STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265681	A. Building B. Wing	03/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Potosi Manor	307 South Highway 21 Potosi, MO 63664

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. Based on observation, interview, and record review, the facility failed to follow physician orders when medication was not given as ordered for one resident (Resident #3), when oxygen tubing was not changed as ordered for one resident (Resident #5) and when medical preparation was not given prior to a scheduled examination, resulting in the procedure needing to be rescheduled for one resident (Resident #31) out of 13 sampled residents. The facility's census was 52.Review of the facility's Oxygen Equipment policy, undated, showed: - All oxygen equipment changed every seven days when heated humidification is used and monthly when unheated humidification is used; - Did not address being changed weekly per the physician orders. Review of the facility's Physician Orders policy, undated, showed it did not address following physician orders. 1. Review of Resident #3's medical record showed: - admission date of 12/28/21; - Diagnoses of diabetes mellitus (a condition that affects the way the body processes blood sugar), vitamin deficiency, and end stage renal disease (ESRD - final, permanent stage of chronic kidney disease). Review of the resident's Physician Order Sheets (POS), dated March 2025, showed: - An order for Lokelma (medication to treat high potassium levels) powder, 10 grams (gm), once a day on Saturday and Sunday for high potassium, dated 09/03/25 and discontinued 03/10/26; - An order for pyridoxine (Vitamin B6), 100 milligrams (mg), one tablet three times a day for vitamin deficiency, dated 09/05/24; - An order for scopolamine (medication for motion sickness or nausea and vomiting) patch, one mg, one patch every three days for nausea and vomiting, dated 08/23/24; - An order for hydrocodone-acetaminophen (narcotic pain medication) 7.5-325 mg, one tablet every six hours as needed (PRN) for pain, dated 01/29/26; - An order for Lyrica (nerve pain medication), 25 mg, on Monday, Wednesday, and Friday after dialysis, dated 12/08/25 and discontinued 03/10/26; (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- An order for Zyrtec (allergy medication), five mg, one tablet daily for allergies, dated 10/24/25; - An order for Tresiba Flex-Touch insulin (a hormone produced by the pancreas that regulates blood sugar) pen (100 units/milliliter (ml), give 52 units subcutaneously (under the skin) once a day for diabetes mellitus, dated 10/24/25; - An order for irbesartan (blood pressure medication), 300 mg, one tablet daily for heart disease, dated 10/22/23; - An order for lorazepam (anxiety medication), 0.5 mg, give one tablet at 6:00 A.M. on mornings of dialysis treatment on Monday, Wednesday, and Friday for anxiety, dated 08/19/25 and discontinued 03/10/26. Review of the resident's Medication Administration Record (MAR), dated January 2026, showed: - The resident did not receive Lokelma due to being unavailable on 01/11/26, 01/17/26, and 01/24/26, for a total of three missed doses out of nine opportunities; - The resident did not receive Vitamin B6 due to being unavailable on 01/02/26 (three doses), 01/03/26 (three doses), 01/04/26 (two doses), 01/05/26 (three doses), 01/06/26 (one dose), 01/07/26 (two doses), 01/08/26 (three doses), 01/09/26 (three doses), 01/10/26 (three doses), and 01/11/26 (three doses), for a total of 26 missed doses out of 93 opportunities; - The resident did not receive a scopolamine patch due to being unavailable on 01/03/26, for a total of one missed dose out of 10 opportunities; - The resident did not receive Zyrtec due to being unavailable on 01/15/26, for a total of one missed dose out of 31 opportunities. Review of the resident's MAR, dated February 2026, showed: - The resident did not receive Vitamin B6 due to being unavailable on 02/10/26 (one dose), for a total of one missed dose out of 84 opportunities; - The resident only received 26 of 52 units of Tresiba insulin due to being unavailable on 02/15/26; - The resident did not receive irbesartan due to being unavailable on 02/09/26, for a total of one missed dose out of 28 opportunities; - The resident did not receive lorazepam due to being unavailable on 02/23/26, for a total of one missed dose out of 12 opportunities. Review of the resident's MAR, dated 03/01/26 through 3/12/26, showed: - The resident did not receive Lokelma due to being unavailable on 03/01/26 and 03/07/26, for a total of two missed doses out of three opportunities; - The resident did not receive PRN hydrocodone-acetaminophen due to being unavailable on 03/08/26 for pain rated 4/10; (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- The resident did not receive Lyrica due to being unavailable on 03/02/26, for a total of one missed dose out of four opportunities; - The resident did not receive Zyrtec due to being unavailable on 03/01/26, for a total of one missed dose