STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265460	A. Building B. Wing	04/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cassville Health Care Center	1300 County Farm Road Cassville, MO 65625

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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 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions. Based on interview and record review, the facility failed to protect all residents' right to be treated with dignity and respect when when two staff members (Certified Nursing Assistant (CNA) A and CNA B) entered the on resident's (Resident #1) room with out the resident's knowledge, rearranged items, and removed personal belongings. Six residents were sampled in the facility with a census of 54. Review of the facility's policy titled Quality of Life - Dignity, revised 08/2009, showed the following: -Each resident shall be cared for in a manner that promotes and enhances quality of life, dignity, respect and individuality; -Residents shall be treated with dignity and respect at all times; -Treated with dignity meant the resident would be assisted in maintaining and enhancing his or her self-esteem and self-worth; -Residents' private space and property shall be respected at all times. Staff will knock and request permission before entering residents' rooms; -Staff shall keep the resident informed and oriented to their environment. Procedures shall be explained before they are performed and residents will be told in advance if they are going to be taken out of their usual or familiar surroundings. Review of the facility's policy titled Resident Rights, revised 12/2016, showed the following: -Employees shall treat all residents with kindness, respect, and dignity; -Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to a dignified existence; be treated with respect, kindness, and dignity; exercise his or her rights as a resident of the facility and as a resident or citizen of the United States; be supported by the facility in exercising his or her rights; exercise his or her rights without interference, coercion, discrimination or reprisal from the facility; and retain and use personal possessions to the maximum extent that space and safety permit. (continued on next page)

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

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

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F 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1. Review of Resident #1's face sheet (a document that gives a resident's information at a quick glance) showed the following: -admission date of 01/07/22; -Resident was his/her own responsible party; -Diagnoses included heart failure, diabetes, and chronic kidney disease. Review of the resident's annual Minimum Data Set (MDS - a federally mandated assessment instrument completed by facility staff), dated 01/19/25, showed the following: -The resident was cognitively intact; -The resident required set-up assistance for eating and was maximum to total assistance for all other Activities of Daily Living (ADL - dressing, eating, bathing, etc.), bed mobility, transfers and locomotion; -The resident had no behaviors. Review of the resident's care plan, revised 08/28/24, showed the following; -Staff to allow sufficient time for completion and encourage independence; -Staff to approach resident in a calm manner, introduce self and explain all procedures; -Staff to provide encouragement and socialization during tasks; -The resident had behavioral symptoms related to diagnoses of dementia and depression; -Staff to approach calmly and unhurried, introduce yourself and explain all procedures; -Staff to attempt to refocus behaviors to something positive; -Staff to speak in a reassuring voice and be supportive of resident's feelings. During interviews on 03/28/25, at 1:28 P.M. and on 04/01/25, at 9:12 A.M., the resident said the following: -Two CNAs went through his/her personal items and moved them around; -No staff talked to him/her prior to doing this; -He/she felt they should have asked his/her permission; -The CNAs threw out his/her newspapers from [NAME] Virginia and said they shredded them; -The CNAs threw out the meal tray slips that he/she used to make notes on; (continued on next page)

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F 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Staff did not know what happened to his/her magazines; -Staff put his/her food in his/her roommates refrigerator; -He/she told a couple of the nurses he/she was upset about this; -Staff did not treat him/her with dignity and respect by going through his/her items and throwing some of them away; -What staff thought was junk was important to him/her and they had no right to do that. During interviews on 03/28/25, at 1:11 P.M., and on 04/01/25, at 9:58 A.M., CNA A said the following: -The resident complained of his/her room being rearranged; -The Director of Nursing (DON) told him/her and CNA B to rearrange the resident's room for safety; -He/she did not ask the resident before rearranging the room and did not know if upper management did; -He/she and CNA B threw away lunch cards from the resident's room; -He/she and CNA B moved the resident's tubs so they would not fall on the resident; -The resident was upset; -It was not appropriate to remove the resident's belongings without the resident's permission; -Removing the items needed to be done, but he/she should have had the resident's permission. This was the resident's home and it was not appropriate to take anything from the resident's home without permission; -He/she and CNA B did not treat the resident with dignity and respect by doing this, but felt it was for the resident's and staff safety; -The items fell over when staff bumped into them and he/she did not want anything to happen to the resident or staff; -Upper management said the newspapers were a fire hazard; -If a resident reported not being treated with dignity and respect, he/she reported this to the charge nurse. During an interview on 04/01/25, at 9:50 A.M., CNA B said the following: -He/she and CNA A took newspapers out that were stacked high per the DON's instructions; (continued on next page)

