STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265608	A. Building B. Wing	04/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Glenwood Rehabilitation & Health Care Center	851 Thoroughfare Seymour, MO 65746

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 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. Based on observation, record review, and interviews, the facility failed to ensure food was protected from possible contamination at all times when staff failed to properly store and label food and when the stacked dishes while still wet. The facility had a census of 54.1. Review of the facility policy titled Food Storage (Dry, Refrigerated, and Frozen), undated, showed the following:-Foods shall be stored at appropriate temperatures and using appropriate methods to ensure the highest level of food safety;-All food items will be labeled, that must include the name of the food and the date by which it should be sold, consumed or discarded;-Discard food that has passed the expiration date, and discard food that has been prepared in the facility after seven days of storing under proper refrigeration;-Leftover contents of cans and prepared food will be stored in covered, labeled, and dated containers in refrigerators and /or freezers;-When freezing food that has been prepared on-site, ensure there is clear labeling of the item. Observation on 04/27/26, at 9:00 A.M., of the refrigerator showed the following:-Seven pieces of cake on small white foam plates uncovered;-Meat mixture in a large, zipped bag not labeled;-Small red plastic bowl, with an unidentifiable orange item in it. Observation on 04/27/26, at 9:00 A.M., of the freezer showed the following:-Six hamburger patties with packages opened and exposed to air with no date or label;-Six chicken patties with packages opened and exposed to air with no date or label. Observation and interview on 04/27/26, at 9:20 A.M., showed the following:-Dietary Aide (DA) C could not identify an unable bag; -HE/She thought it may be chicken alfredo or tune noodle casserole but was unsure. During an interview on 04/30/26, at approximately 1:42 P.M., [NAME] E said the following:-Any opened items should be placed in a plastic container and labeled and dated, so anyone can tell what the item is;-This is the same for the refrigerator, freezer, or pantry. During an interview on 04/30/26, at approximately 1:56 P.M., DA C said staff are not supposed to put anything away without writing the date on the front of it. During an interview on 04/30/26, at approximately 2:17 P.M., the Dietary Manager (DM) said the following:-Every opened item must have a written date and be clearly labeled, before being stored;-This included dry storage, the refrigerator, or the freezer; -Proper storage policy states any unused product would go into container or bag and be labeled and dated. During an interview on 04/30/26, at approximately 3:00 P.M., the DON said the following:-All items should have a label and date written on the outside;-All items should be identifiable. During an interview on 04/30/26, at approximately 3:20 P.M., the Administrator said the following:-Everything should be clearly labeled and dated so staff are aware of what it is and when it must be used by;-Anything that has been opened must be labeled and dated. 2. Review showed the facility did not provide a policy regarding dish washing and drying. Review of the Food and Drug Administration (FDA) 2022 Food Code showed the following:-Items must be allowed to drain and to air-dry before being stacked or stored;-Stacking wet items such as pans prevents them from drying and may allow an environment where microorganisms can begin to grow. Observation on 04/27/26, at 9:25 A.M., showed the following:-Forty-four clear drinking cups stacked wet with no air flow;-Thirty-nine plastic trays stacked wet with no air flow;-Two, medium-sized steam table metal pans, stacked wet with no air flow. Observation on 04/29/26, at approximately 2:40 P.M., showed the following:-Fifty-three plastic (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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	trays stacked and wet with no air flow;-Fifty-four plastic drinking cups stacked and wet with no air flow; During an interview on 04/29/26, at 2:45 P.M., [NAME] D said he/she did not realize that the dishes had to be air dried. During an interview on 04/30/26, at 1:42 P.M., [NAME] E said the following:-To dry the dishes, they are placed in front of the fan and they wait for them to dry air completely;-The dishes are not allowed to be put away until they are totally dry;-He/she always tried to make sure dishes were completely dry before putting them away. During an interview on 04/30/26, at approximately 1:56 P.M., DA C said the following:-Dishes were to be air dried once taken from the dishwasher;-It takes a while to dry all the dishes in this way;-He/she knew there could not be standing water on the dishes when put away;-Dished must be completely dried and thought they just got in a hurry or did not notice the water. During an interview on 04/30/26, at approximately 2:15 P.M., the Dietary Manager said staff should air dry all dishes before putting them away. During an interview on 04/30/26, at approximately 3:00 P.M., the DON said the following:-The dishes should be air dried;-He/she expected that all dishes were being done properly. During an interview on 04/30/26, at approximately 3:20 P.M., the Administrator said dishes should not be stacked wet.

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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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 ensure the residents' environment was free of accident hazards when the resident accessible hot water temperatures in rooms of eight residents' (Resident #41, #27, #31, #42, #3, #7, #34, and #51) measured greater than 120 degrees Fahrenheit (F). The facility census was 54. Review showed the facility did not provide a policy regarding hot water temperature monitoring. Review of the American Burn Association website, updated 2002, showed the following:-Hot water caused third degree burns (full thickness burns which go through the skin and affect deeper tissue resulting in white or blackened, charred skin) at the following temperatures and time parameters:-In 1 second at 155 degrees F;-In 2 seconds at 148 degrees F;-In 5 seconds at 140 degrees F;-In 15 seconds at 133 degrees F;-In 1 minute at 127 degrees F;-In 3 minutes at 124 degrees F.-Older adults, like young children, have thinner skin so hot liquids cause deeper burns with even brief exposure. Their ability to feel heat may be decreased due to certain medical conditions or medications so they may not realize water is too hot until injury has occurred. 1. Review of Resident #41's face sheet (brief resident profile sheet) showed the following:-admission date of 11/26/24;-Diagnoses included Parkinson's disease (a progressive brain disorder that causes problems with movement, balance, and muscle control), need for assistance with personal care, and altered mental status (change in a person's awareness, alertness, or mental sharpness). Review of the resident's care plan, reviewed 03/09/26, showed the following:-Resident required one staff assistance with activities of daily living;-Resident was alert and oriented, but unable to talk. Review of resident's comprehensive Minimum Data Set (MDS - a federally mandated assessment instrument completed by facility staff), dated 04/29/26, showed the following:-Unable to speak clearly, but can understand others;-Required staff assistance for bathing, toileting, personal hygiene and transferring. 