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	04/29/2025

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. Based on interview and record review, the facility failed to ensure each dependent resident received the necessary care and services to maintain good personal hygiene when staff failed to answer one resident's (Resident #1) call light in a timely leaving the resident wet for an extended period. Four residents were sampled and the facility had a census of 50. Review of the facility's policy titled Call Light Response Policy, undated, showed the following: -The purpose was to ensure that all residents' needs are met in a timely, respectful, and safe manner by providing an effective and reliable call light system and by establishing clear procedures for prompt staff response; -The facility is committed to maintaining a culture of safety and responsiveness. The call light system enables residents to request assistance, and all staff are responsible for responding promptly to ensure resident well-being and satisfaction; -The policy applies to all direct care staff, nursing personnel, and other facility employees who may observe or hear a resident call light alarm; -Staff must respond to all call lights within 15 minutes, unless immediate emergencies dictate otherwise; -Incontinence needs, pain requests, and fall risks are considered high-priority and must be addressed as a matter of urgency. 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 04/08/12; -Diagnoses included fracture of the neck of the right femur (long bone of the upper leg), chronic obstructive pulmonary disease (COPD - a progressive lung disease that causes airflow limitation, making it difficult to breathe), and hemiplegia (paralysis of one side of the body). Review of the resident's quarterly Minimum Data Set (MDS - a federally mandated assessment instrument completed by facility staff), dated 04/01/25, showed the following: -The resident was cognitively intact; (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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The resident had impairment on one side of his/her upper and lower extremity; -The resident used a wheelchair for locomotion; -The resident required substantial assistance from staff for lower body dressing and was dependent on staff for toilet hygiene, personal hygiene, and showering; -The resident required substantial assistance from staff for bed mobility and was dependent on staff for transfers; -The resident was frequently incontinent of urine and occasionally incontinent of bowel. Review of the resident's care plan, revised 12/04/24, showed the following: -The resident required assist with activities of daily living (ADL - dressing, eating, bathing, etc.). He/she had contractures to the right ankle, foot, and hand and had a diagnosis of cerebral infarction (stroke - a condition where blood flow to the brain is blocked, leading to brain tissue death) with right sided weakness; -The resident had urinary and bowel incontinence related to post stroke with right sided weakness and diminished perception to void or defecate; -Allow sufficient time for completion of tasks and encourage independence. Provide sequencing if needed; -The resident required extensive assistance with one staff for bed mobility and showers and was dependent on one staff member for transfers, dressing, toileting and personal hygiene; -Staff should assist with changing and toileting; -Ensure call light in reach and answer the call light promptly; -Assist with clothing change as needed; -The resident can become agitated and upset when his/her normal routine was deviated from. Please report to social services all of his/her complaints so that they can help him/her reconcile them. Review of the resident's progress note dated 04/24/25, at 1:42 P.M., showed the Social Services Designee (SSD) was approached by the resident who wanted to have a private conversation with the SSD. The resident and SSD went to the SSD office where the resident proceeded to get upset and cry. The resident told the SSD that he/she lied to the state surveyor that he/she told SSD about ongoing issue with his/her call light not being answered in a timely manner on evening shifts, but he/she had not brought this issue to SSD attention yet. The SSD took the resident's complaint and reported it to the proper department. Review of a Resident/Family Concern/Grievance Form filed by the resident, dated 04/24/25, showed the following: (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Call lights not being answered in a timely manner on evening shift; -Concern received from the resident; -Concern referred to the Director of Nursing (DON); -Review and action taken was will in-service staff on answering call lights in timely manner; -The resident was contacted on 04/25/25 and commented his/her light was not answered fast during the evening shift after dinner (will follow up with staff education); -The grievance decision showed call light not answered fast enough, steps taken by staff to investigate the grievance included check of response times and in-service staff. The summary of the pertinent