STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265547	A. Building B. Wing	03/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Greenville Health Care Center	117 Sycamore Street Greenville, MO 63944

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. 45872 Based on interview and record review, the facility failed to follow physician's orders for one resident (Resident #20) out of 15 sampled residents and one resident (Resident #25) outside the sample. The facility's census was 57. Review of the facility's policy titled, Transcription of Orders/Following Physician's Orders, last reviewed May 2024, showed: -The purpose of this policy is to outline procedures in accurately transcribing physician's orders and to ensure that all physicians' orders are followed. To ensure a process is in place to monitor nurses in accurately transcribing and following physician's orders; - Upon receiving a physician's order via telephone, fax, written order, verbal order, transcribed order or other, it will be documented in residents' electronic medical records in orders section; - The Nurse or Certified Medication Technician (CMT) in charge of medication administration must review all their designated Medication Administration Record (MAR) and Treatment Administration Record (TAR) prior to the end of their shift to ensure that all medications/treatments scheduled to be given on their shift were administered according to physicians' orders and that all necessary interventions were taken in the event of an omission. Review of the facility's policy titled, Administration of Insulin Policy, last reviewed May 2024, showed: - It is the policy of this facility to provide timely administration of insulin in order to meet the needs of each resident and to prevent adverse effects on a resident's condition; - All insulin will be administered in accordance with physician's orders; - Insulin administration will be coordinated with mealtimes and bedtime snacks unless otherwise specified in the physician order; - Monitor blood sugar as ordered by the physician. Review of the facility's policy titled, Blood Glucose Monitoring Policy, last reviewed June 2024, showed: (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: 265547	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/21/2025
NAME OF PROVIDER OR SUPPLIER Greenville Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 117 Sycamore Street Greenville, MO 63944	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- It is the policy of this facility to perform blood glucose monitoring to diabetic residents as per physician's orders. 1. Review of Resident #20's March 2025 Physician's Order Sheet (POS), showed: - Diagnoses of diabetes mellitus (elevated levels of glucose in the blood), acute hepatitis C (inflammation of the liver caused by infection) and schizophrenia (significant disruptions in thought processes, perceptions, emotions, and behaviors); - An order for Novolog (fast-acting insulin) per sliding scale if blood sugar (BS) 151-200= 3 units, 201-250=6 units, 251-300=9 units; 301-350=12 units, 351-400=15 units, over 400 call the physician, subcutaneously (injection under the skin) before meals and bedtime, dated 01/20/22; - An order for Novolog 7 units subcutaneously three times a day, dated 05/19/21. Observation of the resident's medication administration on 03/19/25 at 8:23 A.M., showed: - The resident finished breakfast; - Licensed Practical Nurse (LPN) G did not check the resident's BS and did not administer the sliding scale Novolog insulin; - LPN G administered Novolog 7 units subcutaneously; - LPN G failed to check the resident's BS before administering insulin as ordered; - LPN G failed to administer the resident's insulin before breakfast as ordered. 2. Review of Resident #25's March 2025 POS, showed: - Diagnoses of diabetes mellitus, chronic obstructive pulmonary disease (COPD- persistent airflow obstruction and chronic inflammation of the airways and lungs), major depressive disorder (persistent feelings of sadness, hopelessness, and loss of interest or pleasure in activities), and anxiety; - An order for insulin lispro (Humalog - a fast-acting insulin) per sliding scale if BS 150-200=2 units; 201-250=3 units; 251-300=6 units; 301-250=9 units; 351-400=12 units; 401-450=15 units, over 450 call the physician, subcutaneously four times a day, dated 11/21/2024. Observation of the resident's medication administration on 03/19/25 at 8:37 A.M., showed: - LPN G did not check the resident's BS; - LPN G administered Humalog 3 units subcutaneously; - LPN G failed to check the resident's BS before administering insulin as ordered. During an interview on 03/19/25 at 8:23 A.M., LPN G said he/she did not perform the glucose monitoring for Resident #20 and Resident #25 prior to administering the insulin as ordered. (continued on next page)

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	265547	A. Building B. Wing	03/21/2025

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 03/21/25 at 9:00 A.M., LPN A said he/she would check the resident's BS 30 minutes before the fast-acting insulin was administered as ordered. During an interview on 03/21/25 at 9:05 A.M., the Director of Nursing (DON) said physician orders should be followed. Blood sugars should be checked prior to administering insulin as ordered. During an interview on 03/21/25 at 3:27 P.M., the Administrator said he/she would expect nurses and staff to follow physician orders. Staff should obtain BS and then administer insulin as ordered.

