STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265471	A. Building B. Wing	01/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Buffalo Prairie Center for Rehab and Healthcare	631 West Main Street Buffalo, MO 65622

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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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure resident representatives and physicians were notified of changes in condition in timely fashion when staff failed to document guardian and physician notification for one resident (Resident #3) who had a documented change in condition. The facility census was 44.Review of the facility's policy titled Notification of Changes, dated [DATE], showed the following information:-The facility must inform the resident, consult the resident's physician, and/or notify the resident's family member or legal representative when there is a change requiring notification;-Circumstances requiring notification include a significant change in the resident's physical, mental, or psychosocial condition such as deterioration in health, mental, or psychosocial status; -For residents that are incapable of making decisions, the representative would make any decisions that have to be made.1. Review of the Resident #3's face sheet (brief look at resident information) showed the following information: -admission date of [DATE];-Diagnoses include heart failure (a chronic condition where the heart muscle cannot pump enough blood to meet the body's needs), diabetes, high blood pressure, and paranoid schizophrenia (a chronic mental disorder marked by intense, irrational distrust, auditory hallucinations and delusions of being persecuted or plotted against).Review of the resident's care plan, initiated on [DATE], showed the following information:-Enjoyed participating in activities;-Had a potential for decline in mood; -Staff to administer medication as prescribed and monitor for signs of depression;-History of care and medication refusals;-History of self harm;-History of heart disease; -History of diabetes. Review of the resident's admission Minimum Data Set (MDS - a federally mandated assessment completed by facility staff), dated [DATE], showed the resident was cognitively intact.Review of the resident's progress note dated [DATE], at 10:47 P.M., showed the following:-The resident was refusing care and all medications;-The resident believed that staff and other residents were trying to kill him/her by poisoning him/her;-Additionally, the resident was self-isolating in his/her room more.(Staff did not document physician and resident representative notifications.) Review of the resident's behavior note dated [DATE], at 2:23 A.M., showed the resident had experienced a loss of appetite and did not eat dinner. (Staff did not document physician and resident representative notifications.)Review of the resident's behavior note dated [DATE], at 9:27 P.M., showed the resident was refusing his/her insulin administration and was swatting at the nurse. (Staff did not document physician and resident representative notifications.)Review of the resident's progress note dated [DATE], at 11:01 P.M., showed the following:-The resident continued to self-isolate and was no longer attending activities, smoking, or eating;-The resident began to only offer one worded answers when staff would attempt to converse with him/her;-The resident continued to refuse medications.(Staff did not document physician and resident representative notifications.)Review of the resident's progress note dated [DATE], at 5:27 A.M., showed the following:-The resident continued to self-isolate and was refusing to attend activities that he/she normally would enjoy. The resident is typically very social;-The resident has been taking all of his/her clothing off and refusing to put clothing on;-The resident continued to refuse medications including insulin and glucose checks, stating no that is poison, you (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	all are trying to kill me.(Staff did not document physician and resident representative notifications.)Review of the resident's physician progress note dated [DATE], at 11:23 A.M., with a service date of [DATE], showed the following:-The resident was seen on [DATE] at the request of nursing staff for hypoglycemia (low blood sugar) and delusions;-Over the past several weeks, staff notes showed two episodes of hypoglycemia;-The staff reported the resident was experiencing increased agitation, paranoia, and confusion, with the resident stating that medications and insulin were poison and that the staff were trying to kill him/her;-He/she had been refusing all medications, insulin, and blood glucose monitoring and was no longer participating in activities he/she previously enjoyed and was isolating his/herself;-New orders included new medication, a decrease in insulin, and lab work.(Staff did not document resident representative notification.)Review of the resident's behavior note dated [DATE], at 8:41 A.M., showed the resident refused mediation and insulin. (Staff did not document physician and resident representative notifications.)Review of the resident's progress note dated [DATE], at 8:25 P.M., showed the resident continued to refuse medications. (Staff did not document physician and resident representative notifications.)Review of the resident's physician progress note dated [DATE], at 2:33 P.M., with a service date of [DATE], showed the following:-The resident was seen on [DATE] for continued delusions;-He/she reported feeling terrible and expressed fixed beliefs that there was no infection, so he/she was refusing the previously ordered labs;-The resident stated that there was a bobcat, snakes, and different animals all over his/her body;-Staff report variable by mouth intake over the last several days;-New orders include labs, chest x-ray, and urinary analysis.