2. Review of Resident #27's face sheet showed the following:-admission date of 02/14/22;-Diagnoses included Alzheimer's disease (a progressive, irreversible brain disorder that slowly destroys memory, thinking skills, and eventually the ability to perform simple daily tasks), generalized epilepsy (a brain condition characterized by recurring, unprovoked seizures that start on both sides of the brain simultaneously), altered mental status, depression, and anxiety. Review of resident's care plan, dated 02/03/26, showed the following:-Resident was alert and oriented but may be forgetful due to the dementia disease process;-Required staff assistance with toileting, transferring, bathing and personal hygiene. Review of resident's MDS, dated [DATE], showed the following:-Cognitively intact;-Dependent on staff for bathing, toileting, and personal hygiene. 3. Review of Resident #31's face sheet showed the following:-admission date of 05/01/25;-Diagnoses included type two diabetes with neuropathy (the body doesn't produce enough insulin which can cause nerve damage with long-term high blood glucose levels), and need for assistance with personal care. Review of resident's care plan, dated 02/05/26, showed dependent on staff for transferring, toileting, bathing, and dressing. Review of resident's quarterly MDS, dated [DATE], showed the following:-Cognitively intact;-Dependent on staff for bathing, toileting, transfers, and personal hygiene. 4. Review of Resident #42's face sheet showed the following:-admission date of 09/28/15;-Diagnoses included dementia with other behavioral disturbance (a decline in mental ability such as memory, thinking, or reasoning, that is severe enough to interfere with daily life), type two diabetes, and chronic pain syndrome (a condition where pain lasts for more than 3 to 6 months). Review of resident's MDS, dated [DATE], showed the following:-Cognitively intact;-Independent for toileting, bathing, dressing and personal hygiene. Review of resident's care plan, dated 04/18/26, showed the following:-Resident had history of traumatic brain injury and could affect decision making;-Independent for all activities of daily living. 5. Observation on 04/29/26, of the bathroom sink water temperature for Resident #41, # 27, #31, and #42 showed the following: -At 6:18 P.M., the hot (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	water measured 124.1 degrees F;-At 7:23 P.M., the hot water measured 124.7 degrees F. 6. Review of Resident #3's face sheet showed the following:-admission date of 03/20/26;-Diagnoses included vascular dementia (decline in thinking, memory, and behavior caused by conditions that block or reduce blood flow to the brain) with agitation, delusional disorders (a mental health condition where a person holds strong, irrational beliefs that are untrue), and depression. Review of the resident's comprehensive MDS, dated [DATE], showed the following:-Cognitively intact;-Dependent on staff for repositioning, transferring and bathing. Review of resident's care plan, dated 04/27/26, showed resident was dependent on staff for toileting, bathing, dressing, eating, personal hygiene, and transferring. 7. Review of Resident #7's face sheet showed the following:-admission date of 01/24/25;-Diagnoses included Parkinson's disease, dementia, obsessive-compulsive disorder (a mental health condition causing uncontrollable thoughts and repeated behaviors), and anxiety.Review of resident's quarterly MDS, dated [DATE], showed the following:-Severe cognitive impairment;-Dependent on staff for transfers, toileting, bathing and personal hygiene. 8. Review of Resident #34's face sheet showed the following:-admission date of 04/01/25;-Diagnoses included Huntington's disease (a rare, inherited, and progressive brain disorder that causes nerve cells to break down over time), depression, and insomnia. Review of resident's MDS ,dated 04/15/2026, showed the following:-Cognitively intact;-Independent with toileting, transfers and dressing;-Substantial assistance from staff with personal hygiene. Review of resident's care plan, dated 04/28/26, showed the following:-Alert and oriented with some short-term memory deficit;-Independent with most activities of daily living but may need one staff assistance for personal hygiene. 9. Review of Resident #51's face sheet showed the following:-admission date of 03/04/24;-Diagnoses included cerebrovascular disease (a condition that affects blood flow to the brain), dementia, reduced mobility, and generalized muscle weakness. Review of the resident's MDS, dated [DATE], showed the following:-Moderate cognitive impairment;-Dependent on staff for transfers, bathing and personal hygiene. Review of resident's care plan, dated 04/22/26, showed resident dependent on staff for all activities of daily living. 10. Observation on 04/29/26, at 7:20 P.M., showed the bathroom sink water temperature for Resident #3, #7, #34, and #51 measured 122.8 degrees F. 11. During an interview on 04/30/26, at 2:07 P.M., the Maintenance Director said he/she expected water temperatures in the resident rooms to be between 105 degrees and 120 degrees F. During an interview on 04/30/26, at 2:10 P.M., the Dietary Manager said the following:-He/she was the prior maintenance director;-He/she conducted all weekly water temperature monitoring during the day shift when most resident showers given;-He/she would expect water temperatures in the resident room to be between 105 degrees and 120 degrees F; -He/she would test water temperatures in two different resident rooms in each hallway. During an interview on 04/30/26 at 4:02 P.M., the Director of Nursing (DON) said the following:-He/She expected staff to check the resident water temperatures and ensure temperatures were in a safe range;-He/She expected staff to conduct water temperatures monitoring at different times and shifts. During an interview on 04/30/26, at 4:19 P.M., the Administrator said the following:-He/She expected staff to notify maintenance and administration if water temperatures were too hot;-He/She expected staff to conduct weekly water temperature monitoring and ensure temperatures were in a safe range

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on observation, interview and record review, the facility failed to maintain a complete infection prevention and control program when staff failed to follow Enhanced Barrier Precautions (EBP - an infection control intervention designed to reduce transmission of multidrug-resistant organisms (MDRO - microorganisms, predominantly bacteria that are resistant to one or more classes of antimicrobial agents. Although the names of certain MDROs describe resistance to only one agent, these pathogens are frequently resistant to most available antimicrobial agents) that employs targeted gown and glove use during high contact resident care activities)) when providing wound and incontinent care to one resident (Resident #3) with a wound. Staff failed to completed proper hand hygiene while providing incontinent cares for two residents (Resident #3 and #47). Staff failed to ensure Tuberculin Skin Tests (TST) were completed in accordance with the requirements for tuberculosis (TB - an infectious disease that primarily affects the lungs, characterized by fever, cough, and difficulty breathing) testing for long-term care employees and per facility policy for one staff member (Registered Nurse (RN) A. The facility census was 54. 