STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265656	A. Building B. Wing	10/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Strafford Care Center	505 West Evergreen Strafford, MO 65757

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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Protect each resident from the wrongful use of the resident's belongings or money. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34906 Based on interview and record review, the facility failed to protect all residents from misappropriation of resident property when the facility could not account for all resident medication, while in the medications were in the possession of the facility staff, for four residents (Resident #1, Resident #2, Resident #3, and Resident #4). The facility census was 68. Review of the facility's Abuse Prohibition Protocol Manual, dated 11/28/2016, showed the following: -The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation, including freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms; -Ensure that all allegations violations involving abuse, neglect, exploitation, or mistreatment, including injuries of unknown source, and misappropriation of resident property are reported immediately, but no later that 2 hours after the allegation is made, if the event that cause the allegation involve abuse (all allegations of abuse are reported within 2 hours) or if an event, results in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with state law through established protocols; -Have evidence that all alleged violations are thoroughly investigated and report the results within 5 days to the state survey agency; -Definition of misappropriation of resident property is the deliberate misplacement, exploitation, or wrongful, temporary, or permanent use of a resident's belongings or money without the resident's consent. 1. Review of the facility's Administrator's Summary of Investigation Process of Incident completed by the Assistant to the Administrator showed the following: (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Strafford Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 505 West Evergreen Strafford, MO 65757	

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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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-On 10/05/24, at 5:15 A.M., Certified Medication Technician (CMT) B arrived at the facility. Licensed Practical Nurse (LPN) C handed CMT B the narcotic (controlled medication) keys and proceeded to walk away. CMT B informed LPN C he/she needed to count the narcotics with CMT B. While waiting for LPN C to return for the count, CMT B noticed the controlled count book was opened to Resident #4. CMT B noticed that three Norco (a pain medication) 5/325 milligram (mg) was signed out at 4:30 A.M., 4:30 A.M., and 4:00 A.M. The count was correct, however the times recorded were incorrect. Upon further investigation, three other residents had medications signed out, but not administered. These medication were as needed (PRN) doses that were signed out on the narcotic sheet as given however, were never popped out and administered. CMT B asked LPN C to please correct the count and amend the administration of the medication. LPN C was unstable on his/her feet at this time and very confused. CMT B called LPN A at 5:55 A.M. to get his/her estimated time of arrival (ETA). LPN A arrived in the building at the time of CMT B's phone call. -On 10/05/24, at 5:55 A.M., LPN A arrived at the facility. Upon clocking in for his/her shift, LPN A noticed LPN C from night shift leaning on the nurses' station with his/her head resting on the top tier of the nurses' station. LPN A tried to wake LPN C, but LPN C was not able to be awoken. CMT B informed LPN A that CMT B had already called the Assistant Director of Nursing (ADON). -On 10/05/24, at 6:15 A.M., the Director of Nursing (DON) received a phone call from the ADON. The ADON requested that the DON was needed in the facility immediately. The DON proceeded to the facility and placed a call to LPN A that he/she was on his/her way. At 6:40 A.M., the DON arrived at the facility. Upon entering, the DON found LPN C slumped over a chair behind the nurses' station. The DON proceeded to have LPN A and CMT B ensure that the narcotic count was correct in each cart and if any discrepancies they were to be reported to the DON immediately. At 6:45 A.M., the ADON arrived at the facility. The DON and ADON approached LPN C, who was still slumped over in a chair at the nurses' station. The DON was able to wake LPN C and escort LPN C to the DON's office. The DON asked LPN C if LPN C had taken any drugs or alcohol during his/her shift as he/she seemed impaired. He/She denied taking any substance and insisted he/she was tired. LPN C left the building via the front entrance at 7:10 A.M. CMT C and LPN A finished up the count with a total of 4 residents missing a total of 6 medications. 2. Review of Resident #1's face sheet showed the following: -admitted [DATE]; -Readmitted [DATE] at 3:59 P.M.; -Diagnoses included of dementia, type II diabetes mellitus, left humerus (upper arm) fracture with surgical repair, pain in the left shoulder, and history of a diabetic foot ulcer. Review of the resident's physician orders showed an order, dated 10/03/24, for oxycodone/acetaminophen (APAP) (a controlled opioid pain medication) 10/325 milligram (mg) tablet, administer one tablet every four hours as needed for pain. Review of the resident's October 2024 Medication Administration Record (MAR) showed the following: -An order, dated 10/03/24, for oxycodone/APAP administer one tablet by mouth every four hours as needed for pain for diagnosis of fracture of humerus with surgical repair; (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-On 10/03/24, at 3:23 P.M., LPN A signed the administration of one tablet for pain with effective results; -On 10/03/24, at 8:02 P.M., LPN A signed administration of one tablet for pain with effective results; -On 10/04/24, staff did not sign for administration of any doses of the medication. Review of the resident's Control Drug Receipt/Record/Disposition Form for oxycodone/acetaminophen (APAP) tablet 10/325 milligrams (mg) showed the following: -Directions: take one tablet by mouth every four hours as needed; -Thirty tablets received by the facility from the pharmacy on 10/02/24; -On 10/03/24, at 3:23 P.M., LPN A signed administration of one tablet and remaining count of 28 tablets; -On 10/03/24, at 8:00 P.M., LPN A signed administration of one tablet and remaining count of 27 tablets; -On 10/04/24, at 3:00 A.M., LPN A signed administration of one tablet and remaining count of 26 tablets; -No other nurses signed subsequent administration of the medication; -On 10/04/24, the Assistant to the Administrator and the ADON documented an audit of the medication which showed 24 remaining tablets; -The audit showed two missing oxycodone/APAP 10/325 mg tablets. Review of the facility's Administrator's Summary of Investigation Process of Incident, completed by the Assistant to the Administrator showed oxycodone/acetaminophen 10/325 milligrams tablet documented count was 26 tablets, actual amount was 24 tablets, missing dose 2 tablets. 3. Review of Resident #2's face sheet showed the following: -admitted [DATE]; -Re-admitted [DATE]; -admitted to hospice services on 04/17/24; -Diagnoses included displaced intertrochanteric (hip) fracture of the left femur with surgical repair, Alzheimer's disease, spinal stenosis (a condition that occurs when the spinal canal narrows, putting pressure on the spinal cord and nerve roots) of the lumbosacral (low back) region, anxiety, and chronic pain. (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the resident's physician orders an order, dated 05/22/24, for lorazepam (a controlled antianxiety medication) intensol concentrate, 2 mg/milliliter (ml), give 0.5 mg (0.25 mL) every two hours as needed for anxiety. Review of the resident's October 2024 MAR showed the following: -An order, dated 05/22/24, for lorazepam intensol concentrate, 2 mg/ml, amount to administer 0.5 mg (0.25 mL) every two hours as needed for anxiety; -The ADON signed administration of one dose on 10/01/24, at 9:23 A.M. with effective results. Review of the resident's Controlled Drug Receipt/Record/Disposition form for lorazepam concentrate 2 mg/mL showed the following: -Directions to give 0.25 mL (0.05 mg) by mouth every two hours as needed for anxiety; -Thirty mL dispensed from the pharmacy on 04/19/24; -Most recent dose recorded as administered on 09/28/24, at 6:15 P.M., 0.25 mL dose, with 26.25 remaining; -The next entry, dated 10/05/24, showed two staff audited the amount of medication with a corrected count of 22 mL remaining; -This audit showed 4.25 mL of lorazepam missing. Review of the resident's physician orders showed an order, dated 04/18/24, for morphine concentrate solution (a controlled opioid pain medication), 100 mg/5 mL (20 mg/mL), give 10 mg (0.5 mL) every 30 minutes as needed for pain and/or air hunger. Review of the resident's October 2024 MAR showed the following: -An order, dated 04/18/24, for morphine concentrate solution, 100 mg/5 mL, give 10 mg (0.5 mL) by mouth every two hours as needed for pain and/or air hunger; -Staff did not document administration of the medication during October 2024. Review of the resident's Controlled Drug Receipt/Record/Disposition Form for morphine solution 100 mg/5 mL showed the following: -Directions: Give 0.5 mL (10 mg) by mouth every 30 minutes as needed; -Thirty mL dispensed from the pharmacy on 06/10/24; -Most recent dose recorded as administered on 9/28/24, at 6:15 P.M., by LPN A, 0.5 mL given, with 23.0 mL remaining; (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-The next entry, dated 10/05/24, showed two staff audited the amount of medication with a corrected count of 20 mL remaining; -This audit showed 3.0 mL of morphine missing. Review of the facility's Administrator's Summary of Investigation Process of Incident, completed by the Assistant to the Administrator showed the following: -The resident's morphine liquid documented count was 23.0 mL, actual amount was 20.0 mL, missing dose was 3.0 mL; -The resident's lorazepam liquid documented count was 26.25 mL, actual amount was 22.0 mL, missing dose was 4.25 mL. 4. Review of Resident #3's face sheet showed the following: -admitted [DATE]; -Readmitted [DATE]; -Diagnoses included of stroke and type II diabetes mellitus; -admitted to hospice on 05/24/23. Review of the resident's physician orders showed an order, dated 01/19/24, for morphine concentrate solution, 100 mg/5 mL (20 mg/mL) give 0.25 mL orally every two hours as needed for pain. Review of the resident's October 2024 MAR showed the following: -An order, dated 01/19/24, for morphine concentrate solution, 100 mg/5 mL (20 mg/mL) give 0.25 mL orally every two hours as needed for pain. -LPN A administered the medication on 10/01/24, at 5:53 A.M., for pain with effective results. Review of the resident's Controlled Drug Receipt/Record/Disposition Form for morphine solution 100 mg/5 mL showed the following: -Directions: take 0.25 mL (5 mg) by mouth every two hours as needed for pain; -Thirty mL dispensed from the pharmacy on 01/22/24; -On 10/01/24, at 5:50 A.M., a nurse signed administration of 0.25 mL, with 23.00 mL remaining. Review of the resident's October 2024 MAR showed LPN A administered the medication on 10/02/24, at 4:56 P.M., for pain with non-effective results. (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the resident's Controlled Drug Receipt/Record/Disposition form for Morphine solution 100 mg/5 mL showed on 10/02/24, at 5:00 P.M., LPN A signed administration of 0.25 mL with 22.75 mL remaining. Review of the resident's October 2024 MAR showed LPN A administered the medication on 10/03/24, at 4:40 P.M., for pain with non-effective results. Review of the resident's Controlled Drug Receipt/Record/Disposition Form for morphine solution 100 mg/5 mL showed the following: -On 10/03/24, at 4:35 P.M., LPN A signed administration of 0.25 mL, with 22.50 mL remaining; -On 10/03/24, at 7:35 P.M., LPN A signed administration of 0.25 mL, with 22.25 mL remaining. (This dose was not signed as administered on the resident's MAR); -On 10/03/24, at 10:35 P.M., LPN A signed administration of 0.25 mL, with 22.00 mL remaining. (This