NUMBER] said the following: -His/Her room needed a deep cleaning, especially around the baseboards; staff sweep daily and mop almost daily, but they never do a deep clean and never clean the baseboards;-The duct tape on the bathroom floor had been there for a long time;-He/She had reported the broken bathroom floor tiles and the raised tack strip going from the bedroom to the bathroom a few times and did not know if a maintenance request was completed.-The metal strip going into his/her bathroom is raised and he/she has stumbled on it about three times;-He/She has not fallen but is afraid he/she will. 2. Observations on 01/07/26 at 9:32 A.M. and 01/09/26 at 10:15 A.M., in the women's shower room on 200 hall, showed the following:-The door to the room did not close fully and remained open approximately 1 inch (the door did not latch in the frame or have a privacy latch);-The door frame was chipped and missing paint across 25% of the lower 3-foot section of the frame. The plastic material that covered the left side of the frame was torn in a 4-inch section;-The toilet was marred with gray scratches across the front surface and the caulk around the base of the toilet was discolored brown with sections of missing caulk;-Approximately ten tiles on the wall next to the toilet were duct taped to the wall; the wall had one missing tile and several bulging tiles. Where wall tile was missing the wall surface underneath was brown and crumbling. Wall tiles near the toilet were cracked and damaged;-The grip strips on the floor in front of the toilet, were worn and disintegrating with adhesive showing;-The shower head had scaling, and the water pressure was low when turned on with water leaking between the head and the hose; -Drywall tape was coming loose from the wall, with cracks in the tape and mud, where the wall and the ceiling met near the room divider;-The linen cart cover was folded over the top of the cart with two clean, unused incontinent briefs, nine pairs of gripper socks and a hanger, the top shelf had clean linens and a bath basin with scissors and a resident's personal shampoo sitting on top of the clean gowns, the second shelf had another bath basin sitting on top of clean linens with a used shampoo and condition bottle in it, the third shelf had the ties of a gown hanging down touching the floor; -The tile on the floor by the tub was soiled with dark brown debris. During an interview on 01/07/26 at 2:42 P.M., Resident #20 said the shower rooms needed to be repaired. The rooms were dirty and smelled bad. 3. Observation on 01/06/26 at 10:48 A.M., showed the following: -The flooring of occupied resident room [ROOM NUMBER] had residue left from old gripper strips in the middle of the floor and chips in the paint on the door frame exposing metal underneath;-The brass door plate of occupied resident room [ROOM NUMBER] had several black marred areas at the base of the brass door plate;-The wall from room [ROOM NUMBER] to 105 had a long, black marred area below the handrail;-The wall from room (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	[ROOM NUMBER] to room [ROOM NUMBER] had a long, black marred area above the handrail;-The 100 hall wooden handrail had mars and nicks down the entire handrail with exposed wood;-The door frame of occupied resident room101 had nicks in the paint, exposing the metal underneath;-The door frame of occupied resident room103 had nicks in the paint, exposing the metal underneath;-The door frame of occupied resident room105 had nicks in the paint, exposing the metal underneath;-The door frame of occupied resident room110 had nicks in the paint, exposing the metal underneath. 4. Observation on 01/06/26 at 12:30 P.M., showed the ceiling in the dining room with dry wall tape hanging, and a large amount of mud from repairing the ceiling that was not sanded or painted. 5. Observations on 01/07/26 at 9:40 A.M. and 01/09/26 at 10:25 A.M., in the men's shower room on the 200 hall showed the following:-The paint was missing on 25% of the door frame and the plastic material that covered the hinge side of the frame was missing in a two-inch by eight-inch area;-The room smelled like sewer gas;-The toilet bowl lid had an opening exposing the bowl of the toilet; the bowl of the toilet had silver streaks and gouges in the toilet bowl; -The floor in front of the toilet had grip strips that were worn with irregular shapes and holes in the black strips;-An approximate six foot section of trim was missing between the wall and the ceiling with some paint peeled back and the area between the wall and the ceiling had varying shades of a brown substance. 6. Observations on 01/07/26 from 8:34 A.M. to 4:42 P.M., during the Life Safety Code tour of the facility, showed the following: -In room [ROOM NUMBER], a board that was previously attached to the wall (to protect the wall from damage from the bed frame) was no longer attached, sat along the base of the bed between the wall and the bed, and had exposed screws sticking out of the board; -In the bathroom to room [ROOM NUMBER], the floor around the toilet was discolored brown and was missing caulk around the toilet base; -In room [ROOM NUMBER], a 3-inch by 18-inch section of cove base trim was no longer attached to the wall. There was a 1-inch hole in the wooden door to the bathroom; -In room [ROOM NUMBER], approximately 25% of the paint on the door frame to the bathroom was missing. The wooden door was badly chipped on the hinge side of the door; -In room [ROOM NUMBER], the metal threshold strip between the room and bathroom was not securely attached to the floor and was coming up approximately 0.5-inches on both sides of the strip; -In the bathroom between rooms [ROOM NUMBERS], there were pieces of duct tape on the floor. The threshold from room [ROOM NUMBER] to the bathroom was raised at the edges and corners and did not provide a smooth transition between the two areas. The mounting hardware on the grab bars was not mounted flush to the wall and created a 0.5-inch gap between the wall and upper portion of the grab bar; -In room [ROOM NUMBER], an approximate 1-foot by 2-foot brown stained area was on the ceiling. There was excessive wear on the bathroom door frame with approximately 50% of the paint missing from the lower left (latch side) portion of the frame; -In room [ROOM NUMBER], there was a 3-inch by 3-inch missing section of floor tile and two 1-inch by 2-inch missing sections of floor tile. The floor under the wardrobe had an excess accumulation of dirt and debris buildup; -In room [ROOM NUMBER], a 3-inch by 12-inch broken section of unpainted wall by the heating/air conditioning unit was pushed in 0.5-inches and was not flush with the rest of the wall. There were worn, scraped areas on the wall by the door to the bathroom that were missing paint in a 3-inch by 2-foot area. The cove base trim was loose from the wall, with an approximate 1-inch gap between the trim and the wall, and had exposed nails; -In room [ROOM NUMBER], an approximate 2-foot by 2-foot patched area of ceiling was loose and coming away from the ceiling surface. The metal kickplate on door to the bathroom was loose and missing a screw on the top left corner of the kickplate; -In the bathroom between rooms [ROOM NUMBERS], there were two 1-inch holes in the wall above the grab wall that were not filled or painted; -In room [ROOM NUMBER], there was a 1-inch hole and six pencil-sized holes in the wall above the television; -In room [ROOM NUMBER], a board that was once attached to the wall was coming off the wall and created a 3-inch gap between the board and the wall. Behind the loose board, there was a large, unpainted indented area on the wall; -In room [ROOM NUMBER], the wall near the bathroom was heavily marred across its surface with gray marks and peeling paint. The door frame to (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	the bathroom was missing paint across 75% of the lower 2-foot portion of both sides of the frame. The door to the bathroom was badly worn and had several chipped and scraped areas across its surface; -In the bathroom of room [ROOM NUMBER], the floor around the toilet was discolored gray and black and was missing caulk around the toilet base; -In room [ROOM NUMBER], there was a 0.5-inch by 3-inch areas of painted wall that was coming loose above the cove base trim. The veneer on the base of the wardrobe was badly chipped, the exposed particle board was swollen, and the drawers would not open freely; -In the bathroom between room [ROOM NUMBER] and 308, the base of the toilet had a 6-inch long crack in it and the floor around the toilet was discolored brown in a 4-inch by 6-inch area; -In room [ROOM NUMBER], there was a heavy accumulation of dirt buildup under both wardrobes; -In room [ROOM NUMBER], there was a moderate accumulation of dirt and debris under the wardrobe. A board that was once attached to the wall behind a bed was on the floor. Where the board had been attached, there were deep gouges in the unpainted wall; -In room [ROOM NUMBER], a board approximately 1-foot by 5-foot in size that was once attached to the wall lay on the nearby bed. The unpainted wall where the board was attached had several small holes. The floor around the base of the toilet was discolored brown and was missing caulk around the toilet which created a 0.25-inch gap between the floor and the toilet; -In room [ROOM NUMBER], 90% of the paint on the bathroom door was missing from the lower 1-foot section of door frame (hinge side) and there was a 1-inch by 3-inch tear in the plastic material that covered the latch side of the door frame; -In the soiled utility room, a 6-inch by 2-foot section of tile flooring and a 3-inch by 3-inch area tile flooring was missing and the concrete under the missing tiled areas was exposed; -The sitting area by the nurses' station had a 2-foot by 2-foot section of ceiling that was discolored brown; -The drinking water fountain by the janitor's closet (across from the nurses' station) had dried drips and stains across the surface of the unit. There was dried black and brown debris on the drain area and white crusty debris around the nozzle. 7. Observations on 01/07/26 from 4:43 P.M. to 5:08 P.M., during the outside Life Safety Code tour, showed the following: -Several triangular sections of wood, measuring approximately 2-foot by 8-inches and located at the corners of the building, had heavy rot damage and approximately 75% of the paint was missing from the wood. The trim boards near these triangular sections and under the roof line and gutters were also missing paint across their surface; -The gutter outside room [ROOM NUMBER] was not securely connected and the downspout was disconnected; -A section of gutter on the 300 hall was cracked and an excess accumulation of dried leaves was visible in the cracked area. 8. During an interview on 01/09/26 at 9:05 A.M., the Maintenance Director said he started at the facility a couple days prior to the survey. He was just trying to get acquainted with the facility. He had not done a full environment assessment and did not know where the maintenance documentation was other that what the Administration had in his office. During an interview on 01/06/25 at 8:53 P.M. and 01/09/26, at 8:53 P.M., the Administrator said the following:-The metal plate between the room and bathroom should be flush and not create a potential fall hazard.; -Environment issues are taken care of through housekeeping and maintenance staff when they are working or cleaning;-He was trying to get quotes on fixing the broken tiles in the women's shower room, but the work had not been scheduled yet;-The dining room ceiling keeps coming down; he has personally tried to fix it without success;-If staff identify an area that needs to be fixed, they are to put the identified need in the maintenance book.

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F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician. Based on interview and record review, the facility failed to employ a qualified dietary manager with appropriate competencies and skills set to carry out the function of the food and nutrition services program. This practice affected all residents at the facility. The facility census was 40.Review of the facility's Facility Assessment, dated 02/11/25, showed the following:-Average daily census 45;-Services and care offered are based on our resident needs: Nutrition - individualized dietary requirements, liberal diets, specialized diets, IV nutrition, tube feeding, cultural or ethnic dietary needs, assistive devices, fluid monitoring or restrictions, hypodermoclysis;-Facility resources needed to provide competent support and care for our resident population every day and during emergencies: Food and Nutrition Services (Director, support staff, registered dietitian);-Staffing plan for food and nutrition service staff: three full time staff on days, three part time staff on evenings, one dietitian or other clinically qualified nutrition professional to serve as the director of food and nutrition services. Review of the facility's current employee list showed Head Dietary [NAME] A started employment with the facility on 9/22/25. During an interview on 01/09/26 at 3:15 P.M., Head Dietary [NAME] A said he/she started at the facility four months ago. The facility did not have a dietary manager, and he/she was unsure how long the facility had been without a dietary manager. He/She was working to become a certified dietary manager but had not started any training. During an interview on 01/09/26 at 3:05 P.M., the Administrator said the facility had been without a dietary manager since June 2025. Head Dietary [NAME] A was currently going through training to become a certified dietary manager.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. Based on observation, interview, and record review, the facility failed to provide food items at a safe and appetizing temperature and taste. The facility census was 40. Review of the facility policy, Meal Service Temperatures, revised January 2016, showed the following: -Hot food shall be cooked or heated to a temperature above 165 degrees. Cold food shall be chilled to a temperature below 40 degrees;-The [NAME] shall take temperatures of food (as appropriate) during meal preparation to ensure food is cooked or chilled to the appropriate temperature. Staff shall also take the temperatures once the food is on the steamtable prior to the start of meal service.-Food which registers temperatures outside acceptable range shall be removed and reheated or rechilled to meet acceptable temperatures. 1. During an interview on 01/06/26 at 11:05 A.M., Resident #7 said the following:-He/She preferred to eat in his/her room. Sometimes the food staff served was warm but was not hot;-The food did not have much flavor;-Sometimes the food wasn't completely cooked; the vegetables were hard. -The textures of the food were not good. During an interview on 01/06/26 at 12:04 P.M., Resident #14 said the following:-He/She always ate in his/her room;-The food staff served at meals was not always warm; -The oatmeal was always cold; it tasted like it came straight out of the refrigerator. During an interview on 01/06/26 at 12:26 P.M., Resident #37 said the following:-The food did not taste good;-The bread was always hard and dry and did not have a good flavor. During an interview on 01/06/26 at 1:16 P.M., Resident #34 said the food was terrible. During an interview on 01/07/26 at 9:46 A.M., Resident #2 said the following:-The food was not good and usually was not well seasoned;-Sometimes the food looked good, but the flavor was bland;-The food was not always served hot;-Sometimes the food tasted like it came straight out of the can, and staff did not heat it. During an interview on 01/07/26, at 12:29 P.M., Resident #8 said sometimes the food at the facility was not good. 2. Review of the Diet Orders, printed 01/06/26, showed the following: -37 residents had a physician-ordered regular diet; -Three residents had a physician-ordered mechanical soft diet. 3. Observation on 01/06/26, in the kitchen, showed the following:-From 12:21 P.M. to 12:37 P.M., Head Dietary [NAME] A served food from the steam table to residents in the dining room;-From 12:37 P.M. to 12:59 P.M., Head Dietary [NAME] A plated hall trays, added a plate cover to each plate of food, and staff placed the trays of food on a cart;-At 12:59 P.M., Head Dietary [NAME] A plated a test tray of food items. Dietary Aide Q placed the test tray on the cart with the resident hall meal trays and transported the cart to each of the resident halls;-Staff did not check the temperature of the food during the meal service. Observation on 01/06/26 from 1:02 P.M. to 1:22 P.M., showed staff served trays from the meal tray cart to residents' rooms on the 100-300 halls. Observation on 01/06/26 at 1:23 P.M., of the test tray, after staff served all residents, showed the following:-The temperature of the Italian vegetable blend was 104.9 degrees Fahrenheit (F). The vegetables tasted bland, and the green beans were very firm;-The temperature of the garlic bread was 98.8 degrees F. The crust of the bread was tough and the bread inside the crust was very chewy;-The lasagna tasted bland;-The chips (an alternate food item) tasted stale. 3. Observation on 01/07/26, in the kitchen, showed the following:-From 12:15 P.M. to 12:35 P.M., Head Dietary [NAME] A served food from the steam table to residents in the dining room;-From 12:35 P.M. to 12:48 P.M., Head Dietary [NAME] A plated hall meal trays, added a plate cover to each plate of food, and staff placed the trays of food on a cart;-At 12:48 P.M., Head Dietary [NAME] A plated a test tray of food items. Dietary Aide Q placed the test tray on the cart with the resident hall meal trays and wheeled the cart to each of the resident halls;-Staff did not check the temperature of the food during the meal service. Observation on 01/07/26 from 12:50 P.M. to 1:14 P.M., showed staff served trays from the meal tray cart to residents' rooms on the 100-300 halls. Observation on 01/07/26 at 1:15 P.M., of the test tray, after staff served all the residents, showed the following:-The temperature of the corn was 111 degrees F. The corn tasted cool, oily, and bland;-The temperature of the peach cobbler was 66.9 degrees F. The cobbler consisted primarily of 1-inch by 2-inch slices of peach that were very firm with a small (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Country View Nursing	2106 West Main Bowling Green, MO 63334

