STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265545	A. Building B. Wing	12/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Citizens Memorial Healthcare Facility	1218 West Locust Bolivar, MO 65613

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 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to maintain an environment as free of accident hazards as possible when staff failed to check the temperature of soup prior to serving and failed to ensure the resident was in an appropriate upright position prior to meal service for one resident (Resident #44) resulting in a burn from the hot liquid. The facility census was 95. Review of the facility policy titled, Event Reporting, approved 10/2025, showed the following:-The incident reporting system will be used to report possible errors, untoward events, and near misses to management, risk manager/administration;-To promptly document information relative to possible errors, untoward events, and near misses;-Definition of event is an occurrence that ideally should not have happened to a patient/resident, client, visitor, or other, whether or not an injury resulted;-An occurrence that is inconsistent with the desired outcome of the patient/resident, client or visitor;-An occurrence having an adverse effect on the patient/resident, client, visitor or other. Review of the facility's policy titled, Safe Food Handling and Preparation, approved 12/2025, showed the Director of Nutritional Services/Food Service supervisor is responsible for maintaining and establishing safe food procedures which meet the conditions set up by the Missouri Department of Health and Senior Services. Review showed the facility did not provide a policy regarding accident hazards or steps taken to prevent them or a policy regarding hot liquids. 1. Review of Resident #44's face sheet (a brief summary of the resident's medical and admission history) showed the following: -admission date of 04/10/25;-Diagnoses included cerebral palsy (a group of neurological disorders affecting movement, posture, and coordination), chronic obstructive pulmonary disease (COPD -a lung disease that makes it difficult to breathe), and insomnia (decreased ability to fall asleep and/or stay asleep). Review of the resident's care plan, last reviewed 12/11/25, showed the resident required set up/clean up assistance with eating and the resident resident was able to feed him/herself. Review of the resident's quarterly Minimum Data Set (MDS - a federally required assessment tool completed by facility staff), dated 12/19/25, showed the following: -The resident was cognitively intact;-The resident had impairment on both sides of his/her upper extremities;-The resident requires setup or clean-up assistance with eating; -The resident used an electric wheelchair for mobility. During an interview and observation on 12/15/25, at 1:23 P.M., the resident said the following: -The resident had a sore on his/her left shoulder;-The resident spilt soup on his/her left side;-The resident had a bandage on his/her left shoulder. (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 0689 Level of Harm - Actual harm Residents Affected - Few	Review of the resident's medical record showed staff documented the following: -On 12/10/25, at 4:58 P.M., the nurse was called to the resident room by Domestic Care Technician (DCT) L. Staff had given the resident his/her hot potato soup and it had spilt over his/her left shoulder extending down his/her upper arm and to his/her elbow. The nurse cleaned off what he/she could of the hot soup, removed the shirt the resident was wearing, and cleaned off the resident's skin. The resident had a reddened area where the hot soup had landed and a blister had formed on his/her left shoulder, where the majority of the soup was stationed. The resident requested a cool rag on the areas;-On 12/10/25, at 5:06 P.M., staff notified the on-call doctor about the burn incident. The doctor suggested cool compresses to area until area is cooled for comfort, then apply Silvadene cream (a type of cream used to treat burns) for five days to burn area, and wrap lightly with gauze/Kerlex (a think gauze wrap) for comfort. During an interview on 12/22/25, at 8:31 A.M., the resident said the following: -The resident was sitting up in bed with the back of the bed in the raised position when DCT L brought in his/her dinner tray;-The resident picked up the bowl of soup with his/her right hand and was trying to get a better hold on it with his/her left hand when the soup spilt on his/her left shoulder and down his/her left arm;-DCT L immediately called for help after seeing the soup spill;-Staff came to the resident's room, cleaned up the resident, and took care of the burn. Review of a written statement, dated 12/10/25, showed DCT L said on 12/10/25, he/she was passing a tray to the resident, and he/she asked the resident twice if he/she needed to get a certified nurse aide (CNA) to help him/her sit up to eat. The resident told DCT L no and told DCT L to give him/her the soup. DCT L gave the resident the soup and told the resident to be careful. By the time DCT L realized the soup was slipping, he/she did not have enough time to grab the soup. DCT L yelled for a CNA. During an interview on 12/18/25, at 9:21 A.M., DCT L said the following: -He/she passed meal trays down the halls which come in a hot box;-He/she takes the meal trays to the resident's rooms;-The resident normally sits up in his/her chair. The resident was in his/her bed on the day he/she delivered the soup;-He/she sat the meal tray down on the resident's bedside table and asked if he/she needed a CNA to assist him/her to sit up in bed. The resident said no. He/she asked the resident again and the resident said no and to give him/her the soup;-He/she handed the resident the cup of soup and reached to get the resident a spoon, by this time, he/she saw the soup slipping in the resident's hand;-The soup went backwards on the resident's shoulder;-When the soup fell, the resident's body twitched, and he/she ran out of the door and screamed at a CNA;-He/she was not trained to obtain temperatures on food. During an interview on 12/17/25, at 6:12 P.M., Licensed Practical Nurse (LPN) K said the following: -He/she had gone to the resident's room after DCT L had requested an aide;-The resident was lying in bed and had spilt hot soup on her shirt and pillow;-LPN K cleaned up the soup and removed the resident's shirt;-The resident's left shoulder, arm, and left side of his/her neck were red in color;-The first layer of the resident's skin had sloughed off his/her shoulder;-Measurements were not taken of the burn. LPN K estimated that the burn was the size of a silver dollar;-LPN K staged the burn as first-degree burn, similar to a sunburn. During an interview on 12/18/25, at 10:27 A.M., the on-call physician said the following:-The physician was contacted after hours regarding a resident being burned;-LPN K reported that the resident had spilled hot soup on his/her left shoulder and that it ran down the resident's left arm and up the left side of the resident's neck;-LPN K described the resident as having red skin with a large (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	blister on the left shoulder;-Based on the description of the wound the physician staged the wound as a partial thickness burn;-The physician gave orders for Silvadene treatment and a cold compress for comfort. During an interview on 12/17/25, at 4:36 P.M., the Director of Nursing (DON) said he/she was notified by the charge nurse that the resident had spilt hot soup on his/herself. LPN K reported that the resident's left shoulder was red in color and appeared to have been burned. During an interview on 12/17/25, at 4:29 A.M., the DD said the following: -The resident had ordered soup for dinner. The soup was being served off the steam table;-DCT L said he/she went to the resident's room with the dinner tray. When DCT L saw the resident in bed, he/she told the resident that they would get a CNA to help the resident up in bed;-The resident picked up the soup off the bedside table and spilt it on his/herself;-DCT L immediately called for a nurse. The resident was assessed by the nurse;-The resident told the DD that he/she picked up the soup off the table and it spilt;-The resident said DCT L asked the resident to wait for help sitting up in bed. During an interview on 12/17/25, at 4:24 P.M., the Administrator said the following: -The DON received a phone call that let her know that the resident had been burned by hot soup;-The DON and DD completed an investigation of the incident;-The responsibilities of the DCT were to deliver resident trays, fill water cups, and take resident food orders;-DCT L sat the resident's tray on the resident's bedside table. The tray contained hot broccoli and cheese soup;-The resident was lying in bed. The resident picked up the bowl of soup and spilt it on his/her left shoulder;-The DD spoke with the resident about the incident and the resident said he/she picked up the soup and tipped it over to far causing the soup to spill down the resident's shoulder and arm. During an interview on 12/18/25, at 8:50 A.M., Registered Nurse (RN) B said the following:-The resident sometimes eats in his/her room, but staff do try to have him/her go to the dining room;-The resident was independent and fed him/herself, but staff do open cartons and put straws in for him/her;-He/she did a treatment on the resident's shoulder;-This burn on the resident's shoulder looked like a typical burn the size of a silver dollar with red skin around it;-The burn was a blistered area;-He/she did not measure this because he/she did not have the equipment to do this and the resident was crying and was anxious about the burn. During an interview on 12/20/25, at 7:38 P.M., RN V said the following: -RN V worked the night that the resident was burned;-The blister on the resident's shoulder was no longer intact;-The open area of the burn was the size of a [NAME]. Observation on 12/17/25, at 10:42 A.M., of [NAME] Y showed the following: -Cook Y prepared four bowls of tomato soup and two bowls of chicken noodle soup;-Cook Y placed the bowls one at a time into the microwave and set the cook time for one and a half minutes;-When the soup was done cooking, [NAME] Y placed a plastic lid on the bowl of soup and put the soup in the warmer;-Cook Y did not check the temperature on the bowls of soup prior to placing them in the warmer. Observation on 12/17/25, beginning at 3:14 P.M., showed the following: -Cook Y heated a bowl of tomato soup in the microwave for one and a half minutes. [NAME] Y did not check the temperature of the soup, placed a plastic lid on the bowl and gave to the DD;-The DD carried the bowl of soup with the lid on it down to the end of A hall. The DD checked the temperature of the soup, and it was 183.4 degrees F. (continued on next page)

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	265545	A. Building B. Wing	12/22/2025

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During an interview on 12/19/25, at 10:39 A.M., the DD said cooks are responsible for temping all food after preparing it and before serving it. The DD would expect the cook to check the temperature of items heated in the microwave before serving it. During an interview on 12/22/25, at 10:42 A.M., the Dietician said the following: -He/she would expect to be notified if a resident received an injury from hot food;-He/she was not notified of the resident's burn from the hot soup;-He/she would expect the cook to check the temperature of food heated in the microwave prior to serving it. During an interview on 12/22/25, at 11:39 A.M., the physician said he/she would expect kitchen staff to check the temperature of food prior to it being served. During an interview on 12/22/25, at 12:57 P.M., the Administrator he/she expected kitchen staff to check the temperature of all food prior to serving it.

