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	09/10/2025

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

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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Protect each resident from the wrongful use of the resident's belongings or money. (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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure residents were free from misappropriation when a facility staff member coerced money from one resident (Resident #1) and when the staff member dispensed and did not administer or destroy narcotic medications of one resident (Resident #2). The facility census was 44. Review of the facility policy, titled Abuse and Neglect revised 06/12/24, showed the following information:-Misappropriation of resident property includes identity theft, theft of money from bank accounts, theft of money from a resident, unauthorized or coerced purchases on a resident's resident card, unauthorized or coerced purchases from resident funds, a resident who provides a gift to staff in order to receive ongoing care, based on staff's persuasion, a resident who provides monetary assistance to staff after staff had made the resident believe the staff was in a financial crisis, misappropriation of resident property, and misappropriation of resident medication;-The licensed nurse will respond to the needs of the resident to protect him/her from further incident, call 911 when there is a medical emergency, remove the accused employee from the resident care areas, notify the Administrator, notify the attending physician, resident's family, and Medical Director, monitor and document the resident's condition including response to nursing interventions, document actions taken in the medical record, complete an incident report, revise the resident's care plan if the resident's medical, nursing, physical, mental or psychological needs or preferences change as a result of the abuse;-The Administrator will complete an administrative investigation to include personal statements from staff and residents involved in a situation that has any type of accusations of abuse either staff or resident abuse, suspend the accused employee pending completion of the investigation, notify the appropriate agencies immediately, report to the state nurse registry of the nursing board any knowledge of any actions which would indicate an employee is unfit for service.1. Review of Resident #1's face sheet (brief look at resident information) showed the following:-admission date of [DATE];-Diagnoses included chronic obstructive pulmonary disorder (COPD - a group of lung disease that make it hard to breathe), congestive heart failure (CHF - a chronic condition in which the heart does not pump blood as it should), and irregular heartbeat.Review of the resident's quarterly Minimum Data Set (MDS- a federally mandated assessment tool filled out by facility staff), dated 06/26/25, showed the resident was cognitively intact.Review of the facility's Misappropriation of Funds Investigation, dated 09/04/25, showed the following:-At approximately 6:15 P.M., the resident approached the Former Administrator and said that the former Director of Nursing (DON)/Registered Nurse (RN) A had asked him/her for money on several occasions;-The resident said that about two months ago, RN A had requested $540.00 dollars from him/her;-The resident said RN A took him/her to the store and he/she used the ATM to get the RN $200.00, not the full $540.00;-The resident said he/she used a mobile payment app to send the RN money per the RN's request on several other occasions;-The resident also indicated the RN's child was playing with his/her iPad and broke it, shattering the screen;-The resident indicated that RN A told him/her that he/she would pay him/her back, and now the resident indicated he/she felt used and taken advantage of;-Immediate action indicates RN was already on suspension following another incident.Review of the resident's Psychosocial Post-Incident Impact Questionnaire dated 09/04/25, at 11:28 P.M., showed the following:-No coping skills identified. The resident said he/she does not feel he/she was being taken advantage of at the time of in the incident, but felt like it when she later realized he/she was taken advantage of;-The resident [NAME] like he/she should not trust anyone with his/her money now;-The resident felt safe to report due to RN A not being in the building due to previous suspension.Review of the resident's care plan, revised 09/04/25, showed the resident was at risk for financial exploitation related to cognitive impairment and dependence on others for financial management. Education on abuse, neglect, misappropriation, and exploitation provided to the resident.During an interview on 09/07/25, at 1:12 P.M., the resident said the following:-He/she loaned the former DON/RN A around $500.00 over a course of four months starting in July 2025;-RN A was aware the resident got a large back check from social security, so the RN started to ask the resident for money to help with bills, kids sports, and food to feed his/her kids. The resident said he/she had a heart and hearing that made him/her feel horrible to the point he/she could not say no;-RN A frequently brought his/her children to work, who also entered the resident's room and broke his/her tablet;-RN A said he/she would pay him/her back;-The first payment to RN A was via cash. RN A took him/her to the store and the resident pulled out $200.00 cash for RN A. He/she believed this happened maybe two times;-The rest of the transactions were

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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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Develop and implement policies and procedures to prevent abuse, neglect, and theft. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Based on interview and record review, the facility failed to implement policies that prevented abuse, neglect, and exploitation of residents when the facility did not complete the required preemployment screenings including Criminal Background Checks (CBC), Employee Disqualification List (EDL - a list of individuals not able to work in long-term care facilities in the state) checks, and Nurse Aide (NA) Registry (checks for a federal indicator of abuse that makes an individual unable to work in long-term care) checks and when the facility failed to ensure the staff had valid nursing licenses for two staff (Licensed Practical Nurse (LPN) F and LPN G) prior to the nurses working with the residents. The facility census was 44.Review of the facility's policy titled Abuse and Neglect Policy, revised 06/12/24, showed the following:-The facility will develop and operationalize policies and procedures for screening and training employees, protection of residents, and for the prevention, identification, investigation, and reporting of abuse, neglect, mistreatment, and misappropriation of property. The purpose is to assure that the facility is doing all that is within its control to prevent occurrences;-The facility will screen employees for a history of abuse, neglect, or mistreating residents by attempting to obtain information from previous employers and/or current employers, and checking with the appropriate licensing boards and registries;-The facility will not employ individuals who have been convicted of abusing, neglecting, or mistreating individuals. Potential employees are screened for a history of abuse, neglect, or mistreating of residents;-The facility is committed to protecting the residents from abuse by anyone including, but not limited to, facility staff, other residents, consultants, volunteers. and staff from other agencies providing services to the individual, family members or legal guardians, friends, or any other individuals.Review of the facility's policy titled Background Investigations, revised 12/27/24, showed the following:-Job reference checks, drug screenings, licensure verifications, and criminal conviction record checks are conducted on all personnel making application for employment with this company;-The Human Resource Department will conduct all applicable background investigations on each individual making application for employment with this company and on any current employee if such background investigation is appropriate for position for which the individual has applied;-Persons applying for employment and current employees will be informed of this policy. The company will not conduct a background investigation without an applicant's or employee's advance consent. Applicants or employees who do not consent to a background investigation will, however, not be considered for positions that the company has determined to require the completion of a background investigation;-If the background investigations disclose any material misrepresentation or omissions by the applicant or employee on the application form or reveal information indicating that the individual may not be appropriate for hire, the company will investigate the matter further. Upon completion of such investigation, if the company determines that the applicant's or employee's background makes him/her unsuitable for the position he/she is seeking, the applicant will not be employed, or, if already employed, will be terminated;-The facility will not employ individuals who have been found guilty of abuse, neglect, exploitation, misappropriation of property, or mistreatment by a court of law; have had a finding entered into the state nurse aide registry concerning abuse, neglect, exploitation, mistreatment of residents, or misappropriation of resident property; or have a disciplinary action in effect against his or her professional license in a state licensure body as a result of a finding of abuse, neglect, exploitation, mistreatment of resident, or misappropriation of resident property. 1. Review showed the facility did not provide personnel files for LPN F or LPN G.During an observation and interview on 09/09/25, at 9:09 A.M., LPN F said the following:-He/she was not a current employee of the facility. He/she had not worked at the facility since August or October 2024;-The facility staff did not conduct a CBA, Family Care Safety Registry (FCSR - a registry the includes EDL and CBC checks), NA Registry, or EDL check and did not check his/her nursing license prior to him/her starting his/her shift;-He/she did not fill out an application for employment and did not do any orientation or education prior to working his/her shift;-He/she worked last night with a certified nursing assistant (CNA) and a nurse aide (NA);.-The LPN was observed working as the charge nurse.Observation on 09/08/25, at 7:47 PM., showed LPN G working as the charge nurse.During an interview on 09/09/25, at 8:50 A.M., the Business Office Manager (BOM) said the following:-He/she did not have personnel files for LPN F or LPN G;-He/she did not conduct a CBC, EDL, FCSR, or NA Registry on the LPNs prior to the LPNs working the floor.During an interview on 09/09/25, at 12:10 P.M., LPN D said the following:-New staff were required to complete onboarding, orientation, and the appropriate background and licensure checks prior to working a shift;-Nurses should not be allowed to work