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	amount of yellow cake mix powder on top of the peaches;-The tuna noodle casserole had a strong tuna flavor and was dry and pasty in texture;-The temperature of the tomato soup (an alternate food item) was 117.7 degrees F and tasted cool;-The temperature of the grilled cheese sandwich (an alternate food item) was 102.9 degrees F. The sandwich was very firm to bite, difficult to chew, dry, and sponge-like in texture. 4. During an interview on 01/06/26 at 11:58 A.M., Head Dietary [NAME] A said staff should heat the food to 150-160 degrees Fahrenheit (F) and place it into the steam table. He/She was not sure what temperature food should be when served to the residents. During an interview on 01/09/26 at 3:05 P.M., the Administrator said the facility had been without a dietary manager since June 2025. The food staff served to residents should taste good. Hot foods should be hot, and cold foods should be cold.

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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 store, prepare, and serve food in accordance with professional standards for food service safety. Staff did not practice proper hand and glove hygiene or hair restraint usage. Staff did not maintain surfaces and equipment to be free from a buildup of grease and debris. Staff failed to ensure an air gap was present at the ice machine drains to prevent possible backflow from the drain back into the ice machine. The facility census was 40. 1. Review of the facility policy, Sanitation, revised January 2016, showed employees shall wash their hands: after touching bare human body parts (face, nose, etc.); after using the restroom; after coughing, sneezing, using a handkerchief or tissue; after eating or drinking; after handling soiled equipment; as much as possible during food preparation to remove soil and contamination and to prevent cross contamination; when changing tasks; when changing from handling raw to ready-to-eat food; before donning gloves; and after engaging in any activity or task which contaminates hands. Review of the facility policy, Food Handling and Use of Gloves, revised January 2016, showed the following: -Staff shall use gloves when making direct contact with food and when handling the area of utensils or supplies that will come in direct contact with foods;-Glove use will be observed during the following procedures: during food preparation which requires direct hand contact; when handling of utensils may cause direct contact with the part of the utensil that may come in direct contact with food; when handling soiled dinnerware; when bussing tables and washing dinnerware and utensils; and when deemed appropriate by the Dietary Manager or Consulting Dietitian. -When donning gloves, hands must be washed. Once gloves are donned, one job should be completed. When changing jobs or major tasks, gloves should be removed and discarded. New gloves should be put on after hands are washed. Observation on 01/06/26 from 10:24 A.M. to 10:33 A.M., in the kitchen, showed the following: -Nurse Aide H used an ice scoop to scoop ice from a cooler into cups with lids for residents; -He/She dropped a lid to one of the cups onto the floor, picked up the lid, and placed the lid on the beverage preparation counter; -He/She picked up the dropped lid from the counter and carried it to the dishwashing area and placed it into a dishwashing rack; -Without washing his/her hands, he/she returned to the counter where he/she continued to scoop ice into residents' cups. Observation on 01/06/26 from 12:18 P.M. to 12:59 P.M., in the kitchen, showed the following: -Head Dietary [NAME] A used his/her gloved hands to sort residents' meal cards at the steam table counter; -He/She dropped a meal card onto the floor, picked up the card, and placed the card on the steam table counter with the rest of the cards; -Without washing his/her hands or changing his/her gloves, he/she served food from the steam table onto residents' plates for the lunch meal service. He/She touched the serving utensil handles and grasped bread with his/her gloved hands. He/She touched his/her glasses and then touched the eating surface of plates, serving utensil handles, and resident meal cards;-While wearing the same gloves, he/she reached into a bag of chips, grasped chips with his/her hand, and placed the chips onto a resident's plate; -He/She removed his/her gloves, did not wash his/her hands, and made a grilled cheese sandwich at the stove. He/She touched the surface of the sandwich in the pan with his/her bare hands as he/she flipped the sandwich. Observation on 01/06/26, from 12:15 P.M. to 12:35 P.M., showed the following:-Nurse Assistant H served meal trays to residents in the dining room;-He/She served Resident #6 his/her tray. He/She touched each of the resident's beverage cups (filled with beverages) by the drinking surface as he/she took the cups off the tray and placed them on the table;-He/She did not perform hand hygiene and served Resident #11 his/her tray. He/She touched each of the resident's beverage cups by the drinking surface as he/she took them off the tray and placed them on the table; -He/She did not perform hand hygiene and served Resident #3 his/her tray. He/She touched each of the resident's beverage cups by the drinking surface as he/she took them off the tray and placed them on the table;-He/She continued serving trays and drinks to other residents in the dining room and (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	touched the drinking surfaces of each glass. During an interview on 01/09/26 at 3:15 P.M., Head Dietary [NAME] A said staff were to change their gloves when soiled and to wash their hands after they touched dirty surfaces. Staff should not touch ready-to-eat food items with bare hands and should not pick up dropped items and place them on the counter. Staff should not touch the eating and drinking surfaces of cups, plates, and utensils. 2. Review of the facility policy, Personal Hygiene and Appearance, revised January 2016, showed staff shall wear hair nets or hair coverings while in the kitchen or storage areas. Observation on 01/06/26 from 10:20 A.M. to 10:24 A.M., in the kitchen, showed the following: -Nurse Aide H walked into the kitchen and walked by Head Dietary [NAME] A who was cutting up tomatoes at the food preparation table; -Nurse Aide H did not wear a hair restraint and had an approximately 8-inch long ponytail that was not contained in a hair restraint; -Nurse Aide H scooped ice from the ice machine into a cooler on a cart. Observation on 01/06/26 from 12:20 P.M. to 12:59 P.M., in the kitchen during the lunch meal service, showed the following:-Dietary Aide Q wore a hair restraint but several six-inch long sections of his/her hair, located along the front and sides of his/her head, were not contained within the hair restraint;-He/She opened the reach-in refrigerator and removed a tray of uncovered bowls of pudding;-He/She placed the bowls of pudding, cups filled with beverages, and silverware onto residents' meal trays. During an interview on 01/09/26 at 3:15 P.M., Head Dietary [NAME] A said staff were to wear hair restraints in the kitchen that fully covered their hair. 3. Review of the facility policy, Department Sanitation, revised 01/2016, showed the following: -Department sanitation shall be maintained in a manner to support procedures for Food Safety. Staff shall be responsible for daily and weekly cleaning assignments as determined by the Dietary Manager and/or his/her designee. -Cleaning assignments shall include all equipment, cabinets, storage areas, walls, floors and refrigeration units. Cleaning of equipment condensers, lights, vents, etc. shall be completed by the Maintenance Department as determined by the Administrator. Observation on 01/06/26 at 9:58 A.M., during the initial tour of the kitchen, showed the following: -In the walk-in cooler, trash, food debris, and a dried black residue was visible on the middle of the metal floor and under the shelves. The floor had several areas of rust with pitted sections and was not a smooth, cleanable surface; -The rangehood contained four baffle filters that protected a six-burner stove, ovens, griddle, and fryer. The filters above the six-burner stove and oven had a moderate accumulation of yellow grease and fuzzy debris. The filters above the griddle, oven, and fryer had a heavy accumulation of yellow grease and fuzzy debris. Dark yellow and brown grease drips were visible along the edges above and below the filters;-One of two light bulbs under the rangehood did not contain a cover;-The backsplash above the stove and griddle had food splatters and grease across the surface; -Two of six stove burners had a heavy accumulation of black encrusted debris; -The surfaces of the fryer and the surfaces between the fryer and griddle had a heavy accumulation of grease splatters and food debris; -The inside of the ice machine had black moist specks on the underside of the lid and along the edge of the lid; -A large metal ice scoop, located inside a wall-mounted ice scoop holder, had various white drips scattered across the scoop's surface. There was a moderate accumulation of moist, brown residue at the bottom interior of the scoop holder where the tip of the scoop rested; -The metal wire bread storage rack, located next to the ice machine, was heavily corroded with areas of rust across 50% of the rack's surface; -There were ten light fixtures located in the food preparation and serving areas. A heavy accumulation of dust and cobwebs was visible on four of the ten fixtures. Two of the ten fixtures did not have a cover. Six of the ten fixtures were broken and had pieces missing from the covers; One of the ten light fixtures was not illuminated; -The light fixture by the exit did not contain light bulbs or a cover and was not illuminated; -Two of two light fixtures in the clean dish storage area had a heavy accumulation of dust and debris. One of the two light fixtures did not have a cover or light bulbs in the fixture; -Two of the five fixtures in the dishwashing area were not illuminated. Three of the five fixtures did not have a cover, and one fixture was cracked with missing pieces; During an interview on 01/06/26 at 10:24 A.M., Head Dietary [NAME] A said he/she started work at the facility four (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	months ago and the lights (that were not working) had not worked since she started. He/She told the prior maintenance staff who said the reason the lights didn't work was due to the fixtures needing new ballasts. During an interview on 01/09/26 at 3:15 P.M., Head Dietary [NAME] A said he/she expected food and non-food surfaces in the kitchen to be clean. Staff should store, prepare, and serve food in a safe and sanitary manner. Staff deep cleaned the kitchen weekly but there was not a cleaning schedule. There was no dietary manager at the facility. 4. Observation on 01/06/26 at 10:19 A.M., of the ice machine in the kitchen, showed there was no air gap at the drain. The ice machine drain at the back of the unit was connected to an approximately 3-foot gray flexible hose that was inserted directly into an approximately 2-inch PVC floor drainpipe. During interviews on 01/06/26 at 10:19 A.M. and on 01/09/26 at 3:15 P.M., Head Dietary [NAME] A said he/she was unsure if the ice machine drain in the kitchen had an air gap. He/She thought maintenance staff was responsible for ensuring there was an air gap at the ice machine drain. During an interview on 01/028/26 at 10:02 A.M., the Maintenance Director said he was unaware the kitchen ice machine drain did not contain an air gap to prevent possible backflow from the drain back into the ice machine. During an interview on 01/09/26 at 3:05 P.M., the Administrator said maintenance staff was responsible for ensuring the ice machine drain had an air gap.