dose was not signed as administered on the resident's MAR); -The next entry on 10/05/24, showed two staff audited the quantity of medication and corrected the amount to 19 mL; -This audit showed 2.75 mL of morphine missing. Review of the resident's physician orders showed an order, dated 07/03/24, for lorazepam intensol concentrate, 2 mg/mL, give 0.25 ml (0.5 mg) every two hours as needed for anxiety and/or air hunger. Review of the resident's October 2024 MAR showed the following: -An order, dated 07/03/24, for lorazepam intensol concentrate, 2 mg/mL, give 0.25 mL (0.5 mg) every two hours as needed for anxiety and/or air hunger; -LPN A documented administration of the medication on 10/01/24, at 5:53 A.M., for yelling with effective results; -LPN A documented administration of the medication on 10/02/24, at 4:56 P.M., for anxiety with non-effective results; -LPN A documented administration of the medication on 10/03/24, at 4:40 P.M., for anxiety with somewhat effective results; -Registered Nurse (RN) D documented administration of the medication on 10/04/24, at 4:53 P.M., for yelling with effective results; Review of the resident's Controlled Drug Receipt/Record/Disposition Form for lorazepam oral concentrate 2 mg/mL showed: -Directions: Give 0.25 mL (0.5 mg) by mouth every two hours as needed for anxiety/air hunger; (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Thirty mL dispensed from the pharmacy on 07/03/24; -On 10/01/24, at 5:50 A.M., LPN A signed administration of 0.25 mL, with 17.25 mL remaining; -On 10/02/24, at 3:00 P.M., LPN A signed wasted 0.25 mL, with 17.00 mL remaining, with a certified medication tech (CMT) co-signing the wasting of the medication; -On 10/03/24, at 4:30 P.M., LPN A signed administration of 0.25 mL, with 16.75 mL remaining; -On 10/03/24, at 10:30 P.M., LPN A signed administration of 0.25 mL, with 16.50 mL remaining; -On 10/04/24, at 4:53 P.M., RN D signed administration of 0.25 mL, with 16.25 mL remaining; -The next entry on 10/05/24, at 9:00 A.M., showed two staff audited the quantity of medication and corrected the amount to 15 mL; -This audit showed 1.25 mL of lorazepam missing. Review of the facility's Administrator's Summary of Investigation Process of Incident, completed by the Assistant to the Administrator showed the following: -Lorazapam liquid documented count was 16.25 mL, actual amount was 15.0 mL, missing dose of 1.25 mL; -Morphine liquid documented count was 22.0 mL, actual amount was 19.0 mL, missing dose of 2.25 mL. 5. Review of Resident #4's face sheet showed: -admitted [DATE]; -Readmitted [DATE]; -Diagnoses included rheumatoid arthritis, depression, and generalized anxiety disorder. Review of the resident's physician orders showed an order, dated 07/19/24, for hydrocodone/acetaminophen 5/325 mg three times a day at 8:00 A.M., 12:00 P.M., and 8:00 P.M. for diagnosis of chronic pain. Review of the resident's October 2024 MAR showed: -An order, dated 07/19/23, for hydrocodone/acetaminophen 5/325 mg three times a day at 8:00 A.M., 12:00 P.M., and 8:00 P.M., for diagnosis of chronic pain; -The resident did not have any other orders for hydrocodone/acetaminophen. Review of the facility's Administrator's Summary of Investigation Process of Incident, completed by the Assistant to the Administrator showed the following: (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-The resident's hydrocodone/acetaminophen 5/325 mg count was three on hand, there should have been six. -LPN C had signed out three Norco 5/325 at 4:30 A.M., 4:30 A.M., and 4:00 A.M. LPN C should not have signed these medications out due to them being scheduled at 8:00 A.M., 12:00 P.M., and 8:00 P.M. They were no orders for these times or a as needed (PRN) order. These times where incorrect, and the count should have been six tabs. 6. During an interview on 10/16/24, at 11:11 A.M., LPN A said the following: -On the morning of 10/05/24, he/she was not able to count narcotics with LPN C due to his/her condition; -LPN A counted narcotics with CMT B and discovered some of the residents' controlled medications were missing and not signed for and discovered additional doses were signed for on one resident. These discrepancies were reported to the DON. The DON began a reconciliation of all resident controlled medications. 7. During an interview on 10/16/24, at 1:47 P.M., CMT B said the following: -On 10/04/24 at 10:00 P.M., he/she counted the quantity of each controlled medications at the end of his/her shift with oncoming nurse, LPN C; -Both staff were supposed to initial that the count was correct and document the total number of medication containers; -CMT B was not aware LPN C did not document his/her initials of the count of the controlled medication log at the beginning of LPN C's shift at 10:00 P.M. on 10/04/24; -On the morning of 10/05/24, at approximately 5:15 A.M., CMT B arrived to work and LPN C handed CMT B the CMT keys and walked away without counting the carts; -LPN C then returned to the cart and was stumbling sideways into CMT B and into the medication cart, he/she was unable to count and CMT B told LPN C to sit down; -CMT B counted the medication carts with LPN A and found several discrepancies with the controlled medication counts; -The DON and ADON arrived and were notified of the situation. 8. During an interview on 10/16/24, at 3:50 P.M., RN D said the following: -On 10/04/24, he/she came to work at 2:00 P.M. and LPN C came in at 10:00 P.M.; -LPN C counted all the controlled medication with RN D; -RN D was notified on 10/16/24, that LPN C did not sign the control count log for the evening of 10/04/2.; (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	9. During an interview on 10/18/24, at 1:04 P.M., the ADON said the following: -On the early morning of 10/05/24, while off work, he/she received a call from CMT B, who reported an issue with LPN C; -The ADON, then notified the DON and the Assistant to the Administrator of the situation; -On 10/05/24, between 5:00 A.M. and 5:30 A.M., the ADON arrived at the facility to find LPN C passed out at the nurse's station; -LPN C left the facility in his/her car; -The DON and ADON then began an audit of all the controlled medications in the facility; -The facility did not conduct regular audits of the controlled medication and logs. 10. During an interview on 10/17/24, at 4:10 P.M., the Administrator said the following: -Nurses and/or CMTs should count the controlled medications at each change of shift and whenever the keys change hands from one person to another; -Both staff member should visualize with quantity of controlled substance bottle or package and compare to the controlled medication sheet for that medication and should also count the total number of cards/bottles and document that number and both initial the log; -Both the oncoming and off going nurse or CMT should sign the controlled medication count log; -He/she was unsure if anyone was auditing to ensure all staff were counting and signing count for all the resident controlled medications each shift; -Each time a nurse or CMT administered a controlled medication dose from the locked cabinet to a resident, he/she should document on the electronic MAR, as well as the controlled medication sheet; -No staff should take any controlled medication for their own use or administer a controlled medication without a physician's order to administer; -Two nurses or a nurse and a CMT, must witness the wasting of a controlled medication; -If a staff member found a discrepancy in the controlled medication count, he/she should immediately report to the DON or Administrator; -On the morning of 10/05/24, staff determined LPN C had signed administration of three doses of a controlled pain medication to the same resident without a physician's order to administer the medication at that time. MO00243131, MO00243136

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34906 Based on interview and record review, the facility failed to ensure all residents received care per standards of practice when staff failed to administer antibiotics for a food infection timely, failed to routinely monitor the wound dressing follow toe amputation, and failed follow-up with the physician/surgeon when the wound dressing became saturated for one resident (Resident #1). The facility census was 68. Review of the facility policy titled, Resident Examination and Assessment, undated, showed the following: -The purpose of this procedure is to examine and assess the resident for any abnormalities in health status; -Notify the physician or any abnormalities such as, but not limited to abnormal vital signs, labored in breathing, changed in cognitive, behavioral, or neurological status from baseline, wounds or rashes on the resident's skin, worsening pain, as reported by the resident; -Report other information in accordance with facility policy and professional standards of practice. 1. Review of Resident #1's face sheet showed: -admitted [DATE]; -Readmitted [DATE] at 3:59 P.M.; -Diagnoses included dementia, type II diabetes mellitus, left arm humerus (upper arm bone) fracture with surgical repair, pain in left shoulder, and history of diabetic foot ulcer with unspecified wound of foot. Review of the resident's annual Minimum Data Set (MDS - a federally mandated comprehensive resident assessment completed by facility staff), dated 07/07/24, showed the following: -Moderate cognitive impairment; -No rejection of care observed; -Dependent (helper does all the effort) for oral hygiene, toileting hygiene, personal hygiene, rolling left to right in bed, moving from sitting to lying, and moving from lying to sitting; -Required substantial/maximal assistance (helper does more than half the effort) with showering/bathing; -Staff assessed the resident as having no current unhealed pressure ulcers or other skin concern.; (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the resident's Medication Administration Record (MAR) showed an order, dated 08/22/24, for treatment to the resident's left second toe. Staff to clean with wound cleanser, pat dry, apply skin prep to the peri-wound, cut and apply calcium alginate (a cream used to promote wound healing) to the wound bed, cover with gauze and secure with tape, change twice daily and as needed (PRN). Review of the resident's Wound Management Detail Report, dated on 09/23/24, showed the following: -Diabetic ulcer on left second toe, -Identified on 08/25/24; -Length of 1.1 centimeters (cm) and width of 1.3 cm; -No depth; -Light, bloody exudate (drainage); -No wound order; -Loss of epidermis and into but not through dermis; -No undermining (the destruction of tissue or ulceration extending under the skin edges (margins) so that the pressure ulcer is larger at its base than at the skin surface) or tunneling (a passageway of tissue destruction under the skin surface that has an opening at the skin level from the edge of the wound) present; -Epithelial tissue (a type of body tissue that forms the covering on all internal and external surfaces of your body); -Skin surrounding wound had errythema (redness)/blanchable (disappears under applied pressure); -Wound improving. Review of the resident's health plan nurse practitioner's note, dated 10/01/24, showed on 09/25/24 resident had surgical amputation of left third toe secondary to osteomyelitis (infection of the bone). Review of the resident's hospital after visit summary, dated 09/30/24, showed the following: -admitted to the hospital on 09/21/24; -Resident discharged to the skilled nursing facility (SNF) on 09/30/24; (continued on next page)

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NAME OF PROVIDER OR SUPPLIER: Strafford Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 505 West Evergreen Strafford, MO 65757	