1. Review of the facility's policy titled, Standard Precautions - Hand Hygiene, dated 2019, showed the following:-Purpose to cleanse hands to prevent the spread of potentially deadly infections; to provide a clean and healthy environment for residents, staff and visitors; and to reduce the risk to the healthcare provider of colonization or infections acquired from a resident;-Hand hygiene (hand washing and/or alcohol-based hand rub - ABHR) continues to be the primary means of preventing the transmission of infection. Accepted standards of practice such as the use of ABHR instead of soap and water in all clinical situations except when hands are visibly soiled; after caring for a resident with known or suspected Clostridium difficile (C-diff - a bacterium that causes severe diarrhea and harmful inflammation of the large intestine) or norovirus (a highly contagious virus that causes severe, sudden vomiting and diarrhea) infection during an outbreak; before eating; and after using the restroom;-Staff must perform hand hygiene even if gloves are utilized;-Gloves or the use of baby wipes are not a substitute for hand hygiene. Review of the facility's policy titled, Standard Precautions - Gloves, dated 2019, showed the following:-Purpose to reduce the possibility that healthcare workers will become infected with microorganisms (tiny living things that are too small to be seen without a microscope) that are infecting residents and to prevent healthcare worker exposure to blood and other potentially infectious materials from the resident, equipment, and the environment; and to reduce the likelihood that healthcare workers will transmit their endogenous microbial flora (everyone has their own home-grown germs) to residents. To lessen the possibility that personnel will become transiently colonized with microorganisms that can be transmitted to other residents;-Disposable single-use examination gloves are worn when hand contact with blood, other potentially infectious materials, mucous membranes and non-intact skin is anticipated; when performing vascular access procedures; when handling or touching contaminated items or surfaces; if hand of healthcare provider has cuts, abrasions or other open areas healthcare worker; and when caring for a resident with uncontained body fluids or known or suspected drug-resistant organism colonization or infection;-Examination gloves are removed as soon as practical when contaminated; as soon as practical when torn, punctured or when the ability to function as a barrier is compromised; between resident contacts; and before touching uncontaminated surfaces or other areas of the same resident's body that may be uncontaminated. 2. Review of Centers for Disease Control and Prevention' (CDC) Implementation of Personal Protective Equipment (PPE) Use in Nursing Homes to Prevent Spread of MDROs, dated 04/02/24, showed the following:-MDRO transmission is common in skilled nursing facilities, contributing to substantial resident morbidity and mortality and increased healthcare costs;-EBP are an infection control intervention designed to reduce transmission of resistant organisms that employs targeted gown and glove use during high contact resident care activities;-EBP may be indicated (when Contact Precautions do not otherwise apply) for residents with any of the following: wounds or (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	indwelling medical devices, regardless of MDRO colonization status, and infection or colonization with an MDRO;-Examples of high-contact resident care activities requiring gown and glove use for EBP include dressing, bathing/showering, transferring, providing hygiene, changing linens,changing briefs or assisting with toileting, device care or use of central line (a long, flexible tube inserted into a large vein in the chest, neck, or arm, with the tip ending close to the heart), urinary catheter (a thin, flexible, indwelling urinary tube inserted through the urethra into the bladder to drain urine continuously), feeding tube (a medical device used to deliver liquid food, fluids, and medications directly to the stomach or small intestine), tracheostomy (a surgical procedure that creates an opening, called a stoma, through the neck directly into the windpipe (trachea) /ventilator (a medical machine that helps a patient breathe or fully breathes for them)and wound care of any skin opening requiring a dressing. Review of the facility's policy titled, Infection Prevention and Control Manual-Enhanced Barrier Precautions, undated, showed the following:-EBP is an infection control intervention designed to reduce transmission of MDROs in nursing homes. EBP involves gown and glove use during high-contact resident care activities for residents known to be colonized or infected with a MDRO as well as those at increased risk for MDRO acquisition (such as residents that have wounds or indwelling medical devices). This is because devices and wounds are risk factors that place these residents at higher risk for carrying or acquiring a MDRO and many residents colonized with a MDRO are asymptomatic or not presently known to be colonized;-EBP expanded the use of gown and gloves beyond anticipated blood and body fluid exposures. They focus on use of gown and gloves during high-contact resident care activities that have been demonstrated to result in transfer of MDROs to hands and clothing of healthcare personnel, even if blood and body fluid exposure is not anticipated. EBP is recommended for residents known to be colonized or infected with a MDRO, as well as those at increased risk of MDRO acquisition. Standard Precautions still apply while using EBP;-EBP is recommended for residents with infection or colonization with a MDRO or a wound or indwelling medical device, even if the resident is not known to be infected or colonized with a MDRO or indwelling medical devices such as central venous catheters, urinary catheters, feeding tubes, and tracheostomies/ventilators;-High-contact resident care activities where a gown and gloves should be used include bathing/showing, transferring residents from one position to another, providing hygiene, changing bed linens, changing briefs or assisting with toileting, caring for or using an indwelling medical device, or performing wound care. Review of Resident #3's face sheet (brief resident profile sheet) showed the following:-admission date of 03/20/26;-Diagnoses included vascular dementia (decline in thinking, memory, and behavior caused by conditions that block or reduce blood flow to the brain) with agitation, delusional disorders (a mental health condition where a person holds strong, irrational beliefs that are untrue), chronic atrial fibrillation (a continuous heart condition where the top chambers of the heart quiver instead of beating effectively causing an irregular and fast, pounding heartbeat), and depression. Review of the resident's care plan, dated 04/27/26, showed the following:-At risk for skin breakdown related to incontinence and dependent on staff to provide substantial positioning changes;-Resident had skin breakdown to coccyx (tailbone) and heel;-The resident had an activities of daily living (ADL) deficient and was dependent on staff for toilet use and required one staff for transfers.(Staff did not address the need for EBP.) Observation on 04/29/26, at 3:57 P.M., showed the following:-The resident had an EBP sign on the door to his/her room;-Certified Nurse Aide (CNA) J and CNA L entered the resident's room. The CNAs did not complete hand hygiene and put on gloves. The CNAs did not don a gown;-The CNAs positioned the resident for incontinent care and CNA J wiped the front genital area with a clean wipe;-The CNAs repositioned the resident to his/her left side. CNA J pulled out the dirty brief, used a clean wipe to wash between the buttocks from front to back, changed wipes, and wiped entire buttock area;-CNA J placed a clean brief on the resident without changing glove or performing hand hygiene; -CNA L placed pillows behind the resident's back, while CNA J turned the resident on his/her right side, covered with sheet and blanket, and placed the call light on his/her lap. The CNAs did not change gloves or perform hand (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	hygiene;-CNA J took off his/her dirty gloves, washed his/her hands, put new gloves on, and wiped the resident's face with a clean washcloth;-CNA J took off his/her gloves, placed them in the trash can, exited the resident's room, and did not perform hand hygiene;-CNA L took off his/her gloves, placed them in the trash, exited the room with the trash, and did perform hand hygiene. 