(Staff did not document resident representative notification.)Review of the resident's progress note dated [DATE], at 9:40 A.M., showed a phone call was placed to the resident's guardian to communicate that the resident had collapsed and that cardiopulmonary resuscitation was in progress.Review of the resident's progress note dated [DATE], at 9:45 A.M., showed Registered Nurse (RN) B noted the following:-He/she was at the nursing station when an aide came up to him/her and reported that the resident had fallen in the living room;-He/she went back to assess the resident and seen the resident lying on the floor on his/her back with foam and drool coming out of his/her mouth;-CPR was started by staff while the Director of Nursing (DON) called emergency medical services (EMS) and the resident's guardian;-CPR continued until EMS arrived and transported the resident to the emergency Department (ED).During an interview on [DATE], at 12:32 P.M., Certified Nursing Assistant (CNA) F said the following:-When a resident experienced a change in condition, the nurse should assess, document, and make all necessary notifications;-If a resident was frequently refusing medications, meals, and was self isolating. That was something the nurses typically will send the resident out to the hospital for;-The resident was alert and oriented typically but struggled with mental health. He/she was known to cycle and had required hospitalization for psychiatric services about every six months or so.During an interview on [DATE], at 1:31 P.M., CNA E said if a resident experienced a change of condition, he/she would notify the nurse for assessment. The nurse would make his/her assessment and make all necessary notifications as well as document. He/she had heard that the resident was declining.During an interview on [DATE], at 1:51 P.M., CNA I said if a resident experienced a change of condition, he/she would notify the nurse for assessment. The nurse would make his/her assessment, make all necessary notifications, and document.During an interview on [DATE], at 2:06 P.M., Registered Nurse (RN) B said the following:-He/she was aware of the change of condition in the resident. The physician was involved in the care;-He/she tried to get the resident sent to the hospital for altered mental status because the resident was self-isolating, refusing medications, and meals. He/she did communicate that with the physician, but lab work and x-rays were recommended instead. The lab work was refused by the resident;-He/sent an additional message via Mediprocity (a communication application that provides secure communication and workflow tools) to the physician indicating he/she would like to send the resident to the hospital on [DATE] and did not hear back from the physician;-He/she felt that sending the resident out for stabilization would have been the most (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	appropriate action;-He/she did document when the resident would refuse or self-isolate but did not notify the guardian of those changes. Typically those notifications are not made unless there are new orders.During an interview on [DATE], at 2:06 P.M., Licensed Practical Nurse (LPN) C said the following:-If a resident were to experience a change of condition, the physician and guardian should be notified;-Had he/she been the resident's nurse, he/she would of notified the physician and guardian immediately and documented accordingly.During an interview on [DATE], at 2:38 P.M., RN D said the following:-Changes of conditions should be assessed and necessary notifications should be made after a nurse's assessment;-The resident had psychiatric concerns, which he/she documented on in the progress notes;-He/she did not notify the guardian of any changes in the resident and was not sure if anyone else did either.During an interview on [DATE], at 10:55 A.M., the former Assistant Director of Nursing (ADON) said the following:-Residents should be sent to the hospital for altered mental status;-Given the resident's history and symptoms of medication, meal, and socialization refusals he/she should have been sent to the hospital;-She was not sure if the resident's guardian was ever notified of the changes that occurred with the resident;-Ultimately, if there was a change of condition, the resident should be assessed, and the physician and guardian should be notified and everything should be documented.During an interview on [DATE], at 12:26 P.M., LPN A said the following:-He/she had heard the resident was frequently refusing medications and meals;-He/she did not provide care for the resident, but if he/she had and noticed the resident was having a psychotic episode, he/she would notify the physician and ask for a psychiatric evaluation;-The guardian should have been notified and a change of condition assessment should have been documented. During an interview on [DATE], at 1: 51 P.M., the DON said she expected any changes of conditions to be addressed, a change of condition assessment to be completed, and the physician and guardian to be notified.During an interview on [DATE], at 9:45 A.M., the resident's Case Manager said the following:-She and the guardian of the resident had not heard a lot from the facility in regards to the resident;-On [DATE], the facility contacted the guardian's office. She did not hear again about the resident until [DATE] when she was asked for permission on podiatry (foot doctor) services;-The next facility contact made was on [DATE] indicating that the resident had collapsed and CPR was being initiated;-The expectation was for her and the guardian to be contacted with any resident concerns as they have ultimate say on what should be done in response to the resident concerns.During an interview on [DATE], at 11:01 A.M., the Administrator said the following:-Regarding changes of condition, she expected the nurses to assess the situation and document;-Physician and guardians should be notified of any changes of condition.Complaints #2720635