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. (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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on interview and record review, the facility failed to report an allegation of misappropriation to the Department of Health and Senior Services (DHSS) and law enforcement within the required twenty-four hour timeframe when staff noticed and reported missing medications to the Administrator for three residents (Resident #1, #2 and #4) out of twelve sampled residents. The facility census was 44. Review of the facility's policy titled Abuse and Neglect Policy, revised 06/12/24, showed the following:-It is the policy of this facility to report all allegations of abuse/neglect/exploitation or mistreatment, including injuries of unknown sources and misappropriation of resident property are reported immediately to the Administrator of the facility and to other appropriate agencies in accordance with current state and federal regulations within prescribed time frames;-The facility will report all alleged violations and all substantiated incidents to the state agency and to all other agencies as required, and take all necessary corrective actions depending on the results of the investigation. The facility will analyze the occurrences to determine what changes are needed, if any, to policies and procedures to prevent further occurrences;-Any owner, operator, employee, manager, agent, or contractor of the facility can report an allegation of abuse/neglect/exploitation to the abuse agency hotline without fear of retaliation;-The Administrator or designee will refer to the State Operations Manual (SOM) for reporting and utilize the Abuse/-Neglect Reporting Decision Tree to assess the particular incident. Best practice is to include the SOM and Decision Tree with the investigation. Should the incident be a reportable event, notify the appropriate agencies immediately: as soon as possible, but no later than 24 hours after discovery of the incident. In the case of serious bodily injury, no later than 2 hours after discovery or forming the suspicion;- The facility must ensure that all alleged violations involving abuse, neglect, exploitation, mistreatment, or sexual assault including injuries of unknown source and misappropriation of resident property, are reported immediately, but no later than 2 hours after the allegation in made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the State Survey Agency. 1. Review of the facility's investigation, dated 09/15/25, showed the following:-On 09/02/25, at an unknown time, Licensed Practical Nurse (LPN) C reported a possible diversion of medications to Registered Nurse (RN) B;-RN B notified the Administrator on 09/03/25, at 9:26 A.M., about the possibility of medication diversion by RN A;-The Regional Nurse Consultant (RNC) was notified on 09/03/25, at 9:25 A.M., and the Regional Director of Operations (RDO) was notified on 09/03/25, at 9:26 A.M.-Staff did not document notification to DHSS regarding the misappropriation allegation.Review of Resident #2's Electronic Medical Record (EMR) showed an incident report for Diversion of Medications, dated 09/03/25, at 9:00 A.M. The RNC documented the following information:-On 09/02/25, the former Director of Nursing (DON)/RN A asked the night shift nurses to come in at approximately 3:30 P.M. RN B and LPN C entered the building and noted RN A was not in the building. RN B and LPN C did not receive report and were given the medication cart keys by a non-nurse staff member. At this time, staff noted there had been several narcotic medications that were printed from the medication dispensing machine that were unaccounted for. No medications were accounted for from med passes on 09/02/25. The process was to dispense the medications for the day and then fill the cart. Not only were medications unaccounted for, but there was also medication that was dispensed that was not ordered for residents. Dispense record indicates that two hydrocodone/acetaminophen 5-325 milligram (mg) tablets were dispensed as scheduled daily, but when RN A was on duty, she was dispensing six hydrocodone/acetaminophen 10-325 mg tablets, although there was no reason for the four extra tablets to be dispensed;-RN A provided controlled substance destruction logs, but the Former Administrator noted that RN A scribbled on the paper prior to handing it to him/her;-There were still at least 26 hydrocodone/acetaminophen tablets that were unaccounted for at this time in the investigation;-RN A was suspended pending investigation.Review of DHSS records showed the facility did not self-report related to the misappropriation of medications.During an interview on 09/09/25, at 2:10 P.M., the former Administrator said the following:-He/she reported the allegation of misappropriation of narcotics to the RNC and the RDO and they felt the allegation was not reportable, so they did not report to DHSS.During an interview on 09/08/25, at 7:12 P.M., LPN E said if he/she received a report of misappropriation, he/she reported to the Administrator immediately. The Administrator reported to DHSS within two hours.During an interview on 09/09/25, at 12:10 P.M., LPN D said the following:-If a certified nurse aide (CNA) or certified medication technician (CMT) received an allegation of misappropriation, they reported to their charge nurse

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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 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Respond appropriately to all alleged violations. (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to prevent any future potential abuse, neglect, exploitation, or mistreatment while an investigation of misappropriation was in progress, when the facility allowed one staff member (RN A) to return to the facility to work as the only nurse on duty causing one resident (Resident #1) to be fearful of retaliation and taking steps to leave the facility due to the fear. The facility census was 44. The Administrator was notified on 09/08/25, at 2:18 P.M., of an Immediate Jeopardy (IJ) which began on 09/08/25. The IJ was removed on 09/08/25 as confirmed by surveyor on-site verification. Review of the facility's policy titled Abuse and Neglect Policy, revised 06/12/24, showed the following:-The facility will develop and operationalize policies and procedures for screening and training employees, protection of residents and for the prevention, identification. investigation, and reporting of abuse, neglect, mistreatment, and misappropriation of property. The purpose is to assure that the facility is doing all that is within its control to prevent occurrences;-The facility will protect residents from harm during an investigation;-When suspicion of abuse/neglect/exploitation or reports of abuse/neglect/exploitation occur, the following procedure will be initiated: The Licensed Nurse will respond to the needs of the resident and protect him/her from further incident and remove the accused employee from resident care areas;-The Administrator or designee will suspend the accused employee pending completion of the investigation;-The Facility will take steps to prevent mistreatment while the investigation is underway;-Employees of this Facility who have been accused of mistreatment will be immediatelyremoved from contact with any residents and must leave the Facility pending the results of the investigation and review by the Administrator. If the alleged abuse is by the Administrator or Director of Nursing (DON), at the direction of the Executive [NAME] President/Chief Operating Officer or the [NAME] President for Operations, the Administrator or DON may remain at the facility, but are only permitted to be in non-resident areas or his/her office and should have no resident contact pending the outcome of the investigation;-Employees accused of possible mistreatment shall not complete the shift and will immediately be sent home.1. Review of Resident #2's face sheet (brief look at resident information) showed the following information:-re-admission date of [DATE];-Diagnoses included dementia, high blood pressure, Alzheimer's disease, and pain.Review of the resident's Electronic Medical Record (EMR) showed an incident report for Diversion of Medications, dated 09/03/25, at 9:00 A.M. The Regional Nurse Consultant (RNC) documented the following information:-On 09/02/25, the former DON/Registered Nurse (RN) A asked the night shift nurses to come in at approximately 3:30 P.M. Registered Nurse (RN) B and Licensed Practical Nurse (LPN) C entered the building and noted RN A was not in the building. RN B and LPN C did not receive report and were given the medication cart keys by a non-nurse staff member. At this time, staff noted there had been several narcotic medications that were printed from the medication dispensing machine, that were unaccounted for. No medications were accounted for from med passes on 09/02/25. The process was to dispense the medications for the day and then fill the cart. Not only were medications unaccounted for, but there was also medications that were dispensed that were not ordered for residents. Dispense record indicates that two hydrocodone/acetaminophen 5-325 mg tablets were dispense as scheduled daily, but when RN A was on duty, she was dispensing six hydrocodone/acetaminophen 10-325 mg tablets, although there was no reason for the four extra tablets to have been dispensed;-RN A provided controlled substance destruction logs, but the Former Administrator noted that RN A scribbled on the paper prior to handing it to her;-There were still at least 26 hydrocodone/acetaminophen tablets that were unaccounted for at this time in the investigation;-RN A was suspended pending investigation.During an interview on 09/07/25, at 3:46 P.M., the Former Administrator said RN A was placed on suspension pending investigation. 2. Review of Resident #1's face sheet showed the following:-admission date of [DATE];-Diagnoses included chronic obstructive pulmonary disorder (COPD - a group of lung disease that make it hard to breathe), congestive heart failure (CHF - a chronic condition in which the heart does not pump blood as it should), and irregular heartbeat.Review of the resident's quarterly Minimum Data Set (MDS- a federally mandated assessment tool filled out by facility staff), dated 06/26/25, showed the resident was cognitively intact.Review of the facility's Misappropriation of Funds Investigation, dated 09/04/25, showed the following:-At approximately 6:15 P.M., the resident approached the Former Administrator and said the former DON/RN A had asked him/her for money on several occasions;-The resident said that about two months ago, RN A had requested $540.00 dollars from him/her;-The resident