out of 12 opportunities. During an interview on 03/10/26 at 11:41 A.M., Resident #3 said he/she runs out of medicine, like insulin and pain pills. Insulin hasn't been recent, but the pain medicine has been recent. That happens a lot. During an interview on 03/12/26 at 2:27 P.M., Certified Medication Technician (CMT) A said he/she is not aware of medications being unavailable. The only time a med wouldn't be available would maybe be if there is an insurance issue. He/She thinks the Lokelma might have been because of that. With regards to the Vitamin B6, they should have it available all the time since it's a stock medication. He/She thinks it was marked unavailable because the label changed, and they didn't realize it. That label change also happened with folic acid. They should pay better attention to that. The resident wouldn't refuse his Vitamin B6. 2. Review of Resident #5's medical record showed: - admission date of 05/15/19; - Diagnoses of chronic respiratory failure with hypoxia (lungs can't get enough oxygen into the blood, so the body does not receive the oxygen it needs); - An order for oxygen, two liters per minute via nasal cannula (a thin, flexible tube with two small prongs that fit into the nostrils to deliver supplemental oxygen), dated 11/22/24; - An order to change oxygen tubing weekly, dated 03/30/22. Review of the resident's MAR, dated 03/01/26 through 03/12/26, showed: - Tubing change on 03/01/26; - Tubing change on 03/08/26. Observation on 03/12/26 at 2:35 P.M., of Resident #5 showed the resident wore a nasal cannula connected to the concentrator with the tubing dated 02/22. During an interview on 03/12/26 at 2:56 P.M., Resident #5 said staff does not change the tubing often. One time it was almost a month, and the tubing was getting kind of stiff. During an interview on 03/12/26 at 3:00 P.M., Licensed Practical Nurse (LPN) B said nurses are responsible for changing the tubing or assuring it is changed. Anyone wearing oxygen should have an order to change the tubing. It is normally changed on Sunday nights. The tubing should be dated and initialed. During an interview on 3/13/26 at 11:00 A.M., the Administrator and Director of Nursing (DON) said they would expect physician orders to be followed, and oxygen tubing should be changed once a week (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	on Sundays. 3. Review of Resident #31's medical record showed:- admission date of 12/26/25;- Diagnoses of anal cancer, constipation, and Crohn's disease (a chronic disease that causes inflammation in the digestive tract); - An order to administer one saline fleet enema (liquid, such as saline or water, into the rectum through the anus to treat severe constipation or to cleanse the bowel before medical procedures) prior to procedure – one to two hours prior to appointment (2:15 P.M.) and another 15 minutes following the first enema, dated 03/06/26. Review of the resident's Instruction Form for Procedure/Surgery, attached to the Resident #31's bedside table, showed: Procedure: rectal exam; Date of procedure: 03/06/26; Time: 2:15 P.M.; Orders or special instructions: First fleet administered two hours prior to appointment and 2nd fleet administered 15 minutes after first fleet enema; Signed: LPN B; Rescheduled: 04/24/26. Review of a Social Services Progress Note, dated 03/06/26, showed the resident was scheduled today for a rectal exam and an office visit. The resident did not get his preparation, so the appointment for today has been rescheduled to 04/24/26. The doctor's office to fax the new preparation order to the facility. During an interview on 03/10/26 at 11:15 A.M., Resident #31 said he/she was supposed to have medical testing completed on 03/06/26, but staff failed to administer the two fleet enemas that had to be completed before the exam. His/Her family member drove to pick him/her up and then staff said they would have to reschedule the appointment since they forgot to give the enemas. He/She was very upset because not only did it waste his/her family member's gas and time driving all the way there, but now he/she is left wondering if his/her cancer is spreading or worsening. It has caused him/her lots of worry and frustration. During an interview on 03/12/26 at 11:15 A.M., LNP B said he/she was working when the orders were received for Resident #31's enemas for a procedure. He/She entered the order, but was not working the day they should have been administered. The order should have popped up on the MAR/Treatment Administration Record (TAR) and the nurse working that shift would have been responsible for ensuring it was completed. He/she did not know why it was not completed. During an interview on 03/12/26 at 11:38 A.M., the Social Services Director said the nurse working the day Resident #31 was supposed to have the enema said he/she got busy and forgot to do it. The nurse quit, so he/she is no longer working here. When he/she heard Resident #31 missed the (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	appointment, he/she called the doctor's office and got the appointment rescheduled. During an interview on 03/12/26 at 2:00 P.M., the DON said she would expect medications and treatments to be given and completed as ordered. She said Resident #31 missed his/her preparation for the medical procedure because the nurse did not give it. She does not know why the nurse did not administer the fleet enemas, and the nurse quit the following day. During an interview on 03/13/26 at 11:00 A.M., the Administrator and DON said they would expect physician orders to be followed as ordered, medications to be given as ordered and without errors, and oxygen tubing to be changed once a week on Sundays.