

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265471	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/12/2025
NAME OF PROVIDER OR SUPPLIER Buffalo Prairie Center for Rehab and Healthcare		STREET ADDRESS, CITY, STATE, ZIP CODE 631 West Main Street Buffalo, MO 65622	

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)
<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>Based on observation, interview, and record review, the facility failed to ensure appropriate incontinent care (support and management strategies needed to assist individuals who experience the involuntary loss of bladder or bowel control) was provided when staff failed to check and change one resident (Resident #1) who was visibly incontinent of urine. The facility had a census of 54.</p> <p>Review of the facility provided policy titled Incontinent Care, dated 07/21/22, showed the facility staff will provide incontinent care as directed in the plan of care.</p> <p>1. Review of Resident #1's face sheet showed the following information:</p> <p>-admission date of 12/26/22;</p> <p>-Diagnoses included Alzheimer's disease (progressive brain disorder, the most common cause of dementia, that slowly destroys memory and thinking skills, eventually leading to the inability to perform simple daily tasks), chronic kidney disease stage 3 (kidneys are damaged and can't filter blood the way they should, mild to moderate damage), and benign prostatic hyperplasia (BPH - noncancerous enlargement of the prostate gland) with lower urinary tract symptoms (range of problems related to the bladder and urethra (duct by which urine is conveyed out of the body from the bladder), affecting how urine is stored and passed).</p> <p>Review of the resident's care plan, last revised on 07/24/24, showed the following:</p> <p>-Resident had an activities of daily living (ADL) self-care performance deficit related to Alzheimer's disease;</p> <p>-Resident had bowel incontinence related to immobility;</p> <p>-Staff should check resident frequently and assist with toileting as needed;</p> <p>-Staff should provide peri-care after each incontinent episode;</p> <p>-Resident had mixed incontinence of bladder and bowel related to impaired cognition and BPH;</p> <p>-Staff should clean peri-area (area of the body between the anus and the genitals) with each incontinence episode;</p> <p>-Staff should encourage fluids during the day to promote prompted voiding responses;</p> <p>(continued on next page)</p>

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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: Facility ID: 265471	If continuation sheet Page 1 of 6