findings or conclusions regarding the resident's concern was to monitor response times weekly and interview resident. -The grievance was confirmed. Corrective actions included educate staff and random call light answer time audits. During an interview on 04/29/25, at 8:35 A.M. and 7:25 P.M., the resident said the following: -He/she was left wet for 30 to 40 minutes while he/she waited for staff to answer his/her call light; -He/she activated the call light before he/she needed to use the restroom; -He/she only required assistance from one staff member to use the restroom; -He/she would have an episode of incontinence while he/she waited for staff and that embarrassed him/her; -He/she filed a grievance about call light response time on 04/24/25; -He/she had not received any response to his/her grievance and nothing had changed. During an interview on 04/29/25, at 11:58 A.M., Certified Nurse Aide (CNA) A said staff answered call lights when they had time to answer them. Staff should not wait 30 minutes or longer to answer a call light. During an interview on 04/29/25, at 12:01 P.M., CNA B said staff should answer call lights timely. He/she knew a call light was activated by looking at the monitor at the nurses' station. Staff should not wait 30 minutes or longer to answer a call light. During an interview on 04/29/25, at 5:56 P.M., CNA E said the following: -The resident complained of his/her call light not being answered timely if he/she needed to use to restroom or wanted to go to bed; (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The resident only activated his/her call light when he/she needed to use the restroom, wanted water, or wanted to lay down; -The resident was continent to an extent and required assistance of one staff to use the restroom; -The call light response times on 04/25/25 of 30 minutes and 43 seconds and 38 min and 11 seconds; on 04/26/25 of 48 min and 2 sec and 33 minutes and 18 seconds, on 04/27/25 of 45 min and 29 seconds, and on 04/28/25 of 51 minutes and 35 seconds and 28 minutes and 3 seconds for the resident were not appropriate and staff should have answered it sooner; -If the resident's call light was answered sooner, he/she may not have episodes of incontinence; -Staff should answer call lights as soon as possible; -He/she knew a call light was activated by looking at the monitor behind the nurses' station; -Staff did not have pagers and he/she did not know why; -The charge nurse was responsible for ensuring staff answered call lights timely; -The DON was ultimately responsible for ensuring residents call lights were answered timely. During an interview on 04/29/25, at 6:26 P.M., CNA F said the following: -The resident required assistance of one staff member to use the restroom; -The call light response times for the resident on 04/25/25 of 30 minutes and 43 seconds and 38 min and 11 seconds, 04/26/25 of 48 min and 2 sec and 33 minutes and 18 seconds, 04/27/25 of 45 min and 29 seconds and 04/28/25 of 51 minutes and 35 seconds and 28 minutes and 3 seconds were not appropriate and staff should have answered it sooner. (Did we ask what were the inappropriate call response times and what was an appropriate response time?) -Staff should answer call lights within three to ten minutes; -Staff knew a call light was activated by looking at the monitor behind the nurses' station; -Staff did not have pagers or walkie talkies and had to go look at the monitor; -He/she did not know why staff did not have pagers for the call lights; -Any staff member could answer a call light; -The charge nurse should answer call lights when CNAs were busy; -CNAs were responsible for answering call lights timely and the charge nurse and DON were responsible for ensuring staff answered call lights timely. During an interview on 04/29/25, at 12:07 P.M., Registered Nurse (RN) C said the following: (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The resident complained of staff not answering call lights fast enough; -Staff should answer call lights as soon as possible; -Any staff member could answer a call light; -Staff should not wait 30 minutes or more to answer a call light; -Staff knew call lights were activated by looking at the monitor behind the nurses' station; -The charge nurse and the DON were responsible for ensuring staff answered call lights timely. During an interview on 04/29/25, at 5:35 P.M., Licensed Practical Nurse (LPN) D said the following: -The resident used the restroom and only required assistance from one staff member; -The resident did complain about his/her call light taking too long especially around 6:00 P.M.; -The call light response times for the resident on 04/25/25 of 30 minutes and 43 seconds and 38 min and 11 seconds; on 04/26/25 of 48 min and 2 sec and 33 minutes and 18 seconds; on 04/27/25 of 45 min and 29 seconds; and on 04/28/25 of 51 minutes and 35 seconds and 28 minutes and 3 seconds were not appropriate and staff should have answered it sooner; -The resident activated his/her call light when he/she needed to use the restroom or wanted to go to bed; -If the resident's call light was answered sooner, he/she may not have episodes