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Podiatry: Cultures were reviewed and resident did have methicillin resistant staphylococcus aureus (MRSA - an infection that is resistant to certain antibiotics), but there is some susceptibility to oral medication. With the infection removed surgically, physician felt comfortable that there was no residual bone infection currently present; -Resident would likely benefit from a 10 to 14 day course of outpatient oral antibiotics of linezolid (an antibiotic) 600 milligrams (mg) two times a day for 14 days; -Follow up with podiatry appointment on 10/08/24; -Dry dressing can be left intact until he/she does follow up with podiatry, but if falls off can be reapplied as needed; -Procedure performed: Left toe amputation; -Linezolid 600 mg take one tablet every 12 hours, last given on 09/30/24 at 10:45 A.M.; -Antibiotic information: Using an antibiotic the wrong way can make an infection stronger and harder to treat. Take the medication exactly as prescribed. Do not skip doses. Review of the resident's MAR showed the treatment order for left second toe, dated 08/22/23, was discontinued on 09/30/24 upon the resident's return from the hospital. Review of the resident's admission clinical assessment showed the following: -Observation date: 09/30/24 at 10:20 P.M.; -Completed date: 10/02/24, at 1:02 A.M.; -admitted and time 09/30/24 at 3:10 P.M.; -Admitting diagnosis: Amputation of toe on left foot and closed fracture of distal end of left humerus; -Skin integrity upon admission included: Bruises, pressure ulcers, and surgical wounds; -Has surgical wound on the left foot where the toe was amputated; -Infection of the foot, amputation of toe on the left foot. (Staff did not specifically document related to the condition of the wound dressing.) Review of the resident's physician order sheet showed: -An order, dated 09/30/24 to 10/01/24, for linezolid 600 mg 1 tablet every 12 hours at 8:30 A.M. and 8:00 P. M. for 14 days for diagnosis of osteomyelitis; (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-An order, dated 10/01/24 to 10/15/24, for linezolid 600 mg 1 tablet every 12 hours at 8:30 A.M. and 8:00 P. M. for 14 days for diagnosis of osteomyelitis. Review of the resident's October 2024 MAR showed on 10/01/24, at 8:30 A.M., staff documented the linezolid was not administered due to item unavailable. Review of the resident's progress note dated 10/01/24, at 10:09 A.M., showed Registered Nurse (RN) J documented the following: -Resident was admitted to the hospital after falling in his/her room (at the facility) and fracturing his/her left humerus; -While in the hospital, the resident was diagnosed with MRSA. The doctor ordered linezolid for this infection, 600 mg two times per day, for 14 days. The resident's left foot dressing can be left intact until his/her follow up appointment with podiatry, but if the dressing falls off, it can be reapplied as needed. Resident is non weight bearing on the left foot. Resident is bed bound at this time due to unable to use his/her left arm and being non-weight bearing on the left foot. (Staff did not document related to the condition of the wound dressing.) Review of the resident's progress note dated 10/01/24, at 6:28 P.M., showed RN D documented the following: -Resident returned from the hospital and is taking linezolid 600 mg for diabetic foot infection (MRSA). Resident to take one tablet by mouth every 12 hours for 14 more days. Resident denies side effects to the antibiotic. The nurse assessed the resident for any side effects and no side effects were assessed or observed. (Staff did not document related to the condition of the wound dressing.) Review of the resident's progress note dated 10/01/24, at 6:32 P.M., showed RN J documented the following: -Resident was admitted to the hospital after falling in his/her room (at the facility) and fracturing his/her left humerus. -While in the hospital, he/she was diagnosed with MRSA infection of the second toe on his/her left foot and the hospital amputated the resident's toe on 09/26/24. The doctor ordered linezolid for this infection, 600 mg two times per day, for 14 days. The resident's left foot dressing can be left intact until his/her follow up appointment with podiatry, but if the dressing falls off, it can be reapplied as needed. Resident is non weight bearing on the left foot. Resident is bed bound at this time due to unable to use his/her left arm and being non-weight bearing on the left foot. (Staff did not document related to the condition of the wound dressing.) Review of the resident's October 2024 MAR showed on 10/01/24, at 8:00 P.M., staff documented administration of the resident's linezolid. (Approximately 33 hours after hospital administered previous dose.) (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the resident's progress note dated 10/01/24, at 10:26 P.M., showed RN D documented the following: -Resident's insurance needed prior authorization before providing the linezolid. The Director of Nursing (DON) gave the pharmacy permission to send a 5-day supply of the medication to give the resident's physician time to get the medication authorized through the resident's insurance. Review of the resident's progress note dated 10/02/24, at 2:13 A.M., showed the DON documented the following: -Admit and antibiotic: Resident readmitted from the hospital on 09/30/24. He/she continued on alert for left arm fracture and antibiotics for osteomyelitis, second toe of left foot amputated. He/she required two staff assistance with all activities of daily living (ADLs). Zero complaints of pain noted. New skin issue noted on return from the hospital, treatment in place. (The DON did not document related to the condition of the wound dressing.) Review of the resident's progress note dated 10/02/24,at 9:46 A.M., showed the DON documented the following: -DON spoke with pharmacy on 10/01/24, at 9:00 P.M., and authorized a five day supply of linezolid while authorization is addressed. The resident received his/her first dose of linezolid at 11:30 P.M., on 10/01/24. Review of the resident's progress note dated 10/02/24, at 2:18 P.M., showed Licensed Practical Nurse (LPN) A documented resident in bed and complained of pain. Staff administered as needed pain medication. Wrap sling in place, wrap to foot in place. Staff turned and repositioned. Resident incontinent of bowel and bladder, ate well, needs maximum assistance with ADLs, and stayed in bed.(Staff did not document related to the condition of the wound dressing.) Review of the resident's progress note dated 10/03/24, at 11:21 A.M., showed LPN A documented resident bandage to foot amputee toe intact and resident had brace on arm. (Staff did not document related to the condition of the wound dressing.) Review of the resident's progress note dated 10/03/24, at 11:29 A.M., showed LPN A documented resident returned from the physician (arm surgeon) appointment. (Staff did not document related to the condition of the wound dressing.) Review of the resident's progress note dated 10/04/24, at 9:11 A.M., showed the Assistant Director of Nursing (ADON) documented resident was being monitored for antibiotic for a foot infection. Vital signs were stable and staff will continue to monitor and report any changes. (Staff did not document related to the condition of the wound dressing.) Review of the resident's progress note dated 10/04/24, at 10:07 A.M., showed RN E documented he/she left message for return call from podiatrist's office regarding wound care for the resident's left second toe surgical dressing. (The RN did not document the reason for the physician notification or the condition of the wound dressing.) (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the resident's progress note dated 10/04/24, at 10:37 A.M., showed RN E documented the called the resident's podiatrist's office for left foot wound care instructions. (The RN did not document the reason for the physician notification or the condition of the wound dressing.) Review of the resident's progress note dated 10/04/24, at 9:02 P.M., showed RN D documented the following: -Resident was admitted to the hospital after falling in his/her room (at the facility) and fracturing his/her left humerus. -While in the hospital, he/she was diagnosed with MRSA infection of the second toe on his/her left foot and the hospital amputated the resident's toe on 09/26/24. The doctor ordered linezolid for this infection, 600 mg two times per day, for 14 days. The resident's left foot dressing can be left intact until his/her follow up appointment with podiatry, but if the dressing falls off, it can be reapplied as needed. Resident was non weight bearing on the left foot. (The RN did not document regarding the physician notification or the condition of the wound dressing.) Review of the resident's progress note dated 10/04/24, at 9:04 P.M., showed RN D documented the following: -Resident returned from the hospital and is taking linezolid 600 mg for diabetic foot infection (MRSA). Resident to take one tablet by mouth every 12 hours for 14 more days. Resident denied side effects to the antibiotic. The nurse assessed the resident for any side effects and no side effects were assessed or observed. (The RN did not document regarding the physician notification or the condition of the wound dressing.) Review of the resident's progress note dated 10/05/24, at 8:17 A.M., showed the DON documented he/she assessed the resident for pain and the resident had zero complaints of pain and stated was ready for a cup of coffee and breakfast. (The DON did not document regarding the physician notification or the condition of the wound dressing.) Review of the resident's progress note dated 10/05/24, at 11:55 A.M., showed RN J documented the following: -Resident back from hospital stay and was diagnosed with a closed fracture of the distal end of the left humerus. -While in the hospital, he/she was diagnosed with MRSA infection of the second toe on his/her left foot and the hospital amputated the resident's toe on 09/26/24. The doctor ordered linezolid for this infection, 600 mg two times per day, for 14 days. The resident's left foot dressing can be left intact until his/her follow up appointment with podiatry, but if the dressing falls off, it can be reapplied as needed. Resident is non weight bearing on the left foot. (The RN did not document regarding the physician notification or the condition of the wound dressing.) Review of the resident's progress note dated 10/05/24, at 5:41 P.M., showed RN D documented the following: (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Resident was admitted to the hospital after falling in his/her room (at the facility) and fracturing his/her left humerus. The resident was diagnosed with a closed fracture of the distal end of the left humerus. -While in the hospital, he/she was diagnosed with MRSA infection of the second toe on his/her left foot and the hospital amputated the resident's toe on 09/26/24. The doctor ordered linezolid for this infection, 600 mg two times per day, for 14 days. The resident's left foot dressing can be left intact until his/her follow up appointment with podiatry, but if the dressing falls off, it can be reapplied as needed. Resident is non weight bearing on the left foot. (The RN did not document regarding the physician notification or the condition of the wound dressing.) Review of the resident's progress note, dated 10/06/24 at 3:34 A.M., showed Licensed Practical Nurse (LPN) K documented the following: -Resident back from hospital stay and was diagnosed with a closed fracture of the distal end of the left humerus. The resident had surgery on 09/23/24 to his/her left arm to repair the fracture. -While in the hospital, he/she was diagnosed with MRSA infection of the second toe on his/her left foot and the hospital amputated the resident's toe on 09/26/24. The doctor ordered linezolid for this infection, 600 mg two times per day, for 14 days. The resident's left foot dressing can be left intact until his/her follow up appointment with podiatry, but if the dressing falls off, it can be reapplied as needed. Resident is non weight bearing on the left foot. (The LPN did not document regarding the physician notification or the condition of the wound dressing.) Review of the resident's progress note dated 10/06/24. at 11:56 A.M., showed RN J documented the following: -Resident back from hospital stay and was diagnosed with a closed fracture of the distal end of the left humerus. The resident had surgery on 09/23/24 to his/her left arm to repair the fracture. -While in the hospital, he/she was diagnosed with MRSA infection of the second toe on his/her left foot and the hospital amputated the resident's toe on 09/26/24. The doctor ordered linezolid for this infection, 600 mg two times per day, for 14 days. The resident's left foot dressing can be left intact until his/her follow up appointment with podiatry, but if the dressing falls off, it can be reapplied as needed. Resident is non weight bearing on