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F 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-He/she did not ask the resident's permission and the resident was not present in the room; -When the resident found out, the resident was not happy and the CNA told the DON. The DON said he/she would speak to the resident; -The property belonged to the resident and not the CNAs; -This was the resident's home; -Residents should be treated with respect and kindness; -It was not appropriate for staff to go into a resident's room and throw items away or move items around with the resident's permission. During an interview on 03/28/25, at 2:24 P.M., CNA D said the following: -The resident reported to him/her that CNA A and CNA B threw all of the residents' things away; -The resident said he/she was not in the room and was not aware ahead of time; -He/she did not believe this was treating the resident with dignity and respect; -Staff should treat residents with respect; -If he/she heard a staff member not treating a resident with dignity and respect, he/she told the charge nurse; -Staff should not go into a resident's room and rearrange their items or throw items away without the resident's permission. During an interview on 04/01/25, at 9:21 A.M., CNA E said the following: -The resident complained that CNAs went through his/her belongings without his/her knowledge or permission; -Staff should treat residents with dignity and respect; -If he/she heard a staff member not treating a resident appropriately, he/she reported this to the charge nurse; -He/she did not believe it was appropriate to go into a resident's room and rearrange or throw items away without the resident's permission. He/she thought this would be disrespectful. During an interview on 03/28/25, at 12:52 P.M., Certified Medication Technician (CMT) C said staff should treat residents with dignity and respect. During an interview on 04/01/25, at 9:33 A.M., LPN F said the following: (continued on next page)

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F 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The resident did report some of his/her property was missing and wanted to talk to the Social Services Designee (SSD) and DON about it; -If the DON told the CNAs to go through the resident's property and throw items away. The CNAs should not have without the resident's permission; -Staff should treat the residents with dignity and respect. This is the resident's home; -He/she did not believe it was appropriate to go through a resident's belongings and throw some away without the resident's knowledge; -The belongings were the residents' property and the residents did not have much. During an interview on 04/01/25, at 10:53 A.M., the Business Office Manager (BOM) said the following: -It was not appropriate for CNA A and CNA B to go through the resident's belongings without the resident's permission. This was the resident's home; -The DON should not have instructed the CNAs to do this without the resident's permission; -Staff should treat residents with kindness, courtesy and respect. This is the residents' home; -He/she did not believe it was appropriate for staff to go into a resident's room and go through their belongings, rearrange their belongings or throw their belongings away with the resident's permission During an interview on 04/01/25, at 11:27 A.M., the Social Services Director (SSD) said the following: -Staff should have made the resident aware and received the resident's permission prior to rearranging his/her room or removing his/her property; -Staff should not have removed the resident's newspapers and meal tickets without the resident's permission or the resident being present; -Staff did not treat the resident with dignity and respect; -Staff should treat residents with dignity and respect, this is their home; -Staff should not remove items or rearrange residents' property without their permission. During an interview on 04/01/25, at 11:37 A.M., the Housekeeping Supervisor said the following: -He/she did not instruct CNA A and CNA B to rearrange the resident's room or throw the resident's belongings away; (continued on next page)

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F 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-He/she did not know if the DON received permission from the resident prior to instructing the CNAs to do this; -The resident carried a pink bag with his/her laptop, puzzle books, check book, and newspapers in and when he/she came from the office, CNA A and CNA B were going through the bag at the nurses' station getting rid of tray cards and newspapers and said the resident did not need them. The CNAs said the DON gave them permission to do this; -He/she did not know what happened to the resident's newspapers or meal tray cards; -The resident used the back of the meal tray cards to make notes; -He/she believed if the DON or CNAs asked for permission, the resident would have said no; -The resident was not treated with dignity and respect; -Staff should treat residents with respect and dignity. This was their home; -It was not appropriate for staff to remove resident's belongings or rearrange the resident's room without their permission. During interviews on 04/01/25, at 10:59 A.M. and 11:27 A.M., the DON said the following: -On 03/25/25, CNA A and CNA B were in the resident's room cleaning because the Housekeeping (HK) Supervisor told them to; -He/she did not know if the resident gave permission, but the resident was not in the room; -The resident was not pleased with this; -The resident had meal tickets in his/her room. The DON did not know why the resident kept these; -The CNAs asked about the newspapers in the resident's room and he/she told them to take them out of the resident's room and place them in a box. He/she did not know where the newspapers were at this time; -The DON had not received permission prior to having the CNAs remove the newspapers, but they were stacked on the resident's bed side table and bending the table; -He/she should have asked the resident's permission; -The resident was not treated with dignity and respect. -Staff should treat residents with dignity and respect. This was their home; -Staff should not remove property or rearrange a residents room without the residents permission. During an interview on 04/01/25, at 12:00 P.M., the Administrator said the following: (continued on next page)