of incontinence. -Staff should answer call lights as soon as possible; -Staff took longer every now and then around mealtimes or bedtime; -Any staff could answer a call light; -Staff knew call lights were activated by looking at the monitor behind the nurses' station; -Staff used to have pagers, but they were either lost or broken; -Staff should have pagers to alert them that a call light was activated; -The charge nurse and DON were responsible for ensuring staff answered call lights timely. During an interview on 04/29/25, at 6:46 P.M., LPN G said the following: -The resident complained about his/her call light not answered in a timely manner and would call the facility on the telephone when the call light was not answered; (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The call light response times for the resident on 04/25/25 of 30 minutes and 43 seconds and 38 min and 11 seconds; on 04/26/25 of 48 min and 2 sec and 33 minutes and 18 seconds; on 04/27/25 of 45 min and 29 seconds; and on 04/28/25 of 51 minutes and 35 seconds and 28 minutes and 3 seconds were not appropriate and staff should have answered it sooner. Most of those times were during shift change, but staff still should not take that long to answer the resident's call light; -Staff did not answer call lights as timely on days when staffing was lower; -Staff knew a call light was activated by looking at the monitor behind the nurses' station; -Staff used to have pagers, but he/she had not seen them lately; -Any staff member could answer a call light; -On evening and night shifts, if the CNAs were busy, the charge nurse should answer call lights; -The charge nurse was responsible for ensuring CNAs answered call lights timely and the DON was ultimately responsible. During an interview on 04/29/25, at 7:32 P.M., the Director of Nursing (DON) said the following: -The resident filed a grievance about call lights on 04/24/25, but she did not receive the grievance until 04/29/25. The SSD should have given her the grievance immediately; -The call light response times for the resident on 04/25/25 of 30 minutes and 43 seconds and 38 min and 11 seconds; on 04/26/25 of 48 min and 2 sec and 33 minutes and 18 seconds; on 04/27/25 of 45 min and 29 seconds; and on 04/28/25 of 51 minutes and 35 seconds and 28 minutes and 3 seconds were not appropriate and staff should have answered it sooner; -She expected staff to answer call lights within 15 minutes; -During shift change, staff took longer to answer call lights; -Staff knew a call light was activated by looking at the monitor at the nurses' station; -Staff only had one functional pager and she ordered more on 04/29/25; -She did not know how long the pagers had not been functional and found out they were not when she worked on 04/27/25; -Maintenance should check the operation of the pagers and the charge nurse should ensure staff used the pagers. She should check the pagers periodically as well; -If staff noticed a pager was not operational, they should write it in the maintenance book; -Any staff could answer a call light. They may not be able to provide the care needed, but could alert staff to what a resident needed and let the resident know they were heard; (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The charge nurse should answer call lights when the aides were busy; -She had not audited call light times but planned to; -The charge nurse was responsible for ensuring staff answered call lights timely and she was ultimately responsible. During an interview on 04/29/25, at 7:56 P.M., the SSD said the resident filed a grievance about his/her call light on 04/24/25 and the SSD gave the grievance to the DON on 04/25/25. When he/she received a grievance, he/she gave the grievance to the appropriate department head immediately. During an interview on 04/29/25, at 8:12 P.M. and 8:41 P.M., the Administrator said the following: -The resident filed a grievance about his/her call light on 04/24/25; -If the resident's call light was not answered timely, the resident usually called the facility on the telephone; -He did not know when the resident's grievance was given to the DON, but the SSD should have given it to the DON immediately and have a resolution within 14 days unless the need was immediate; -The call light response times for the resident on 04/25/25 of 30 minutes and 43 seconds and 38 min and 11 seconds; on 04/26/25 of 48 min and 2 sec and 33 minutes and 18 seconds; on 04/27/25 of 45 min and 29 seconds, and on 04/28/25 of 51 minutes and 35 seconds and 28 minutes and 3 seconds were not appropriate and staff should have answered it sooner. Shift change was not an excuse for the resident's call light times taking so long; -Any staff member could answer a call light and he expected staff to answer call lights within 15 minutes; -Staff knew a call light was activated by looking at the monitor behind the nurses' station; -The facility had pagers and he found out on 04/29/25 that they were not operational. Some pagers were broken and some were missing. Only one pager was operational; -The charge nurse was responsible for ensuring staff answered call lights timely and the DON was ultimately responsible for ensuring staff answered call lights timely; -He reached out to the company on 04/29/25 about replacing pagers. but did not have pagers ordered. MO00253357