the left foot. (The RN did not document regarding the physician notification or the condition of the wound dressing.) Review of the resident's vital signs showed staff did not document the resident's vital signs during the day shift on 10/06/24. Review of the resident's progress note dated 10/06/24, at 4:28 P.M., showed RN D documented the following: (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Resident is lethargic, hard to wake up, and then goes right back out. Resident has not urinated all day and has not eaten all day. Resident is constantly drooling a white foam out of the corners of his/her mouth. Vital signs are as follows: blood pressure (BP) = 118/56 millimeters (mm)/mercury (Hg), Pulse = 50 beats per minute (normal range =60-110 beats/minute) , respirations = 16/minute , Temperature = 98.1 Fahrenheit (F) and pulse oximetry = 90% on 3 liters (L) of oxygen via nasal cannula (NC). Lung sounds are decreased throughout and breathing is very shallow. RN D notified the physician and paramedics transported the resident to the emergency department via ambulance. During an interview on 10/16/24, at 11:11 A.M., Licensed Practical Nurse (LPN) A said the following: -The resident returned to the facility from the hospital on 09/30/24; -The resident had/his one of the toes on his/her left foot amputated while at the hospital; -The resident did not have orders to treat the area of the amputated toe; -The discharge instructions said to leave the dressing on the resident's foot until his/her return to the podiatrist; -On the resident's final day in the facility, he/she was lethargic during the day, but was taking pain medication; -The aides should have obtained vital signs and would have reported if the resident's vital signs were outside of normal range; -He/she was unsure what the vital signs were and he/she was unsure if the resident ate anything during the day on 10/6/24; -LPN A said he/she passed on in report to the evening nurse, that the resident had been lethargic during the day; -LPN A said he/she was passing medications on 10/06/24 day shift and did not have time to assess the resident fully or call the physician about the resident's lethargy. During an interview on 10/16/24, at 3:50 P.M., RN D said the following: -The resident returned from the facility on the afternoon of 09/30/24 from the hospital where surgeons operated on the resident's fractured arm and amputated the resident's toe; -According to the hospital discharge instructions, the facility was supposed to leave the resident's foot dressing in place until he/she returned to the podiatrist for a follow up appointment. During an interview on 10/16/24, at 4:18 P.M., RN E said the following: -He/she worked on 10/04/24 as the nurse on the floor, for approximately 4 hours that day; (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-During that time, he/she observed the resident's foot dressing was saturated with serosanguinous drainage (a thin and watery fluid that is pink in color due to the presence of small amounts of red blood cells); -He/she did not notice an odor, but was wearing a face mask; -He/she notified the resident's primary care physician, who instructed the nurse to contact the resident's podiatrist for further orders; -On 10/04/24, he/she placed a call to the podiatry office and left a message for them to call back; -The podiatry office did not call back that day, and he/she passed on in report to the evening shift nurse RN D, about the need to follow up. During an interview on 10/16/24, at 4:34 P.M., RN D said the following: -He/she worked the evening of 10/04/24; -He/she did not receive a call from the podiatry office; -He/she did not recall RN E passing onto to him/her in report on 10/04/24 about the need to contact the resident's podiatrist or about the resident's dressing being saturated with drainage; -He/she did not notice the resident's foot was draining until the evening of 10/05/24, when RN D noticed a small amount of blood on the resident's foot dressing; -The hospital discharge orders said to leave the resident's foot dressing in place unless fell off, so he/she did not remove the dressing. During an interview on 10/17/24, at 1:15 P.M., RN J said the following: -He/she worked every other weekend at the facility as the RN weekend supervisor; -He/she worked on the weekend of 10/05/24; -He/she never saw the resident's foot dressing after his/her toe was amputated; -He/she was not notified the resident's foot was draining or that there was a call out to the podiatry surgeon. During an interview on 10/17/24 at 3:45 P.M., RN D said he/she was not aware the resident had a saturated foot dressing, if he/she were aware, he/she would have removed the saturated dressing and replaced with a clean dressing. During an interview on 10/18/24, at 1:04 P.M., the Assistant Director of Nursing (ADON) said the following: (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-On 10/02/24, he/she observed the resident with a foot dressing from the mid foot to the toes and an approximate dime-sized area of blood on the surface of the resident's foot dressing, over the area of the amputated toe; -The facility had hospital orders not to touch the resident's foot dressing, therefore he/she did not attempt to remove or change the dressing; -He/she could not recall if he/she reported or documented the observed blood on the dressing. During an interview on 10/17/24, at 2:35 P.M., the DON said the following: -After re-admission on 09/30/24, the facility did not have a physician's order to monitor the resident's foot dressing (from amputated toe surgery). The hospital gave discharge instructions to leave the dressing on; -He/she was unsure if he/she observed the resident's foot dressing after the resident's 09/30/24 admission; -Staff should have monitored the resident's foot dressing weekly during the skin assessment; -He/she was not aware the resident's foot dressing was saturated with drainage; -The nurse, RN E, did not document the condition of the resident's dressing in the medical record; -RN E should have passed on in report to the next shift to contact the podiatrist, it he/she was not able to reach the podiatrist; -The DON said if RN E received direction for the primary care physician to contact the podiatry office regarding the resident's saturated foot dressing, then the facility staff fulfilled that obligation to contact podiatry. During an interview on 10/17/24, at 4:10 P.M., the Administrator said the following: -During one of the interdisciplinary team meetings, unsure of date, RN E mentioned the resident's foot dressing had drainage on it. Staff reviewed the hospital discharge orders and the directions showed to leave the dressing in place until return to the podiatrist, unless the dressing was falling off; -RN E notified the resident's primary care physician, who said to contact the resident's podiatrist (surgeon) about the foot drainage; -RN E attempted to contact the podiatry office, but if he/she did not receive a call back from the podiatry office. He/she should have reported back to the primary care physician for further direction. MO00243172

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34906 Based on interview and record review, the facility failed to provide wound care and monitoring consistent with standards of practice when when staff did not document complete pressure ulcer wound assessments, when staff did not obtain physician orders to treat pressure ulcers on the resident's left buttocks, and when staff did not obtain timely orders to treat pressure ulcers on the resident's right buttocks for one resident (Resident #1). The facility census was 68. Review of the facility policy titled, Wound Protocol, dated 2018, showed, in part, the following: -Use care when removing dressings and tapes to avoid damage to fragile skin; -Thoroughly document all wound information such as type, location, stage (if applicable), length, width, depth, drainage, notation of tunneling or undermining, description of tissue (necrotic, granulating, etc.) state of peri-wound area, treatment of wound, etc.; -Notify appropriate personnel of all new pressure ulcers, or if you have any questions. 1. Review of Resident #1's face sheet showed the following: -admitted [DATE]; -Re-admitted [DATE] at 3:59 P.M.; -Diagnoses included of dementia, type II diabetes mellitus with nephropathy (a general term for kidney damage or disease), left arm humerus (upper arm bone) fracture with surgical repair, pain in left shoulder, and history of diabetic foot ulcer with unspecified wound of foot. Review of the resident's annual Minimum Data Set (MDS - a federally mandated comprehensive resident assessment completed by facility staff), dated 07/07/24, showed the following: -Moderate cognitive impairment; -No rejection of care observed; -Dependent (helper does all the effort) for oral hygiene, toileting hygiene, personal hygiene, rolling left to right in bed, moving from sitting to lying, and moving from lying to sitting; -Required substantial/maximal assistance (helper does more than half the effort) with showering/bathing; -Staff assessed the resident as at risk for the development of pressure ulcers; -Staff assessed the resident as having no current unhealed pressure ulcers or other skin concerns; -Pressure reducing device for chair and bed. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the resident's hospital after visit summary, dated 09/30/24, showed the following: -admitted to the hospital on 09/21/24 and discharged to the skilled nursing facility (SNF) on 09/30/24; -Closed fracture of distal end of the left humerus. Review of the resident's admission clinical nursing assessment showed: -Observation date: 09/30/24 at 10:20 P.M.; -Completed date: 10/02/24 at 1:02 A.M.; -admitted and time 09/30/24 at 3:10 P.M.; -Admitting diagnosis: Amputation of toe on left foot and closed fracture of distal end of left humerus; -Supportive device: Air mattress; -Peri area exhibits redness; -Risk factors for skin breakdown included decreased activity level, immobility, incontinence, and predisposing diseases; -Skin integrity upon admission included bruises, pressure ulcers, and surgical wounds; -Open area to right buttock. -Open area to left buttock near scarred tissue from previous skin issues. Review of the resident's Braden Scale (assessment completed by facility staff for predicting pressure sore risk), dated 09/30/24, showed the following: -Assessed as moderate risk for pressure sore development; -Pressure reducing device for chair and pressure reducing device for bed. Review of the resident's physician orders, dated 09/30/24 to 10/01/24, showed staff did not document a pressure ulcer treatment order. Review of the resident's progress notes dated 10/01/24, at 10:09 A.M., showed the nurse did not document regarding pressure sores on the resident's buttocks. Review of the resident's progress notes dated 10/02/24, at 1:03 A.M., showed the Director of Nursing (DON) documented the following: (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-A certified nurse aide (CNA) informed of an open area to the resident's right buttock, open area measured 1. 