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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265614	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Clearview Nursing Center	430 Salcedo Road Sikeston, MO 63801

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. Based on observation, interview, and record review, the facility failed to ensure staff used acceptable infection control procedures and practices for wound care for two residents (Residents #1 and #55) out of two sampled residents, one resident (Resident #4) for catheter (a flexible tube placed in the bladder to drain urine) care out of one sampled resident, and one resident (Resident #6) with a gastrostomy tube (g-tube - a medical device surgically placed through the abdomen directly into the stomach to deliver nutrition, fluids, and medication when oral intake is unsafe or insufficient) out of one sampled resident. The facility also failed to ensure laundry was processed in a way to limit the spread of infections. This practice could potentially affect all residents. The facility census was 62. Review of the facility's policy titled, Enhanced Barrier Precautions, revised March 2024, showed:- To prevent broader transmission of multi-drug resistance organisms (MDROs) and to help protect patients with chronic wounds and indwelling devices, enhanced barrier precautions (EBP) should be implemented for the period of their stay or until wounds have resolved or indwelling medical devices have been removed;- Residents who require EBP: are those known to be infected or colonized with MDRO, with an indwelling medical device including the following: central venous catheter, urinary catheter, feeding tube (PEG tube, G-tube), tracheostomy/ventilator regardless of their MDRO status, and wounds, regardless of their MDRO status;- Use EBP when providing high-contact resident care activities such as those listed: bathing/showering, transferring residents from one position to another, providing hygiene, changing bed linens, changing briefs or assisting with toileting, caring for or using indwelling medical device, performing wound care. The facility did not provide a policy regarding infection control practices in laundry services. 1. Observation on 03/03/26 at 1:25 P.M., of Resident #6's medication administration via g-tube showed:- No EBP signage on the resident's door;- No personal protective equipment (PPE) available outside of the resident room;- Licensed Practical Nurse (LPN) G performed hand hygiene, put on gloves, and did not put on a gown;- LPN G performed the medication administration. 2. Observation on 03/04/26 at 8:20 A.M., of Resident #55's wound care showed:- No EBP signage on the resident's door;- No PPE available outside of the resident room;- LPN G and LPN I gathered supplies for the wound care at the resident's door;- LPN G and LPN I did not perform hand hygiene, put on gloves, did not put on a gown, and entered the room; - LPN G performed the wound care. 3. Observation on 03/04/26 at 8:50 A.M., of Resident #1's wound care showed:- No EBP signage on the resident's door;- No PPE available outside of the resident room;- LPN I performed hand hygiene, put on gloves, did not put on a gown, and entered the resident's room;- LPN I provided wound care for the resident. 4. Observation on 03/04/26 at 9:06 A.M., of Resident #4's catheter care showed:- No EBP signage on the resident's door;- No PPE available outside of the resident room;- Certified Nurse Aide (CNA) L and CNA M entered the resident's room, performed hand hygiene, put on gloves, and did not put on a gown;- CNA L provided catheter care for the resident. During an interview on 03/04/26 at 3:50 P.M., LPN P said the EBP was new and not sure what it was for. It was maybe something for the CNAs to use. During an interview on 03/04/26 at 3:55 P.M., CNA Q said he/she put on PPE before going into resident rooms to provide care. The PPE was for infection control. The supplies weren't out there before today. CNA Q was unsure why Resident #6 and Resident #55 required supplies and other residents did not. During an interview on 03/05/26 at 11:52 (continued on next page)

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

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

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NAME OF PROVIDER OR SUPPLIER Clearview Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 430 Salcedo Road Sikeston, MO 63801	