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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. This deficiency is uncorrected. For previous examples refer to the Statement of Deficiencies, dated 09/24/25. Based on observation, interview, and record review, the facility failed to provide care per standards of practice when staff failed to monitor and accurately document regarding a bruise to the left lower extremity and failed to obtain ordered services in a timely manner for one resident (Resident #1). The facility census was 42.Review of the facility policy titled, Notifying Clinicians, revised on 05/18/24, showed:-The purpose of the policy is to ensure clinicians are properly notified of a residents change in condition and overall health and/or mental status;-The clinician shall be notified of changes of conditions, emergent situation, routine diagnostics, and concerns of the resident overall health status;-Examples included falls, incidents, skin tears, out of range vital signs, abnormal labs, altered mental status, new wounds, changes in wounds, medication refusal, and anything regarding a change in the resident's baseline or condition;-All resident health updates, changes in condition, and deviation from the baseline must be reported to the physician;-The nurse will initiate verbal communication with the clinician when a condition arises with the resident which would warrant an immediate change in plan of care to include physician advisement or orders to avoid a delay in treatment that may cause worsening in condition;-The nurse will notify the resident's physician or the on-call physician for all changes in conditions, incidents and accidents, and emergency responses after hours to ensure the physician is kept informed and to give guidance. 1. Review of Resident #1's face sheet (a document that gives a resident's information at a quick glance) showed the following information:-Diagnoses including congestive heart failure (CHF- chronic condition where the heart cannot pump enough blood to meet the body's needs), high blood pressure, expressive aphasia (a language disorder where a person has difficulty speaking and writing, but can understand language), and depression. Review of the resident's admission Minimum Data Set (MDS - a federally mandated assessment instrument completed by facility staff), dated 10/03/25, showed the resident had moderate cognitive impairment. Review of the resident's care plan, revised 10/24/25, showed the following:-Independent with activities of daily living (ADL – basic personal care tasks essential for health and safety, such as eating, bathing, dressing, and mobility).-The resident had a communication problem.-The resident had a bruise to the left medial (toward the center of the body) side of the leg, unknown how obtained. Review of the resident's progress note, dated 10/24/25, showed at approximately 3:30 A.M, (late entry made on 10/29/25 at 3:46 A.M.), the resident reported a bruise to the left medial side of the leg. A large hematoma (a solid swelling of clotted blood within the tissue) was present on the left leg measuring approximately 11 centimeters (cm) in length by 7 cm in width and raised by 1 cm. Bruising to the site was purple in center and had yellow bruising on the outer ring. The resident reported no pain, but the area was very tender. The resident reported not knowing the origin of the injury. The yellow bruise was approximately 4 cm in diameter to the left knee, and a small yellow bruise was present on the right medial lower leg. Cold compress was applied and given to resident to use as needed. The resident oriented to person only and range of motion and grip strength within normal limits. The resident reported pain as a 10 out of 10 to the affected side. The nurse notified the Director of Nursing (DON), physician, and family notified. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the resident's October 2025 Physician Order Sheet (POS) showed the following:-An order, dated 10/27/25, for an extremity ultrasound related to reduced mobility.-An order, dated 10/27/25, for a tibia and fibula (long bones in the lower leg) x-ray related to reduced mobility. (Both orders were obtained three days after the bruising was discovered.) Review of the resident's October 2025 progress notes showed staff did not document related to the ordered ultrasound or x-ray. Review of the resident's venous doppler (ultrasound to assess blood flow) report, dated 10/28/25, showed no evidence of deep vein thrombosis (a blood clot in a vein) involving the left lower extremity. Review of the resident's radiology report, dated 10/28/25, showed no fracture or dislocation seen to the tibia or fibula. Review of the resident's progress note, dated 10/29/25, showed the resident completed 72-hour neuro checks related to a fall (fall occurring on 10/24/25) without incident. Swelling to lower extremity showing marked improvement with cold compress. Staff will continue to monitor. Review of the resident's October 2025 progress notes showed staff did not document related to a fall on 10/24/25 and did not document further monitoring of resident after sustaining left lower extremity bruising. Review of the resident's electronic medical record showed staff did not complete a skin assessment after discovery of bruises to the resident's right and left legs until 10/28/25. Review of the resident's skin assessment, dated 10/28/25, showed no skin issues and noted resident refused the skin assessment. Review of the resident's skin assessment, dated 10/30/25, showed in-house acquired bruising to the left shin was improving. Staff did not document anything additional related to the bruising. Review of the resident's skin assessment, dated 11/04/25, showed in-house acquired bruising to the left shin. Staff did not document anything additional related to the bruising. Review of the resident's skin assessment, dated 11/14/25, showed in house acquired bruising to the left shin resolved with no skin issues noted. Review of the resident's skin assessment, dated 11/20/25, showed in-house acquired bruising to left shin, left foot, and right knee. Staff did not document anything additional related to the bruising. (continued on next page)

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	265460	A. Building B. Wing	09/10/2025

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interviews on 11/20/25 at 1:00 P.M. and on 11/24/25 at 1:47 P.M., Licensed Practical Nurse (LPN) F said the following:-The resident came up to the nurse and said he/she had a bruise on his/her leg.-The resident showed the nurse a giant hematoma on the inside of his/her lower leg. The leg was swollen and resident complained of pain to the area.-The area covered the inner left leg from the bend of the leg to just below the calf and was raised approximately 2 cm off the surface of the leg and appeared blood filled, purple in color.-The nurse asked the resident if he/she fell or bumped into something, but the resident could not recall how the injury occurred.-The nurse did not question any staff regarding how the resident might have sustained the injury or if the resident had a fall.-He/she looked back in the progress notes to see if the resident had a recent fall but was not able to determine a cause for the injury.-He/she notified the DON, and he/she said to document as an unwitnessed bruise of unknown origin on the risk assessment form.-The nurse said it was an odd place for a bruise.-The nurse said he/she texted the resident's physician to notify of the bruise but did not get a response.-The nurse did not receive an order for an ultrasound or x-ray.-The nurse put ice on the hematoma, and the swelling started to decrease in size.-The resident should be monitored every shift until the bruise resolved. During an interview on 11/20/25 at 10:10 A.M., LPN B said the nurse should assess and monitor the resident, obtain vital signs, conduct a neurological assessment, and notify the DON, family, and physician for a change of condition. All information should be documented in a progress note. During an interview on 11/25/25, at 9:58 A.M., LPN D the if he/she observed a large bruise on a resident, he/she would complete an incident report in the electronic medication record, notify the resident's physician, the DON and would report the bruise to the next shift nurse to monitor. During interviews on 11/24/25 at 12:50 P.M. and on 11/25/25 at 1:32 P.M., the DON said the following:-LPN F reported the bruise to him/her on 10/24/25. -LPN F notified the physician and obtained any order to rule out a blood clot to the left leg.-He/she did not know what the delay in entering the order in for the x-ray and ultrasound. -The x-ray and ultrasound order originally was entered incorrectly, and the lab technician brought the wrong equipment on 10/27/25 and had to reschedule the visit.-The resident had a multicolored bruise to the left inner leg that was smaller than a softball, but larger than an apple.-Since the resident complained of pain with movement of the leg and walking, the DON suspected a blood clot.-The resident required stand by assistance with showers but was independent with all other cares.-There was no indication the resident had a fall.-He/she does not know why the nurse documented the resident had a fall.-The nurse should have completed a skin assessment upon discovery of the bruise on 10/24/25.-The bruise should have been monitored every shift until it resolved. -The nurse should document notification to the physician regarding ultrasound and x-ray results. During an interview on 11/25/25 at 11:34 A.M., the ultrasound company representative said the following:-There were no notes showing a technician brought the wrong equipment and had to reschedule the appointment.-The only order for the resident was on 10/27/25 for an x-ray and ultrasound.-The only visit recorded for the resident was on 10/28/25.

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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 0697 Level of Harm - Actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	Based on observation, interview, and record review, the facility failed to ensure that pain management was provided to all residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences, when the facility failed to ensure staff had access to administer as needed pain medication as requested for one resident (Resident #4) who showed physical and verbal signs of pain. The facility census was 44. Review of the facility policy titled Pain Management, revised on 06/26/24, showed the following information:-In order to help a resident attain or maintain his/her highest practicable level of physical, mental, and psychosocial well-being and prevent or manage pain, the facility staff will recognize when the resident is experiencing pain and identify circumstances when the pain can be anticipated, evaluate the resident's pain and the causes upon admission, during ongoing assessments, and when a significant change of condition or status occurs, and manage or prevent pain;-Facility staff will observe for nonverbal indicators of pain which may indicate the presence of pain;-Facility staff will be aware of verbal descriptors a resident may use to report or describe their pain;-The facility will use a pain assessment tool, which is appropriate for the resident's cognitive status;-Based upon the evaluation, the facility in collaboration with the physician will develop, implement, monitor, and revise as necessary interventions to prevent or manage each individual resident's pain;-Pharmacologic interventions will follow a systematic approach to include; evaluating the resident's condition and pain regimen, administering medication around the clock versus as needed, reassess and adjust the medication dose;-Opioids will be prescribed and dosed in accordance with current professional standards to optimize their effectiveness and minimize their adverse consequences;-Facility staff will reassess the resident's pain management at established intervals for effectiveness.1. Review of Resident #4's face sheet showed the following information:-admission date of 03/23/25;-Diagnoses included chronic kidney disease, low blood pressure, and heart disease.Review of the resident's care plan, dated 12/02/24, showed staff to administer analgesic (a medication that relieves pain) medications as ordered by the physician.Review of the resident's quarterly Minimum Data Set (MDS - a federally mandated assessment completed by facility staff), dated 06/04/25, showed the following information:-Resident had intact cognition;-Resident took opioid medications;-Resident was not on a scheduled or as needed (PRN) pain regimen.Review of the resident's September 2025 Physician Order Sheet (POS) showed the following:-An order, dated 03/02/25, for dialysis (treatment that filters waste and excess fluid from the blood when kidneys are failing) three times a week on Tuesdays, Thursdays, and Saturdays;-An order, dated 03/02/25, to perform pain scale two times a day;-An order, dated 03/23/25, for acetaminophen (over the counter medication used to relieve pain) 325 mg, give two tablets every four hours as needed for general discomfort;-An order, dated 03/26/25, for tramadol HCL (a controlled substance and synthetic opioid analgesic used to treat pain) 50 milligram (mg) tablet, give one tablet by mouth every four hours as needed for pain.Review of the resident's assessment titled, Pain interview, dated 09/03/25, showed the following:-The resident had pain frequently;-The pain limited sleep and day to day activities;-There was a PRN pain regimen available of tramadol.Review of the resident's Pain Scale Assessment, dated 09/09/25, showed the following information:-The resident rated his/her pain on day shift pain at a level of 8 out of 10;-The resident rated his/her pain on night shift pain at a level of 8 out of 10.Review of the resident's September 2025 MAR showed the following information:-On 09/09/25, staff did not administer the resident's tramadol 50 mg tablet;-On 09/09/25, staff did administer acetaminophen 325mg two tablets at 5:00 A.M. Review of the resident's progress notes, dated 09/09/25, showed staff did not document regarding the resident's pain, steps taken to address the pain, or why tramadol was not administered. Observation and interview on 09/09/25, at 3:52 P.M., showed the resident appeared upset and in pain as he/she grimaced when talking about his/her pain. He/she normally takes a tramadol before he/she goes to dialysis. This morning, he/she was in pain, and he/she asked for his/her medication. The nurse said it was locked away where he/she could not get to it. The nurse gave him/her acetaminophen instead. It worked some, but not as good as the tramadol. The chairs were so uncomfortable at dialysis they make him/her hurt more, but it is more bearable when he/she gets the tramadol. His/her pain this morning was 8 out of 10.Record review of the resident's progress notes, dated 09/09/25, showed staff did not document physician or management notification related to not being able to access the medication. During an interview on 09/09/25, at 7:25 A.M., the Social Services Director (SSD) said the following:-She was aware the nurse on staff, Licensed Practical