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to ensure residents who were unable to carry out their own activities of daily living (ADL - dressing, grooming, bathing, eating, and toileting) received the necessary services to maintain grooming when the facility failed to ensure showers were offered to one resident (Resident #2). The facility census was 44.Review of the facility policy titled Resident Showers, dated 06/10/25, showed the following information:-It is the practice of this facility to assist resident's with bathing to maintain proper hygiene, stimulate circulation, and help prevent skin issues in accordance with current standards of practice;-Residents will be provided showers in accordance with the resident's preferences, care plan, and safety needs, as well as the facility's scheduled bathing protocol.Review of the resident's face sheet, showed the following information:-admitted to the facility on [DATE];-Diagnoses include diabetes, dementia, high blood pressure, and chronic kidney disease.Review of the resident's admission Minimum Data Sheet (MDS- a federally mandated assessment tool filled out by facility staff), dated 01/09/25, showed the following information:-Moderate cognitive impairment;-Requires partial to moderate assistance from staff for mobility;-Requires substantial to maximum assistance from staff for bathing.Review of the resident's care plan, initiated on 01/09/26, showed the care plan does not address the resident's bathing preferences and/or bathing schedule. Review of the facility policy titled Resident Showers, dated 06/10/25, showed the following information:-It is the practice of the facility to assist residents with bathing to maintain proper hygiene, stimulate circulation, and help prevent skin issues in accordance with current standards of practice;-Residents will be provided showers in accordance with the resident's preferences, care plan, and safety needs, as well as the facility's scheduled bathing protocol.1. Review of Resident #2's face sheet showed the following information:-admission date of 01/05/26;-Diagnoses include diabetes, dementia, high blood pressure, and chronic kidney disease.Review of the resident's progress notes showed the resident discharged from the facility on 01/15/26. Review of the resident's admission Minimum Data Sheet (MDS- a federally mandated assessment tool filled out by facility staff), dated 01/09/26, showed the following information:-Moderate cognitive impairment;-Required partial to moderate assistance from staff for mobility;-Required substantial to maximum assistance from staff for bathing.Review of the resident's care plan, initiated on 01/09/26, showed staff did not care plan related to the resident's bathing preferences and/or bathing schedule.Review of the resident's electronic medical record (EMR) showed staff did not document regarding a shower record.Review showed the facility did not provide any shower sheets for showers completed during the resident's stay.During an interview on 01/20/26, at 2:06 P.M., Licensed Practical Nurse (LPN) C said the following:-He/she did not work during day shift hours, but believed showers were to be completed on the day shift, Monday through Friday;-There should be a schedule posted;-It would not be appropriate for a resident to go without a shower for days;-The shower aides document the showers on a shower sheet. Refusals are also documented on the sheet and then turned into the nurse for review.During an interview on 01/20/26, at 2:38 P.M., Registered Nurse (RN) D said the following:-The facility had a shower aide. The shower aide was expected to have a schedule to follow;-Residents should also be offered showers on an as needed basis;-Showers and shower refusals were documented on shower sheets, and then turned into the nurse for review;-[NAME] had reported to him/her that the resident had not received a shower.During an interview on 01/21/26, at 10:55 A.M., the former Assistant Director of Nursing (ADON) said the following:-The facility had a shower aide;-The expectation was for two showers a week to be offered;-The shower aide made the shower schedule. He/she became aware of new admissions by the nurses accepting the admission;-She was not aware the resident had not received a shower;-Shower sheets were expected to be filled out and indicate if the resident refused. Those shower sheets were then turned into the nurse for review;-She had not seen a progress note on any (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	resident refused and/or missed showers.During an interview on 01/21/26, at 12:11 P.M., Certified Nursing Assistant (CNA) E said the following: -He/she was the shower aide;-He/she did not have a set schedule for showers;-He/she had been pulled to work the floor multiple times possibly causing residents to go without showers;-All aides were able to shower the residents. He/she asked that they leave a note on the shower door indicating whose shower had or had not been completed;-He/she did not shower the resident and was unaware if anyone else did as no one had communicated that