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	A.M., LPN I said staff should be wearing gloves and gowns when entering a resident's room where there was a catheter, wound, or g-tube tube. He/She did not know what happened to the containers with the PPE and they had been outside the resident's room in the past. LPN I thought someone cleaned house and placed all of the containers with PPE in storage. During an interview on 03/05/26 at 11:55 A.M., the Director of Nursing (DON) said she had no idea what happened to the containers of PPE and the signs that had previously been on the residents' door. Staff should be wearing gloves and gowns when entering a resident's room with catheters, g-tubes, wounds or anything with a device entering the body. During an interview on 03/05/26 at 11: 55 A.M., the Infection Preventionist said she was not aware the PPE storage drawers were not outside of the residents' rooms. She would expect staff to come to her and let her know the supplies were not readily available. During an interview on 03/05/26 1:55 P.M., Registered Nurse (RN) R said if a resident had a catheter, staff only needed to wear gloves. If a resident had a wound with Staphylococcus (a common bacteria found on the surface of the skin and in the nose), then gown and gloves needed to be worn. If a wound had eschar (a thick layer of dead tissue) or was a skin tear, only gloves needed to be worn. During an interview on 03/05/26 at 2:35 P.M., the Administrator said residents with any opening of their skin, such as a catheter, wound or a g-tube should have EBP in place. Staff should wear a gown and gloves whenever providing care to residents on EBP. 5. Observation on 03/04/25 at 2:49 P.M., of the laundry room showed:- The laundry building with one door to enter/exit the laundry room;- Dirty laundry barrels sat in the entry of the laundry room;- The washing machines located at the front area of the laundry building;- Dryers, a folding table, and wheeled clothing racks located at the rear area of the laundry building;- Clean linen carts located in the back of the laundry room;- No physical separation between the dirty laundry at the entrance and clean laundry at the back of the room;- Anyone entering or exiting the laundry room had to pass through the dirty laundry holding area;- All clean laundry and linen carts had to pass the dirty linen barrels and the soiled area to exit the laundry room building to be distributed to the residents and facility. During an interview on 03/04/25 at 2:49 P.M., Laundry Aide (LA) O said the dirty laundry came to the laundry room in barrels from each hall. He/She wore gloves when separating the dirty laundry. Once the laundry was dried, staff either hung or folded the laundry and put it on the cart to take to the residents. The laundry was delivered through the same door it entered the laundry room. During an interview on 03/04/26 at 2:55 P.M., LA O said he/she was not aware of any certain way the dirty linens and clean linens should enter and exit the laundry room. During an interview on 03/04/26 at 3:01 P.M., the Laundry Supervisor said the clean linens exited the laundry room through the same door the dirty laundry entered. During an interview on 03/04/26 at 3:21 P.M., the IP said he/she was not aware of any certain way the dirty linens and clean linens should enter and exit the laundry room. During a phone interview on 03/12/26 at 8:57 A.M., the IP said he/she was aware the laundry room only had one entrance/exit, but was not aware of any certain way the dirty linens and clean linens should enter and exit the laundry room. During a phone interview on 03/12/26 at 9:00 A.M., the Administrator said there was only one entrance/exit to the laundry room.

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on observation, interview, and record review, the facility failed to ensure staff maintained or enhanced the quality of life for two residents (Residents #8 and #54) and failed to maintain the dignity of one resident (Resident #55) when left exposed during care out of 16 sampled residents. The facility's census was 62. The facility did not provide a dignity policy. 1. Observation on 03/02/26 at 12:11 P.M., of Resident #8 showed:- The resident sat in the hall and asked two different staff that passed by for a cup of coffee; - No staff acknowledged the resident. Observation on 03/02/26 at 12:31 P.M., showed:- The resident asked Certified Nursing Assistant (CNA) J if he/she could have a cup of coffee as CNA J walked by;- CNA J responded in a loud and stern voice, No, the kitchen is closed. CNA J continued to walk past the resident without offering another option or redirecting the resident. During an interview on 03/02/26 at 12:32 P.M., CNA J said the staff try not to give the resident coffee because it caused the resident to be anxious and then the resident wanted to get out of bed. The kitchen was not actually closed and would get the resident a drink when he/she was finished with his/her task. During an interview on 03/05/26 at 2:32 P.M., the Director of Nursing (DON) said he/she would expect staff to acknowledge the resident's requests. She would expect staff to offer the resident another option to drink or redirect the resident. 