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. Based on interview and record review, the facility failed to ensure communication forms that reflected ongoing coordination and collaboration between facility staff and the dialysis (a life-sustaining medical treatment that filters waste, toxins, and excess fluids from the blood when the kidneys have failed) staff were sent with two residents (Residents #3 and #42) out of two sampled dialysis residents on all dialysis days and failed to follow their policy to ensure Resident #3's arteriovenous (AV - connection of an artery and a vein) fistula (artificial blood vessel connections between an artery and a vein) was checked daily for the thrill (vibrating sensation)/bruit (whooshing sound). The facility's census was 52. Review of the facility's policy, Dialysis, Care of a Resident Receiving, undated, showed:- Care of the AV shunt/fistula/graft (artificial blood vessel connections between an artery and a vein): Feel for the thrill sensation daily; Inspect the access for redness, swelling, or warmth; Watch for bleeding after dialysis;- Checking the thrill sensation: Nurses will check the thrill daily and document daily. This will be documented on the resident's treatment record; At the AV site, feel for a pulse. The pulse is the blood flow through the access; If no thrill sensation is felt, notify the physician;- Communication between the Facility and Dialysis Unit: The Dialysis Communication Record will be sent with the resident on each dialysis visit; All care concerns in the last 24 hours will be addressed, including last medications given and facility contact person; The dialysis unit will complete the lower portion of the report to include weight prior to and after dialysis, any labs completed, medication given, follow up information and any new physician orders; The lower portion will be signed by the dialysis nurse and returned to the facility; These records will be maintained in the medical record.1. Review of Resident #3's medical record showed:- admission date of 12/28/21;- Diagnoses of end stage renal disease (ESRD - the final, permanent stage of chronic kidney disease), muscle weakness, and hyperkalemia (high potassium).Review of the resident's Physician Order Sheets (POS), dated 03/12/26, showed:- An order for dialysis three times a week on Monday, Wednesday, and Friday, dated 05/30/25 and discontinued 03/10/26;- An order for dialysis three times a week on Tuesday, Thursday, and Saturday, dated 03/11/26;- An order to remove the pressure dressing from the fistula site in the morning the day after dialysis on Tuesday, Thursday, and Saturday, dated 12/29/21;- An order to check the AV fistula daily for the thrill/bruit on every shift on Tuesday, Thursday, and Saturday, dated 10/08/25 and discontinued 03/10/26;- An order to check the AV fistula daily for the thrill/bruit on Sunday, Wednesday, and Friday, dated 03/10/26;- The orders to check the AV fistula for the thrill/bruit daily do not include every day of the week per the policy.Review of the resident's care plan, revised 03/11/26, showed:- Resident receives dialysis related to ESRD;- Check AV fistula daily for the thrill/bruit;- Assure medications are administered before and after dialysis as ordered by the physician to ensure maximum effectiveness and to avoid adverse effects of the medications.Review of the resident's Progress Notes showed no dialysis due to the weather on 01/26/26.Review of the resident's Dialysis Communication Forms, dated 12/01/25 through 03/12/26, showed 29 forms not completed for 12/01/25, 12/10/25, 12/12/25, 12/15/25, 12/17/25, 12/19/25, 12/22/25, 12/24/25, 12/26/25, 12/29/25, 12/31/25, 01/02/26, 01/05/26, 01/07/26, 01/09/26, 01/12/26, 01/14/26, 01/16/26, 01/19/26, 01/21/26, 01/23/26, 01/28/26, 02/02/26, 02/13/26, 02/20/26 not completed by facility staff, 03/04/26, 03/06/26, 03/09/26, and 03/12/26.Review of the resident's Medication Administration Record (MAR), dated December 2025 through 03/12/26, showed the resident attended dialysis a total of 43 times with a total of 29 missed opportunities for the communication forms to be completed.During an interview on 03/10/26 at 11:41 A.M., Resident #3 said he/she had been going to dialysis on Monday, Wednesday, and Friday, but would now go Tuesday, Thursday, and Saturday starting next week. Staff took his/her vital signs in the morning, and he/she got medicines before dialysis. He/She came back at noon, and they gave his/her medicine and insulin. Staff didn't take vital signs after he/she came back from dialysis. When he/she got back, the form stayed in his/her backpack, then when he/she went to dialysis again, staff (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	took it out. That meant with his/her dialysis schedule changing, when he/she went Thursday, they would get Monday's paper. 