STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265716	A. Building B. Wing	02/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hubble Creek	1115 K Land Drive Jackson, MO 63755

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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 0943 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Give their staff education on dementia care, and what abuse, neglect, and exploitation are; and how to report abuse, neglect, and exploitation. Based on interview and record review, the facility failed to provide abuse/neglect training for three Certified Nursing Assistants (CNAs) and one Licensed Practical Nurse (LPN) of four sampled staff hired since September 2025. The facility census was 64.Review of the facility's policy titled, In-Service Training, All Staff, dated 2001, showed:- The primary objective of the in-service training is to ensure that staff are able to interact in a manner that enhances the resident's quality of life and quality of care and can demonstrate competency in the topic areas of the training;- Required training topics include preventing abuse, neglect, exploitation and misappropriation of resident property;- Completed training is documented by the staff development coordinator, or his/her designee. 1. Review of CNA B's employee file showed:- A hire date of 12/27/25;- No documentation of abuse/neglect training. 2. Review of CNA H's employee file showed:- A hire date of 01/07/26;- No documentation of abuse/neglect training. 3. Review of CNA I's employee file showed:- A hire date of 01/19/26;- No documentation of abuse/neglect training. 4. Review of LPN D's employee file showed:- A hire date of 12/28/25;- No documentation of abuse/neglect training. During an interview on 02/10/26 at 3:53 P.M., CNA B said he/she did not remember getting abuse/neglect training since being employed at the facility. During an interview on 02/10/26 at 5:00 P.M., the Administrator said he took over as the Administrator in December after the facility was bought in September. The facility had just gotten all of their staff signed up through the contracted training company last week so the staff could do the required trainings. During an interview on 02/12/26 at 6:35 P.M., the Administrator and Director of Nursing (DON) said they would expect all nursing staff to have abuse/neglect training upon hire and before working with residents.

