STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265643	A. Building B. Wing	03/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Village Care Center Inc	810 East Edwards Street Maryville, MO 64468

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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51166 Based on observation, interview, and record review, the facility failed to ensure staff obtained physicians' orders and assess residents for safe administration of medication to be kept at the bedside for two of 12 sampled residents (Resident #19 and #25). The facility census was 35. Review of the facility's policy for Resident Self-Administration of Medication, dated 12/2016, showed: -Residents have the right to self-administer medications if the interdisciplinary team has determined that it is clinically appropriate and safe to do so; -In addition to general evaluation of decision-making capacity, the staff and practitioner will assess each resident's mental and physical abilities to determine whether self-administering medications is clinically appropriate for the resident; -The staff and practitioner will document their findings and the choices of residents who are able to self-administer medications; -For self-administering residents, the nursing staff will determine who will be responsible (the resident or nursing staff) for documenting that medications were taken; -Staff shall identify and give to the charge nurse any medications found at the bedside that are not authorized for self-administration, for return to the family or responsible party. 1. Review of Resident #19's Annual Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 1/2/25, showed: -Resident is cognitively intact; -Resident is independent with activities of daily living (ADL's). -Diagnoses included: anemia (low red blood cell count), heart disease, high blood pressure, gastroesophageal reflux disease (stomach contents to back up into the esophagus), thyroid disorder, dementia (a disease that affects memory and reasoning), depression, diabetes, kidney disease, and debility (general state of weakness and decline). (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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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation and interview on 3/27/25 at 8:21 A.M. showed a 3.53 oz. tube of diclofenac sodium topical gel arthritis pain reliever and a bottle of Latanoprost drops, .005%, eye drops on the resident's bedside table. The resident said staff told him/her that they can keep the topical gel and eye drops in their room for self-administration. Review of the resident's care plan, dated 1/23/25, showed the care plan did not reflect the resident's ability to administer diclofenac sodium topical gel and eye drops and did not reflect the resident's ability to keep these medications at bedside. Review of the resident's physician order sheet (POS), dated 2/26/25 through 3/26/25, showed: -Diclofinac gel, 1%, four grams, topical. Apply to the affected area in the morning and at bedtime; -Latanoprost drops, .005%, one drop in the eye at bedtime; -No physician's orders for keeping diclofenac or eye drops at bedside for self-administration. 2. Review of Resident #25's MDS, dated [DATE], showed: -Resident is cognitively intact; -Diagnoses included: heart failure, anxiety, depression, asthma, and respiratory failure; -Resident was independent with ADL's. Observation and interview on 3/25/25 at 11:56 A.M. showed three pills in a cup (two white and one green) and Scalpicin cream (hydrocortisone) on the resident's bedside table. The resident said the white pills were probiotics, the green pill was Ropinerol and the Scalpicin cream was to relieve itching on the resident's scalp. The resident said the nurse left the items on his bedside table but didn't know why. Review of the resident's care plan, dated 1/13/25 showed the care plan did not reflect the resident's ability to administer Scalpicin cream and medications. Review of the resident's POS, dated 2/26/26 to 3/26/25 showed: -No orders for Scalpicin cream -No orders for keeping medications or Scalpicin cream at bedside for self-administration. During an interview on 3/28/25 at 10:17 A.M., CNA B said: -If he/she saw medications, eye drops, or ointments in a resident's room, he/she would report it to the charge nurse; -If there were no orders for the medications, then the resident should not have them in their room. (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 3/27/25 at 2:15 P.M., Registered Nurse (RN) B said: -If a resident wanted to keep medications in their room, there would need to be doctor's orders; -Nursing staff would need to monitor the medications in a resident's room; - The administering nurse should watch the residents take the medications rather than leave them in a cup in the resident's room; -If he/she sees saw medications in a resident's room, he/she would take it and put in the treatment cart, unless there were orders for self-administration. During an interview on 3/28/25 at 2:30 P.M., the Administrator said: -If a resident wanted to self-administer medications, the facility should perform an assessment to ensure safety; -The facility should obtain physician's orders for self-administration; -The facility should update the resident's care plan to reflect self-administration of specific medications. -Medications should not be left in a cup on a resident's bedside table; -The administering nurse should watch the resident take the medications.

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31102 Based on interview and record review, the facility failed to ensure they utilized the correct Skilled Nursing Facility Advance Beneficiary Notice of non-coverage (SNFABN) form (a form that provides information to residents/beneficiaries so that they can decide if they wish to continue receiving the skilled services that may not be paid for by Medicare and assume financial responsibility), for two of the 12 sampled residents, (Resident #20 and #25). The facility census was 35. The facility did not provide a policy for ABN's. 1. Review of Resident #20's medical records showed: - Notice of Medicare Non-coverage (NOMNC) CMS - 10123 showed the last date of coverage was [DATE]. The resident signed it on [DATE]; - The facility used an outdated ABN form CMS - R-131 (expired [DATE]) and was signed by the resident on [DATE]. 2. Review of Resident #25's medical records showed: - NOMNC CMS - 10123 showed the last date of coverage was [DATE]. The resident signed it on [DATE]; - The facility used an outdated ABN form CMS - R-131 (expired [DATE]) and was signed by the resident on [DATE]. During an interview on [DATE] at 2:30 P.M., the Administrator said:- Social Services was new to the position; - They should be using the correct forms.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31102 Based on observation, interview and record review, the facility failed to ensure dependent residents who were unable to carry out activities of daily living (ADL) received the necessary serviced to maintain good personal hygiene when staff did not provide complete perineal care which affected two of the 12 sampled residents, (Resident #18 and #21). Additionally, the staff failed to provide A.M. care to Resident #18. The facility census was 35. Review of the facility's policy titled, Supporting Activities of Daily Living, revised March 2018 showed: - Residents will be provided with care, treatment and services as appropriate to maintain or improve their ability to carry out ADLs; - Appropriate care and services will be provided for residents who are unable to carry out ADLs independently, with the consent of the resident and in accordance with the plan of care, including appropriate support and assistance with hygiene (bathing, dressing, rooming and oral care). Review of the facility's policy titled, Perineal Care, revised February 2018 showed: - The purpose of this procedure are to provide cleanliness and comfort to the resident, to prevent infections and skin irritation , and to observe the resident's skin condition; - Wash and dry hands thoroughly and put on gloves; - Wash the perineal area, wiping from front to back; - Separate the skin folds and wash the area downward from front to back; - Continue to wash the skin folds moving from inside outward to the thighs; - Turn the resident on their side; - Wash the rectal area thoroughly, wiping from the base of the skin folds towards and extending over the buttocks. 