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. Based on record review and interview, the facility to provide care as per facility policy and the resident's care plan when staff failed to treat one resident's (Resident #3) rash in a timely manner. The facility's census was 45. Review of the facility's Change in a Resident's Condition or Status Policy, revised May 2017, showed the following: -The facility shall promptly notify the resident, his or her attending physician, and representative (sponsor) of changes in the resident's medical/mental condition and/or status (e.g., changes in level of care, billing/payments, resident rights, etc.); -The nurse will notify the resident's attending physician or physician on-call when there has been a need to alter the resident's medical treatment significantly; -A significant change of condition is a major decline or improvement in the resident's status that will not normally resolve itself without intervention by staff or by implementing standard disease-related clinical interventions. 1. Review of Resident #3's medical record showed the following: -admission date of 08/16/21; -Diagnoses including dementia, schizophrenia (a serious mental health condition that affects how people think, feel and behave), and anxiety. Review of the resident's quarterly Minimum Data Set (MDS - a federally mandated assessment tool completed by facility staff), dated 04/01/25, showed the following: -Severe cognitive impairment; -Requires maximal assistance with upper and lower body dressing; -Requires moderate assistance with showers; -Application of ointments/medications other than to feet. Review of the resident's weekly skin observation tool, dated 04/25/25, showed a nurse documented observing redness in the resident's abdominal folds and under his/her breasts. Review of the resident's weekly skin observation tool, dated 05/02/25, showed a nurse documented he/she observed yeast (a common fungal infection caused by an overgrowth of the yeast Candida on the skin. These infections often appear in warm, moist areas like skin folds (under breasts, groin, armpits), and symptoms include a red, itchy rash, which may have small blisters or pus-filled bumps) under the resident's breasts. Staff did not document physician notification of the change. (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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the resident's May 2025 medication administration record (MAR) and physician order sheet (POS), showed the following: -An as needed order for Nystatin External Cream was discontinued; -An order dated 05/22/25, for Nystatin External Cream (a medicated cream or ointment that treats fungal or yeast infections on skin) 100000 UNIT/GM, apply to abdominal folds and breast topically every day and evening shift for yeast. -An active order for Nystatin External Cream 100000 Unit/Gram (GM) (topical), apply to abdominal folds and breast topically every six hours as needed for yeast. Review of the resident's care plan, revised 05/06/25, showed the following: -Resident at risk for impaired skin integrity related to occasional incontinence of bladder and bowel, required assist with hygienic cares, and had a diagnosis of dementia; -Resident had moisture associated skin damage (MASD- skin damage caused by prolonged exposure to moisture, such as urine, sweat, wound drainage, or saliva) to his/her abdominal folds. -Complete weekly skin assessment per schedule; -Notify physician of any new skin impairment and implement treatment orders. Review of the resident's May 2025 MAR and POS, showed staff did not document applying the as needed Nystatin to the observed reddened/yeast area from 05/01/25 to 05/08/25. Review of the resident's weekly skin observation tool dated 05/09/25, showed a nurse documented observing redness/yeast in the resident's abdominal folds and under his/her breasts. Review of the resident's weekly skin observation tool, dated 05/16/25, showed a nurse documented observing redness/yeast in the resident's abdominal and breast folds. Review of the resident's May 2025 MAR and POS, showed staff did not document applying the resident's as needed Nystatin to the observed reddened/yeast area from 05/16/25 to 05/22/25. Review of the resident's progress notes showed staff did not document why the Nystatin was not applied from 05/01/25 to 05/22/25 and staff did not document notification of the physician of the change in skin condition. During an interview and observation on 06/17/25, at 9:10 A.M., the resident said he/she had a red rash underneath his/her breasts that staff treated with cream. During an interview on 06/17/25, at 4:00 P.M., Licensed Practical Nurse (LPN) D said the following: -If he/she observed a new rash or a yeast infection on a resident's skin, he/she would clean and dry the area thoroughly then perform a complete skin assessment, document the findings in a nurse's note, and contact the