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-Staff should remember resident had a diagnosis of BPH with lower urinary tract symptoms;</p> <p>-Staff should remember resident had a diagnosis of have a diagnosis of chronic kidney disease.</p> <p>Observations of the resident, on 04/12/25, showed the following:</p> <p>-At 9:00 A.M., the resident was seated in a Broda chair (wheelchair that provides a customizable fit to eliminate slipping and slouching) near the nurses' desk. The resident was dressed and had a blanket covering his/her lap;</p> <p>-At 9:40 A.M., the resident was seated in the Broda chair in the same location with liquid dripping from the underside of the middle of the chair. There was a small puddle of about 3 inches in diameter;</p> <p>-At 9:56 A.M., the resident remained in the same location near the nurses' desk. Registered Nurse (RN) A stopped, pulled the resident's shirt down, and spoke briefly with the resident. A puddle of liquid remained under the resident's chair. There was no longer dripping noted;</p> <p>-At 10:03 A.M., a housekeeping staff walked by the resident and briefly said hello;</p> <p>-At 10:07 A.M., RN A walked past the resident with the treatment cart;</p> <p>-At 10:08 A.M., Certified Medication Tech (CMT) B pushed the resident in his/her Broda chair to his/her room and cleaned his/her face with a cloth. The CMT removed some debris from the resident shirt. He/she did not check the resident for toileting needs and pushed the resident back to the nursing station area;</p> <p>-At 10:20 A.M., the resident remained in Broda chair near nurse desk with the blanket covering lap;</p> <p>-At 10:45 A.M., the resident remained near the nurse desk with his/her eyes closed;</p> <p>-At 11:00 A.M., the resident remained near the nurse desk with his/her eyes closed;</p> <p>-At 11:10 A.M., Nurse Aide (NA) D spoke with the resident and said he/she would push the resident to the dining room for lunch. The surveyor requested the resident be checked for toileting needs. The NA went and requested assistance from additional staff;</p> <p>-At 11:14 A.M., Certified Nurse Aide (CNA) C pushed the resident down to his/her room, and NA D pushed the Hoyer lift (mobile, wheeled device used to assist individuals with limited mobility in transferring from one place to another) into the room. NA E entered the room as well. Staff applied gloves;</p> <p>-The staff removed the blanket from the resident's lap. The resident's sweat pants were visibly wet from the private area and down the interior of the thigh area. The staff attached the Hoyer pad that was under the resident to the Hoyer lift and raised the resident out of the Broda chair. The backside of the resident's pants were visibly wet throughout the bottom area. The lift pad was visibly wet under the resident's backside. The Broda chair was visibly wet on the bottom of the chair. There was a urine odor when the resident was moved from the chair;</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-Staff provided incontinent care;</p> <p>-The staff put clean shorts on the resident and hooked the Hoyer pad to the Hoyer lift. The staff wiped the Broda Chair with a bed bath wipe and transferred the resident to the chair.</p> <p>During an interview on 04/12/25, at 11:35 A.M., with CNA C said that the resident was normally checked and changed every two hours and as needed. The aide was unsure when the resident was last changed or checked. The aide said it had been a busy day and was working with two NA's. The resident was already dressed and in the Broda chair at the nurses' station when the staff arrived to work at 6:00 A.M. The aide had not personally checked or changed the resident since started his/her shift. If someone noted a puddle under a resident they should immediately change the resident and get the area cleaned up.</p> <p>During an interview on 04/12/25, 11:45 A.M., RN A said that he/she does not generally see residents wet when seated in the common areas. If he/she saw a puddle under a resident he/she would move the resident to a private area to check for incontinence.</p> <p>During an interview on 04/12/25, at 11:53 A.M., Licensed Practical Nurse (LPN) F said the aides check residents every two hours and as needed. The resident was in the Broda chair at about 5:00 A.M. He/she sits in the Broda chair until after lunch and then is put to bed and transferred back to his/her chair for supper and then back to bed. The staff should check the resident every two hours. If there was a puddle under a resident's chair, he/she would call for aides to change resident.</p> <p>During an interview on 04/12/25, at 12:00 P.M., NA D said that residents were checked every two hours. He/she did not know when the resident had last been checked, but he/she should have been checked sooner. Staff were busy with other tasks.</p> <p>During an interview on 04/12/25, at 12:05 P.M., CNA H said residents should be checked every two hours for toileting assistance. If there was a puddle under a resident, he/she would provide dignity and privacy and take them to their room. The resident should then be toileted and changed, and the area and chair cleaned.</p> <p>During an interview on 04/12/25, at 12:15 P.M., Housekeeper G Said if he/she saw a puddle under a resident, he/she would notify the nursing staff.</p> <p>During an interview on 04/12/25, at 12:30 P.M., the Director of Nursing (DON) said staff should check and change residents every two hours and as needed. If the resident was already in the Broda chair when their shift started they should be doing walking rounds at each shift and find out the last time the resident had been checked. The aides are regularly checking residents. If there was a puddle under a resident staff should take the resident to the room and clean up the resident and wipe down the chair. He/she saw the resident in the hall when he/she arrived this day.</p> <p>During an interview on 04/12/25, at 12: 35 P.M., the Administrator said staff should be monitoring residents and checking and changing residents per protocol.</p> <p>MO00252032</p>		