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F 0689

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.

45872

Based on observation, interview, and record review, the facility failed to provide protective oversight when facility staff left the medication carts unattended and unlocked on three separate occasions. This had the potential to affect all residents in the facility. The facility census was 57.

Review of the facility's policy titled, Medication Storage Policy, last reviewed May 2024, showed:

- It is the policy of this facility to ensure all medications housed on our premises will be stored in the medication rooms according to the manufacturer's recommendations and sufficient to ensure proper sanitation, temperature, light, ventilation, moisture control, segregation, and security;

- All drugs and biologicals will be stored in locked compartments (i.e. medication carts, cabinets, drawers, refrigerators, medication rooms) under proper temperature controls;

- Only authorized personnel will have access to the keys to locked compartments;

- During a medication pass, medications must be under the direct observation of the person administering medications or locked in the medication storage area/cart;

- Schedule II (medications with a high potential of abuse) drugs and back-up stock of Schedule III (medications with a moderate to low potential of abuse), Schedule IV (medications with a low potential of abuse), and Schedule V (medications with a lower potential of abuse than Schedule IV medications) medications are stored under double-lock and key.

1. Observation on 03/19/25 at 8:21 A.M., showed:

- Licensed Practical Nurse (LPN) G left the unlocked and unattended medication cart for two minutes;

- A resident paced in front of and around the unlocked medication cart.

2. Observation on 03/19/25 at 8:37 A.M. showed:

- LPN G left the unlocked and unattended medication cart, left the keys to the narcotic box on top of the medication cart, and left the bottom drawer of the cart partially open;

- Two residents in the hallway near the unlocked and unattended medication cart.

3. Observation on 03/21/25 at 8:07 A.M., showed:

- The unlocked and unattended medication cart sat near the nurses' station;

- Two residents and several staff were near and around the unlocked and unattended cart;

(continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- At 8:08 A.M., Certified Medication Technician (CMT) D walked up to the unlocked cart, locked it, and took it into the medication stock room. During an interview on 03/21/25 at 8:10 A.M., CMT D said he/she should have locked the medication cart before walking away from it. During an interview on 03/21/25 at 9:00 A.M., LPN A said medication carts and keys should be secured before walking away from medication cart. During an interview on 03/21/25 at 9:25 A.M., the Director of Nursing (DON) said medication carts should never be left unattended and unlocked. He/she expected staff to keep keys out of reach of the residents. During an interview on 03/21/25 at 3:28 P.M., the Administrator said staff should never leave a medication cart unlocked and unattended.