2. Review of Resident #42's medical record showed:- admission date of 12/10/24;- Diagnoses of ESRD, vitamin deficiency, and shortness of breath.Review of the resident's POS, dated 03/12/26, showed:- An order for dialysis three times per week with the dialysis center. Special instructions: Complete the dialysis communication form, send with the resident, upload the returned/completed communication form to the resident documents in the electronic health record (EHR) daily on Monday, Wednesday, and Friday, dated 07/30/25 and discontinued 02/25/26;- An order for dialysis three times per week with the dialysis center. Special Instructions: Complete the dialysis communication form observation, send with the resident, upload returned/completed communication form to the resident documents in the EHR daily on Monday, Wednesday, and Friday, dated 01/01/26 and discontinued 02/02/26;- An order for dialysis three times per week with the dialysis center. Special Instructions: Complete the dialysis communication form observation, send with the resident, upload returned/completed the communication form to the resident documents in the EHR daily on Tuesday, Thursday, and Saturday, dated 02/25/26;- An order to check the central venous catheter (CVC - a flexible tube inserted into a large vein to provide immediate access for dialysis) dressing every shift for signs and symptoms of infection, dated 01/01/26;- An order to check the AV fistula daily for the thrill/bruit, dated 07/30/25 and discontinued 12/11/25;- An order to remove the pressure dressing from the fistula site in the morning the day after dialysis, daily on Tuesday, Thursday, and Saturday, dated 11/17/25 and discontinued 12/11/25.Review of the resident's Care Plan, revised 01/20/26, showed:- Dialysis three times per week per physician orders;- Remove pressure dressing from the fistula site in the morning the day after dialysis.Review of the resident's Hemodialysis Communication forms, dated 12/01/25 through 03/12/26, showed 17 forms not completed for 12/12/25, 12/15/25 (no vital signs by the facility staff prior to dialysis) 01/02/26, 01/05/26, 01/09/26, 01/12/26, 01/16/26, 01/19/26, 01/21/26, 02/02/26, 02/09/26 (not signed by the facility staff), 02/11/26, and 02/16/26 (only vital signs completed and no facility staff signature), 02/20/26, 03/07/26, 03/10/26, and 03/12/26. Review of the resident's MAR, dated December 2025 through 03/12/26, showed the resident attended dialysis a total of 18 times with a total of 17 missed opportunities for the communication forms to be completed.During an interview on 03/11/26 at 9:05 A.M., Resident #42 said staff sometimes did vital signs before dialysis and sometimes they gave him/her the communication form. Staff didn't really do anything when he/she got back from dialysis, and they didn't ask for the communication form all the time. The other person who got dialysis had a folder, but he/she didn't have a folder. During an interview on 03/13/26 at 11:00 A.M., the Administrator said he would expect dialysis communication forms to be completed by both the facility and dialysis center for each dialysis visit treatment as per the regulation.During an interview on 03/18/26 at 2:57 P.M., the Director of Nursing (DON) said she did not find any notes on refusals for Resident #3, but one day dialysis was cancelled because of weather. Post dialysis, they have orders to monitor the access site every shift and, on Resident #3, to remove the pressure dressing the following day and monitor for bleeding.During an interview on 03/19/26 at 11:16 A.M., the DON said Resident #42 did have a shunt placed in his/her arm. Dialysis tried to access one time, and then it developed an infection and was removed. Resident #42 now had a CVC in the right chest for dialysis access. They did have orders to check the central line every shift. Dialysis was doing dressing changes and maintaining the CVC. The current order for Resident #3 was to check the AV fistula on Sunday, Wednesday, and Friday. She would correct the order to include Monday.During an interview on 03/23/26 at 8:07 A.M., the DON said that staff did not check the thrill/bruit on dialysis days because that was done at dialysis, and the resident had a pressure dressing on when he/she came back. When asked if a resident was scheduled for dialysis but refused, who would be checking the thrill/bruit on those days since the orders did not include staff checking it on those days, she said the nurses usually would check on those days, but she would put in an order to confirm they did.