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F 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-He/she did not know who instructed the CNAs to rearrange the resident's room or remove the resident's belongings, but they should not have done this without the resident's permission; -The resident had the right to have his/her personal belongings; -He/she heard the resident did not give permission. -Staff should treat residents with dignity and respect; -Staff should not rearrange a resident's room or remove their property without the resident's consent. MO00251081, MO00251763

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure establish an accurate system of administration of medications when staff failed to accurately document administration of topical medications and administer them within the parameters of physicians' orders for two residents (Resident #2 and Resident #3). Five residents were sampled out of a facility census of 54. Review of the facility's policy titled Medication Administration, undated, showed the following: -Document the administration after it is confirmed that the resident has taken the medication in the resident's medical record and sign; -Any discrepancies in medication administration must be immediately brought to the Director of Nursing (DON). The physician and family must be notified. An incident report needs to be completed. 1. Review of Resident #2's face sheet (a document that gives a patient's information at a quick glance) showed the following: -admission date of 05/29/24; -Diagnoses included chronic obstructive pulmonary disease (COPD - a progressive lung disease), asthma and diabetes. Review of the resident's quarterly Minimum Data Set (MDS - a federally mandated comprehensive assessment instrument completed by facility staff), dated 03/27/25, showed the following: -The resident was cognitively intact; -The resident had no other ulcers, wounds or skin problems; -The resident had application of ointments or medication other than to his/her feet. Review of the resident's care plan, revised 09/06/24, showed the following: -Administer medications per physician's order and report any adverse side effects to physician. -Apply barrier cream as ordered. Review of the resident's February 2025 Physician's Order Sheet (POS), February 2025 Medication Administration Record (MAR), and corresponding MAR Progress Notes showed the following: -An order, with a start date of 11/21/24 and end date of 03/17/25, for triamcinolone acetonide cream (a prescription corticosteroid that treats skin conditions) 0.1%, apply to buttocks topically every day and evening shift for contact dermatitis; -On 02/06/25, staff did not document of application for the evening shift; (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-On 02/12/25, at 11:15 A.M., a nurse documented other/see progress note with no reason noted; -On 02/13/25, at 10:14 A.M., a nurse documented other/see progress note with not available noted; -On 02/14/25 and 02/15/25, staff did not document of application for the daytime shift; -On 02/16/25 and 02/17/25, a nurse documented the resident was sleeping for the evening application; -On 02/21/25, staff did not document application for the daytime shift; -On 02/26/25, staff did not document application for the evening shift; -On 02/27/25, a nurse documented sleeping for the evening application. Review of the resident's March 2025 POS, March 2025 MAR, and corresponding MAR Progress Notes showed the following: -An order, with start date 11/21/24 and end date 03/17/25, for triamcinolone acetonide cream 0.1%, apply to buttocks topically every day and evening shift for contact dermatitis; -On 03/03/25, a nurse documented the resident was sleeping for the evening application; -On 03/05/25, at 2:44 P.M., a nurse documented other/see progress note with no reason noted; -On 03/12/25, at 2:39 P.M., a nurse documented other/see progress note with up in wheelchair noted; -On 03/12/25, a nurse documented the resident was sleeping for the evening application; -On 03/14/25, 03/15/25, and 03/17/25, staff did not document application of the medication; -An order, dated 03/18/25, for triamcinolone acetonide cream 0.1%, apply to left hip topically every day and evening shifts for contact dermatitis; -On 03/20/25, 03/24/25, 03/28/25 and 03/29/25 daytime and 03/18/25, 03/19/25, 03/24/25 and 03/31/25 evening, staff did not document of application of the medication. During an interview on 03/28/25, at 9:21 A.M., Certified Nursing Assistant (CNA) E said the resident had a rash and nurses applied cream to it. During an interview on 03/28/25, at 10:05 A.M., Licensed Practical Nurse (LPN) F said the following: -The resident had an order for triamcinolone twice daily; -The resident should receive this medication per physician's orders; (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-If staff did not apply the medication, they should document in the MAR and make a progress note with the reason; -If the resident was asleep, the nurse should attempt to wake them and then document their attempt. During an interview on 04/01/25, at 10:59 A.M., the DON said the following: -The resident had an order for triamcinolone twice daily and should have received the medication per physician's orders; -The nurses should have documented a reason the medication was not administered and notified the physician and pharmacy and documented this as well; -The resident did not receive his/her medications per physician's orders. During an interview on 04/01/25, at 12:00 P.M., the Administrator said the resident did not receive their triamcinolone per physician's orders. 