STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265522	A. Building B. Wing	01/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lakeview Health Care & Rehabilitation Center	1450 Ashley Road Boonville, MO 65233

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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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, facility staff failed to provide a comfortable and homelike environment for residents when staff failed to attempt to minimize foul odors in the hallway and facility entrance, failed to repair wall damage and failed to repair wheelchairs. The facility census was 46.1. Review of the facility's Homelike Environment policy, dated February 2021, showed:-The facility staff and management maximize, to the extent possible, the characteristics of the facility that reflect a personalized, homelike setting to include: a clean sanitary and orderly environment, clean bed linens that are in good condition and pleasant, neutral scents;-The facility staff and management minimize, to the extent possible, the characteristics of the facility that reflect a depersonalized, institutional setting, to include, institutional odors. 2. Observation on 01/05/26 at 9:45 A.M., showed the entranceway to the facility with a foul strong odor.Observation on 01/05/26 at 1:35 P.M., showed the entranceway to the facility with a strong foul odor.Observation on 01/06/26 at 8:02 A.M., showed the entranceway to the facility with a foul strong odor.Observation on 01/06/26 at 3:25 P.M., showed the entranceway to the facility with a strong foul odor. Observation on 01/07/26 at 08:02 A.M., showed the entranceway to the facility with a strong foul odor. 3. Observation on 01/05/26 at 11:32 A.M., showed the 400 hallway with a strong foul odor.Observation on 01/06/26 at 8:25 A.M., showed the 400 hallway with a strong foul odor. Observation on 01/06/26 at 1:54 P.M., showed the 400 hallway with a strong foul odor.Observation on 01/07/26 at 8:17 A.M., showed the 400 hallway with a strong foul odor. Observation on 01/07/26 at 1:01 P.M., showed the 400 hallway with a strong foul odor. 4. Observation on 01/05/26 at 11:17 A.M., showed resident occupied room [ROOM NUMBER] with a strong foul odor.Observation on 01/05/26 at 1:59 P.M., showed resident occupied room [ROOM NUMBER] with a strong foul odor. The wall behind the bed was gouged and chipped paint. Observation on 01/06/26 at 2:12 P.M., showed resident occupied room [ROOM NUMBER]'s wall behind the bed gouged with chipped paint.Observation on 01/08/26 at 9:12 A.M., showed resident occupied room [ROOM NUMBER]'s wall behind the bed gouged with chipped paint. 5. Observation on 01/05/26 at 1:38 P.M., showed Resident #21's room with a strong foul odor. During an interview on 01/07/26 at 1:32 P.M., the resident said he/she knows the facility has an odor. He/She said it is there every day, sometimes it is worse than others and some areas are worse than others. He/She said he/she believes it's just part of the facility and it never goes away. 6. Observation on 01/05/26 at 11:53 A.M., and 01/06/26 at 10:15 A.M., showed Resident #9 in a wheelchair in the dining room. The right armrest to the wheelchair hung to the side of the chair secured by a piece of black tape at the back edge. The left armrest was torn and cracked.7. Observation on 01/05/26 at 12:34 P.M., showed Resident #3 in a wheelchair in the dining room. The foot cushion frayed and exposed the inner foam. Observation on 01/05/26 at 2:02 P.M., showed the resident sat in a wheelchair. The foot cushion frayed and exposed the inner foam. Observation on 01/06/26 at 11:07 A.M., showed the resident sat in a wheelchair. The foot cushion frayed and exposed the inner foam.Observation on 01/07/26 at 8:18 A.M., showed the resident sat in a wheelchair at the nurse's station. The foot cushion frayed and exposed the inner foam. 8. During an interview on 01/07/26 at 3:25 P.M., Certified Nurse Aide (CNA) A (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	said he/she had not noticed the odors in the building, but he/she is not surprised. He/She said if he/she notices a wheelchair is broken, he/she would tell maintenance so they can get it fixed. During an interview on 01/08/26 at 11:15 A.M., the maintenance director said if something needs repaired, staff are directed to document it in the maintenance request log located at the nurse's station. The maintenance director said staff had not notified him/her or documented in the repair needs in the maintenance log about repairs needed to Resident #3 and Resident #9's wheelchairs. He/She said he/she did not know about the wall repairs needed in room [ROOM NUMBER]. During an interview on 01/08/26 at 1:29 P.M., the administrator said he/she expects staff to complete maintenance work orders when they notice something is broken, which would include wheelchairs. He/She said maintenance staff are responsible to address work orders. The Administrator said he/she knows the facility has odors and there are a few residents who are heavy wetters and unfortunately their rooms are by the front door. He/She said some of the residents have their families wash their clothes and linens. The families do not always come in to take the items to be washed and refuse for staff to wash the items.