2 by 1.2 centimeters (cm). Area was cleansed and first aid applied. Will endorse day shift to notify the physician. Resident is own responsible party and is aware of the skin issue. The resident was readmitted , and open areas documented on the admission assessment. Review of the resident's physician orders showed an order, dated 10/02/24, to cleanse open area to right buttock with wound cleanser, pat dry, apply collagen (supports a moist wound healing environment) dressing, and cover with bordered gauze. Staff to change daily and as needed and discontinue treatment when area resolved. (Staff did not document a wound treatment for the left buttock.) Review of the resident's progress note dated 10/03/24, at 8:25 A.M., the Assistant Director of Nursing (ADON) documented the following: -Writer changed dressing per order. In attendance were three aides and the lead nurse. When writer removed the resident's dressing slowly, writer observed that the dressing was removing skin. Many attempts made to save the skin. When dressing was removed completely areas were measured. -Right top 1.5 centimeters (cm) by 1.3 cm, bottom right 2.1 cm by 2.0 cm, left top 1.5 cm by 2.0 cm, left bottom, 3.0 cm by 1.5 cm. Area cleaned and left open to air. Spoke to the DON discussed possibly changing the dressing and decided to continue the dressing with extra precautions to the skin due to the proximity of the wounds to the anus and infection control concerns. Staff to continue to monitor and report any changes. Review of the resident's weekly Wound Documentation Sheet, provided by the Assistant to the Administrator and created by the ADON showed the following: -When: 10/02/24; -Type: stage II (partial-thickness loss of skin with exposed dermis, presenting as a shallow open ulcer); -Location: Left buttock top; -Admit/in house: Admit; -Length: 1.5 centimeters (cm) -Width 2.0 cm; -Depth 0.1 cm; -Wound tissue %: Left blank -Improved: Left blank (Staff did not address the periwound appearance, wound bed appearance, or in any drainage or odor.) (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the resident's physician orders showed staff did not document a treatment order to the resident's left buttock. Review of the weekly Wound Documentation Sheet, provided by the Assistant to the Administrator and created by the assistant director of nursing (ADON) showed the following: -When: 10/03/24; -Type: stage II; -Location: Left buttock bottom; -Admit/in house: In house; -Length: 3.0 centimeters (cm) -Width: 1.5 cm; -Depth: 0 cm; -Wound tissue %: Left blank -Improved: Left blank (Staff did not address the periwound appearance, wound bed appearance, or in any drainage or odor.) Review of the resident's physician orders showed staff did not document a treatment order to the resident's left buttock. Review of the weekly Wound Documentation Sheet, provided by the Assistant to the Administrator and created by the ADON showed the following -When: 10/03/24; -Type: stage II; -Location: Right buttock top; -Admit/in house: In house; -Length: 1.5 centimeters (cm) -Width: 1.3 cm; -Depth: 0 cm; -Wound tissue %: Left blank (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Improved: Left blank (Staff not address the periwound appearance, wound bed appearance, or in any drainage or odor.) Review of the weekly Wound Documentation Sheet, provided by the Assistant to the Administrator and created by the ADON showed the following: -When: 10/03/24; -Type: stage II; -Location: Right buttock bottom; -Admit/in house: In house; -Length: 2.1 centimeters (cm) -Width: 2.0 cm; -Depth: 0 cm; -Wound tissue %: Left blank -Improved: Left blank (Staff did not address the periwound appearance, wound bed appearance, or in any drainage or odor.) During an interview on 10/16/24, at 11:11 A.M., Licensed Practical Nurse (LPN) A said the following: -The resident returned to the facility from the hospital on 09/30/24; -The hospital placed a large, bordered gauze type dressing on the resident's buttocks and when the ADON and LPN A attempted to carefully remove the dressing from the resident's buttocks, they ripped the resident's skin off in several areas; -LPN A and the ADON attempted to soak the dressing with wound cleanser before removing, but this did not keep the resident's skin from tearing. During a phone interview on 10/17/24, at 11:02 A.M., Certified Nurse Aide (CNA) H said the following: -On 9/30/24, he/she assisted LPN C with the resident's peri-care after his/her return from the hospital and observed several open areas to the resident's buttocks that were not present before the hospitalization . During an interview on 10/17/24, at 3:45 P.M., RN D said the following: (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The ADON spoke to the DON about what the best course of action would be for treatment, and the DON said would replace with same type of dressing due to resident's incontinence of bowel and the proximity of the wounds to the resident's rectum and possibility of infection; -The open areas had red tissue noted to each; -The DON obtained treatment orders for the resident's buttocks from the physician on 10/02/24. During an interview on 10/17/24, at 2:35 P.M., the Director of Nursing (DON) said the following: -The admitting nurse should conduct a skin assessment as part of the nurse admitting assessment; -The resident returned from the hospital on 09/30/24 with an open area to his/her buttocks; -He/she worked overnight on 10/01/24 to 10/02/24 and measured one open area on the resident's right buttock which measured 1.2 centimeters by 1.2 centimeters and passed on the information to the day shift nurse to notify the physician; -The wound appeared to be a Stage II pressure ulcer; -On 10/03/24, the ADON removed the dressing, he/she pulled some of the resident's buttocks skin off with the dressing and the resident subsequently had multiple open areas as a result; -Nurses are not allowed to stage pressure ulcers and the nurses usually want the ADON or the DON to check the resident's wounds; -A wound assessment should include the location, type of wound, date acquired, measurements of the length, width, and depth (if possible), the condition of the wound bed and peri-wound, and description of any drainage or odor. -Facility staff did not conduct a full wound assessment of the resident's pressure ulcer, but he/she looked at the wound; -The ADON generally completed weekly wound assessments, but the staff had a lack of communication about who would document a wound assessment on the resident. -The admitting nurse on 09/30/24, did not obtain an order for treatment of the resident's pressure ulcer, but instead used barrier cream on the wound. During an interview on 10/17/24 at 4:10 P.M., the Administrator said the following: -On 09/30/24, when the nurse readmitted the resident to the facility, the nurse should have conducted a head-to-toe skin assessment and contact the physician or on-call physician for treatment orders, if needed; -The ADON generally conducted the resident wound assessments on Thursdays, but if staff discovered a new wound, the nurse should notify the DON or ADON to assess the wound and obtain treatment orders; (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Within 24 hours of admission, staff should complete a resident wound assessment and have treatment orders in place. MO00243172

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34906 Based on record review and interview, the facility failed to ensure an effective pain management program was provided to each resident when staff failed to maintain a supply of ordered pain medications and access to emergency use medications resulting in three residents (Resident #7, #8, and #9) not receiving pain medications as ordered. The facility census was 57. Review of the facility's policy titled Medication, Administration Guidelines, undated, showed it was the purpose of the facility that residents receive their medications on a timely basis and in accordance with established policies. 1. Review of Resident #7's face sheet showed the following: -Diagnoses included congestive heart failure (CHF - chronic condition where the heart muscle is weakened and cannot pump blood efficiently throughout the body), kidney disease, and depression. Review of the resident's annual Minimum Data Set (MDS - a federally mandated assessment completed by facility staff), dated 01/21/25, showed the following: -Moderate cognitive impairment; -Received as needed pain medication and prescribed pain medication. Review of the resident's January 2025 and February 2025 Physician Order Sheets showed the following: -An order, dated 12/27/23, for acetaminophen 325 mg two tablets three times per day at 7:00 A.M., 1:00 P.M. , and 7:00 P.M., for viral pneumonia; -An order, dated 09/10/24, for Lidocaine (pain medication) patch 4%, apply one patch to lower back two times per day at 5:00 A.M. and 7:00 P.M. for chronic pain. Review of the resident's January 2025 Medication Administration Record (MAR) showed the following: -From 01/01/25 to 01/06/25, at 5:00 A.M., staff did not apply the resident's Lidocaine due to the patch being unavailable; -From 01/07/25 to 01/08/25 at 5:00 A.M., staff did not apply the resident's Lidocaine patches due to the patch unavailable; -From 01/26/25, at 7:00 P.M., to 01/31/25, at 7:00 P.M., staff did not administer the resident's acetaminophen 325 mg, two tablets due to medication being unavailable; -From 01/08/25 to 01/31/25, Lidocaine patches were on hold. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the resident's progress notes, dated January 2025, showed the staff did not document the physician was contacted regarding the medications not administered. Review of the resident's February 2025 MAR showed the following: -On 02/01/25, at 7:00 A.M. to 02/03/25 at 1:00 P.M., staff did not administer the resident's acetaminophen 325 mg, two tablets, due to the medication being unavailable; -On 02/01/25 at 5:00 A.M., to 02/03/25 at 5:00 A.M., staff did not apply the resident's Lidocaine patches due being on hold; -On 02/03/25 at 7:00 P.M., to 02/04/25, at 5:00 A.M., staff did not apply the resident's Lidocaine patches due the patch being unavailable. Review of the resident's February 2025 progress notes showed staff did not contact the physician regarding the medications not being administered. 2. Review of Resident #8's face sheet showed the following: -Diagnoses included Parkinson's disease (progressive neurological disorder that affects movement), type 2 diabetes with diabetic polyneuropathy (a condition that affects multiple peripheral nerves), and polyosteoarthritis (multiple joints are affected by osteoarthritis). Review of the resident's quarterly MDS, dated [DATE], showed the following: -Moderate cognitive impairment; -Received prescribed pain medications. Review of the resident's care plan, last revised on 01/24/25 , showed the following: -Resident had pain/discomfort because of arthritis; -Resident takes acetaminophen for occasional pain and will ask the nurse for the medications; -Staff will watch for signs of pain and encourage resident to ask for medication if hurting. Review of the resident's POS, dated January through February 2025, showed the following: -An order, dated 11/09/22, for acetaminophen 325 mg, staff to give two tablets at bedtime at 7:00 P.M. for muscle spasm; -An order, dated 08/08/24, for acetaminophen 325 mg, staff to give one tablet one time per day at 7:00 A.M. for polyosteoarthritis. Review of the resident's January 2025 MAR showed the following: (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-From 01/08/25 to 01/31/25, staff did not administer the resident's acetaminophen 325 mg, two tablets at bedtime, due to the medication being unavailable; -From 01/08/25 to 01/31/25, staff did not administer the resident's acetaminophen 325 mg, one tablet, one time per day at 7:00 am due to the medication unavailable. Review of the resident's progress notes, dated January 2025, showed the staff did not contact the physician regarding the medications not being administered. Review of the resident's February 2025 MAR showed the following: -On 02/01/25 at 7:00 P.M., staff did not administer the resident's acetaminophen 325 mg, two tablets at bedtime, due to the medication being unavailable; -On 02/01/25, staff did not administer the resident's acetaminophen 325 mg, one tablet, one time per day due, to the medication being unavailable. Review of the resident's progress notes, dated February 2025, showed the staff did not contact the physician regarding the medications not being administered. During an interview on 02/03/25, at 10:40 A.M., the resident said the following: -Staff were not administering his/her acetaminophen as ordered and had not been consistently administering the medication for approximately the past month; This led to the resident having increased pain all over his/her body; -The resident described the pain as an achiness and stated the pain was a 6 on a scale of 0-10 (with 10 being the worst pain). During an interview on 02/03/25, at 1:32 P.M., Certified Medication Technician (CMT) D said the following: -The resident complained about not getting his/her acetaminophen and complained of pain as a result; -He/she notified the charge nurse when the resident complained of pain and when the CMT did not have ordered medications for the resident; -He/she was unsure which nurse he/she had reported to. 3. Review of Resident #9's face sheet showed the following: -Diagnoses included cerebral ischemic attack (blood flow to the brain is blocked), chronic pain, and pain in the left leg. Review of the resident's quarterly MDS, dated [DATE], showed the following: -Severe cognitive impairment; (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-On prescribed pain regime. Review of the resident's care plan, last revised on 01/30/25, showed the following: -Resident has complaints of chronic pain of right lower extremity related to contracture (a permanent shortening of muscles, tendons, ligaments, or skin that results in limited range of motion and joint stiffness); -Monitor and record any complaints of pain, location, frequency, effect on function; -Assess past effective and ineffective pain relief measures. Review of the resident's January 2025 through February 2025 POS showed the following: -An order, dated 02/05/22, for staff to administer hydrocodone (a narcotic pain medication) 5-325 mg one tablet every 6 hours at 12:00 A.M., 6:00 A.M., 12:00 P.M., and 6:00 P.M., for chronic pain; -An order, dated 09/10/24, for staff to apply a Lidocaine patch 4%, apply twice per day at 5:00 A.M. and 5:00 P.M. for pain in left leg. Review of the resident's January 2025 MAR showed the following: -On 01/01/25 to 01/11/25 at 5:00 A.M., staff did not apply the Lidocaine patch due to patch not being available; -On 01/12/25, at 5:00 P.M., to 01/15/25, at 5:00 A.M., staff did not apply the Lidocaine patch due to patch not being available; -On 01/17/25, at 5:00 A.M. and 5:00 P.M., staff did not apply the Lidocaine patch due to the patch not being available; -On 01/18/25 at 5:00 P.M. to 01/19/25 at 5:00 P.M., staff did not apply the Lidocaine patch due to not being available; -On 01/24/25 at 5:00 A.M. to 01/31/25 at 5:00 P.M., staff did not apply the Lidocaine patch due to on order or out of stock; -On 01/30/25, at 6:00 P.M., staff did not administer the resident's hydrocodone 5-325 mg due to drug not available; -On 01/31/25, at 12:00 A.M. and 6:00 P.M., staff did not administer the resident's hydrocodone 5-325 mg due to drug not available; Review of the resident's January 2025 progress notes showed staff did not contact the physician regarding the medications that were not administered. Review of the resident's February 2025 MAR showed on 02/01/25 at 5:00 A.M. to 02/05/25, staff did not apply the Lidocaine patch due to the patch not being available. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the resident's February 2025 progress notes showed the staff did not contact the physician regarding the medications that were not administered. Observation and interview of Resident #9 on 02/03/25 at 2:45 P.M., showed the following: -He/she answered questions yes and no; -When asked if the resident has been getting his/her Lidocaine patch, he/she said no and shook his/her head no; -He/she said he/she did not have a patch on at the time of the interview; -He/she said he/she had pain at a 6 on a scale from 1 to 10; -He/she said yes to not being able to sleep well due to pain. During an interview on 02/03/25 at 10:50 A.M., CMT D said the following: -He/she administered medications to residents on both the day and evening shift: -In the past, the facility ran out of the resident's hydrocodone for pain and there were no staff working at that time in the facility who had access to the E-kit (an emergency supply of medications) to pull the needed pain medication; -The resident needed the medication to control his/her pain; -He/she notified the charge nurse of the issue and was unsure what happened next. 4. During interviews on 02/03/25 at 10:48 A.M. and on 02/06/25 at 9:12 A.M., CMT A said the following: -Only facility employees have access to the facility's E-kit; -He/she worked for a temporary agency and was not an employee of the facility so he/she did not have access to the E-kit; -The facility frequently ran out of resident supply of stock medications such as Tylenol (generic name Acetaminophen); -When he/she ran out of stock medications, he/she notified his/her charge nurse and marked unavailable on the resident's MAR; -When he/she worked in the dementia unit and ran out of stock medications, he/she notified CMT C; -CMT C was the dementia unit coordinator and was responsible for ordering stock medications for the residents; (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-The facility did not provide any training to CMT A on what to do when medications were not available for resident use. During an interview on 02/03/25 at 10:50 A.M., CMT D said the following: -For the last 3 to 4 weeks approximately, the facility had frequently ran out of over the counter (OTC) medications (stock medications) for resident use; -The facility will get in a supply and then run out again; -CMT C was responsible for ordering the OTC medications; -CMT D spoke to CMT C, the Director of Nursing (DON), and the Assistant Director of Nursing (ADON) about the issue of running out of OTC medications for the residents; -The facility was currently out of Tylenol 325 mg; -At times, on the weekends, the facility ran out of resident pain medications and there have been occasions when no staff working in the facility had access to the E-kit to pull the needed pain medication; -When he/she did not have the resident medication, he/she marked unavailable on the resident MAR and notified his/her nurse on duty; -When he/she did not have ordered medications, he/she notified his/her nurse of the situation. During an interview on 02/03/25 at 11:08 A.M., CMT B said the following; -He/she experienced issues with the facility running out of some of the OTC medications (stock medications) for resident use, such as Tylenol and vitamin D; -He/she informed his/her charge nurse when he/she could not find ordered stock medications for the residents; -In the past, at times, staff had gone to the local Dollar Store to pick up the medications when the facility did not have a supply; -Only CMTs and nurses who are employed by the facility have access to the E-Kit medications, temporary agency staff did not; -When the facility had only agency staff in the facility on the shift following CMT B's, he/she tried to obtain any needed medications for the next shift out of the E-kit before leaving for the day. During an interview on 02/06/25 at 3:30 P.M., CMT C said the following; -He/she was aware of staff charting some medications being unavailable for one to two days at a time; (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-He/she was aware the facility was out of Tylenol and Lidocaine patches for resident use; -Staff were supposed to write down any medications they were out of and provide that list to CMT C; -He/she usually ordered stock medications on Monday of each week and the medications were arrived on Wednesday; -He/she had not received any instruction on auditing medications to ensure availability; -He/she had been going into the supply room weekly to ensure there were additional bottles of medications, and to check and see what might need to be ordered; -Sometimes the medications were at the facility, but the temporary agency staff did not look for the medications. He/she one time found a medication at the bottom of the medication cart; -Staff should notify the nurse or the DON, if they facility was out of any resident medications to administer. During an interview on 02/03/25 at 11:00 A.M., Licensed Practical Nurse (LPN) E said the following: -He/she worked at the facility through a temporary agency on a full time basis for approximately one month, since the first part of January 2025; -The facility had an issue with running out of OTC medications at times; -He/she informed CMT C, who was in charge of ordering the OTC medications; -When he/she went to CMT C, he/she would inform the nurse to write the medication down on paper and CMT C would order the medication; -At time the facility did not have the ordered medications and the staff mark medication unavailable on the resident MAR; -He/she talked to the Registered Nurse (RN) Supervisor (RN F) about the issue but the issue had not improved; -He/she should probably have notified the residents' physician about not having the ordered medications, but he/she had not done so; -Facility staff could pull needed medications from the E-kit at times; -Because he/she worked for a temporary agency, he/she did not have access to the E-kit, and sometimes, there were no staff in the facility working who had access to the E-kit. During an interview on 02/03/25 at 2:30 P.M., RN F said the following: (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-The facility had ran out of some of the resident stock medications and he/she suspected the problem was that CMT C was not getting the medications ordered soon enough and as a result the facility was running out; -He/she had not called the physician about running out of resident medications and had not told the nurses to call the physician; -There are times, when the agency nurses were the only ones working and the agency nurses did not have access to the E-kit to obtain medications; -The facility ran out of resident pain medications in the past and there have been times when there were not two staff, as required, with access to the E-kit to obtain the narcotic pain medications for the residents; -He/she notified the DON and ADON of agency nurses and CMTs not having access to the E-kit and the DON and ADON said to make it work. During an interview on 02/06/25 at 1:30 P.M., RN G said the following: -The facility had an issue with running out of stock medications for resident use, such Lidocaine patches; -He/she notified CMT C, who was in charge of ordering the stock medications about not having the needed medications; -CMT C said he/she would order the medications; -When he/she did not have the ordered resident medications, he/she documented unavailable on the MAR; -He/she thought, he/she told the nurse practitioner (NP) about being out of resident Lidocaine patches, but he/she was unsure when that occurred of if he/she charted the conversation and did not recall the NP's response. During an interview on 02/03/25 at 3:25 P.M., the Assistant Director of Nursing (ADON) said the following; -If the resident's medications were not available, the facility staff should print the physician's order and send it to the pharmacy; -If the resident medications were needed immediately, staff could get obtain those immediately; -Some of the management team have gone to the local stores and purchased over the counter medications, including Tylenol when the facility ran out; -The facility recently changed ownership and the providing pharmacy also changed; -He/she was not aware of the facility being out of Tylenol or Lidocaine patches; (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-CMTs ordered medications online and all nursing staff could order medications; -The facility tried to ensure there were always two facility staff working with access to the E-kit; -If medications/pain medications were unavailable the nurse should contact the RN on call for the facility. During interviews on 02/03/25 at 4:00 P.M. and on 02/06/25 at 2:50 P.M., the DON said the following; -He/she was aware of some medications not being available; -He/she at times staff were unaware of where to look for the medications in the facility, but the issues were resolved; -If the facility did not have a physician ordered resident medication available, nursing staff should call the pharmacy and order the medication; -He/she was not aware of several resident medications being unavailable for multiple days; -He/she did audit the resident MARs in the past, but had not done so consistently in the past month or so; -If staff did not have the resident medications available, they should inform the charge nurse, DON or ADON; -The facility staff went to the local dollar store in the past and purchased medications; -CMT C was in charge of ordering supplies and stock medications; -If CMT C did not receive ordered supplies or medications, CMT C should notify the ADON and DON; -Facility staff had not notified the DON the facility was out of Tylenol for resident use; -He/she knew the Lidocaine patches were out in December 2024, but the patches did arrive. He/she was not aware they supply was out again and staff did not apply the patches to residents as ordered in January 2025. -Prior to this week, he/she was not aware that nurses were having an issue accessing needed medications including pain medications from the facility E-kit; -If pain medications were not available, he/she expected the nurses to order the medications from the pharmacy; -He/she had a person in charge of auditing the resident MARs to ensure nurses/CMTs were administering medications as ordered, but that staff member quit in December 2024 and the DON had not assigned anyone to take over that responsibility. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 02/06/25 at 4:00 P.M., the Administrator said the following; -If staff did not have the ordered medications for residents, they should notify the DON and the Administrator; -He/she was not aware until the end of last week, that the facility had been out of some medications; -He/she expected staff to order the medications online and if they were not able to obtain the medications soon enough to follow the physician orders, they should go to the local stores or pharmacy to get the medications; -CMT C was in charge of ordering the stock medications and blood sugar test strips; -The facility should ensure all ordered medications were available for resident use; -The DON was responsible for auditing the MARs to ensure staff were administering resident medications as ordered by the physician; -If a medication was not available for administration, the nurse should notify the resident's physician. MO00248905 45176