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to store and prepare food in accordance with professional standards of practice and protect all food from possible contamination when the facility staff failed to date stored food in the refrigerator and freezer; failed to discard prepared food after the use by date; and failed to follow proper hygiene practices when two staff failed to wear beard nets. The facility's census was 95.Based on observation, interview, and record review, the facility failed to store and prepare food in accordance with professional standards of practice and protect all food from possible contamination when the facility staff failed to date stored food in the refrigerator and freezer; failed to discard prepared food after the use by date; and failed to follow proper hygiene practices when two staff failed to wear beard nets. The facility's census was 95.1.Review of the facility's policy titled, Dry Storage of Food and Non-Food Supplies, approved 07/2023, showed the following:-Food items and non-food items are stored in compliance with regulations established by the Missouri Department of Health and Senior Services;-Purpose was to preserve quality and prevent contamination;-Opened products are covered, labeled, and dated before storing. Review of the facility's policy titled, Refrigerated storage of Perishable Foods, approved 09/2025, showed the following: -Food items and non-food items are stored in compliance with regulations established by the Missouri Department of Health and Senior Services;-Purpose was to preserve quality and prevent contamination;-Foods are to be covered, and if removed from original packaging clearly labeled with the common name of the food and dated prior to storage;-Use by labels are to be placed on covered foods with the opened date and use by date clearly marked and kept no more than three days.Review of the facility's policy titled, Safe Food Handling and Preparation, approved 12/2025, showed the following:-The Director of Nutritional Services/Food Service Supervisor (DNS) is responsible for maintaining and establishing safe food procedures which meet the conditions set up by the Missouri Department of Health and Senior Services;-Purpose was to prevent cross contamination and avoid conditions which might cause food borne illness;-Freshly prepared potentially hazardous foods are to be covered, labeled, and dated after preparation and immediately stored according to refrigerated storage of perishable foods guidelines or per state and federal regulations.Observation on 12/15/25, at 9:53 A.M., of the refrigerator labeled salad bar/resident freezer, showed the following: -Four clear hinged take-out containers that contained salad. The containers were not labeled or dated;-Two clear hinged take-out containers that contained cottage cheese. The containers were not labeled or dated.Observation on 12/15/25, at 10:01 A.M., of the refrigerator labeled cooks fridge, showed the following: -One gallon size zipper bag containing raw hamburger. The bag was not labeled or dated;-Twenty-two clear plastic bowls, covered with saran wrap that contained salad. The bowls were not labeled or dated;-Two clear plastic bowls, covered with saran wrap that contained cottage cheese. The bowls were not labeled or dated;-Two clear plastic bowls, covered with saran wrap that contained sliced tomatoes. The bowls were not labeled or dated.Observation on 12/16/25, at 9:30 A.M., of the refrigerator labeled cooks fridge, showed the following: -One gallon size zipper bag containing raw hamburger. The bag was not labeled or dated;-Twenty clear plastic bowls, covered with saran wrap that contained salad. The bowls were not labeled or dated;-One clear plastic bowls, covered with saran wrap that contained cottage cheese. The bowls were not labeled or dated.Observation on 12/16/25, at 10:33 A.M., of the refrigerator labeled salad bar/resident freezer, showed the following: -Nine clear hinged take-out containers that contained salad. The containers were not labeled or dated;-One clear hinged take-out containers that contained cottage cheese. The containers were not labeled or dated.Observation on 12/17/25, at 9:53 A.M., of the refrigerator labeled cooks fridge, showed the following: -One gallon size zipper bag containing raw hamburger. The bag was not labeled or dated.Observation on 12/19/25, at 9:44 A.M., (continued on next page)

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	265545	A. Building B. Wing	12/22/2025

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	of the freezer labeled cooks freezer showed the following: -Three 8-ounce Styrofoam containers with lids, not labeled or dated, sitting on tray labeled chocolate ice cream, with a made date of 12/14/25 and use by date of: 12/17/25;-Five 8-ounce Styrofoam containers with lids, not labeled or dated, sitting on tray labeled vanilla ice cream, with a made date of 12/14/25 and use by date of: 12/17/25;-Six 8-ounce Styrofoam containers with lids, not labeled or dated, sitting on tray labeled strawberry ice cream, with a made date of 12/14/25 and use by date of: 12/17/25;-Four 8-ounce Styrofoam containers with lids, containing an orange substance, labeled [NAME], with no date.During an interview on 12/19/25, at 9:51 A.M., Dietary Aide (DA) W said the following:-The DA making food was responsible for dating and labeling food before putting in refrigerator/freezer;-The night shift was responsible for discarding food after the use by date;-Food was good for three days after the prepared date.During an interview on 12/19/25, at 10:13 A.M., DA Z said the following: -All staff are responsible for dating and labeling food prior to putting in refrigerator/freezer;-Food was good for three days after it was prepared;-Kitchen staff are responsible for throwing away food passed the use by date.During an interview on 12/22/25, at 10:29 A.M., DA X said the following: -All staff are responsible for dating and labeling food before it was put up;-Food was good for three days after the made date;-All staff are responsible for discarding food that is past the use by date.During an interview on 12/19/25, at 10:39 A.M., the Dietary Director (DD) said the following: -Kitchen staff are responsible for dating and labeling food before putting in refrigerator/freezer;-All staff are responsible for pulling out of date food out of the refrigerator/freezer.During an interview on 12/22/25, at 10:42 A.M., the Dietician said the following: -He/she expected staff to follow facility policy regarding food storage;-He/she expected staff to discard food that was past the use by date.During an interview on 12/22/25, at 12:57 P.M., the Administrator said she expected food to be dated and identified prior to storing in the refrigerator/freezer.2.Review of the facility's policy titled, Nutritional Services, approved 06/2025, showed the following:-Employees shall follow good hygiene practices as described in the Human Resource Policy and procedure manual, in order to maintain an overall clean and healthy working environment;-Beards and goatees are not permitted in the department. Mustaches are to be neatly trimmed and groomed not to extend below the corners of the mouth;-Daily shaving is required as part of the employee uniform.Review of the 2022 Food and Drug Administration (FDA) Food Code showed the following: -Food employees may contaminate their hands when they touch their hair;-A hair restraint keeps dislodged hair from ending up in the food and may deter employees from touching their hair;-Food employees shall wear hair restraints such as hats, hair coverings or nets, beard restraints, and clothing that covers body hair, that are designed and worn to effectively keep their hair contacting exposed food, clean equipment, utensils, linens, and unwrapped single-service and single-use articles. Observation on 12/15/25, at 10:16 A.M., showed DA X with facial hair not wearing a beard net. Observation on 12/15/25, at 10:30 A.M., showed [NAME] Y with facial hair not wearing a beard net. Observation on 12/16/25, at 10:32 A.M., showed DA X with facial hair wearing a black surgical mask and no beard net.Observation on 12/17/25, at 10:01 A.M., showed DA X with facial hair wearing a black surgical mask and no beard net.During an interview on 12/17/25, at 3:14 P.M., [NAME] Y said staff with a beard, goatee, or mustache were required to always wear a beard net while in the kitchen.During an interview on 12/22/25, at 10:29 A.M., DA X said the facility policy states that staff must wear a beard net to cover the beard and mustache regardless of length.During an interview on 12/19/25, at 10:39 A.M., the DD said the facility policy stated that beards and goatees were not permitted in the Nutritional Services Department.During an interview on 12/22/25, at 10:42 A.M., the Dietician said he/she expected staff to follow facility policy regarding hygiene, including beard nets.During an interview on 12/22/25, at 12:57 P.M., the Administrator said he/she expected kitchen staff to follow facility policy regarding personal hygiene/beard nets.

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	265545	A. Building B. Wing	12/22/2025

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to have a process in place to ensure food was served at a palatable temperature to all residents when food was below the optimal holding temperature before leaving the kitchen and was not routinely temped by all kitchen staff. This resulted in complaints regarding cold food from seven residents (Resident #55, #39, #72, #11, #83, #61, and #52.) The facility census was 95. Review of the facility's policy titled, Safe Food Handling and Preparation, approved 12/2025, showed the following:-The Director of Nutritional Services/Food Service Supervisor (DNS) is responsible for maintaining and establishing safe food procedures which meet the conditions set up by the Missouri Department of Health and Senior Services;-Purpose was to prevent cross contamination and avoid conditions which might cause food borne illness;-Hot prepared foods are to be fully cooked to proper temperatures and then held at a temperature of 140 degrees Fahrenheit (F) or above, not to exceed 4 hours;-Cold stops germs from growing and heat destroys bacteria. Prepared food should not be left standing at room temperature longer than four hours. Keep hot foods above 140 degrees F and cold foods below 41 degrees F; -Food service personnel shall use timers and metal tip thermometers to monitor the temperature of foods as a means of avoiding excessive shrinkage, overcooking foods, and to retain the nutritional value an appearance of foods prepared.1. Review of the Resident #55's comprehensive Minimum Data Set (MDS - a federally required assessment tool completed by facility staff), dated 11/21/25, showed the resident was cognitively intact.During an interview on 12/15/25, at 10:57 A.M., the resident said the food was cold by the time it was served to him/her in his/her room.2. Review of Resident #39's quarterly MDS, dated [DATE], showed the resident was cognitively intact.During an interview on 12/15/25, at 11:35 A.M., the resident said that the waffle that he/she had for breakfast was cold. 3. Review of Resident #72's quarterly MDS, dated [DATE], showed the resident was cognitively intact.During an interview on 12/15/25, at 11:20 A.M., the resident said he/she ate in the dining room and the food was cold when it was served.4. Review of Resident #11's comprehensive MDS, dated [DATE], showed moderate cognitive impairment.During an interview and observation on 12/15/25, at 12:06 P.M., the resident sat at a table in the dining room. The resident was not eating and stated that the food was cold.5. Review of Resident #83's comprehensive MDS, dated [DATE], showed the resident was cognitively intact.During an interview on 12/15/25, at 12:11 P.M., the resident said the food was cold by the time it was served to him/her in his/her room.6. Review of Resident #61's 5-day scheduled MDS, dated [DATE], showed the resident was cognitively intact.During an interview on 12/15/25, at 1:22 P.M., the resident said that he/she had to ask staff to reheat his/her food because it was cold when it was served to him/her.7. Review of Resident #52's quarterly MDS, dated [DATE], showed moderate cognitive impairment.During an interview on 12/15/25, at 2:12 P.M., the resident said there had been multiple times that the food was served cold when it should have been hot.8. Observation on 12/17/25, at 10:42 A.M., of [NAME] Y showed the following: -Cook Y prepared four bowls of tomato soup and two bowls of chicken noodle soup;-Cook Y placed the bowls one at a time into the microwave and set the cook time for one and a half minutes;-When the soup was done cooking, [NAME] Y placed a plastic lid on the bowl of soup and put the soup in the warmer;-Cook Y did not check the temperature on the bowls of soup prior to placing them in the warmer.Observation on 12/17/25, at 11:42 A.M., of the serve out process showed the following:-Cook Y prepared residents' trays and set them on top of steam table to be served;-The Dietary Director (DD) checked the temperature of the food on the plate before served to the resident. The baked ham measured 140 degrees F, the French fries measured 114 degrees F, the Philly cheese steak measured 132 degrees F, and the cooked carrots measured at 130 degrees F.9. During an interview on 12/19/25, at 9:51 A.M., Dietary Aide (DA) W said the following:-Cooks were responsible to checking the temperature of the food prior to serving;-When a resident stated their food was cold, DA W would heat the food up in (continued on next page)

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	265545	A. Building B. Wing	12/22/2025