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<p>F 0728</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure that nurse aides who have worked more than 4 months, are trained and competent; and nurse aides who have worked less than 4 months are enrolled in appropriate training.</p> <p>Based on interview and record review, the facility failed to ensure nurse aides (NA) completed their training, competencies, and testing in a timely manner when two NA's failed to complete a state approved certified nursing assistant (CNA) training program, competency evaluation, and certification test within four months of hire and continued to work providing direct care to residents. The facility census was 54.</p> <p>Review showed the facility did not provide a policy regarding NA training classes.</p> <p>1. Review of the facility list of NA's currently employed at the facility, and working the floor as an NA, dated 04/02/25, showed the following:</p> <p>-NA I was hired as an NA on 09/02/24;</p> <p>-NA J was hired as a dietary staff on 03/23/24 and transitioned to NA on 09/23/24.</p> <p>Review of NA I's personnel file showed staff did not have documentation of a CNA certification.</p> <p>Review of NA J's personnel file showed staff did not have documentation of a CNA certification.</p> <p>During an interview on 04/12/25, at 10:56 A.M., the Director of Nursing (DON) said NA's have 120 days from their date of hire to complete training, clinicals, and pass their test to become a CNA. NA I and NA J are ready to test, but it has not been completed. The previous DON was the clinical supervisor, but did not follow through on the certification. She was responsible for compliance.</p> <p>During an interview on 04/12/25, at 12:35 P.M., the Administrator said once an NA is hired they have 120 days from their date of hire to complete the training course, clinicals, and pass certification to become a CNA. NA I and NA J should have completed testing. The completion slipped through the cracks. He and the DON were responsible for compliance.</p> <p>MO00251228</p>		

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<p>F 0835</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Administer the facility in a manner that enables it to use its resources effectively and efficiently.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure the facility was administered in an effective and efficient manner to ensure the highest practical well-being of all residents when the facility failed to pay their bills in a timely manner for a generator that was being utilized resulting in the generator being removed. The facility census was 54.</p> <p>Review showed the facility did not provide a policy regarding timeliness of payments to companies providing services.</p> <p>1. Observation on 04/02/25, at 9:30 A.M., showed the following:</p> <ul style="list-style-type: none"> -A disconnected natural gas generator outside the facility on a concrete pad near the kitchen exterior wall; -No other connected or operational generator was observed on the facility grounds. <p>Review of facility invoices for generator services showed the following:</p> <ul style="list-style-type: none"> -An invoice, dated 04/07/25, with an amount due of \$41,796.95; -The invoice showed \$27,838.45 was over 90 days past due; -The invoice showed \$3,000 was 61-90 days past due; -The invoice showed \$3,000 was 31-60 days past due; -The invoice showed \$3000 was 1-30 days past due; -The invoice had a notation stating this was the final bill for the rental generator. <p>Review of an email from the company providing the portable generator to the facility, dated 03/11/25, showed the following:</p> <ul style="list-style-type: none"> -The company noted two prior communications had occurred regarding past due invoices related to the generator services; -The company stated the generator would be removed and outstanding balances turned over to collections if not paid in full by 03/31/25; -The company noted the facility owed \$41,796.95. <p>(continued on next page)</p>		

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<p>F 0835</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>During an interview on 04/12/25, at 11:08 A.M., the Director of Fiscal Services said the facility was in negotiation with the company providing the generator. There were questions regarding the amount being charged and they requested an initial contract specifying terms of their agreement. The generator company had not provided the agreement. The generator company removed the generator during negotiation of billing. The facility is still working on negotiation with the generator company.</p> <p>During an interview on 04/12/25, at 12:05 P.M., a representative for the company providing the portable generator said the facility had multiple past due invoices with the company. The facility had the generator since 2020 or 2021. The company that owned the facility owed around \$80,000 between two facilities utilizing their services for portable generators. He/She could not recall the exact amount the facility owed. The generator was removed around the beginning of the month due to non-payment.</p> <p>During an interview on 04/02/25, at 6:15 A.M., and on 04/12/25, at 12:35 P.M., the Administrator said the company providing the portable generator came to the facility on [DATE] and removed the portable generator. He said he had not been receiving the invoices for the generator. The invoices went directly to the owners. He did not know of any outstanding balances or issues with the generator. The facility has 90 day terms for services. If there is a dispute with billing it typically is not paid until the dispute is solved and approved through the corporate office. He and the Business Office Manager were responsible for ensuring bills were current.</p> <p>MO00252037, MO00252309</p>		