STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265521	A. Building B. Wing	01/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Seville Care Center	35625 Highway 72 Salem, MO 65560

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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 0583 Level of Harm - Potential for minimal harm Residents Affected - Some	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39440 Based on observation, interview, and record review, facility staff failed to protect residents' privacy when staff failed to provide privacy during perineal care for two residents (Resident #1 and # 9) out of two sampled residents. The facility's census was 49. 1. Review of the facility's policy titled, Resident Rights, dated October 2009, showed employees shall treat all residents with kindness, respect, and dignity, and each resident has the right to privacy and confidentiality. 2. Review of Resident #1's quarterly Minimum Data Set (MDS), a federally mandated assessment, dated 11/03/24 showed staff assessed the resident as follows: -Severe cognitive impairment; -Dependent on staff for dressing, toileting hygiene, and personal hygiene. Review of the resident's care plan, dated 11/14/24, showed staff are directed to assist the resident with transfers, dressing, toileting, and personal hygiene. Observation on 01/15/25 at 1:35 P.M., showed Certified Nursing Assistant (CNA) A and Nursing Assistant (NA) B transferred the resident from his/her chair to bed, and provided perineal care to the resident with the resident's roommate in his/her bed positioned facing the resident. CNA A and NA B did not pull the privacy curtain between the residents' beds to provide privacy during perineal care. During an interview on 01/15/25 at 2:10 P.M., CNA A said he/she should have pulled the privacy curtain between the two residents, especially since the resident's roommate was awake in the room, but he/she was just nervous and forgot to pull the curtain. During an interview on 01/15/25 at 2:12 P.M., NA B said the privacy curtain should be pulled during perineal care, and he/she realized the privacy curtain between the resident and his/her roommate's bed was not closed, but he/she did not think to prompt CNA A to pull the curtain either. 3. Review of Resident #9's quarterly MDS, dated [DATE], showed staff assessed the resident as follows: -Severe cognitive impairment; (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 0583 Level of Harm - Potential for minimal harm Residents Affected - Some	-Dependent on staff for dressing, toileting hygiene, and personal hygiene. Review of the resident's care plan, dated 11/23/24, showed staff are directed to assist the resident with transfers, dressing, toileting, and personal hygiene. Observation on 01/13/25 at 1:33 P.M., showed CNA A and CNA C transferred the resident from his/her chair to bed, and provided perineal care to the resident, the resident's window blinds raised and open, and a car drove by the driveway that led to the rear parking lot of the building. The CNAs did not lower and close the window blinds to provide privacy during perineal care. Observation on 01/15/25 at 1:58 P.M., showed CNA A and NA B transferred the resident from his/her chair to bed, and provided perineal care to the resident, the resident's window blinds raised and open, with clear view of a driveway that led to the rear parking lot of the building. Staff did not lower and close the window blinds to provide privacy during perineal care. During an interview on 01/15/25 at 2:10 P.M., CNA A said he/she should have lowered and closed the resident's window blinds for privacy during perineal care but he/she was nervous and just did not think about it. During an interview on 01/15/25 at 2:12 P.M., NA B said he/she should have lowered the blinds to ensure the resident's privacy during perineal care but he/she just did not think about it at the time. 4. During an interview on 01/15/25 at 2:34 P.M., Licensed Practical Nurse (LPN) D said staff should close the privacy curtain, as well as close and lower the window blinds in a resident's room to ensure the resident's privacy during perineal care. During an interview on 01/16/25 at 12:52 P.M., the Director of Nursing (DON) said staff should knock prior to entering a resident's room, pull the privacy curtain, use a sheet to cover the resident, lower and close the window blinds in the room to provide privacy and maintain modesty to each resident during perineal care. He/She said staff should absolutely pull the privacy curtain particularly if the resident's roommate is inside the room during care. During an interview on 01/16/25 at 1:02 P.M., the administrator said staff should knock prior to entering a resident's room, pull the privacy curtain, use a sheet to cover the resident, and close the window blinds in the room to provide privacy to the resident during perineal care.