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F 0725 Level of Harm - Actual harm Residents Affected - Few	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. (continued on next page)

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F 0725 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to maintain sufficient nursing staff to provide nursing and related services to assure resident safety and allow residents to maintain their highest practicable physical, mental, and psychosocial well-being, when the facility failed to maintain a nursing schedule to ensure sufficient staff were on-site to assist all residents resulting in nurses working over 24 shifts, lack of staff on-site to meet the needs all residents, and left the building unattended for a short period of time. This resulted in residents being left wet for an extended period of time and residents feeling concern regarding their well-being. The facility census was 44 residents.Review of the facility's policy titled Sufficient Staff Policy, revised 05/18/24, showed the following:-It is the policy of this facility to provide sufficient staff with appropriate competencies and skill sets to assure resident safety and attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident. The facility's census, acuity, and diagnoses of the resident population will be considered based on the facility assessment;-The facility will supply services in sufficient numbers of each of the following personnel types on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans. Except when waived, licensed nurses; and other nursing personnel, including but not limited to nurse aides (NA).1. Review showed the facility did not provide any working nursing staffing sheets or nursing staff schedule when requested for review.During interview on 09/07/25, at 10:30 A.M., the Former Administrator said the following:-As of 09/07/25, the facility had three nurses on staff and Registered Nurse (RN) B was the only RN;-RN B had been working for over 36 hours and felt he/she could not leave the facility, but was concerned for the resident's safety due to being tired;-The Former Administrator expressed this concern to corporate staff.During interviews on 09/07/25, at 12:42 P.M., and 09/08/25, at 1:03 P.M., Licensed Practical Nurse (LPN) C said the following:-He/she arrived at the facility on 09/06/25, at 5:15 A.M., and had no relief until he/she was terminated and had worked for over 30 hours;-He/she and RN B were fired on 09/08/25 and left the facility at approximately 1:50 A.M. ;-When he/she and RN B left, Certified Nurse Aide (CNA) N, Nurse Aide (NA) T, and another CNA left as well. This left CNA O and RN A in the facility;-The facility census was 44 and should have at least three staff overnights for that census. Corporate was aware of how many staff were left in the building.-The facility had never completed staffing sheets, even when RN A was the Director of Nursing (DON). The only time he/she saw a staffing sheet prior to this was when state was in the building for a complaint;-They do not currently use agency staff;-No staff was actively making the schedule. Staff were just trying to call other staff for help as needed.During interviews on 09/07/25, at 2:42 P.M., and 09/08/25, at 10:55 A.M., CNA N said the following:-There were several days when he/she was the only CNA in the building, and he/she had to stay over due to no CNA coming in to cover for him/her;-He/she was not supposed to work on 09/07/25, but came in to help due to RN B and LPN C being so exhausted. He/she came in at approximately 5:00 P.M.;-The Former Administrator was on the telephone with the Regional Nurse Consultant (RNC) and Regional Director of Operations (RDO) attempting to get coverage for the nurses;-The LPN who was supposed to cover the night shift called in and another LPN had already resigned, but said they would come in if the company gave them a bonus;-The police department came to the facility due to multiple phone calls from residents related to their safety and the police department called the Department of Health and Senior Services (DHSS). The police contacted the owner and told the owner they needed to have a plan for nursing relief;-RN A came to the facility on [DATE], at approximately 12:30 A.M., and the owner told RN B, LPN C, and the Former Administrator they were fired and to give the keys to RN A;-The facility did not have a schedule and would just call staff in if they were shorthanded.During an interview on 09/08/25, at 11:15 A.M., CNA O said the following:-When he/she arrived at the facility on 09/07/25, at 10:00 P.M., LPN C and RN B had been working for 30 hours. CNA N, NA T, and another CNA were also in the facility;-NA T and another CNA said they would stay until 6:00 A.M.;-The CNA did not feel it was safe for LPN C and RN B to continue working, because they were so tired and could possibly pass the wrong medication;-The owner called and said he/she was going to send another nurse;-RN A came to the facility at approximately 12:00 A.M.;-The owner fired LPN C and RN B, because they refused to hand the keys over to RN A because RN A was under investigation for misappropriation of narcotic medication;-LPN C and RN B left the facility around 12:30 A.M. to 1:00 A.M. and CNA N, NA T, and the other CNA walked out at this time. This left him/her and RN A to care for the residents;-Some residents were still wet when day shift arrived, because he/she and the RN could not

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F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Post nurse staffing information every day. Based on observation, interview, and record review, the facility failed to post the current daily nurse staffing information in a clear and readable format and in a prominent place readily accessible to residents and visitors. The facility census was 44.Review of the facility's policy titled Nurse Staffing Posting Information Policy, revised 06/26/24, showed the following:-It is the policy of this facility to make nurse staffing information readily available in a readable format to residents and visitors at any given time;-The Nurse Staffing Sheet will be posted on a daily basis and will contain facility name; the current date; facility's current census; the total number and the actual hours worked by the licensed and unlicensed nursing staff directly responsible for resident care per shift;-The facility will post the Nurse Staffing Sheet at the beginning of each shift;-The information posted will be presented in a clear and readable format and in a prominent place readily accessible to residents and visitors;-A copy of the schedule will be available to all supervisors to ensure the information posted is up-to-date and current. The information shall reflect staff absences on that shift due to callouts and illness. Staffing shall include all nursing staff who are paid by the facility (including contract staff). Any staff not paid for by the facility, such as hospice staff or individuals hired by families, shall not be included;-Nursing schedules and posting information will be maintained in the Human Resources Department for review for a minimum of 18 months or as required by State law, whichever is greater;-The facility will, upon oral or written request, make the nurse staffing data available to the public for review at a cost not to exceed the community standard.1. Observations on 09/08/25, at 11:03 A.M. and 4:41 P.M., 09/09/25, at 9:03 A.M., and 09/10/25, at 12:27 P.M., showed staff did not have the Nurse Staffing Posting displayed in the entry hall, at the nurses' station, or by the time clock.During an interview on 09/08/25, at 11:06 A.M., Certified Nursing Assistant (CNA) S said he/she did not know where the Nurse Staffing Sheet was posted, but thought it should be posted.During an interview on 09/08/25, at 11:52 A.M., Registered Nurse (RN) A said the following:-The Nurse Staffing Sheet should be posted behind the nurses' station under the white board on the wall visible to anyone that came to the facility;-The Director of Nursing (DON) was responsible for the Nurse Staffing Sheet;-He/she did not know the last time it was posted, and the sheet was not posted today;-He/she was the former DON and was responsible for posting the Nurse Staffing Sheet, but had not posted it for at least four months.During an interview on 09/08/25, at 1:03 P.M., Licensed Practical Nurse (LPN) C said the following:-The Nurse Staffing Sheet should be posted daily;-He/she had not seen the Nurse Staffing Sheet posted and did not know where the DON posted it;-RN A (the former DON) was responsible for posting it.During an interview on 09/08/25, at 7:12 P.M., LPN E said the following:-He/she had not seen the Nurse Staffing Sheet in at least three months; -RN A (the former DON) filled the Nurse Staffing Sheet out and posted it.During an interview on 09/09/25, at 12:10 P.M., LPN D said the following:-He/she had not seen the Nurse Staffing Sheet posted in a long time;-The night nurse was responsible for filling out the Nurse Staffing Sheet.During an interview on 09/10/25, at 12:00 P.M., the Business Office Manager said the facility had not completed the Nurse Staffing Sheet in a long time, so he/she was unable to provide any copies.During an interview on 09/10/25, at 3:36 P.M., the Administrator said the Nurse Staffing Sheet should be posted daily.