1. Review of Resident #18's Significant Change in Status Minimum Data Set, (MDS), a federally mandated assessment instrument completed by facility staff, dated 2/2/25 showed: - Cognitive skills severely impaired; - Upper extremities impaired on both sides; - Lower extremities impaired on one side; - Dependent on the assistance of staff for oral care, personal hygiene, transfers and toilet use; (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Had a Suprapubic catheter (a catheter surgically inserted through the wall of the abdomen); - Always incontinent of bowel; - Diagnoses included obstructive uropathy (condition where urine flow is blocked in the urinary tract, preventing the body from properly eliminating waste products), Alzheimer's disease (a progressive brain disorder that gradually destroys memory, thinking skills, and eventually, the ability to carry out the simplest tasks), psychotic disorder (a mental illness characterized by a significant disconnect from reality, often involving symptoms like delusions (false beliefs) and hallucinations (seeing or hearing things that aren't there), and dementia (inability to think). Review of the resident's care plan, revised 3/26/25 showed: - The resident required maximum assist for daily care tasks needs; - He/She was dependent on staff for toileting needs. He/She was incontinent of bowel and had a supra pubic catheter; - He/She required substantial assistance of two staff for bed mobility. Observation on 3/26/25 at 7:53 A.M., showed: - Certified Medication Technician (CMT) B and Certified Nurse Aide (CNA) A entered the resident's room to get him/her up for breakfast; - CMT B and CNA A did not wash their hands and applied gloves; - CMT B did not separate and clean all the skin folds; - CMT B removed gloves, washed his/her hands and applied new gloves; - CMT B and CNA A turned the resident on his/her side; - The resident had an undated dressing on his/her coccyx (tailbone); - CNA A used the same area of the wipe and cleaned different areas of the buttocks; - CNA A removed gloves, sanitized and applied new gloves; - CMT B and CNA A turned the resident to the other side and removed the soiled brief and placed a clean brief under the resident; - CMT B and CNA dressed the resident and used the mechanical lift and transferred the resident from the bed to his/her wheelchair; - CMT B propelled the resident to the dining room for breakfast and did not offer or provide oral care, or wash the resident's face and hands. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 3/27/25 at 1:15 P.M., CMT B said: - We should not use the same area of the wipe to clean different areas of the skin; - He/She should have separated and cleaned all areas of the skin folds; - We should have washed the resident's face and hands and provided oral care. During an interview on 3/27/25 at 1:54 P.M., CNA A said: - When providing peri care, should separate and clean all the skin folds; - He/She should not have used the same area of the wipe to clean different areas of the skin; - Before taking the resident to breakfast, we should have provided oral care and washed the resident's face and hands; - Should wear a gown and gloves when providing would care or catheter care. 2. Review of Resident #21's Quarterly MDS, dated [DATE], showed: - Cognitive skills intact; - Lower extremities impaired on both sides; - Required set up and clean up with oral care; - Dependent on the assistance of staff for toilet use and transfers; - Required substantial to maximum assistance for personal hygiene; - Always incontinent of bowel and bladder; - Diagnoses included anxiety, depression, Congestive Heart Failure (CHF, accumulation of fluid in the lungs and other areas of the body), Chronic Obstructive Pulmonary Disease, (COPD, obstruction of air flow that interferes with normal breathing), diabetes mellitus and renal insufficiency (RI, a condition where the kidneys are unable to effectively filter waste products and excess fluid from the blood). Review of the resident's care plan, revised 3/26/25 showed: - The resident required substantial assistance with all of his/her ADLs; - The resident was incontinent of bowel and bladder; - The resident was maximum assistance with transfers of two staff and the mechanical lift. Observation on 3/27/25 at 9:01 A.M., showed: (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Nurse Aide (NA) A and NA B gave the resident a bed bath; - NA A and NA B turned the resident on his/her side; - The resident urinated; - NA A and NA B did not separate and clean all the areas of the skin where urine had touched; - NA A and NA B dressed the resident and used the mechanical lift and transferred the resident from the bed to his/her wheelchair. During an interview on 3/27/25 at 1:37 P.M., NA B said he/she should have separated and cleaned all areas of the skin where urine or feces had touched. During an interview on 3/28/25 at 11:44 A.M., NA A said he/she should have separated and cleaned all areas of the skin where urine or feces had touched. During an interview on 3/28/25 at 2:30 P.M., the Director of Nursing (DON) said:- Staff should wash the residents face and hands, brush their hair and offer oral care before taking the resident to breakfast; - Staff should not use the same area of the wipe to clean different areas of the skin; - Staff should separate and clean all areas of the skin where urine or feces had touched.

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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** 31102 Based on observation, interview, and record review, the facility failed to ensure staff used proper techniques to reduce the possibility of accidents or injuries when transferring two of the 12 sampled residents, (Resident #18 and #21) during the use of a mechanical lift. The facility census was 35. Review of the facility's policy titled, Using a Mechanical Lifting Machine, revised July 2017, showed: - The purpose of this procedure is to establish the general principles of safe lifting using a mechanical lifting device; - It is not a substitute for manufacturer's training or instructions; - At least two nursing assistants are needed to safely move a resident with a mechanical lift. Review of the undated manufacturer's guidelines for the Direct Supply lift showed: - When lifting and lowering the resident, ensure legs on the adjustable base are in the maximum open position for optimal stability. 1. Review of Resident #18's Significant Change in Status Minimum Data Set, (MDS), a federally mandated assessment instrument completed by facility staff, dated 2/2/25 showed: - Cognitive skills severely impaired; - Upper extremities impaired on both sides; - Lower extremities impaired on one side; - Dependent on the assistance of staff for oral care, personal hygiene, transfers and toilet use; - Had a Suprapubic catheter (a catheter surgically inserted through the wall of the abdomen); - Always incontinent of bowel; - Diagnoses included obstructive uropathy (condition where urine flow is blocked in the urinary tract, preventing the body from properly eliminating waste products), Alzheimer's disease (a progressive brain disorder that gradually destroys memory, thinking skills, and eventually, the ability to carry out the simplest tasks), psychotic disorder (a mental illness characterized by a significant disconnect from reality, often involving symptoms like delusions (false beliefs) and hallucinations (seeing or hearing things that aren't there), and dementia (inability to think). Review of the resident's care plan, revised 3/26/25 showed: (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- The resident required maximum assist for daily care tasks needs; - He/She was dependent on staff for toileting needs. He/She was incontinent of bowel and had a supra pubic catheter; - He/She required substantial assistance of two staff for bed mobility. Observation on 3/26/25 at 7:53 A.M., showed: - Certified Medication Technician (CMT) B and Certified Nurse Aide (CNA) A entered the resident's room to get him/her up for breakfast and brought the mechanical lift into the resident's room; - CMT B and CNA A did not wash their hands and applied gloves and did not have on personal protective equipment (PPE, specialized clothing or gear worn to minimize exposure to workplace hazards that can cause serious injuries or illnesses); - CMT B and CNA A provided incontinent care and dressed the resident; - CNA B placed the wheelchair by the resident's bed and locked the brakes; - CMT B placed the mechanical lift under the resident's bed with the legs in the closed position; - CMT B raised the resident up in the mechanical lift and backed away from the bed with the legs of the lift closed then opened the legs of the lift to go around the resident's wheelchair and lowered the resident into the wheelchair. During an interview on 3/27/25 at 1:15 P.M., CMT B said the legs of the mechanical lift should be open when raising or lowering the resident. During an interview on 3/27/25 at 1:54 P.M., CNA A said when he/she is raising or lowering a resident in the mechanical lift, the legs of the lift should be in the open position. Observation and interview on 3/27/25 at 9:37 A.M., showed: - Nurse Aide (NA) A brought the mechanical lift into the resident's room; - NA A opened the legs of the lift and went around the resident's wheelchair; - NA A and NA B hooked the lift sling up to the lift; - NA A raised the resident up in the lift and backed away from the resident's wheelchair; - NA A closed the legs of the mechanical lift and moved across the room and placed the legs of the lift under the resident's bed with the legs of the lift closed and lowered the resident onto the bed; - NA A and NA B unhooked the lift sling from the mechanical lift. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Review of Resident #21's Quarterly MDS, dated [DATE], showed: - Cognitive skills intact; - Lower extremities impaired on both sides; - Required set up and clean up with oral care; - Dependent on the assistance of staff for toilet use and transfers; - Required substantial to maximum assistance for personal hygiene; - Always incontinent of bowel and bladder; - Diagnoses included anxiety, depression, Congestive Heart Failure (CHF, accumulation of fluid in the lungs and other areas of the body), Chronic Obstructive Pulmonary Disease, (COPD, obstruction of air flow that interferes with normal breathing), diabetes mellitus and renal insufficiency (RI, a condition where the kidneys are unable to effectively filter waste products and excess fluid from the blood). Review of the resident's care plan, revised 3/26/25 showed: - The resident required substantial assistance with all of his/her ADLs; - The resident was incontinent of bowel and bladder; - The resident was maximum assistance with transfers of two staff and the mechanical lift. Observation on 3/25/25 at 2:36 P.M., showed: - CNA C placed the mechanical lift under the resident's bed with the legs of the lift closed; - CNA C and CNA D hooked the lift sling up to the mechanical lift; - CNA C raised the resident up in the mechanical lift with the legs of the lift closed; - CNA C backed away from the bed with the legs of the lift closed and moved across to the floor to the resident's recliner; - CNA C opened the legs of the lift to go around the resident's recliner and lowered the resident into the recliner; - CNA C and CNA D unhooked the lift sling from the mechanical lift. During an interview on 3/28/25 at 11:27 A.M., CNA D said the legs of the mechanical lift should be open when raising or lowering the resident. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 3/38/25 at 2:12 P.M., CNA C said the legs of the mechanical lift should always be open when raising or lowering a resident. Observation on 3/27/25 at 9:01 A.M., showed: - NA A and NA B gave the resident a bed bath; - NA A and NA B dressed the resident; - NA A placed the Direct Supply mechanical lift under the resident's bed with the legs of the lift closed; - NA A and NA B hooked the lift sling up to the lift; - NA A raised the resident up in the lift with the legs of the lift closed; - NA A backed away from the bed with the legs of the lift closed, turned the lift around with the legs closed and moved to the resident's wheelchair; - NA A opened the legs of the lift to go around the resident's wheelchair and lowered the resident into his/her wheelchair; - NA A and NA B unhooked the lift sling from the wheelchair. During an interview on 3/27/25 at 1:37 P.M., NA B said: - The legs of the mechanical lift should be closed when raising or lowering the resident; - The legs of the mechanical lift should be closed because of the way the beds are made; - The legs of the lift should be open when moving across the floor to the wheelchair or the bed. During an interview on 3/28/25 at 11:44 A.M., NA A said the legs of the mechanical lift should be closed when raising or lowering the resident and opened to go around the wheelchair. During an interview on 3/28/25 at 2:30 P.M., the Director of Nursing (DON) said the legs of the mechanical lift should be open when staff are raising or lowering the residents.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51166 Based on observation, interview and record review, the facility failed to ensure staff provided proper respiratory care when staff failed to keep oxygen tubing off the floor for three residents (Resident #22, #25, and #134), failed to date oxygen tubing for one resident (Resident #134), and failed to fill humidifier bottle with distilled water for one resident (Resident #134), resulting in possible exposure to bacteria and discomfort during oxygen usage. This affected three of 12 sampled residents. The facility census was 35. Review of the facility's Oxygen Administration policy, dated 10/2010, showed: -The purpose of this procedure is to provide guidelines for safe oxygen administration; -Be sure there is water in the humidifying jar and that the water level is high enough that the water bubbles as the oxygen flows through; -Periodically recheck water level in humidifying jar; -Securely anchor the tubing so that it does not rub or irritate the resident's nose, behind the resident's ears, etc. 1. Review of Resident #134's Face Sheet, undated, showed diagnoses included: skin cancer, anemia (low red blood cell count), kidney disease, lung disease, and kidney disease. Review of baseline care plan, dated 3/17/2025, directed staff to administer oxygen as ordered. Observation on 3/26/25 at 7:59 A.M. showed: -No date on oxygen tubing; -Excess oxygen tubing was coiled on the floor; -Water bottle was empty. Observation on 3/26/25 at 12:27 P.M. showed: -Excess oxygen tubing was coiled on the floor; -No date on oxygen tubing; -Water bottle was empty; -No date on oxygen tubing. Observation on 3/27/25 at 9:01 A.M. showed: (continued on next page)

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	265643	A. Building B. Wing	03/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Village Care Center Inc	810 East Edwards Street Maryville, MO 64468

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Excess oxygen tubing was coiled on the floor; -No date on oxygen tubing. 2. Review of Resident #25's Annual Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 1/2/25, showed: -Resident is cognitively intact; -Diagnoses included: heart failure, anxiety, depression, asthma, and respiratory failure; -Resident is independent with ADL's. Review of care plan, dated 1/28/2025, showed the resident wears oxygen continuously. Review of physician's orders, dated 10/2/2024 and 10/4/2024 showed: -Change oxygen tubing and clean oxygen filter every two weeks on Friday night shift; -Titrate oxygen, as needed, to maintain saturation greater than 92%, every shift. Observation on 3/25/25 at 11:56 A.M. showed excess oxygen tubing was coiled on the residents floor. 3. Review of Resident #22's Quarterly MDS, dated [DATE] showed: -Resident was cognitively intact; -Active diagnoses include: debility (general weakness), anemia, high blood pressure, peripheral vascular disease (circulation disorder), anxiety, asthma, and respiratory failure. Review of care plan, dated, 12/18/2024, showed no information regarding oxygen use. Review of physician's orders, dated 6/20/2023. showed to change oxygen and nebulizer tubing every two weeks on Friday night shift, date and initial tubing with small piece of medical tape. Observation on 3/25/25 at 4:40 P.M. showed excess oxygen tubing was coiled on the floor in the reisdent's room. Observation on 3/27/25 at 8:40 A.M. showed excess oxygen tubing was coiled on the floor in the residents room. During an interview on 3/28/25 at 10:17 A.M., CNA B said: -Oxygen tubing should not be touching the floor; -Oxygen tubing should be stored in a bag on the resident's concentrator; -The oxygen humidifier bottle should be filled to the line, about halfway. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 3/27/25 at 2:15 P.M., RN B said: -If there is excess oxygen tubing, it should be coiled and stored on the concentrator; -Oxygen tubing should not be coiled on the floor; -The oxygen humidifier bottle should be half full and should be checked daily. During an interview on 3/28/25 at 2:30 P.M., the Administrator said: -Oxygen tubing should be neatly coiled and kept off the floor; -The humidifier bottle for the oxygen concentrator should not be empty.