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures to prevent abuse, neglect, and theft. 50422 Based on interview and record review, the facility staff failed to develop an abuse and neglect policy which met the required time frame to report immediately, but not later than two hours after an allegation of abuse or neglect. The facility census was 49. 1. Review of the facility's Policy & Procedure Abuse and Neglect Prevention policy, revised on 02/15/2012, showed: -The resident has the right to be free from verbal, sexual, and physical, and mental abuse, corporal punishment, and involuntary seclusion; -Once the facility administration becomes aware of any of these alleged violations, the home must report immediately to the designated state agency, CMS indicates that the term immediately means as soon as possible, but no more than 24-hours after the alleged incident is discovered. The facility's policy did not include direction the facility is required to report all alleged violations-immediately but not later than, two hours- if the alleged violation involves abuse or results in serious bodily injury, 24 hours if the alleged violation does not involve abuse and does not result in serious bodily injury. During an interview on 01/16/25 at 1:25 P.M., the Director of Nursing said he/she is aware abuse and neglect time frames for reporting is two hours but is not sure what their policy states. During an interview on 01/16/25 at 1:28 P.M., the administrator said this was the most recent policy provided by the new owners but she was not aware of what the policy said. The administrator said she had not looked at or reviewed the policy.

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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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39440 Based on observation, interview and record review, facility staff failed to ensure services provided met professional standards of practice when staff did not contact the physician for a pain medication refill order in a timely manner for one resident (Resident#30) of one sampled resident. Facility staff failed to follow physician orders when staff did not document the administration of medications and tube feedings for one resident (Resident #45). Staff failed to complete and document neurological checks for three (Resident #1, #18, and #30) of six sampled residents who had unwitnessed falls, as directed by the facility policy. The facility's census was 49. 1. Review of the facility's policy, Physicians Medication Orders, revised April 2010, showed drugs and biologicals that are required to be refilled must be reordered from the issuing pharmacy not less then three days prior to the last dosage being administered to ensure refills are readily available. 2. Review of Resident #30's Quarterly Minimum Data Set (MDS), a federally mandated assessment, dated 12/04/24, showed staff assessed the resident as follows: -Cognitively intact; -Resident on scheduled pain regimen; -Resident has frequent pain. Review of the Physician Order Sheet (POS), dated 11/22/24, showed an order for Buprenorphine (controlled substance used to treat pain) HCl 150 micrograms (MCG) every 12 hours for nonmalignant pain. Review of the Controlled Drug Receipt/Record/Disposition Form, dated 12/02/2024, showed staff documented the last Buprenorphine dose administered to the resident on 01/04/25. Review showed the form did not contain documentation staff ordered a refill of the medication. Review of the nurses' note, dated 01/05/25, showed staff documented the resident did not have any Buprenorphine. Staff received an order from the on-call doctor for Hydrocodone-Acetaminophen ((APAP) (narcotoc pain medication) 10/325 milligrams (mg) one tablet twice daily for three doses or until Buprenorphine available. Review of the resident's Medication Administration Record (MAR), dated January 2025, showed an order for Hydrocodone-Acetaminophen oral tablet 10-325 MG, one tablet every day and night for pain. Review showed staff did not document they adminstered the medication after 01/06/25. Review of the resident's MAR, dated January 2025, showed it did not contain documentation staff administered the residents Buprenorphine or Hydrocodone-Acetaminophen 01/07/25, 01/08/25, and 01/09/25. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 01/14/25 at 1:30 P.M., the resident said he/she had a pain medication pouch they were using, but that prescription ran out, and he/she was told insurance does cover that medication any longer. The resident said he/she did not get other pain medication while they waited for this to get figured out. He/She said they went about three days without a substitute pain medication. The resident said he/she has a Tylenol order but it does not work, and a muscle relaxer also. The resident said it was uncomfortable for her to have to go without pain medication. During an interview on 01/16/25 at 10:25 A.M., the Medical Director (MD) said the expectation is medication refills be ordered about a week before they run out. The MD said a resident does not have to go without pain medication. He/She said there is always someone on call to sign for narcotics, if needed. The MD said it would be uncomfortable for the resident to not have the pain medication for the few days. During an interview on 01/16/25 at 1:20 P.M., the Director of Nursing (DON) said medication should be ordered between seven and 10 days before the last pill is used. The DON said the nurse is expected to contact the pharmacy and they will automatically send to the doctor for the refill and signature. If the medication is not available, then it should be pulled from the emergency medication kit (ekit). The DON said she/he was not aware the resident went without pain medication, but there is no reason when it can be pulled from the ekit. During an interview on 01/16/25 at 1:25 P.M., the administrator said the expectation is for medications be ordered at least a week before they are to run out. The administrator said the nurse should request an order for something for the resident to take while they are waiting on the medication to come or be refilled. If the medication doesn't come promptly then they should pull from the ekit. The administrator was not aware the resident went with out medication while he/she waited for the refill. 3. Review of the facility's policy titled, Administering Medications, revised April 2010, showed staff are directed as follows: -Medications shall be administered in a safe and timely manner, and as prescribed; -Medications must be administered in accordance with the orders, including any required time frames; -The individual administering the medication must initial the resident's MAR on the appropriate line after giving each medication and before administering the next ones; 4. Review of Resident #45's admission MDS, dated [DATE], showed staff assessed the resident as follows: -admitted [DATE]; -Cognition not assessed; -Diagnoses Stroke, Traumatic brain injury, and Thyroid Disorder. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Received 51 percent (%) or more total calories via tube feeding, and received 501 cubic centimeters (cc) or more average daily fluid intake via tube feeding. Review of the resident's care plan, dated 12/17/24, showed the resident required tube feeding, is dependent with tube feeding and water flushes, and follow physician orders for current feeding. Review of the resident's POS, dated November 2024 through January 2025, showed the physician ordered medications and nutrition to be administered via Gastric Tube ((G-Tube) a surgically inserted tube which provides nutrition, hydration, or medicine directly into the stomach) as follows: -Hydrocortisone (to treat hormone imbalance) five mg tablet, give three tablets in the morning; -Levothyroxine (to treat Thyroid Disorder) 50 mcg tablet, give one tablet in the morning; -Famotidine (to treat heartburn and indigestion) 20 mg tablet, give one tablet two times per day; -Caffeine 200 mg tablet, give one tablet two times per day; -Desmopressin Acetate (to reduce the amount of urine made) 0.1 mg tablet, give one tablet two times per day; -Jevity 1.5 Cal (sole-source nutrition for tube feeding) 240 cc, give bolus (a single large dose) four times per day; -Flush tube with at least 75 milliliters (ml) water before and after feeding. Review of the resident's MAR, dated November 2024, showed the MAR did not contain documentation staff administed the Hydrocortisone or Levothyroxine at 6:00 A.M. on 11/23/24, 11/24/24, 11/26/24 and 11/27/24, and the Jevity or water flushes on 11/23/24, 11/24/24, and 11/27/24. Review of the resident's MAR, dated December 2024, showed the MAR did not contain documentation staff administed the Hydrocortisone, Levothyroxine, Caffeine, Desmopressin, Famotidine, Jevity, or water flushes at 6:00 A.M. on 12/02/24, 12/11/24, and 12/12/24. Review of the resident's MAR, dated January 1st through 14th 2025, showed the MAR did not contain documentation staff administed the Hydrocortisone, Levothyroxine, Caffeine, Desmopressin, Famotidine, Jevity, or water flushes at 6:00 A.M. on 1/07/24 and 1/12/24. During an interview on 01/15/25 at 8:56 A.M., LPN D said if the nurse did not administer a medication, feeding, or water