2. Review of Resident #3's face sheet showed the following: -admission date of 11/16/20; -Diagnoses included diabetes, bullous pemphigoid (a rare skin condition causing large, fluid filled blisters), and high blood pressure. Review of the resident's quarterly MDS, dated [DATE], showed the following: -The resident had severe cognitive impairment; -The resident required set-up assistance for eating and oral hygiene, moderate assistance for toilet hygiene, showers, upper body dressing, putting on/taking off footwear and personal hygiene and maximum assistance for lower body dressing. The resident required moderate assistance for bed mobility and transfers; -The resident had no other ulcers, wounds or skin problems and did not receive skin and ulcer treatments. Review of the resident's care plan, revised 09/19/24, showed the following: -The resident required assist with ADLs related to diagnoses of dementia, osteoporosis, depression and anxiety. Allow sufficient time for completion and encourage independence. Provide sequencing as needed; -The resident was at risk for impaired skin integrity related to requiring assist with transfers and diminished awareness of pressure sensations related to dementia. Apply barrier cream as ordered. Complete weekly skin assessment per schedule. Notify the physician of any new skin impairment and implement treatment orders; (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The resident had a skin condition caused by bullous pemphigoid. Notify his/her physician with any concerns or changes in his/her wound areas. Treat per physician's orders. Review of the resident's February 2025 POS, February 2025 MAR, and corresponding MAR Progress Notes showed the following: -An order, dated 12/06/23, for triamcinolone acetonide external cream 0.5%, apply to left arm, back and face sores topically every day and night shift related to zoster (viral infection that causes an outbreak of a painful rash or blisters on the skin), without complications; -On 02/14/25, 02/15/25, and 02/21/25 daytime, and on 02/20/25 and 02/24/25 evening, staff did not document application of the medication; -On 02/16/25, daytime, a nurse documented hold/see progress note with nurse passing medications the entirety of shift noted. Review of the resident's March 2025 POS, March 2025 MAR, and corresponding MAR Progress Notes showed the following: -An order, dated 12/06/23, for triamcinolone acetonide external cream 0.5%, apply to left arm, back and face sores topically every day and night shift related to zoster, without complications; -On 03/02/25, at 9:03 P.M., a nurse documented other/see progress note with no reason noted; -On 03/14/25, 03/15/25, 03/20/25, 03/24/25, 03/28/25 and 03/29/25, daytime, and on 03/12/25, 03/18/25, 03/19/25, 03/24/25, 03/25/25, 03/26/25, and 03/31/25, evening, staff did not document application of the medication; -On 03/13/25, 03/14/25, and 03/15/25 the evening a nurse documented sleeping. Review of the resident's March 2025 POS, March 2025 MAR, and corresponding MAR Progress Notes showed the following: -An order, with start date of 03/07/25 and end date of 03/21/25, for clobetasol propionate external cream (used to treat skin conditions that involve inflammation and itchiness) 0.06%, apply to rash topically every day and night shift for rash for 14 days, upper extremities and face; -On 03/07/25, at 2:56 A.M., a nurse documented other/see progress note with no reason noted; -On 03/07/25, at 9:51 P.M., a nurse documented other/see progress note with no cream available noted; -On 03/08/25, at 12:31 P.M., a nurse documented other/see progress note with waiting on delivery noted; -On 03/08/25, at 10:29 P.M., a nurse documented other/see progress note with no cream in treatment cart noted; (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-On 03/09/25, at 12:01 P.M., a nurse documented other/see progress note with no reason noted; -On 03/09/25, at 11:58 P.M., a nurse documented other/see progress note with no reason noted; -On 03/10/25, at 9:45 A.M., a nurse documented other/see progress note with on order noted; -On 03/14/25, 03/15/25, and 03/20/25, daytime, and on 03/12/25, 03/18/25, and 03/19/25, evening, staff did not document application of the medication. Review of the resident's Skin Observation Tool, dated 03/21/25, showed the resident had psoriatic areas noted to face, trunk, and upper and lower extremities. During an interview on 03/28/25, at 2:24 P.M., CNA D said the resident had rashes and a skin condition and the nurses applied the residents cream to these. During an interview on 03/28/25, at 10:05 A.M., LPN F said the following: -The resident had an order for triamcinolone twice daily and should receive this per physician's orders; -The resident had an order for clobetasol twice daily to start 03/07/25 for fourteen days. Staff should have administered twice daily for the full fourteen days. During an interview on 04/01/25, at 10:59 A.M., the DON said the following: -The resident had an order for triamcinolone twice daily and staff should have administered it twice daily; -The resident had an order for clobetasol twice daily for fourteen days and did not receive the medication per physician's orders; -Staff should have adjusted the end date of the clobetasol to be fourteen days from the date the medication was received and notified the physician and pharmacy. The nurses should have documented this as well; -When staff did not administer the medications, they should have documented a reason and notified the physician and resident's responsible parties; -The resident did not receive his/her medications per physician's orders; -He/she expected nursing staff to administer medications per physician's orders and properly document when a dose was missed. During an interview on 04/01/25, at 12:00 P.M., the Administrator said the resident did not receive their triamcinolone or clobetasol per physician's orders. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265460	A. Building B. Wing	04/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cassville Health Care Center	1300 County Farm Road Cassville, MO 65625