to him/her;-The expectation was for each resident to receive two showers a week;-Shower sheets were filled out with each shower and/or refusal and then turned into the nurse for review.During an interview on 01/21/26, at 12:26 P.M., LPN A said the following:-The expectation was for resident to receive showers two times a week;-The facility was short staffed and often pulled the shower aide to the floor, possibly causing residents to go without showers;-He/she had not heard about the resident refusing showers;-He/she had not heard that the resident had not had a shower;-Shower sheets were filled out for showers and/or refusals and then turned into the nurse for review. During an interview on 01/21/26, at 1:31 P.M., RN B said the following:-Showers were expected to be offered two times a week;-The shower aide was usually pulled to the floor, possible causing residents to go without showers;-All showers and shower refusals should be documented on a shower sheet and then turned into the nurse for review.During an interview on 01/21/26, at 1:51 P.M., the Director of Nursing (DON) said the following:-She expected all residents to have two showers a week;-The former ADON was responsible for overseeing showers;-She cannot locate any shower sheets for the resident; -The resident was at the facility for a short period of time, but should have had at least one shower;-All showers and shower refusals should be documented on the shower sheet and then turned into the nurse for review.During an interview on 01/22/26, at 11:01 A.M., the Administrator said the following:-She expected showers to be offered two times a week;-The shower aide should fill out shower sheets for all showers and shower refusals and then turn those into the nurse for review;-Shower schedules should be personalized to the resident's preference. Complaint #2720635

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on interview and record review, the facility failed to ensure residents were free from accidents when the facility failed to notify the resident's physician and family after a fall and failed to review and update the resident's care plan for one resident (Resident #2) who suffered a fall. The facility census was 44.Based on interview and record review, the facility failed to ensure residents were free from accidents when the facility failed to notify the resident's physician and family after a fall and failed to review and update the resident's care plan for one resident (Resident #2) who suffered a fall. The facility census was 44.Review of the facility policy titled Accidents and Supervision, dated 05/16/25, showed the following information:-Each resident will receive adequate supervision and assistive devices to prevent accidents including identifying hazards, evaluating and analyzing hazards, implementing interventions to reduce hazards, and monitoring for effectiveness and modifying interventions when necessary;-Fall refers to unintentionally coming to a rest on the ground, but not as a result of an overwhelming external force. An episode where a resident lost his/her balance and would have fallen is considered a fall. A fall without injury is still a fall.Review of the facility policy titled Fall Risk Assessment, dated 06/09/25, showed the following:-A risk assessment is to be completed by the nurse or designee upon admission, quarterly, and when a change has occurred;-The risk assessment will identify environmental hazards and individual risks, including the need for supervision, and evaluate and analyze hazards;-An at risk for falls care plan will be completed for each resident to address items identified on the risk assessment and updated accordingly;-An at risk for falls care plan will include interventions, including adequate supervision consistent with a resident's needs, goals, and current standards of practice;-Monitor the effectiveness of the care plan interventions and modify as necessary.Review of the facility policy titled Fall Prevention Program, dated 05/29/25, showed when any resident experiences a fall, the facility will assess the resident, complete a post-fall assessment, complete an incident report, notify physician and family, review the resident's care plan and update, document all assessments and actions, and obtain witness statements in care of an injury.1. Review of the Resident #2's face sheet showed the following information:-admission date of 01/05/26;-Diagnoses include diabetes, dementia, high blood pressure, and chronic kidney disease.Review of the resident's fall risk assessment, dated 01/05/26, showed the following information:-Experienced one to two falls in the past three months;-Had intermittent confusion;-Ambulatory with a balance problem and required an assistive device;-At risk for falls.Review of the resident's admission Minimum Data Sheet (MDS- a federally mandated assessment tool filled out by facility staff), dated 01/09/25, showed the following information:-Moderate cognitive impairment;-Required partial to moderate assistance from staff for mobility;-History of falls with no falls since admission.Review of the resident's care plan, dated 01/09/26, showed the following:-At risk for falls;-Ensure the call light is within reach and encourage the resident to use it for prompt assistance.Review of the resident's progress note dated 01/13/26, at 4:08 A.M., showed Licensed Practical Nurse (LPN) C said the following:-The resident was attempting to use the restroom at 3:30 A.M. and fell against the bathroom door. Staff did not see any injuries;-Resident had full range of motion for all extremities;-Vital signs and neurological checks within normal limits;-Small bruise located in the middle of the lower back appeared to be older in nature;-Staff will continue to monitor resident;-Reminded the resident to use the call light for assistance.