flush, he/she is supposed to document the reason with a code such as refused, medication not available, other, and if applicable, he/she is expected to also document a nurse's note with explanation. He/She said if there is a hole or missing initials on the resident's MAR, it means the medication, feeding or water flushes did not get completed (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 01/16/25 at 12:52 P.M., the DON said he/she expects staff to always follow the physician's orders and if there was a hole in the MAR then the medication or tube feeding was not given. He/She said no one currently double checks for blank spots on the MAR because there should always be either an inital or code in each spot, and regardless of the reason for non-administration of a medication or feeding, there should never be a blank spot on the MAR. During an interview on 01/16/25 at 1:02 P.M., the administrator said he/she expects staff to always follow the physician's orders. 5. Review of the facility's Fall Prevention policy, dated 04/12/2009, showed if the fall is not witnessed or the resident hit his/her head, initiate neurological checks based on the schedule on the neurological status evaluation per facility policy. 6. Review of the facility's policy titled, Neurological Assessments, dated 10/2001, showed when a resident has an unwitnessed fall, accident/injury involving head trauma, the nurse is to perform a neurological assessment. Review showed the nurse is required to complete checks- every 15 minutes for one hour, every 30 minutes for one hour, every hour for six hours, every four hours times two, every eight hours times seven for a total of 72 hours. 7. Review of Resident #1's quarterly MDS, dated [DATE], showed: -Severe cognitive impairment; -Dependent on staff for transfers from chair to bed/bed to chair; -Diagnosis of Stroke, Parkinson's Disease, and Traumatic Brain Injury. Review of the resident's nurses' notes, dated 11/22/24, showed staff documented the resident found on his/her stomach, on the left side of the bed, with blankets under him/her and a fall mat in place. Review showed the resident said I tried to roll over in bed and fell out. Review of the resident's electronic medical record (EMR) showed the record did not contain documentation staff completed the neurological checks after the resident's unwitnessed fall on 11/22/24. 8. Review of Resident #18's Quarterly MDS, dated [DATE], showed staff assessed the resident as: -Cognitively intact; -Impairment on one side upper and lower extremity; -Independent for chair/bed-to-chair transfers. Review of the resident's nurses' notes, dated 10/04/24, showed staff documented the resident found sitting on the floor next to the side of the bed. Review showed staff documented the fall unwitnessed. Review of the resident's EMR showed the record did not contain documentation staff completed the neurological checks after the resident's unwitnessed fall on 10/04/24. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	9. Review of Resident #30's Quarterly MDS, dated [DATE], showed staff assessed the resident as: -Cognitively intact; -Impairment to lower extremity both sides; -Partial/moderate assist with chair/bed-to-chair transfer. Review of the resident's nurses' notes, dated 09/05/24, showed staff documented the resident yelled help and found sitting on the floor in front of his/her wheelchair by the bed. Review of the resident's nurses' notes, dated 12/01/24, showed staff documented the resident found sitting on the floor by his/her bed by staff. Review showed the resident said I transferred myself to the bed and I slid off onto the floor. Review of the resident's EMR showed the record did not contain documentation staff completed the neurologoical checks after the resident's fall on 09/05/24 and 12/01/24. 10. During an interview on 01/16/25 at 9:08 A.M., the MDS/Care plan Coordinator said per facility protocol, staff are expected to conduct and document neurological checks/assessments on a resident after any unwitnessed fall. He/She said the neurological checks are not documented on paper, and the charge nurse usually initiates the assessment in the residents' EMR's. During an interview on 01/16/25 at 12:10 P.M., LPN D said when a resident falls the nurse will assess the resident. He/She said neurological checks are usually case by case on unwitnessed falls and are started depending on if the resident is alert and oriented and can tell him/her exactly what happened and whether they did or did not hit their head. He/She said if resident is not alert and orientated and the fall was unwitnessed then neurological checks are started. He/She it is the nurse's responsibility on duty to start neurological checks. He/She said