

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265522	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/29/2026
NAME OF PROVIDER OR SUPPLIER Lakeview Health Care & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1450 Ashley Road Boonville, MO 65233	
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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on interviews and record review, facility staff failed to ensure residents were given the right to make choices about aspects of their lives in the facility, when staff did not give one resident (Resident #1) the choice to refuse his/her medication. The facility census was 56.1. Review of the facility's Resident Rights policy, dated 02/2001, showed employees shall treat all residents with kindness, respect, and dignity. Federal and state laws guarantee certain basic rights to all residents of the facility. 2. Review of Resident #1's quarterly Minimum Data Set (MDS), a federally mandated assessment tool, dated 04/16/26, showed staff assessed the resident as cognitively intact, rejects care daily, and received antipsychotic medication. Review of the resident's care plan, dated 06/19/26, showed staff documented resident at risk for adverse reactions to his/her health and safety due to use of psychotropic medications for behavior management, hallucinations, and paranoid schizophrenia. Review of the resident's Physician Order Summary, undated, showed an order for staff to administer a 50 milligram/milliliter injection of Haloperidol Decanoate (used to treat schizophrenia and acute psychosis) Intramuscular Solution intramuscularly one time a day every 28 day(s). Review of the resident's progress note, dated 07/22/26, showed staff documented the Director of Nursing (DON), a Certified Nursing Assistant (CNA) and a nurse went to the residents' room to administer the resident's Haldol injection. Staff documented the resident refused the injection and staff explained to the resident that he/she had a court order to receive the medication. Staff documented the DON attempted to administer the medication to the resident and the resident began to hit the DON and knocked the needle out of DON's hand. Review of the facility investigation, dated 07/29/26, showed the DON documented he/she went to Resident #1's room to administer the resident's Haldol injection. Review showed the DON greeted the resident and explained and educated the resident about the injection and court order. The resident became combative and aggressive. He/she explained it had to be done and positioned himself/herself to ensure safe administration of the medication. The DON documented he/she positioned himself/herself with his/her back towards the resident to stabilize the resident's right leg. He/She documented he/she attempted the injection, and the resident pushed him/her multiple times in the back and scratched his/her arms up. During an interview on 07/29/26 at 9:26 A.M., the DON said the resident was due for his/her Haldol injection. The DON initially said the resident received the injection but then said the resident refused to take the medication. The DON said he/she straddled his/her legs across the resident's leg, with his/her back towards the resident, and braced his/her legs against the resident's leg to prevent movement. The DON said the resident was hitting his/her back during the attempted medication administration and then the resident knocked the syringe out of his/her hand. The DON said if a resident refused to take medication, he/she would expect staff to call the physician, but since there was a court order to administer the medication, there was no other route, other than sending the resident to the emergency room, so (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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	he/she attempted to force the resident to take his/her medication. The DON said sending the resident to the emergency room would be a waste of a trip. The DON said he/she did not contact the physician because he/she believed he/she had a legal obligation to administer the medication and he/she did not need to follow facility policy and procedure. The DON said he/she did let the guardian know the resident had refused his/her medication and he/she was going to attempt to give it to him/her. During an interview on 07/29/26 at 12:30 P.M., Licensed Practical Nurse (LPN) A said the resident had the right to refuse medication. He/She said if a resident refuses medications, staff are directed to notify the nurse and contact the physician. He/She said the resident had a history of refusing and he/she did contact the doctor for guidance in the past. The LPN said he/she did not notify the physician related to the resident's refusal to take his/her Haldol injection. During an interview on 07/29/26 at 12:50 P.M., the administrator said the resident had a right to refuse medication. He/She said if a resident refused to take his/her medication, staff are educated to reapproach and educate the resident on the importance of taking his/her medication. The administrator said he/she expected the resident's guardian and/or family and physician to be notified if a resident refused to take his/her medication. He/She said even though the resident had the right to refuse medication, he/she said it was a gray area because the resident had a court order to take the medication. During an interview at 07/29/26 at 12:51 P.M., the Assistant Director of Nursing (ADON) said the resident refused to have staff administer his/her medication and was screaming the hospital needed to give him/her the injection. He/She said staff did not administer the medication to the resident because the resident knocked the syringe out of the DON's hand. He/She said the resident had the right to refuse medication. He/She said due to the court order for the facility to administer the medication, he/she did not know how to handle the situation with the resident refusing the medication. 3118060		