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the microwave, then stir the food to make sure it was warm enough;-DA W did not check the food with a thermometer. He/she would reheat it for two minutes and tell the resident the food was hot.During an interview on 12/19/25, at 10:13 A.M., DA Z said residents were to get a fresh, new tray if their food was cold when served to them.During an interview on 12/19/25, at 10:39 A.M., the DD said the following: -When a resident's food was cold, staff were to get the resident a new tray with fresh food;-Cooks were responsible for temping all food after preparing it, before serving it, and during serve out;-The DD was not aware that residents had complaints about cold food. During an interview on 12/22/25, at 10:42 A.M., the Dietician said the following: -The Dietician would expect for dietary staff to temp food at start of serve out and maintain that temperature during serve out.During an interview on 12/22/25, at 12:57 P.M., the Administrator said he/she expected kitchen staff to check the temperature of all food prior to serving and during serve out.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265545	A. Building B. Wing	12/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Citizens Memorial Healthcare Facility	1218 West Locust Bolivar, MO 65613

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to establish and maintain a complete infection control program when staff failed to use Enhanced Barrier Precautions (EBP - an infection control intervention designed to reduce transmission of multidrug-resistant organisms (MDROs - microorganism that has developed resistance to one or more classes of antibiotics, making infections caused by it more difficult to treat) in nursing homes) during personal cares for one resident (Residents #5) who had a catheter (thin tube that remains in the bladder for continuous urine drainage, often held in place by a small balloon and connected to a collection bag) and when the staff failed to complete proper hand hygiene during personal cares for two residents (Resident #5 and #57) and during wound care for one resident (Resident # 12). The facility census was 95. Review of the facility provided policy titled Enhanced Barrier Precautions for Long Term Care, dated September 2024, showed the following:-EBP are an infection control intervention designed to reduce transmission of MDROs in nursing homes;-EBP involved gown and glove used during high-contact resident care activities for residents known to be colonized or infected with MDROs as well as those with increased risk for MDRO acquisition (e.g., residents with wounds or indwelling medical devices);-High contact activities included dressing, transferring, bathing, providing hygiene, changing linens, changing briefs, and device care or use; -Indwelling medical devices include, but are not limited to, central venous lines, indwelling urinary catheter, feeding tubes, and tracheostomy tubes. Review of the facility provided policy titled Hand Hygiene, dated April 2025, showed the following: -Preform hand hygiene on ungloved hands with approved alcohol-based hand rub (ABHR) or soap and water;-Preform hand hygiene before touching a patient, before a clean or aseptic procedure, after body fluid exposure or risk, after touching a patient, after touching a patient's surroundings;-Use ABHR before entering the patient's room, before donning gloves, before donning any personal protective equipment (PPE), before inserting invasive device, before moving from a contaminated body site to a different body site during the care of the same patient, after contact with the patients skin, body fluid, excretions, mucous, or dressing, after contact with objects in the patients immediate vicinity, after doffing sterile or non-sterile gloves, after doffing PPE, and upon exiting a patient room;-Use soap and water when hands are visibly soiled and before eating;-Gloves are not substitute for hand hygiene;-Change gloves during patient care if moving from a contaminated body site to a different body site of the same patient;-Preform hand hygiene between glove changes. 1. Review of Resident #5's face sheet showed the following:-admission date of 05/01/17;-Diagnoses included unspecified intracapsular fracture (a break in the upper part of the thigh bone) of the left femur (thigh bone). Review of the resident's quarterly Minimum Data Set (MDS – a federally mandated assessment completed by facility staff), dated 9/30/25, showed the resident had moderately impaired cognitive skills. Review of the resident's current physician orders showed the following: -An order, dated 01/21/25, for a foley catheter with a urinary catheter size of 16 and balloon amount of 10;-An order, dated 09/09/25, for staff to clean bilateral groins and apply antifungal powder every shift. Review of the resident's care plan, dated 02/11/25, showed the following:-The resident had a foley catheter related to his/her diagnosis of a neurogenic bladder (a condition where the nerves that control the bladder do not function properly, leading to difficulty with urination);-Staff to use EBP per policy. Observation of resident care on 12/16/25, at 12:45 P.M., showed the following: -Certified Nurse Aide (CNA) G and CNA H entered the resident's room; -The CNAs washed their hands and donned gloves. The CNAs did not don gowns;-CNA H touched the resident's foley catheter bag with gloved hand and placed it the bag on the bed. With the same hand the CNA proceeded to touch the resident and assist him/her in turning over;-CNA G and CNA H then assist resident with removing a soiled brief;-CNA G touched the resident's hair with gloved hand and without performing hand (continued on next page)

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	265545	A. Building B. Wing	12/22/2025

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	hygiene;-CNA G held resident to his right while CNA H cleaned his/her buttocks with sanitary wipes. The CNA then turn the resident to the center of the bed and cleans the resident's peri area with new sanitary wipe with same gloved hands and without performing hand hygiene; -CNA G and CNA H then assist the resident with fastening new brief;-The CNAs collected trash, doffed gloves, and exited the room without performing hand hygiene. During an interview on 12/16/25, at 12:50 P.M., CNA H said the following: -Residents with foley catheters are on EBP. There is a sign on the door indicating EBP;-Staff were supposed to wear gowns while changing the resident. He/she and the other aide forgot;-Staff wash hands and put on new gloves whenever staff do patient care. Staff wash hands when changing gloves. During an interview on 12/16/25, at 12:55 P.M., CNA G said the following:-Residents with foley's are on EBP, which means staff are supposed to wear a gown and gloves;-The CNAs did not wear gowns during the resident care because they forgot;-Staff are supposed to wash hands and change gloves when going from one task to another;-Staff can use hand sanitizer in between if hands are not soiled. During an interview on 12/17/25, at 10:30 A.M. and 1:30 P.M., Registered Nurse (RN) A said the resident had chronic urinary tract infection (UTIs). If staff did not provide proper peri-care, it could cause infections. Staff should wash hands during peri care. For residents on EBP staff wear gowns and gloves when caring for the resident. Any resident with a foley catheter or wound would be on EBP. During an interview on 12/22/25, at 11:38 A.M., the physician said he/she expected all staff to wash hands before and after each patient encounter and staff to wear gown and gloves as needed by their EBP policy. During interview on 12/19/25, at 2:00 P.M., the Director of Nursing (DON) she expected staff to wear protective equipment, such as gown and gloves, for EBP for residents with a urinary catheter. 2. Review of Resident #57's annual MDS, dated [DATE], showed the following:-Severely impaired cognition;-Inattention and altered level of consciousness behavior that fluctuates (comes and goes, and changes in severity);-Dependent on staff for toileting and personal hygiene;-Required substantial/maximal assistance for eating, dressing, and transfers;-Always incontinent of bowel and bladder;-Diagnoses included anemia (low iron in the blood), high blood pressure, arthritis, stroke, and hip fracture. Review of the resident's care plan, reviewed 12/11/25, showed the following:-Required dependent assistance from staff with dressing, personal hygiene, toileting, and perineal care;-Required maximal assistance from staff with bed mobility and transfers.-Diagnoses of acute and chronic respiratory failure;-Wears oxygen, has an oxygen concentrator at the bedside, and uses an oxygen tank on the wheelchair. Observation on 12/19/25, at 10:50 A.M., showed the following:-The resident was on the bed and fully dressed;-CNA S entered the resident's room, put on gloves without performing hand hygiene, and then removed the resident's damp incontinence brief. The CNA then performed perineal care;-Without removing his/her gloves or performing hand hygiene of his/her hands, CNA S went to the resident's closet and took out a pair of pants and put the pants on the resident;-Without removing his/her gloves and performing hand hygiene, CNA S turned off the resident's oxygen concentrator, put a gait belt (belt used to transfer a resident) around the resident, and assisted the resident to stand and pivot to sit in a chair;-He/she then removed his/her gloves and washed his/her hands. During interview on 12/19/25, at 11:06 A.M., CNA S said the following:-Staff were to wash hands when they entered and left a resident's room;-Staff were to wash hands before applying gloves;-When staff change a resident's incontinence brief, staff were to remove their gloves and wash hands before they re-applied gloves;-He/she did not do wash hands and re-apply gloves after performing perineal care. (continued on next page)

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	265545	A. Building B. Wing	12/22/2025

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. Review of Resident #12's face sheet (admission data) showed the following:-admission date of 8/07/25;-Diagnoses included fever. Review of the resident's quarterly MDS, dated [DATE], showed the following:-Impaired cognitive skills;-Dependent on staff for toileting, showering/bathing and personal hygiene;-Had pressure ulcers;-The resident was at risk for developing pressure ulcers. Review of the resident's care plan, updated 10/03/25, showed the following:-The resident was at risk for impaired skin integrity with his/her history of falls and limited mobility;-Skin assessment every seven days;-Skin treatment daily. Review of the resident's Physician Orders showed the following:-An order, dated 09/27/25, for staff to cleanse the sacral area (triangular bone in the lower back), dry well, apply skin prep (creates a protective film on skin) to the skin and apply a mepilex (dry gauze dressing) patch for protection. Staff to check daily and change weekly unless soiled;-An order, dated 09/27/25, for staff to cleanse left heel with wound cleanser, dry well, apply skin prep to intact surrounding skin area, apply betadine (broad-spectrum antiseptic and antimicrobial) to wound bed only, cover with gauze, wrap with kerlix or kling and then secure with paper tape. Staff to change daily;-An order, dated 10/03/25, for staff to cleanse the resident's right heel with wound cleanser, dry well, apply skin prep to intact surrounding skin, apply Betadine to wound bed, cover with gauze, wrap with kerlex or kling (a type of bulky woven cotton gauze bandage) and secure with tape. Staff to change daily. Observation of wound care on 12/17/25, at 10:00 A.M., showed the following: -Registered Nurse (RN) A and Licensed Practical Nurse (LPN) D washed their hands and donned gowns and gloves;-LPN D assisted while RN A removed dressing from the resident. After removing the dressing, RN A doffed gloves and donned new glove. The RN did not complete hand hygiene during the glove change;-RN A cleansed the wound to resident's right heel. The RN then doffed gloves and donned new gloves. The RN did not complete hand hygiene during the glove change;-RN A applied a clean dressing to the resident right heel;-RN A and LPN D doffed gloves and gowns and washed their hands. During an interview on 12/17/25, at 10:30 A.M., RN A said he/she forgot to wash are hands when changing gloves. 4. During interviews on 12/19/25, at 8:42 A.M. and 2:00 P.M., the DON said the following:-She expected staff to wash and or sanitize their hands during personal cares such as incontinence care;-All staff are educated on infection control policies and procedures;-Management does frequent rounds to ensure compliance;-The facility utilizes a staff vision board in the break room with statics and education on EBP;-She expected all staff to be following infection control policies. During an interview on 12/22/25, at 11:38 A.M., the physician said the following: -I expect all staff to wash hands before and after each patient encounter;-Staff should be wearing gown and gloves as needed by their EBP policy. During interviews on 12/22/25, at 12:58 P.M. and 1:26 P.M., the Administrator said the following: -The facility educates all staff on infection control. She expected all staff to follow all infection control policies;-She expected all staff to wash their hands before and after patient care;-She expected all staff to wash their hands when changing their gloves.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265545	A. Building B. Wing	12/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Citizens Memorial Healthcare Facility	1218 West Locust Bolivar, MO 65613