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observe each nurse aide's job performance and give regular training. Based on interview and record review, the facility failed to ensure three of the three sampled Certified Nurse Aides (CNAs) received an annual performance review. The facility's census was 52.The facility did not provide a policy regarding CNA annual performance reviews.1. Review of CNA D's personnel file showed:- Hire date of 10/30/24;- No documentation of an annual performance review.2. Review of CNA E's personnel file showed:- Hire date of 10/04/24;- No documentation of an annual performance review.3. Review of CNA F's personnel file showed:- Hire date of 07/18/24;- No documentation of an annual performance review.During an interview on 03/12/26 at 2:12 P.M., the Director of Nursing (DON) said the prior Administrator did not do performance reviews, and they haven't been doing them.During an interview on 03/13/26 at 11:00 A.M., the Administrator said he would not necessarily expect performance reviews to be completed annually, and the facility does not have a policy. They follow the regulations.

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F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Post nurse staffing information every day. Based on observation, interview, and record review, the facility failed to post the nurse staffing data at the beginning of each shift for three of four observed days. The facility's census was 52.The facility did not provide a policy regarding daily staffing data postings.Observations of the posted nurse staffing data showed:- On 03/11/26 at 10:15 A.M., nurse staffing data posted and dated 03/10/26, including the census, and total number and actual hours worked per shift by licensed and unlicensed staff responsible for resident care;- On 03/12/26 at 12:00 P.M., nurse staffing data posted and dated 03/10/26, including the census, and total number and actual hours worked per shift by licensed and unlicensed staff responsible for resident care;- On 03/13/26 at 9:00 A.M., nurse staffing data posted and dated 03/10/26, including the census, and total number and actual hours worked per shift by licensed and unlicensed staff responsible for resident care.During an interview on 03/13/26 at 9:02 A.M., the Director of Nursing (DON) said Licensed Practical Nurse (LPN) G updates the staffing postings, and they should be updated daily.During an interview on 03/13/26 at 11:00 A.M., the Administrator and DON said they would expect staffing to be posted daily.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. Based on observation, interview, and record review, the facility failed to maintain a medication error rate of five percent or less when staff failed to prime insulin pens before the administration of insulin and administered the incorrect amount of insulin. There were 33 opportunities with three errors made, for an error rate of 9.09%. This affected two residents (Residents #2 and #23) out of 13 sampled residents. The facility's census was 52.Review of the facility's checklist, Insulin Pen Skills Checklist, undated, showed:- Gather necessary supplies on clean field;- Verify pen is within expiration date;- Cleanse the stopper with alcohol;- Attach safety needle;- Dial units as per physician's orders;- [NAME] gloves;- Cleanse area to be administered with alcohol;- Administer insulin;- Cleanse area again with alcohol and apply bandage if needed;- Dispose of needle in sharps container;- Remove gloves and perform hand hygiene. Review of the facility's policy, Medications, Errors and Drug Reactions, undated, showed:- Purpose: to safeguard the resident and provide emergency care as necessary;- If necessary, provide emergency care to resident;- Report all medication errors and adverse drug reactions to the attending physician, Director of Nursing (DON) and Administrator;- Document and follow the attending physician's orders;- Complete a resident assessment including the following: obtain vital signs and record, complete a body assessment, assess respiratory, cardiac, and circulatory status, assess every shift for at least 72 hours;- Open a medication error event in the electronic health record and complete the following: date error began/ended, date error found, error found by whom, document the correct order, describe the error, type of error, document if any adverse drug reactions are present, document implemented interventions, notify the