3. Review of Resident #47's face sheet showed the following: -admission date of 02/04/25;-Diagnoses included hemiplegia and hemiparesis affecting left non-dominant side (the right side of the brain is damaged, causing weakness or paralysis on the left side of the body), cerebral infarction (a blockage in the brain when a blood clot or narrowing artery blocks blood flow to part of the brain, causing brain cells to die from lack of oxygen), major depressive disorder, convulsions (uncontrollable shaking or jerking of the body caused by involuntary muscle contractions and relaxation), and generalized muscle weakness. Review of the resident's care plan, dated 02/18/26, showed the following:-The resident had an ADL deficit and required two staff participation to reposition, turn, and dressing;-Required total assistance with personal hygiene care;-Dependent on staff to change and cleanse skin related to incontinence of bowel and bladder;-The resident required a Hoyer lift (a mechanical lift for resident who cannot bear weight) for transfers with two staff assistance. Observation on 04/29/26, at 3:34 P.M., showed the following:-CNA J entered the resident's room and put on gloves without performing hand hygiene;-Nurse Aide (NA) K entered the resident's room with the Hoyer lift, did not perform hand hygiene, and donned gloves;-Both aides positioned the resident to provide incontinent care;-NA K washed the resident's front genital area with a clean wipe, then the aides turned the resident on his/her left side;-NA K pulled out the dirty brief, used a clean wipe to wash between the buttocks and entire buttock area, wiped from front to back, and used clean wipes with each pass; -NA K placed clean brief on the resident and covered the resident with a sheet without performing hand hygiene or changing his/her gloves;-Both aides washed their hands and transferred the resident. 4. During an interview on 04/29/26, at 5:05 P.M., CNA L said the following:-Staff should perform hand hygiene when entering and exiting a resident's room, before feeding residents, and after any resident care;-Staff should wear gloves with incontinent care and any direct resident care;-Staff should change gloves after providing care when dirty and before touching a clean area;-Staff should wear EBP for residents with an open wound or Foley catheter (a device that drains urine from the bladder into an external collection bag);-Staff should wear gloves and a gown when providing direct care for residents on EBP. During an interview on 04/29/26, at 5:10 P.M., CNA J said the following:-Staff should perform hand hygiene before going into a resident's room, before and after feeding residents, between passing dinner trays, after incontinent care, and after leaving a resident's room;-Staff should put on gloves before providing incontinent care, bath care, shaving, and any cares with body fluids;-Staff should perform hand hygiene before putting on gloves and after taking off gloves; -Staff should change gloves after providing care when dirty and before touching a clean area; -Staff should follow EBP for residents with a catheter, feeding tube, open wound or a colostomy (an opening created on the belly for the colon and waste collects to a pouch outside the body);-Staff should wear gloves and a gown when providing direct care for residents on EBP;-Staff should wear gloves and a gown when providing care for Resident #3. During an interview on 04/30/26, at 3:18 P.M., Licensed Practical Nurse (LPN) I said the following:-Staff should perform hand hygiene before entering and after leaving each resident's room, before and after meals, before and after feeding, before and after changing gloves, and in between each resident care;-Staff should wear EBP for residents with a catheter, open wound, and colostomy;-Staff should wear gloves and a gown when providing direct care such as catheter care, wound care, incontinent care, and showers; -An EBP sign on the resident's door tells staff to wear gloves and a gown for direct patient care;-Resident #3 has a EBP sign outside of his/her room. Staff should wear gloves and a gown for the resident's direct care. During an interview on 04/30/26, at 3:39 P.M., the Social Services Director (SSD)/Infection Control Preventionist (IP) said the following:-Expected staff to perform hand hygiene when entering and leaving a resident's room, before and after eating, after using the bathroom, after smoking, and (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	between clean and dirty treatments;-Expected staff to change gloves between clean and dirty treatments and between each resident;-Staff should perform hand hygiene before putting on gloves and after taking gloves off;-Expected staff to wear gloves and a gown for residents on EBP;-Expected staff to wear EBP when providing wound care, catheter care, changing a catheter, tube feeding, showers, incontinent care, and any other type of direct resident care;-Expected a resident on EBP to be included in the care plan. During an interview on 04/30/26 at 4:02 P.M., the Director of Nursing (DON) said the following:-Expected staff to perform hand hygiene before entering and after leaving a resident's room, before and after all cares;-Expected staff to perform hand hygiene before and after changing gloves;-Expected staff to change gloves after touching anything dirty and before touching a clean area;-Expected staff to use EBP on residents with an open wound or with any indwelling device; -Expected a resident on EBP to be included in the care plan;-Expected staff to wear EBP when providing care for Resident #3. During an interview on 04/30/26, at 4:19 P.M., the Administrator said the following:-Expected staff to use proper hand hygiene, wear and change gloves according to policy and professional standards for all resident care; -Expected staff to wear EBP for all designated residents direct care. 5. Review of the facility's policy titled Tuberculosis Screening - Employees, dated 2019, showed the following:-It is the policy of this facility to assess risks for tuberculosis based on region/community data and screen staff according to State law. For example, all healthcare workers are to be tested for tuberculosis upon hire and yearly thereafter unless contraindicated or in accordance with State requirements;-Initial testing will be a two-step procedure with the first dose given before beginning work and the second booster dose given sever to 21 days after the first if the first dose is negative along with an employee risk screening tool;-New employees will not be allowed to work until the TST, or chest x-ray results are known;-Employees who will be receiving the two-step TST may begin work after the first step results are negative;-TST results will be documented in the employee's medical record;-TST is read between 48 and 72 hours after administration by someone trained in reading and interpretation. Review of the general requirements of 19 CSR 20.20.100 (3), TB testing for employees in Long Term Care Facilities, showed the following:-Long-term care facilities shall screen their employees for TB using the Mantoux method (tool for screening for tuberculosis and for tuberculosis diagnosis) PPD two-step tuberculin test within one month prior to starting employment; -It is the responsibility of the facility to maintain documentation of each employee's tuberculin status;-If the initial test is negative, the second test should be given as soon as possible within three weeks after employment begins unless documentation is provided indicating a Mantoux PPD test in the past and at least one subsequent annual test within the past two years. Review of the Employee TB Screening Tool for Registered Nurse (RN) A showed the following information:-Date of hire of 04/25/25;-Step one administered on 04/25/25;-The test was required as a condition of employment;-Employee must report back within 48 to 72 hours to be examined;-Step one results read on 04/30/25 (five days after administration). During an interview on 04/30/26, at 3:43 P.M., the IP/SSD said