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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. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to have pharmacy systems in place to ensure proper administration of medications when staff entered two orders for the same medication for one resident (Resident #4) which resulted in errors in administration. The facility census was 42.Review of the facility policy titled, Medication Administration, revised on 6/26/24, showed:-Medications are administered by licensed nurses, other staff who are legally authorized to do so in this state, as ordered by the physician and in accordance with professional standards of practice, in a manner to prevent contamination or infection. It is the policy of this facility to ensure the safe and effective administration of all medication by utilizing best practice guidelines;-Review MAR (Medication Administration Record) to identify medication to be administered;-Administer within 60 minutes prior to or after the scheduled time unless otherwise ordered by the physician;-Sign MAR after administered. For those medications requiring vital signs, record the vital signs onto the MAR;-Correct any discrepancies and report to the nurse manager.Record review of Trelegy Ellipta (an inhaled medication used to open airways and decrease inflammation in the lungs intended for one time per day use) manufacturer safety information showing the following warnings and precautions:-Trelegy is not a rescue medication and should not be used for the relief of acute bronchospasm or symptoms. Acute symptoms should be treated with an inhaled, short-acting beta-agonist.-Trelegy should not be used more often or at higher doses than recommended or with another long-acting beta2-adrenergic agonist ([NAME]) for any reason, as an overdose may result. Clinically significant cardiovascular effects and fatalities have been reported in association with excessive use of inhaled sympathomimetic drugs, like [NAME].1.Review of Resident #4's face sheet showed:-Diagnoses of stage 4 (severe) kidney disease, general anxiety disorder, major depression, high blood pressure, and blindness in one eye. Review of the resident's care plan, revised on 10/01/25, showed the following:-The resident had impaired thought processes related to metabolic encephalopathy (a brain dysfunction caused by a chemical imbalance from a metabolic problem, such as an organ not working properly);-Staff to administer medications as ordered and monitor for side effects and effectiveness;-The resident needed hemo-dialysis (a life-sustaining treatment for kidney failure that filters waste, salt, and extra fluid from the blood, acting as artificial kidneys to keep the body in balance) due to kidney failure;- The resident went to dialysis on Tuesday, Thursday, and Saturday. Review of the resident's current Physicians Order Sheet showed an order, dated 10/25/25, for Trelegy Ellipta Inhalation Aerosol Powder breath activated 100-62.5-25 micrograms (mcg)/actuation, inhale orally one time a day at 9:00 A.M. for shortness of breath. (Staff did not document an order related to administration at 7:00 A.M.) Review of the resident's October 2025 Medication Administration Record (MAR) showed the following:-An order, dated 10/06/25, for Trelegy Ellipta Inhalation Aerosol Powder breath activated 100-62.5-25 mcg/actuation, inhale one puff orally one time a day at 7:00 A.M. for bilateral pleural effusions (an abnormal buildup of fluid in the space between the lungs and the chest wall);-A duplicate order, dated 10/25/25, for Trelegy Ellipta Inhalation Aerosol Powder breath activated 100-62.5-25 mcg/actuation, inhale orally one time a day at 9:00 A.M. for shortness of breath;-On 10/25/25, 10/26/25, 10/27/25, and 10/29/25, staff documented administering the Trelegy at 7:00 A.M. and 9:00 A.M.Review of the resident's November 2025 MAR showed the following:-An order, dated 10/06/25, for Trelegy Ellipta Inhalation Aerosol Powder breath activated 100-62.5-25 mcg/actuation, inhale one puff orally one time a day at 7:00 A.M. for bilateral pleural effusions;-A duplicate order, dated 10/25/25, for Trelegy Ellipta Inhalation Aerosol Powder breath activated 100-62.5-25 mcg/actuation, inhale orally one time a day at 9:00 A.M. for shortness of breath; -On 11/02/25, 11/03/25, 11/05/25, 11/07/25, 11/09/25, 11/10/25, 11/12/25, 11/13/25, 11/15/25, 11/16/25, 11/17/25, 11/18/25, and 11/19/25 staff documented administering the Trelegy at 7:00 A.M. and 9:00 A.M.During an interview on 11/19/25 at 12:27 P.M., the resident said at times staff did not administer his/her medicine as ordered.During an interview on 11/19/25 at 10:55 A.M., Licensed Practical Nurse (LPN) A said the following:-He/she had observed some duplication of orders on the medication administration record;-He/she spoke to the Director of Nursing (DON) about the issue recently (unsure what day). During an interview on 11/19/25 at 11:00 A.M., LPN B said he/she observed some duplicate physician orders for medications and tried to discontinue the extra order when he/she found the errors. During an interview on 11/24/25 at 9:38 A.M., Certified Medication Technician (CMT) E said the following:-The facility had an issue with some of the medications appearing twice on resident MARs;-He/she was unsure why the resident had two separate Trelegy orders;-The CMT

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident’s drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure all residents were free from unnecessary medications when staff administered medications to two residents (Resident #1 and #10) without following physician ordered monitoring. The facility census was 42.Review of the facility policy titled, Medication Administration, revised on 06/26/24, showed the following:-Medications are administered by licensed nurses, or other staff who are legally authorized to do so in this state, as ordered by the physician and in accordance with professional standards of practice, in a manner to prevent contamination or infection. It is the policy of this facility to ensure the safe and effective administration of all medication by utilizing best practice guidelines;-Obtain and record vital signs, when applicable or per physician orders. When applicable, hold medication for those vital signs outside of physician's prescribed parameters;-Sign MAR (medication administration record) after administered. For those medications requiring vital signs, record the vital signs onto the MAR;-Medications requiring vital signs prior to administration includes anti-hypertensives (used to treat high blood pressure). 1. Review of Resident #1's face sheet (a document that gives a resident's information at a quick glance) showed the following information:-Diagnoses including congestive heart failure (CHF - chronic condition where the heart cannot pump enough blood to meet the body's needs) and high blood pressure. Review of the resident's admission Minimum Data Set (MDS - a federally mandated assessment instrument completed by facility staff), dated 10/03/25, showed the following: -Moderate cognitive impairment.-Diagnosis of high blood pressure. Review of the resident's care plan, revised 10/24/25, showed the following:-Independent with activities of daily living (ADL – basic personal care tasks essential for health and safety, such as eating, bathing, dressing, and mobility).-The resident had a communication problem.-The resident had CHF and high blood pressure. -Staff should administer cardiac medications and high blood pressure medications as ordered. Review of the resident's November 2025 Physician Orders showed an order, dated 04/18/25, for metoprolol tartrate (blood pressure medication) tablet 25 milligrams (mg), give a half tablet by mouth one time a day related to CHF. Hold if systolic blood pressure (SBP) is 110 millimeters of Mercury (mm/Hg) or less or heart rate is less than 65 beats per minute (bpm). Review of the resident's November 2025 MAR showed an order, dated 04/18/25, for metoprolol tartrate tablet 25 mg, give a half tablet by mouth one time a day related to CHF. Hold if SBP is 110 mm/Hg or less or heart rate is less than 65 bpm. Staff administered the resident's metoprolol tartrate medication when the resident's heart rate was below the ordered perimeters on the following dates:-On 11/15/25, the resident's heart rate was 50 bpm and staff documented medication was administered.-On 11/17/25, the resident's heart rate was 62 bpm and staff documented medication was administered.-On 11/18/25, the resident's heart rate was 62 bpm and staff documented medication was administered.-On 11/19/25, the resident's heart rate was 61 bpm and staff documented medication was administered.-On 11/21/25, the resident's heart rate was 45 bpm and staff documented medication was administered.-On 11/22/25, the resident's heart rate was 42 bpm and staff documented medication was administered.-On 11/24/25, the resident's heart rate was 49 bpm and staff documented medication was administered.-On 11/25/25, the resident's heart rate was 48 bpm and staff documented medication was administered. (continued on next page)

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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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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Review of Resident #10's face sheet showed the following information:-Diagnoses including CHF and orthostatic hypotension (a condition where blood pressure drops significantly and suddenly when changing positions). Review of the resident's quarterly MDS, dated [DATE], showed the following: -Cognitively intact.-Diagnoses including CHF and orthostatic hypotension. Review of the resident's current November 2025 Physician Orders showed an order, dated 03/05/25, for Entresto (heart failure medication) tablet 24-26 mg, give one tablet by mouth two times a day for CHF. Hold if SBP was less than 100 mm/Hg. Review of the resident's November 2025 MAR showed the following: -An order, dated 03/05/25, for Entresto tablet 24-26 mg, give one tablet by mouth two times a day for CHF. Hold if standing blood pressure (SBP) was less than 100 mm/Hg.-Staff administered the resident's Entresto medication without checking the resident's blood pressure from 11/01/25 through 11/19/25, twice daily at 7:00 A.M. and 3:00 P.M., except on 11/05/25 and 11/18/25 at 7:00 A.M. due to resident's refusal of medication. Review of the resident's vital sign summary for November 2025 showed staff documented the resident's blood pressure was taken one time on 11/11/25. During an interview on 11/24/25, at 12:40 P.M., Certified Medication Technician (CMT) E said the following:-The resident did not need his/her blood pressure checked prior to administering his/her medications.-He/she did not know what the resident's blood pressure that morning was prior to administering his/her medication. 3. During an interview on 11/24/25 at 12:40 P.M., CMT E said the following:-If a medication required a blood pressure or pulse to be taken it would be indicated on the MAR.-The blood pressure or pulse should be checked prior to medication administration to make sure it was within the ordered parameters.-There was no place to document residents' blood pressure on the MAR. During an interview on 11/25/25 at 1:47 P.M., Licensed Practical Nurse (LPN) F said a resident's blood pressure and pulse should be checked prior to administering medication if there are parameters. The vital signs should be documenter on the MAR. During an interview on 11/24/25 at 12:50 P.M., the Director of Nursing said staff should check the resident's blood pressure or pulse if it was indicated on the MAR. There should be a spot to document vital signs on the MAR. During an interview on 11/25/25 at 4:10 P.M., the Administrator said blood pressure and pulse should be listed in the MAR if indicated. Staff should follow physician orders, including any parameters ordered, when administering medication.