the importance of starting neurological checks is to ensure there is not head injury. During an interview on 01/16/25 at 12:44 P.M., the DON said neurological checks should be started on any resident who has an unwitnessed fall. He/She said it does not matter whether the resident is alert and orientated, if it is unwitnessed, then neuros should start by the nurse on duty at that time. He/She said the importance of neuros is to see if mental status changes or grips strengths to ensure not a head injury. During an interview on 01/16/25 at 12:50 P.M., the administrator said in regards to unwitnessed falls, if a resident falls and they are alert and orientated and can tell you they didn't hit their head then the on duty nurse can assess and make the call if the resident needs to be started on neuro checks. 39644 50422

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F 0680 Level of Harm - Potential for minimal harm Residents Affected - Many	Ensure the activities program is directed by a qualified professional. 50422 Based on interview and record review, facility staff failed to ensure the activities program was directed by a qualified professional. The facility census was 49. 1. Review of facility's policies showed staff did not provide a policy in regards to qualifications for the Activity Director position. 2. Review of the facility's Activities Designee job description, undated, showed the Activity Director must receive Activity Designee certification within six months of hire. 3. Review of the facility maintained personnel records showed the Activity Director with a hire date of 05/17/24. During an interview on 01/15/25 at 11:45 A.M., the Activity Director said he/she does not have his/her Activity Director certification. He/She said he/she has been the Activity Director Since June 2024 and states the Activity Director course has been talked about but he/she is not currently enrolled in any courses at this time. During an interview on 01/16/25 at 12:41 P.M., the Director of Nursing (DON) said he/she was not aware the Activity Director did not have his/her Activity Director certification. He/She said the Activity Director was hired before he/she came and he/she does not do anything with the hiring process. He/She said he/she was not aware of a time frame the Activity Director needed their certification. During an interview on 01/16/25 at 12:43 P.M., the Administrator said he/she was aware the current Activity Director did not have his/her Activity Director certification. He/She said there is another staff who works part time/two days a week and has his/her certification and he/she thought that would carry over.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39440 Based on observation, interviews and record review, facility staff failed to properly complete weekly skin assessments, and failed to notifiy the physician and obtain a treatment order for one resident (Resident #6) of one sampled resident who developed a new facility-acquired pressure ulcer to the resident's right buttock. The facility's census was 49. 1. Review of the facility's policy titled, Pressure Ulcer/Pressure Injury Prevention, dated April 2018, showed, if a pressure ulcer/pressure injury is present, provide treatment to heal it and prevent development of additional pressure ulcers/pressure injuries. 2. Review of the facility's policy titled, Wound Assessment, dated April 2018, showed the facility is to assess each wound initially at the time of admission or at the time the wound is identified, and each wound will be assessed weekly thereafter or with any significant noted change in the wound. The wound assessment and documentation should include: -Anatomic location includes anatomic landmarks; -Size- specify length, width, depth, tunneling/undermining; -Drainage, include amount, color and consistency; -Pain or tenderness which may be indicators of underlying tissue destruction, or vascular insufficiency; -Peri-wound (skin surrounding the wound) skin condition; -Odor. 3. Review of Resident #6's Quarterly Minimum Data Set (MDS), a federally mandated assessment tool, dated 11/19/24, showed staff assessed the resident as follows: -Cognitive; -At risk for developing pressure ulcer; -One Stage three (full-thickness skin loss potentially extending into the subcutaneous tissue layer) Pressure Ulcer not present on admission; -Frequently incontinent of urine and bowel movement. Review of the resident's care plan, dated 11/25/24, showed staff assessed the resident with a potential for impairment to skin integrity, a Stage two (partial thickness loss of skin with a red or pink wound bed) pressure ulcer on his/her left buttock dated, 11-8-24. Staff are directed to administer treatments as ordered and monitor for effectiveness. Document location of wound, amount of drainage, peri-wound area, pain, edema, and circumference measurements weekly. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the resident's mobile wound care physician's visit report, dated 11/26/24, showed the wound physician documented the left buttock wound as a Stage two Pressure Ulcer and received an outcome of resolved, the peri-wound skin texture, moisture, and color are normal. Review of the resident's weekly skin assessment dated [DATE], 12/11/24, 12/18/24, 12/25/24, 01/05/25, and 01/08/25, showed Registered Nurse (RN) E documented ongoing treatment to stage two on left buttocks, no new skin issues noted, skin clean/dry/intact. The weekly skin assessments did not contain a complete wound assessment to include measurements or description of the wound. Review of the resident's Physician's Order Sheet (POS), dated 11/27/24 through 01/13/25, showed the POS did not contain documentation of a physician's ordered wound treatment for the resident's buttock area. Review of the resident's Treatment Administration Record (TAR), dated 12/01/24 through 01/13/25, showed the TAR did not contain documentation staff provided wound treatments to the resident's buttock area. Review of the resident's nurses' notes, dated 11/27/24 through 01/13/25, showed the nurse's notes did not contain documentation in regards of the resident's pressure ulcer. During an interview 01/14/25 at 10:38 A.M., the resident said he/she had an open area but facility staff have not been doing any treatments to the area. Observation on 01/14/25 at 10:46 A.M., showed the resident's right buttock with an open area partially covered with a pink substance. During an interview on 01/14/25 at 10:46 A.M., Licensed Practical Nurse (LPN) G said he/she was not aware the resident had an open area which required a treatment, and his/her skin assessment is not typically done on the day shift. Review of the resident's mobile wound care physician's visit report, dated 01/14/25 at 4:46 P.M., showed the wound physician documented the patient seen today as a consultation for evaluation of the patient's wound, and assessed the wound as follows: -Wound to right buttock Stage three pressure injury/pressure ulcer (full-thickness skin loss potentially extending into the subcutaneous tissue layer) with a status of not healed; -Initial wound encounter measurements are 1.1 centimeter (cm) length x 0.6cm width x 0.1 cm depth, with an area of 0.66 square cm, volume of 0.066 cubic cm; -Small amount of sero-sanguineous drainage (thin, pink, watery fluid); -Wound bed has 76-100 percent pink, granulation tissue; -The peri-wound skin texture, moisture, and color are normal. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265521	A. Building B. Wing	01/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Seville Care Center	35625 Highway 72 Salem, MO 65560

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 01/15/25 at 2:34 P.M., LPN D said the nurses are responsible to perform weekly skin assessments and if he/she identifies a new wound, he/she should measure and document his/her observation of the wound. The LPN said the wound care doctor was seeing the resident for the left buttuck wound that was healed on 11/26/24. The LPN said about two weeks prior, he/she noticed the resident had a new wound on his/her buttock and did not have a treatment order, but the wound physician was unavailable, and he/she just got busy and did not assess the wound, or attempt to obtain an order from the resident's physician in the absence of the wound physician. During an interview on 01/15/25 at 2:52 P.M., RN E said when he/she performed the resident's weekly skin assessments, he/she did not measure or assess the wound, and did not verify there was a treatment order in place. The RN said he/she just wrote what he/she documented on the previous skin assessment. During an interview on 01/16/25 at 9:19 A.M., the resident's physician said he/she expects staff to call him/her for a new wound treatment in the absence of the wound physician, as he/she is ultimately responsible for the resident's medical care. During an interview on 01/16/25 at 12:52 P.M., the Director of Nursing (DON) said the nurses are responsible to perform the resident's weekly skin assessment, document his/her current observations under the assessments tab in the electronic medical record (EMR), and sign the TAR when finished. He/She said if the nurse notices an open area, he/she should obtain measurements, describe the wound (color, drainage, odor), complete an incident/communication form with physician, document who he/she contacted regarding wound, and obtain a treatment order from the physician until the physician is able to physically assess the resident. The DON said he/she expects the nurses' documentation to be accurate, and the nurses should always verify if there is an active treatment in place. During an interview on 01/16/25 at 1:02 P.M., the administrator said the nurses are responsible to perform the resident's weekly skin assessments, document accurately under the assessments tab in the EMR and sign the TAR once complete. He/She said if a nurse identifies a new wound on a resident, he/she expects the nurse to document the assessment and contact the physician for a treatment order.