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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 develop complete policies and procedures to monitor the facility's water system and implement the facility policy to monitor for Legionella (a bacterium that can cause a serious type of pneumonia called Legionnaires' Disease that included specific control parameters based on the Center for Disease Control and Prevention (CDC) and the American Society of Heating, Refrigerating and Air Conditioning Engineers (ASHRAE)) standards. The facility failed to follow infection control practices when staff failed to utilize proper Transmission Based Precautions (TBP) when caring for one resident (Resident #34), who was positive for COVID (coronavirus disease 2019 - a contagious respiratory disease) infection and in isolation. The facility failed to ensure a barrier was utilized during use of a blood glucose monitor (device used to evaluate a drop of blood to determine the amount of sugar in the blood) for two residents (Resident #3 and #29) and one additional sampled resident (Resident #15). The facility failed to ensure the multi-use blood glucose monitor was properly cleaned after each resident use for two residents (Resident #3 and #29). The facility failed to ensure Tuberculin Skin Tests (TST) were completed and documented in accordance with the requirements for Tuberculosis (TB) (infectious bacterial disease that affects the lungs) testing for long-term care employees when the facility failed to ensure the first-step TST was administered and read in the appropriate time frame for two employees (Licensed Practical Nurse (LPN) B and Housekeeper O) in a review of 10 newly hired employees and failed to ensure the second-step TST was administered and/or read in the appropriate time frame for one employee (Certified Occupational Therapy Assistant (COTA) O). The facility census was 40. Review of the Centers for Medicare and Medicaid Services (CMS) Survey and Certification (S&C) letter 17-30, dated 06/02/17 and revised on 06/09/17, showed the following:-Facilities must develop and adhere to policies and procedures that inhibit microbial growth in building water systems that reduce the risk of growth and spread of Legionella and other opportunistic pathogens in water;-CMS expects Medicare certified healthcare facilities to have water management policies and procedures to reduce the risk of growth and spread of Legionella and other opportunistic pathogens in building water systems. An industry standard calling for the development and implementation of water management programs in large or complex building water systems to reduce the risk of legionellosis was published in 2015 by American Society of Heating, Refrigerating, and Air Conditioning Engineers (ASHRAE). In 2016, the CDC and its partners developed a toolkit to facilitate implementation of this ASHRAE Standard (https://www.cdc.gov/Legionella/maintenance/wmp-toolkit.html). Environmental, clinical and epidemiological considerations for healthcare facilities are described in this toolkit;-Conduct a facility risk assessment to identify where Legionella and other opportunistic waterborne pathogens could grow and spread in the facility water system;-Implement a water management program that considers the ASHRAE industry standard and the CDC toolkit, and includes control measures such as physical controls, temperature management, disinfectant level control, visual inspections, and environmental testing for pathogens;-Specify testing protocols and acceptable ranges for control measures and document the results of testing and corrective actions taken when control limits are not maintained. Review of the undated, Centers for Disease Control and Prevention Legionella Environmental Assessment Form, showed Legionella generally grew well between 77 degrees Fahrenheit (F) and 113 degrees F. The optimal growth range for Legionella is between 85 degrees F and 108 degrees F. Review of the Centers for Disease Control Developing a Water Management Program to Reduce Legionella Growth & Spread in Buildings Toolkit, dated 06/24/21, showed the following: -Clinicians should test patients with healthcare-associated pneumonia (pneumonia with onset ^48 hours after admission) for Legionnaires' disease. This is especially important among patients at increased risk for developing Legionnaires' disease (see Appendix B), among patients with severe pneumonia (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	(particularly those requiring intensive care), or if any of the following are identified in your facility: -Other patients with healthcare-associated Legionnaires' disease diagnosed in the past 12 months;-Positive environmental tests for Legionella in the past 2 months; -Current changes in water quality that may lead to Legionella growth (e.g., low residual disinfectant levels, temperatures permissive to Legionella growth, nearby construction, areas of stagnation); -Other patients, besides those with healthcare-associated pneumonia, should also be tested for Legionnaires' disease (see Appendix B). The preferred diagnostic tests for Legionnaires' disease are culture of lower respiratory secretions on selective media and the Legionella urinary antigen test.-Symptoms of Legionella include headache, confusion, cough, shortness of breath, nausea, vomiting, diarrhea, fever, chills, tiredness, muscle or body aches;-Symptoms usually begin two to ten days after being exposed to Legionella. Review of the undated, facility Legionella Water Management Program, showed the following:-Our facility is committed to the prevention, detection and control of water-borne contaminants, including Legionella;-As part of the infection prevention and control program, our facility has a water management program, which is overseen by the water management team;-The water management team will consist of at least the following personnel: Infection preventionist, administrator, medical director (or designee), director of maintenance, and director of environmental services;-The purpose of the water management program is to identify areas in the water system where Legionella bacteria can grow and spread, and to reduce the risk of Legionnaire's disease;-The water management program used by our facility is based on the Centers for Disease Control and Prevention and ASHRAE recommendations for developing a Legionella water management program;-The water management program includes the following elements: 1. An interdisciplinary water management team; 2. A detailed description and diagram of the water system in the facility, including receiving, cold water distribution, heating, hot water distribution; and waste; -The identification of areas in the water system that could encourage the growth and spread of Legionella or other waterborne bacteria, including storage tanks, water heaters, filters, aerators, showerheads and hoses, misters, atomizers, air washers, humidifiers, hot tubs, fountains, and medical devices such as CPAP machines, hydrotherapy equipment; etc.;-The identification of situations that can lead to Legionella growth, such as construction, water main breaks, changes in municipal water quality, the presence of biofilm, scale or sediment, water temperature fluctuations, water pressure changes, water stagnation and inadequate disinfection;-Specific measures used to control the introduction and/or spread of legionella (e.g., temperature, disinfectants);1. The control limits or parameters that are acceptable and that are monitored;2. Diagram of where control measures are applied;3. System to monitor control limits and the effectiveness of control measures;4. Plan for when control limits are not met and/or control measures are not effective; and;5. Documentation of the program;-The Water Management Program will be reviewed at least once a year, or sooner if any of the following occur:a. The control limits are consistently not met;b. There is a major maintenance or water service change;c. There are any disease cases associated with the water system; or;d. There are changes in laws, regulations, standards or guidelines.Review of the facility's Legionella policy, dated 01/14/23, showed the previous administration had developed a water flow map and had parts of the CDC Legionella tool kit in the binder. The binder included the members of the water management team by staff name and their responsibilities. All the staff listed were former employees that were no longer employed by the facility. Review of the facility Water Safety Management Assessment and Plan, dated 01/14/23, showed the following:The building is a healthcare facility where residents stay overnight, and house/treat people who have chronic and acute medical problems or weakened immune systems;-The building primarily house people older than sixty-five years old;-The facility must have a water management program for hot and cold-water distribution system;-The facility water flow map was last updated 01/14/23 (the plan had not been reviewed yearly as the Legionella Water Management Program policy directed). Upon request, the facility was not able to provide a facility risk assessment to identify where Legionella and other opportunistic waterborne pathogens could grow (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	and spread in the facility water system as CMS directed. 1. Review of the facility Antibiotic Stewardship Log, dated 09/01/25-12/31/25, showed the following:-Resident #116 was diagnosed with pneumonia on 09/25/25; no documentation to show the resident was tested for Legionnaires' disease;-Resident #45 was diagnosed with pneumonia on 10/6/25; no documentation to show the resident was tested for Legionnaires' disease;-Resident #31 was diagnosed with pneumonia on 11/6/25; no documentation to show the resident was tested for Legionnaires' disease. During an interview on 01/08/26 at 5:46 P.M., the facility Infection Preventionist (IP) said the following:-Legionella is a water borne disease;-Maintenance staff would be the water management team, so she is not on the water management team;-She does not know how to test for Legionella; -They do not do any screening or testing for residents with new cases of pneumonia for possible Legionella. During an interview on 01/09/26 at 9:05 A.M., the Maintenance Director said the following:-He just started this week;-He does not know what Legionella is, or the ASHRAE guidelines; -He knows to check to make sure the water was hot but not scalding;-He did not know if there was a water management policy or if there was a water flow map for the facility;-He was not sure what the water temperatures should be; -He has not seen the facility water temperature documentation. During an interview on 01/09/26 at 9:10 A.M., the Director of Nursing (DON) said the following:-She did not know if the facility had a water management team; -She did not know what the signs and symptoms of Legionella infection were; nursing was not monitoring for Legionella. During an interview on 01/09/26 at 9:15 A.M., the Administrator said the following:-The facility did not have an active water management team;-The facility was expected to check water temperatures and do test sticks, but he was not sure what the test sticks measured;-He did not know if the facility implemented the CDC Legionella toolkit;-He was not familiar with ASHRAE guidelines;-The facility did not have a water management program at this time;-He had not seen the facility water temperature documentation and did not think they had any water temperatures documented. 3. Observation of water temperatures on 01/09/26 at 10:00 A.M. to 10:36 A.M., showed the following water temperatures fell between 77 and 113 degrees, temperatures at which legionella generally grows well:-At 10:00 A.M., occupied resident room [ROOM NUMBER] sink, hot water temperature measured with a digital thermometer read 105 degrees Fahrenheit (F); -At 10:05 A.M., occupied resident room [ROOM NUMBER] sink, hot water temperature measured with a digital thermometer read 104.3 degrees F; -At 10:13 A.M., occupied resident room [ROOM NUMBER] sink, hot water temperature measured with a digital thermometer read 107.2 degrees F; -At 10:15 A.M., 200 hall women's shower room, shower head read with a digital thermometer showed the hot water read 104.5 degrees F, the shower head had very low water pressure and scaling;-At 10:27 A.M., 200 hall men's shower room, shower head read with a digital thermometer showed the hot water read 104.5 degrees F, the shower head had very low water pressure and scaling. 4. Review of the facility's COVID-19 Action Plan, updated 05/22/23, showed the following: -Policy statement: The practices are based on infection prevention and control recommendations form the CDC, Centers for Medicare and Medicaid Services (CMS), World Health Organization (WHO);-Source Control: refers to use of respirators, well-fitting face masks, or well-fitting cloth masks to cover a person's mouth and nose to prevent spread of respiratory secretions when they are breathing, talking, sneezing, or coughing;-PPE for healthcare personnel (HCP) who enter the room of a resident with suspect or confirmed COVID-19 should adhere to standard precautions and use a NIOSH approved respirator with N95 filters or higher, gown, gloves, and eye protection (goggles or face shield). 5. Review of Resident #34's electronic health record showed the resident had a positive diagnosis of COVID on 01/05/26. Observation on 01/07/26 at 6:38 A.M. showed the following: -Resident #34 had his/her call light activated;-The resident was in an isolation room due to a diagnosis of Covid; the door was closed with a droplet precautions sign on the outside of the resident's door and a PPE cart directly outside the resident's room that included N95 masks, goggles, gloves and gowns; the signage instructed staff to utilize gowns, gloves and mask (not specifically N95);-Certified Nurse Assistant (CNA) I was wearing a black surgical mask;-CNA I (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Country View Nursing	2106 West Main Bowling Green, MO 63334