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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** Based on observation, interview, and record review, the facility failed to provide care per standards of practice when staff failed to ensure complete weekly skin assessments and wound assessments were completed and document for two residents (Resident #12 and Resident #84) with pressure ulcers (localized damage to the skin and/or underlying soft tissue usually over a bony prominence or related to a medical or other device). The facility census was 95. Review of the facility policy titled Pressure Ulcer/Wound Assessment and Treatment, dated May 2025, showed the following: -The skin risk assessment score will be documented by nursing on the admission assessment and then weekly for the first four weeks;-Basic skin assessment is completed on the resident each week;-The Minimum Data Set (MDS – a federally mandated assessment tool completed by facility staff), care plan, and changes in cognition, functional abilities, or health status may trigger extra skin risk assessments;-Long term care will obtain exact dressing change orders from the physician with the materials to be used and the frequency to be changed;-Document assessment in the patient's medical record; -Long term care setting document the assessment and treatment of wounds in the wound assessment intervention once per shift and as needed;-Long term care photos (of the wound) are taken on admission, weekly, and when newly acquired. 1. Review of the Resident #84 face sheet (document that gives the resident's information at a quick glance) showed the following: -admission date of 09/28/25;-Diagnoses included unspecified fracture of the right tibia, closed fracture. Review of the resident's nursing note dated 10/09/25, at 1:35 P.M., showed the resident has an air cast in place to right ankle. The resident's right lateral (outside) ankle noted to have a deep tissue injury (DTI - intact skin with localized area of persistent non-blanchable deep red, maroon, purple discoloration due to damage of underlying soft tissue) and right medial (midline) ankle noted to have a pressure injury stage 1 (intact skin with a localized area of non-blanchable erythema (redness)). Staff notified physician in person and via message/task. New skin treatment orders received for both areas. Order for skin prep (used prevent damage from bandage) to area and apply Mepilex (soft foam dressing). The air cast has been reapplied after skin check and areas addressed. Air cast adjusted to ensure proper alignment and fit. Staff updated orthopedic office updated via message/task about new area of concern. Low air loss mattress has been noted for placement. Review of the resident's Wound/Pressure Ulcer Skin Assessment, dated 10/09/25, showed the following: -A facility acquired deep tissue pressure injury to the right lateral (outside) ankle identified on 10/09/25. The wound measured 2.9 cm (centimeters) by 2.8 cm by 0.0 cm;-A facility acquired stage 1 pressure injury to the right medial (close to midline) ankle identified on 10/09/25. The wound measured 1.5 cm by 1.7 cm by 0.0 cm. Review of the residents Wound/Pressure Ulcer Skin Assessment, dated 10/15/25, showed the following: -A facility acquired deep tissue pressure injury to the right lateral ankle identified on 10/09/25. Wound measured 2.7 cm by 2.5 cm by 0.0 cm;-A facility acquired stage 1 pressure injury to the right medial ankle identified on 10/09/25. -Wound measured 1.3 cm by 1.3 cm by 0.0 cm. Review of the resident's physician orders showed an order, dated 10/17/25, to cleanse (right ankle) well, dry well, apply skin prep to discolored area and surrounding intact skin, and apply 4x4 Mepilex. Check daily for placement and change weekly. Review of the resident's Wound/Pressure Ulcer Skin Assessment, dated 10/23/25, showed the following: -A facility acquired deep tissue pressure injury to the right lateral ankle identified on 10/09/25. The wound measured 1.7 cm by 2.51 cm by 0.0 cm;-A facility acquired stage 1 pressure injury to the right medial ankle identified on 10/09/25. The wound (continued on next page)

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	265545	A. Building B. Wing	12/22/2025

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	was listed as healed. Review of the residents' care plan, revised 12/03/25, showed the following:-Resident was at risk for skin breakdown and had a history of wounds and skin breakdown;-Weekly and as needed (PRN) skin monitoring by a professional nurse;-Weekly skin assessment;-Daily skin treatments. Review of the resident's MDS, dated [DATE], showed the following: -Resident was cognitively intact;-Resident was incontinent of bowel and bladder;-Resident at risk for pressure injuries with no current pressure injuries noted. Review of the resident's nursing notes, dated 10/10/25 to 12/15/25, showed staff did not document related to the resident's wound or wound assessments completed. Review of the resident's Wound/Pressure Ulcer Skin Assessment, dated 10/23/25 to 12/15/25, showed staff did not document an assessment completed. Review of the resident's Weekly Skin Assessments, dated 11/06/25 to 12/15/25, showed staff did not document skin assessments completed. Review of the resident's Wound/Pressure Ulcer Skin Assessment. dated 12/16/25, showed the following: -A facility acquired deep tissue pressure injury to the right lateral ankle identified on 10/09/25. Wound measured 1.5 cm by 1.7 cm by 0.0 cm;-A facility acquired stage 2 (partial-thickness loss of skin with exposed dermis, presenting as a shallow open ulcer) pressure injury to the left heel. Wound measured 0.4 cm by 0.4 cm by 0.0 cm. Review of the resident's physician orders showed an order, dated 12/16/25, to clean and dry (left heel) with wound cleanser, apply calcium alginate (used to promote wound healing), and cover with Mepilex daily. 2. Review of Resident #12's face sheet (admission data) showed the following:-admission date of 8/07/25;-Diagnoses included fever. Review of the resident's care plan, dated 8/08/25, showed the following:-The resident was at risk for impaired skin integrity with his/her history of falls and limited mobility;-Skin assessment every seven days. Review of the resident's physician orders showed the following:-An order, dated 09/27/25, for staff to cleanse the area, dry well, apply skin prep to the skin and apply a Mepilex patch to the sacral area (a triangular bone in the lower back) for protection. Staff to check daily and change weekly unless soiled;-An order, dated 09/27/25, for staff to cleanse with wound cleanser to the left heel, dry well, apply skin prep to intact surrounding skin area, apply betadine (wound cleanser) to wound bed only, cover with gauze, wrap with Kerlix (gauze bandage) or kling (gauze bandage), secure with paper tape, and change daily;-An order, dated 10/03/25, for staff to cleanse the resident's right heel with wound cleanser, dry well, apply skin prep to intact surrounding skin, apply betadine to wound bed, cover with gauze, wrap with Kerlex or kling and secure with tape. Staff to change daily. Review of the resident's nurses note dated 10/14/25, at 2:25 P.M., showed a nurse documented staff updated the resident's family on wounds and skin concerns. The nurse spoke with the resident's family in person and reviewed the current treatment plan for the resident's bilateral heels and buttocks pressure injuries. Review of the resident's Weekly Skin assessment dated [DATE], at 1:00 P.M., showed the following:-Location: left heel. Staff did not document a description or size of area on left heel;-Location: left buttock, abrasion, warm, edematous (swollen), and skin texture fragile;-Location: right heel. Staff did not document a description or size of area on left heel. Review of the resident's Wound assessment dated [DATE], at 11:17 A.M., showed a the following:-Acquired right heel stage III (a deep wound that involves full-thickness skin loss) pressure injury, identified 9/27/25, measured 2.7 cm long by 2.9 cm wide by 0.1 cm in depth. Wound had granulation (new connective tissue), was reddened, and had slough (yellowish, stringy, dead tissue) with no undermining (destruction of tissue or ulceration extending under the skin edges (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265545	A. Building B. Wing	12/22/2025

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	(margins) so that the pressure ulcer is larger at its base than at the skin surface) or tunneling (passageway of tissue destruction under the skin surface that has an opening at the skin level from the edge of the wound) present;-Acquired left heel stage III pressure injury, identified on 09/30/25, that measured 2.1 cm long by 1.8 cm wide by 0.2 cm in depth. Wound had granulation, was reddened, and had slough with no undermining or tunneling present with a small amount of serous (thin, watery drainage) with no odor;-Acquired stage III pressure injury measured 2.1 cm long by 2 cm wide by 0.2 cm in depth. Wound had granulation with no undermining or tunneling present and scant amount of serous drainage with no odor. Slough had decreased and less than 25% of wound bed. Review of the resident's Wound assessment dated [DATE], at 12:05 P.M., showed a the following:-Acquired right heel stage III pressure injury, wound identified 09/27/25, measured 2.5 cm long by 2.9 cm wide by 0.1 cm in depth with eschar (a dry, dark scab or falling away of dead skin), granulation, and slough. There was no undermining or tunneling present;-Acquired left heel stage III pressure injury, identified 09/30/25, measured 2.0 cm long by 1.5 cm wide by 0.2 cm in depth with granulation and slough. There was no undermining or tunneling present and a thin, small amount of drainage with no odor;-Acquired sacrum stage III, identified 09/27/25, measured 1.5 cm long by 1.5 cm wide by 0.2 cm in depth with granulation and slough. There was no undermining or tunneling present with scant amount of serous drainage with no odor. Review of the resident's Weekly Skin assessment dated [DATE], at 12:44 P.M., showed the following:-Location: left heel. Wound was cool, dry, with pallor (unhealthy pale appearance) with loose, thin, saggy, fragile, and wrinkled skin;-Staff did not document information for the resident's right heel and sacrum;-Skin comment: pressure areas to buttocks and bilateral heels. See wound assessment. Review of the resident's medication record showed staff did not document completion of wound assessment on 11/05/25. Review of the resident's nurses note dated 11/05/25, at 12:28 P.M., showed a nurse documented the resident had orders for medihoney (used to promote healing in wounds) to his/her bilateral heels. The nurse spoke with the nurse practitioner and physician about the concerns that the medihoney did not seem to work on the wounds. The nurse asked if Santyl (medication used in wound care to help remove dead tissue) would be appropriate due to dead tissue in both of the resident's wounds. The physician stated the wounds did not need debrided. The physician ordered betadine to be applied to the wounds and covered with bandage to 'dry out'. Review of the resident's quarterly MDS, dated [DATE], showed the following:-Moderately Impaired cognitive skills;-Diagnoses included Alzheimer's disease and depression;-Had pressure ulcers;-The resident was at risk for developing pressure ulcers. Review of the resident's Weekly Skin assessment dated [DATE], at 5:10 A.M., showed the following:-Left heel was cool, dry, erythema (skin redness caused by inflammation, increased blood flow or irritation), loose skin; and boggy;-Left buttock was cool and dry;-Right heel was cool, dry, erythema, thin and boggy;-Skin comment: pressure areas to buttocks and bilateral heels. See wound assessment. Review of the resident's Wound assessment dated [DATE], at 7:20 A.M. showed a the following:-Acquired right heel stage III pressure injury, identified 09/27/25, measured 1.5 cm long by 0.7 cm wide by 0.1 cm in depth. Wound had granulation with no undermining or tunneling present and no wound drainage or odor. Wound had improved since last assessment;-Acquired left heel stage III pressure injury, identified on 09/30/25, measured 1.4 cm long by 0.4 cm wide by 0.2 cm in depth. Wound was granulation pink with no undermining or tunneling present and no drainage or odor. Improved measurements since last assessment;-Acquired sacrum stage III, identified 09/27/25, measured 0.5 cm long by 0.4 cm wide by 0.1 cm in depth. Wound was granulation pink with no undermining or tunneling present and no drainage or odor. Much improvement noted. Some shearing noted below area; -Staff will continue with treatment plan to all wounds. (continued on next page)