(Staff did not document physician or family notification. Staff did not document any additional interventions or reason for no additional interventions being implemented.)Review of the resident's care plan, dated 01/09/26, showed staff did not update the care plan with the fall or new interventions.Review of the resident's electronic medical record (EMR) showed LPN C did not complete a new fall risk assessment.During an interview on 01/20/26, at 2:06 P.M., LPN C said the following:-The process for falls was to assess the resident for injury, ensure vital signs, range of (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	motion, and neurological checks are within normal limits;-He/she was alerted to the resident's room, where he/she found the resident sitting on his/her bottom leaning against the bathroom door. The door was noted to be dented in, assuming from the resident's bottom hitting the door. The resident was confused generally, but denied hitting his/her head;-Everything was within normal limits, so the resident was assisted up off the floor-He/she did start neurological checks on the resident;-He/she was unsure of any other documentation needed;-He/she assumed the following shift would make any necessary notifications;-If there had been an injury he/she would have made the notifications his/herself. During an interview on 01/20/26, at 2:38 P.M., Registered Nurse (RN) D said the following:-LPN C told him/her that the resident had fallen overnight on 01/13/26 and was placed on fall follow up;-Proper fall protocol included assessing the resident, beginning neurological checks, initiating fall follow up documentation, completing an incident report, notifying the physician and family, and updating the care plan.During an interview on 01/21/26, at 10:55 A.M., the former Assistant Director of Nursing (ADON) said the following:-After a fall a resident should be left where they are until a nurse assessed them for injury;-Nurses are expected to notify the physician and family, complete an incident report, initiate fall follow up documentation, complete a new fall risk assessment, and update the care plan;-She was not aware the resident had fallen.During an interview on 01/21/26, at 12:11 P.M., Certified Nursing Assistant (CNA) E said the following: -After a fall, the person finding the resident should stay with them while alerting a nurse for assessment;-Once the nurse assesses the resident, the resident is assisted back up;-In report, it was told to him/her that the resident actually fell multiple times in the early hours of 01/13/26;-Nurses should make necessary notifications;-He/she was unaware of what all reports and or documentation needs done on the nurses' end for falls. During an interview on 01/21/26, at 12:26 P.M., LPN A said the following:-After a fall, the residents should be assessed by the nurse;-He/she liked to fill out change of condition forms for falls versus incident reports;-The physician, family and the Director of Nursing (DON) should be notified of falls; -The resident should be educated on interventions, and those interventions should be added in the care plan.During an interview on 01/21/26, at 1:31 P.M., RN B said proper fall protocol included assessing the resident, beginning neurological checks, initiating fall follow up documentation, completing an incident report, notifying the physician and family, and updating the care plan.During an interview on 01/22/26, at 10:44 A.M., the MDS/Medical Records Nurse said care plans should be individualized and include all aspects of the resident's care.During an interview on 01/21/26, at 1:51 P.M., the DON said the following:-Nurses should assess the resident prior to the resident being moved;-Full assessments should be completed regardless of fall type and incident reports should be completed;-LPN C did not complete an incident report. Within the incident report, it prompts the staff member to do a fall risk evaluation, a skin assessment, and update the care plan;-Progress notes should also be completed for fall follow ups for 72 hours;-Physician, family, and she should be notified of all falls. During an interview on 01/22/26, at 11:01 A.M., the Administrator said the following:-She expected falls to be documented, therapy to evaluate the resident, incident reports to be completed, and the care plan to be updated with interventions.Complaint #2720635

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **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 of significant medication errors when the facility failed to have a chemotherapy medication (a powerful drug that kill fast-growing cancer cells by disrupting their ability to grow and divide) on hand for administration and failed to follow-up with the pharmacy and physician when the medication was not administered for one resident (Resident #1). The facility census was 44. Review of the facility policy titled Medication Errors. dated 04/07/25, showed the following information:-Medication error means the observed or identified preparation or administration of medications or biologicals which is not in accordance with the prescriber's order, manufacturer's specifications regarding the preparation and administration of the medication or biological or accepted professional standards and principles which apply to professionals providing services;-Significant medication error means one which causes the resident discomfort or jeopardizes his/her health and safety;-The facility shall ensure medications will be