

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 02/18/2026
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 0678</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident's advance directives.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, facility staff failed to have a process in place to ensure all resident's wishes regarding cardio-pulmonary resuscitation (CPR - an emergency procedure that is performed when a person's heartbeat or breathing has stopped) were honored when staff stopped performing CPR prior to Emergency Medical Services (EMS) arrival for one resident (Resident #1) who was found unresponsive. The facility census was 41. Review of the facility's policy titled, Cardiopulmonary Resuscitation (CPR), revised [DATE], showed the following:-The facility will follow current American Heart Association (AHA) guidelines regarding CPR;-If a resident experiences cardiac arrest, facility staff will provide basic life support, including CPR prior to the arrival of EMS and in accordance to with the resident's advance directives, and if the resident does not show obvious signs of clinical death. 1. Review of Resident #1's face sheet (a document that gives a resident's information at a quick glance) showed the following:-admission date of [DATE];-The resident was full code (if a person's heart stopped beating and/or they stopped breathing, staff would perform CPR);-Diagnoses included chronic obstructive pulmonary disease (COPD-a progressive, incurable lung disease that causes severe breathing difficulties by obstructing airflow, primarily through bronchitis or emphysema) with acute exacerbation (a sudden, sustained worsening of symptoms&mdash;specifically increased breathlessness, cough, and sputum production), nontraumatic intracerebral hemorrhage (a spontaneous bleeding into the brain tissue, not caused by trauma, often resulting from chronic high blood pressure), and malignant neoplasm (cancer) of unspecified kidney. Review of the resident's quarterly Minimum Data Set (MDS - a federally mandated comprehensive assessment instrument completed by facility staff), dated [DATE], showed the following:-The resident had moderate cognitive impairment;-Shortness of breath with exertion, sitting, at rest, and when lying flat;-He/She received oxygen therapy. Review of the resident's care plan showed the following:-The resident's code status was full code (wished to receive CPR). If noticed with respiratory arrest or absent vital signs, get assistance immediately, notify physician and family, and start CPR;-The resident was his/her own responsible party. Review of the resident's February 2026 Physician's Order Sheet (POS) showed an order, dated [DATE], for full code.</p> <p>Review of the resident's progress note dated [DATE], at 7:20 A.M., showed the following:-Upon coming into the resident's room at 5:45 A.M., Licensed Practical Nurse (LPN) A noticed the resident had his/her legs on the side of the bed and a cup in his/her left hand. LPN A asked the resident if he/she was getting up to get something to drink. LPN A went over to tend to the resident's roommate;-LPN A came back over to the resident and he/she was still in the same position. He/she asked the resident if he/she was going to get a drink but got no response;-LPN A tapped the resident's legs and immediately saw fluid coming from the resident's nose and mouth;-He/she asked another staff member the resident's code status and they advised the resident was full code and LPN A advised staff to call 911;-LPN A immediately started chest compressions and</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: 265471	Facility ID: 265471 If continuation sheet Page 1 of 7

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<p>F 0678</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>arrives.</p> <p>During an interview on [DATE], at 11:20 A.M., LPN F said the following:-If a resident was unresponsive, staff should notify the nurse, obtain code status and the crash cart;-Chest compressions should be initiated if a resident is full code;-If fluids are observed coming out of a resident's nose or mouth, the resident should be turned to their left side. Staff can also utilize the suction machine on the crash cart;-Staff should continue compressions until EMS arrives and takes over. During an interview on [DATE], at 2:10 P.M., LPN G said the following:-If a resident was found unresponsive, staff should immediately notify the charge nurse, obtain code status and the crash cart, and call 911;-Staff should check for pulse and breathing, and if the resident is full code, initiate CPR;-The suction machine should be utilized if staff observe liquid/vomit coming from the resident's mouth;-CPR should be continued until EMS arrives. During an interview on [DATE], at 3:17 P.M., the DON said the following:-If a resident was found unresponsive, staff should check their breathing, pulse, and airway;-Staff should obtain the resident's code status, obtain the crash cart, and initiate CPR;-If a resident has fluid coming out of their mouth, they should turn the resident to their side. The suction machine on the crash cart can also be utilized;-Staff are to continue to perform CPR until EMS arrival. During an interview on [DATE], at 4:20 P.M., the Administrator said the following:-If staff find a resident unresponsive, they should check the resident's code status, and if full code, initiate CPR;-Staff should also obtain the crash cart, and call 911;-If a resident has fluid coming out of their nose or mouth, they should utilize the suction machine;-Staff should continue to administer CPR until EMS arrival.