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 51166 Based on observation, interview, and record review, the facility failed to ensure they assessed residents for risk of entrapment from bed rails prior to installation, failed to ensure the bed's dimensions were appropriate for the resident's size, (for resident #134). Additionally the facility failed to obtain physicians orders and care plan the use of bed rails for three residents (Resident #23, #19 and #134). This included three of 12 residents sampled (Residents #23, #19, and #134). The facility census was 35. Review of facility policy, Proper Use of Side Rails, revised 12/2016, showed: -The purpose of these guidelines is to ensure the safe use of side rails as resident mobility aids and to prohibit the use of side rails as restraints unless necessary to treat a resident's medial symptoms; -An assessment will be made to determine if the resident's symptoms, risk of entrapment, and reason for using siderails; -When used for mobility, or transfer, an assessment will include a review of the residents: a) Bed mobility; b) Ability to change positions, transfer to and from bed or chair; c) Risk of entrapment from the use of siderails; d) That the bed's dimensions are appropriate for the resident's size and weight; -The use of side rails as an assistive device will be addressed in the resident care plan; -Consent for using restrictive devices will be obtained from the resident or legal representative after reviewing risks and benefits; -The resident will be checked periodically for safety relative to side rail use; -When side rail usage is appropriate, the facility will assess the space between the mattress and side rails to reduce the risk for entrapment. 1. Review of resident #23's admission minimum data set (MDS), a federally mandated assessment tool completed by facility staff, dated 2/11/25, showed: -He/She is cognitively intact; -He/She had impairment on both sides of lower extremities; (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-He/She required substantial assistance to move from sitting to lying and to move from lying to sitting; -He/She required total assistance for toileting, lower body dressing, and to move from sitting to standing; -He/She required partial/moderate assistance for upper body dressing; -Diagnoses included debility (general weakness), cardiorespiratory conditions, high blood pressure, and asthma. Observation on 3/25/25 at 1:58 P.M. showed U-shaped bed rails on the left and right side of the resident's bed. Review of physician's orders, dated 2/4/25 through 3/27/35, showed no orders for the use of side rail or assist bars. Review of resident's care plan, dated 2/24/25, showed: -Resident uses positioning wand (bedrail) on both sides of the bed to pull himself/herself over in bed; -Resident has been assessed for safety in using the positioning devices; -Resident has reviewed the risks and benefits of using the positioning wand and, despite the risk, he/she was able to maintain mobility independence by using the device. Review of positioning device assessment, dated 2/25/25 showed: -He/She was assessed for side rails to use to assist with transfers and bed mobility; -Positioning wands to be used; -No box was checked to indicate which side(s) of the bed the rail would be used on; -Resident's family signed for consent; -No bed measurements or height and weight of the resident noted. During an interview on 3/25/25 at 1:58 P.M., the resident said: -He/She uses the side rail to get in and out of bed. 2. Review of Resident #19's Annual (MDS), dated [DATE], showed: -Resident is cognitively intact; -Resident is independent with activities of daily living (ADL's). (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Impairment on one side of the upper extremity; -Diagnoses included: anemia (low red blood cell count), heart disease, high blood pressure, gastroesophageal reflux disease (stomach contents to back up into the esophagus), thyroid disorder, dementia, depression, diabetes, kidney disease, and debility (general state of weakness and decline). Observation on 3/25/25 at 3:29 P.M. showed U-shaped rail on the left side of the resident's bed. Review of physician's orders, dated 2/26/25 to 3/26/25, showed no order for bed rails. Review of care plan, dated 9/30/24, showed the Resident requested a handrail on the left side of the bed to have something to grab onto when getting out of bed. Review of positioning device assessment, dated 10/2/24, showed: -He/She was assessed for side rails to use to assist with transfers and bed mobility; -Positioning wand to be used on the left side of the bed; -No bed measurements or height and weight of the resident noted. During an interview on 3/25/25 at 3:29 P.M., the resident said he/she used the rail to get out of bed because he/she cannot use their right arm. 3. Review of Resident #134's face sheet showed: -Resident was admitted on [DATE]; -Diagnoses included: skin cancer, anemia (low red blood cell count), kidney disease, lung disease, and kidney disease. Observation on 3/26/25 at 7:59 A.M. showed U-shaped rail on the left side of the resident's bed. Review of resident's care plan, dated 3/18/25 did not include the use of or staff direction regarding the use of positioning bar. Review of resident's physician's orders dated 2/27/25 to 3/37/35 showed no order for positioning rails. During an interview on 3/26/25 at 7:59 A.M., resident #134 said he/she used the bed rail to keep himself/herself on the bed. During an interview on 3/27/25 at 2:15 P.M., RN B said physical therapy is responsible for requesting and placing the bedrails for residents. During an interview on 3/28/25 at 10:42 A.M., Physical Therapist A said: -Transfer bars were used to help residents to get in and out of bed; (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-If a resident was being seen by physical therapy, and the therapist deemed the resident needed a positioning bar, they will make a recommendation to the DON (director of nursing) and the administrator; -Physical therapy does not perform any assessments or measurements for positioning rails. During an interview on 3/28/25 at 2:30 P.M., the Administrator said: -Positioning rails should be provided when a resident requests one or when therapy recommends one; -An assessment that includes bed measurements should be completed and reviewed by the interdisciplinary team; -There should be physician's orders for positioning rails; -The use of positioning rails should be care planned.

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F 0728 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that nurse aides who have worked more than 4 months, are trained and competent; and nurse aides who have worked less than 4 months are enrolled in appropriate training. 31102 Based on observation, interview and record review, the facility failed to ensure nurse aides met the minimum qualifications which included satisfactory participation in a State-approved nurse aide training and competency evaluation program within four months of hire. The facility census was 35. Review of the facility's policy titled, Nurse Aide (NA) Qualifications and Training Requirements, revised May, 2019 showed: - Nurse Aides must undergo a state-approved training program; - In keeping with the Omnibus Budget Reconciliation Act of 1987 (OBRA), our facility will only employ those nurse aides who meet the requirements set forth in the federal and state statutes concerning the staffing of long-term care facilities; - Our facility will not employ any individual as a nurse aide for more than four months full-time, temporary, per diem, or otherwise, unless: that individual is competent to provide designated nursing care and nursing related services; and that individual has completed a training program and competency evaluation program, or a competency evaluation program approved by the state; or that individual has been deemed competent as provided in 483.150 (a) and (b) of the Requirements of Participation; - Nursing assistants failing to successfully completed the required training program within the first four months of their date of employment may be terminated from employment or may be reassigned to non-nursing related services. 1. Review of facility employee list showed;- Nurse Aide A was hired on 8/14/24; - Nurse Aide B was hired on 10/17/24; - Nurse Aide C was hired on 9/28/23; - Nurse Aide D was hired on 9/11/18. During an interview on 3/28/25 at 2:30 P.M., the Administrator said the nurse aides should be enrolled in Certified Nurse Aide (CNA) classes within four months of their hire date.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. 