the following:-Newly hired employees must be TB tested with negative results prior to starting to work in the facility;-The test should be read in 48 to 72 hours;-Step #2 of the process should be done in approximately seven to ten days. If it was more than 21 days they would need to start the 2-step process over;-The TB tests are documented on the Employee TB Screening Tool form; -The employee answers the questions and either the SSD or another nurse should document the administration and result reading of each test;-RN A would need to start a new 2-step TB testing process because the first test was not read timely;-The forms are kept in a binder and reviewed at morning meetings to monitor for required completion dates. During an interview on 04/30/26, at 4:02 P.M., the Director of Nursing (DON) said the following: -The IP/SSD was responsible for initiating and monitoring completion of staff TB tests;-If SSD was not present, any other nurse could administer the TB test and initiate the documentation;- Any nurse could read the test result;-The testing was tracked on the form that is filled out for that employee;-TB tests should be read within 48 to 72 hours. During an interview on (continued on next page)

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	265608	A. Building B. Wing	04/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Glenwood Rehabilitation & Health Care Center	851 Thoroughfare Seymour, MO 65746

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	04/30/26, at 4:19 P.M., the Administrator said the following: -TB testing was monitored by the SSD;-If the SSD was not there when the test should be done, another nurse would do the test at the nurses' station where the documentation binder was kept;-SSD audits the binder at every morning meeting;-TB tests should be read within 48-72 hours.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure residents who were unable to carry out activities of daily living (ADL - dressing, grooming, bathing, eating, and toileting) received the necessary services to maintain good personal hygiene when the facility failed to document reapproaches after bathing refusals for two residents (Residents #28 and #50) of 19 residents reviewed. The facility census was 54.Review of the facility policy titled Activities of Daily Living, dated 09/24/25, showed the following information:-The facility provides each resident with care, treatment, and services according to the resident's individualized care plan;-Based on the comprehensive assessment of each resident, facility staff will ensure that the resident's ability to perform activities of daily living does not decline unless the resident's medical condition circumstances make the decline unavoidable. Review showed the facility did not provide a policy related to showers. 1. Review of Resident #28's face sheet (brief look at resident information) showed the following:-admission date of 07/11/25;-Diagnoses included dementia with behavioral disturbances, Alzheimer's disease, high blood pressure, high blood pressure, and dizziness. Review of the resident's quarterly Minimum Data Set (MDS- a federally mandated assessment tool filled out by facility staff), dated 04/22/26, showed the following:-Severe cognitive impairment;-Dependent on assistance from staff for bathing;-Required supervision from staff for dressing. Review of the resident's care plan, dated 07/21/25, showed the following:-Dependent on staff for bathing;-The resident often refused bathing and required staff to reapproach as needed;-The resident able to dress his/herself;-The resident can perform his/her own personal hygiene of brushing his/her hair. Review of the resident's Electronic Medical Record (EMR), under ADL-bathing assessments, dated April 2026, showed the following:-On 04/03/26, the resident received a shower;-On 04/07/26, the resident was offered a shower once and refused;-On 04/09/26, the resident was offered a shower once and refused;-On 04/14/26, the resident was offered a shower once and refused;-On 04/17/26, the resident was offered a shower once and refused;-On 04/21/26, the resident was offered a shower once and refused;-On 04/22/26, the resident was offered a shower once and refused. Review of the resident's progress notes, dated 04/07/26, 04/09/26, 04/14/26, 04/17/26, 04/21/26, and 04/22/26, showed staff did not document regarding resident bathing refusals or attempts to reapproach. Review of the resident's progress note, dated 04/24/26, showed the following information:-Staff assisted the resident to the shower room without issue;-Once in the shower room, the resident kept trying to leave the room;-Both staff members talked with the resident in a soothing reassuring tone;-The resident sat on the shower chair, but staff were unable to undress the resident;-Staff were unable to bathe the resident. Staff escorted the resident back to the unit;-No new interventions, second attempt or reschedule documented. Review of the resident's EMR, under ADL-bathing assessments, dated April 2026, showed on 04/28/26, the resident was offered a shower twice and refused. Review of the resident's progress note, dated 04/28/26 showed staff did not document regarding the bathing refusals. Observation on 04/27/26, at 11:00 A.M., showed the following:-Resident #38 wandering about the halls of the unit;-The resident wore Aztec printed leggings;-The resident's hair appeared disheveled and unwashed as evidenced by uncombed hair appearing with an oily substance throughout the root to the ends of his/her hair. Observation on 04/28/26 at 6:16 A.M., showed the following:-The resident sat on the couch in the main living room area of the unit;-The resident's hair appeared disheveled and unwashed. His/her hair was uncombed with an oily substance throughout the root to the ends of his/her hair. Observation on 04/29/26, at 12:09 P.M., showed the following:-The resident sat in the dining area;-The resident's hair appeared disheveled and unwashed. His/her hair was uncombed with an oily substance throughout the root to the ends of his/her hair. During an interview on 04/29/26, at 4:08 P.M., Licensed Practical Nurse (LPN) F said the following:-The resident was non-compliant with cares;-He/she was unsure what the proper procedure (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	would be to get the resident to bathe;-He/she assumed staff would just need to reapproach the resident at different times of the day to be successful. During an interview on 04/30/26, at 1:02 P.M., Registered Nurse (RN) A said the following:-The resident's shower days were Tuesday and Friday;-The resident was very confused and is difficult to assist with bathing;-Staff tried to reapproach the resident at other times of the day and talk in a calm reassuring voice;-If the current interventions of reapproaching and redirecting were not working, he/she was unsure of what else can be implemented to get the resident to bathe. 