physician; (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The resident had a current yeast infection under his/her breasts that staff were treating; -The rash was not a new issue for the resident as he/she developed these rashes off and on. Staff treated the rash, it cleared, and then it returned; -The resident had an as needed order for Nystatin cream for a long time, but it was now a scheduled treatment. During an interview on 06/17/25, at 5:00 P.M., the Director of Nursing (DON) said the following: -The nurses completed weekly skin assessments on all residents and documented their findings on the weekly skin observation tool located in the electronic medical record; -If the nurse observed a new yeast rash on a resident, the nurse contacted the physician for orders; -The resident had a yeast infection in his/her left arm pit and underneath both of his/her breasts; -He/she developed yeast type rashes often in his/her skin folds and under his/her breasts; -He/she had an as needed Nystatin order for staff to use when he/she re-developed the rash; -The DON did not know there was a twenty-day delay in staff observing the rash and documenting treatment. During an interview conducted on 06/17/25, at 7:00 P.M., the Administrator said the following: -When staff identified a new skin issue, they should assess the area, document the assessment in the nurse's notes and notify the physician; -Staff should document when they administer medications and/or treatments. MO00254042

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on record review and interview, the facility failed to provide pharmacy services that ensured only appropriate licensed personnel administered medications when the facility allowed one certified nurse aide (CNA C) to administer medications to residents and perform blood sugar checks on residents. The facility's census was 45. Review of the facility's Administering Medications Policy, revised December 2012, showed the following information: -Medications shall be administered in a safe and timely manner, and as prescribed; -Only persons licensed or permitted by this state to prepare, administer, and document the administration of medications may do so; -The Director of Nursing Services will supervise and direct all nursing personnel who administer medications and/or have related functions. 1. During an interview on 06/17/25, at 9:17 A.M., Resident #1 said the following: -He/she observed CNA C and another CNA administer medications to residents; -One of the CNAs (CNA C) was a nursing student; -The resident did not know if a nurse prepared the medication for CNA C to administer or if the nurse allowed CNA C to prepare the medications unassisted; -He/she only observed CNA C enter residents' rooms, unaccompanied by licensed or certified staff, and administer the prepared medication. During an interview on 06/17/25, at 12:10 P.M., Resident #2 said the following: -He/she observed a nurse place medication in a medication cup, then give the cup to CNA C to administer to a resident; -CNA C administered medications multiple times to multiple residents; -The resident also witnessed a nurse give a medication cup to another CNA (CNA A), but that only happened one time; -The resident did not remember a specific nurse who did this, but said he/she saw several nurses follow this practice; -The resident said the CNAs should not administer medications to residents and thought the nurses did this because they were short-staffed. During an interview on 06/25/25, at 10:15 A.M., CNA C said the following: (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-He/she worked at the facility as a CNA since September 2024; -He/she also attended nursing school at a local college and just finished his/her first semester; -At the end of his/her first semester, either the end of April or beginning of May 2025, he/she finished his/her pharmacology class which included a clinical skill check off for medication administration; -The CNA's instructor told the CNA he/she needed to redo the medication administration check off again due to difficulty with medication dosage calculations and medication administration charting; -The CNA said he/she did well on the other aspects of medication administration, but wanted more practice; -The DON (Director of Nursing) said the CNA could practice at the facility, but did not know when that would occur; -One day (05/29/25), on the CNA's day off, the DON called the CNA and said if he/she was available, he/she could administer medications to residents; -While at the facility, the DON observed/assisted him/her with preparing the medications for administration, including comparing the order to the medication card, as well as documenting the administration; -After preparing the medications, the CNA administered the medications to the resident; -CNA C also performed fingerstick blood sugars and scanned residents' continuous glucose monitoring (CGM - a glucose monitoring system for diabetes management) systems and documented the reading on the MAR (medication administrator record); -The DON administered the insulin. The CNA performed no injections; -The nurse's MAR included