</p> <p>During an interview on [DATE], at 1:29 P.M., the Medical Director said if a resident was full code, staff should administer CPR until EMS arrival.</p> <p>Complaint #2744009, #2744144, and #2744377</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>Based on observation, interview, and record review, facility staff failed to provide pharmaceutical services that assured the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals to meet the needs of each resident when staff staff documented one resident (Resident #1) received Cefdinir (antibiotic used to treat various bacterial infections, including pneumonia) for multiple days after the stop date. The facility staff also failed to ensure one resident (Resident #1) received prednisone (a potent steroid used to treat inflammation, severe allergies, autoimmune diseases, asthma, and certain cancers by suppressing the immune system and reducing swelling) as ordered when 10 of 11 possible doses were not documented. The facility had a census of 41. Review of the facility policy titled Medication Errors, revised 05/07/25, 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 prescribers 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;-If a medication error occurs, the nurse will assess and examine the residents condition and notify the physician or health care provider as soon as possible, monitor and document the residents condition, including response to medication treatment or nursing interventions, document actions taken in the medical records, and once the resident is stable, the nurse will report the incident to the appropriate supervisor and complete the incident report. 1. Review of Resident #1's face sheet (a document that gives a resident's information at a quick glance) showed the following:-admission date of 07/05/24;-Diagnoses included chronic obstructive pulmonary disease (COPD-a progressive, incurable lung disease that causes severe breathing difficulties by obstructing airflow, primarily through bronchitis or emphysema) with acute exacerbation (a sudden, sustained worsening of symptoms-specifically increased breathlessness, cough, and sputum production), nontraumatic intracerebral hemorrhage (a spontaneous bleeding into the brain tissue, not caused by trauma, often resulting from chronic high blood pressure), and malignant neoplasm (cancer) of unspecified kidney. Review of the resident's quarterly Minimum Data Set (MDS - a federally mandated comprehensive assessment instrument completed by facility staff), dated 01/01/26, showed the following:-The resident had moderate cognitive impairment;-He/she received antibiotic medication;-Shortness of breath with exertion, sitting at rest, and when lying flat;-He/She received oxygen therapy. Review of the resident's care plan showed the following:-Resident had a current diagnosis of COPD;-Administer COPD medication per order. Review of resident's progress notes dated 02/01/26, at 4:09 P.M., showed the following:-Resident found to have an oxygen saturation of 78% (normal oxygen saturation levels for healthy individuals typically range between 95% and 100%, measured via pulse oximetry, indicating the percentage of hemoglobin carrying oxygen) on six liters of oxygen via nasal cannula;-Staff administered albuterol inhalation solution nebulizer (a medical device that converts liquid medication into a fine mist for inhalation) treatment and oxygen saturation increased to 88%;-Resident was currently on prednisone (a potent steroid used to treat inflammation, severe allergies, autoimmune diseases, asthma, and certain cancers by suppressing the immune system and reducing swelling) until 02/02/26;-Resident completed cefdinir (antibiotic used to treat various bacterial infections, including pneumonia) due to</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>pneumonia;-Resident was concerned pneumonia was still present;-Bilateral (both sides) wheezing and rhonchi sounds (low-pitched, rattling, or snoring-like lung sounds caused by airway obstruction from mucus or fluid in the larger airways) in upper lobes with diminished lung sounds in bases bilateral;-Staff notified physician and were waiting further recommendation. Review of resident's progress notes dated 02/01/26, at 6:08 P.M., showed the following:-Provider ordered extension on cefdinir 300 milligrams (mg), IM (injection of medication directly into muscle tissue) ceftriaxone (antibiotic used to treat serious bacterial infections, including pneumonia) 1 gram reconstituted with 1% lidocaine (used to significantly reduce pain during deep IM injections) once, and solumedrol (a potent intravenous or intramuscular steroid used to rapidly reduce severe inflammation, treat autoimmune flare-ups, severe allergies, asthma, and certain cancers) 125 mg IM injection once and duoneb (a prescription, combination medication used to treat, but not abort, sudden COPD symptoms by opening airways) treatments four times daily for five days;-Staff updated orders;-No acute respiratory distress noted. Resident was alert and oriented and sitting in room watching television. Review of resident's physician's notes, dated 02/06/26, showed the following:-Patient seen on 02/03/26 at the request of nursing staff for pneumonia;-Non-resolving pneumonia, completed Rocephin (ceftriaxone) and solumedrol, continued on Omnicef (cefdinir) 300 mg by mouth (PO) twice a day (BID) for seven days and change prednisone (steroid) to 40 mg PO daily for five days and decrease by 5 mg every 5 days until off. Review of resident's February 2026 Physician Order Sheet showed the following:-An order, dated 02/02/26, for cefdinir capsule 300 mg, one capsule by mouth two times a day for infection for seven days until finished; -An order, dated 02/04/26, for prednisone, oral tablet, give 40 mg by mouth one time a day for wheeze for five days;-An order, dated 02/09/26, for prednisone, oral tablet, give 35 mg by mouth one time a day for wheeze for five days. Review of the resident's February 2026 Medication Administration Record (MAR), showed the following information:-Cefdinir documented as administered twice a day for ten days (02/02/26 to 02/11/26) (three more days than ordered);-Staff did not document administration of prednisone from 02/04/26 to 02/08/26;-Staff did not document administration of prednisone from 02/09/26 to 02/12/26;-Staff prednisone administered documented on 02/13/26. Review of resident's progress notes dated 02/10/26 and 02/11/26, showed cefdinir capsule 300 mg not available. Observation on 02/17/26, at 11:20 A.M., showed the following:-An unopened package of prednisone, 35 mg by mouth for one time a day for wheeze for five days, start date 02/09/26;-A medication card, dated 02/02/26, with three capsules of cefdinir remaining out of 14. During an interview on 02/17/26, at 1:29 P.M., the Medical Director said the following:-If a medication was not administered, staff should contact the physician;-All medications should be administered as prescribed;-Medications administered should be documented. He/she would presume the medication was not administered if there was no documentation;-He/she prescribed cefdinir and prednisone to treat the resident's pneumonia. Both medications were to be administered as prescribed and would have helped his/her pneumonia. During an interview on 02/18/26, at 9:15 A.M., Certified Medication Technician (CMT) C said the following:-Some medications have been unavailable since the facility changed pharmacies. If a medication was unavailable, he/she notified the charge nurse and/or Director of Nursing (DON);-Staff should always document in the MAR, even if a medication is unavailable. The MAR should never be left blank;-Medications should be administered as prescribed;-He/she does not recall the resident having a prescription for prednisone. During an interview on 02/18/26, at 10:00 A.M., CMT D said the following:-If the MAR was blank, the medication was not administered;-Staff should always document in the MAR, even if the resident refused the medication, or if it was unavailable. A progress note should also be entered;-Medications should be administered as prescribed;-He/she believes the resident had packages of</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>prednisone, but does not recall administering the medication;-The resident did not refuse medications;-There have been issues with medication availability due to changing pharmacies;-Staff report unavailable medications to the DON. During an interview on 02/18/26, at 11:06 A.M., CMT E said the following:-If a medication was unavailable, staff should make a note for the charge nurse and/or DON;-When administering medications, staff should always document in the MAR. If the MAR was blank, it would be assumed the medication was not administered;-Medications should be administered as prescribed. During an interview on 02/18/26, at 11:20 A.M., Licensed Practical Nurse (LPN) F said the following:-If a medication was unavailable, staff should notify the charge nurse;-Some unavailable medications can be pulled from the emergency kit;-Medications should be administered as prescribed;-There should not be blanks on the MAR, as there should always be documentation. If staff cannot administer a medication, a reason should be indicated and a progress note made. During an interview on 02/18/26, at 2:10 P.M., LPN G said the following:-Medications should be administered as ordered;-There should not be blanks on the MAR, as it would indicate the medication was not administered. If a medication cannot be administered, it should be documented in the MAR and in the resident's progress note;-If a medication is unavailable, it should be reported to the charge nurse. During interviews on 02/18/26, at 10:45 A.M. and at 3:17 P.M., the DON said the following:-The facility changed pharmacies on 02/10/26;-Staff should document in the MAR when a medication is administered. There should not be any blanks on the MAR;-Medications should be administered as prescribed;-It is important to complete all medications. Both medications, cefdinir and prednisone, would help the resident feel better;-He/she was unaware why the resident had three remaining doses of cefdinir or why it was documented as administered past the seven-day prescription;-A medication should not remain on the MAR if it is past the stop date;-The DON was unaware why there was no documentation on the MAR regarding the resident's prednisone or why there were no doses given from the prednisone 35 mg card. During an interview on 02/18/26, at 4:20 A.M., the Administrator said the following:-Medications should be administered as prescribed;-If a medication dose was missed was unavailable, staff should notify the physician;-There should not be blanks on the MAR. Staff should document appropriately, and a progress note should be made if the medication was not given;-The DON should be regularly auditing the MAR. Complaint #2740299</p>		