resident's responsible party, and frequently observe the resident until condition is stable. Review of insulin lispro (a synthetic or human-derived hormone injected into the fatty tissue under the skin to regulate high blood sugar levels, commonly known as Humalog) pen (insulin in a pen-type device) manufacturer's instructions from pi.lilly.com showed:- Remove cap;- Attach needle;- Prime pen by turning dose selector to select two units;- Press and hold button to make sure drop of insulin appears;- Select dose;- Give injection;- After dose counter reaches zero, hold for 5-10 seconds;- After injection, remove needle and place in sharps container;- Place cap back on pen and store until next use. Review of insulin glargine (commonly known as Lantus) pen manufacturer's instructions from lantus.com showed:- Wash your hands;- Take off the pen cap, and make sure the insulin is clear and colorless. Do not use if it is cloudy or if you see particles, throw it away;- Wipe the rubber seal, remove the protective seal, and attach the needle;- Perform a safety test, dial a dose of two units and hold the pen upright and tap the insulin reservoir to get the air bubbles to rise up, press the button down and check for insulin on the needle tip;- If insulin doesn't come out, try the safety test two more times, and change the needle. If it still doesn't work, the pen may be damaged - do not use it;- Select your required dose, and cleanse the skin with an alcohol swab;- Inject the dose, keep the button pressed, and count to 10;- Remove and discard the needle, place in a sharps container;- Put the pen cap back on and store the pen. 1. Review of Resident #2's Physician Order Sheet (POS), dated 03/13/26, showed:- An order for Humalog Kwik pen insulin (insulin lispro) 100 units/milliliter (ml) per sliding scale, subcutaneously (under the skin), before meals and at bedtime, dated 02/07/26;- An order for Humalog Kwik pen (insulin lispro) 100 units/ml, 15 units subcutaneously, along with sliding scale, before meals and at bedtime, dated 02/25/26;- An order for Lantus (insulin glargine) 100 units/ml (3ml), 52 units subcutaneously twice a day, dated 02/18/26. Observation on 03/13/26 at 8:00 A.M., showed:- The DON obtained the resident's finger stick blood sugar (FSBS) with a reading of 263;- The DON obtained the insulin lispro pen from the medicine cart and adjusted the pen to the amount of insulin ordered;- The DON did not prime the pen with two units of insulin per the manufacturer's instructions prior to administering the ordered dose to the resident;- The DON obtained the Lantus insulin pen from the medicine cart and adjusted the pen to the amount of insulin ordered;- The DON did not prime the pen with two units of insulin per the manufacturer's instructions prior to administering (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265681	A. Building B. Wing	03/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Potosi Manor	307 South Highway 21 Potosi, MO 63664

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the ordered dose to the resident.2. Review of Resident #23's POS, dated 03/13/26, showed:- An order for insulin glargine 300 units/ml (3ml), 20 units subcutaneously, twice a day, dated 02/12/26;- An order for insulin lispro 100 units/ml, subcutaneously per sliding scale before meals and at bedtime, dated 02/12/26.Observation on 03/13/26 at 8:15 A.M., showed:- The DON obtained the resident's FSBS with a reading of 251;- The DON primed the insulin pen;- The DON administered 20 units of insulin lispro to the resident when the physician's order was for 6 units per sliding scale;- The DON administered the incorrect dose of insulin lispro to the resident.- The DON immediately called the physician regarding the error and was told to hold the resident's insulin glargine 20 units and to monitor the resident's blood sugar every hour and to monitor for symptoms. The DON made a progress note regarding the error.During an interview on 03/13/26 at 9:02 A.M., the DON said insulin pens should typically be primed with two units of insulin, but there is one type that requires the pen to be primed with three units. Medication administration should be error free.During an interview on 03/13/26 at 11:00 A.M., the Administrator and DON said they would expect medications to be given as ordered and without errors, for insulin pens to be primed per manufacturer's instructions, and for the medication error rate to be less than 5%.