antibiotics and some blood pressure medications. The CNA did not administer any narcotic medications; -The DON did not accompany the CNA to resident rooms as he/she was comfortable with administering medications; -The DON instructed the CNA on how to document medication administration in the MAR and observed him/her following those instructions; -CNA C only administered medications that one day, but administered medications to multiple residents. During an interview on 06/17/25, at 7:00 P.M., the DON said on 05/29/25, CNA C performed finger stick blood sugar checks on the residents listed on the blood glucose check list (three residents) and administered all of the medications listed on the nurse MAR (22 residents) for the day shift. (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	04/29/2025

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 - Some	During an interview on 06/17/25, at 2:57 P.M., CNA A said the following: -Nurses or certified medication technicians (CMT) passed medications; -The nurses checked residents' blood sugars; -He/she did not know if passing medications or checking blood sugars was within a CNA's scope of practice; -He/she did not administer medications to any residents. During an interview on 06/17/25, at 3:37 P.M., Certified Medication Technician (CMT) B said the following: -CMTs and nurses administered medications to residents per physician's order; -Nurses checked residents' blood sugars; -He/she observed CNA C scan a resident's CGM, but did not see the CNA administer any medications or perform a finger stick to check a resident's blood sugar; -The CNA completed the blood sugar check as a CNA and employee of the facility, and not as a nursing student at the facility; -A CNA was not allowed to check a residents' CGM system, because it was not within a CNAs scope of practice. During an interview on 06/17/25, at 4:00 P.M., Licensed Practical Nurse (LPN) D said the following: -He/she never prepared medications for a CNA to administer; -The LPN said CNA C was in nursing school and was trying to get his/her medication technician certification, but did not have it yet; -The LPN said it was inappropriate to ask CNAs to administer medications as it was not in their scope of practice. During an interview on 06/17/25, at 4:50 P.M., Registered Nurse (RN) E said the following: -He/she did not give a CNA medications to administer to residents; -CNA C was not only a CNA, but a nursing student who completed medication training; -The RN said CNA C worked with another nurse (DON) administering medications to residents; -Towards the end of his/her shift (around 4:00 P.M.), the charge nurse (DON) left the facility leaving CNA C with the RN to prepare and administer medications to residents; (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-The RN did not ask for any specifics related to the CNA's qualifications or if he/she was working at the facility as a nursing student, because the CNA worked the beginning of the shift with the charge nurse (DON); -The RN prepared the medications and gave the medication cups to the CNA to administer to the residents; -When the CNA administered the medications, the RN did not enter resident rooms with the CNA but stood outside the residents' doors; -The RN did not remember the exact date the CNA administered medications but thought it was over two weeks ago. During an interview on 06/17/25, at 5:00 P.M., the DON said the following: -CNA C attended nursing school and worked the day shift; -The CNA told the DON he/she completed his/her check off for medication administration, but his/her instructor said he/she needed more practice; -CNA C asked the DON if he/she could practice administering medications at the facility; -The DON told the CNA yes, but she did not know when this would occur; -The next time the DON worked as a charge nurse (05/29/25), the DON called the CNA and asked if the CNA wanted to practice administering medications and performing blood sugar checks. The CNA did, and came to the facility; -The DON said she observed and assisted CNA C with preparing the medications according to physician order and administer the medication to the resident; -The DON accompanied the CNA into resident rooms to observe him/her administering the medications; -The DON also observed the CNA scan residents' CGM system to obtain their blood sugar reading and observed the CNA perform finger stick blood sugar checks on residents. The CNA did not change a resident's CGM system; -The DON left before the shift ended and RN E assisted and observed the CNA the remainder of the shift; -The nursing school the CNA attended did not have a contract with the facility to use the facility as a clinical site; -A partnership contract could not be initiated until the student's third semester of training; -The DON said she would not allow a CNA/nursing student to administer medications again unless they had a contract/partnership with the school. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 06/17/25, at 7:00 P.M., the Administrator said CNAs should not administer medications or perform blood sugar checks or CGM scans on residents. MO00254895