2. Review of Resident #50's face sheet showed the following information:-admission date of 11/01/25;-Diagnoses included stroke, changes to the brain, right/dominant sided weakness/immobility, difficulty with speech following stroke, arthritis, muscle wasting, difficulty swallowing, difficulty in walking/lack of coordination, cognitive communication deficit, pain, and history of falling. Review of the resident's quarterly MDS, dated [DATE], showed the following:-Severe cognitive impairment;-Functional limitation in range of motion upper and lower extremities impaired, one side;-Dependent on staff for oral, toileting, and personal hygiene, showers/bathing, dressing, bed mobility, and transfers. Review of the resident's care plan, updated 11/13/25, showed self care performance deficit related to right side paralysis; totally dependent on staff to provide a bath as necessary. Staff to provide with a sponge bath when a full bath or shower cannot be tolerated. Review of the resident's EMR, under ADL-bathing assessments, dated April 2026, showed the following:-On 04/03/26, the resident received a shower with the assistance of two staff;-On 04/14/26, the resident refused a shower. Review of a nurse practitioner's progress note, dated 04/20/26, showed the following:-Recommend good hygiene and skin care to prevent skin breakdown;-Continue with moderate assistance with ADLs as needed. Review of the resident's EMR, under ADL-bathing assessments, dated April 2026, showed the following:-On 04/21/26, the resident refused a shower;-On 04/22/26, the resident refused a shower;-On 04/24/26, the resident refused a shower. Review of the resident's care plan, updated 4/28/26, showed the resident preferred to only have one bath per week on Fridays and refused showers often. Review of the resident's EMR, under ADL-bathing assessments, dated April 2026, showed on 04/29/26, the resident refused a shower. Review of the resident's April 2026 progress notes showed staff did not document regarding resident bathing refusals or staff reapproaching the resident. Observation on 04/27/26, at 11:47 A.M., showed the resident sat in a wheelchair in the front lobby of the facility. The resident's hair appeared to be uncombed and dirty. During an interview on 04/30/26, at 4:30 P.M., Certified Medication Technician (CMT) B said the following:-The resident resisted cares at times, but staff can sometimes explain the care enough for the resident to accept assistance;-He/she believed the resident received showers or was bathed but did not have direct knowledge of the method or frequency. 3. During an interview on 04/30/26 at 1:02 P.M., Registered Nurse (RN) A said the following:-Staff are expected to offer each resident two showers a week;-When a resident refuses showers for almost a month, it would be appropriate to notify the resident's family. He/she has attempted to make contact with the resident's family and has been unsuccessful;-All attempts at bathing and/or any refusals should be documented in the nurse's notes. 4. During an interview on 04/30/2, at 2:18 P.M., the MDS Nurse said the following:-Any aspects of a resident's care should be found on the care plan;-Staff nurses have not brought any new bathing interventions to her to add to the resident care plans;-A resident should be reapproached later in the day if the resident initially refuses bathing. If the resident continued to refuse, the staff should notify the charge nurse and the charge nurse should document the attempt, intervention, and refusal;-If a resident refused to bathe one day, the staff should try again the following day;-Sometimes different staff approaches can make all the difference. During an interview on 04/30/26, at 2:25 P.M., the Social Services Director (SSD) said the following:-Any aspects of a resident's care should be found on the care plan;-The resident should be reapproached later in the day if the resident initially refuses bathing. If the resident continued to refuse, the staff should notify the charge nurse and the charge nurse should document the attempt, intervention, and refusal;-If a resident refused to bathe one day, the staff should try again the following day;-Sometimes different (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	staff approaches can make all the difference. During an interview on 04/30/26, at 4:02 P.M., the Director of Nursing (DON) said the following:-She expected all residents to be offered at least two bathing opportunities a week;-Showers were documented in the resident's EMR under ADL-bathing;-If the resident frequently refused, the resident should be asked again at a later time with a different approach. If the resident continues to refuse, the charge nurse should document the refusal in the progress notes;-If a resident refused bathing for an extended period of time, she expected staff to notify the resident's family. During an interview on 04/30/26, at 4:02 P.M., the Administrator said the following:-She expected all residents to be offered at least two bathing opportunities a week;-Showers were documented in the resident's EMR under ADL-bathing;-For residents that have frequent refusals, she expected staff to offer again with a different approach and document refusals in the progress notes;-Frequent refusals and/or new interventions should be documented in the care plan;-She expected the resident's family to be notified if the resident frequently refuses bathing.

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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, the facility failed to ensure medication error rates did not exceed five percent when the facility completed two medication errors out of an 25 opportunities (an 8% error rate) affecting two residents (Resident #53 and #2). The facility census was 54.Review of the facility procedure titled Medication Pass Tips, dated 05/2019, showed the following:-Prior to preparing medication verify the resident's identity, verify each drug against the electronic medical record (eMAR); and if the resident requires the medication is to be crushed; check to see if the drug can be crushed;-Verify the route against the eMAR;-Administer each medication as instructed on the eMAR and within the timeframe established by the facility;-For insulin; prime insulin pens with two units (u) before each use. 1. Review of Resident #53's face sheet (brief look at resident information) showed the following:-admission date of 03/08/24;-Diagnoses included hypokalemia (low potassium). Review of the resident's care plan, dated 06/05/25, showed staff to administer medications as ordered. Review of the resident's April 2026 Physician Order Sheet (POS) showed an order, dated 05/21/25, for potassium chloride 20 milliequivalents (meq) ER (extended release). Staff to give one tablet by mouth two times a day and do not crush. May dissolve in 120 milliliters (ml) of water. Observation on 04/29/26, at 4:05 P.M., showed the following: -Licensed Practical Nurse (LPN) F prepared the resident's evening medications;-LPN F obtained and placed all evening medications, including one tablet of potassium chloride) into a plastic sleeve and crushed the medications prior to adding them to applesauce and administering them to the resident. During an interview on 04/30/26, at 11:15 A.M., Registered Nurse (RN) A said the following:-Medications in capsule, delayed release, or extended-release form should not be crushed;-Potassium chloride should not be crushed. The medication can be dissolved in water if the resident has trouble swallowing. During an interview on 04/30/26, at 2:12 P.M., Certified Medication Technician (CMT) M said the following:-Medications in capsule, delayed release, extended release, or enteric coated should not be crushed;-Potassium chloride should not be crushed. The medication can be dissolved in water if the resident has trouble swallowing. During an interview on 04/30/26, at 2:15 P.M., CMT N said the following:-Medications in capsule, delayed release, extended release, or enteric coated should not be crushed;-Potassium chloride should not be crushed. The medication can be dissolved in water if the resident has trouble swallowing. During an interview on 04/30/26, at 4:00 P.M., the Director of Nursing (DON) said the following:-Medications in capsule, delayed release, extended release, or enteric coated should not be crushed;-Potassium chloride should not be crushed. The medication can be dissolved in water if the resident has trouble swallowing. During an interview on 04/30/26, at 4:19 P.M., the Administrator said the following:-Medications in capsule, delayed release, extended release, or enteric coated should not be crushed;-Potassium chloride should not be crushed. The medication can be dissolved in water if the resident has trouble swallowing. 