2. Observation on 03/03/26 at 12:23 P.M., of Resident #54 showed:- The resident lay in bed with his/her eyes open and his/her call light and water sat out of reach of the resident on the nightstand;- The resident said he/she had not had lunch yet and was hungry. During an interview on 03/03/26 at 12:25 P.M., CNA E said he/she was unsure why the resident was not up for lunch. Observation on 03/03/26 at 12:37 P.M., showed:- At 12:33 P.M., CNA E and CNA F transferred the resident from the bed into his/her wheelchair;- At 12:37 P.M., the resident sat at the dining room table, asked for water, and quickly ate his/her lunch. The resident ate 90% of the meal, drank one cup of water and one cup of chocolate milk. During an interview on 03/03/26 on 1:04 P.M., Licensed Practical Nurse (LPN) G said the resident refused to get out of bed earlier. When the resident refused to get up for lunch, he/she left the resident alone because he/she was on hospice. Sometimes staff would put a tray back and check on the resident later. If a tray was put back for the resident, LPN G would have to stay in the dining room later and that put him/her behind in his/her duties. During an interview on 03/05/26 at 1:32 P.M., the Administrator said he would expect staff to make sure residents were up every day for lunch, and the call lights to be in reach to ensure the residents were able to get up at their liberty. During an interview on 03/05/26 at 2:34 P.M., the DON said staff should make sure residents were up for meals, and if the residents refused to get up, the staff should re-visit a short time later and ensure the residents were fed. She would expect staff to notify him/her if this continued. 3. Observation on 03/04/26 at 8:20 A.M., of Resident #55 showed:- LPN G and LPN I performed wound care for the resident without the privacy curtain pulled and/or the door closed;- The resident's bare backside was exposed to the hallway;- Two unknown persons passed by the resident's door during his/her care. During an interview on 03/04/26 8:34 A.M., LPN I said normally staff closed the door when providing wound care or treatments. LPN G said he/she normally pulled the curtain when doing wound care or treatments. During an interview on 03/05/26 at 2:34 P.M., the DON said she would expect staff to provide privacy during any wound care or treatments, including closing the privacy curtain and/or closing the door.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to assess for the risk of entrapment, review the possible risks and benefits of the side rails prior to installation or use, and the facility failed to obtain informed consent of the side rails prior to use for four residents (Residents #1, #6, #52, and #55) out of four sampled residents. The facility census was 62. Review of the facility's policy titled, Minimum Data Sets (MDS - a federally mandated assessment completed by the facility) and Care Planning Guidelines, dated September 2013, showed:- It is the policy of this facility to use the most current Centers for Medicare and Medicaid Services (CMS) MDS Resident Assessment Instrument (RAI) Manual, any published interim RAI manual errata (error) documents, and applicable federal guidelines as the authoritative guide for completion of MDS, care area assessments (CAA), and resident care planning. 1.Review of Resident #1's medical record showed:- admitted on [DATE];- Diagnoses of fracture (broken bone) of the left leg, pain, muscle weakness, and chronic obstruction pulmonary disease (COPD - a long-term chronic airway disease);- Cognition moderately impaired. Observations on 03/02/26 at 1:10 P.M, 03/03/26 at 10:00 A.M., 03/04/26 at 8:50 A.M., and 03/05/26 at 9:00 A.M., showed:- The resident's bed with both half side rails in an upright position. Observations on 03/04/26 at 8:50 A.M., and 03/05/26 at 9:00 A.M., showed:- The resident lay in bed with both half side rails in an upright position. During an interview on 03/04/26 at 8:55 A.M., the resident said he/she used the half side rails to turn side to side while in bed. The resident said the half side rails were already on his/her bed upon admission. Review of the resident's Care Plan, revised on 02/26/26, showed:- Did not address the resident's both half side rail use. 2. Review of Resident #6's medical record showed:- admitted on [DATE];- Diagnoses of autistic disorder (developmental disability), pervasive developmental disorder (delays in developing communication), seizures (sudden, uncontrolled movement, behavior, sensations, or consciousness), and unspecified intellectual disabilities;- Cognition severely impaired-never/rarely made decisions. Observations on 03/02/26 at 10:53 A.M., 03/03/26 at 8:45 A.M., 03/04/26 at 9:48 A.M., and 03/05/26 at 9:21 A.M., showed:- The resident's bed with both half rails in an upright position. Observations on 03/02/26 at 2:41 P.M., 03/03/26 at 3:21 P.M., and 03/05/26 at 11:04 A.M., showed:- The resident lay in bed with both half side rails in an upright position. Review of the resident's Care Plan, dated 01/09/26, showed:- Did not address the resident's both half side rail use. 3. Review of Resident #52's medical record showed:- admitted on [DATE];- Diagnoses of dementia (a disorder marked by memory loss, personality changes, and impaired reasoning that interferes with daily functioning), history of falls, urinary tract infection (UTI - an infection anywhere in the urinary tract), hypertension (high blood pressure) and history of falls;- An unwitnessed fall with no injury on 01/15/26;- An unwitnessed fall with no injury on 01/21/26. Observations on 03/02/26 at 1:30 P.M., 03/03/26 at 9:32 A.M., 03/04/26 at 1:39 P.M., and 03/05/26 at 10:34 A.M., of the resident showed:- Resident lay in bed with both side rails in an upright position;- A fall mat lay on the floor on the left-side of his/her bed. Review of the resident's Care Plan, revised 01/08/26, showed:- Falls on 08/16/25, 08/24/25, 09/9/25, 09/19/25, 10/09/25, and 10/14/25 with no specific interventions put in place for safety measures;- No documentation of falls on 01/15/25 and 01/26/26 with no specific interventions put in place for safety measures;- Did not address the resident's both half side rail use. 4. Review of Resident #55's medical record showed:- admitted on [DATE];- Diagnoses of spinal stenosis cervical region (narrowing of the spine in the neck region), multiple sclerosis (breakdown of the protective covering of nerves), heart failure, and acute respiratory failure with hypoxia (lungs cannot get enough oxygen to the blood);- Cognition intact. Observations on 03/02/26 at 11:14 A.M., 03/02/26 at 3:11 P.M., 03/04/26 at 10:42 A.M., and 03/05/26 at 1:41 P.M., showed:- The resident's bed with both half rails in an upright position. Review of the resident's Care Plan, revised, 01/16/26, showed:- Did not address the resident's both half side (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	rail use. During an interview on 03/05/26 at 2:00 P.M., the Director of Nursing (DON) said she would expect resident falls and side rail use to be addressed on the care plan. During an interview on 03/05/26 at 2:30 P.M., the Administrator said he would expect falls and side rail use to be on the care plan. During an interview on 03/11/26 at 12:00 P.M., the MDS Coordinator said he/she would expect falls and side rails to be addressed on the care plan.

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to assess for the risk of entrapment, review the possible risks and benefits of the side rails prior to installation or use, and the facility failed to obtain informed consent of the side rails prior to use for four residents (Residents #1, #6, #52, and #55) out of four sampled residents. The facility census was 62. The facility did not provide a side rail assessment policy. 1.Review of Resident #1's medical record showed:- admitted on [DATE];- Diagnoses of fracture (broken bone) of the left leg, pain, muscle weakness, and chronic obstruction pulmonary disease (COPD - a long-term chronic airway disease);- Cognition moderately impaired;- No documentation of a side rail assessment or informed consent for the use of side rails. Observation on 03/02/26 at 1:10 P.M., 03/03/26 at 10:00 A.M., 03/04/26 at 8:50 A.M., and 03/05/26 at 9:00 A.M., showed:- The resident's bed with both half side rails in an upright position. Observation on 03/04/26 at 8:50 A.M., and 03/05/26 at 9:00 A.M., showed:- The resident lay in bed with both half side rails in an upright position. During an interview on 03/04/26 at 8:55 A.M., the resident said he/she used the side rails to turn side to side while in bed. The rails were already on the bed upon his/her admission. 2. Review of Resident #6's medical record showed:- admitted on [DATE];- Diagnoses of autistic disorder (developmental disability), pervasive developmental disorder (delays in developing communication), seizures (sudden, uncontrolled movement, behavior, sensations, or consciousness), and unspecified intellectual disabilities;- Cognition severely impaired-never/rarely made decisions;- The resident with a legal guardian;- No documentation of a side rail assessment or informed consent for the use of the side rails. Observations on 03/02/26 at 10:53 A.M., 03/03/26 at 8:45 A.M., 03/04/26 at 9:48 A.M., and 03/05/26 at 9:21 A.M., showed:- The resident's bed with both half rails in an upright position. Observations on 03/02/26 at 2:41 P.M., 03/03/26 at 3:21 PM., and 03/05/26 at 11:04 A.M., showed:- The resident lay in bed with both half side rails in an upright position. 