STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265451	A. Building B. Wing	05/28/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Prairie View Skilled Nursing	606 West Missouri Street Bloomfield, MO 63825

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility failed to ensure the ice machine drain line maintained a required air gap (empty space that ensures dirty sewer water cannot flow backward into the ice machine and contaminate the ice) to prevent potential contamination. This deficient practice had the potential to affect all residents who consumed ice from the facility ice machine. The facility census was 45. Review of the facility's policy titled, Ice Machine and Ice Storage Chests, revised January 2012, showed:- Ice machines and ice storage/distribution will be used and maintained to assure a safe and sanitary supply of ice;- Ice-making machines, ice storage chests/containers, and ice can all become contaminated by:a. unsanitary manipulation by employees, residents, and visitors;b. waterborne microorganisms naturally occurring in the water source;c. colonization by microorganisms; and/ord. improper storage or handling of ice;- Did not address the air gap required for the ice machine. Observations on 05/26/26 at 9:32 A.M., and 3:36 P.M., 05/27/26 at 8:09 A.M., and 05/28/26 at 9:28 A.M., of the ice machine located in the dining room showed:- A bucket of discolored water placed on the left-side of the floor;- Two silk arrangements with a buildup of dust lay on top;- A round black plastic pipe connected from the back of the ice machine and inserted into a floor drain;- Water dripped from the pipe directly into the floor drain;- The ice machine drain line lacked an air gap to prevent direct contact between the pipe and the floor drain. During an interview on 05/28/26 at 1:46 P.M., the Dietary Manager said the ice machine drain line should have a maintained air gap to prevent backflow contamination and should not have been inserted directly into the floor drain. There should be nothing placed on top of the ice machine unrelated to its use.During an interview on 05/28/26 at 1:53 P.M., the Maintenance Supervisor said the ice machine drain line should have a maintained air gap to prevent contamination from the floor drain. During an interview on 05/28/26 at 2:05 P.M., the Administrator said the ice machine drain line should have a maintained air gap to prevent contamination from the floor drain. There should be nothing placed on top of the ice machine unrelated to its use.

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

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

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(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 - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on interview and record review, the facility failed to assess and investigate a choking incident that required the Heimlich maneuver (a procedure used to clear a blocked airway in a choking person) and failed to determine whether additional interventions were necessary to reduce a foreseeable risk of recurrent choking for one resident (Resident #2) out of one sampled resident. Following a choking incident that resulted in airway obstruction and required emergency intervention, the facility failed to investigate the cause of the incident, assess the resident's continued choking risk, evaluate the effectiveness of existing interventions, or determine whether revisions to the resident's care plan, diet, supervision, or other interventions were necessary to reduce the risk of recurrence. The facility census was 45.Review of the facility policy titled, Accidents and Incidents, revision date July 2017, showed:- All accidents or incidents involving residents, employees, visitors, etc., occurring on the premises shall be investigated and reported to the administrator;- Reports of accidents and incidents shall be reviewed to identify trends, accident hazards, and individual resident vulnerabilities. 1. Review of Resident #2's quarterly Minimum Data Set (MDS, a federally mandated assessment completed by the facility), dated 04/02/26, showed:- Diagnoses of dementia (general term for a group of neurological conditions that cause a decline in mental abilities that affects daily life), history of stroke, hemiplegia (paralysis on one side of the body), dysphagia (difficulty swallowing), anxiety, hypertension, post-traumatic stress disorder (PTSD), and psychotic disorder;- Partial/moderate assistance with eating;- Mechanically altered diet;- Dependence on staff for activities of daily living and mobility. Review of the resident's physician order sheet (POS), May 2026, showed:- Regular diet with mechanical soft texture, dated 09/17/24;- No bread or peanut butter sandwiches, dated 09/17/24. Review of the resident's care plan, last reviewed 04/16/26, showed:- Mechanical soft diet with small portions;- No bread and no peanut butter sandwiches;- One serving at a time;- Remind the resident to eat slowly and provide small portions to reduce choking risk;- Monitor for chewing and swallowing difficulties and obtain speech therapy evaluation if indicated;- History of choking requiring the Heimlich maneuver on 08/17/24. Review of the resident's nursing documentation, dated 05/24/26, showed:- The resident choked while eating in the dining room;- The resident turned red, could not cough or speak, and was unable to respond to verbal stimuli;- Staff performed the Heimlich maneuver three times before the resident expelled the obstruction and resumed breathing and speaking;- The physician and responsible party were notified. Review of the resident's medical record following the choking incident showed:- No documentation the facility investigated the choking incident;- No documentation staff assessed the cause of the choking episode;- No documentation staff evaluated the effectiveness of the resident's existing choking interventions following the incident;- No documentation staff reviewed whether changes to the resident's diet, supervision, feeding assistance, or care plan were necessary following the incident;- No documentation staff implemented additional interventions to address the resident's choking risk. Observations on 05/26/26, 05/27/26, and 05/28/26 showed Resident #2 continued to receive meals in the dining room. The medical record lacked evidence the facility had evaluated whether existing interventions remained effective following the choking incident requiring the Heimlich maneuver. During an interview on 05/28/26 at 9:40 A.M., the Director of Nursing stated she was unaware Resident #2 required the Heimlich maneuver during the choking incident. She said the resident's diet should have been reviewed following the incident and expected the resident to receive further evaluation after the choking episode. During an interview on 05/28/26 at 9:40 A.M., the Administrator said no investigation had been completed regarding Resident #2's choking incident and was unsure what investigation staff should have conducted. During an interview on 05/28/26 at 9:58 A.M., the Physician said he/she had been notified of the choking incident. He/She would expect further evaluation of speech and swallowing if the resident continued to experience swallowing difficulties.

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F 0690 Level of Harm - Minimal harm or potential for 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 observation, interview, and record review, the facility failed to obtain an order for a catheter (a flexible tube inserted into the bladder to drain urine) and catheter care for one resident (Resident #13) out of three sampled residents. The facility census is 45.Review of the facility's policy titled, Catheter Care, Urinary, revised August 2022, showed: - The purpose of this procedure is to prevent urinary catheter-associated complications, including urinary tract infections;- Did not address the need for catheter and catheter care orders. 1. Review of Resident #13's medical record showed:- admission date of 11/26/25;- Diagnosis of reflex neuropathic bladder (the blader does not empty properly due to a neurological condition); - Urology notes, dated 05/06/26, urinary catheter was placed during the visit due to urinary retention related to reflex neuropathic bladder with no additional orders or instructions;- Nurse's note, dated 05/06/26 at 4:20 P.M., the resident returned from the urology appointment. Urinary catheter in place upon arrival. The urinary catheter was requested to remain in place for 30 days as tolerated. No new skin issues noted;- Physician order sheet (POS), dated 05/26/26, with no current physician order for the urinary catheter to be in place or for catheter care; - Treatment administration record (TAR), dated 05/06/26 - 05/26/26, with no documentation of urinary catheter care. During an interview on 05/26/26 at 3:00 P.M., the resident said he/she had a catheter placed by the urologist (physician who specializes in treating diseases of the urinary tract). Staff did not provide his/her urinary catheter care. Observation on 05/28/26 at 1:25 P.M., of the resident's urinary catheter care showed:- Certified Medication Technician (CMT) D and Certified Nurse Assistant (CNA) E provided the resident's urinary catheter care. During an interview 05/28/26 at 2:00 P.M., the Director of Nursing (DON) said there should be documented orders for a urinary catheter and catheter care. During an interview 05/28/26 at 2:30 P.M., Licensed Practical Nurse (LPN) A said there should be documented orders for a urinary catheter and catheter care.