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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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26904 Based on interview and record review, the facility failed to provide documentation of ongoing assessments, monitoring, and communication between the facility and the dialysis (a process for removing waste and excess water from the blood) center for one resident (Resident #51) out of one sampled resident. The facility census was 57. Review of the facility's policy titled, Dialysis, revised 03/18/22, showed: - Ensure that residents who require dialysis and such services as ordered by the physician; - The facility will ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences; - The facility will ensure that each resident receives care and services for the provision of hemodialysis (a procedure that acts as an artificial kidney, filtering blood to remove waste and excess fluid when the kidneys cannot) and/or peritoneal (lining of the the stomach) dialysis consistent with professional standards of practices including the: 1. Ongoing assessment of the resident's condition and monitoring for complications before and after dialysis treatment received at a certified dialysis facility; 2. Ensure the resident has transportation to and from an off-site certified dialysis facility for dialysis treatments; 3. Ongoing assessments and oversight of the resident before and after dialysis treatments; 4. Ongoing communication and collaboration with dialysis clinic, regarding dialysis care and services. 1. Review of Resident #51's medical record showed: - admitted on [DATE]; - Diagnoses of end stage renal disease (the kidneys can no longer adequately filter waste and excess fluid from the blood) and dependence on renal dialysis (relying on a machine to filter the blood and remove waste due to kidney failure), dated 02/11/25. Review of the resident's March 2025 Physician's Order Sheet (POS), showed: - Renal (kidney) diet, regular texture, thin/regular consistency, dated 02/12/25; - Cover the dialysis port (soft tubes used to allow blood to travel through the dialysis machine where it is cleaned as it passes through a special filter) to the left upper arm with a large border gauze every day, dated 02/11/25; (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- An order for acetaminophen (medication used to treat minor aches and pain) tablet 325 milligram (mg) two tablets by mouth every Monday, Wednesday and Friday for pain before leaving for dialysis, dated 03/12/25; - An order for Lidocaine-Prilocaine (a numbing medication) External Cream 2.5-2.5 % apply to the area of the dialysis port topically every day shift every Monday, Wednesday, and Friday for dialysis. Apply to the length of the dialysis access 45 to 60 minutes prior to dialysis, dated 03/12/25; - No order for dialysis. Review of the resident's Progress Note, dated 03/19/25, showed: - The resident received dialysis on Monday, Wednesday and Friday. Review of the resident's Care Plan, revised 02/12/25, showed: - Renal diet with regular texture and thin liquids; - Dialysis due to renal failure; - Renal insufficiency related to kidney disease end stage. Review of the resident's Dialysis Communication Log showed: - The facility did not have a communication log between the dialysis center and the facility for the resident. Observation on 03/18/25 at 9:38 A.M., and 03/19/25 at 12:23 P.M., of a note posted on the kitchen wall showed: - Resident #51 needed to eat early or have a lunched packed on Tuesdays, Thursdays and Saturdays. During an interview on 03/19/25 12:18 P.M., the Business Office Manager (BOM) said he/she was the temporary administrator at the time the resident was admitted . He/She was not aware of a communication log between the facility and the dialysis facility. During an interview on 03/19/25 at 3:35 P.M., the Minimum Data Set (MDS - a federally mandated assessment instrument completed by the facility staff) Coordinator said he/she knew the resident had an order for dialysis when the resident was admitted . The facility had trouble getting transportation for Tuesday, Thursday and Saturday, so the order was probably discontinued, and did not get put back on the resident's POS for dialysis to be on Monday, Wednesday and Friday. During an interview on 03/20/25 at 2:05 P.M., Licensed Practical Nurse (LPN) A said the facility did what was ordered prior to dialysis such as the Lidocaine cream and the ordered acetaminophen. If the resident required a snack taken with them to dialysis, the dietary staff provided the snack. The facility did not perform any vital signs or anything else prior to the resident going to dialysis. The facility did not send any documentation with the resident to dialysis. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 03/21/25 at 2:15 P.M., the Assistant Director of Nursing (ADON) said she thought the dialysis was on the resident's POS. Dialysis was supposed to be sending the facility documentation to the facility, however the facility had not received any documentation. During an interview on 03/21/25 at 3:31 P.M., the Administrator said there should be an order for dialysis. She was not here when the resident was admitted , but there should always be an order for dialysis. There should be a communication log showing the communication between the dialysis center and the facility.