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	265545	A. Building B. Wing	12/22/2025

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 12/17/25, at 10:00 A.M., of wound care showed the following: -Right heel had an open irregular shape wound with serosanguineous (watery red fluid that is a mix of blood and serum) fluid on the bandage;-Left heel had no open wounds;-Coccyx (tailbone) area had two small superficial wounds with no drainage. During an interview on 12/17/25, at 10:39 A.M., Certified Nurse Aide (CNA) G said the following:-The resident has an open area on his/her bottom and one sore on each of his/her heels. He/she did not think the areas were opened;-The resident's heels are wrapped and should float on two pillows when in bed and heel protectors on while up out of bed. During an interview on 12/17/25, at 1:30 P.M., Registered Nurse (RN) A said the following:-The resident has a little open area on his/her buttock area and below is a shearing with no signs of infection;-The resident's left heel had dry skin and a chunk pealed out, an indentation. The resident's right heel was open. During an interview on 12/19/25, at 12:46 P.M., the Director of Nursing (DON) said the following:-Staff did not complete the resident's weekly skin assessments from 11/05/25 through 12/16/25;-Staff did not complete a wound assessment on the resident for 11/05/25;-There were no wound assessments for the resident from 10/27/25 through 12/16/25. 3. During an interview on 12/17/25, at 8:40 A.M., Licensed Practical Nurse (LPN)s D said the following: -The nurses on the floor do the wound treatments and monitor all wounds;-Staff run a skin report that pulls all orders to see which treatments need to be completed each day;-New skin concerns are to be measured, photos taken, and the physician, DON, abd family would be notified;-Charge nurses complete weekly skin assessments and wound assessments. During an interview on 12/17/25, at 9:40 A.M., RN A said the following: -Certified Nurse Aides (CNA) and Shower Aides will report any new skin concerns to the charge nurse;-Nurses are to assess all residents skin weekly;-Wound assessments and interventions should be documented in the nursing notes;-He/she did not measure wounds when completing wound treatments;-Wounds should be assessed and documented weekly. During an interview on 12/19/25, at 10:00 A.M., the DON said the following: -The DON and RN B were responsible for ensuring all weekly skin assessments were completed;-Currently the charge nurse on the floor should be completing skin assessments and wound assessments weekly;-Staff have missed some assessments after the wound care nurse left. During an interview on 12/22/25, at 11:38 A.M., the physician said the following: -He/she expected nursing staff to provide all wound treatments and wound assessments as ordered;-He/she expected nursing staff to notify him/her of any wound concerns;-He/she would get a weekly wound list when they had a wound nurse, but they do not currently have one;-It was very important for nurses to assess the wounds every week and more depending on severity more often. During an interview on 12/22/25, at 12:58 P.M., the Administrator said the following: -The wound nurse was responsible for completing wound assessments and they do not currently have a wound nurse;-Charge nurses were responsible for completing wound assessments if they did not have a wound nurse;-Nursing staff should be completing all weekly skin and wound assessments.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265545	A. Building B. Wing	12/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Citizens Memorial Healthcare Facility	1218 West Locust Bolivar, MO 65613

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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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility staff failed to ensure residents who were incontinent of bladder received appropriate treatment and services to prevent and treat urinary tract infections when staff failed to notify the physician of and provide treatment for suspected urinary tract infections (UTI) for one resident (Resident #36). The facility also failed to ensure proper catheter (a thin, flexible tube inserted into the body to drain fluid) care when staff failed to keep the catheter tubing below bladder level and failed to keep the catheter bag off the floor for one resident (Resident #7). The facility census was 95.1. Review of the facility policy titled, Long Term Urinary Symptoms, revised January 2025, showed the following:-To provide for the immediate treatment for residents who screen positive in the infection screening tool for urinary symptoms;-Registered nurses (RN) and licensed practical nurses (LPN)s in long term care may order and initiate the following protocol;-This protocol may be utilized on residents who screen positive for urinary symptoms on the infection screening tool;-The RN/LPN may order the following items individually utilizing the protocol order source: urinalysis and urine culture;-Document vital signs and assessments as appropriate in the electronic medical record. Review of Resident #36's face sheet (admission data) showed the following:-admission date of 1/05/18;-Diagnoses included major depressive disorder. Review of the resident's care plan, updated 03/20/25, showed the following:-Resident had a history of occasional urinary incontinence and limited mobility;-The resident was at risk for infections due to residing in a nursing facility, his/her age, and underlying health conditions;-Monitor for signs and symptoms of infection;-Utilize the infection/sepsis screening tool;-Notify the provider and responsible party of changes or abnormal screenings. Review of the resident's quarterly Minimum Data Set (MDS - a federally mandated assessment tool completed by facility staff), dated 11/07/25, showed the following:-Cognitive skills intact;-Required partial to moderate assistance of staff with toileting and showering/bathing;-Occasional incontinent of urine; -Always continent of bowel. Review of the resident's infection screening assessment dated [DATE], at 10:14 A.M., showed the following:-Mental status change, acute onset;-Functional decline of personal hygiene and toilet use;-General illness, myalgias, or body aches;-UTI symptoms: Infection screening urinary pain/frequency;-Criteria met - yes. Review of the resident's physician orders showed an order dated 12/09/25, at 12:27 P.M., to obtain a urinalysis (UA) and urine culture and sensitivity if indicated. Staff noted it had been collected. Review of the resident's final urine culture results received on 12/09/25, at 1:16 P.M., showed the following:-Result of greater than 100,000 colony-forming units (CFU)/milliliter (mL) of Escherichia coli (a common bacterium found in the intestines of humans);-Result of greater than 100,000 CFU/ml of Klebsiella pneumoniae (a type of bacteria that can cause pneumonia, UTIs, wound infections and more);-An accompanying list of antibiotics for the bacteria with sensitivity and resistance listed. Review of the resident's medical record showed staff did not document notification of the physician regarding the urine culture results. Review of the resident's nurse's note dated 12/14/25, at 6:10 P.M., showed LPN C documented at 5:50 P.M. the resident was noted to continue to have tenderness in his/her lower abdomen and peri area when voiding as well as with palpation of the area. LPN C also noted resident to have some tenderness in the kidney area of the ribcage anterior and posterior. LPN C passed on this information to the night nurse for continued monitoring and notification of the physician regarding the UA results. During an interview on 12/17/25, at 1:30 P.M., Registered Nurse (RN) A said the following:-Signs and symptoms of a UTI include burning, increased frequency and change in confusion;-Nurses enter on a work list of the sepsis monitoring in the computer and it informs staff of qualifications to obtain a UA; -Nurses obtain the UA, send to the laboratory, notify the physician with the results, and enter the order for an antibiotic in the computer if ordered. During an observation and interview on 12/18/25, at 1:06 P.M. and 1:44 P.M., the Director (continued on next page)

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	265545	A. Building B. Wing	12/22/2025

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	of Nursing (DON) said the following: -She reviewed the 12/09/25 UA and culture and sensitivity results in the computer and said the resident had a UTI and it should be documented in the nurses' note. There should be a provider note regarding the UA results and the resident should be on an antibiotic; -The DON said she did not find the provider message, or a progress note of the resident's UA results and the resident was not on an antibiotic. During an interview on 12/19/25, at 9:56 A.M., Certified Nurse Aide (CNA) G said signs and symptoms of UTI include a burning sensation, increased urination, and decrease in appetite. Staff should inform the charge nurse if a resident has symptoms of a UTI. Observation and interview on 12/19/25, at 10:15 A.M., showed the resident sat in his/her wheelchair in his/her room. The resident said he/she had burning with urination a couple weeks ago. Staff obtained a UA, and he/she received an antibiotic yesterday (12/18/25). It took two weeks to get an antibiotic. He/she had pain while waiting for the antibiotic and it was uncomfortable. He/she was glad to have the antibiotic now. During an interview on 12/19/25, at 10:22 A.M., LPN C said the following:-Signs of a UTI include change in attitude, complaints of general discomfort, discomfort in the kidney and lower back;-Nurses complete the UTI criteria, contact the physician, and obtain an order for a UA and culture if indicated;-Staff deliver the collected specimen to the laboratory which is down the road;-Nurses obtain the results on the computer system within two to three hours;-Nurses inform the physician of the results and follow orders;-Preliminary culture and sensitivity results are within 24 to 36 hours and the final report within 72 hours;-Staff document notification of the physician in the nurses' notes or messages;-He/she thought the resident's antibiotic should had started before 10 days after the results were obtained. During an interview on 12/19/25, at 12:46 P.M., the DON said the following:-Staff should monitor for signs and symptoms of a UTI which include confusion, falls, pain with urination or a change in frequency;-Staff utilize an infection sepsis screening tool on the work list which is an intervention on the computer;-Nurses enter the symptoms and information on the infection screening tool which informs if criteria for further testing were met and it messages a task system to the provider;-If the infection screening tool shows criteria was met, a UA is ordered at that time;-Nurse enter the UA order and the provider notes it as agreed;-Nursing staff collect the UA and take it to the laboratory which is down the road;-The computer system did not notify the facility easily. Nurses should check the computer;-The laboratory results go to the provider which is in a queue;-The provider should receive it and initiate an order for treatment;-Nurses should communicate in shift report of the UA order and check for any outstanding laboratory reports;-The provider or the nurse can enter the antibiotic order;-The pharmacist looks to see if the antibiotic is correct;-Sometimes staff wait for the culture and sensitivity, but the initial results should return within 24 hours;-A culture and sensitivity can take up to 72 hours, but staff can treat for broad spectrum;-If the culture and sensitivity is not back to show resistant but a resident is symptomatic, staff want to start a treatment;-Nurses should message the physician or nurse practitioner who worked in the facility to determine what treatment until the culture and sensitivity results are received;-The physician ordered the UA for the resident. The administrator checked into this further and the physician was not set up in the system yet, so the physician did not receive the UA results in her queue;-She expected the nurses to monitor for UA results each shift and communicate during shift report. During an interview on 12/22/25, at 11:38 A.M., the physician said nursing staff had a protocol to obtain a UA. Sometimes the laboratory results did not come to her. She was not aware of the resident's 12/09/25 UA results. During an interview on 12/22/25, at 12:57 P.M., the Administrator said she expected staff to notify the provider with laboratory results and obtain the ordered antibiotic timely. The computer system was the fail safe, and it failed them. The computer system was designed to send laboratory results automatically to the provider to order any needed antibiotic. It was not turned on for the physician until Thursday (12/18/25).2. Review of the Cleveland Clinic article Urine Drainage Catheter Bags, dated 05/20/25, showed the following:-Try not to let the catheter bag or openings touch any dirty surfaces;-Do not place the catheter bag on the floor;-Keep the catheter bag below waist or hip when emptying it;-Keep the catheter bag below the bladder when (continued on next page)