31102 Based on observation, interview, and record review, the facility failed to ensure staff administered medications with a medication error rate of less than five percent. Facility staff made three medication errors out of 25 opportunities for error, which resulted in a medication error rate of 12%, which affected two of the 12 sampled residents, (Resident # 19 and #27). The facility census was 35. Review of the facility's policy titled, Medication and Treatment Orders, revised July 2016, showed: - Orders for medications and treatments will be consistent with principles of safe and effective order writing; - Medications shall be administered only upon the written order of a person duly licensed and authorized to prescribe such medications in this state; - Drug and biological orders must be recorded on the Physician Order Sheet (POS) in the resident's chart; - All drug and biological orders shall be written, dated, and signed by the person lawfully authorized to give such an order; - Orders for medications must include: name and strength of the drug; number of doses, start and stop date, and/or specific duration of therapy; dosage and frequency of administration; route of administration; clinical condition or symptoms for which the medication is prescribed. Review of the facility's policy titled, Administering Medications, revised April 2019, showed: - Medications are administered in a safe and timely manner, and as prescribed; - Medications are administered in accordance with prescriber orders, including any required time frames. Review of the facility's policy titled, Administering Topical Medications, revised October 2010, showed: - The purpose of this procedure is to provide guidelines for the safe administration of topical medications; - Verify that there is a physician's medication order for this procedure; - Review the resident's care plan to assess for any special needs of the resident; - Perform hand antisepsis by either washing with soap and water or applying alcohol-based rub; - Place the Medication Administration Record (MAR) within easy viewing distance; (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Check the label on the medication and confirm the medication name and dose with the MAR; - Calculate the medication dose; - Prepare the correct dose of medication; - Apply glove to your dominant hand; - Remove tongue blade from sterile wrapper; - Place medication on the tongue blade and transfer to gloved hands; - Warm the medication in gloved hands and apply gently to the skin in the direction of hair growth; - Remove gloves. Wash and dry hands thoroughly. 1. Review of Resident #19's POS, dated 2/26/25 - 3/26/25 showed: - Start date: 9/23/24 - Diclofenac Sodium over the counter (OTC) gel 1%, 4 grams topically, apply to affected area in the A.M., and at bedtime for arthritis. Review of the resident's MAR, dated 3/1/25 - 3/26/25 showed: - Diclofenac Sodium OTC gel 1%, 4 grams topically, apply to affected area in the A.M., and at bedtime for arthritis. Observation on 3/27/25 at 7:24 A.M., showed: - Certified Medication Technician (CMT) B did not wash his/her hands and applied gloves; - CMT B applied an unknown amount of Diclofenac gel to his/her gloved hands and applied across the resident's shoulders, removed gloves and did not wash his/her hands. During an interview on 3/27/25 at 1:15 P.M., CMT B said the Diclofenac gel should be measured but he/she can not always find the measuring device. During an interview on 3/28/25 at 2:30 P.M., the Director of Nursing (DON) said staff should measure the Diclofenac gel. 2. Review of the facility's policy titled, Instillation of Eye Drops, revised January 2014, showed: - The purpose of this procedure is to provide guidelines for instillation of eye drops to treat medical conditions, eye infections and dry eyes; - To steady the eye dropper during the instillation process, rest your hand on the bridge of the resident's nose or on his/her forehead; - Wash and dry your hands thoroughly and don gloves; (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- If the resident is sitting up, tilt his/her head backward slightly; - Gently pull the lower eyelid down, instruct the resident to look up; - Drop the medication into the mid lower eyelid. (Do not touch the eye or eyelid with the dropper); - Instruct the resident to slowly close his/her eyelid to allow for even distribution of the drops; - Instruct the resident not to blink or squeeze the eyelids shut, which forces the medicine out of the eye. Review of the website, www.webmd.com for administration of artificial tears showed: - Tilt the head back, look up and pull down the lower eyelid to make a pouch; - Place the dropper directly over the eye and squeeze out one or two drops as needed; - Look down and gently close your eye for one or two minutes; - Place one finger at the corner of the eye near the nose and apply gently pressure. This will prevent the medication from draining away from the eye. Review of the manufacture's guidelines for Flonase nasal spray (used to treat allergies) showed: - Shake the bottle gently; - Blow your nose to clear the nostrils; - Close one side of the nostril. Tilt your head forward slightly and carefully insert the nasal applicator into the other nostril; - Start to breathe in through your nose, and while breathing in press firmly and quickly down one time on the applicator to release the spray; - Repeat in the other nostril; - Wipe the nasal applicator with a clean tissue and replace the cap. Review of Resident #27's POS, dated 2/27/25 - 3/27/25, showed: - Start date: 6/7/24 - Flonase Allergy Relief spray 50 micrograms (mcg.) one spray in each nostril as needed for rhinitis (inflammation of the nasal mucous membranes); - Start date: 3/25/25 - Artificial tears 1.0 - 2.0, 2% one drop in both eyes as needed for dry eyes. Complete hand hygiene. Tilt head back, gently pull down lower eyelid to create a pocket, and instill one drop into both eyes in the pocket, avoid touching the dropper tip to your eye or surrounding areas. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the resident's MAR, dated 3/1/27 - 3/27/25, showed: - Flonase Allergy Relief spray 50 mcg. one spray in each nostril as needed for rhinitis; - Artificial tears 1.0 - 2.0, 2% one drop in both eyes as needed for dry eyes. Observation on 3/27/25 at 7:49 A.M., showed: - CMT B had the resident blow his/her nose. He/She shook the bottle and gave one spray in each nostril and did not close one side of the nostril; - CMT B gave one drop of Visine in the right eye and touched the tip of the eye dropper to the resident's eye lashes, then gave one drop in the resident's left eye and touched the tip of the eye dropper to the resident's eye lashes. He/She did not apply lacrimal pressure to either eye. During an interview on 3/27/25 at 1:15 P.M., CMT B said: - He/She should have used artificial tears instead of the Visine; - He/She should not have touched the tip of the eye dropper to the resident's eyelid; - He/She was never taught to apply lacrimal pressure; - Should follow the manufacturer's guidelines for administering nasal spray and should close each side of the nostril. During an interview on 3/28/25 at 3: 20 P.M., the DON said;- The tip of the eye dropper should not touch the resident's eye lashes and staff should apply lacrimal pressure; - Staff should follow the manufacturer's guidelines for administration of the nasal spray; - Staff should administer the correct eye drop.

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F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician. 51166 Based on observation and interviews, the facility failed to ensure the Dietary Manager (DM) had the appropriate competencies and skills sets to carry out the functions of the food and nutritional services. The facility census was 35. 1. The facility did not provide a policy for the Dietary Manager qualifications. During an interview on 3/27/25 at 9:42 A.M., Dietary Manager said: -He/She has worked at the facility for ten years; -He/She has been the Dietary Manager for a year; -He/She did not have any dietary manager certifications; -He/She did not know what certifications were required for a dietary manager; -He/She was not currently enrolled in classes for dietary manager certifications; -He/She needed to make a plan with the dietician about enrolling in dietary certification classes. -The facility dietician was contracted to come in once a month. During an interview on 3/28/25 at 2:30 P.M., the Administrator said: -The dietary manager needed to take the dietary management course to obtain the required certifications; -The dietary manager was an interim dietary manager; -He/She had been advertising to fill the dietary manager position for a while; -He/She said they would have to look at the regulation to determine the deadline for the dietary manager to obtain the required certifications.