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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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 48532 Based on interview and record review, the facility failed to ensure staff reconciled narcotics (a process that allows one staff to reconcile the exact narcotic inventory on hand with another staff) at each shift change for three out of three sampled medication carts. This practice had the potential to affect all residents. The facility census was 57. Review of the facility's policy titled, Controlled Substance Administration and Accountability Policy, last reviewed 05/14/24, showed: - The charge nurse or other designee conducts a daily visual audit of the required documentation of controlled substances. Spot checks are performed to verify; - Inventory verification: for areas without automated dispensing systems, two licensed nurses account for all controlled substances and access keys at the end of each shift. 1. Review of the 100/200/400 Hall Medication Cart Narcotic Count Log for Controlled Substances showed: - For day/evening/night shifts for 12/27/24 - 01/17/25, 57 missed out of 88 opportunities to reconcile the narcotic counts; - For day/evening/night shifts for 01/18/25 - 02/12/25, 76 missed out of 104 opportunities to reconcile the narcotic counts; - For day/evening/night shifts for 02/13/25 - 03/05/25, no documentation of the Narcotic Count Log with 132 missed out of 132 opportunities to reconcile the narcotic counts; - For day/evening/night shifts for 03/06/25 - 03/21/25, 49 missed out of 60 opportunities to reconcile the narcotic counts. 2. Review of the 300 Hall Medication Cart Narcotic Count Log for Controlled Substances showed: - For day/evening/night shifts for 12/27/24 - 01/17/25, 59 missed out of 88 opportunities to reconcile the narcotic counts; - For day/evening/night shifts for 01/18/25 - 02/08/25, 50 missed out of 88 opportunities to reconcile the narcotic counts; - For day/evening/night shifts for 02/09/25 - 02/12/25, no documentation of the Narcotic Count Log with 16 missed out of 16 opportunities to reconcile the narcotic counts; - For day/evening/night shifts for 02/13/25 - 03/06/25, 54 missed out of 88 opportunities to reconcile the narcotic counts; (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- For day/evening/night shifts for 03/07/25 - 03/21/25, 37 missed out of 58 opportunities to reconcile the narcotic counts. 3. Review of the Nurses' Treatment Medication Cart Narcotic Count Log for Controlled Substances showed: - For 6 A.M. - 6 P.M. shift for 01/01/25-01/31/25, 31 missed out of 122 opportunities to reconcile the narcotic counts; - For 6 A.M. - 6 P.M. shift for 02/01/25-02/28/25, 16 missed out of 112 opportunities to reconcile the narcotic counts; - For 6 A.M. - 6 P.M. shift for 03/01/25-03/21/25, 16 missed out of 82 opportunities to reconcile the narcotic counts. During an interview on 03/21/25 at 9:44 A.M., Certified Medication Technician (CMT) D said he/she counted the narcotics when on-coming and off-going each shift. During an interview on 03/21/25 at 9:45 A.M., Licensed Practical Nurse (LPN) A said two nurses counted the narcotics on the nurses' medication/treatment cart at the beginning and end of each shift. During an interview on 03/21/25 at 9:50 A.M., the Director of Nursing (DON) said the off-going and on-coming staff should count the narcotics on each cart after each shift. During an interview on 03/21/25 at 3:26 P.M., the Administrator said the narcotics should be counted with two staff members, the on-coming and off-going staff, for each shift.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. 26904 Based on interview and record review, the facility staff failed to ensure that as needed (PRN) orders for antipsychotic (medications that treat psychotic disorders) medications were limited to 14 days for one resident (Resident #46) of five sampled residents. The facility census was 57. Review of the facility's policy titled, Use of Psychotropic (medications that affect the mind, emotions, and behavior) Medication Policy, dated 06/26/24, showed: - PRN orders for all psychotropic medications shall be used only when the medication is necessary to treat a diagnosed specific condition that is documented in the clinical record and for a limited duration (14 days); - If the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond the 14 days, he/she shall document their rationale in the resident's medical record and indicate the duration for the PRN order. 1. Review of Resident #46's medical record showed: - A diagnosis of anxiety (an intense, excessive, and persistent worry and fear about everyday situations); - An order for haloperidol (an antipsychotic medication) 5 milligram (mg) by mouth every 12 hours PRN for anxiety and agitation, dated 12/21/24; - The haloperidol order did not indicate the duration for the PRN order; - The prescribing practitioner did not document the appropriateness for the PRN antipsychotic medication to be extended beyond 14 days and did not document the duration for the PRN order. Review of the resident's haloperidol PRN Medication Administration Records (MARs) showed: - For January 2025, the resident received the medication five times; - For February 2025, the resident received the medication eight times; - For March 2025, the medication was discontinued on 03/04/25. Review of the resident's Monthly Medication Regimens (MMRs) showed: - On 01/10/25, and on 02/09/25, the Pharmacist recommended a review of the psychotropic haloperidol PRN order(s) for addition of a stop date (14 days) or have the physician or psychiatry provide a progress note for the continued use. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 03/21/25 at 2:20 P.M., the Assistant Director of Nursing (DON) said she was responsible for retrieving the pharmacy recommendations. Once she received the recommendations, if it needs a physician's order, then she contacted the primary care physician (PCP) and received the orders. The physician order should link with the recommendation if there a new order was written. She did not know how she missed this particular recommendation. There should be a 14 day stop date for PRN medications. During an interview on 03/21/25 at 2:23 P.M., the Director Of Nursing (DON) said she knew the psychiatric physician always put a 14 stop date on the PRN medications. She thought all of the PRN medications should be written that way.