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	entered the resident's room at 6:38 A.M. and provided care with no PPE applied or N95 mask applied per facility policy;-CNA I exited the resident's room at 6:45 A.M., performed hand hygiene with alcohol based hand sanitizer, continued to wear the same black surgical mask, answered another resident's call light (this resident was not in an isolation room) and assisted the resident with a transfer and to use the bathroom. During an interview on 01/07/26 at 6:58 A.M., CNA I said the following:-Resident #34 was on isolation due to a diagnosis of Covid;-When caring for a Covid resident, staff should wear a gown, gloves and an N95 mask;-He/She did not apply a gown or N95 to care for the resident because the resident was on the commode, and he/she was unsure how long the resident's call light had been going off;-He/She would normally put on all the PPE, gown, gloves, N95 mask or goggles, when going into a Covid positive resident room, but did not with Resident #34 because he/she was in a hurry;-Without using proper PPE, the infection could be spread to another resident or staff member. During an interview on 01/08/26 at 1:30 P.M. and 01/09/26 at 8:53 P.M., the DON said the following:-The facility followed CDC guidelines on PPE use for residents on isolation due to COVID positive status;-She expected staff to apply a gown, gloves, N95 face mask and eye protection when entering a COVID positive room to provide any resident care. 6. Upon request, the facility did not provide a policy related to blood glucose testing. 7. Review of the undated American Health Care Association, Tips for Meeting the Cleaning and Disinfection of Blood Glucose Meters Requirements in Skilled Nursing Facilities, showed the following: -Place barrier under blood glucose meter when in resident's room or placed on top of medication cart to avoid spread of microorganisms and contamination of surfaces and other equipment or supplies;-Tip: Place clean and dry paper towel(s) under blood glucose meter before placing on resident table or on top of medication cart. 8. Review of the undated Sani-Cloth Germicidal Disposable Wipes online manufacturer's instructions for use showed the following:-Sani-Cloth wipes are used for fast-acting, broad-spectrum disinfection of hard, non-porous surfaces in healthcare settings;-To use: remove visible soil, wipe the surface thoroughly with a fresh cloth to ensure it remains visibly wet for the required contact time (2 minutes for Super Sani-Cloth);-Key Procedures for Use:-Disinfecting: Using a new wipe, thoroughly wipe the surface, ensuring all areas and crevices are covered.Contact Time: The surface must remain visibly wet for the full, EPA-registered contact time specified on the canister (typically 2 minutes depending on the product);-Drying & Disposal: Allow the surface to air dry completely. 9. Review of Resident #15's annual Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 12/12/25, showed the resident had a diagnosis of diabetes mellitus (a chronic disease process where there is too much sugar in the blood stream). Observation on 01/08/26 at 5:50 P.M., showed the following: -The IP removed supplies and a multi resident used glucometer from the medication cart drawer and laid them on the top of cart without a barrier; -The IP took the supplies into the resident's room, and without preparing a barrier, placed the supplies, including the single test strip, on the resident's bedside table; -Items on the resident's bedside table included two empty food packets, a urinal half full of yellow urine, an empty urinal and food crumbs in the same location of the blood glucose testing supplies;-The IP completed the Accu check procedure, rolled the supplies up (including the lancet and blood filled test strip) into her gloves, removed the gloves and threw them into the resident's trash can and performed hand hygiene with an alcohol based hand sanitizer;-The IP took the glucometer and placed it on top of the medication cart;-The IP cleaned the glucometer with a purple top Sani-wipe for approximately 2-3 minutes, threw the wipe away and placed the glucometer on top of the medication cart; the top of the medication cart had not been cleaned and no barrier under the glucometer. During an interview on 1/8/25, at 6:03 P.M., the IP said the following: -She should have placed a barrier on the resident's bedside table prior to placing the blood glucose testing supplies on the table;-The glucometer should not have been placed on the medication cart without a barrier, after the glucometer had been cleaned;-A barrier should have been placed on the medication cart to place the glucometer on to allow it to air dry. 9. Review of Resident #3's quarterly MDS, dated [DATE], showed the resident had a diagnosis of diabetes mellitus. Observation on 01/07/26 at 5:42 (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	P.M., showed the following: -LPN B had just used the multi resident use glucometer on a resident and sat it on top of the medication cart without a barrier; -LPN B took two Sani-wipes out of a purple top container and placed the glucometer between the two wipes and left it sitting for two minutes;-LPB B picked up the glucometer and threw the wipes away;-LPN B did not rub the glucometer off with the wipes;-LPN B placed the glucometer back on top of the medication cart;-The top of the medication cart had not been cleaned and no barrier placed for the glucometer. Observation on 01/07/26 at 5:46 P.M. and 5:49 P.M., showed the following:-LPN B placed the glucometer directly on top of Resident #3's left leg while he/she cleaned the resident's finger with an alcohol pad;-LPN B performed the Accu check procedure and sat the glucometer directly on top of the medication cart without a barrier;-LPN B took two Sani-wipes out of a purple top container and placed the glucometer between the two wipes and left it sitting for two minutes;;-At 5:49 P.M. LPB B picked up the glucometer and threw the wipes away;-LPN B did not rub the glucometer off with the wipes;-LPN B placed the glucometer directly on top of the medication cart without a barrier. 10. Review of Resident #29's quarterly MDS, dated [DATE], showed the resident had a diagnosis of diabetes mellitus. Observation on 01/07/26 at 5:53 P.M., showed the following:-LPN B gather supplies from the cart to check the resident's blood sugar;-LPN B picked the glucometer up off the medication cart, took the supplies into the resident's room and sat the glucometer directly on top of a desk without a barrier;-LPN B completed the Accu check procedure and sat the glucometer directly on top of the medication cart without a barrier;-LPN B took two Sani-wipes out of a purple top container and placed the glucometer between the two wipes and left it sitting for two minutes;-At 5:54 P.M. LPN B picked up the glucometer and threw the wipes away;-LPN B did not rub the blood glucometer off with the wipes. During an interview on 01/09/26 at 11:55 A.M., LPN B said the following:-He/She did not put the glucometer on a barrier;-He/She did not rub the glucometer with Sani-wipes; he/she thought the glucometer was clean after sitting in between two Sani-wipes for two minutes;-He/She did not know the glucometer needed to be on a barrier in a residents' room or on the medication cart;-He/She did not feel the glucometer needed to be on a barrier after it was cleaned;-He/She had never been instructed to use a barrier; -He/She did not know the glucometer should not have been set directly on the residents' leg before she used the blood glucometer to conduct an Accu check for a resident. During an interview on 01/09/26, at 8:53 P.M., the DON said the multi resident use glucometers should not be placed on a resident's bedside table or a resident's leg but should always have a barrier between the surface and the glucometer. 11. Review of the facility policy, Tuberculosis Screening - Employees, dated March 2019, showed the following: -It is the policy of this facility to assess risks for TB based on regional/community data and screen staff according to state law;-All healthcare workers are to be tested for TB upon hire and yearly thereafter unless contraindicated or in accordance with state requirements;-Initial testing will be a two-step procedure with the first does given before beginning work and the second given seven to 21 days after the first if the first dose is negative;-TST: employees who will be receiving the two-step TST may begin work after the first step results are negative. 12. Review of the Department of Health and Senior Services Tuberculosis Screening for Long-Term Care Facility Employees Flowchart (based on the requirements identified in the state regulation for administering TB testing), updated 03/11/14, showed the following:-Administer TST first step prior to employment. (Can coincide reading the results with the employee start date by administering TST two to three days prior to the employee start date);-Read results of first step TST within 48-72 hours of administration (results must be read and documented in millimeters (mm) induration prior to or on the employee start date);-If first TST is negative, administer second step within 1-3 weeks;-Read results within 48-72 hours of administration;-The employee cannot start work for compensation until the first step TST is administered and read. 13. Review of LPN B's employee file showed the following:-First date of paid compensation was 02/19/25;-First-step TST administered on 02/19/25 (the same day as paid compensation);-First-step TST read on 02/21/25 (two days after first date of paid compensation), results were 0 millimeters (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	(mm);(The employee received compensation before the first step TST was administered and read). Review of Housekeeper O's employee file showed the following:-First date of paid compensation was on 03/13/24;-First-step TST administered on 04/11/24 (29 days after first date paid compensation);-First-step TST read on 04/13/24 (30 days after first date of paid compensation), results were 0 mm;(The employee received compensation before the first step TST was administered and read). Review of COTA O's employee file showed the following: -First date of paid compensation was on 10/31/25;-An immunization record provided by the employee showed a first-step TST performed on 05/09/25, read on 05/12/25, results were 0 mm;-No documentation of a second step TST completed within 1-3 weeks after the first TST was read;-No record of a prior 2-step TST;-No documentation of a first-step TST administered by the facility;-No documentation of a second-step TST administered by the facility. 14. During an interview on 01/08/26 at 1:30 P.M. and 01/09/26 at 8:53 P.M., the DON said the following:-New employee TB tests were done by any nurse;-The first-step TST should be administered before starting and read either before starting work or on the first day of work;-She was responsible for tracking the new employee TB tests to ensure they were administered and read on or by the first day of compensation and resident contact. During an interview on 01/09/26, at 8:53 P.M., the administrator said the DON was responsible for ensuring the new hire TB tests are completed as required.

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F 0568 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Properly hold, secure, and manage each resident's personal money which is deposited with the nursing home. Based on interview and record review, the facility failed to implement policies and procedures to ensure resident trust accounts were not allowed to go into a negative balance for four residents (Resident #29, #9, #44 and #10) and one additional resident (Resident #103) in a review of 17 sampled residents. Further review showed the facility failed to obtain a signature from the resident when funds were removed from the Resident Trust Fund account, failed to send quarterly statements to the residents or the resident representatives for those with transactions in the Resident Trust Fund Account, and failed to reimburse the Resident Trust Fund account after charges for check printing fees were taken out of the Resident Trust Fund account. The facility held funds in the Resident Trust Fund account for 31 residents. The facility census was 40. Review of the facility policy, Facility Resident Trust Fund, revised May 2012, showed the following:-Purpose: To establish policy and procedures for the Facility Resident Trust Fund.-Policy: It will be the policy of the management company that the Resident Trust Fund is managed and accounted for in accordance with state and federal regulations. Each facility should follow the State Guidelines of the payment programs using the greatest level of specificity if requirements vary in State and Federal programs;-Procedure: All Resident Trust withdrawals must have the resident signature on a receipt & ledger page;-The manual Resident Trust Ledger cards, the Accounts Receivable Trust Balances per Resident, and the Bank Statement/Checkbook register should always all balance to each other. Any discrepancies should be reported to Administrator, Regional and Field Analyst immediately;-The above balancing should be done as close to month end as possible, any discrepancies or variances should be resolved immediately;-Any bank charge or fees for this account are the responsibility of the facility and shall be reimbursed to the Resident Trust bank account. 1. Review of the facility provided list of residents who held money in the Resident Trust Fund account, showed the facility held funds for 31 residents, including Resident #9, 10, 29, 44 and 103. 2. Review of Resident #29's face sheet showed he/she was his/her own responsible party. Upon request, the facility did not provide ledgers or receipts with the resident signature for transactions regarding the Resident Trust Fund account. Review of the resident's monthly, Resident Trust Fund account statement, dated 08/31/25, showed the following:-The statement was addressed to the resident in an apartment in another city; -Opening balance $0.00;-Effective date 08/20/25;-Description: Beauty Shop;-Debit amount $12.00;-Balance (-$12.00). Review of the resident's monthly, Resident Trust Fund account statement, dated 10/31/25, showed the following:-The statement was addressed to the resident in an apartment in another city; -Opening balance (-$12.00);-Closing balance (-$12.00). Review of the resident's monthly, Resident Trust Fund account statement, dated 11/30/25, showed the following:-The statement was addressed to the resident in an apartment in another city; -Opening balance (-$12.00);-Closing balance (-$12.00). During an interview on 01/08/26 at 11:37 A.M., the resident was able to respond to interview questions using a written communication board as well shaking his/her head yes or no:-He/She had no money in a resident trust account;-He/She had not been told by anyone he/she owed any money;-He/She had not received any statements showing he/she owed any money. 2. Review of Resident #9's face sheet showed he/she had a power of attorney. Upon request, the facility did not provide ledgers or receipts with the resident signature for transactions regarding the Resident Trust Fund account. Review of the resident's monthly, Resident Trust Fund account statement, dated 10/31/24, showed the following:-Opening balance $0.00;-Effective date 12/06/24;-Description: Beauty Shop; -Debit amount $12.00;-Balance (-$12.00). Review of the resident's monthly, Resident Trust Fund account statement, dated 03/31/25, showed the following:-Opening balance (-$12.00);-03/13/25 deposit $12.00;-Closing balance $0.00. Review of the resident's monthly, Resident Trust Fund account statement, dated 06/30/25, showed the following:-Opening balance $0.00;-Effective date 04/24/25;-Description: Beauty Shop:-Closing balance (-$12.00). Review of the (continued on next page)

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F 0568 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	resident's monthly, Resident Trust Fund account statement, dated 08/31/25, showed the following:-Opening balance (-$12.00);-Closing balance (-$12.00). Review of the resident's monthly, Resident Trust Fund account statement, dated 10/31/25, showed the following:-Opening balance (-$12.00);-09/25 deposit $100.00;-Balance $88.00. During an interview on 01/08/25 at 2:42 P.M., the resident's power of attorney said the following:-He/She had given the facility $100.00 for haircuts for the resident; -He/She had never been notified there was no money in the account;-He/She had never been notified the account had a negative balance;-He/She had never received a resident trust fund account statement from the facility. 3. Review of Resident #44's face sheet showed he/she had a legal guardian. Upon request, the facility did not provide ledgers or receipts with the resident signature for transactions regarding the Resident Trust Fund account. Review of the resident's monthly, Resident Trust Fund account statement, dated 08/31/25, showed the following:-Opening balance $0.00;-Effective date 08/20/25;-Description: Beauty Shop; -Debit amount $12.00;-Balance (-$12.00). Review of the resident's monthly, Resident Trust Fund account statement, dated 10/31/25, showed the following:-Opening balance (-$12.00);-Closing balance (-$12.00). Review of the resident's monthly, Resident Trust Fund account statement, dated 11/30/25, showed the following:-Opening balance (-$12.00);-Effective date 11/24/25 deposit $50.00;-Balance $38.00;-Closing balance $38.00. During an interview on 01/09/26 at 2:08 P.M., the resident's legal guardian said the following:-He/She had not received a resident trust statement from the facility;-He/She believed the resident was caught up and no longer in debt. 3. Review of Resident #10's face sheet showed he/she was his/her own responsible party. Upon request, the facility did not provide ledgers or receipts with the resident signature for transactions regarding the Resident Trust Fund account. Review of the resident's monthly, Resident Trust Fund account statement, dated 12/31/24, showed the following:-Addressed to the resident at an old address;-Opening balance $0.00;-Effective date 12/06/24;-Description: Beauty Shop; -Debit amount $12.00;-Balance (-$12.00);-Effective date 12/06/24; -Description: Beauty Shop;-Debit amount $12.00;-Closing balance: (-$24.00)(The statement showed two withdrawals for the same date of service for the same amount that no current employee could explain). Review of the resident's monthly, Resident Trust Fund account statement, dated 03/31/25, showed the following:-Addressed to the resident at an old address;-Opening balance (-$24.00);-Effective date 03/13/25 deposit $24.00;-Closing balance $0.00. During an interview on 01/09/26 at 10:15 A.M. the resident said the following:-He/She did not know if he/she had any money in the Resident Trust Fund account;-His/Her family took care of his/her money and any money that was in the Resident Trust Fund account would have to be sent by his/her family member;-He/She had never received a statement from the facility. During an interview on 01/09/26 at 7:23 P.M., the resident's family member said the following:-He/She did not know anything about a Resident Trust Fund;-He/She had never received a statement;-He/She had never been told his/her family member had a negative balance in the resident trust account. 4. Review of Resident #103's face sheet showed he/she had a guardian. Upon request, the facility did not provide ledgers or receipts with the resident signature for transactions regarding the Resident Trust Fund account. Review of the resident's monthly, Resident Trust Fund account statement, dated 08/31/25, showed the following:-Opening balance $0.00;-Effective date 08/20/25;-Description: Beauty Shop; -Debit amount $10.00; -Balance (-$10.00). Review of the resident's monthly, Resident Trust Fund account statement, dated 10/31/25, showed the following:-Opening balance (-$10.00);-Closing balance (-$10.00). Review of the resident's face sheet showed he/she discharged from the facility on 11/07/25. Review of the resident's monthly, Resident Trust Fund account statement, dated 11/30/25, showed the following:-Opening balance (-$10.00);-Closing balance (-$10.00). Review of the accounting records and Resident Trust Fund account showed no documentation the former resident, his/her guardian, or the facility, refunded the Resident Trust Fund account for the discharged resident's negative balance which began on 08/20/25. During an interview on 01/21/25 at 1:47 P.M., the resident's guardian said the following:-He/She did t know the resident owed any money to the Resident Trust Fund account for a (continued on next page)