administered according to physician's orders, per manufacturer's specifications regarding the preparation and administration of the drug, and in accordance with accepted standards and principles which apply to professionals providing services.1. Review of the resident's face sheet showed the following information:-admission date of 07/05/24;-Diagnoses included malignant neoplasm (a cancerous tumor capable of invading surrounding tissue and growing rapidly) of kidney, chronic obstructive pulmonary disease (COPD- a progressive lung disease that causes airflow obstruction and breathing difficulties), and benign intracranial hypertension (a condition of elevated cerebrospinal fluid pressure around the brain).Review of the resident's quarterly Minimum Data Sheet (MDS- a federally mandated assessment tool filled out by facility staff), dated 12/26/25, showed the following information:-Moderate cognitive impairment;-Receives chemotherapy medication;-Requires supervision from staff for mobility. Review of the resident's care plan, revised on 01/22/26, showed the resident had a diagnosis of neoplasm of the kidney. (Staff did not care plan related to the management of the neoplasm.)Review of the resident's January 2026 Medication Administration Record (MAR) showed the following:-An order, dated 07/05/24, Lenvima (a prescription oral multikinase inhibitor medication used to treat certain advanced cancers. The medication works by blocking specific proteins that stimulate tumor growth and inhibiting the formation of new blood vessels that nourish tumors) oral capsule therapy pack 10 milligram (mg), give one capsule by mouth daily for cancer treatment;-On 01/01/26, the staff did not administer the Lenvima due to other/see progress notes.Review of the resident's progress note dated 01/01/26, at 9:26 A.M., showed staff needed to order the Lenvima.Review of the resident's January 2026 MAR showed on 01/05/26, the staff did not administer the Lenvima due to other/see progress notes.Review of the resident's progress note dated 01/05/26, at 10:20 A.M., showed the Lenvima was not available. (Staff did not document physician or pharmacy notification.)Review of the resident's January 2026 MAR showed on 01/07/26, the staff did not administer the Lenvima due to other/see progress notes.Review of the resident's progress note dated 01/07/26, at 8:21 A.M., showed the Lenvima was not available. (Staff did not document physician or pharmacy notification.)Review of the resident's January 2026 MAR, showed on 01/09/26, the staff did not administer the Lenvima due to other/see progress notes.Review of the resident's progress note dated 01/09/26, at 8:50 A.M., showed the staff were waiting on the Lenvima. (Staff did not document physician or pharmacy notification.)Review of the resident's January 2026 MAR showed on 01/10/26, staff did not administer the Lenvima due to other/see progress notes.Review of the resident's progress note dated 01/09/26, at 8:50 A.M., showed the staff were waiting on Lenvima to be delivered. (Staff did not document physician or pharmacy notification.)Review of the resident's January 2026 MAR showed on 01/11/26, staff did not administer the Lenvima due to other/see progress notes.Review of the resident's progress note dated 01/11/26, at 7:57 A.M., showed the staff were waiting on Lenvima to be delivered. (Staff did not (continued on next page)

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	265471	A. Building B. Wing	01/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Buffalo Prairie Center for Rehab and Healthcare	631 West Main Street Buffalo, MO 65622

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	document physician or pharmacy notification.)Review of the resident's January 2026 MAR showed on 01/12/26, staff did not administer the Lenvima due to other/see progress notes.Review of the resident's progress note dated 01/12/26, at 8:13 A.M., showed the staff were waiting on Lenvima that was on order. (Staff did not document physician or pharmacy notification.)Review of the resident's progress note dated 01/12/26, at 9:41 A.M., showed the medication was on order. Staff were only able to currently fill at specific pharmacy per cancer center. Staff spoke to pharmacy rep who said he/she needed verbal consent from the patient directly. Staff notified the Interdisciplinary Team (IDT).Review of the resident's January 2026 MAR showed on 01/13/26, staff did not administer the Lenvima due to other/see progress notes.Review of the resident's progress note dated 01/13/26, at 8:26 A.M., showed the staff were waiting on Lenvima was on order. (Staff did not document physician or pharmacy notification.)Review of the resident's January 2026 MAR, showed on 01/14/26, staff did not administer the Lenvima due to other/see progress notes.Review of the resident's progress note dated 01/14/26, at 9:15 A.M., showed staff did not document regarding the Lenvima not being administered. Review of the resident's January 2026 MAR showed on 01/15/26, staff did not administer the Lenvima due to other/see progress notes.Review of the resident's progress note, dated 01/15/26, showed staff did not document regarding the Lenvima not being administered Review of the resident's January 2026 MAR showed on 01/16/26, staff did not administer the Lenvima due to other/see progress notes.Review of the resident's progress note dated 01/16/26, at 8:47 A.M., showed the staff were waiting on Lenvima to be delivered. (Staff did not document physician or pharmacy documentation.)Review of the resident's January 2026 MAR, showed on 01/17/26, staff did not administer the Lenvima due to other/see progress notes.Review of the resident's