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34906 Based on interview and record review, the facility did not ensure that all licensed nurses had the specific competencies and skills necessary to care for residents, when one facility staff member (Licensed Practical Nurse (LPN) C) continued to work as a nurse in the facility after his/her nurse license was no longer valid in the State of Missouri. The facility census was 68. Review of the facility policy/protocol titled, Screening, undated, showed: -It is the policy of the facility to screen employees and volunteers prior to working with residents. Screening components include verification of references, certification and verification of license and criminal background check; -The facility will not hire an employee or engage an individual who was found guilty of abuse, neglect, exploitation, or mistreatment, or misappropriation of property by a court of law, or who has a finding in the State nurse aide registry concerning abuse, neglect, exploitation, mistreatment of residents, or misappropriation or resident property, or has had a disciplinary action in effect taken against his/her professional license; -Before new employees are permitted to work with residents, references provided by the prospective employee will be verified as well as appropriate board registrations and certifications regarding the prospective employee's background; -For prospective employees, reviewing the employment history particularly where there is a [NAME] of inconsistency. Information from former employers, whether favorable or unfavorable, and/or documentation of status and any disciplinary actions from licensing or registration boards; -The facility can then determine whether it can safely and competently provide the necessary care to meet the resident's needs; -Licensed staff: The facility will not employee or otherwise engage a licensed professional who: Has a disciplinary action in effect against his/her professional license by a state licensure body as a result of a finding of abuse, neglect, exploitation, mistreatment or residents, or misappropriation of resident property; -In addition, the facility will report to the state licensing authorities any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a licensed professional. 1. Review of LPN C's personnel file showed: -A check through Nursys of the nurse license verification report, dated [DATE], showed LPN C had a valid New Mexico multi-state unencumbered LPN license, original issue date of [DATE], with an expiration date of [DATE]; (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-Hire date of [DATE]. Review of Nursys, on [DATE], showed the following: -Effective [DATE] through [DATE], LPN C's New Mexico issued nursing license was placed on probationary status and was no longer a multi-state license. -Basis for action: Misappropriation of Resident property or other property, failure to maintain or provide adequate medical records, financial records or other required, and error in prescribing, dispensing, or administering medication or sedation. Review of the facility provided list of dates worked by LPN C showed: -First date worked at the facility [DATE]; -Last date worked at the facility [DATE]. During an interview on [DATE], at 10:50 A.M., the Administrator said the following: -The facility checked LPN C upon hire and he/she had a valid nurse (LPN) license; -After the incident with LPN C on [DATE], the facility again checked LPN C's nurse license and there were issues with the license; -The license showed suspended. During an interview on [DATE], at 11:55 A.M., the Business Office Manager (BOM) said the following: -He/she was responsible for completing employee background checks on new hires for the facility; -The Assistant to the Administrator helped with some of the background checks at times; -He/she always requested a copy of the new employee's identification card/driver's license and social security card; -The BOM checked the Employee Disqualification List (EDL), the Family Care Safety Registry (FCSR), the Nurse Aide (NA) Registry, the Federal Exclusionary List, and if a nurse, look up their nurse license; -For LPN C, the BOM ran a Missouri License initially based on the staff member's name and then result showed an expired Missouri nurse license; -The BOM then called LPN C and he/she said he/she had a valid multi-state LPN license out of New Mexico; -The BOM checked online and confirmed LPN C had a valid multi-state Licensed Practical Nurse (LPN) license out of New Mexico. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	MO00243131

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 34906 Based on interview and record review, the facility failed to to have pharmacy services in place to ensure a consistent counting and reconciliation of controlled substances when staff failed to consistently document the number of medication packages and when staff failed to consistently initial the change of shift controlled medication count on the controlled substance shift change log located in four of four medication carts in the facility. The facility census was 68. 1. Review of the October 2024 Controlled Substance Shift Change Log, for the Alzheimer's unit medication cart, showed the following: -Every shift, 6:30 A.M., 2:30 P.M., and 10:30 P.M., staff to initial oncoming and off going counts and list the total number of medication packages; -On 10/02/24, 10/03/24, and 10/04/24, at 10:30 P.M., the oncoming staff failed to initial the count; -On 10/05/24, at 6:30 A.M., the off going staff failed to initial the count; -On 10/06/24, at 6:30 A.M., staff failed to document the number of medication packages and the oncoming staff failed to initial the count; -On 10/06/24, at 2:30 P.M., the oncoming and the off going staff failed to initial the count; -On 10/07/24, at 6:30 A.M., staff failed to document the number of medication packages and the oncoming staff failed to initial the count; -On 10/07/24, at 10:30 P.M., staff failed to document the number of medication packages; -On 10/08/24, at 2:30 P.M., staff failed to document the number of medication packages and the oncoming staff failed to initial the count; -On 10/11/24, at 10:30 P.M., staff failed to document the number of medication packages; -On 10/12/24, at 6:30 A.M., staff failed to document the number of medication packages and the oncoming staff failed to initial the count; -On 10/12/24, at 2:30 P.M., staff failed to document the number of medication packages and the off going staff failed to initial the count; -On 10/12/24, at 10:30 P.M., staff failed to document the number of medication packages; -On 10/14/24, at 10:30 P.M., the off going staff failed to initial the count. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the October 2024 Controlled Substance Shift Change Log, for the 100/400/500 hall medication cart, showed the following: -Every shift, 6:30 A.M., 2:30 P.M., and 10:30 P.M., staff to initial oncoming and off going counts and list the total number of medication packages; -On 10/04/24, at 10:30 P.M., the oncoming staff failed to initial the count; -On 10/05/24, at 6:30 A.M., the off going staff failed to initial the count; -On 10/06/24, at 2:30 P.M., staff failed to document the number of medication packages; -On 10/08/24 at 6:30 A.M., the off going staff failed to initial the count. Review of the October 2024 Controlled Substance Shift Change Log, for the 300-hall medication cart, showed the following: -On 10/04/24, at 10:30 P.M., the oncoming staff failed to initial the count; -On 10/05/24, at 6:30 A.M., the off going staff failed to initial the count; -On 10/06/24, at 6:30 A.M., staff failed to document the number of medication packages and the oncoming staff failed to initial the count; -On 10/06/24, at 2:30 P.M., staff failed to document the number of medication packages; -On 10/08/24, at 6:30 A.M., the off going staff failed to initial the count; -On 10/13/24,at 2:30 P.M., staff failed to document the number of medication packages. Review of the October 2024 Controlled Substance Shift Change Log, for the nurse cart containing as needed (PRN) medications, showed the following: -On 10/01/24, at 2:30 P.M., the oncoming staff did not initial the count; -On 10/01/24, at 10:30 P.M., the off going staff did not initial the count; -On 10/04/24, at 2:30 P.M., the off going staff did not initial the count; -On 10/04/24, at 10:30 P.M., the oncoming staff did not initial the count; -On 10/05/24, at 6:30 A.M., the off going staff did not initial the count; -On 10/12/24, at 10:30 P.M., the off going staff did not initial the count. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 10/16/24, at 11:11 A.M., Licensed Practical Nurse (LPN) A said at the beginning and end of each shift, the nurse or certified medication technician (CMT) should count each controlled medication, then should count the number of all controlled medication cards and bottles, and then document the number and initial the count on the shift change log located on each medication cart. During an interview on 10/16/24, at 12:52 P.M., CMT L said nurses and CMTs should count the controlled medication in the carts that they are assigned to at the beginning and end of each shift and complete and initial the log. During an interview on 10/16/24, at 1:47 P.M., CMT B said the following: -On 10/04/24, at 10:00 P.M., he/she counted the quantity of each controlled medications at the beginning and end of each shift with the off going and oncoming staff; -Both staff were supposed to initial that the count was correct and document the total number of medication containers; -CMT B was not aware some of the nurses were not signing or initialing the controlled medication log at the beginning and end of each shift; -He/she was not aware, that LPN C did not sign the count log on the evening of 10/04/24 and was not able to sign on the morning of 10/05/24. During an interview on 10/18/24, at 1:04 P.M., the Assistant Director of Nursing (ADON) said nurses and/or CMTs should count all controlled medications and sign the controlled medication log at the beginning an end of each shift. The facility did not conduct regular audits of the controlled medication and logs. During an interview on 10/17/24, at 4:10 P.M., the Assistant to the Administrator said the following: -Nurses and/or CMTs should count the controlled medications at each change of shift and whenever the keys change hands from one person to another; -Both staff member should visualize with quantity of controlled substance bottle or package and compare to the controlled medication sheet for that medication and should also count the total number of cards/bottles and document that number and both initial the log; -Both the oncoming and off going nurse or CMT should sign the controlled medication count log; -He/she was unsure if anyone was auditing to ensure all staff were counting and signing count for all the resident controlled medications each shift; -If a staff member found a discrepancy in the controlled medication count, he/she should immediately report to the Director of Nursing (DON) or Administrator. MO00243131