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	265545	A. Building B. Wing	12/22/2025

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	walking;-When sleeping, keep the catheter bag below the bladder.Review of Resident #7's quarterly MDS, dated [DATE], showed the following:-Moderately impaired cognition;-Dependent on staff for toileting;-Had an indwelling urinary catheter (tube that drains urine from the bladder) in the bladder;-Diagnoses included renal failure (kidney fail to remove waste and excess fluid) and neurogenic bladder (nerve damage that disrupts bladder control leading to difficulty urinating, leakage (incontinence), and incomplete emptying). Review of the resident's care plan, reviewed 11/21/25, showed the following:-Had a foley catheter related to neurogenic bladder and urinary retention;-Staff to monitor resident for complications of catheter and report to charge nurse;-Change catheter per orders.Review of the resident's physician's order showed an order, dated 03/26/25, for urinary catheter. Staff to insert urinary catheter every 30 days and continue foley catheter care. Review of the resident's progress notes, dated 8/27/25, showed the resident was incontinent of bowel and bladder at this time and had a foley catheter due to diagnosis of neurogenic bladder. Observation on 12/17/25, at 9:03 A.M., showed the resident up in the wheelchair in his/her room and the indwelling urinary catheter bag touched the floor beneath the wheelchair (potentially contaminating the catheter bag/system). Observation on 12/17/25, at 9:41 A.M. showed the following:-Nurse Aide (NA) T brought the sit-to-stand transfer lift (a mechanical lift to assist in transfers) into the resident's room;-The urinary catheter bag touched the floor beneath the wheelchair;-The CNA and NA transferred the resident with the sit-to-stand lift from the wheelchair to the bed. NA T put the catheter bag on the bed when they transferred the resident to the bed;-The CNA and NA removed the resident's pants where the tubing ran down his/her right leg. The resident wore an incontinence brief;-The catheter tubing ran up and over the incontinence brief and a dressing anchor apparatus was attached to the lower abdomen. There was urine was in the tubing from the resident's entry into the body/bladder to the bend in the tubing up on the lower abdomen (resulting in the urine not draining properly);-The CNA and NA did perineal care and attached the catheter bag to the side of the bed. The catheter bag touched the floor;-The CNA and NA removed left the resident's room. Observation on 12/17/25, at 3:40 P.M., showed the following:-CNA P and CNA Q entered the room. The resident's catheter bag touched the floor with urine in the tubing;-CNA Q drained the urine from the catheter into a graduated (measurement) container;-CNA Q noticed the anchor dressing apparatus for the catheter tubing up on the abdomen was loose;-The CNAs removed this anchor apparatus and placed another dressing anchor apparatus on the upper thigh for the catheter tube to run down the resident's pant leg and re-attached the incontinence brief;-The CNAs pulled up the resident's pants, changed his/her shirt, and then transferred the resident with the sit-to-stand lift with the catheter bag to the wheelchair and placed the dignity bag holding the catheter under the wheelchair which touched the floor;-CNA P opened the resident's door and pushed the resident to the dining room in the wheelchair with the bag touching the floor. Observation on 12/18/25, at 9:00 A.M., the resident sat in the wheelchair with urine in the catheter bag tubing under the wheelchair. The catheter bag touched the floor. Observation on 12/18/25, at 12:29 P.M., showed the resident in the wheelchair in the dining room with the catheter bag under the wheelchair. The catheter bag touched the floor. There was urine in the catheter tubing.During interview on 12/19/22 at 2:00 P.M., the DON said when a resident had a urinary catheter, she would expect staff to keep the catheter bag above the floor and not to touch the floor under the wheelchair or while they were in bed. During interview on 12/22/25, at 12:25 P.M., the physician said any urinary catheter bag was not to touch the floor. During interview on 12/22/25 at 12:56 P.M., the Administrator said she would expect the catheter dignity bag not to be on the floor at any time whether under the wheelchair or on the side of the resident's bed.

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	265545	A. Building B. Wing	12/22/2025

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. Based on interview and record review, the facility failed to ensure an effective pain management system was in place when staff failed to accurately assess and document pain levels, failed to document follow-up after a change in pain medication, and failed to update the care plan related to pain for one resident (Resident #80) resulting in the resident having continued pain that affected his/her desire to get out of bed. The facility's census was 95.Review of a facility policy titled Pain Management, dated April 2026, showed the following:-The facility will assist with establishing a mutual plan between caregiver and patient for the control of pain;-Pain will be assessed upon admission, with as needed (PRN) pain medication administration, and documented on a routine basis within the pain assessment intervention or more frequently as appropriate and care planned as appropriate for each individual resident; -Assessment of pain shall include the circumstance of onset, location, description of pain, aggravating factors, intensity on 0 to 10 pain scale, and the patient's individualized pain level goal;-Reassessment of pain shall be completed at appropriate levels not to exceed 60 minutes following pharmacological and non-pharmacological interventions;-Notify the physician for inadequate pain control, a rating of pain for which pain medicine is not ordered, or unacceptable adverse effects;-Develop a plan of care for the resident's pain management and update as needed. 1. Review of Resident #80's face sheet (facility form that shows basic resident information) showed the following:-admission date of 10/14/13-Diagnoses included diabetes (a chronic disease where your body cannot regulate blood sugar) and pneumonia (a lung infection). Review of the resident's quarterly Minimum Data Set (MDS - a federally mandated comprehensive assessment completed by facility staff), dated 11/11/25, showed the following:-Cognitively intact;-Received scheduled pain medication;-Received no non-medical pain interventions;-Pain assessment indicated resident had no pain.Review of the resident's care plan, last reviewed 12/15/25, showed the following:-Potential for pain due to left hip pain, low back pain, and arthritis involving multiple joints on both sides of the body;-Pain assessment interviews every seven days and pain plan every 90 days.(Staff did not document related to non-pharmological pain interventions.) Review of the resident's Physician Orders Sheet (POS), dated 12/17/25, showed the following:-An order, dated 05/06/20, for baclofen (a medication used to treat muscle spasms, cramping, and stiffness) 20 milligrams (mg), by mouth, three times a day;-An order, dated 11/24/20, for Tylenol (a medication used to treat pain or fever) 1,000 mg by mouth every twelve hours; -An order, dated 01/23/24, for gabapentin (a medication used to treat types of nerve pain) 300 mg by mouth three times a day;-An order, dated 02/15/25, for duloxetine (a medication used to treat chronic pain) 60 mg by mouth, twice a day. Review of the resident's nurses' notes, dated 10/01/25 to 12/22/25, showed the following: -A note dated10/29/25, at 3:05 P.M., by the Director of Nursing (DON). The DON called the resident's sister who had expressed concerns with pain control. The DON consulted with the pharmacist and tramadol (used to treat moderate to severe pain) was recommended. The physician was contacted with the new recommendations;-Staff did not document any other notes related to resident's chronic pain. Review of the resident's care plan, last reviewed 12/15/25, showed staff did not update the care plan to reflect the pain concerns and request for new medication. Review of the resident's pain assessment interview, dated 11/03/25, showed the following:-The resident should be assessed for pain;-The resident has not had pain in the last five days;-The resident rarely or not at all experienced pain or hurting over the last five days;-The resident rarely or not at all had trouble sleeping because of pain;-The resident rarely or not at all had limitations to day-to-day activities because of pain over the last five days.(Staff did not address the resident's pain that warranted the request for the tramadol.)Review of the resident's Physician Orders Sheet (POS), dated 12/17/25, showed an order, dated 11/05/25, for tramadol (a medication used to treat pain) 50 mg by mouth as needed three times a day.Review of the resident's pain assessment interviews, dated 11/10/25, 11/17/25, 11/24/25, 12/01/25 and 12/08/25, showed the following:-The resident should be assessed (continued on next page)

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	265545	A. Building B. Wing	12/22/2025