progress note dated 01/17/26, at 9:36 A.M., showed staff noted Lenvima order pending. (Staff did not document physician or pharmacy notification.)Review of the resident's January 2026 MAR showed on 01/18/26, staff did not administer the Lenvima due to other/see progress notes.Review of the resident's progress not, dated 01/18/26, at 8:50 A.M., showed the Lenvima was not available, pending delivery. (Staff did not document physician or pharmacy notification.)Review of the resident's January 2026 MAR showed on 01/19/26, staff did not administer the medication with no reason provided. Review of the resident's January 2026 MAR showed on 01/20/26, staff did not administer the Lenvima due to other/see progress notes.Review of the resident's progress note, dated 01/20/26, showed staff did not document regarding the Lenvima.During an interview on 01/21/26, at 10:55 A.M., the former Assistant Director of Nursing (ADON) said the following:-Medications were expected to be administered per physician orders;-If a medication was not able to be administered due to not being available, staff should follow up with the pharmacy and physician. The nurses have not been doing that;-She was aware that the resident had been without his/her chemotherapy medication for at least a couple of weeks;-She brought this to the Director of Nursing (DON)'s attention when she noticed that nurses continuously were documenting not available;-The DON told her that the medication needed to come from a different pharmacy than where it had previously been sent to and that another nurse was handling it;-The expectation was to immediately call the pharmacy and physician regarding the medication not being available, as well as document those notifications.During an interview on 01/21/26, at 12:26 P.M., Licensed Practical Nurse (LPN) A said the following:-He/she did not administer medications often, but when he/she did, he/she noticed that a lot of medications were not available to be administered;-Chemotherapy drugs were administered by nurses;-If the medication was not available for administration, the nurse should check the E-Kit (emergency drug kit);-If the medication was not in the E-kit, the pharmacy and physician should be called and notified. The notification should be documented in the progress notes;-He/she would also notify the DON of any medications that were not able to be given.During an interview on 01/21/26, at 1:31 P.M., Registered Nurse (RN) B said the following:-There was an issue with their pharmacy service for a while;-He/she was aware the resident was out of chemotherapy drugs;-He/she did notify the resident's oncologist;-Staff are expected to notify, the physician, (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	pharmacy, and the DON when medications were not available to be administered;-All notifications should be documented in the progress note.During an interview on 01/22/26, at 10:44 A.M., the MDS/Medical Records Nurse said the following:-Anyone can update a resident's care plan;-The care plan should be individualized and include the resident's diagnoses as well as the management of those diagnoses.During an interview on 01/21/26, at 1:51 P.M., the DON said the following: -She expected medication to be administered per physician orders;-If a medication was not available, she expected staff to bring that to her attention;-She expected staff to notify the pharmacy and document the notification;-She was not aware the resident was without his/her chemotherapy medication;-The nurses were responsible for administration of chemotherapy drugs;-She believed the chemotherapy drugs came from an outside pharmacy.During an interview on 01/21/26, at 4:21 P.M., the Medical Director said the following:-He expected physician orders to be followed;-He was not aware of any current medications not being filled;-There have been some issues with the facility's pharmacy service; -[NAME] had notified him of chemotherapy drugs not being available for administration;-He does not manage chemotherapy drugs;-The facility staff should be notifying the resident's oncologist of any medication concerns.During an interview on 01/22/26, at 11:01 A.M., the Administrator said the following:-She expected medications to be administered per physician order;-She was not aware of medications not being available for administration;-If a nurse saw there was a medication that was not available, they were expected to notify the DON, pull from the E-Kit, and notify the pharmacy;-Any interventions should be documented. Complaint 2721550

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Administer the facility in a manner that enables it to use its resources effectively and efficiently. Based on observation, interview, and record review the facility failed to be administered in a manner that enables it to use its resources (facility's operating budget) effectively and efficiently when the facility failed to ensure all bills were paid in a timely manner to prevent credit holds and delays in maintenance of the fire and rescue system. The facility census was 44. Review showed the facility did not provide policy and procedure regarding bill pay.1. During an interview on 01/18/26, at 9:52 A.M., the Maintenance Director said the following:-The fire and safety system, including sprinklers, was serviced by Marmic Fire and Rescue;-The only current concern with the system is an air pressure leak; -Marmic provided inspection and maintenance services quarterly.During an interview on 01/21/26, at 10:02 A.M., Marmic Fire and Safety Representative said the following:-The facility was currently on a credit hold;-The facility's last quarterly review was