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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 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, the facility failed to provide a safe and functional environment by allowing items to be stored on top of overbed light fixtures for residents in seven rooms. Storing items on the overbed light creates a hazard of the items falling on the resident below and does not utilize the light fixtures as intended. The deficient practice had the potential to affect all residents and staff in the facility. The facility census was 52.The facility did not provide a policy regarding overbed light safety. Observation of resident rooms showed: - On 03/10/26 at 11:26 A.M., room [ROOM NUMBER] with multiple stuffed animals on the light fixture above the bed by the door and above the bed by the window; - On 03/10/26 at 11:38 A.M., room [ROOM NUMBER] with two hats and a stuffed animal on the light fixture above the bed by the window; - On 03/12/26 at 9:10 A.M., room [ROOM NUMBER] with two picture frames and three small flower decorations on the light fixture above the bed by the window; - On 03/10/26 at 11:15 A.M., room [ROOM NUMBER] with two canvas pictures and some flowers on the light fixture above the bed by the door; - On 03/12/26 at 2:08 P.M., room [ROOM NUMBER] with a horse picture on the light fixture above the bed by the door; - On 03/12/26 at 2:10 P.M., room [ROOM NUMBER] with two framed pictures and a piece of paper with a drawing on it on the light fixture above the bed by the door; - On 03/12/26 at 2:12 P.M., room [ROOM NUMBER] with two crocheted plant decorations hanging from either side of the light fixture above the bed by the window. During an interview on 03/12/26 at 2:10 P.M., Certified Nurse Aide (CNA) C said he/she does not put things on top of the lights in the resident rooms, but family members will often place pictures and items on them. During an interview on 03/12/26 at 2:00 P.M., the Director of Nursing (DON) said items should not be placed on the light fixtures due to possible hazards. During an interview on 03/13/26 at 11:00 A.M., the Administrator and DON said they would expect overbed light fixtures to be free from items due to possible hazards.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265681	A. Building B. Wing	03/13/2026

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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 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. Based on interview and record review, the facility failed to provide the required 12 hours of in-services per year to include dementia management, abuse/neglect prevention, areas of personal weakness, areas of concern based on the facility assessment, the care of cognitively impaired residents and the care of residents with special needs for three Certified Nurse Aides (CNAs D, E, and F) out of three sampled CNAs. The deficient practice had the potential to affect all residents. The facility's census was 52.The facility did not provide a policy regarding nurse aide training and in-service requirements. 1. Review of CNA D's personnel file showed:- Hire date of 10/30/24;- No in-services recorded from 10/30/24-02/27/26;- No documented trainings for dementia management, abuse/neglect prevention, areas of personal weakness, the care of cognitively impaired residents, and the care of residents with special needs. 2. Review of CNA E's personnel file showed:- Hire date of 10/04/24;- A total of eight in-services, dated from 02/24/25 through 02/27/26, with the length of each in-service not documented;- No documented trainings for dementia management, areas of personal weakness, the care of cognitively impaired residents, and the care of residents with special needs. 3. Review of CNA F's personnel file showed:- Hire date of 07/18/24;- No in-services recorded from 07/18/24 through 02/27/26;- No documented trainings for dementia management, abuse/neglect prevention, areas of personal weakness, the care of cognitively impaired residents, and the care of residents with special needs.During an interview on 03/12/26 at 11:15 A.M., the Director of Nursing (DON) said she has no recorded in-services for CNA D and CNA F because they work as needed (PRN).During an interview on 03/12/26 at 3:00 P.M., Licensed Practical Nurse (LPN) G said in-services are conducted by the DON and himself/herself. Staff should have at least 12 in-services per year and should include resident rights, peri care, hand hygiene, privacy, and workplace violence. He/She couldn't remember them all and provided a typed list of upcoming in-services which included two in-services in each month for March, April, May, June, and July to include the required training for abuse/neglect and misappropriation.During an interview on 03/13/26 at 11:00 A.M., the Administrator and DON said they would expect nurse aides to have at least 12 hours of in-services a year to include dementia care/management and the care of cognitively impaired residents.