STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265474	A. Building B. Wing	11/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Country Aire Retirement Center	18540 State Highway 16 Lewistown, MO 63452

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 0563 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to receive visitors of his or her choosing, at the time of his or her choosing. (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 0563 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 have written policies and procedures in place regarding visitation rights, including restrictions placed on two residents' visitation (Resident #2 and #3), in a review of six sampled residents. The facility failed to have a system in place regarding the limitations on visitors and failed to communicate the reasons for those limitations to staff. The facility census was 34. During interview on 9/29/25 at 2:15 P.M. the Administrator said the facility did not have a policy regarding visitation rights. Review of the facility policy Resident Rights, dated 6/10/25 showed the following:-The facility will inform the resident both orally and in writing, in a language a resident understands, of his or her rights and all rules and regulations governing conduct and responsibilities during the stay in the facility;-Prior to admission, the social service designee or designated staff member, will inform the resident and/or resident's representative of the resident's rights and responsibilities;-Information about resident's rights and responsibilities will be given to the resident both orally and in writing. 1. Review of Resident #2's letter of guardianship of an incapacitated person and conservatorship of a disabled person showed the following: -On July 17, 2025, Family Member M was appointed and qualified as guardian of the person and conservator of the estate of the resident, an incapacitated and disabled person;-The above-named guardian and conservator was authorized and empowered to perform the duties of guardian and to perform the duties of conservator as provided by law, under the supervision of the court, having the care and custody of the person and the estate of the above named incapacitated and disabled person. Review of the resident's undated, face sheet showed the following:-The resident admitted to the facility on [DATE];-Diagnoses included Alzheimer's disease, anxiety disorder, and cognitive communication deficit. Review of the resident's Social Service Designee (SSD) note, dated 8/28/25 at 9:57 A.M., showed no one could visit the resident if they had a specific last name. Three other names of individuals were listed as not being allowed to visit the resident. Review of the facility's Resident Rights form, provided to the resident's guardian upon admission, showed the following: -The resident has the right, and the facility must provide immediate access to any resident, subject to the resident's right to deny or withdraw consent at any time, immediate family or other relatives of the resident;-Subject to reasonable restrictions and the resident's right to deny or withdraw consent at any time, others who are visiting with the consent of the resident;-The guardian signed the form on 8/28/25. Review of the resident's admission Minimum Data Set (MDS), a federally mandated assessment instrument, completed by the facility staff, dated 9/3/25, showed the resident had severe cognitive impairment. Review of the resident's care plan, revised on 9/24/25, showed the following:-The resident had a psychosocial well-being problem related to family discord. There was a list of people who could not have contact with the resident per guardian's wishes (date initiated 9/24/25);-A list of 11 people who could not visit the resident was included on the care plan. Observation on 9/29/25 at 10:00 A.M. showed a sign posted in the nurse's station and that showed the following:-The following people are not to have contact with Resident #2 per his/her guardian's wishes, the list included 11 names, which were also on the resident's care plan;-When visitors come in, please ask for identification and name. If they are on the list inform them they cannot have contact with Resident #2. If they insist, contact the police, administration, and Director of Nurses (DON). During an interview on 9/24/25 at 3:45 P.M. the resident smiled and interacted. The resident said he/she saw Family Member I recently and Family Member G. He/She felt safe and had no concerns with anyone visiting him/her. During an interview on 9/24/25 at 12:30 P.M. Family Member M, Resident #2's guardian said the following:-He/She provided the facility a list of family members who could not visit Resident #2;-Family Member I called the guardian and asked if he/she could visit Resident #2 and he/she was told he/she could not visit the resident; -Family Member I had done some vandalism years ago at the cemetery and wasn't a good person;-Family Member I went to the facility to visit the resident anyway and refused to leave. He/She was on the list the guardian provided to the facility and was not to have contact with the resident; -Family Member G went to visit the resident, he/she was also on the list and not allowed to have contact with Resident #2; -Family Member G had no history of crime. Family Member G did not agree with the guardian that one of the family members had taken advantage of the resident therefore he/she did not want Family Member G around the resident. Also, Family Member I and Family Member G made a comment about reporting the guardian for elder abuse; -He/She was also concerned some of the family members had taken advantage of the resident financially. The resident had a large amount of money in the bank, and it was