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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. 48532 Based on observation, interview, and record review, the facility failed to maintain a medication error rate of less than five percent (%). There were 38 opportunities with five errors made, resulting in an error rate of 13. 15% for two residents (Residents #20 and #25) out of four sampled residents. The facility's census was 57. Review of the facility's policy titled, Administration of Insulin Policy, last reviewed May 2024, showed: - It is the policy of this facility to provide timely administration of insulin in order to meet the needs of each resident and to prevent adverse effects on a resident's condition; - All insulin will be administered in accordance with physician's orders; - Insulin administration will be coordinated with mealtimes and bedtime snacks unless otherwise specified in the physician order; - Monitor blood sugar as ordered by the physician. Review of the facility's policy titled, Blood Glucose Monitoring Policy, last reviewed June 2024, showed: - It is the policy of this facility to perform blood glucose monitoring to diabetic residents as per physician's orders. 1. Review of Resident #20's March 2025 Physician's Order Sheet (POS), showed: - Diagnosis of diabetes mellitus (elevated levels of glucose in the blood); - An order for Novolog (fast-acting insulin) per sliding scale if blood sugar (BS) 151-200= 3 units, 201-250=6 units, 251-300=9 units; 301-350=12 units, 351-400=15 units, over 400 call the physician, subcutaneously (injection under the skin) before meals and bedtime, dated 01/20/22; - An order for Novolog 7 units subcutaneously three times a day, dated 05/19/21. Review of the resident's Medication Administration Record (MAR), dated March 2025, showed: - On 03/18/25 at 5:00 A.M., the night nurse documented the glucose reading as 147. At 7:00 A.M., Licensed Practical Nurse (LPN) G documented the glucose reading as 147; - On 03/19/25 at 5:00 A.M., the night nurse documented the glucose reading as 150. At 7:00 A.M., LPN G documented the glucose reading as 150; - On 03/20/25 at 5:00 A.M., the night nurse documented the glucose reading as 187. At 7:00 A.M., LPN G documented the glucose reading as 187. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Greenville Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 117 Sycamore Street Greenville, MO 63944	