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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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. During an interview on 03/28/25, at 12:52 P.M., Certified Medication Technician (CMT) C said the resident should receive medication per physician's order. Nurses applied creams and ointments such as triamcinolone and clobetasol. During an interview on 03/28/25, at 2:24 P.M., CNA D said residents should receive medication per physician's order. CNAs can apply barrier cream, but nurses applied medicated creams. If a resident had an order for a cream, they should receive the cream per that order. During an interview on 03/28/25, at 9:21 A.M., CNA E said CNAs applied nystatin, zinc, and barrier creams, but nurses applied triamcinolone and clobetasol. If a resident had an order for a cream, staff should apply it per physician's orders. During an interview on 03/28/25, at 10:05 A.M., LPN F said the following: -Nurses applied clobetasol and triamcinolone; -If a resident had an order for a cream, the nurse should follow the physician's orders; -If a medication was not available, the nurse should document in the MAR, call the pharmacy and physician and document this in a progress note; -If a resident had a prescription for fourteen days and the medication was not available the first few days, the nurse can call the physician to change the stop date or to change the order to until finished; -If several days of the medication were missed, the nurse should notify the physician and document this. At times, the physician may change to another medication or request STAT orders from the pharmacy or get at a local pharmacy. During an interview on 04/01/25, at 10:59 A.M., the DON said the following: -Staff should administer resident's medications per physician's orders; -If a resident had an order for twice daily, they should receive twice daily unless the resident refused; -If a medication was not available, staff should contact the pharmacy and physician to either change the medication, place it on hold, or prescribe something comparable and document this; -If a resident had an order for a medication for fourteen days and the medication was not available for the first few days, the nurse should contact the physician and the fourteen days should start when the medication was received; -He/she believed the issue with the triamcinolone and clobetasol was these medications were on the Treatment Administration Record (TAR) and the nurses were not switching from the MAR to the TAR in the computer; -The nurses were responsible for checking both the MAR and TAR; (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265460	A. Building B. Wing	04/01/2025

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-He/she expected the nurses to check both the MAR and TAR for the residents. During an interview on 04/01/25, at 12:00 P.M., the Administrator said the following: -He/she expected staff to administer medications per physician's orders; -If staff did not administer a medication, they should document a reason why and notify the physician; -If a medication was not available, nurses should notify the DON and the Administrator so they could possibly obtain locally; -If an order was for twice daily for fourteen days, the resident should receive the medication per physician's orders unless the physician changed the order and the fourteen day time frame should start when the medication was received; -If a resident was sleeping, he/she expected staff to attempt to wake the resident and then document their attempt. MO00251081, MO00251709