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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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are free from significant medication errors. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure all residents were free of significant medication error, when staff failed to administer insulin as ordered for three residents (Resident #5, # 6, and #7). The facility census was 44. Review of the facility policy, titled Medication Administration, revised 06/06/24, showed the following information:-Ensure the six rights of medication administration are followed included right resident, right drug, right dosage, right route, right time, and right documentation;-Administer medication as ordered;-Injections are administered by licensed nurses as ordered by the physician and in accordance with professional standards of practice.1. Review of Resident # 5 face sheet (brief look at resident information) showed the following information:-re-admission date of 06/18/25;-Diagnoses included diabetes.Review of the resident's quarterly Minimum Data Set (MDS- a federally mandated assessment tool filled out by facility staff), dated 06/18/25, showed the following information:-Cognitively intact;-Received insulin injections seven days out of the week.Review of the resident's care plan, revised on 08/18/25, showed the following information:-Accu-Check's (blood glucose monitoring) per physician order;-Administer diabetic medication per physician order;-Rotate insulin injection locations and document as indicated.Review of the resident's September 2025 Physician Order Sheet (POS) showed the following information:-An order, dated 08/07/25, for insulin glargine (Lantus - a long-acting synthetic form of human insulin used to manage blood sugar) subcutaneous (under the skin) solution pen injector 100 unit/milliliter (ml), inject 30 units subcutaneously every morning and at bed time;-An order, dated 08/28/25, for Novolog (a modified type of rapid acting medical insulin used to treat diabetes) FlexPen, inject 10 units subcutaneously three times a day, in addition to sliding scale;-An order, dated 06/24/25, for Novolog FlexPen, inject three times a day per the following sliding scale;-If blood glucose level is 121 mg/dL to 175 mg/dL, administer 4 units of insulin;-If blood glucose level is 176 mg/dL to 225 mg/dL, administer 8 units of insulin;-If blood glucose level is 226 mg/dL to 275 mg/dL, administer 10 units of insulin;-If blood glucose level is 276 mg/dL to 325 mg/dL, administer 12 units of insulin;-If blood glucose level is 326 mg/dL to 425 mg/dL, administer 19 units of insulin and call the physician;-If blood glucose level is 426 mg/dL to 475 mg/dL, administer 21 units of insulin and call the physician;-If blood glucose level is 476 mg/dL to 500 mg/dL, administer 24 units of insulin and call the physician.Review of the resident's September 2025 Medication Administration Record (MAR) showed the following information:-On 09/09/25, staff did not document a blood sugar check at 7:00 A.M.;-On 09/09/25, staff did not document administration of the resident's 7:00 A.M. dose of insulin glargine. Staff noted hold/ see progress notes;-On 09/09/25, staff did not document administration of the resident's 7:00 A. M. dose of scheduled Novolog. Staff noted hold/ see progress notes;-On 09/09/25, staff did not document administration of the resident's 7:00 A.M. dose of sliding scale Novolog. Staff noted hold/ see progress notes. Review of the resident's progress notes, dated 09/09/25, showed staff did not document why the resident's insulin was not administered.Observation and interview on 09/09/25, at 11:15 A.M., showed the resident lay in bed appearing flushed and said the following:-He/she did not receive his/her insulin this morning;-He/she was worried, because his/her blood sugar level had been running high;-He/she asked staff about his/her insulin and it was reported to him/her the nurse did not have access to administer the insulin. The nurse also did not check his/her blood glucose level this morning though he/she believed the nurse does not need access to be able to do that.During an interview on 09/09/25, at 1:30 P.M., the Regional MDS and Care Plan Coordinator said the following:-The resident missed his/her morning dose of insulin;-She had checked the resident at this time, and it was 390 mg/dL resulting in an insulin administration of 10 units plus an additional 19 units of sliding scale.Review of the resident's September 2025 MAR showed the Regional MDS and Care Plan Coordinator administered the resident's insulin on 09/09/25 after the lunch meal. 2. Review of Resident #6's face sheet showed the following information:-re-admission date of 04/22/24;-Diagnoses included diabetes. Review of the resident's MDS, dated [DATE], showed the following information:-Cognitively intact;-Received insulin injections seven days out of the week.Review of the resident's care plan, revised 08/18/25, showed the resident had a nutritional need related to diabetes. Staff did not care plan related to the resident's medication management of the resident's diabetes. Review of the resident's September 2025 POS showed an order, dated 08/15/25, for Lantus Solostar Subcutaneous Solution Pen Injector 100 unit/ml, inject 65 units subcutaneously one time a day at 7:00 A.M. Review of the resident's September 2025 MAR showed the following:-On 09/09/25, staff did not document checking the resident's blood sugar at 7:00 A.M. -On

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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 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Administer the facility in a manner that enables it to use its resources effectively and efficiently. (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure a licensed Administrator was available to the facility, that staff were aware of who the Administrator was, and that the Administrator was aware of and involved in the day-to-day happenings of the facility. This resulted in the facility not having sufficient staffing scheduled and available on-hand to ensure proper care resulting in multiple residents being left wet for extended periods of time; in staff not having access to administer ordered insulin and pain medications; allowing an unlicensed driver to transport residents; and failing to provide protective oversight of residents after a staff member was allowed to return with an investigation of allegations of misappropriation against a staff member ongoing. The facility census was 44. The Administrator was notified on 09/08/25, at 2:18 P.M., of an Immediate Jeopardy (IJ) which began on 09/08/25. The IJ was removed on 09/08/25 as confirmed by surveyor on-site verification. Review showed the facility did not provide a policy related to the Administrator. 1. Review of the Former Administrator's license showed the Administrator was not licensed in Missouri. Review of the Board of Nursing Home Administrator's records showed there was no Temporary Emergency Administrator License issued for the facility. During an interview on 09/07/25, at 10:30 A.M., the former Administrator said the following:-He/she was hired on 09/02/25;-He/she did not have a Missouri Administrator license;-He/she was supposed to have someone over him/her, but had never met that person and did not know that person's name.During an interview on 09/09/25, at 2:10 P.M., the Former Administrator said he/she was the Administrator until he/she was terminated on 09/07/25.During an interview on 09/10/25, at 8:26 A.M., the Business Office Manager (BOM) said he/she could not provide a Missouri Administrator License for the former Administrator because the former Administrator only had a license for Arkansas. 2. During an interview on 09/08/25, at 10:49 A.M., the Corporate Operating Officer (COO) said there was an Administrator who was took over after 08/31/25. The Former Administrator was an interim and did not have a Missouri Administrator License yet. The Former Administrator should have had the current Administrator's contact information. During an interview on 09/08/25, at 2:16 P.M. and 2:38 P.M., the Administrator said the following:-He/she was licensed in Missouri;-He/she was the Administrator as of 09/08/25, at 8:00 A.M. and arrived at the facility at 10:00 A.M.;-He/she did not know whose name was listed as the Administrator;-He/she had not heard anything related to the misappropriation allegations.During an interview on 09/08/25, at 2:40 P.M., the Regional Director of Operations (RDO) said he/she could not confirm who the Administrator was for the facility.2. Observation, interview, and record review showed the facility failed to provide routine drugs and biologicals to its residents when the facility failed to ensure nursing staffing had access to and the ability to administer insulin to three residents (Resident #5, # 6, and #7). Observation, interview, and record review showed the facility failed to ensure pain management was provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences when the facility failed to ensure pain medication was administered as needed to one resident (Resident #4) who displayed signs of untreated pain. During an interview on 09/10/25, at 3:36 P.M., the Administrator said the following:-He was not aware residents were not receiving their medication;-He was not familiar with the medication dispensing system, but access should have been provided to nurses prior to starting their shifts. If the nurses did not have access or the ability to perform their jobs, they should have contacted him.3. Interview and record review, showed the facility failed to maintain sufficient nursing staff to provide nursing and related services to assure resident safety and allow residents to maintain their highest practicable physical, mental, and psychosocial well-being, when the facility failed to maintain a nursing schedule that provided sufficient staff on-site to assist all residents resulting in nurses working over 24 shifts, lack of staff on-site to meet the needs all residents, and the building left unattended for a short period of time. This resulted in residents being left wet for an extended period of time and in residents feeling concern regarding their well-being. During an interview on 09/09/25, at 10:50 A.M., the Administrator said the following:-The facility was actively recruiting staff for nursing;-The facility had a contract with a staffing agency, but they were not going to use the agency unless they had an emergency with staffing. He/she did not feel the facility had a staffing emergency at the time.During an interview on 09/10/25, at 3:36 P.M., the Administrator said the following:-He/she was getting nursing staffing covered, but the facility did not have enough staff so he/she was bringing staff from other facilities to assist;-Two staff was not enough to care for the residents at night;-He/she had worked on a

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F 0836 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure the facility is licensed under applicable State and local law and operates and provides services in compliance with all applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards. (continued on next page)