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F 0568 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	haircut;-He/She had never received a statement for the Residents' Trust Fund account. 5. Review of the facility Resident Trust Fund Account bank statement, dated 12/31/24, showed a debit on 12/10/24 for deluxe checks for $22.50. Review of the facility, Resident Trust Fund Monthly Reconciliation, prepared by the BOM, showed the following:-December 2024; Variance of $22.50 for check order;-January 2025; no documentation of a variance of $22.50 for check order;-February 2025; no documentation of a variance of $22.50 for check order;-March 2025; no documentation of a variance of $22.50 for check order;-April 2025; -9. Variance of $22.50 for check order;-May 2025; -9. Variance of $22.50 for check order;-June 2025; -9. Variance of $22.50 for check order;-July 2025; -9. Variance of $22.50 for check order. Review of the accounting records and bank statements for the Resident Trust Fund account, showed no documentation in the months of December 2024, January 2025, February 2025, March 2025, April 2025, May 2025, June 2025 or July 2025, that the facility had refunded the Resident Trust Fund account for the 12/10/24 check order. Review of the facility Resident Trust Account bank statement, dated 08/31/25, showed a debit on 08/19/25 for deluxe checks for $22.50. Review of the facility, Resident Trust Fund Monthly Reconciliation, prepared by the BOM, showed the following:-August 2025; Variance of $45.00 for check order;-September 2025; Variance of $45.00 for check order;-October 2025; Variance of $45.00 for check order;-November 2025; Variance of $45.00 for check order. Review of the accounting records and bank statements for the Resident Trust Fund account, showed no documentation in the months of August 2025, September 2025, October 2025 or November 2025, that the facility had refunded the Resident Trust Fund account for the 12/10/24 or the 08/19/25 check orders. 6. During an interview on 01/16/26 at 12:55 P.M., the Social Service Director (SSD) said the following:-All checks must be signed by the administrator; -She could see a resident's Resident Trust Fund account balance in the facility electronic record, but she did not have physical access to the resident's monies; only the administrator had access to the Resident Trust Fund account. During an interview on 01/09/25 at 8:18 A.M. and 01/16/26 at 12:21 P.M., the Regional BOM said the following:-It was not okay for a resident to have a negative balance in the resident trust fund account;-Before October 2025, she would tell the previous SSD if a resident had a negative balance, the resident trust fund would be reimbursed with the facility petty cash; she did not know how residents got a negative balance in the first place;-The previous SSD should have been getting signatures from residents for withdrawals from the Resident Trust Fund account;-She was responsible for sending the Resident Trust Fund statements to residents and or their representatives;-Check fees should be reimbursed to the Resident Trust Fund account by the facility within 30 days; there were two check printing fees that still had not been refunded to the Resident Trust Fund account. She was responsible for ensuring any fees accrued were reimbursed back into the Resident Trust Fund account; she had not sent the paperwork to corporate for the reimbursement process yet. During an interview on 01/08/25 at 4:44 P.M., 01/16/26 at 12:00 P.M. and 01/21/25 at 1:24 P.M., the Administrator said the following:-Basic haircuts were billed by adding up the total haircuts given to residents and writing a check out of the Resident Trust Fund account to the beautician; -The Resident Trust Fund account should not be used to pay for haircuts for those residents who do not have an account or any funds available;-He was unsure if residents were aware a Resident Trust Fund account was opened for them to pay for a haircut;-He did not know if residents were signing any document allowing money to be taken out of the Resident Trust Fund account for their haircut;-He checked each individual resident's balance in the Resident Trust Fund account before he authorized money to be taken out of a residents' Resident Trust Fund account;-If a resident went into a negative balance, it was okay because they would have a check/deposit for $50.00 put in the account the next month; -It would not be okay for another resident to be using another residents' money;-The SSD should have a resident sign a paper with a receipt for each withdrawal that was made from the resident's Resident Trust Fund Account for record keeping purposes;-If a resident discharged and had a negative balance in the Resident Trust Fund account, it would be corporate's responsibility to put money back into the resident trust account to cover the negative balance;-The (continued on next page)

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	265419	A. Building B. Wing	01/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Country View Nursing	2106 West Main Bowling Green, MO 63334

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F 0568 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Regional BOM was responsible for sending monthly Resident Trust Fund statements to the resident or responsible party for those who had a Resident Trust Fund account;-The Resident Trust Fund account was not supposed to be charged any kind of fees, i.e. check printing.

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F 0569 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Notify each resident of certain balances and convey resident funds upon discharge, eviction, or death. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure ten additional residents (Resident #108, #109, #110, #112, #106, #107, #111, #113, #114 and #115), who were discharged from the facility and held money in the Resident Trust Fund account, had their funds reimbursed to the appropriate entity within the required timeframe of their discharge. The facility census was 40. Review of the facility policy, Facility Resident Trust Fund, revised [DATE], showed the following:-Policy: It will be the policy of the management company that the Resident Trust Fund is managed and accounted for in accordance with state and federal regulations. Each facility should follow the State Guidelines of the payment programs using the greatest level of specificity if requirements vary in State and Federal programs;-Refund check requests for discharged or expired residents should have copies of the resident's ledger card balance and A/R system balance before a check can be signed. This must be completed within five business days of the resident discharge. Per state regulations, a completed discharge/trust fund accounting form reflecting discharge date and monies disbursed must be sent to the caseworker within five business days;-The facility shall refund the balance of the resident's personal funds when a resident is discharged . The amount shall be refunded by the end of the month following the month of discharge or by State/Federal specific guidelines if such policies are more stringent. The date, check number, and to close account should be noted on the Resident's ledger sheet. A copy of the check in the resident file shall serve as sufficient documentation that funds were released;-If the facility does not receive notification of appropriate claim for deceased /discharged resident's funds, the unclaimed funds will be sent to the Unclaimed Property Section, Secretary of Revenue for the State with detailed information about the resident, next of kin if known, and amount of funds and such disbursement will be handled per the guidelines. 1. Review of the facility provided list of residents who held money in the resident fund account showed the facility held funds for thirty-one residents, including Resident #106, #107, #108, #109, #110, #111, #112, #113, #114 and #115. 2. Review of Resident #108's face sheet showed the following:-He/She was his/her own responsible party;-He/She discharged on [DATE]. Review of the resident's monthly Resident Trust Fund account statement dated [DATE], showed the resident maintained a balance of $2,162.73 in the Resident Trust Fund account. Review of the accounting records and Resident Trust Fund account showed no documentation the facility refunded money in the Resident Trust Fund account to the resident within five days of discharge. The facility held the resident's money 1,007 days past the date the money should have been returned/refunded. 3. Review of Resident #114's face sheet showed he/she discharged on [DATE]. Review of the resident's death in facility tracking Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated [DATE], showed the following:-The resident had expired;-The resident had been on Medicaid. Review of the resident's monthly Resident Trust Fund account statement dated [DATE] through [DATE], showed the resident maintained a balance of $45.36 in the Resident Trust Fund account. Review of the accounting records and Resident Trust Fund account showed no documentation the facility sent a notice of death to the state or refunded money in the Resident Trust Fund account to the State of Missouri by the end of the month that the resident expired, following the resident's death. The facility held the resident's money 342 days past the date the money should have been returned/refunded. 4. Review of Resident #109's face sheet showed the following:-He/She had a responsible party;-He/She discharged on [DATE]. Review of the resident's monthly Resident Trust Fund account statement dated [DATE], showed the resident maintained a balance of $105.11 in the Resident Trust Fund account. Review of the accounting records and Resident Trust Fund account showed no documentation the facility refunded money in the Resident Trust Fund account to the resident's responsible party within five days of discharge and as the facility policy directed. The facility held the resident's money 302 days past the date the money should have been returned/refunded. 5. Review of (continued on next page)

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F 0569 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #113's face sheet showed he/she was discharged on [DATE]. Review of the resident's death in facility tracking MDS, dated [DATE], showed the following:-The resident had expired;-The resident had been on Medicaid. Review of the resident's monthly Resident Trust Fund account statement dated [DATE] through [DATE], showed the resident maintained a balance of $462.80 in the Resident Trust Fund account. Review of the accounting records and Resident Trust Fund account showed no documentation the facility sent a notice of death to the state or refunded money in the Resident Trust Fund account to the State of Missouri by the end of the month that the resident expired, following the resident's death. The facility held the resident's money 283 days past the date the money should have been returned/refunded. 6. Review of Resident #115's face sheet showed he/she was discharged on [DATE]. Review of the resident's death in facility tracking MDS, dated [DATE], showed the following:-The resident had expired;-The resident had been on Medicaid. Review of the resident's monthly Resident Trust Fund account statement dated [DATE] through [DATE], showed the resident maintained a balance of $846.14 in the Resident Trust Fund account. Review of the accounting records and Resident Trust Fund account showed no documentation the facility sent a notice of death to the state or refunded money in the Resident Trust Fund account to the State of Missouri by the end of the month that the resident expired, following the resident's death. The facility held the resident's money 283 days past the date the money should have been returned/refunded. 7. Review of Resident #110's face sheet showed the following:-He/She was his/her own responsible party;-He/She discharged on [DATE]. Review of the resident's monthly, Resident Trust Fund account statement dated [DATE], showed the resident maintained a balance of $2.19 in the Resident Trust Fund account. Review of the accounting records and Resident Trust Fund account showed no documentation the facility refunded money in the Resident Trust Fund account to the resident within five days of discharge. The facility held the resident's money 219 days past the date the money should have been returned/refunded. 8. Review of Resident #112's face sheet showed the following:-He/She was his/her own responsible party;-He/She discharged on [DATE]. Review of the resident's monthly Resident Trust Fund account statement dated [DATE] through [DATE], showed the resident maintained a balance of $40.02 in the Resident Trust Fund account. Review of the accounting records and Resident Trust Fund account showed no documentation the facility refunded money in the Resident Trust Fund account to the resident within five days of discharge and as the facility policy directed. The facility had been holding the resident's money 210 days past the date the money should have been returned/refunded. 9. Review of Resident #106's face sheet showed the following:-He/She had a responsible party;-He/She was discharged on [DATE]. Review of the resident's monthly, Resident Trust Fund account statement, dated [DATE], showed the resident maintained a balance of $14.00 in the Resident Trust Fund account. Review of the accounting records and Resident Trust Fund account showed no documentation the facility refunded money in the Resident Trust Fund account tothe resident's responsible party within five days of discharge and as the facility policy directed. The facility had been holding the resident's money 200 days past the date the money should have been returned/refunded. 10. Review of Resident #107's face sheet showed the following:-He/She was his/her responsible party;-He/She was discharged on [DATE]. Review of the resident's monthly, Resident Trust Fund account statement, dated [DATE], showed the resident maintained a balance of $139.81 in the Resident Trust Fund account. Review of the accounting records and Resident Trust Fund account showed no documentation the facility refunded money in the Resident Trust Fund account to the resident's responsible party within five days of discharge. The facility held the resident's money 52 days past the date the money should have been returned/refunded. 11. Review of Resident #111's face sheet showed the following:-He/She had a responsible party;-He/She discharged on [DATE]. Review of the resident's monthly Resident Trust Fund account statement dated [DATE], showed the resident maintained a balance of $280.51 in the Resident Trust Fund account. Review of the accounting records and Resident Trust Fund account showed no documentation the facility refunded money in the Resident Trust Fund account to the (continued on next page)