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	for pain;-The resident has not had pain in the last five days;-The resident rarely or not at all experienced pain or hurting over the last five days;-The resident rarely or not at all had trouble sleeping because of pain;-The resident rarely or not at all had limitations to day-to-day activities because of pain over the last five days. Review of the resident's current pain plan, dated 12/08/25, showed the following:-Pain goal of a 0;-Pain scale of 1 to 10;-Medication/interventions included baclofen 20 mg three times a day and Tylenol 1000 mg every 12 hours.(Staff did not document regarding the PRN tramadol.) Review of the resident's pain assessment interview, dated 12/15/25, showed the following:-The resident should be assessed for pain;-The resident has not had pain in the last five days;-The resident rarely or not at all experienced pain or hurting over the last five days;-The resident rarely or not at all had trouble sleeping because of pain;-The resident rarely or not at all had limitations to day-to-day activities because of pain over the last five days. During an interview on 12/15/25, at 2:50 P.M., the resident said the following: -He/she had pain every day in his/her left hip;-The pain ranged from 2 to 5 on a 1 to 10 scale. This day the pain was a 5;-He/she did not like to get out of bed because it hurt to be up in the chair for very long;-He/she tells the nursing staff that he/she is having pain but states they won't give him anything for it;-He/she did not feel like nursing staff was taking his/her pain seriously.During an interview on 12/19/25, at 9:20 A.M., the resident said the following:-He/she had pain at a 2 to 5 level all morning, on a 1 to 10 scale;-He/she was not sure if he/she would get out of bed that day because he/she was scared of making the pain worse;-He/she tells staff what his/her pain is every day;-He/she was not aware of what his/her pain plan said or what was in their care plan. During an interview on 12/17/25, at 12:40 P.M., Certified Medication Technician (CMT) F said the following:-Residents or staff will tell the CMT if they are having pain;-If a resident complains of pain, staff will check their orders and let the nurse know;-Staff will administer PRN medications for pain if staff have an order. If not, staff will let the nurse know;-If a resident was still complaining of pain, staff will tell the nurse. During an interview on 12/19/25, at 10:50 A.M., Certified Nurse Assistant (CNA) E said the following: -The resident complained of pain to his/her left hip and shoulder all the time;-CNA's report the resident's pain to the CMT and the nurse;-He/she has reported the resident's pain to the CMT and to the nurse; -The resident's care plan was in their charting system and the CNA's could review it for information on how to help residents. During an interview on 12/19/25, at 11:10 A.M., Licensed Practical Nurse (LPN) C said the following:-CNAs and CMT's will inform the nurse if a resident was in pain;-Nursing staff will assess the resident's pain and administer medication if necessary;-If a resident's pain was not resolved, nursing staff should notify the provider; -The resident had chronic pain in his/her left hip and frequently told staff he/she was in pain;-Staff have PRN medication they can give him/her if he/she was in pain;-He/she was not sure when the resident last received a PRN pain medication. During an interview on 12/19/25, at 2:40 P.M., the MDS Coordinator said the following:-The resident had chronic pain, and this was included in his/her care plan;-The resident has two interventions in their care plan, the pain plan and weekly pain assessment;-Nursing staff completed the weekly pain assessments;-He/she had no reason to believe the resident's pain plan was not adequate. During an interview on 12/19/25, at 10:00 A.M., the DON said the following: -The resident had chronic pain;-He/she had a meeting with the resident's family over concerns related to the resident's pain;-Nursing staff complete weekly pain assessments on all residents taking pain medication;-These assessments appear on the nurse's worklist, so they are not missed;-MDS is responsible for care planning patient specific pain interventions for residents;-He/she expected the care plan would include non-pharmacological, resident specific goals and interventions;-He/she expected nursing staff to administer PRN medication to a resident who complained of pain and to notify the physician if a resident was having pain that was not relieved by PRN medication;-He/she expected nursing staff to document communication with the provider in the nurses' notes or message to provider task. During an interview on 12/22/25, at 11:38 A.M., the physician said the following:-The resident had chronic pain and several medications to help treat his/her pain;-He/she expected nursing staff to assess (continued on next page)

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	265545	A. Building B. Wing	12/22/2025

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	residents' pain using a pain scale, vital signs, and non-verbal signs of pain, and administer PRN medication based on that assessment;-He/she expected nursing staff to reassess pain after PRN pain medication and non-pharmacological interventions are used;-He/she expected staff to be using non-pharmacological pain interventions based on resident preference and that those would be in the resident's care plan;-He/she would expect to be notified if pain interventions are not working, and the resident was still experiencing pain. During an interview on 12/22/25, at 12:58 P.M., the Administrator said the following:-He/she expected nursing staff to complete pain assessments and reassess after interventions for any residents experiencing pain;-He/she expects nursing staff to document pain interventions used;-He/she would expect nursing staff to communicate with the provider when pain interventions are not effective;-He/she would expect the care plan to be individualized to the resident's pain plan and goals.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. Based on observation, interview, and record review, the facility failed to provide dialysis (the cleaning of the blood with a machine due to the kidneys not working) services per professional standards of practice when the facility failed to obtain an order for dialysis and routine assessment and monitoring of the dialysis site, failed to document ongoing communication with the dialysis center, and failed to provide a lunch meal timely for one resident (Resident #3) who received dialysis. The facility census was 95. Review of the facility's policy titled Assessments in Long Term Care, revised December 2025, showed the following:-Purpose to provide an initial assessment to use as a baseline and provide reassessments as needed if a change is indicated for the patient's response to care, condition changes, and/or diagnosis;-Hemodialysis assessment;-Dialysis communication report sent on dialysis days for center to fill out and return to facility and staff to scan into the electronic medical record (EMR);-Assess for bruit (an audible vascular sound associated with blood flow)/palpate thrill (indicates the fistula is working) at AV (arteriovenous - an abnormal connection between an artery and a vein) shunt site and document assessment in EMR;-Monitor weights and vital signs;-Assess for swelling;-Monitor for fatigue, vomiting, pallor, itching, chest pain, shortness of breath, changes in cognition or abnormalities, and notify provider;-Assessments will be completed according to the standard of care. 1. Review of Resident #3's face sheet (admission data) showed the following:-admission date of 10/20/25;-Diagnoses included end stage renal disease (ESRD-a condition in which the kidneys lose the ability to remove waste and balance fluids). Review of the resident's admission Minimum Data Set (MDS - a federally mandated assessment tool completed by facility staff), dated 10/20/25, showed the following information:-Moderately impaired cognitive skills;-Diagnoses included anemia, heart failure, and hypertension (high blood pressure);-Resident received dialysis.Review of the resident's care plan, last reviewed 12/15/25, showed the following:-The resident had end stage renal failure and went to dialysis every Monday, Wednesday, and Friday at 12:30 P.M.;-Dressing changes completed at the dialysis center every treatment;-Monitor the resident for changes in condition;-Coordinate the resident's transportation to the dialysis center as scheduled and any after care as directed by the dialysis center. (Staff did not care plan related to communication forms to and from the dialysis center, monitoring of the dialysis site, or meal provisions on dialysis days.) Review of the resident's current Physician Order Sheet (POS) showed staff did not document an order, for dialysis and staff did not have an order regarding assessment of the resident's dialysis site. Review of the resident's medical record showed staff did not have documentation of the dialysis communication forms between the facility and the dialysis center since 11/01/25. Staff did not document follow-up contact with the dialysis center after each dialysis visit. Staff did not document related to assessment of dialysis site. During an observation and interview on 12/15/25 at 10:14 A.M., the resident was in his/her bed. The resident said the facility did not send communication forms with him/her to his/her dialysis appointments. During an interview on 12/17/25, at 1:30 P.M., Registered Nurse (RN) A said the following: -The resident went to the dialysis center on Monday, Wednesday, and Fridays for his/her appointments;-The resident had a dialysis packet on the back of his/her chair, and the Director of Nursing (DON) reviewed the communication form before the dialysis appointment;-The resident has a port in his/her right upper chest and the dialysis center changes the dressings at the appointments. During an interview on 12/17/25, at 1:55 P.M., Certified Nurse Aide (CNA) G said staff should provide the resident a meal tray before the dialysis appointment on scheduled days. Today, the resident did not get a meal tray, the resident said he/she was fine with the ensure drink and did not want anything to eat. During an observation and interview on 12/18/25, at 10:58 A.M., the resident was in his/her bed. The resident said he/she would have lunch, but staff never deliver it to him/her in time before the appointment. He/she sometimes did not want to eat but asked if staff could bring the lunch meal early. When the van is ready, then his/her lunch comes. The staff bring him/her an ensure drink, but he/she wants something to eat so (continued on next page)

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	265545	A. Building B. Wing	12/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Citizens Memorial Healthcare Facility	1218 West Locust Bolivar, MO 65613

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	his/her dialysis procedure did not make him/her sick. During an interview on 12/19/25, at 10:22 A.M., Licensed Practical Nurse (LPN) C said the following:-The dialysis center called the facility with any reports of the resident's dialysis appointment. No communication form came back with the resident from the dialysis appointment;-Nurses should check the resident's dialysis site for any discoloration, drainage or discomfort.During an interview on 12/19/25, at 10:13 A.M., Dietary Aide (DA) Z said the following:-There was a list of residents who had doctor appointments/dialysis in the kitchen;-CNA's were responsible to notify the kitchen staff when a resident needed an early meal;-When a resident had an appointment during lunch staff would deliver lunch to that resident as soon as it was prepared;-The resident required lunch early on Monday, Wednesday, and Fridays. Staff should deliver lunch to the resident no later than 11:30 A.M.During an interview on 12/19/25, at 10:39 A.M., the Dietary Director (DD) said the following: -There was a weekly list printed and hung in the kitchen that showed which residents had doctor appointments and required an early meal;-The DD was not aware that the resident required lunch early until 12/17/25;-There was now a sign in the kitchen informing that the resident needed his/her meal tray by 11:00 A.M. on Monday, Wednesday, and Friday.During interviews on 12/19/25, at 1:48 P.M., and on 12/22/25, at 9:33 A.M., the MDS/Care Plan Coordinator said the following: -Staff discuss in morning meetings, by email, or verbally of any needed changes to a resident's care plan;-Staff should check the resident's dialysis site and have lunch before the resident's dialysis appointment and it should be on the care plan;-The resident stated in an interview that he/she was used to skipping lunch on dialysis days and it should be on the care plan;-He/she has called and spoke with the dialysis center manager to request the communication forms;-The communication forms inform staff about how the resident did at the appointment;-The resident takes the communication form and staff call the dialysis center if the form is not returned;-He/she did not see any of the communication forms uploaded in the computer that the facility sends with the resident for appointments During interviews on 12/19/25, at 9:40 A.M. and at 12:46 P.M., the DON said the following:-Nurses should monitor the resident for any change of condition;-Nurses should check the resident's dialysis site in his/her chest for any signs of infection, pain or swelling, and document in the resident's medical record;-There was no order for staff to monitor the resident's dialysis site;-There was no order for the resident's dialysis treatments, but the dialysis appointment days was in the resident's care plan;-Staff send communication forms with the resident to his/her appointments but the dialysis center did not always send the forms back with the resident;-She expected the MDS Coordinators to notify the dialysis center to obtain the communication forms;-She did not have any communication forms since 11/01/25 for the resident;-Staff should communicate with the dietary staff to provide an early lunch tray before the resident's scheduled dialysis appointments;-Dialysis procedure can cause low blood pressure and sugar;-The resident needed adequate nutrition before a scheduled dialysis appointment. During an interview on 12/22/25, at 12:57 P.M., the Administrator said she expected staff to send communication forms for dialysis to the dialysis center. She expected staff to have an order and check the resident's dialysis site and document it in the resident's medical record. She expected staff to deliver lunch to the resident before the dialysis appointments.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, facility failed to ensure the facility maintained a medication administer error rate of less than 5% when staff failed to administer the correct insulin dosage to one resident (Resident #42) and failed to prime the insulin pen prior to use for two resident (Residents #42 and #72), resulting in two error out of 26 opportunities (a medication error rate of 7.69%). The facility census was 95.Review of the facility policy Medication Errors and Near Misses, dated 04/25, showed the following:-A medication error was defined as a preventable event that may cause or lead to inappropriate medication use or patient harm;-Example of medication errors would include wrong dose and omission of ordered medication.Review of the facility policy Medication Administration and Documentation, dated 03/25, showed the following:-For the safety of the resident, the provider will observe the right dose by comparing dosage on medication to dosage on Medication Administration Record (MAR);-Before administration, the licensed professional should check the dose, time, and route of administration;-Do a visual examination of the product to be administered noting particulates or discoloration. Review showed the facility did not provide the policy regarding a protocol for sliding scale insulin which was not included in the physician's orders for residents.Review showed the facility did not provide a policy regarding priming insulin pens. Review of the manufacturer's instructions for the Novolog (rapid acting insulin) Flex pen, showed the following:-Wash hands and gather supplies;-Attach new needle;-Dial the dose selector to two units;-Hold the pen with the needle pointing upwards and gently tap the cartridge holder to move any air bubbles to the top;-Press the push button all the way in until the dose counter shows 0;-A drop of insulin should appear at the needle tip. If no drop appears, repeat this step. 1. Review of Resident #42's quarterly Minimum Data Set (MDS - a federally mandated assessment instrument completed by facility staff), dated 11/26/25, showed the following:-Diagnoses that included diabetes mellitus (high blood glucose);-Medications received the last seven days included insulin. Review of the resident's care plan, reviewed 12/10/25, showed the following:-History of diabetes and takes routine medication;-Sliding scale for insulin administration;-Prefer the physician to be notified if blood sugar reaches a level outside the resident's sliding scale range;-Administer medications as directed by the physician;-Monitor signs and symptoms of hyperglycemia (high blood sugar) and hypoglycemia (low blood sugar);-Accuchecks (device which reads the blood sugar levels) as ordered by the physician. Review of the resident's physician's orders showed the following:-An order, dated 01/21/25, for insulin aspart/Novolog flex pen. Staff to see protocol. Administer subcutaneous (SQ - under the skin) before meals (AC) and at bedtime (HS). (The protocol for sliding scale insulin was not on the physician's orders.)- An order, dated 04/02/25, for insulin aspart/Novolog Flex pen 10 units SQ three times a day (TID) with meals. Observation on 12/17/25, at 11:30 A.M., showed the following:-Licensed Practical Nurse (LPN) D reviewed the insulin order on the computer, noting there were two insulin orders for the Novolog insulin to administer for the noon dose;-LPN D said he/she checked the resident's blood sugar level which was 130 milligrams (mg)/deciliter (dL); -LPN D dialed up 13 units of Novolog insulin with the resident's Novolog flex pen, did not prime the pen, and then administered the 13 units of Novolog insulin in the resident's abdomen. During interview on 12/17/25, at 3:25 P.M., LPN D said the following:-He/she did not look at the resident's physician's orders correctly and read the resident's insulin order wrong on the computer;-The sliding scale level for blood sugar of 130 gm/dl would not have had any extra units of insulin to administer to the resident;-He/she did not prime the resident's Novolog insulin pen before administering the insulin to the resident. Review of the resident's progress notes dated 12/17/25, at 3:37 P.M., showed the following:-The resident's blood sugar at lunch was 130 mg/dL);-Staff administered 13 units of Novolog per Sliding Scale Insulin (SSI) and the scheduled insulin. The resident was only to receive was 10 units per scheduled insulin and no SSI;-Staff notified the resident, nurse practitioner, and Director of Nursing (DON). The resident's blood sugar was (continued on next page)