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265521	A. Building B. Wing	01/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Seville Care Center	35625 Highway 72 Salem, MO 65560

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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 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. 39644 Based on interview and record review, facility staff failed to provide the services of a Registered Nurse (RN) for at least eight consecutive hours per day, seven days a week. The facility census was 49. 1. Review of the facility's policies showed the facility did not provide a policy for RN coverage. 2. Review of the facility's RN staff schedule, dated July 2024, showed the facility did not have an RN, eight consecutive hours a day, in the building for the dates on: -Thursday 07/04/24; -Friday 07/05/24; -Saturday 07/06/24; -Sunday 07/07/24; -Wednesday 07/10/24; -Saturday 07/13/24; -Sunday 07/14/24; -Monday 07/15/24; -Tuesday 07/16/24; -Saturday 07/20/24; -Sunday 07/21/24; -Saturday 07/27/24; -Sunday 07/28/24. 3. Review of the facility's RN staff schedule, dated August 2024, showed the facility did not have an RN, eight consecutive hours a day, in the building for the dates on: -Saturday 08/03/24; -Thursday 08/08/24; -Saturday 08/10/24; (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265521	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Seville Care Center	35625 Highway 72 Salem, MO 65560

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 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Sunday 08/11/24; -Thursday 08/15/24; -Friday 08/16/24; -Saturday 08/17/24; -Sunday 08/18/24; -Monday 08/19/24; -Thursday 08/22/24; -Saturday 08/24/24; -Sunday 08/25/24; -Saturday 08/31/24. 4. Review of the facility's RN staff schedule, dated September 2024, showed the facility did not have an RN, eight consecutive hours a day, in the building for the dates of: -Sunday 09/01/24; -Monday 09/02/24; -Saturday 09/07/24; -Sunday 09/08/24; -Saturday 09/14/24; -Sunday 09/15/24; -Monday 09/16/24; -Thursday 09/19/24; -Friday 09/20/24; -Saturday 09/21/24; -Sunday 09/22/24; -Thursday 09/26/24; -Saturday 09/28/24; (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265521	A. Building B. Wing	01/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Seville Care Center	35625 Highway 72 Salem, MO 65560

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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 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Sunday 09/29/24. 5. Review of the facility's RN staff schedule, dated October 2024, showed the facility did not have an RN, eight consecutive hours a day, in the building for the dates on: -Friday 10/04/24; -Monday 10/07/24; -Saturday 10/12/24; -Sunday 10/13/24; -Sunday 10/27/24. 4. Review of the facility's RN staff schedule, dated November 2024, showed the facility did not have an RN, eight consecutive hours a day, in the building for the dates on: -Saturday 11/02/24; -Sunday 11/03/24; -Saturday 11/09/24. 4. Review of the facility's RN staff schedule, dated December 2024, showed the facility did not have an RN, eight consecutive hours a day, in the building for the dates on: -Saturday 12/28/24; -Sunday 12/29/24. 5. During an interview on 01/16/25 at 12:48 P.M., the Director of Nursing (DON) said he/she was not aware of any days currently without eight consecutive RN coverage, at least not since he/she started at the facility in November. During an interview on 01/16/25 at 12:50 P.M., the administrator said he/she was aware of the regulation of having RN in building eight consecutive hours daily. He/She said when he/she first took over as administrator he/she knew the regulation was not being met and he/she was trying his/her best to make sure it was understood midnight starts a new day and night shift would not count as eight consecutive hours. He/She said recent missed days may have been because the nurses took off over the weekend and they didn't have coverage. He/She said it is important to have RN in building for the continuation of care and having the extra oversight of the building.