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, facility staff failed to ensure three residents (Resident #3, #42, and #45), who were unable to carry out activities of daily living (ADLs), received the necessary care and services to maintain personal hygiene out of eight sampled residents. The facility census was 46. 1. Review of the facility's ADL policy, dated April 2025, showed appropriate care and services are provided for residents who are unable to carry out ADL's, independently, with the consent of the resident, and in accordance with the plan of care, including appropriate support and assistance with bathing, dressing grooming and oral care) and toileting. 2. Review of Resident #3's Quarterly Minimum Data Set (MDS), a federally mandated assessment tool, dated 11/18/25, showed staff assessed the resident as:-Cognitively impaired;-Did not have behaviors or reject care;-Dependent on staff for personal hygiene;-Diagnoses of dementia and diabetes.Review of the resident's care plan, dated 10/10/25, showed staff documented the resident is totally dependent on staff for personal hygiene.Review of the resident's shower sheets for December 2025 and January 3, 2026, showed staff did not document the resident refused a shave or nail care on 12/03/25, 12/10/25, 12/13/25, 12/17/25, 12/24/25, 12/27/25, 12/31/25 or 01/03/26. Observation on 01/05/26 at 12:24 P.M., showed the resident in the dining room with long facial hair and long jagged fingernails. His/Her hands were visibly soiled with buildup under his/her fingernails. He/She used his/her hands to eat his/her noon meal. Observation on 01/05/26 at 1:59 P.M., showed the resident in bed with visibly soiled hands, long jagged fingernails and long facial hair.Observation on 01/06/26 at 11:07 A.M., showed the resident in his/her wheelchair with long jagged fingernails and long facial hair.Observation on 01/07/26 at 8:18 A.M., showed the resident in his/her wheelchair at the nurse station. He/She had long jagged fingernails. Observation on 01/07/26 at 1:02 P.M., showed the resident in the dining room with long jagged fingernails. 4. Review of Resident #42's Quarterly MDS, dated [DATE], showed staff assessed the resident as moderately cognitively impaired and required some assistance with personal hygiene. Review of the resident's care plan, dated 02/06/26, showed staff documented the resident required assistance with showers and personal hygiene. Check nail length, trim and clean nails on bath days and as needed. Observation on 01/08/2026 at 10:51 A.M. showed the resident's feet with long and curled toenails. During an interview on 01/08/26 at 10:51 A.M., the resident said staff had not offered to trim his/her toenails during showers or since he/she was admitted . The resident said he/she is unable to trim his/her own toenails. The resident said he/she would allow staff to trim his/her nails if they offered and he/she could not recall if he/she had ever asked. 5. Review of Resident #45's, Quarterly MDS, dated [DATE], showed staff assessed the resident as:-Cognitively impaired;-Did not reject care;-Dependent on staff for toileting, dressing and personal hygiene;-Required substantial to maximum assistance of staff for toilet transfers;-Frequently incontinent of urine and occasionally incontinent of bowel;-Diagnoses of Schizophrenia and diabetes.Review of the resident's care plan, dated 11/05/25, showed staff assessed the with -Poor toileting habits and required maximum assistance of one staff for toilet hygiene. Staff documented to provide structured activities to include toileting, assess and anticipate his/her toilet needs. Ensure toilet routine is enforced to encourage appropriate emptying of bowel and bladder. Perform frequent checks and assist with toileting as needed. Totally dependent on staff for personal hygiene. Check nail length and trim and clean nails on bath day and as needed (prn).Observation on 01/06/26 at 8:32 A.M., showed the resident in the dining room. He/She had long fingernails and long facial hair. Observation on 01/07/26 at 8:33 A.M., showed the resident ambulated the halls and wore black pants with a visible white debris build-up on the front. He/She had long fingernails.Observation on 01/07/26 at 9:48 A.M., showed the resident ambulated the halls and wore black pants with a visible white debris build up on the front. He/She had long fingernails. An unknown staff member had the resident sit in a chair by the vending machines and did not offer to change his/her pants or clip his/her (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	nails.Observation on 01/07/26 at 1:10 P.M., showed the resident wore the same black pants to the dining room with the while build up on the front. The resident had long fingernails and had a strong smell of urine.During an interview on 01/07/26 at 3:25 P.M., CNA A said the resident's clothing is stained. The CNA said he/she has not had time to shave or provide nail care to the resident. 