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. Based on observation, interview and record review, facility staff failed to ensure one resident (Resident #1) remained free from restraint when the Director of Nursing (DON) used his/her body to restrain and prevent the freedom of movement for the resident to administer the resident's injectable medication. The facility census was 56. 1. Review of the facility's Use of Restraints policy, dated 2001, showed restraints shall only be used for the safety and well-being of the resident(s) and only after other alternatives have been tried unsuccessfully. Physical restraints are defined as any manual method or physical or mechanical device, material or equipment attached or adjacent to the resident's body that the individual cannot remove easily, which restricts freedom of movement or restricts normal access to one's body. Restraints may only be used if/when the resident has a specific medical symptom that cannot be addressed by another less restrictive intervention and a restraint is required to treat the medical symptom; protect the resident's safety; and help the resident attain the highest level of his/her physical or psychological well-being. Review of the facility investigation, dated 07/29/26, showed the DON documented he/she went to Resident #1's room to administer the resident's Haldol injection. Review showed the DON greeted the resident and explained and educated the resident about the injection and court order. The resident became combative and aggressive. He/She explained it had to be done, positioned himself/herself to ensure safe administration of the medication. The DON documented he/she positioned himself/herself with his/her back towards the resident to stabilize the resident's right leg. He/She documented he/she attempted the injection, and the resident pushed him/her multiple times in the back and scratched his/her arms up. 2. Review of Resident #1's quarterly Minimum Data Set (MDS), a federally mandated assessment tool, dated 04/16/26, showed staff assessed the resident as cognitively intact and received an antipsychotic medication. Review of the resident's care plan, dated 06/19/26, showed the resident had a court order to administer psychotropic medication monthly by the least restrictive means necessary. Review showed staff documented the resident was at risk for adverse reactions to his/her health and safety due to the use of psychotropic medications related to behavior management, hallucinations, and paranoid schizophrenia. Review of the resident's Physician Order Summary, undated, showed an order for staff to administer a 50 milligram/milliliter injection of Haloperidol Decanoate (used to treat schizophrenia and acute psychosis) Intramuscular Solution intramuscularly one time a day every 28 day(s). Review of the resident's Medication Administration Record (MAR), dated July 2026, showed it did not contain documentation the resident received his/her Haldol injection. The MAR showed staff documented the resident refused his/her medication often. Review of the resident's progress note, dated 07/22/2026, showed staff documented the DON, a Certified Nursing Assistant (CNA) and a nurse went to the residents' room to administer his/her Haldol injection. Staff documented the resident refused the medication and staff explained to the resident that he/she had a court order for the medication. Staff documented the DON attempted to give the medication to the resident and the resident began to hit the DON and knocked the needle out of DON's hand. Staff documented the resident continued to curse and yell at staff. During an interview on 07/29/26 at 9:26 A.M., the DON said the resident was due for his/her Haldol injection. The DON initially said the resident received the injection but then said the resident refused to take the medication. The DON said he/she straddled his/her legs across the resident's leg, with his/her back towards the resident, and braced his/her legs against the resident's leg to prevent movement. The DON said the resident was hitting his/her back during the attempted medication administration and then the resident knocked the syringe out of (continued on next page)		

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	his/her hand. The DON said if a resident refused to take medication, he/she would expect staff to call the physician, but since there was a court order to administer the medication, there was no other route, other than sending the resident to the emergency room, so he/she attempted to force the resident to take his/her medication. The DON said sending the resident to the emergency room would be a waste of a trip. The DON said he/she did not contact the physician because he/she believed he/she had a legal obligation to administer the medication and he/she did not need to follow facility policy and procedure. During an interview on 07/29/26 at 10:55 A.M., the Nurse Practitioner (NP) said the resident had a history of refusing care, including his/her Haldol. The NP said if the resident refused he/she would have asked staff to speak with legal guardian about the refusal. The NP said he/she would consider straddling a resident's leg, bracing their legs against the resident's leg to hold the leg in place to administer a shot, to be a restraint and not appropriate. During an interview on 07/29/26 at 12:30 P.M., Licensed Practical Nurse (LPN) A said if a resident refuses medications, staff are directed to notify the nurse and contact physician. He/She said the resident had a history of refusing and he/she did contact the doctor for guidance in the past. The LPN said staff are not allowed to force a resident to take medication. He/she said if staff were to straddle a resident's legs in a manner to hold them and prevent movement to administer medications then he/she would consider that restraining a resident, which was abuse. During an interview on 07/29/26 at 12:50 P.M., the administrator said if a resident refused to take his/her medication, staff are educated to reapproach and educate the resident on the importance of taking his/her medication. He/She said straddling the resident's leg and bracing his/her legs against the resident's leg to prevent movement, was a gray area when being considered a restraint, since there was a court order for the facility to administer the resident's medication. During an interview at 07/29/26 at 12:51 P.M., the Assistant Director of Nursing (ADON) said he/she was in the room during the incident between the resident and the DON. The ADON said the DON had his/her legs straddled over the resident's leg and braced his/her legs against the resident's leg. He/She said the resident was hitting the DON. He/She said the resident refused to have staff administer his/her medication and was screaming the hospital needed to give him/her the injection. He/She said staff did not administer the medication to the resident because the resident knocked the syringe out of the DON's hand. He/She said staff did not offer to send the resident to the hospital to receive the injection prior to the incident. The ADON said the facility had a court order to administer the resident's medication and he/she had never dealt with a court order before. The ADON said he/she did not feel like the DON was restraining the resident but stabilizing his/her leg. The ADON said he/she did understand how the resident being combative and hitting the DON while he/she held the syringe, could be considered dangerous. 3118060		