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F 0569 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	resident's responsible party within five days of discharge. The facility held the resident's money 40 days past the date the money should have been returned/refunded. 12. During an interview on [DATE] at 12:55 P.M., the Social Service Director (SSD) said the following:-She had been in the SSD position since around the end of [DATE];-Prior to her assuming the role, it was the Regional Business Office Manager (BOM) who was responsible to track residents who had discharged or expired and if they had money in the Resident Trust Fund account; -If a resident was discharged or expired, money should be reimbursed back to the resident or their next of kin or responsible party; -If the resident was discharged after the end of October or [DATE], she would have been responsible for ensuring the resident got their money; -If the resident was receiving Medicaid when he/she expired, their money in the Resident Trust Fund should go back to the State of Missouri; -If a resident expired, she would reach out to the next of kin/responsible party to clarify were the Resident Trust Fund money should be sent;-If a resident was their own person and discharging from the facility, the facility would refund them their Resident Trust Fund account balance immediately. She would let the administrator know the resident was discharging and he would write out a check for the resident;-If she did not refund the money at the time of discharge, she would reach out to the resident by phone to get an address to send a check to. The check would come from their Resident Trust Fund and the facility would send the check;-All checks must be signed by the administrator; -She could see a resident's Resident Trust Fund account balance in the facility electronic record, but she did not have physical access to the resident's monies; only the administrator had access to the Resident Trust Fund account. Durning an interview on [DATE] at 8:18 A.M. and [DATE] at 12:21 P.M., the Regional BOM said the following:-A resident who had been discharged or had expired should not have money in the Resident Trust Fund account;-When a resident discharges, she emails the SSD letting them know if the resident had money in the Resident Trust Fund account and it was the SSD's responsibility to contact the resident and/or resident representative to find out where to send the refund check; -If a resident expired and had money in the resident trust account, it was the SSD's responsibility to notify the next of kin or representative there was money to be refunded and get the information on where to send a check, except if the resident was on Medicaid, then the money would be sent back to the State of Missouri;-It would be the SSD's responsibility to know if an expired resident was on Medicaid or was private pay to ensure the money was sent to the correct entity;-If an expired resident was on Medicaid, she would send a notice of death to the state and a letter would be sent back to let their corporate office know where the money needed to be sent; -The previous SSD had been doing these things, but with the new SSD, she had begun assisting her with her responsibilities beginning in [DATE];-She did not have a tracking system in place to know what residents had money in the resident trust fund account and had discharged or expired or to ensure the monies were reimbursed to the proper entity;-None of the monies had been refunded to the residents who had discharged or expired that were listed on the [DATE] Resident Trust Fund current account balance sheet, including Resident #106, 107, 108. 109, 110, 111, 112, 113, 114 and 115;-She was aware there were discharged and/or expired residents who still held funds in the resident fund trust account. During an interview on [DATE] at 4:44 P.M., [DATE] at 12:00 P.M. and [DATE] at 1:24 P.M., the Administrator said the following:-The BOM could find reports in the computer of the residents who were discharged or had expired;-He had not written any check out of the Resident Trust Fund after a resident had discharged . There were certain steps to take and documentation to be sent to the corporate office;-The BOM was to notify corporate when a resident had been discharged or expired and held money in the resident trust fund account;-The BOM and corporate should refund a discharged or expired resident's Resident Trust Fund account balance to the resident or the resident's representative;-A resident who had been discharged or expired should not have money in the Resident Trust Fund account;-Residents #106, #107, #108, #109, #110, #111 and #112, #113, #114 and #115 were discharged resident or residents who had expired and still held money in the Resident Trust Fund account. No refunds had been made for these residents that he was aware of;-He did not know the timeframe for money to be (continued on next page)

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F 0569 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	refunded to a resident or next of kin/responsible party;-He did not know any further information on why resident's who were discharged had not been reimbursed their money from the Resident Trust Fund account.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide a written notice of transfer to two residents (Residents #1 and #37), or their representatives, in a review of 17 sampled residents and to one resident (Resident #42), in a closed record review, when the residents were transferred to the hospital. The facility failed to provide a recapitulation of the resident's stay that included a summary of the resident's stay, a summary of the resident's status at the time of discharge and a reconciliation of all pre-discharge medications with the resident's post-discharge medications for Resident #42. The facility census was 40. Review of the facility policy, Transfer or Discharge Notice, revised December 2018, showed the following: -Under the following circumstances, the notice will be given as soon as it is practicable but before the transfer or discharge: -The health of individuals in the facility would otherwise be endangered; -An immediate transfer or discharge is required by the resident's urgent medical needs;-The resident and/or representative will be notified in writing of the following information: a. The reason for the transfer or discharge; b. The effective date of the transfer or discharge; c. The location to which the resident is being transferred or discharged ; d. A statement of the resident's rights to appeal the transfer or discharge, including: (1) the name, address, email and telephone number of the entity which receives such requests; (2) information about how to obtain, complete and submit an appeal form; and (3) how to get assistance completing the appeal process; e. The facility bed-hold policy; f. The name, address, and telephone number of the Office of the State Long-term Care Ombudsman; g. The name, address, email and telephone number of the agency responsible for the protection and advocacy of residents with intellectual and developmental (or related) disabilities (as applies); h. The name, address, email and telephone number of the agency responsible for the protection and advocacy of residents with a mental disorder or related disabilities (as applies); and i. The name, address, and telephone number of the state health department agency that has been designated to handle appeals of transfers and discharge notices. 1. Review of Resident #1's face sheet showed he/she had a durable power of attorney (DPOA). Review of the resident's nursing progress notes showed the following:-On 08/19/25 at 9:36 P.M., the resident went to the local hospital emergency room (ER) via ambulance with a temperature of 104.9 degrees Fahrenheit (normal is 98.6 degrees Fahrenheit) and vomiting;-On 08/28/25 at 2:00 P.M., the resident returned to the facility via ambulance.(Review of the resident's medical record showed no documentation the facility provided a transfer/discharge notice or copy of the bed hold policy to the resident or the resident's representative when the resident transferred to the hospital on [DATE]). Review of the resident's nursing progress notes showed the following:-On 09/18/25 at 9:35 P.M., the resident had complaints of nausea and shakiness. Staff notified the on-call physician at 9:14 P.M. and received orders to transfer the resident to the local hospital ER via ambulance. The ambulance transported the resident to the local hospital ER at 9:20 P.M. -On 09/19/25 at 6:24 A.M., the local hospital reported the resident was being admitted with acute respiratory distress (difficulty breathing), sepsis (a serious condition because of a complication with an infection) and urinary tract infection;-On 09/23/25, at 4:19 P.M., the resident was re-admitted to the facility. (Review of the resident's medical record showed no documentation the facility provided a transfer/discharge notice or copy of the bed hold policy to the resident or the resident's representative when the resident transferred to the hospital on [DATE]). During an interview on 01/09/26 at 4:36 P.M., the resident's DPOA said he/she did not receive any paperwork related to a transfer/discharge or the bed hold policy with any of the resident's hospitalizations. 2. Review of Resident #37's face sheet showed he/she had a DPOA/responsible party. Review of the resident's nursing progress notes showed the following:-On 07/29/25 at 2:06 A.M., the resident had aggressive projectile vomiting and a fever of 102.1 degrees F. The resident transferred to the local hospital ER via ambulance at 1:55 A.M.;-On 07/29/25 at 11:35 (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A.M., the resident admitted to the hospital for treatment of a urinary tract infection with sepsis;-On 08/02/25 at 12:39 A.M., the resident returned to the facility with a discharge diagnosis of bacteremia (bacteria in the blood). (Review of the resident's medical record showed no documentation the facility provided a transfer/discharge notice or copy of the bed hold policy to the resident or the resident's representative when the resident transferred to the hospital on [DATE]). During an email communication on 01/21/26 at 1:47 P.M., the resident's DPOA said he/she did not receive any paperwork related to a transfer/discharge or the bed hold policy with any of the resident's hospitalizations. 3. Review of Resident #42 closed record showed he/she had a DPOA. Review of the resident's progress notes showed staff documented the following: -On 12/03/25, at 12:13 P.M., the resident continued to hit, kick and yell at staff. The resident was sent for evaluation via ambulance at 12:00 P.M.; -On 12/03/25, at 9:20 P.M., the resident returned to the facility via ambulance after receiving as needed medication with no new orders and no specific diagnosis documented. (Review of the resident's medical record showed no documentation the facility provided a transfer/discharge notice or copy of the bed hold policy to the resident or the resident's representative when the resident transferred to the hospital on [DATE]). Review of the resident's progress notes showed the following: -On 12/06/25, at 11:23 P.M., the resident continued to have behaviors. The resident was transferred to the hospital via ambulance at 9:21 P.M.; -On 12/07/25, at 7:30 A.M., the resident returned to the facility via ambulance after receiving as needed medication with no new diagnosis. (Review of the resident's medical record showed no documentation the facility provided a transfer/discharge notice or copy of the bed hold policy to the resident or the resident's representative when the resident transferred to the hospital on [DATE]). Review of the resident's electronic health record census list showed he/she discharged from the facility on 12/09/25. Review of the resident's progress notes showed no documentation the resident was discharged from the facility on 12/09/25. Review of the resident's medical record showed no documentation the facility completed a recapitulation of the resident's stay which included a summary of the resident's stay, a summary of the resident's status at the time of discharge or a reconciliation of all pre-discharge medications with the resident's post-discharge medications. During an interview on 01/08/26 at 3:37 P.M., the resident's DPOA said the following:-He/She did not receive any paperwork related to a transfer/discharge or a bed hold policy with any of the resident's hospitalizations;-It was decided during a care plan meeting the resident would be discharged home;-The facility did not provide any paperwork at the time of discharge. The facility did not provide a summary of the resident's stay and did not provide a list of the resident's medications. 4. During an interview on 01/09/26 at 6:20 P.M., Licensed Practical Nurse (LPN) B said the following:-The charge nurse was responsible to provide the resident or their representative with a bed hold policy when the resident transferred to the hospital;-Staff did not give a written discharge notice upon transfer to the hospital. During interviews on 01/09/26 at 10:28 A.M. and 9:25 A.M., and 8:53 P.M., the Director of Nursing (DON) said the following:-The charge nurse completed a bed hold agreement with the resident prior to or at the time the resident was sent to the hospital or as soon as possible;-The facility did not have a written transfer/discharge notice to give to the resident or their representative when a resident transferred to the hospital. -Staff should complete a discharge summary/recapitulation and give it to the resident or representative prior to discharge;-Resident #42 discharged from the facility after his/her care plan meeting, and there was not enough time for staff to give him/her or his/her DPOA a recapitulation of his/her stay.

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F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure meals and snacks are served at times in accordance with resident?s needs, preferences, and requests. Suitable and nourishing alternative meals and snacks must be provided for residents who want to eat at non-traditional times or outside of scheduled meal times. Based on observation, interview and record review, the facility failed to ensure residents received sufficient nourishing bedtime snacks. The facility census was 40. Upon request, the facility did not provide a policy for bedtime snacks. 1. Review of the facility provided, mealtime service schedule, showed the following:-Supper to be served at 5:30 P.M.;-Breakfast to be served at 7:45 A.M.;(14.25 hours between meals). 2. During the group interview on 01/07/26 at 2:42 P.M., residents said the following:-Resident #17 said staff used to pass snacks every night, but now the residents must ask for snacks; snacks most generally are cookies and snack cakes, sometimes graham crackers; there are not enough snacks available for everyone in the building to have one if they want it;-Resident #25 said snacks used to be put on a cart at the nursing station, but one resident would go up and take multiple snacks, so now they are not available for residents to go up and get one; he/she asks for snacks in the evening, and they frequently run out of snacks, so he/she does not get one;-Resident #20 said staff tell the residents they must get their work done before they can get a snack if the resident requests it; sometimes they don't get him/her a snack until after 9:00 P.M. and that snack is a high sugar snack. He/She is diabetic and should not have a sugary snack because it affects his/her morning blood sugar; it would be nice to have a snack that was not sweet but rather something with some protein. 3. Observation on 01/07/26 and 01/08/26 at 6:30 P.M. and 01/09/26, from 6:30 P.M. through 8:50 P.M., showed the following:-No snacks at the nursing station;-No staff passing or offering snacks to the residents; -No cooler was observed at the nursing station. 4. During an interview on 01/09/26 at 3:15 P.M., Head [NAME] A, said the following: -He/She directs staff to prepare the evening snack in a cooler and deliver it to the nursing staff to take care of the snack pass; -Bedtime snacks included graham crackers, oatmeal cream pies and cookies; no protein type snack was offered;-There are only 12-15 snacks prepared for the bedtime snack because not everyone takes one or wants one. During an interview on 01/09/26 at 3:05 P.M. and 8:53 P.M., the administrator said the following:-Bedtime snacks include vanilla wafers, cookies, graham crackers, pudding, applesauce and occasionally oatmeal cream pies;-Staff are to pass bedtime snack at 8:00 P.M.;-He feels like there are enough snacks put out every night for each resident to have one if they want it;-He would expect there to be enough snacks provided for each resident to have one;-There are no specific snacks for diabetic residents;-There are no specific protein-based snacks given nightly. During an interview on 01/15/26 at 4:10 P.M., the Medical Director said he would expect a protein-based snack to be available at bedtime for diabetic residents. He expects the facility to offer all residents a bedtime snack.