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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation of the resident's medication administration on 03/19/25 at 8:23 A.M., showed: - The resident finished breakfast; - LPN G did not check the resident's BS; - LPN G administered Novolog 7 units subcutaneously for a BS of 150 received at 5:00 A.M.; - LPN G failed to check the resident's BS, failed to administer the correct dose of insulin, and failed to administer the insulin before the resident ate breakfast as ordered. 2. Review of Resident #25's POS, dated March 2025, showed: - Diagnosis of diabetes mellitus; - An order for insulin lispro (Humalog - a fast-acting insulin) per sliding scale if BS 150-200=2 units; 201-250=3 units; 251-300=6 units; 301-250=9 units; 351-400=12 units; 401-450=15 units, over 450 call the physician, subcutaneously four times a day, dated 11/21/2024. Review of the resident's MAR, dated March 2025, showed: - On 03/18/25 at 5:00 A.M., the night nurse documented the glucose reading as 203. At 7:00 A.M., LPN G documented the glucose reading as 203; - On 03/19/25 at 5:00 A.M., the night nurse documented the glucose reading as 235. At 7:00 A.M., LPN G documented the glucose reading as 235; - On 03/20/25 at 5:00 A.M., the night nurse documented the glucose reading as 241. At 8:00 A.M., LPN G documented the glucose reading as 241. Observation of the resident's medication administration on 03/19/25 at 8:37 A.M., showed: - LPN G did not check the resident's BS; - LPN G administered Humalog 3 units subcutaneously per the sliding scale for a BS of 235 that was taken at 5:00 A.M.; - LPN G failed to check the resident's BS, and failed to administer the correct dose of insulin. During an interview on 03/19/25 at 8:23 A.M., LPN G said he/she did not perform the glucose monitoring for Resident #20 and Resident #25 prior to administering the insulin as ordered. The BS readings for the residents were obtained at 5:00 A.M., by the night nurse. He/She used those BS readings to administer the insulin to the residents during their medication pass. During an interview on 03/21/25 at 8:10 A.M., Certified Medication Technician (CMT) D said BS were checked again for the sliding scale insulins. BS were checked at 5:00 A.M., for the long-acting insulin administration. Fast-acting insulin should be administered 30 minutes before each meal if ordered that way. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 03/21/25 at 9:00 A.M., LPN A said he/she would check the resident's BS 30 minutes before the fast-acting insulin was administered. LPN A said he/she always verified insulin was administered prior to the resident eating breakfast if it was ordered that way. LPN A would not administer fast-acting insulin off of a 5:00 A.M. BS reading. During an interview on 03/21/25 at 9:05 A.M., the Director of Nursing (DON) said blood sugars should be checked prior to administering insulin. It was not appropriate to use a glucose reading from two or more hours prior to administering the insulin. During an interview on 03/21/25 at 3:27 P.M., the Administrator said he/she would expect nurses and staff to obtain BS and then administer insulin.

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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** 45872 Based on observation, interview, and record review, the facility failed to ensure that two residents (Residents #20 and #25) out of two sampled residents were free from significant medication errors when staff did not check blood sugars prior to administering insulin (a medication that regulates blood sugar levels). The facility's census was 57. Review of the facility's policy titled, Administration of Insulin Policy, last reviewed May 2024, showed: - It is the policy of this facility to provide timely administration of insulin in order to meet the needs of each resident and to prevent adverse effects on a resident's condition; - All insulin will be administered in accordance with physician's orders; - Insulin administration will be coordinated with mealtimes and bedtime snacks unless otherwise specified in the physician order; - Monitor blood sugar as ordered by the physician. Review of the facility's policy titled, Blood Glucose Monitoring Policy, last reviewed June 2024, showed: - It is the policy of this facility to perform blood glucose monitoring to diabetic residents as per physician's orders. 1. Review of Resident #20's March 2025 Physician's Order Sheet (POS) showed: - admitted [DATE]; - Diagnosis of diabetes mellitus (elevated levels of glucose in the blood); - An order for Novolog (fast-acting insulin) per sliding scale if blood sugar (BS) 151-200= 3 units, 201-250=6 units, 251-300=9 units; 301-350=12 units, 351-400=15 units, over 400 call the physician, subcutaneously (injection under the skin) before meals and bedtime, dated 01/20/22; - An order for Novolog 7 units subcutaneously three times a day, dated 05/19/21; - An order for Tresiba (long-acting insulin) FlexTouch Pen 25 units subcutaneously in the morning, dated 06/13/24; - An order for metformin (diabetic medication) 1,000 milligrams (mg) by mouth twice daily, dated 5/19/21. Observation of the resident's medication administration on 03/19/25 at 8:23 A.M., showed: (continued on next page)

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NAME OF PROVIDER OR SUPPLIER: Greenville Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 117 Sycamore Street Greenville, MO 63944	