2. Review of resident #2's face sheet showed the following:-admission date of 11/05/25;-Diagnoses included diabetes. Review of the Food and Drug Administration (FDA) package insert and patient information for insulin lispro, dated 03/2013, showed the following: -Prime before each injection. Priming ensures the pen is ready to dose and removes air that may collect in the cartridge during normal use. If you do not prime before each injection, you may get too much or too little insulin;-Turn the dose knob to select two units;-Hold your pen with the needle pointing up;-Tap the cartridge holder gently to collect air bubbles at the top;-Hold your pen with needle pointing up; -Push the dose knob in until it stops, and 0 is seen in the Dose window.;-Hold the dose knob in and count to five slowly. A stream of insulin should be seen from the needle. If you do not see a stream of insulin, repeat the priming steps no more than four times;-If you still do not see a stream of insulin, change the needle and repeat the priming steps. Review of the resident's comprehensive MDS, dated [DATE], showed the resident received insulin injections seven days out of the week. Review of the resident's April 2026 POS showed the following information:-An order, (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	dated 04/01/26, for insulin lispro (a rapid acting man-made insulin used to treat high blood sugar/glucose) subcutaneous (the layer of fatty tissue located directly beneath the dermis and epidermis of the skin) solution pen injector 200 u/ milliliter (ml), inject per sliding scale;-If the blood glucose level is 181 milligrams/deciliter (mg/dL) to 200 mg/dL, administer 2 units of insulin;-If the blood glucose level is 201 mg/dL to 250 mg/dL, administer 4 units of insulin;-If the blood glucose level is 251 mg/dL to 300 mg/dL, administer 6 units of insulin;-If the blood glucose level is 301 mg/dL to 350 mg/dL, administer 8 units of insulin;-If the blood glucose level is 351 mg/dL to 400 mg/dL, administer 10 units of insulin;-If the blood glucose level is 401 mg/dL to 450 mg/dL, administer 12 units of insulin;-If the blood glucose level is greater than 450 mg/dL, call the physician. Observation on 04/30/26 at 11:15 A.M., showed the following:-RN A obtain the resident's blood glucose level. The residents' blood glucose level was 371 mg/dL and per order required 10 units (u) of insulin;-The RN obtained the insulin pen, attached the needle, and dialed up to 10 units;-RN A administered the insulin without priming the needle. During an interview on 04/30/26, at 1:02 P.M., RN A said the following:-Insulin pens should be primed with two units prior to each administration;-The purpose of priming is to get the air out of the needle, to ensure the resident receives the full dose of medication;-Physician orders should be followed. During an interview on 04/30/26, at 2:18 P.M., the MDS Nurse said insulin pens should be primed with two units with every administration to ensure residents receive the correct dosage. During an interview on 04/30/26, at 2:25 P.M., the Social Services Director/Infection Preventionist said the following:-Physician orders should be followed;-Insulin pens should be primed with two units with every administration to ensure residents receive the correct dosage. During an interview on 04/30/26, at 4:02 P.M., the DON said the following:-Physician orders should be followed;-Insulin pens should be primed with two units with every administration to ensure residents receive the correct dosage. During an interview on 04/30/26, at 4:19 P.M., the Administrator said the following;-Physician orders should be followed;-Insulin pens should be primed with two units with every administration to ensure residents receive the correct dosage.

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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. Based on observation, interview, and record review the facility failed to ensure residents were free from significant medication errors when the facility failed to administer noon insulin on dialysis (a life- sustaining treatment for kidney failure, filtering waste and excess fluid from the blood when the kidneys have less than 10-15 % function) days and failed to prime the insulin pen before administration for one resident (Resident #2). The facility census was 54.Review of the facility procedure titled Medication Pass Tips, dated 05/2019, showed administer each medication as instructed on the electronic Medication Administration Record (eMAR) and within the timeframe established by the facility. 1. Review of Resident #2's face sheet (brief look at resident information) showed the following:-admission date of 11/05/25;-Diagnoses include chronic kidney disease, diabetes, and dependence on renal (kidney) dialysis. Review of the resident's comprehensive Minimum Data Set (MDS- a federally mandated assessment tool filled out by facility staff), dated 04/01/26, showed the following:-Cognitively impaired;-Received dialysis;-Receives hypoglycemics (medications used to lower blood sugar/glucose levels in patients with diabetes). Review of the resident's care plan, dated 06/05/25, showed the following:-Monitor blood glucose levels as ordered and provide insulin as ordered;-Encourage the resident to attend dialysis appointments on Mondays, Wednesdays, and Fridays. Review of the resident's April 2026 Physician Order Sheet (POS) showed the following:-An order, dated 03/20/26, for dialysis every Monday, Wednesday, and Friday with pick up time of 7:00 A.M.- 7:30 A.M.;-An order, dated 04/01/26, for insulin lispro (a rapid acting man-made insulin used to treat high blood sugar/glucose) subcutaneous (the layer of fatty tissue located directly beneath the dermis and epidermis of the skin) solution pen injector 200 u/ milliliter (ml), inject per sliding scale;-If the blood glucose level is 181 milligrams/deciliter (mg/dL) to 200 mg/dL, administer 2 units of insulin;-If the blood glucose level is 201 mg/dL to 250 mg/dL, administer 4 units of insulin;-If the blood glucose level is 251 mg/dL to 300 mg/dL, administer 6 units of insulin;-If the blood glucose level is 301 mg/dL to 350 mg/dL, administer 8 units of insulin;-If the blood glucose level is 351 mg/dL to 400 mg/dL, administer 10 units of insulin;-If the blood glucose level is 401 mg/dL to 450 mg/dL, administer 12 units of insulin;-If the blood glucose level is greater than 450 mg/dL, call the physician. Review of the resident's medication administration record (MAR), dated 04/01/26, showed the resident's noon blood sugar check and dose of sliding scale insulin were not administered. Review of the resident's progress note dated 04/01/26, at 9:47 A.M., showed the resident's noon medications were held due to the resident attending dialysis. Review of the resident's MAR, dated 04/03/26, showed the resident's noon blood sugar check and dose of sliding scale insulin were not administered. Review of the resident's progress note dated 04/03/26, at 7:08 A.M., showed the resident's noon insulin was held due to the resident attending dialysis. Review of the resident's MAR, dated 04/06/26, showed the resident's noon blood sugar check and dose of sliding scale insulin were not administered. Review of the resident's progress note dated 04/06/26, at 5:35 A.M., showed the resident's A.M. medications and noon insulin were held due to the resident attending dialysis. Review of the resident's MAR, dated 04/08/26, showed the resident's noon blood sugar check and dose of sliding scale insulin were not administered. Review of the resident's progress note dated 04/08/26, at 5:36 A.M., showed the resident's noon insulin was held due to the resident attending dialysis. Review of the resident's MAR, dated 04/10/26, showed the resident's noon blood sugar check was administered and sliding scale insulin was not required. Review of the resident's MAR, dated 04/13/26, showed the resident's noon blood sugar check and dose of sliding scale insulin were not administered. Review of the resident's progress note dated 04/13/26, at 7:08 A.M., showed the noon insulin medications was held due to the resident attending