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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. 51166 Based on observation, interview, and record review, the facility failed to prepare and serve food in accordance with professional standards for food service safety when staff failed to keep a record of the dishwasher temperature and chemical tests, failed to cease using dishwasher when temperatures did not meet requirements, failed to keep a daily record of refrigerator temperatures, failed to wash hands in between tasks and in between glove changes, failed to label and date all foods upon receiving and upon opening, failed to ensure kitchen was clean and in good repair, and failed to ensure dishwasher temperature reached minimum temperatures. The facility census was 35. 1. Review of the facility's Food Handling policy, dated 7/2014, showed: -Food will be stored, prepared, handled, and served so that the risk of foodborne illness is minimized; -All employees who handle, prepare or serve food will be trained in the practices of safe food handling and preventing foodborne illness. The facility's Employee Hygiene and Sanitary Practices policy, dated 10/2017, showed: -Employees must wash their hands: a) Whenever entering or re-entering the kitchen; b) Before coming into contact with any food surfaces; c) After handling soiled equipment or utensils; d) During food preparation, as often as necessary to remove soil ad contamination and to prevent cross contamination when changing tasks, or; e) After engaging in other activities that contaminate the hands; -Contact between food and bare (ungloved) hands is prohibited; -The use of disposable gloves does not substitute for proper handwashing. Observation on 3/26/25 from 11:07 A.M. to 12:01P.M. showed: -Cook A used gloved hands to turn on the faucet to fill a measuring cup with water; -Cook A added spaghetti noodles to the boiling water with the same gloved hands that were used to turn on the faucet to fill the measuring cup with water with no handwashing was done in between tasks. (continued on next page)

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Village Care Center Inc	810 East Edwards Street Maryville, MO 64468

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	- [NAME] A used gloved hands to turn on faucet to fill water pitcher. - [NAME] A cut up chicken with same gloved hands that were used to fill the water pitcher at 11:19 A.M. with no handwashing since filling the pitcher. Observation on 3/26/25 at 11:41 A.M. showed Dietary Aid B washed the workstation by the coffee maker with a dishcloth, did not wash hands before pulling pre-poured drinks from the refrigerator to pass out to residents in dining room. Observation on 3/26/25 at 12:01 P.M. showed: -Cook A removed gloves, did not wash hands and put on oven mitts to remove the garlic bread from the oven; -Cook A did not wash hands before putting on new gloves on to remove garlic bread from the pan. During an interview on 3/27/25 at 9:26 A.M., Dietary Aid A said: -Hands should be washed before handling food; -Hands should be washed before handling food or clean dishes if a dietary aid touches any dirty dishes. During an interview on 3/27/25 at 9:42 A.M., the dietary manager said hands should be washed when switching tasks. During an interview on 3/28/25 at 2:30 P.M., the Administrator said he/she expects staff to wash hands upon entry into the kitchen, if hands are visibly contaminated, and before/after donning gloves; 2. Review of the facility's Sanitization policy, dated 10/2008, showed; - All equipment, food contact surfaces, and utensils shall be washed to remove or completely loosen soils by using the manual or mechanical means necessary and sanitized using hot water/and/or chemical sanitizing solutions. Observation on 3/25/25 at 10:09 A.M. showed: -Missing baseboard behind steam table and unpainted patched areas 3x3 inches; -Garbage can next to the stove was covered with spills and grime; -Dirty fan next to handwashing sink was covered in dirt and grime; -Dirty air purifier next to the oven was covered in spills on the front; -Grills on the bottom of upright refrigerator doors and freezer were covered in grime and spatters. During an interview on 3/27/25 at 9:26 A.M., Dietary Aid A said: (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-The outside of garbage cans and refrigerator grills should be free of spatters and grime and should cleaned twice a day and in between if there was something that recently spilled; -The walls and ceiling in the kitchen should be in good repair. During an interview on 3/27/25 at 9:42 A.M., the Dietary Manager said: -The outside of garbage cans, refrigerator grills, and fans should be cleaned twice a week and be free of spatters and grime; -Kitchen walls and ceiling should be in good repair and painted. During an interview on 3/28/25 at 2:30 P.M., the administrator said: -He/She expects the outside of garbage cans, refrigerator grills, and items used in the kitchen to be clean and free of spatters and grime; -He/She expects the walls and baseboards in the kitchen to be in good repair. 3. Review of the facility's Food Receiving and Storage policy, dated 7/2014, showed: -All foods stored in the refrigerator or freezer will be covered, labeled and dated; -Functioning of the refrigeration and food temperatures will be monitored at designated intervals throughout the day by the food and nutrition services manager and documented. The facility's Refrigerators and Freezers policy, dated 12/2014, showed: -Monthly tracking sheets for all refrigerators and freezers will be posted to record temperatures; -Food service supervisors will check and record refrigerator and freezer temperatures daily with first opening and at closing in the evening; -All food shall be appropriately dated to ensure proper rotation by expiration dates. Received dates (dates of delivery) will be marked on cases and on individual items removed from cases for storage. Continuous observation on 3/25/25 at 10:09 A.M. to10:40 A.M. showed: -No received date or best by date on frozen peas in pantry upright freezer; -No best by date or received date on brussel sprouts in pantry upright freezer; -No best by or received date on 12 packages of unbranded frozen lunch meat in pantry upright freezer; -No open date on two packages of broccoli in pantry upright freezer; (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-Two packages of opened, unsealed, undated, wilted and browning cabbage in refrigerator; -sliced white cheese in the refrigerator with no opened date; -Opened and unsealed 5 lbs. shredded mild cheddar cheese in the refrigerator; - Butter in the refrigerator with no received date; -No dates on frozen breadsticks in deep freezer; -No dates on frozen dinner rolls in deep freezer; -Temperature logs missing for evening refrigerator temperatures for the two-door refrigerator from 3/22-3/24; from 3/22 to 3/24; -Temperature logs missing for the white freezer from 3/22-3/24; -Temperature logs missing for the white chest freezer from 3/22 - 3/24; -Temperature logs missing for the drink refrigerator from 3/22 - 3/24. Observation of the two-door freezer on 3/25/25 at 10:40 A.M. showed: -No opened date and unsealed frozen peas; -No opened date on 4 Lb. bag of frozen vegetables; -No opened date, received date, or best by date on frozen sausage links; -No opened date received date, or best by date on frozen chicken drumsticks; -No opened date, received date, or best by date on frozen chicken cordon blue; -No opened date or received date on a bag of frozen sausage patties; -No received or opened date on frozen eggs. During an interview on 3/27/25 at 9:26 A.M., Dietary Aid A said: -All opened food packages must be wrapped in plastic or placed in a sealed tub; -Frozen vegetables should be folded over and clipped; -Bagged dry goods should be folded and clipped; -Refrigerator and freezer temperatures should be recorded in the morning and in the evening; -Freezer burned food and browned product should be thrown away; (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-Foods should be dated when received and dated again once opened. During an interview on 3/27/25 at 9:42 A.M., the Dietary Manager said: -Opened food should be sealed when in storage; -Opened food packages should be clipped to seal the bag; -When food is received, it should be dated and then dated again when opened; -Refrigerator and freezer temperatures should be recorded when staff arrives in the morning and evening; -Browning produce or freezer burned foods should be thrown away. During an interview on 3/28/25 at 2:30 P.M., the Administrator said: -Opened food should be sealed for storage; -Foods should be labeled with a received date and an opened date when opened; -Opened food should be sealed for storage; -Foods should be labeled with a received date and an opened date when opened. -He/She expects the refrigerator and freezer temperatures be recorded every shift; 4. Facility did not provide the requested dishwasher user manual. Review of the facility's Dishwashing Machine Use policy, dated 2/2010, showed: -Dishwashing machines that use hot water to sanitize must contain the following wash solution temperatures: a) 150 degrees Farenheit for stationary rack, dual temperature machines or multi-tank, conveyor, multi-temperature machines; b) 160 degrees Fahrenheit for single tank, conveyor, dual temperature machines; c) 165 degrees Fahrenheit for stationary rack, single temperature machines. -Dishwashing machine hot water sanitation rinse temperatures may not be more than 194 degrees Fahrenheit, or less than: a) 165 degrees Fahrenheit for stationary rack, single temperature machines; b) 180 degrees Fahrenheit for all other machines. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-The operator will check temperatures using the machine gauge with each dishwashing machine cycle and will record the results in a facility approved log; -Inadequate temperatures will be reported to the supervisor and corrected immediately; -If hot water temperatures or chemical sanitization concentration do not meet requirements, cease use of dishwashing machine immediately until temperatures or PPM are adjusted. -Dishwasher temperature log missing readings for 3/3-3/4; 3/7-3/10; 3/13-3/14; 3/17-3/18; 3/20-3/24. Observation on 3/25/25 10:09 A.M. showed: -Dishwasher temperature recordings were below the required temperature (in Fahrenheit) on: -3/1/25 Breakfast: wash temperature was 95 degrees, rinse temperature was 100 degrees; Lunch: wash temperature was 95 degrees, rinse temperature was 100 degrees; -3/2/25 Breakfast: wash temperature was 90 degrees; Lunch: wash temperature was 90 degrees and rinse temperature was 90 degrees; Dinner: wash temperature was 90 degrees; lunch temperature was 90 degrees; -3/5/25 Breakfast: wash temperature was 90 and rinse temperature was 95 degrees; Lunch wash temperature was 90 degrees and rinse temperature was 95 degrees; -3/6/25 Breakfast: wash temperature was 100 degrees, and the rinse temperature was 100 degrees; Lunch temperature was 100 degrees and lunch temperature was 100 degrees; -3/11/25 Breakfast: wash temperature was 95 degrees, and the rinse temperature was 100 degrees; -3/12/25 Breakfast: wash temperature was 90 degrees, and the rinse temperature was 95 degrees; Lunch: was temperature was 90 degrees and the rinse temperature was 95 degrees; -3/15/25 Breakfast: wash temperature was 90 degrees, and the rinse temperature was 90 degrees; Lunch: wash temperature was 90 degrees, and the rinse temperature was 95 degrees; -3/16/25 Breakfast: wash temperature was 90 degrees, and the rinse temperature was 90 degrees; Lunch: wash temperature was 90 degrees, and the rinse temperature was 95 degrees; -3/19 Breakfast: wash temperature was 100 degrees, and the rinse temperature was 100 degrees; Lunch: wash cycle was 100 degrees, and the rinse temperature was 100 degrees; -3/25 Breakfast: wash temperature was 100 degrees, and the rinse temperature was 100 degrees; Lunch: wash temperature was 100 degrees, and the rinse temperature was 100 degrees. During an interview on 3/27/25 at 9:26 A.M., Dietary Aid A said: (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-Temperatures for the wash cycle were done twice at breakfast: once for a wash cycle and once for the rinse cycle; -Wash cycle and rinse cycle test should read 120 degrees Fahrenheit at a minimum; -If the dishwasher temperatures were not high enough, the dietary staff may run dishes through the dishwasher again; -If the dishwasher temperature was too low then the dishes must be hand washed; -If the dishwasher temperature was too low, then the dietary staff would notify maintenance; -The water heater ran low on hot water when laundry and showers were being done at the same time the dishwasher was running; -The dietary staff has not been hand washing dishes recently; -The administrator was made aware of the low dishwasher temperatures and was working with the maintenance supervisor to correct the issue; During an interview on 3/27/25 at 9:42 A.M., the Dietary Manager said: -The facility had a low temperature, chemical dishwasher; -The dishwasher temperatures should be at 100 degrees Fahrenheit; -Dishes should be washed again if the dishwasher temperature reading is too low; -Maintenance supervisor has been notified that the dishwasher has been running low temperatures; -Dishwasher wash/rinse cycle temperatures should be recorded first thing in the morning and during the evening shift. During an interview on 3/28/25 at 9:48 A.M., the Maintenance Supervisor said: -Last December, the kitchen staff said they were having troubles getting dishwasher to an acceptable temperature; -He/She believes the dishwasher does not reach a high enough temperature due to the hot water heater; -He/She has been in touch with an HVAC company to request some warranty work on the water heater; -Food distributing company A checked the dishwasher a week ago and determined the dishwasher is working properly. During an interview on 3/28/25 at 2:30 P.M., the Administrator said: (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-The facility had a low temperature, chemical dishwasher; -He/She expects the dishwasher wash/rinse cycle temperatures to be recorded according to the facility policy; -He/She expects the dishwasher temperatures to be within the range according to the facility policy and dishwasher manual; -He/She expects staff to wash dishes using the three-sink method if the dishwasher temperature levels are unsafe.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31102 Based on observations, interviews and record review, the facility failed to ensure staff wore the proper personal protective equipment (PPE, specialized clothing or gear worn to minimize exposure to workplace hazards that can cause serious injuries or illnesses) which affected one of the 12 sampled residents, (Resident #18), failed to wear gloves when obtaining Resident #19's blood sugar, and failed to clean the port of the insulin pen prior to attaching the needle for Resident #1, #5, and #21. The facility census was 35. Review of the facility's policy titled, Infection Prevention and Control Manual, showed:- Enhanced Barrier Precautions, (EBP), are an infection control intervention designed to reduce transmission of multidrug-resistant organisms (MDROs) in nursing homes; - EBP involve 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 of MDRO acquisition (residents with wounds or indwelling medical devices); - EBP can be applied (when Contact Precautions do not otherwise apply) to residents with any of the following: wounds or indwelling medical devices, regardless of MDRO colonization status and infection or colonization with an MDRO; - Examples of indwelling medical devices include: central line, urinary catheter (sterile tube inserted into the bladder to drain urine) , feeding tube and tracheostomy (an artificial opening into the wind pipe to aid breathing)/ventilator (a device that supports or takes over the breathing process, delivering breaths to a person who is unable to breathe adequately on their own or who is breathing insufficiently); - Examples of high contact resident care activities include: dressing, bathing or showering, transferring, providing hygiene, changing linens, changing briefs or assisting with toileting , device care or use, and wound care; - Process: identify residents with wounds or indwelling medical devices, who have active MDRO infection or known to have MDRO colonization, and those at risk for MDROs due to wounds or indwelling medical devices; set up a room with Enhanced Barrier Precautions PPE supplies; use gown and gloves while providing high contact care activities; post clear signage outside of resident rooms indicating the type of PPE required and defining high risk resident care activities; gowns and gloves should be available outside of each resident room, and alcohol based hand rub should be available for every resident room (ideally both inside and outside of the room); do not need to wear gowns and gloves if transferring residents in dining room and /or commons area; a trash can (or laundry bin) large enough to dispose of multiple gowns should be available for each room; - Residents are not restricted to their rooms and do not require placement in a private room. Review of the facility's undated policy titled, Handwashing/Hand Hygiene, showed: - The facility considers hand hygiene the primary means to prevent the spread of infections; (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- All personnel shall be trained and regularly in-serviced on the importance of hand hygiene in preventing the transmission of healthcare-associated infections; - Wash hands with soap and water for the following situations: when hands are visible soiled and after contact with a resident with infectious diarrhea; - Use an alcohol-based hand rub containing at least 62% alcohol, or soap and water for the following situations: - Before and after direct contact with residents, before performing any non-surgical invasive procedures, before and after handling an invasive device (urinary catheters, intravenous (IV) sites), before moving from a contaminated body site to a clean body site during resident care, after contact with blood or bodily fluids, and before and after entering isolation precaution settings; - Hand hygiene is the final step after removing and disposing of PPE; - The use of gloves does not replace hand washing/hand hygiene; - Integration of glove use along with routine hand hygiene is recognized as the best practice for preventing healthcare-associated infections. 