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Licensed Practical Nurse (LPN) G did not check the resident's BS; - LPN G administered Novolog 7 units subcutaneously; - LPN G failed to check the resident's blood sugar prior to the administration of the insulin. 2. Record review of Resident #25's POS, dated March 2024, showed: - admitted [DATE]; - Diagnosis of diabetes mellitus; - An order for Lantus (long-acting insulin) 30 units in the morning subcutaneously, dated 11/20/24; - An order for Lantus 45 units at bedtime subcutaneously, dated 11/20/23; - An order for insulin lispro (Humalog - a fast-acting insulin) per sliding scale if BS 150-200=2 units; 201-250=3 units; 251-300=6 units; 301-250=9 units; 351-400=12 units; 401-450=15 units, over 450 call the physician, subcutaneously four times a day, dated 11/21/2024. Observation of the resident's medication administration on 03/19/25 at 8:37 A.M., showed: - LPN G did not check the resident's BS; - LPN G administered Humalog 3 units subcutaneously; - LPN G failed to check the resident's blood sugar prior to the administration of the insulin. During an interview on 03/19/25 at 8:23 A.M., LPN G said he/she did not perform the glucose monitoring for Resident #20 and Resident #25 prior to administering the insulin as ordered. During an interview on 03/21/25 at 9:00 A.M., LPN A said he/she would check the resident's BS 30 minutes before the fast-acting insulin was administered. During an interview on 03/21/25 at 9:05 A.M., the Director of Nursing (DON) said blood sugars should be checked prior to administering insulin. During an interview on 03/21/25 at 3:27 P.M., the Administrator said he/she would expect nurses and staff to obtain BS and then administer insulin.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26904 Based on observation, interview, and record review, the facility failed to implement Enhanced Barrier Precautions (EBP) during urinary catheter (a flexible tube placed in the body to drain and collect urine) care for two residents (Residents #2 and #56) out of two sampled residents. The facility failed to put interventions in place to ensure the facility's Legionella (a type of bacteria that can cause serious lung infection) testing was completed in a timely manner. The facility census was 57. Review of the facility's policy titled, Enhanced Barrier Precautions, last reviewed 05/18/24, showed: - EBP of gown and gloves must be used for high-contact resident care activities for residents with any of the following: infection or colonization with a Centers for Medicare and Medicaid (CDC)-targeted multidrug-resistant organism (MDRO) when contact precautions do not otherwise apply; or wounds and/or indwelling medical devices even if the resident is not known to be infected or colonized with a MDRO; - High-contact resident care activities include, but are not limited to, dressing, bathing/showering, transferring, providing hygiene, changing linens, changing briefs or assisting with toileting, indwelling device care or use, or wound care; - Wounds that require EBP are chronic wounds, including, but not limited to pressure ulcers (a localized area of skin damage that develops when prolonged pressure is applied to a specific area of the body), diabetic foot ulcers, unhealed surgical wounds, and venous stasis (a chronic wound on the lower leg that develops due to impaired blood flow in the veins, leading to blood pooling and tissue breakdown) ulcers. These are wounds that generally require a dressing. Any wound care requires EBP; - Indwelling medical devices include, but are not limited to, central lines, urinary catheters, feeding tubes, and tracheostomies; - Make gowns and gloves available immediately near or outside of the resident's room; - Ensure access to alcohol-based hand rub in every resident room (ideally both inside and outside of the room); - Position a trash can inside the resident room and near the exit for discarding personal protective equipment (PPE) after removal, prior to exit of the room, or before providing care for another resident in the same room. Review of the facility's policy titled, Legionella Surveillance Policy, last reviewed June 2024, showed: - It is the policy of this facility to establish primary and secondary strategies for the prevention and control of Legionella infections; (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	- Legionella surveillance is one component of the facility's water management plans for reducing the risk of Legionella and other opportunistic pathogens in the facility's water systems; - Primary prevention strategies: diagnostic testing and investigation for the source of Legionella. For diagnostic testing, the facility shall use McGreer criteria (designed to identify and track health-associated infections in long-term care facilities) when diagnosing pneumonia; residents with health-care associated pneumonia or who have failed antibiotic therapy for community-acquired pneumonia shall be tested for Legionella using both culture of lower respiratory secretions and the Legionella urinary antigen test. For the investigation for a facility source of Legionella, this may include culturing of the facility water for Legionella. 