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	265419	A. Building B. Wing	01/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Country View Nursing	2106 West Main Bowling Green, MO 63334

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to maintain documentation to show the staff notified the resident's physician and the resident's representative following a significant weight loss and falls for one resident (Resident #5), in a sample of 17 residents. The facility census was 40. Review of the facility's policy Change in a Resident's Condition or status, revised December 2016, showed the following:-Our facility shall promptly notify the resident, his/her attending physician, and representative (sponsor) of changes in the resident's medical/mental condition and/or status;-The nurse will notify the resident's attending physician or physician on-call when there has been an accident or incident involving the resident, significant change in the resident's physical/emotional/mental condition, a need to alter the resident's medical treatment significantly;-Unless otherwise instructed by the resident, a nurse will notify the resident's representative when the resident is involved in any accident or incident, and when there is a significant change in the resident's physical, mental, or psychosocial status;-Except in medical emergencies, notifications will be made within 24 hours of a change occurring in the resident's medical/mental condition or status;-Notifications will be documented in the resident's medical record. 1. Review of Resident #5's face sheet showed the resident admitted to the facility on [DATE] and had a representative. Review of the resident's admission Minimum Data Set (MDS), a federally mandated assessment completed by staff, dated 10/30/25, showed the following:-Moderate cognitive impairment;-Required partial/moderate assistance from staff for chair/bed-to-chair transfer and toilet transfer;-Required substantial/maximal assistance from staff to stand, wheel 50 feet with two turns or wheelchair 150 feet; -Two non-injury falls, and one injury fall since admission;-Weight 115 pounds;-No weight loss or therapeutic/mechanical diet. Review of the resident's Weight Record showed the following: -On 10/31/25 at 1:55 P.M., the resident weighed 115.2 pounds; -On 11/07/25 at 4:57 P.M., the resident weighed 106.0 pounds (a 9.2 pounds, or 7.96%, weight loss in one week). Review of the resident's medical record showed no documentation staff notified the resident's physician, dietician or the resident's representative of the resident's significant weight loss. Review of the resident's Nurses Notes, dated 11/10/25, at 3:01 A.M., showed staff found the resident on the floor. The resident was able to move all his/her extremities without pain or discomfort. Staff notified the resident's representative. (Review showed no documentation staff notified the resident's physician of the resident's fall on 11/10/25.) Review of the resident's Nurses Notes, dated 12/15/25, at 10:30 A.M., showed the nurse and an aide noticed the resident tried to reach for his/her wheelchair. The resident reached too far and went down onto his/her knees from the bed in front of the wheelchair. Staff notified the Director of Nursing (DON), hospice and physician. (Review showed no documentation staff notified the resident's representative of the resident's fall on 12/15/25.) Review of the resident's Nurses Notes, dated 12/17/25, at 2:20 A.M. and 6:52 A.M., showed the resident walked out of his/her room with his/her walker and attempted to run towards the nurse's station. The walker wheels got caught and the resident fell on the floor. The resident grazed his/her head in the doorway near the door frame and landed on his/her right side. The resident complained of pain in the right side of his/her body near his/her hip. The resident refused pain medication. Staff notified hospice who advised not to send the resident to the hospital. Staff notified the resident's representative of the fall. (Review showed no documentation staff notified the resident's physician of the resident's fall on 12/17/25.) Review of the resident's Nurses Notes, dated 1/5/26, at 5:15 A.M., showed staff observed the resident on the floor in his/her bathroom. Staff assessed the resident assessed, and he/she had no obvious injuries. (Review showed no documentation staff notified the resident's physician or the resident's representative of the resident's fall on 01/05/25.)During an interview on 01/07/26, at 11:51 A.M., the resident's representative said the following:-Staff did not (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	call him/her every time the resident fell. Staff did not call him/her when the resident fell on [DATE]; -Staff did not make him/her aware the resident had lost weight;-He/She wanted to know everything regarding the resident, including falls, weight loss, or anything else significant. During an interview on 01/09/26 at 6:20 P.M., Licensed Practical Nurse (LPN B) said the charge nurses were responsible to call the physician and resident representatives when a resident fell or lost weight. During an interview on 01/09/26 at 8:53 P.M., the Director of Nursing said the charge nurse was responsible to update the physician and resident representative when a resident fell or had weight loss. During an interview on 01/09/26 at 8:53 P.M., the Corporate Nursing Manager said when staff identified a resident lost weight, staff should notify the resident's physician, representative, and the dietician. During an interview on 01/15/26, at 4:10 P.M., the Medical Director said the following:-A weight loss of 5% in one month was a significant weight loss; -He expected staff to contact the resident's physician when a resident had a significant weight loss;-Staff were to notify the resident's physician every time the resident fell, so the physician could investigate possible causes to prevent future falls.

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident when there is a significant change in condition **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to complete a significant change in status assessment (SCSA) Minimum Data Set (MDS), a federally mandated assessment instrument required to be completed by facility staff, for two residents (Residents #6 and #2), in a review of 17 sampled residents, within 14 days after the facility determined, or should have determined, there had been a significant change in the resident's physical or mental condition which had an impact on more than one area of the residents' health status and required interdisciplinary review and/or revision of the care plan. The facility census was 40.Review of the Long-Term Care Facility Resident Assessment Instrument (RAI) User's Manual, version 3.0 showed a significant change is a decline or improvement in a resident's status that:-Will not normally resolve itself without intervention by staff or by implementing standard disease-related clinical interventions and is not self-limiting;-Impacts more than one area of the resident's health status;-Requires interdisciplinary review and/or revision to the care plan.-The manual also showed a SCSA was appropriate if there was a consistent pattern of changes, with either two or more areas of decline, or two or more areas of improvement. This may include two changes within a particular domain (e.g., two areas of activities of daily living (ADL) decline or improvement);-Decline in two or more of the following: -Resident's decision-making ability has changed; -Presence of a resident mood item not previously reported by the resident or staff and/or an increase in the symptom frequency (PHQ-2 to 9(C)), e.g., increase in the number of areas where behavioral symptoms are coded as being present and/or the frequency of a symptom increases for items in Section E (Behavior); -Changes in frequency or severity of behavioral symptoms of dementia that indicate progression of the disease process since the last assessment; -Any decline in an ADL physical functioning area (e.g., self-care or mobility) (at least 1) where a resident is newly coded as partial/moderate assistance, substantial/maximal assistance, dependent, resident refused, or the activity was not attempted since last assessment and does not reflect normal fluctuations in that individual's functioning; -Resident's incontinence pattern changes or there was placement of an indwelling catheter; -Emergence of unplanned weight loss problem (5% change in 30 days or 10% change in 180 days); -Emergence of a condition/disease in which a resident is judged to be unstable.-Improvement in two or more of the following: -Any improvement in an ADL physical functioning area (at least 1) where a resident is newly coded as Independent, setup or clean-up assistance, or supervision or touching assistance since last assessment and does not reflect normal fluctuations in that individual's functioning.Review of the facility's policy Significant Change in Status Assessment (SCSA) Completion-To ensure accurate, timely, and compliant completion of Significant Change in Status Assessments (SCSAs) in accordance with the Resident Assessment Instrument (RAI) Manual and all applicable federal and state regulations;-The MDS Department will follow the most current version of the CMS RAI Manual as the authoritative guidance for determining when a Significant Change in Status Assessment is required and for ensuring its completion within required timeframes;-All Significant Change in Status Assessments will be completed accurately, thoroughly, and within the timeframes outlined in the RAI Manual to reflect the resident's current condition, -support appropriate care planning, and maintain regulatory compliance;-A Significant Change in Status is defined by the RAI Manual as a major decline or improvement in a resident's physical, mental, or psychosocial status that:Is not self-limiting;Impacts more than one area of the resident's health or function;Requires interdisciplinary review or revision of the care plan;-The MDS nurse is responsible for using the RAI Manual criteria to determine whether a change meets the definition of significant. 1. Review of Resident #6's annual Minimum Data Set (MDS), a federally mandated assessment completed by staff, dated 10/31/25, showed the following:-Severe cognitive impairment, BIMS (Brief Interview for Mental Status) score five (0-15 scale, 0-7 scale severe cognitive impairment, 8-12 moderate cognitive impairment, and 13-15 cognitively intact;-No pain, or (continued on next page)

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	interventions for pain;-Weighs 117 pounds (lbs.);-AD, Antiplatelet, anticonvulsant-Oxygen therapy, -Influenza 10/14/24-Pneumococcal up to date, COVID not up to dateSection V: Cognitive loss/dementia, ADL, Urinary incontinence, falls, nutrition, pressure ulcer, psychotropic drugs Review of the resident's quarterly MDS, dated [DATE], showed the following:-Moderate cognitive impairment, BIMS 10 (improvement);-New as needed (PRN) pain medications administered, and non-medication intervention for pain (decline with new pain and new interventions);-Weighs 110 lbs. 5.9% in one month weight loss (change);-New mechanically altered diet (new intervention related to new weight loss);-New opioid (new medication in response to pain but can have side effects that could change other parts of the resident's care). The facility did not complete a SCSA when the resident had new weight loss, new pain, a new diet, new medications, and new interventions. 2. Review of Resident #2's annual MDS, dated [DATE], showed the following:- Cognitively intact;-Independent with eating;-Requires partial/moderate assistance from staff for toileting hygiene, lower body dressing, personal hygiene; - Indwelling urinary catheter;-Continent of bowel;-Diagnoses include stroke, heart failure, high blood pressure, benign prostatic hyperplasia (non-cancerous, age-related enlargement of the prostate gland), obstructive uropathy (blockage of urinary tract), diabetes mellites (inability to regulate blood sugar) hemiplegia (weakening or paralysis of one side of the body), anxiety, respiratory failure, insomnia, irregular heartbeat, tremor, and post-traumatic stress disorder;-PRN pain medications;-Occasional pain, rarely effects sleep, rates a seven (on 1-10 scale, 10 being worst pain);-Risk of pressure ulcers, no current skin issues;-No antidepressant medication;-Radiation therapy while a resident. Review of the resident's quarterly MDS, dated [DATE], showed the following:-Set up or clean up assistance from staff for eating (a decline); -Dependent on staff for toileting hygiene (decline), lower body dressing (decline), and personal hygiene (decline), -Indwelling urinary catheter removed (change);-Occasionally incontinent of bowel and bladder (decline);-New scheduled pain medication, and new non medication intervention for pain (new interventions);-New skin tear and dressing, nutrition and hydration intervention (change and new interventions)-Antidepressant medication added (change);-The resident no longer received radiation (improvement/change). During an interview on 1/8/26, at 2:58 P.M. and 01/26/26, at 12:26 P.M., the MDS/Care plan coordinator said the following:-She did all the MDS and care plan updates offsite;-She had been covering that position since the MDS coordinator left (a couple of months ago);-She does not get a lot of communication from the facility about who needs a significant change; if it triggered when she completed a MDS she will change the assessment to a significant change;-A significant change was required to be completed within 14 days of a change to the resident that would involve changes in two or more areas of the Activities of Daily Living (ADL)s or two changes other sections that are not expected to resolve within two weeks;-A SCSA is expected to be completed if there are two or more changes compared to the last comprehensive assessment (annual, admission, or SCSA);-She would complete the SCSA after communicating with the Director of Nurses (DON) and other department heads via emails or phone calls. During an interview on 01/09/26, at 8:53 P.M., the DON said she did not know much about SCSA requirements. She would ask the MDS coordinator for assistance with MDS questions. During an interview on 01/09/26, at 8:53 P.M., the Corporate Operations Manager said a SCSA was required when there were two or more changes compared to the last MDS, quarterly assessment or otherwise.