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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 notify one resident's (Resident #1) representative when the resident was started on Rexulti (an antipsychotic medication), in a review of six sampled residents. The facility census was 34.During an email correspondence on 10/9/25 at 10:40 A.M. the Director of Nursing said she was unaware of facility policy regarding family notification for a change of condition. Review of the facility's Resident Rights form provided upon admission showed the following:-Free Choice: The resident has the right to be fully informed about care and treatment and of any changes in that care or treatment that may affect the resident's well-being unless incompetent or otherwise found to be incapacitated under the laws of the state, participate in care and treatment or changes in care and treatment;-Resident Right's under Missouri omnibus nursing home act: each resident admitted to the facility, or his/her guardian or legally qualified representative, shall fully be informed of his/her rights and responsibilities of a resident. 1. Review of Resident #1's consent to treat form, dated 11/17/22, showed it was signed by responsible party/Family Member K. Review of the resident's face sheet, undated, showed the following:-The resident admitted on [DATE];-Diagnoses included Parkinson's disease (a progressive movement disorder of the nervous system), unspecified dementia, history of transient ischemic attack (a stroke that only lasts a few minutes), cerebral infarction (stroke), and cognitive communication deficit. Review of the resident's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument, completed by the facility staff, dated 5/30/25, showed the following: -Severe cognitive impairment;-Disorganized thinking and inattention continuously present. Review of the resident's physician orders, dated 6/4/25, showed an order for Rexulti (an atypical antipsychotic; reduces agitation, aggression, and other disruptive behaviors in people with Alzheimer's dementia) 1 milligram (mg) by mouth one time a day related to anxiety. Review of the resident's progress notes showed no evidence the facility notified the resident's responsible party of the new medication that was started. Review of the resident's care plan, dated 7/21/25, showed the following:-Administer psychotropic medications as ordered and report any side effects noted, such as nausea and vomiting, over sedation or agitation; -Educate the resident/family/ caregiver regarding expectations of treatment, concerns with side effects and potential adverse effects, evaluation and maintenance. Review of the resident's physician orders, dated July 2025, showed an order for Rexulti 1 mg, a half a tablet by mouth one time a day related to anxiety. During an interview on 9/25/25 at 8:15 A.M. the resident's family member K said the following:-The facility notified him/her of other changes involving the resident including falls and other medication changes, but the facility did not notify him/her when Rexulti was started for the resident;-He/She noticed a change in the resident around June to July 2025, noting the resident really did not know the family and was very groggy. The resident's speech was hard to understand also;-When staff were questioned about the resident's change in behavior, family member K was informed about the Rexulti being started. During an interview on 9/25/25 at 11:10 A.M. the resident's family member L said the following:-The facility did not notify the family when the resident was started on Rexulti;-The family questioned the resident's change in behavior and was told the resident had been on Rexulti. During an interview on 9/24/25 at 9:15 A.M. the Director of Nursing (DON) said he/she would expect the facility to notify the resident's responsible party/representative of any new medications. During an interview on 9/29/25 at 2:15 P.M. the Administrator said the resident did not have a guardian and did not have a legal power of attorney (POA). The facility needed to talk to the family about getting POA paperwork. She did not feel the facility was required to notify the family of a new medication if they were not a legal POA. Intake 2612003

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. (continued on next page)