6. During an interview on 01/07/26 at 3:25 P.M., CNA A said it is routinely hard to get everything done with only two CNA's. Things like nail care, showers, and shaving are the things that are harder to get to, due to naps, toileting, and meal assistance. Dependent residents are the ones he/she tries to get to first, but there are a lot of residents that are more demanding of the aides' time which takes away from the care of others. He/She feels there is not enough teamwork to get everything done. During an interview on 01/08/26 at 9:07 A.M., the Director of Nursing (DON) said residents should be shaved and provided nail care including trims during showers. This can be done by the CNA's and/or the licensed nurses. He/She said he/she feels this is only getting done about 50 percent of the time depending on the staff that is working. During an interview on 01/08/26 at 1:29 P.M., the administrator said the facility has a resident shower schedule. Shaves and nail care should be a part of the shower process and/or as needed. CNA's and nurses are responsible to ensure resident care needs are being met but the DON is responsible to ensure the aides and nurses are completing the assigned tasks.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. Based on observation, interview and record review, facility staff failed to reheat pureed food items in accordance with standardized recipes and failed to maintain the internal temperature of pureed food items placed on the steam table to prevent the growth of food-borne pathogens and potential for food-borne illness. The facility census was 46.1. Review of the facility's Cooking and Cooling policy, dated 2020, showed: -Foods will be cooked thoroughly, reaching the appropriate internal temperature specific to each item;-Length of cooking time and internal temperatures vary according to the type of food and temperatures must be reached and held for a specified amount of time;-A properly calibrated thermometer should be inserted into the thickest part of the food, and at least two readings should be taken in different places to ensure the proper temperature has been reached. Review of the facility's Pureed Food Preparation policy, dated 2020, showed the policy did not provide guidance to reheat pureed food items in accordance with the standardized recipes to prevent the growth of food-borne pathogens and potential for food-borne illness. 2. Review of the facility's diet spreadsheet for 01/07/26, showed the menu directed staff to provide the residents on pureed diets with pureed rosemary boneless chicken, pureed cauliflower au gratin, and pureed mushroom rice at the lunch meal. Review of the facility's standardized recipes for the pureed rosemary boneless chicken, pureed cauliflower au gratin and pureed mushroom rice, showed the recipes directed staff to reheat the pureed food items internal temperature to 165 F after blending the food items and to maintain an internal holding temperature of 135 F or 140 F (Based on current local state regulations). 3. Observation on 01/07/26 from 11:15 A.M., showed the dietary manager (DM) added four portions of rosemary boneless chicken, broth, and food thickener into the food processor and blended until smooth. Observation showed the DM scooped the pureed rosemary boneless chicken into a metal pan and, without checking the internal temperature of the pureed food, placed the pan in the steamtable and walked away. Observation on 01/07/26 at 11:35 A.M., showed the DM placed prepared portions of the cauliflower au gratin into the food processor and blended until smooth. Observation showed the DM scooped the pureed cauliflower au gratin into a metal pan, and without checking the internal temperature of the pureed food, placed the pan in the steamtable and walked away. Observation on 01/07/26 at 11:40 A.M., showed the DM placed portions of mushroom rice into the food processor and blended until smooth. Observation showed the DM scooped the pureed mushroom rice into a metal pan, and without checking the internal temperature of the pureed food, placed the pan in the steamtable and walked away. Observation on 01/07/26 at 11:50 A.M., showed the lid of the large metal pan containing the smaller metal pans of pureed food items, not fully closed and with approximately a two-inch gap between the metal pan and lid. Observation on 01/07/26 