1. Observation on 03/20/25 at 9:50 A.M., of Resident #56's wound care showed: - No EBP signage posted or PPE outside of the resident's room; - Licensed Practical Nurse (LPN) A did not put on an isolation gown and entered the resident's room; - LPN A performed the wound dressing; - LPN A removed the gloves, performed hand hygiene, and exited the room. 2. Observation on 03/20/25 at 11:05 A.M. of Resident #2's catheter care showed: - No EBP signage posted outside of the resident's room; - Certified Nurse Aide (CNA) E and CNA F did not put on an isolation gown and entered the resident's room; - CNA E performed the resident's catheter care; - CNA E removed the gloves, did not perform hand hygiene, and put on clean gloves; - CNA E and CNA F rolled the resident from side to side and placed clean pants and a Hoyer (a mechanical device used to safely transfer individuals with limited mobility) sling under the resident; - CNA E and CNA F removed the gloves, did not perform hand hygiene, gathered the trash, and exited the resident's room; - CNA F assisted the resident to the main dining room. 3. Observation on 03/21/25 at 10:44 A.M., of Resident #56's catheter care showed: - No EBP signage posted outside of the resident's room; - CNA B and CNA C did not put on an isolation gown and entered the resident's room; - CNA B performed the resident's catheter care; (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	- CNA B and CNA C removed the gloves, performed hand hygiene, gathered the trash, and exited the residents room. During an interview on 03/21/25 at 2:07 P.M., CNA B said he/she did not know what EBP was and had not had any training on EBP. During an interview on 03/21/25 at 2:08 P.M., CNA C said he/she was not aware of EBP and had not had any training on EBP. During an interview on 03/21/25 at 2:20 P.M., the Infection Preventionist (IP) said he/she just received information from corporate to implement EBP last week. He/She had not provided education to the staff yet. The IP had completed the corporate-wide training last week. During an interview on 03/21/25 at 2:26 P.M., the Regional Director of Operations said he/she just had a meeting about EPB corporate wide several weeks ago. The training information went out to the facilities on 03/07/25. He/She expected for EBP to be implemented throughout the facilities. Residents with chronic wounds and indwelling medical devices should have EBP. Corporate had ordered magnets for the resident doorframes and the CDC guideline sheets were being used for now. The PPE cart should be outside the residents' doors of who were on EBP. The cart should have gloves, gowns, masks, and hand sanitizer for use. 4. Review of the facility's Legionella results, dated 02/10/25, showed: - Sampled potable (drinkable) water collected on 12/23/24; - Sampled potable water received on 12/24/24; - Sampled potable water processed on 12/24/24; - Sampled potable water analyzed on 01/06/25; - Facility received the laboratory results on 02/10/25; - Legionella identified in the central bath, bath house west, room [ROOM NUMBER], room [ROOM NUMBER], and room [ROOM NUMBER]. Review of the corporate maintenance supervisor's email, dated 02/28/25 at 10:03 A.M., showed: - A list of the specific items that needed to be ordered to complete the Legionella retesting at the facility; - Did not address any specific instructions for the facility retesting for Legionella. During an interview on 03/21/25 at 10:16 A.M., the Administrator said she took the Administrator position for the facility on 03/01/25. This was the first she had been made aware of the Legionella report. She had never seen the lab results or its findings until it was brought to her attention on 03/21/25. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 03/21/25 at 10:30 A.M., the Maintenance Supervisor did not have a contact person, nor did he/she speak with a representative from the lab company regarding the lab results. He/She received the Legionella report from the previous acting Administrator sometime in February. There were no instructions in the email, dated 02/28/25, from the testing company. He/She contacted the corporate maintenance director and was not offered any guidance or instructions on what to do next after the lab results were received. During an interview on 03/21/25 at 10:48 A.M. and 2:14 P.M., the Business Office Manager (BOM) said he/she was the acting Administrator at the time the facility received the laboratory results for the Legionella testing. A couple of days after receiving the lab results, he/she contacted the city office and was prompted to contact the local health department. The local health department was contacted and he/she was prompted to call the Department of Health and Senior Services (DHSS). He/She contacted the corporate maintenance supervisor before calling DHSS due to following the corporate chain of command policy. The corporate maintenance supervisor told him/her to order the test kits and retest the facility for any inaccuracies. The lab test kits were ordered last Thursday, 03/13/25 and arrived at the facility a couple of days ago. He/She did not contact DHSS or report the laboratory results that were received on 02/10/24 because the facility was going to retest for inaccuracies. 48532