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F 0658 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 staff followed professional standards of practice when staff removed resident medications from packaging and placed them in medication cups prior to morning medication pass for 13 residents. Also, staff failed to ensure insulin was administered correctly for one resident (Resident#3) in a review of six sampled residents. Staff failed to follow the facility's policy to keep the dose button/plunger of the insulin pen pressed and the needle in the skin for six to ten seconds during administration. The facility census was 34.Review of the facility policy Medication Storage, dated 5/9/25, showed it was the policy of this facility to ensure all medications housed on our premises will be stored in the pharmacy and/or medication rooms according to the manufacture's recommendations and sufficient to ensure proper sanitation, temperature light, ventilations, moisture control, segregation, and security. During an interview on 9/29/25 the Director of Nursing said the facility did not have a medication administration policy regarding setting up medications prior to administration.Review of the facility policy Insulin Pen, dated 5/16/25, showed the following:-It is the policy of this facility to use insulin pens to improve the accuracy of insulin dosing, provide increased resident comfort, and service as a teaching aid to prepare residents for self-administration of insulin therapy upon discharge;-Injecting the insulin, while still pressing the plunger, keep the needle in the skin for 6-10 seconds and then remove the needle from the skin. 1. Observation of medication cart one on 9/29/25 at 11:20 P.M. showed Certified Medication Technician (CMT) C opened the medication cart drawer, inside the drawer were three paper medication cups with a resident's first name written on the side of each of the cups. Each cup contained medications that had been removed from the original packaging. The medications cups were not labeled to show what medications were in each cup. 2. Observation of medication cart two on 9/29/25 at 11:40 A.M. showed the following:-CMT C opened the medication cart drawer, inside the drawer were ten medications cups with a resident's first name written on the side of each cup. Each cup contained medications that had been removed from the original packing. The medications cups were not labeled to show what medications were in each cup. 3. Review of Resident #3's undated face sheet showed the following:-The resident admitted to the facility on [DATE];-Diagnoses included diabetes. Review of the resident's physician orders, dated September 2025, showed insulin Aspart (a fast-acting insulin used to treat diabetes) solution 100 units/milliliter (ml) 6 units subcutaneously (under the skin) one time a day before lunch. Review of drugs.com showed the following:-Aspart was a fast-acting insulin; -Insert the needle and start injection;-Press and hold down the dose button until the dose counter showed 0;-Continue to keep the dose button pressed and keep the needle in the skin and slowly count to 6 and remove the needle from the skin. Observation on 9/29/25 at 11:25 A.M. showed the following:-Certified Medication Technician (CMT) C turned the Aspart insulin flex pen dose selector to 6 units;-CMT C injected the needle into the resident's stomach and depressed the plunger, a click was heard and the dose counter showed 0;-CMT C immediately removed the needle from the resident's skin;-CMT C did not continue to press the plunger and keep the needle in the skin for 6 seconds to assure all the medication was administered to the resident. 3. During an interview on 9/29/25 at 11:22 A.M. CMT C said the following:- The medications in the cups were to be administered during his/her medication pass;-CMT C said he/she labeled each cup with the resident's first name and placed them back inside the divided drawer until it was time for the medication pass;-He/She knew medications were not to be removed from packaging until time of administration. He/She had so many medications to pass, preparing all the medications ahead of the medication pass time made it easier and quicker to complete his/her medication pass;-He/She was unaware when administering insulin that he/she was to keep pressure on the plunger and keep the needle in the skin for 6 seconds to assure the resident received the full dose of insulin. During an interview on 9/29/25 at 2:00 P.M. the Director of Nursing said the following:-Staff should not remove medications from the packaging until time of administration; -Preparing all the medications ahead of the medication pass could cause a medication error;-Staff should hold the insulin pen needle in the skin for 10 seconds to assure the resident received the full dose of medication. During an interview on 9/29/25 at 2:15 P.M. the Administrator said the facility should follow the facility's policy on medication pass and insulin administration.

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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 one resident (Resident #4) in a sample of six residents, remained free of a significant medication error when staff crushed and administered glipizide 24 hour extended release (used to manage blood sugars, the form of medication is gradually released throughout 24 hours) and metoprolol 24 hour extended release (used to manage high blood pressure, the form of medication is gradually released throughout 24 hours) to Resident #4. The facility census was 34. Review of the facility policy, Crushed Medications, dated 6/10/25, showed the following:-Medications shall be crushed in accordance with standards of practice for safety and accuracy in medication administration;-Medications shall be crushed in accordance with physician orders;-Medications that typically should not be crushed include enteric coated medications and sustained-release or extended-release absorption. Review of drugs.com showed inform patients that glipizide ER tablets should be swallowed whole. Inform residents that they should not chew, divide or crush tablets. Review of drugs.com showed Metoprolol ER tablets were not to be crushed or chewed. 1 Review of Resident #4's undated, face sheet showed the following:-The resident was admitted to the facility on [DATE];-Diagnoses included diabetes and hypertension (high blood pressure). Review of the resident's physician orders, dated September 2025, showed the following:-Glipizide ER 5 milligrams (mg) extended release 24-hour tablet one tablet one time a day for diabetes;-Metoprolol ER extended release 24 hour/25 mg, one tablet one time daily for hypertension. Observation on 9/29/25 at 11:55 A.M. showed the following:-Certified Medication Technician (CMT) C removed a medication cup from the medication cart which contained two tablets. CMT C said one tablet was glipizide and the other tablet was metoprolol;-CMT crushed both tablets and placed the medication in yogurt and administered the medication to the resident. Review of the resident's Medication Administration Record (MAR), dated September 2025, showed the following:-On 9/29/25 CMT C documented he/she administered the resident's glipizide ER 5 mg in the morning;-On 9/29/25 CMT C documented he/she administered metoprolol 25 mg ER in the morning. During an interview on 9/29/25 at 1:40 P.M. CMT C said the following:-He/She was not aware the resident's glipizide and metoprolol was extended release medications;-Extended-release medications should not be crushed because it would be absorbed all at once instead of over 24 hours. During an interview on 9/29/25 at 2:00 P.M. and 3:00 P.M. the Director of Nursing said glipizide extended release and metoprolol extended release should not be crushed because the resident would get too much medication at once instead of over 24 hours, which could affect blood sugar and blood pressure. During an interview on 9/29/25 at 2:15 P.M. the Administrator said staff should follow the medication policy for crushed medications. Intake 2612003