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F 0836 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide services in compliance with all applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards and principles that apply to professionals providing services in such a facility, when the Transport Driver transported four residents (Resident #1, #9, #11 and #12) in the facility's van to physician appointments when his/her driver's license was suspended. The facility census was 44.Review of the facility's policy titled Licensure Verification, revised 12/27/24, showed the following:-All personnel that require a license, or certification shall be verified through the appropriate issuing agency;-The Human Resources Director, or designee, is responsible for maintaining and ensuring the validity and current status of individual's certification/licensure;-An individual will not be employed and or/will be terminated from employment (whichever case may apply) if the individual has lost licensure/certification for any reason;-Any licensed/certified employee is responsible for submitting verification of licensure/certification renewal to Human Resources prior to expiration.Review showed the facility did not provide a policy or job description related to the Transport Driver.1. During an interview on 09/08/25, at 5:11 P.M., Certified Nursing Assistant (CNA) N said the Transport Driver showed him/her a letter the driver received where the driver got arrested for driving on a suspended license and was in possession of drug paraphernalia. During an interview on 09/08/25, at 5:28 P.M., Nurse Aide (NA) T said the following:-The transport driver did not have a driver's license;-The transport driver showed him/her a letter that said the driver was arrested for driving on a suspended license.Review of Case.Net (www.courts.mo.gov a website to view cases in Missouri courts) showed the following related to the Transport Driver:-Case filed on 07/23/25, with charges dated 07/19/25, for driving while license suspended/revoked;-Case filed on 07/31/25, with charges dated 07/18/25, for unlawful possession of drug paraphernalia and driving while license suspended/revoked.Review of the facility's transports documentation, dated 08/18/25 through 09/09/25, showed the following:-On 08/19/25, Resident #1 was transported to a physician's appointment in [NAME], Missouri (MO) (approximately 120 miles round trip);-On 08/25/25, Resident #9 was transported to a physician's appointment in Neosho, MO (approximately 76 miles round trip); -On 08/26/25, Resident #9 was transported to a physician's appointment in town; -On 08/27/25, Resident #9 and Resident #12 were transported to physician's appointments in [NAME], MO (approximately 38 miles round trip); -On 08/28/25, Resident #11 was transported to a physician's appointment in [NAME], MO (approximately 120 miles round trip)During an interview on 09/08/25, at 3:05 P.M., Resident #4 said the facility's Transport Driver did not have a valid license. During interviews on 09/08/25, at 6:43 P.M., and on 09/09/25, at 10:06 A.M., the Business Office Manager (BOM) said the following:-He/she completed background checks quarterly;-The Transport Driver was pulled over in his/her personal vehicle on 07/28/25 and had drug paraphernalia and a suspended license;-The transport driver completed transports up to 09/08/25;-He/she heard through the grapevine that the driver had been arrested and called the local sheriff's office to confirm this. The sheriff's office said the transport driver's license was suspended on 08/18/25;-If he/she had not been told by other staff, the transport driver would still be driving the van.During an interview on 09/09/25, at 10:06 A.M., the Housekeeping Supervisor said he/she learned the Transport Driver's license was suspended on 08/18/25 when he/she looked on-line and he/she told the BOM.During an interview on 09/10/25, at 11:58 A.M., Certified Medication Technician (CMT) J said if a staff member transported residents, they needed a transport license.During an interview on 09/09/25, at 12:10 P.M., Licensed Practical Nurse (LPN) D said the following:-Staff were required to have a chauffer's license to operate the facility's van;-He/she saw the Transport Driver take residents to appointments recently;-He/she did not know if the driver had a valid driver's license.During an interview on 09/10/25, at 11:04 A.M., the Medical Director said he/she would not expect anyone with a suspended license to drive or be the transport driver for the facility.During an interview on 09/10/25, at 3:36 P.M., the Administrator said the following:-He/she understood that when the Transport Driver was hired, the driver's license was not suspended;-When the BOM found out the driver's license was suspended, the BOM told the driver they could not drive the van.

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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. Based on interview and record review, facility staff failed to fully implement their infection control program when staff failed to ensure the required two step tuberculosis (TB-a communicable disease that affects the lungs characterized by fever, cough, and difficulty breathing) screening test was administered timely as per policy for two staff (Licensed Practical Nurse (LPN) F and LPN G) of two staff sampled. The facility census was 44. Review of the facility's policy titled Tuberculosis Testing, revised 06/29/23, showed the following:-The purpose of the policy was to ensure each resident and employee of the facility is tested for tuberculosis (TB) after entering the facility to prevent the spread of infection;-Upon hire, a new employee will receive a two-step PPD skin test (a test used to determine exposure to TB);-Each employee will also have an annual one-step TB test to ensure that any possible infections can be triggered proactively to prevent further spread;-All TB tests will be kept on file in the according areas (employee files).1. Reviewed showed the facility did not provide personnel files for LPN F and LPN G upon request. Observation on 09/08/25, at 7:46 P.M., showed LPN G was working as the charge nurse.During an observation and interview on 09/09/25, at 9:09 A.M., LPN F said the following:-He/she was not currently employed by the facility. He/she used to work for the facility but left in August or October 2024;-He/she worked the floor last night with a certified nursing assistant (CNA) and a nurse aide (NA);-He/she did not have a TB test prior to working on the floor with the residents.-The LPN was working as the charge nurse.During an interview on 09/09/25, at 8:50 A.M., the Business Office Manager (BOM) said the following:-He/she did not have personnel files for LPN F and LPN G;-LPN F and LPN G were not employees of the corporation and were not employees of a staffing agency;-He/she did not have TB tests for the LPNs.During an interview on 09/09/24, at 12:10 P.M., LPN D said staff should have a negative TB test prior to working the floor and if they did not, this was not safe for the residents. During an interview on 09/09/25, at 4:33 P.M., the facility physician said staff should have a negative TB test prior to working with the residents. During an interview on 09/10/25, at 11:04 A.M., the Medical Director said staff should have a negative TB test prior to working the floor but in the case of emergency staffing needs, he believed if the staff wore a mask that would be sufficient to protect the residents.During interviews on 09/09/25, at 11:02 A.M. and 09/10/25, at 3:36 P.M., the Administrator said the following:-Upon hire, staff should have their first TB skin test read prior to working on the floor;-He did not know who had LPN F and LPN G come to the facility to work and did not know if they were employees of the corporation or a staffing company;-LPN F and LPN G did not have a negative TB test prior to working the floor.Complaint #2611677

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide residents with a complete and fully functional call light system when the facility failed to provide staff with pagers for notification of call lights. This failure resulted in two residents (Resident #7 and #8) waiting for longer periods of time for staff to address incontinent care needs. The facility census was 42. Review of the facility policy titled, Call light Accessibility and Timely Response, revised [DATE], showed the following:-The purpose of this policy is to assure the facility is adequately equipped with a call light at each resident's bedside, toilet, and bathing facility to allow residents to call for assistance. Call lights will directly relay to a staff member or centralized location to ensure appropriate response;-All staff will be educated on the proper use of the resident call system, including how the system works and ensuring resident access to the call light;-Staff will report problems with a call light or the call system immediately to the supervisor or the maintenance director and will provide immediate or alternative solutions until the problem can be remedied;-Ensure the call light system alerts staff members directly or goes to a centralized staff work area;-All members who see or hear an activated call light are responsible for responding. If the staff member cannot provide what the resident desires, the appropriate personnel should be notified. 1. Review of the Department of Health and Senior Services (DHSS) database for exceptions showed the following: -On [DATE], the facility was approved for an exception to part of the state call light requirements to allow for a wireless call system (use of pagers);-The facility was required to ensure the wireless nurse call system was fully operational 24 hours a day, seven days a week;-The facility was required to maintain the system per manufacturer's recommendations;-The facility was required to ensure all direct care staff always carried and utilized the wireless nurse call pages;-The exception expired on [DATE]. 2. Review of Resident #7's face sheet showed diagnoses included chronic obstructive pulmonary disease (COPD, inflammation and obstruction of the airways in the lungs), stroke, diabetes mellitus type II, major depression, and anxiety. Review of the resident's care plan, revised on [DATE], showed the following:-The resident required assistance with activities of daily living (ADLs – dressing, grooming, bathing, eating, and toileting) related to COPD, depression, anxiety, and lack of motivation;-Ensure call light is in reach and answered promptly. Review of the resident's quarterly Minimum Data Set (MDS - a federally mandated assessment tool completed by facility staff, dated [DATE], showed the following:-Cognitively intact;-Required partial/moderate assistance of staff with toileting hygiene and showers;-Required supervision/touching assistance with personal hygiene;-Frequently incontinent of bowel. During an interview on [DATE] at 1:00 P.M., the resident said the following:-At night he/she frequently waited 15 to 30 minutes for staff to answer his/her call light and has had to wait up to an hour for staff to answer his/her light;-He/She had to urinate in the bed due to longer wait times.-Laying in urine caused a burning sensation to the resident's skin and was embarrassing to the resident. (continued on next page)

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	265460	A. Building B. Wing	09/10/2025