dialysis. Review of the resident's MAR, dated 04/15/26, showed the resident's noon blood sugar check and dose of sliding scale insulin weas not administered. Review of the resident's progress note dated 04/15/26, at 5:58 A.M., showed the noon insulin medications was held due to the resident attending dialysis. Review of the resident's (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	MAR, dated 04/17/26, showed the resident's noon blood sugar check and dose of sliding scale insulin was not administered. Review of the resident's progress note dated 04/17/26, at 5:34 A.M., showed the noon insulin medications were held due to the resident attending dialysis. Review of the resident's MAR, dated 04/20/26, showed the resident's noon blood sugar check and dose of sliding scale insulin were not administered. Review of the resident's progress note dated 04/20/26, at 5:24 A.M., showed the noon insulin medications were held due to the resident attending dialysis. Review of the resident's MAR, dated 04/22/26, showed the resident's noon blood sugar check and dose of sliding scale insulin were not administered. Review of the resident's progress note dated 04/22/26, at 4:15 A.M., showed the resident's noon insulin medications were held due to the resident attending dialysis. Review of the resident's MAR, dated 04/24/26, showed the resident's noon blood sugar check and dose of sliding scale insulin were not administered. Review of the resident's progress note dated 04/24/26, at 8:50 A.M., showed the resident's noon insulin medications were held due to the resident attending dialysis. Review of the resident's progress note dated 04/24/26, at 10:23 A.M., showed the following:-Staff spoke to the Nurse Practitioner (NP) about whether the resident's medications were to be held prior to dialysis treatments;-The NP advised to administer the medications as prescribed. Review of the resident's MAR, dated 04/27/26, showed the resident's noon blood sugar check and dose of sliding scale insulin were not administered. Review of the resident's progress note, dated 04/27/26, showed no documentation regarding the administration or withholding of the resident's medications. During an interview on 04/30/26, at 11:15 A.M., Registered Nurse (RN) A said the following:-Physician orders should be followed. If an order is not clear, he/she will call the physician for clarification;-The resident goes to dialysis three times a week;-The Infection Preventionist(IP)/Social Services Director (SSD) spoke with a pharmacist, who conferred with the NP, and it was determined that the resident should be receiving his/her medications;-Orders for a resident's medication to be held (not administered) are documented on the POS;-Staff notified the NP that the resident missed several medication administrations;-Missed medication administrations should be documented on the MAR and in the resident's progress notes. The physician should be notified. During an interview on 04/30/26, at 2:12 P.M., Certified Medication Technician (CMT) M said the following:-Physician orders should be followed;-All medications should be given unless there is a specific hold order documented in the POS. During an interview on 04/30/26, at 2:15 P.M., CMT N said the following:-Physician orders should be followed;-All medications should be given unless there is a specific hold order documented in the POS. During an interview on 04/30/26 ,at 2:20 P.M., the IP/SSD said the following:-Physician orders should be followed;-In March 2026, the IP/SSD verified with the pharmacist and the NP that the resident should be receiving his/her medications on dialysis days;-The IP/SSD documented the information in the resident's progress notes and verbally notified all nurses. During an interview on 04/30/26 at 4:00 P.M., the Director of Nursing (DON) said the following:-Physician orders should be followed;-All medications should be given unless there is a specific hold order documented in the POS;-The resident previously missed medication administrations because the NP was unsure if the medications would be dialyzed or not and wanted clarification from the pharmacist;-The pharmacist clarified that the resident's medications should be administered as ordered. Nursing staff were notified;-If a medication is not administered, she expects staff to document in the MAR and progress notes. Staff should also notify the NP. During an interview on 04/30/26 at 4:19 P.M., the Administrator said the following:-Physician orders should be followed;-All medications should be given unless there is a specific hold order documented in the POS;-The resident missed medication administrations because the NP was unsure if the medications would be dialyzed or not and wanted clarification from the pharmacist;-The pharmacist clarified that the resident's medications should be administered as ordered. Nursing staff were notified;-If a medication is not administered, she expects staff to document in the MAR and progress notes. Staff should also notify the NP.-The NP is changing the resident's orders to better accommodate the dialysis schedule. 2. Review of the Food and Drug Administration (FDA) package insert and patient information for insulin lispro, dated 03/2013, showed (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265608	A. Building B. Wing	04/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Glenwood Rehabilitation & Health Care Center	851 Thoroughfare Seymour, MO 65746

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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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the following: -Prime before each injection. Priming ensures the pen is ready to dose and removes air that may collect in the cartridge during normal use. If you do not prime before each injection, you may get too much or too little insulin;-Turn the dose knob to select two units;-Hold your pen with the needle pointing up;-Tap the cartridge holder gently to collect air bubbles at the top;-Hold your pen with needle pointing up; -Push the dose knob in until it stops, and 0 is seen in the Dose window.;-Hold the dose knob in and count to five slowly. A stream of insulin should be seen from the needle. If you do not see a stream of insulin, repeat the priming steps no more than four times;-If you still do not see a stream of insulin, change the needle and repeat the priming steps. Observation on 04/30/26 at 11:15 A.M., showed the following:-RN A obtain the resident's blood glucose level. The residents' blood glucose level was 371 mg/dL and per order required 10 units (u) of insulin;-The RN obtained the insulin pen, attached the needle, and dialed up to 10 units;-RN A administered the insulin without priming the needle. During an interview on 04/30/26, at 1:02 P.M., RN A said the following:-Insulin pens should be primed with two units prior to each administration;-The purpose of priming is to get the air out of the needle, to ensure the resident receives the full dose of medication;-Physician orders should be followed. During an interview on 04/30/26, at 2:18 P.M., the MDS Nurse said insulin pens should be primed with two units with every administration to ensure residents receive the correct dosage. During an interview on 04/30/26, at 2:25 P.M., the Social Services Director/Infection Preventionist said the following:-Physician orders should be followed;-Insulin pens should be primed with two units with every administration to ensure residents receive the correct dosage. During an interview on 04/30/26, at 4:02 P.M., the DON said the following:-Physician orders should be followed;-Insulin pens should be primed with two units with every administration to ensure residents receive the correct dosage. During an interview on 04/30/26, at 4:19 P.M., the Administrator said the following;-Physician orders should be followed;-Insulin pens should be primed with two units with every administration to ensure residents receive the correct dosage.