3. Review of Resident #52's medical record showed:- admitted on [DATE];- Diagnoses of dementia (a disorder marked by memory loss, personality changes, and impaired reasoning that interferes with daily functioning), history of falls, urinary tract infection (UTI - an infection anywhere in the urinary tract), hypertension (high blood pressure) and history of falls;- Cognition severely impaired;- The resident with a legal guardian;- No documentation of a side rail assessment or informed consent for the use of the side rails. Observations on 03/02/26 at 1:30 P.M., 03/03/26 at 9:32 A.M., 03/04/26 at 1:39 P.M., and 03/05/26 at 10:34 A.M., showed:- The resident lay in bed with both half side rails in an upright position. 4. Review of Resident #55's medical record showed:- admitted on [DATE];- Diagnoses of spinal stenosis cervical region (narrowing of the spine in the neck region), multiple sclerosis (breakdown of the protective covering of nerves), heart failure, and acute respiratory failure with hypoxia (lungs cannot get enough oxygen to the blood);- Cognition intact;- No documentation of a side rail assessment or informed consent for the use of the side rails. Observations on 03/02/26 at 11:14 A.M., 03/02/26 at 3:11 P.M., 03/04/26 at 10:42 A.M., and 03/05/26 at 1:41 P.M., showed:- The resident's bed with both half rails in an upright position. During an interview on 03/02/26 at 3:11 P.M., the resident said he/she couldn't physically use the side rails right now but had in the past. During an interview on 03/04/26 at 2:00 P.M., the Director of Nursing (DON) said when a resident was admitted with a concern of side rail use, nursing would complete an initial side rail assessment. After the initial admission assessment, the side rail assessments were supposed to be completed quarterly thereafter. She thought the side rail assessments had been missed because they were not included in the admission packet. During an interview on 03/04/26 at 2:30 P.M., the Administrator said he would expect an assessment to be completed before the side rails were put on a resident's bed and be assessed quarterly.

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F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Post nurse staffing information every day. Based on observation and interview, the facility staff failed to post the required daily nurse staffing information in a prominent location readily accessible to residents and visitors for four out of four days. The facility census was 62.The facility did not provide a policy on nurse staff posting. Observations on 03/02/26 at 12:05 P.M., 03/03/26 at 9:00 A.M., 03/04/26 at 8:45 A.M., and 03/05/26 at 12:30 P.M., showed:- Daily nurse staffing posted on the east end of the facility near the nurses' station;- No daily nurse staffing posted at the main entrance of the facility or at the west end area of the facility;- Daily nurse staffing not posted in a prominent place readily accessible to all residents and visitors. During an interview on 03/05/26 at 1:30 P.M., Certified Nurse Aide (CNA) K said the nursing staff information had always been posted on the east end of the facility. He/she had never known of the staffing posted anywhere else in the facility. During an interview on 03/05/26 at 1:33 P.M., the Minimum Data Set (MDS - a federally mandated assessment instrument required to be completed by facility staff) Coordinator said the charge nurse that worked the east end was usually the nurse that filled out the daily staff and posted it. The nurse staff posting had never been anywhere other than the east end of the facility near the nurses' station. During an interview on 03/05/26 at 1:34 P.M., Licensed Practical Nurse (LPN) G said the charge nurse on the east end was responsible for filling out the daily staff sheet and posted it every morning. The staffing sheet had always been posted by the nurses' station on the east end of the facility. During an interview on 03/05/26 at 1:45 P.M., the Director of Nursing (DON) said she was not sure who was responsible for posting the nurse staffing, however it was always completed and hung near the bulletin board on the east end of the facility. During an interview on 03/05/26 at 2:20 P.M., the Administrator said the east end of the facility was the only place the nurse staffing had ever been posted.