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34906 Based on record review and interview, the facility failed to ensure residents were free from significant medication errors when staff failed to maintain a supply of glucometer (a machine used to test blood sugar) test strips for resident use and as a result nurses were unable to perform physician ordered blood sugar checks and subsequently did not administer insulin as ordered to the three residents (Resident #3, #4, and #6). The facility census was 57. Review of the facility's policy titled Blood Glucose Monitoring, dated December 2016, showed the following: -Check physician's order for blood sugar testing; -Glucometer testing is conducted a maximum of one hour prior to administration of insulin; -Insulin should not be administered until accurate glucometer results obtained, for the best interest of the resident. Review of the facility's policy titled Medication, Administration Guidelines, undated, showed it was the purpose of the facility that residents receive their medications on a timely basis and in accordance with established policies. 1. Review of Resident #3's face sheet (resident's information at a quick glance) showed the following: -Diagnoses included type 2 diabetes (body cannot use insulin properly resulting in high blood sugar levels). Review of the resident's quarterly Minimum Data Set (MDS - a federally mandated assessment tool completed by staff), dated 12/03/24, showed the following: -Moderate to severe cognitive impairment; -Diagnosis of diabetes. Review of the resident's care plan, last updated 12/02/24, showed staff did not care plan related to the resident's diagnosis of diabetes. Review of the resident's February 2025 Physician Order Sheet (POS) showed the following current orders: -An order, dated 02/18/23, for Januvia (used to help lower blood sugar) 100 milligram (mg) tablet, give one tablet by mouth once per day at 8:00 A.M.; -An order, dated 04/11/24, for staff to check the resident's blood sugar before meals at 8:00 A.M., 12:00 P.M. , and 5:00 P.M., and at hour of sleep (HS); (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-An order, dated 11/03/24, for Metformin (used to treat diabetes) 500 mg tablet, give one tablet by mouth two times per day at 6:00 A.M. and 6:00 P.M.; -An order, dated 01/10/25, for insulin aspart (a fast-acting insulin), 100 units/milliliter (mL), administer 6 units subcutaneous (SQ - an injection under the skin into the fatty tissue), before meals at 8:00 A.M.,11:30 A.M., and 5:00 P.M.; -An order, dated 01/30/25, for Lantus (a long-acting insulin), administer 70 units SQ one time per day at 8:15 A.M.; -An order, dated 02/06/25, for Lantus insulin, administer 10 units SQ at HS at 8:00 P.M.; -An order, dated 01/10/25, for NovoLog (insulin aspart - a rapid acting insulin) administer per sliding scale (an increasing scale of insulin with administration based on blood sugar levels) at 8:00 A.M., 11:30 A.M., and 5:00 P.M. If blood sugar is 150 mg/deciliter (dL) to 200 mg/dL, give 2 units of insulin. If blood sugar is 201 mg/dL to 250 mg/dL, give 4 units of insulin. If blood sugar is 251 mg/dL to 300 mg/dL, give 6 units of insulin. If blood sugar is 301 mg/dL to 350 mg/dL, give 8 units of insulin. If blood sugar is 351 mg/dL to 400 mg/dL, give 12 units of insulin. If blood sugar is greater than 500 mg/dL, call medical director, before meals at 8:00 A. M., 11:30 A.M., and 5:00 P.M. Review of the resident's February 2025 Medication Administration Record (MAR) showed the following: -On 02/02/25, at 8:00 A.M., staff administered Januvia 100 mg tablet; -On 02/02/25, at 6:00 A.M., staff administered Metformin 500 mg tablet; -On 02/02/25, at 8:00 A.M., staff did not perform the resident's blood sugar check as ordered. Staff noted reason of drug/Item unavailable. Staff noted he/she had nothing to check the blood sugar with and he/she asked the nurse. The nurse said not to administer the medication; -On 02/02/25, at 8:00 A.M., staff did not administer insulin aspart 6 units SQ as ordered. Staff noted reason of drug/Item unavailable. Staff noted he/she had nothing to check the blood sugar with and he/she asked the nurse. The nurse said not to administer the medication; -On 02/02/25, at 8:15 A.M., staff did not administer Lantus 70 units SQ as ordered. Staff noted reason of drug/Item unavailable. Staff noted he/she had nothing to check the blood sugar with and he/she asked the nurse. The nurse said not to administer the medication; -On 02/02/25, at 11:30 A.M., staff performed the resident's blood sugar check as ordered. Results were 294 mg/dL. Staff administered NovoLog (insulin aspart) 6 units SQ per routine order and 6 units SQ per the resident's sliding scale order. Review of the resident's progress notes, dated 02/02/25, showed staff did not notify the physician of the missed doses of insulin or obtain guidance on what insulin to administer/not administer. 2. Review of Resident #4's face sheet showed the following: -Diagnoses included type 2 diabetes. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265656	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/18/2024
NAME OF PROVIDER OR SUPPLIER Strafford Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 505 West Evergreen Strafford, MO 65757	

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the resident's quarterly MDS, dated [DATE], showed the following: -Cognitively intact; -Diagnosis of diabetes. Review of the resident's care plan, last updated 01/17/25, showed staff did not care plan related to the resident's diabetes diagnosis and related insulin use. Review of the resident's POS, dated January through February 2025, showed the following: -An order, dated 12/29/23, for insulin aspart, administer SQ per sliding scale based upon blood sugar levels. Staff to check blood sugar before meals at 8:00 A.M., 12:00 P.M., and 5:00 P.M.; -An order, dated 07/19/24, for Lantus Insulin 7 units, administer SQ one time per day at 8:00 A.M. Review of the resident's February 2025 MAR showed on 02/01/25, at 8:00 A.M., staff did not record the resident's blood sugar and did not administer the resident's ordered Lantus insulin 7 units. Comment showed physician notified. Review of the resident's progress notes, dated 02/01/25 at 10:43 A.M., showed facility staff notified the resident's physician of the missed dose of insulin. The resident had no signs or symptoms of hypo/hyperglycemia (low/high blood sugar) at this time. 3. Review of Resident #6's face sheet showed the following: -Diagnoses included type 2 diabetes. Review of the resident's admission MDS, dated [DATE], showed the following: -Moderate cognitive impairment; -Diagnosis of diabetes. Review of the resident's care plan, last revised on 01/28/25, showed the following: -Resident may have complications related to diabetes mellitus; -Staff will administer medication insulin as ordered; -Staff will monitor for signs of hyperglycemia and hypoglycemia. Review of the resident's POS, dated January 2025 to February 2025, showed the following: -An order, dated 11/24/24, for daily accuchecks due to low sugars on labs; -An order, dated 12/20/24, for Jardiance (a medication used to treat diabetes) 10mg, staff to administer one tablet daily; (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-An order, dated 12/20/24, for NovoLog (insulin aspart - a rapid acting insulin), administer per sliding scale before meals at 8:00 A.M., 11:30 A.M., and 5:00 P.M. If blood sugar is 150 mg/dL to 200 mg/dL, give 2 units of insulin. If blood sugar is 201 mg/dL to 250 mg/dL, give 4 units of insulin. If blood sugar is 251 mg/dL to 300 mg/dL, give 6 units of insulin. If blood sugar is 301 mg/dL to 350 mg/dL, give 8 units of insulin. If blood sugar is 351 mg/dL to 400 mg/dL, give 12 units of insulin. If blood sugar is greater than 500 mg/dL, call medical director. Review of the resident's January 2025 MAR showed on 01/24/25, at 7:30 A.M. and 11:30 A.M., staff did not administer the resident's Novolog insulin SQ due to the medication being unavailable. Review of the resident's progress notes, dated January 2025, showed the staff did not contact the physician regarding the medications not administered or obtain further guidance due to the missed dosages. Review of the resident's February 2025 MAR showed the following: -On 02/01/25 at 7:30 A.M. and 11:30 A.M., the resident's accuchecks were not completed. Staff noted the physician was notified. -On 02/01/25, at 6:00 to 7:00 A.M., staff did not administer the resident's Tresiba insulin 8 units SQ. Staff noted the physician was notified; -On 02/01/25, at 5:00 P.M., staff documented the resident's blood sugar was 292 mg/dL. Review of the resident's progress notes dated 02/01/25 at 10:43 A.M., showed a nurse documented the physician was notified of missed doses of insulin with no signs or symptoms of hypo/hyperglycemia at that time. 4. During an interview on 02/03/25 at 10:50 A.M., Certified Medication Tech (CMT) D said one day in the past week, the facility nurses ran out of resident blood sugar test strips. During an interview on 02/03/25 at 11:00 A.M., Licensed Practical Nurse (LPN) E said the following: -A few days prior, on the evening of 01/31/25, he/she ran out of blood sugar test strips and he/she looked, but could not find any in the facility; -He/she called and asked CMT C what to do about the test strips. CMT C advised LPN E on some locations in the facility to look for the test strips, but LPN E was not able to locate any of the test strips; -LPN E passed on to the next shift nurse about the issue before leaving for the day; -The next morning on 02/01/25, he/she returned to work to find the facility still did not have any blood sugar test strips. He/she then contacted the RN on call, RN F, who brought test strips to the facility by noon on 02/01/25; (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-He/she notified the residents physician because he/she was not able to check blood sugars on the evening of 01/31/25 or on the morning of 02/01/25, as ordered and therefore did not administer insulin to those residents. During an interview on 02/03/25 at 2:30 P.M., RN F said the following: -While he/she was the RN on duty on 02/01/25. When he/she arrived at work at approximately 10:00 A.M. that morning, LPN E said the facility was completely out of blood sugar test strips and ran out on Friday evening of 01/31/25; as a result, he/she had not been able to test the residents blood sugars or administer the ordered insulin; -On 02/01/25, he/she contacted some of the other facilities within the corporation and was able to obtain a few boxes of blood sugar test strips; -RN F said he/she checked with CMT C, who said he/she had ordered the test strips, but RN F later checked the order and CMT C had not ordered the test strips; -RN F notified both the Director of Nursing (DON) and the Assistant Director of Nursing (ADON) of the situation. During an interview on 02/06/25, at 3:30 P.M., CMT C said he/she was aware the facility ran out of blood sugar test strips on 01/31/25 and on 02/01/25 staff went to another facility and picked up some test strips for the facility. During an interview on 02/03/25 at 3:25 P.M., the ADON said the following: -CMT C was responsible for ordering blood sugar test strips; -He/she was not aware the facility was out of blood sugar test strips, but staff should contact the RN on call if this happens. During interviews on 02/03/25 at 4:00 P.M. and on 02/06/25 at 2:50 P.M., the DON said the following; -He/she did audit the resident MARs in the past, but had not done so consistently in the past month or so; -He/she had a person in charge of auditing the resident MARs to ensure nurses/CMTs were administering medications as ordered, but that staff member quit in December 2024 and the DON had not assigned anyone to take over that responsibility. -CMT C was in charge of ordering supplies; -If CMT C did not receive ordered supplies, CMT C should notify the ADON and DON; During an interview on 02/06/25 at 4:00 P.M., the Administrator said the following; -CMT C was in charge of ordering blood sugar test strips; (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-The DON was responsible for auditing the MARs to ensure staff were administering resident medications as ordered by the physician; -If a medication was not available for administration the nurse should notify the resident's physician. MO00248905 45176