at 11:55 A.M., showed the following internal temperatures of the pureed food items placed on the steam table: -Pureed rosemary boneless chicken at 130 F;-Pureed cauliflower au gratin at 124 F;-Pureed mushroom rice at 120 F. Observation on 01/07/26 at 12:16 P.M., showed the DM continued to not check the internal temperature of the pureed food items after blending the food items and after he/she placed the items on the steam table. Observation showed the DM dished out the pureed rosemary boneless chicken, pureed cauliflower au gratin, and pureed mushroom rice onto four separate plates. Observation showed the four plates that contained the pureed food items were placed on the meal cart and wheeled out of the kitchen to serve to the residents. Observation showed the internal temperature of the pureed rosemary boneless chicken at 135 F, the pureed cauliflower au gratin at 125 F, and the pureed mushroom rice at 125 F. During an interview on 01/07/26 at 2:10 P.M., the DM said he/she should have checked the internal temperature of the pureed food items immediately after blending to determine if the food items needed to be reheated to 165 F. He/She said he/she should have checked the pureed food items internal temperatures again before the items were placed on the steam table. The DM said he/she is expected to check the internal temperature of all food items placed on the steam table prior to serving the food items to residents to ensure they are (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	holding at 140 F. The DM said he/she was feeling overwhelmed and forgot to check the internal temperatures of the pureed food items after blending the items in the food processer and before serving the pureed food items from the steam table. During an interview on 01/07/26 at 2:41 P.M., Resident #35 said he/she has a pureed diet and sometimes the food is not hot, but lukewarm. The resident said he/she does not like to eat his/her food if it is not hot and said he/she will not eat the meal if it is not hot. During an interview on 01/07/26 at 3:31 P.M., the administrator said he/she is not sure what internal temperature pureed food items should be reheated to after blending in the food processor. The administrator said he/she would expect staff to check the internal temperature of the pureed food items prior to placing them on the steam table and said he/she would expect staff to check the internal temperatures of the pureed food items while on the steam table prior to serving the food to residents.

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F 0577 Level of Harm - Potential for minimal harm Residents Affected - Many	Allow residents to easily view the nursing home's survey results and communicate with advocate agencies. Based on observation, and interview, facility staff failed to provide complaint investigation results in a prominent and publicly available space for investigations completed January 30, 25 to December 8, 25. The facility staff also failed to post the location to for the reports. The facility census was 46.1. Review of the facility's Survey Binder located at the nurse's station did not contain complaint investigation results or documentation for investigations completed for 01/30/25, 03/11/25, 3/31/25, 05/01/25, 05/06/25, 06/12/25, 07/01/25, 07/04/25, 08/12/25, 09/16/25, 10/2/25, 12/01/25, and 12/08/25.2. Observation on 01/05/26 at 10:15 A.M., showed the survey binder on the nurse's station. The binder did not contain investigation results or documentation for investigations completed since 01/15/25. The facility did not post the location to for the reports. 3. Observation on 01/06/26 at 8:02 A.M., showed a survey binder sat on the nurse's station. The binder did not contain investigation results or documentation for investigations completed since 01/15/25. The facility did not post the location to for the reports. 4. Observation on 01/07/26 at 11:30 A.M., showed a survey binder sat on the nurse's station. The binder did not contain investigation results or documentation for investigations completed since 01/15/25. The facility did not post the location to for the reports. 5. Observation on 01/08/25 at 07:00 A.M., showed a survey binder sat on the nurse's station. The binder did not contain investigation results or documentation for investigations completed since 01/15/25. The facility did not post the location to for the reports. During an interview on 01/08/26 at 1:29 P.M., the administrator said he/she was responsible to ensure the survey binder was kept available and up to date for the residents and public to view. He/She said he/she had not updated it for a while and had the information available in his/her office. He/She did not have a reason why the binder was not updated with the complaint investigation results or why a sign to alert the public of the report availability was not posted.