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F 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Regularly inspect all bed frames, mattresses, and bed rails (if any) for safety; and all bed rails and mattresses must attach safely to the bed frame. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to conduct inspections of all bed frames, mattresses, and side rails as part of a regular maintenance program for four residents (Residents #1, #6, #52 and #55) out of four sampled residents. The facility census was 62. The facility did not provide a side rail inspection policy. 1. Review of Resident #1's medical record showed:- admitted on [DATE];- Diagnoses of fracture (broken bone) of the left leg, pain, muscle weakness, and chronic obstruction pulmonary disease (COPD - a long-term chronic airway disease);- No maintenance inspection for the side rail. Observations on 03/02/26 at 1:10 P.M., and 03/03/26 at 10:00 A.M., of the resident's bed showed:- A side rail in the upright position on both half sides of the resident's bed and moved with minimal effort. Observation on 03/04/26 at 8:50 A.M., and 03/05/26 at 9:00 A.M, showed:- The resident lay in bed with both half side rails in an upright position. 2. Review of Resident #6's medical record showed:- admitted on [DATE];- Diagnoses of autistic disorder (developmental disability), pervasive developmental disorder (delays in developing communication), seizures (sudden, uncontrolled movement, behavior, sensations, or consciousness), and unspecified intellectual disabilities;- No maintenance inspection for the side rail. Observation on 03/02/26 at 10:53 A.M., 03/03/2026 at 8:45 A.M., 03/04/26 at 9:48 A.M., and 03/05/26 at 9:21 A.M., showed:- A side rail in the upright position on both half sides of the resident's bed and moved with minimal effort. Observations on 03/02/26 at 2:41 P.M., 03/03/26 at 3:21 PM., and 03/05/26 at 11:04 A.M., showed:- The resident lay in bed with both half side rails in an upright position. 3. Review of Resident #52's medical record showed:- admitted on [DATE];- Diagnoses of dementia (a disorder marked by memory loss, personality changes, and impaired reasoning that interferes with daily functioning), history of falls, urinary tract infection (UTI - an infection anywhere in the urinary tract), hypertension (high blood pressure) and history of falls;- No maintenance inspection for the side rail. Observations on 03/02/26 at 9:59 A.M., and 2:17 P.M., and 03/03/26 at 8:25 A.M., and 2:31 P.M., of the resident's bed showed:- A side rail in the upright position on both half sides of the resident's bed and moved with minimal effort. 4. Review of Resident #55's medical record showed:- admitted on [DATE];- Diagnoses of spinal stenosis cervical region (narrowing of the spine in the neck region), multiple sclerosis (breakdown of the protective covering of nerves), heart failure, and acute respiratory failure with hypoxia (lungs cannot get enough oxygen to the blood);- No maintenance inspection for the side rail. Observations on 03/02/26 at 11:14 A.M., 03/02/26 at 3:11 P.M., 03/04/26 at 10:42 A.M., and 03/05/26 at 1:41 P.M., of the resident's bed showed:- A side rail in the upright position on both half sides of the resident's bed and moved with minimal effort. During an interview on 03/04/26 at 2:32 P.M., the Director of Nursing (DON) said if there were side rails on a resident's bed, then maintenance should be inspecting the side rails at least monthly. During an interview on 03/05/26 at 9:32 A.M., the DON said she spoke to the maintenance staff and the maintenance staff had not completed any inspections on the side rails. During an interview on 03/05/26 at 1:00 P.M., the Maintenance Staff said he/she placed the rails on the resident's bed when the nursing department requested it. If staff had not placed anything in the maintenance log about the side rails, then he/she knew nothing about the side rails until staff notified him/her. The side rails had not been inspected. During an interview on 03/05/26 at 2:30 P.M., the Administrator said he expected staff to inspect side rails on resident beds at least quarterly.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265614	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/05/2026
NAME OF PROVIDER OR SUPPLIER: Clearview Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 430 Salcedo Road, Sikeston, MO 63801	

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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 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. Based on observation and interview, the facility failed to ensure call lights were placed within reach to meet resident needs for five residents (Residents #5, #6, #52, #54 and #67) out of 16 sampled residents and one resident (Resident #12) outside the sample. The facility census was 62.The facility did not provide a call light policy. 1. Observations on 03/02/26 at 9:56 A.M., and 2:13 P.M., 03/03/26 at 8:33 A.M., and 12:47 P.M., and 03/04/26 at 2:28 P.M., of Resident #67 showed:- The resident lay in bed and the call light out lay on the floor out of the resident's reach;- The resident sat in a Geri-chair (a specialized, heavy padded recliner) and the call light lay on the floor out of the resident's reach. 2. Observations on 03/02/26 at 9:59 A.M., and 2:17 P.M., and 03/03/26 at 8:25 A.M., and 2:31 P.M., of Resident #52 showed:- The resident lay in bed and the call light lay on the floor out of the resident's reach. 