completed on 08/31/25 of the sprinkler system; -There was a deficientcy in the sprinkler system to include multiple leaks causing the system to trip. This would not be fixed until the facility is no longer had a credit hold;-Additionally, the facility was supposed to have an inspection of the kitchen exhaust system in November of 2025;-The facility was past due for their annual alarm testing, as well as the alarm inspection. -There are several outstanding bills.During an interview on 01/21/26, at 10:15 A.M., Marmic Fire and Safety Supervisor said the following:-The facility was 90 days overdue on $4,838.00. Sometime in the last 60 days the facility paid $2,300.00. At 60 days the facility remained overdue on $2,326.57-The facility currently had a remaining balance of $2,512.08;-There would be no repaired or inspections performed until the facility is no longer on credit hold. During an interview on 01/21/26, at 1:15 P.M., the Business Office Manager said the following:-She was not aware of there being any credit holds;-The Maintenance Director obtained any invoices from the service company and gave them to her. She then sent those invoices to accounts payable;-The credit hold was just brought up to her yesterday;-She was not aware that there are issues within the fire and safety system needing fixed and inspections needing completed. During an interview on 01/22/26, at 11:01 A.M., the Administrator said the following:-She just became aware that there was a bill sent to accounts payable;-Marmic sent all invoices to the Maintenance Director;-On 01/20/26, the Maintenance Director told her that there was a past due bill that was needing to be paid;-She was not aware of any services that have not been provided due to past due bills;-She assumed that all inspections have been completed and that no current maintenance is needed as that has not been relayed to her;-She expected any concerns to be brought to her attention.Complaint #2721480

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, the facility failed to ensure a safe, functional, sanitary, and comfortable environment was provided for residents and staff when the facility failed to keep the walls in the kitchen free from discoloration, moisture, and fuzzy/powdery substance. The facility census was 44. 1. Observation and interview on 01/18/26, at 1:15 P.M., showed the following:-Upon entering the cleaning side of the kitchen and looking to the right there was black and green spotted discoloration was seen in the corner from the top of the sink area up to the ceiling. The texture appeared powdery;-DA H pulled back the splash guard behind the sink and black and green spotted discoloration was seen. The area also appeared wet;-DA H continued to pull back splash guards/protective paneling going further into the kitchen area near a window. Underneath the paneling was drywall with black and green spotted discoloration. The texture of the discoloration appeared powdery;-DA H pulled back the protective paneling to show dry wall with nearly floor length black and green spotty discoloration. The texture of the discoloration appeared powdery and almost furry in this area;-There was an air unit under the window in between the kitchen sink wall and the furthest corner wall that also appeared to have a black powdery substance on the vents;-DA H said this has been an issue for a long time.During an interview on 01/18/26, at 12:59 P.M., DA G and DA H said the following:-There were concerns of mold in the kitchen. They believed mold could be found behind all splash guards on the dishwasher side of the kitchen;-They spoke with the Administrator regarding this matter before;-They spoke with the Maintenance Director regarding this matter, and he pulled back the splash guard, took a picture, reported to them that he is allergic to it, and left the kitchen.During an interview on 01/20/26, at 1:50 P.M., the Dietary Manager said the following:-She believed the black and green powdery/[NAME] substance to be mildew;-The areas of concern just came to her attention a couple of days ago;-She believed that the Maintenance Director was instructed to get a quote to get the area of concern removed;-She had instructed her staff to clean the areas of concern with vinegar; but believed the panels will need replaced.During an interview on 01/20/26, at 1:54 P.M., the Maintenance Director said the following:-If a mildew or mold concern were brought to him; he would recommend cleaning the area;-He was made aware of the black and green discoloration on 01/18/26;-He has taken the paneling off the wall and the area has been washed. He was currently working on getting all of the old caulk scrapped off. After the walls are thoroughly cleaned, he will replace the paneling;-If the area that is affected is the dry wall, he will call a company to have that addressed;-He was not aware that the areas of concern area on drywall;-He was only aware of the area of concern on the actual paneling, not behind the paneling.During an interview on 01/21/26, at 1:51 P.M., the Director of Nursing (DON) said the following:-She has not personally been in the kitchen, but has heard about some mold concerns;-She believed the Dietary Manager had her staff cleaning the areas of concern with vinegar.During an interview on 01/22/26, at 11:01 A.M., the Administrator said the following:-The Maintenance Director told her on approximately 01/20/26 about a mildew or mold concern in the kitchen;-Since then, housekeeping has been asked to wash the walls; -She asked the Maintenance Director to call some local companies and get some quotes on removal;-Dietary should also have a cleaning schedule.Complaint #2719681