1. Review of Resident #18's Significant Change in Status Minimum Data Set, (MDS), a federally mandated assessment instrument completed by facility staff, dated 2/2/25 showed: - Cognitive skills severely impaired; - Upper extremities impaired on both sides; - Lower extremities impaired on one side; - Dependent on the assistance of staff for oral care, personal hygiene, transfers and toilet use; - Had a Suprapubic catheter (a catheter surgically inserted through the wall of the abdomen); - Always incontinent of bowel; - Diagnoses included obstructive uropathy (condition where urine flow is blocked in the urinary tract, preventing the body from properly eliminating waste products), Alzheimer's disease (a progressive brain disorder that gradually destroys memory, thinking skills, and eventually, the ability to carry out the simplest tasks), psychotic disorder (a mental illness characterized by a significant disconnect from reality, often involving symptoms like delusions (false beliefs) and hallucinations (seeing or hearing things that aren't there), and dementia (inability to think). Review of the resident's care plan, revised 3/26/25 showed: - The resident required maximum assist for daily care tasks needs; (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- He/she was dependent on staff for toileting needs. He/she was incontinent of bowel and had a supra pubic catheter; - He/she required substantial assistance of two staff for bed mobility. Observation on 3/26/25 at 7:53 A.M., showed: - Certified Medication Technician (CMT) B and Certified Nurse Aide (CNA) A entered the resident's room to get him/her up for breakfast; - CMT B and CNA A did not wash their hands and applied gloves and did not have on personal protective equipment (PPE, specialized clothing or gear worn to minimize exposure to workplace hazards that can cause serious injuries or illnesses); - The resident had an undated dressing on his/her coccyx (tailbone); - CMT B and CNA A provided incontinent care to the resident; - CMT B sanitized, applied gloves and a gown; - CMT B emptied the resident's drainage bag (a medical device, typically connected to a catheter, that collects urine or other fluids from the body); - CMT B removed the gown and gloves, sanitized hands and donned new gloves; - CMT B and CNA A dressed the resident and placed the lift sling under the resident; - CMT B and CNA A removed gloves and did wash their hands; - CMT B and CNA A used the mechanical lift and transferred the resident from the bed to his/her wheelchair; - Without gloves on, CMT B passed the drainage bag under the resident's wheelchair to CNA A who did not have gloves on and placed the drainage bag in the dignity bag (a bag used to cover and hold the catheter drainage bag so it is not visible); - CMT B propelled the resident to the dining room for breakfast. During an interview on 3/27/25 at 1:15 P.M., CMT B said: - He/She should wash hands anytime when providing cares for a resident, after providing resident cares and after cleaning fecal material. Should wash hands or sanitize between glove changes; - He/She thought you only had to wear PPE if you were emptying the drainage bag; - He/She was told to only gown up when providing wound care or catheter care. During an interview on 3/27/25 at 1:54 P.M., CNA A said: (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- The purpose of this procedure is to obtain a blood sample to determine the resident's blood glucose level (the concentration of glucose (a type of sugar) in your blood); - Wear clean gloves; - Assess the resident's fingertips for good blood supply; - Wash the selected fingertip with warm and water and soap. If alcohol is used to clean the fingertip, allow it to dry completely because the alcohol may alter the reading. Review of the resident's Annual MDS, dated [DATE] showed: - Cognitive skills intact; - Upper extremity impaired on one side; - Independent with eating and transfers; - Diagnoses included diabetes mellitus. Review of the resident's care plan revised 1/22/25 showed the resident was on a therapeutic diet for diabetes to control the resident's blood sugar. Review of Resident #19's Physician Order Sheet (POS), dated 2/26/25 - 3/26/25 showed the staff did not have an order to obtain blood sugar levels. Review of the resident's MAR, dated 3/1/25 - 3/26/25 showed the resident did not have a physician's order to obtain blood sugars. Observation on 3/27/25 at 7:24 A.M., showed:- CMT B entered the resident's room and did not wash his/her hands or apply gloves; - CMT B cleaned the resident's fingertip with an alcohol wipe, let it air dry and obtained the resident's blood sugar. During an interview on 3/27/25 at 1:15 P.M., CMT B said he/she was not taught to wear gloves when obtaining blood sugars. During an interview on 3/28/25 at 2:30 P.M., the DON said staff should wear gloves when obtaining blood sugars. 3. Review of the facility's undated policy titled, Insulin Pen Device, showed: - To attach the safety pen needle: remove the blue cap from the insulin pen; wipe the rubber seal with an alcohol pad; twist open and remove outer cover from the safety pen needle; screw the pen safety needle securely onto the insulin pen. Review of Resident #5's Quarterly MDS, dated [DATE] 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
	265643	A. Building B. Wing	03/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Village Care Center Inc	810 East Edwards Street Maryville, MO 64468

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 - Some	- Cognitive skills intact; - Upper and lower extremities impaired on both sides; - Diagnoses included diabetes mellitus, anxiety and depression. Review of the resident's POS dated 2/26/25 - 3/26/25 showed: - Order start date: 3/19/25 - Novolog (fast acting) Insulin Flex Pen, 18 units three times a day for diabetes mellitus. Review of the resident's MAR,dated 3/1/25 - 3/26/25 showed: - Novolog Insulin Flex Pen, 18 units three times a day for diabetes mellitus. Observation on 3/26/25 at 11:44 A.M., showed: - CMT A removed the cap from the Novolog insulin pen, did not clean the port with an alcohol wipe and attached the needle; - CMT A primed the insulin pen with two units, dialed to 18 units and administered the insulin to the resident. 4. Review of Resident #21's Quarterly MDS, dated [DATE], showed;- Cognitive skills intact; - Lower extremity impaired on both sides; - Diagnoses included diabetes mellitus, depression, anxiety, and renal insufficiency (RI, a condition where the kidneys are unable to effectively filter waste products and excess fluid from the blood). Review of the resident's POS dated 2/27/25 - 3/27/25 showed: - Start date: 11/8/24 - Fiasp (fast acting) Flex Touch Insulin Pen per sliding scale. Blood sugar 316. For blood sugar range 301 - 350 - give 14 units with meals for diabetes mellitus. Review of the resident's MAR, dated 3/1/25 - 3/27/25 showed: -FiaspFlex Touch Insulin Pen per sliding scale. Blood sugar 316. For blood sugar range 301 - 350 - give 14 units with meals for diabetes mellitus. Observation and interview on 3/26/25 at 11:51 A.M., showed: - CMT A removed the cap from the Fiasp insulin pen, did not clean the port with an alcohol wipe and attached the needle; - CMT A primed the insulin pen with four units, he/she said there was not enough insulin and the resident would need a new insulin pen; (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265643	A. Building B. Wing	03/28/2025

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- CMT A dialed the Fiasp insulin pen to 11 units and administered it to the resident; - CMT A removed the cap from a new Fiasp insulin pen, did not clean the port with an alcohol wipe and attached the needle; - CMT A primed the Fiasp insulin pen with three units, dialed the Fiasp insulin pen to three units and administered it to the resident. During an interview on 3/28/25 at 9:43 A.M., CMT A said he/she should have cleaned the insulin ports with an alcohol wipe before attaching the needle. During an interview on 3/28/25 at 2:30 P.M., the DON said staff should clean the insulin ports with an alcohol wipe before attaching the needle.