3. Observations on 03/02/26 at 1:26 P.M., and 3:45 P.M., 03/03/26 at 8:25 A.M., 10:08 A.M., and 1:17 P.M., and 03/04/26 at 12:44 P.M., of Resident #5 showed:- The resident lay in bed and the call light lay on the floor out of the resident's reach;- The resident sat in a Geri-chair at the head of his/her bed and the call light was attached to a privacy curtain at the foot of his/her bed out of the resident's reach. 4. Observations on 03/02/26 at 2:38 P.M., 03/03/26 at 12:23 P.M., and 03/05/26 at 8:52 A.M., of Resident #54 showed:- The resident lay in bed and the call light lay on the nightstand out of the resident's reach;- The resident lay in bed and the call light lay inside a trash can on the floor beside the nightstand out of the resident's reach. 5. Observations on 03/02/26 at 2:39 P.M., and 03/03/26 at 10:03 A.M., of Resident #6 showed:- The resident lay in bed and the call light was attached to a privacy curtain at the foot of his/her bed out of the resident's reach. 6. Observations on 03/02/26 at 2:40 P.M., 03/04/26 at 8:15 A.M., and 03/04/26 at 2:18 P.M., of Resident #12 showed:- The resident lay in bed and the call light hung from a metal frame attached to the wall at the foot of his/her bed out of the resident's reach;- The resident sat beside his/her bed in a wheelchair and the call light hung from a metal frame attached to the wall at the foot of his/her bed out of the resident's reach. During an interview on 03/05/26 at 1:15 P.M., the Administrator said he would expect staff to make sure call lights were always within the residents' reach. During an interview on 03/05/26 at 2:06 P.M., Certified Nurse Assistant (CNA) A said staff should make sure a call light was placed within a resident's reach before leaving his/her room. During an interview on 03/05/26 at 2:09 P.M., Licensed Practical Nurse (LPN) B said a resident should have a call light always placed within reach while in his/her room. During an interview on 03/05/26 at 2:27 P.M., the Director of Nursing (DON) said call lights should always be in reach for residents. She expected staff to check periodically and when entering and exiting a resident's room to make sure the call lights were within reach of the resident.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265614	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/05/2026
NAME OF PROVIDER OR SUPPLIER Clearview Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 430 Salcedo Road Sikeston, MO 63801	

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 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. Based on interview and record review, the facility failed to conduct at least twelve hours of nurse aide in-service education per year and failed to provide the required annual competencies of Dementia Care (care of a resident with an impaired ability to remember, think, or make decisions), Abuse (infliction of physical, sexual or emotional injury/harm), and Neglect (failure to provide necessary services for an adult's safety or health) prevention for two Certified Nurse Aides (CNA) (CNA C and CNA D) out of two sampled CNAs. The facility census was 62.The facility did not provide a nurse aide in-service education policy. Review of the facility's 2026 Quality Assurance and Performance Improvement (QAPI) Plan showed:- The facility will provide the necessary training to enable staff to perform their jobs effectively;- Ongoing training includes mandatory all-staff competency updates addressing topics such as changes in policies and procedures and regulatory requirements. Review of the Facility Assessment, revised 01/21/26, showed:- Topics to be trained at hire and annually thereafter for a CNA; - Required in-service training for nurse aides: a. Be sufficient to ensure the continuing competence of nurse aides, but must be no less than 12 hours per year; b. Include dementia management training and resident abuse prevention; c. Address areas of weakness as determined by facility assessment and may address the special needs of residents as determined by the facility staff; d. For nurse aides providing services to individuals with cognitive impairments, also address the care of the cognitively impaired. 1. Review of the facility's December 2024 through December 2025 in-service records showed:- CNA C's hire date of 12/12/24 ;- CNA C attended three in-services;- CNA C did not attend the annual competency in-service on Dementia Care, Abuse, and Neglect;- No documentation of times for each in-service on the monthly in-service sheets;- The facility failed to provide CNA C with the required twelve hours of in-service education for December 2024 through December 2025 and failed to provide annual competency in-services on Dementia Care and Abuse and Neglect. 2. Review of the facility's November 2024 through November 2025 in-service records showed:- CNA D's hire date of 11/01/24;- CNA D attended five in-services;- CNA D did not attend the annual competency in-service on Dementia Care, Abuse, and Neglect;- No documentation of times for each in-service on the monthly in-service sheets;- The facility failed to provide CNA D with the required twelve hours of in-service education for November 2024 through November 2025 and failed to provide annual competency in-services on Dementia Care and Abuse and Neglect. During an interview on 03/05/26 at 10:02 A.M., the Director of Nursing (DON) said CNAs should have 12 hours of in-services annually. Abuse, neglect, and dementia training should be topics covered and included in the in-services. There should be a time duration on each in-service given to the facility staff. All staff were required to attend the monthly in-services. During an interview on 03/05/26 at 2:20 P.M., the Administrator said CNAs should have the required in-services annually. He was not aware of staff not having the required in-services.