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	265545	A. Building B. Wing	12/22/2025

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	checked and was 152 mg/dl. 2.Review of Resident #72's quarterly MDS, dated [DATE], showed the following:-Diagnoses included diabetes mellitus;-Medications received the last seven days included insulin. Review of the resident's care plan, reviewed 12/10/25, showed the following:-History of diabetes and takes routine medication;-Administer medications as directed by the physician;-Monitor signs and symptoms of hyperglycemia and hypoglycemia;-Accuchecks as ordered by the physician. Review of the resident's physician's orders, dated 09/08/25, showed an order for insulin aspart/Novolog flex pen 16 units subcutaneously TID with meals for Type 2 diabetes mellitus. Observation on 12/17/25, at 11:26 A.M., showed LPN D took the Novolog insulin pen and dialed up 16 units of the Novolog insulin, did not prime the pen, and administered the insulin in the resident's right arm. During interview on 12/17/25, at 3:25 P.M., LPN D said he/she did not prime the pen by wasting two to three units before dialing up the Novolog insulin pen before administering Novolog insulin 16 units to the resident. 3. During an interview on 12/19/25, at 2:00 P.M., the Director of Nursing (DON) said the following:-The nurse was to read and follow the physician's order for insulin. When administering insulin using the Novolog flex pen, they were to dial two units of insulin to waste before they dial up the units to administer to the resident;-The nurse was to double check orders when there was additional insulin per sliding scale to administer. During interviews on 12/22/25, at 10:45 A.M. and 12:56 P.M., the Administrator said the following:-He/she expected staff to prime the insulin flex pens before administering insulin to the resident;-He/she expected staff to check the sliding scale order for proper dose of insulin based on their blood glucose (sugar) level;-There was no specific policy regarding staff priming the insulin pen before administration. During an interview on 12/22/25, at 12:25 P.M., the physician said she expected staff to prime the insulin pen prior to use. She expected staff to administer the correct amount of insulin.

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	265545	A. Building B. Wing	12/22/2025

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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, facility failed to ensure all residents were free from significant medication errors when staff failed to administer the correct insulin dosage to one resident (Resident #42) and failed to prime the insulin pen prior to use for two resident (Residents #42 and #72). The facility census was 95.Review of the facility policy Medication Errors and Near Misses, dated 04/25, showed the following:-A medication error was defined as a preventable event that may cause or lead to inappropriate medication use or patient harm;-Example of medication errors would include wrong dose and omission of ordered medication.Review of the facility policy Medication Administration and Documentation, dated 03/25, showed the following:-For the safety of the resident, the provider will observe the right dose by comparing dosage on medication to dosage on Medication Administration Record (MAR);-Before administration, the licensed professional should check the dose, time, and route of administration;-Do a visual examination of the product to be administered noting particulates or discoloration. Review showed the facility did not provide the policy regarding a protocol for sliding scale insulin which was not included in the physician's orders for residents.Review showed the facility did not provide a policy regarding priming insulin pens. Review of the manufacturer's instructions for the Novolog (rapid acting insulin) Flex pen, showed the following:-Wash hands and gather supplies;-Attach new needle;-Dial the dose selector to two units;-Hold the pen with the needle pointing upwards and gently tap the cartridge holder to move any air bubbles to the top;-Press the push button all the way in until the dose counter shows 0;-A drop of insulin should appear at the needle tip. If no drop appears, repeat this step. 1. Review of Resident #42's quarterly Minimum Data Set (MDS - a federally mandated assessment instrument completed by facility staff), dated 11/26/25, showed the following:-Diagnoses that included diabetes mellitus (high blood glucose);-Medications received the last seven days included insulin. Review of the resident's care plan, reviewed 12/10/25, showed the following:-History of diabetes and takes routine medication;-Sliding scale for insulin administration;-Prefer the physician to be notified if blood sugar reaches a level outside the resident's sliding scale range;-Administer medications as directed by the physician;-Monitor signs and symptoms of hyperglycemia (high blood sugar) and hypoglycemia (low blood sugar);-Accuchecks (device which reads the blood sugar levels) as ordered by the physician. Review of the resident's physician's orders showed the following:-An order, dated 01/21/25, for insulin aspart/Novolog flex pen. Staff to see protocol. Administer subcutaneous (SQ - under the skin) before meals (AC) and at bedtime (HS). (The protocol for sliding scale insulin was not on the physician's orders.)- An order, dated 04/02/25, for insulin aspart/Novolog Flex pen 10 units SQ three times a day (TID) with meals. Observation on 12/17/25, at 11:30 A.M., showed the following:-Licensed Practical Nurse (LPN) D reviewed the insulin order on the computer, noting there were two insulin orders for the Novolog insulin to administer for the noon dose;-LPN D said he/she checked the resident's blood sugar level which was 130 milligrams (mg)/deciliter (dL); -LPN D dialed up 13 units of Novolog insulin with the resident's Novolog flex pen, did not prime the pen, and then administered the 13 units of Novolog insulin in the resident's abdomen. During interview on 12/17/25, at 3:25 P.M., LPN D said the following:-He/she did not look at the resident's physician's orders correctly and read the resident's insulin order wrong on the computer;-The sliding scale level for blood sugar of 130 gm/dl would not have had any extra units of insulin to administer to the resident;-He/she did not prime the resident's Novolog insulin pen before administering the insulin to the resident. Review of the resident's progress notes dated 12/17/25, at 3:37 P.M., showed the following:-The resident's blood sugar at lunch was 130 mg/dL);-Staff administered 13 units of Novolog per Sliding Scale Insulin (SSI) and the scheduled insulin. The resident was only to receive was 10 units per scheduled insulin and no SSI;-Staff notified the resident, nurse practitioner, and Director of Nursing (DON). The resident's blood sugar was checked and was 152 mg/dl. 2.Review of Resident #72's (continued on next page)

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	265545	A. Building B. Wing	12/22/2025

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	quarterly MDS, dated [DATE], showed the following:-Diagnoses included diabetes mellitus;-Medications received the last seven days included insulin. Review of the resident's care plan, reviewed 12/10/25, showed the following:-History of diabetes and takes routine medication;-Administer medications as directed by the physician;-Monitor signs and symptoms of hyperglycemia and hypoglycemia;-Accuchecks as ordered by the physician. Review of the resident's physician's orders, dated 09/08/25, showed an order for insulin aspart/Novolog flex pen 16 units subcutaneously TID with meals for Type 2 diabetes mellitus. Observation on 12/17/25, at 11:26 A.M., showed LPN D took the Novolog insulin pen and dialed up 16 units of the Novolog insulin, did not prime the pen, and administered the insulin in the resident's right arm. During interview on 12/17/25, at 3:25 P.M., LPN D said he/she did not prime the pen by wasting two to three units before dialing up the Novolog insulin pen before administering Novolog insulin 16 units to the resident. 3. During an interview on 12/19/25, at 2:00 P.M., the Director of Nursing (DON) said the following:-The nurse was to read and follow the physician's order for insulin. When administering insulin using the Novolog flex pen, they were to dial two units of insulin to waste before they dial up the units to administer to the resident;-The nurse was to double check orders when there was additional insulin per sliding scale to administer. During interviews on 12/22/25, at 10:45 A.M. and 12:56 P.M., the Administrator said the following:-He/she expected staff to prime the insulin flex pens before administering insulin to the resident;-He/she expected staff to check the sliding scale order for proper dose of insulin based on their blood glucose (sugar) level;-There was no specific policy regarding staff priming the insulin pen before administration. During an interview on 12/22/25, at 12:25 P.M., the physician said she expected staff to prime the insulin pen prior to use. She expected staff to administer the correct amount of insulin.