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F 0646 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the appropriate authorities when residents with MD or ID services has a significant change in condition. Based on interview and record review, the facility failed to notify the state mental health authority promptly after a significant change in the mental condition of a resident who has mental illness for one resident (Resident #4) in a review of 17 sampled residents. The facility census was 40. Review of the Resident Assessment Instrument (RAI) Manual, dated October 2025, showed the following:-Guidelines for Determining When a Significant Change Should Result in Referral for a Preadmission Screening and Resident Review (PASRR) Level II Evaluation:-If a Significant Change in Status Assessment (SCSA) occurs for an individual known or suspected to have a mental illness, intellectual disability, or related condition (as defined by 42 CFR 483.102), a referral to the State Mental Health or Intellectual Disability/Developmental Disabilities Administration authority (SMH/ID/DDA) for a possible Level II PASRR evaluation must promptly occur as required by Section 1919(e)(7)(B)(iii) of the Social Security Act.5;-Referral should be made as soon as the criteria indicating such are evident. The facility should not wait until the SCSA is complete;-Referral for Level II Resident Review Evaluations is also required for individuals who may not have previously been identified by PASRR to have mental Illness, intellectual disability/developmental disability, or a related condition in the following circumstances:A resident who exhibits behavioral, psychiatric, or mood related symptoms suggesting the presence of a diagnosis of mental illness as defined under 42 CFR 483.100 (where dementia is not the primary diagnosis). 1. Review of Resident #4's Level One Nursing Facility Pre-admission Screening for Mental Illness/Mental Retardation or related condition, dated 01/27/11, showed the following:-Section B: Level one screening criteria for serious mental illness;-Document was checked No;-Section C: Level on screening criteria for mental retardation or related condition;-Document was checked No;-Section D: Special admission categories;-Document was checked No. Review of the resident's Face Sheet showed the following:-Original admission date of 1/28/11;-admission diagnoses included no mental illness or mood disorders;-re-admission date of 12/23/15;-Diagnosis of major depressive disorder, recurrent, severe with psychotic symptoms;-New diagnosis of paranoid schizophrenia with an onset date of 09/26/22. Review of the resident's re-entry MDS, a federally mandated assessment instrument completed by facility staff, dated 12/05/22, showed the resident's acute hospital diagnosis included schizophrenia. Review of email communication from the surveyor with Central Office Medical Review Unit (COMRU), on 01/08/26 at 10:05 A.M., showed a Change in Status PASRR should have been submitted to COMRU when the new mental illness of schizophrenia was diagnosed. During an interview on 01/09/26 at 2:00 P.M., the Social Services Director (SSD), said the following -Residents usually had a DA124 (a state form used for applicants for nursing facility placement, including medical necessity) and Level I PASARR screening for mental illness or intellectual disability upon admission;-If a resident triggered for a Level II PASARR in the computer, she would follow up to ensure it was completed;-She would print the Level II PASARR out and put the document in the resident's chart;-The resident would need a level II PASARR if there was a change in condition, a new diagnosis or coming from a psychiatric hospital;-She had started as the SSD in October and was not responsible for obtaining a PASARR II for Resident #4;-Resident #4 had not been recently diagnosed with schizophrenia, so it would not have popped up on her list to conduct a follow up. During an interview on 01/09/26 at 8:53 P.M. the Director of Nursing (DON), said the following:- If someone had a new diagnosis of schizophrenia or a major change to their psychology, it would be between social services and MDS staff to determine if there needed to be a new PASSAR. During an email correspondence on 01/27/26 at 6:46 P.M., the MDS Coordinator said the following:-Social Services was responsible for the Level II PASARR to be done and scanned into the medical record;-If a new diagnosis of schizophrenia was determined in the hospital, the hospital staff should complete the PASARR prior to discharge;-The Social Service designee was responsible for ensuring a resident has a Level II PASARR with a new diagnosis of (continued on next page)

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F 0646 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	schizophrenia;-If a resident reentered the facility 12/05/22 with a new diagnosis of schizophrenia a Level II PASARR should have been completed by the hospital prior to discharge.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure one resident's (Resident #2) of 17 sampled resident's, comprehensive care plan included direction to the staff for the resident with a diagnosis of Post Traumatic Stress Disorder (PTSD, (a treatable mental health condition triggered by experiencing or witnessing terrifying, life-threatening, or traumatic events like violence, accidents, or disasters.) to ensure trauma-informed care was provided. The facility did not communicate triggers or interventions to eliminate or mitigate the resident's triggers that may cause re-traumatization. The facility census was 40. Review of the facility's policy Comprehensive Assessment and the Care Delivery Process, revised December 2016, showed the following:-Comprehensive assessments, care planning and the care delivery process involve collecting and analyzing information, choosing and initiating interventions, and then monitoring results and adjusting interventions;-Complete the Minimum Data Set (MDS) within 14 days after admission, within 14 days after it is determined that the resident has had a significant change in physical or mental condition, and annually.-Define issues, including problems, risk factors, and other concerns (to which all disciplines can relate).-Define conditions and problems that are causing, or could cause, other problems.-Identify potential causes or contributing factors of problems and symptoms, including:a. Medical;b. Psychosocial;c. Environmental; andd. Functional;-Try to determine the interrelationship between existing problems. -Determine the most plausible relationships between conditions and their causes. Review of the Resident Assessment Instrument (RAI) Manual, dated October 2025, showed the following:-The RAI and Care Planning as required at the comprehensive care plan is an interdisciplinary communication tool;-It must include measurable objectives and time frames and must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being;-The care plan must be reviewed and revised periodically, and the services provided or arranged must be consistent with each resident's written plan of care.-Following the decision to address a triggered condition on the care plan, key staff or the IDT should subsequently: Review and revise the current care plan, as needed; and communicate with the resident or their family or representative regarding the resident, care plans, and their wishes. Review the facility's policy Trauma Informed Care Policy, dated February 2021, showed the following:-It is the policy of this facility to consider residents' past traumatic experiences in developing person- centered care plans designed to avoid re-traumatization through the application of the principles of trauma-informed care;-Definitions:Trauma: Individual trauma results from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual well- being. The individual's experience of the event(s) determines whether it is a traumatic event. An event may be traumatic for one individual & not for another. The individual's interpretation will determine whether it is experienced as traumatic.Trigger: Something that causes the survivor to remember the traumatic event and induces a reaction similar to when they were originally traumatized. Triggers can re-traumatize survivors.Re-traumatization: Occurs when any situation, interaction, or environmental factor replicates events or dynamics of prior traumas and evokes feelings and reactions associated with the original traumatic experiences.-Care Planning for Trauma Survivors-Interdisciplinary staff work together with the resident/resident's representatives to assess the resident's needs and to identify triggers that may cause the survivor to remember the traumatic event and induce a reaction like when the resident was originally traumatized;-Strategies (interventions) to cope with triggers are included in the resident's plan of care;-Care plans are reviewed and revised as needed on at least a quarterly basis. 1. Review of Resident #2's face sheet showed a diagnosis of PTSD and anxiety disorder. Review of resident's Trauma Informed Care (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assessment, dated 11/27/19, showed the following:-The resident was interviewed about traumatic life events;-The resident has combat or exposure to a war zone;-The resident has PTSD, he said it bothers him/her when there is a crowd of people that are loud, seeing someone in an argument, or if it's quiet and a loud noise startles him/her. Review of resident's Trauma Informed Care Assessment, dated 11/11/22, showed the following:-The resident was interviewed about traumatic life events;-The resident experienced a very stressful event that makes him/her feel fearful, he/she prefers not to share information about it;-Triggers that prompt him/her to recall the previous traumatic events are loud noises and a sudden change in environment. Review of the resident's Care Plan, last updated 08/24/23, showed the following:-Psychotropic drug use related to PTSD, nightmares and insomnia;-Resident will be on lowest possible therapeutic dose through the next review;-Document any reports of insomnia or nightmares;-Follow up with psychiatric services for medication management;-Physician and consulting pharmacist to review medications and attempt a gradual dose reduction (GDR) as appropriate. The care plan did not identify what the resident's triggers were or what triggers had the potential to retraumatize the resident or increase the resident's anxiety. The care plan did not provide direction to staff for what interventions were specific relative to the resident's PTSD. Review of the resident's annual Minimum Data Set (MDS), a federally mandated assessment completed by staff, dated 07/23/25, showed the following:-The resident was a veteran;-No PASSR checked;-Cognitively intact;-No signs and symptoms of depression;-Diagnosis includes stroke, PTSD, anxiety, and insomnia; -Receives antipsychotic medication GDR attempted last attempt 06/05/25, physician documented clinical contraindication on 06/05/25. Review of the resident's quarterly MDS, dated [DATE], showed the resident has no symptoms of depression, no depression diagnosis, and was started on a new antidepressant medication. Review of the resident's care plan did not include the new antidepressant medication, why the resident required new antidepressant medication, or the resident's PTSD triggers with interventions on how to minimize possible triggers that could cause re-traumatization of the resident. During an interview on 01/06/26 at 9:43 A.M., the resident said the following:-He/She was a war veteran;-He/She had PTSD and loud crowds of people, people arguing and loud sudden noises, sometimes gave him/her flashbacks;-He/She can have nightmares at times;-He/She has told staff about it and thought it was on his/her care plan; this was important because the facility used a lot of agency staff, and he/she would want them to know what was going on if he/she could not tell someone. During an interview on 01/09/26, at 7:35 P.M., Certified Nurse Assistant (CNA) E said he/she had heard the resident had a diagnosis of PTSD. To his/her knowledge it had not affected the resident. He/She did not know what the resident's triggers were; these should be on the care plan. He/She was not sure if the resident had his/her PTSD triggers listed on the care plan. During an interview on 01/09/26, at 6:20 P.M., Licensed Practical Nurse (LPN) B said the following:-He/She worked as a charge nurse;-All information needed to take care of a resident was expected to be on the resident's care plan;-The resident has PTSD. During an interview on 01/09/25, at 8:43 P.M., showed the Director of Nursing said the following:-Trauma and diagnosis of PTSD were expected to be on the resident's care plan with triggers, and interventions to minimize triggers that could potentially retraumatize residents;-The facility does not have an in house MDS coordinator/care plan coordinator at this time, (offsite corporate staff assisting) but that role would normally ensure that PTSD and triggers were on the resident's care plan.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265419	A. Building B. Wing	01/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Country View Nursing	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)
F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure one resident (Resident #29), received the prescribed insulin dosage when staff failed to prime the insulin pen prior to administration per the manufacturer's guidelines, in a review of 17 sampled residents. The facility census was 40. Review of the facility's policy, Specific Medication Administration Procedures, dated June 1, 2018, showed the following:-Purpose: To ensure safe, accurate, and consistent administration of insulin using insulin pens or syringes;-Policy statement: All licensed nursing staff must follow proper priming and administration procedures when giving insulin to prevent dosing errors and ensure resident safety;- Priming the Insulin Pen: -Dial two units (or per manufacturer instructions); -Hold pen upright with needle pointing up; -Tap gently to move air bubbles to the top; -Press injection button until a drop of insulin appears at the needle tip; -If no drop appears, repeat priming once. If still unsuccessful, replace needle. Review of the online Novolog manufacturer's administration guidelines, dated September 2025, showed the following:-Novolog flex pen administration;-Apply the needle and take off the cap;-The air shot: -To avoid injecting air and to ensure proper dosing, perform an air shot; -Turn the dose selector to select 2 units; -Hold the Novolog flex pen with the needle pointing up; -Tap the cartridge gently with your finger a few times to get rid of any air bubbles that has collected at the end of the cartridge; -Keep the needle pointed upwards and push the dose selector until it returns to zero; -A drop of insulin should appear at the end of the needle; -With the dose selector at zero, dial up the correct dose of insulin units. 1. Review of Resident #29's quarterly [NAME] Data Set (MDS, a federally mandated assessment instrument required to be completed by facility staff), dated 10/21/25, showed the following:-Diagnosis of diabetes mellitus (inability to control blood sugar);-Daily insulin administration. Review of the residents' Medication Administration Record (MAR), dated January 2026, showed the following:-NovoLog injection solution 100 unit/milliliter (ML) (insulin Aspart), inject five (5) units subcutaneously (under the skin) before meals for blood sugar control;-Staff documented on 01/07/26 at 5:30 P.M., staff administered five units of insulin Aspart. Review of the resident's Treatment Administration Record (TAR) dated 01/07/26 at 5:57 P.M., Licensed Practical Nurse (LPN) B documented Novolog injection solution 100 units/ml was administered subcutaneously in the resident's left arm. Observation on 01/07/26 at 5:56 P.M., in an office by the dining room, showed the following:-LPN B cleaned the resident's left arm with an alcohol wipe;-LPN B cleaned the end of the Novolog pen with alcohol and applied a needle;-LPN B did not prime the needle;-He/She dialed up 5 units of Novolog insulin and showed the dose to the resident;-He/She administered the Novolog insulin subcutaneously into the resident's left arm;-He/She held the needle on the resident's arm for 17 seconds. During an interview on 01/09/26 at 11:55 A.M., LPN B said the following:-He/She had not primed the needle before administering Resident #29's insulin;-He/She was not aware he/she needed to prime insulin pens before administering the medication. During an interview on 01/09/26 at 8:53 P.M., the Director of Nursing (DON) said during insulin administration using a pen, staff needed to prime the needle with two units, administer the insulin and hold the pen on the resident's skin for 10 seconds.