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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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	3. Review of Resident #8's face sheet showed diagnoses included chronic respiratory failure, major depression, anxiety, and diabetes mellitus type II. Review of the resident's care plan, revised on [DATE], showed the following:-The resident required assistance with ADLs related to impaired balance and gait and assistive devices;-Incontinent of bowel and bladder;-Ensure call light is within reach and answered promptly. Review of the resident's quarterly MDS, dated [DATE], showed:-Cognitively intact;-Functional limitation in range of motion to both legs;-Required substantial/maximal assistance of staff with toileting hygiene and personal hygiene;-Occasionally incontinent of bladder;-Frequently incontinent of bowel. During an interview on [DATE] at 1:02 P.M., the resident said the following:-He/she waited up to one hour for staff to answer his/her call light;-He/she had to lay in feces for an hour;-This made the resident feel undignified and mad to have to lay in feces.4. During an observation on [DATE] at 2:51 P.M., surveyors tested the call bell system by pressing call buttons in two resident rooms (room [ROOM NUMBER] and room [ROOM NUMBER]). The lights did not illuminate outside the doorways and the system made no audible sound when the call button was pressed. 5. During an interview on [DATE], at 3:00 P.M., Certified Nurse Assistant (CNA) G said the following:-He/she worked at the facility for approximately a year and a half;-The resident call lights have not illuminated or sounded during that time;-He/she had to walk to the nurses' desk and check the monitor mounted on the wall to see if any resident call lights were on;-He/she did not have a pager to carry. During interviews on [DATE] at 12:00 P.M., CNA H and CNA I said the following:-The CNAs began working in the facility in [DATE] and work the night shift 6:00 P.M. to 6:00 A.M.;-Both aides said they had not had pagers for the call system since starting work at the facility;-The lack of pagers lead to a delay in answering resident call lights;-When assigned to work the back hall, staff must walk to the front of the facility to view the monitor at the nurses' station to see if any resident call lights are turned on. During an interview on [DATE] at 2:15 P.M., CNA M said the following:-The call lights do not light up on the outside of the resident doors or have sound;-Staff have to check a board at the nurses' station to see if there are any call lights on;-He/she used a pager when working on the back hall about six months ago, but does not have one anymore. During an interview on [DATE] at 2:58 P.M., CNA N said the following:-The aides use to have pagers to alert of a resident call light, but he/she thinks they are lost;-The CNAs have not had pagers for two months or more;-Residents have complained to him/her about the time it takes to respond to call lights During an interview on [DATE] at 12:40 P.M., Certified Medication Technician (CMT) C said the following:-When a resident presses a call light, staff must come to the nurses' station and check the monitor to see the call light;-He/she would like a monitor on the back hallway, so staff did not have to run to the front and check the monitor for call lights;-The facility had some old pagers in a tackle box at the nurses' station, but they were all broken or needed batteries. (continued on next page)

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on [DATE] at 9:58 A.M., Licensed Practical Nurse (LPN) D said the following:-He/she worked at the facility for approximately 2 months part time and for the last 2 weeks full time, 6:00 P.M. to 6:00 A.M.;-Staff check the monitor at the nurses' station to see if resident call lights are turned on;-The call system did not have an audible sound or a visual light, just the monitor;-The staff assigned to the back halls come to the nurses' desk located between the two front halls to check and see if any residents have call lights on for the back hall, because there is no way to see or hear call lights on the back hall and no monitor on the back halls. During an interview on [DATE] at 4:10 P.M., the Administrator said the following:-He/she determined the waiver for the current call light system expired in 2023;-He/she applied for a new waiver, but had not received the waiver at this time;-The waiver was for the currently used system which worked with pagers to notify staff of a call light;-He/she ordered pagers three weeks ago, but they had not arrived;-Staff found two functional pagers on [DATE];-He/she expected staff to answer call lights within 10 to 15 minutes and answer emergency (bathroom) call lights within 3 to 5 minutes. Complaint 2675693

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This deficiency is uncorrected. For previous examples, refer to the Statement of Deficiencies dated 09/24/25. Based on observation, interview, and record review, the facility failed to provide an effective pest control system when the facility failed to take steps for pest control within the facility after multiple reported sightings of mice and mice droppings in multiple areas of the facility. The facility census was 42.Review of the facility policy titled, Pest Control Program Policy, revised 05/14/24, showed:-It is the purpose of this facility to maintain an effective pest control program that eradicates and contains common household pests and rodents;-Effective pest control program is defined as measures to eradicate and contain common household pests (e.g. bed bugs, lice, roaches, ants, mosquitos, flies, mice, and rats);-Facility will maintain a written agreement with a qualified outside pest service to provide comprehensive pest control services on a regular and scheduled basis;-Facility will ensure that appropriate chemicals are used to control pests but can be used safely inside the building without compromising resident health;-Facility will maintain a report system of issues that may arise in between scheduled visits with outside pest service and treat as indicated;-Facility will utilize a variety of methods in controlling certain seasonal pests. These will involve indoor and outdoor methods that are deemed appropriate by the outside pest service and state and federal regulations;-Facility will ensure that the outside pest service also treats the exterior perimeter of the facility and any outlying buildings or structures, i.e. dumpster area, etc. 1. Review of a facility document titled, Pest Sightings Log, dated October 2025 to November 2025, showed the following:-On 10/16/25, at 2:45 P.M., staff documented observation of a mouse running in the back hallway;-On 10/16/25, at 3:48 P.M., staff documented observation of a mouse in room [ROOM NUMBER];-On 10/17/25, at 9:48 A.M., staff documented observation of a mouse in room [ROOM NUMBER];-On 10/18/25, at 2:05 P.M., staff documented observation of a mouse in room [ROOM NUMBER];-On 11/11/25, at 7:02 A.M., staff documented observation of a mouse in room [ROOM NUMBER];-On 11/13/25, at 6:17 A.M., staff documented observation of a mouse in room [ROOM NUMBER];-The pest control technician acknowledgment section for each entry was blank. Review of facility pest control service summary reports showed the following:-On 10/13/25, an outside vendor completed pest control service. The service included seven exterior rodent bait stations. The report noted, light activity, for the exterior rodent bait stations. No interior rodent pest control measures were documented;-On 11/18/25, an outside vendor completed pest control service. The service included seven exterior rodent bait stations. The report noted, heavy activity, for the exterior rodent bait stations. No interior rodent pest control measures were documented. Observation and interview on 11/19/25 at 10:35 A.M., showed the following:-Resident #2 sat in his/her room in his/her wheelchair watching television;-Approximately 12 mice droppings were in the bottom drawer of the resident's clothes closet. (continued on next page)

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation and interview on 11/20/25 at 11:01 A.M., showed the following:-Resident #3 was on his/her bed;-A sticky paper trap was located under his/her sink;-The resident said he/she saw a mouse and reported it to staff last night. Observation and interview on 11/25/25 at 1:05 P.M., showed the following:-Resident #3 sat in a wheelchair is his/her room;-The floor of the resident's wardrobe closet and the drawer located below the closet both contained mouse droppings;-The resident said he/she saw mice about every day running across the floor of his/her room and had reported to staff. Observation and interview on 11/25/25 at 12:15 P. M., showed the following:-Resident #9 lying on his/her bed in his/her room;-With the resident's permission, this surveyor opened a lower drawer below the resident's wardrobe closet and two mice jumped out of the drawer and scurried behind a box under the resident's sink. The drawer contained several clothing items. -The resident reported seeing mice a few times in the last couple weeks in his/her room;-He/she thought the facility put traps out for the mice, but did not think the traps were working to catch the mice. During an interview on 11/19/25 at 10:47 A.M., Housekeeper (HK) J the following:-He/she observed mice on the back resident halls;-Last week, he/she saw a mouse run across the hall into resident room [ROOM NUMBER];-He/she documented the mouse observation in the exterminator's logbook. During an interview on 11/25/25 at 11:35 A.M., HK K said the following:-He/she changed positions from maintenance assistant to housekeeper in the early part of October 2025;-He/she had not seen any mice, but the residents had reported seeing a few mice. During interviews on 11/25/25 at 12:00 P.M., Certified Nurse Assistants (CNA) H and CNA I said the following:-The CNAs began working in the facility in August 2025 and both worked the night shift 6:00 P.M. to 6:00 A.M. Both aides said they saw one to two mice every night in the facility;-The CNAs said they have seen mice droppings in Resident #9's room;-Mice were frequently seen on the back hall near Resident #2's room and Resident #3's room. During an interview on 11/25/25 at 12:30 P.M., CNA N said he/she witnessed a mouse running in the hallway on Friday. He/she had seen mice in the back hall rooms on more than one occasion. During an interview on 11/25/25 at 12:50 P.M., CNA M said he/she saw mice on the back hall all the time. Several residents had complained about seeing mice in the rooms. During an interview on 11/25/25 at 12:40 P.M., Certified Medication Technician (CMT) C said the following the facility had a pest log for staff documentation of pest sightings. The log was a blue binder from the pest company and was kept in a file cabinet behind the nurses' station. He/she said they wrote pest issues in the binder and that was the end of their part. During an interview on 11/25/25, at 1:10 P.M., the Activity Director said the following:-He/she saw a mouse running down the hall last month, but had not seen one for a few weeks. Observation on 11/25/25 at 1:10 P.M., of the activity area showed the following: -This surveyor observed the library/activity area at the end of the back hall (located on the northwest wing) of the facility;-The surveyor opened a lower cabinet containing boxes of jigsaw puzzles for resident use. Mouse droppings (approximately 20) were visible along the front edge of the cabinet;-The surveyor opened a drawer containing boxes of playing cards for resident use. The drawer contained mouse droppings. (continued on next page)

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 11/25/25 at 1:32 P.M., the Director of Nursing said the following:-One of the night shift staff reported seeing mouse droppings one to two days ago and he/she notified the Administrator;-He/she had not observed any mice. During an interview on 11/25/25 at 1:54 P.M., Pest Control Service Technician L said the following:-He/She serviced the facility for pest control monthly;-He/She only provided rodent control measures for the exterior of the facility;-He/She completed monthly pest service on 11/18/25 and noted heavier activity at the exterior rodent traps;-He/She was unaware of any reports of rodents inside the facility until 11/25/25;-He/she was not aware of a logbook;-He/She was scheduled to return to the facility on [DATE]. During an interview on 11/25/25 at 4:10 P.M., the Administrator said the following:-He/she was unsure if the pest control company reviewed the pest logbook located in the nurses' station;-He/she observed that the pest control company had not signed the logbook;-If staff observe or receive reports of pests in the facility, he/she would expect the staff to notify the Administrator, so that he/she could mention areas of concern to the pest control company. Complaint 2652499