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

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

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility staff failed to allow residents or their representatives to make informed decisions about their care by not providing psychotropic (medications that affect behavior, mood, thoughts, or perception) medication consents for seven residents (Residents #1, #2, #4, #6, #12, #35, and #64) out of 11 sampled residents and one resident (Resident #13) outside the sample. The facility census was 64.Review of the facility's policy titled, Psychotropic Medication Use, revised February 2025, showed: - Prior to initiating the use of, increasing the dose of, or switching to a different psychotropic medication, the staff and physician will review the following with the resident/representative prior to obtaining documented consent or refusal: non-pharmacological alternatives; the indications and rationale for the recommendation; the potential risks and benefits (including possible side effects, adverse consequences, and black box warnings) and; the resident's/representative's right to accept or decline the treatment. 1. Review of Resident #1's medical record showed: - admitted on [DATE]; - Diagnoses of dementia (a disorder marked by memory loss, personality changes, and impaired reasoning that interferes with daily functioning) with behavioral disturbance, dementia with agitation, anxiety (persistent worry and fear about everyday situations), insomnia (difficulty sleeping), restlessness, and agitation; - An order for divalproex sodium (anticonvulsant medication and also used as a mood-stabilizer medication) 24-hour extended release (ER) 500 milligrams (mg) by mouth one time a day for restlessness and agitation per hospital physician, dated 01/20/26; - An order for melatonin (a hormone that helps regulate the sleep cycle) 3 mg two tablets by mouth at bedtime related to insomnia, dated 09/05/25; - An order for donepezil (a medication to help memory) 24 hour-extended release 28-10 mg by mouth one time a day related to unspecified dementia with behavioral disturbance, dated 09/06/25; - An order for mirtazapine (an antidepressant medication) 15 mg by mouth at bedtime for restlessness and agitation and insomnia per hospital physician, dated 09/05/25; - An order for quetiapine (an antipsychotic (psychiatric medications that treat symptoms of psychosis – such as hallucinations, delusions, and severe paranoia) medication) 300 mg by mouth at bedtime for dementia with agitation per hospital physician, dated 09/05/25; - No documentation of consents or education of risks and benefits for the psychotropic medication use were provided to the resident and/or their representative. 2. Review of Resident #2's medical record showed: - admitted on [DATE]; (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Diagnoses of dementia with agitation, anxiety, mood disturbance, and depression (a mood disorder that causes a persistent feeling of sadness and loss of interest); - An order for olanzapine (an antipsychotic medication) 5 mg by mouth at bedtime related to restlessness and agitation, dated 01/20/26; - An order for escitalopram (an antidepressant medication) 20 mg by mouth one time a day related to generalized anxiety disorder, dated 11/05/25; - No documentation of consents or education of risks and benefits for the psychotropic medication use were provided to the resident and/or their representative. 3. Review of Resident #4's medical record showed: - An admission date of 10/14/25; - Diagnosis of dementia; - An order for risperidone (an antipsychotic medication) 0.5 mg by mouth one time a day for dementia, dated 10/14/25; - An order for quetiapine 25 mg by mouth one time a day for depression, dated 10/14/25; - No documentation of consents or education of risks and benefits for the psychotropic medication use were provided to the resident and/or their representative. 4. Review of Resident #6's medical record showed: - An admission date of 04/18/25; - Diagnoses of anxiety disorder, auditory hallucinations (the perception of sounds, such as voices, music, or noises, without an external source), schizoaffective disorder (a chronic mental health condition combining hallucinations, delusions, and disorganized thinking with mood disorder symptoms like mania, depression), and unspecified intellectual disability (a diagnosis for individuals over age five with clear, significant limitations in intellectual and adaptive functioning, but whose impairment cannot be formally assessed or categorized due to severe co-occurring conditions); - An order for Seroquel (an antipsychotic medication) 300 mg by mouth at bedtime for schizoaffective disorder, dated 12/06/25; - No documentation of consent or education of risks and benefits for the psychotropic medication use was provided to the resident and/or their representative. 5. Review of Resident #12's medical record showed: - admitted on [DATE]; - Diagnoses of Alzheimer's disease (brain disorder with progressive mental deterioration), dementia with mood disturbance, and depression; (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- An order for citalopram (an antidepressant medication) 20 mg by mouth one time a day related to depression, dated 10/18/25; - An order for Seroquel 25 mg 0.5 tablet by mouth at bedtime related to Alzheimer's disease, dated 01/19/26; - An order for buspirone (an anxiety medication) 5 mg by mouth two times a day related to dementia with mood disturbance, dated 10/17/25; - No documentation of consents or education of risks and benefits for the psychotropic medication use were provided to the resident and/or their representative. 6. Review of Resident #13's medical record showed: - An admission date of 04/10/25; - Diagnoses of unspecified mood disorder, bipolar disorder (a mental health condition that causes extreme mood swings that include emotional highs, called mania, and lows, known as depression), generalized anxiety disorder, and unspecified dementia without behavioral disturbance; - An order for aripiprazole (an antipsychotic medication) 5 mg by mouth at bedtime for unspecified mood disorder, dated 11/05/25; - No documentation of a consent or education of risks and benefits for the psychotropic medication use was provided to the resident and/or their representative. 7. Review of Resident #35's medical record showed: - An admission date of 10/01/25; - Diagnoses of Alzheimer's disease with late onset, anxiety disorder, and dementia with mood disturbance; - An order for quetiapine 75 mg by mouth two times a day for dementia with behaviors, dated 02/05/26; - No documentation of consent or education of risks and benefits for the psychotropic medication use was provided to the resident and/or their representative. 8. Review of Resident #64's medical record showed: - admitted on [DATE]; - Diagnoses of dementia with agitation and insomnia; - An order for sertraline (an antidepressant medication) 25 mg by mouth at bedtime for mood, dated 01/16/26, and discontinued on 01/22/26; - An order for haloperidol (an antipsychotic medication) 2 mg by mouth two times a day for (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	restlessness/agitation, dated 01/28/26; - An order for memantine (a medication for memory) 10 mg by mouth two times a day for memory, dated 01/17/26, and discontinued 01/22/26; - An order for morphine sulfate (an opioid pain medication) 100 mg/5 milliliters (ml) 0.5 ml by mouth every 1 hour as needed for pain and shortness of breath, dated 01/22/26; - An order for ondansetron (a nausea medication) 4 mg by mouth every 6 hours as needed for nausea and vomiting, dated 01/22/26; - An order for haloperidol inject 0.2 ml intramuscularly (IM – injection into the muscle) at bedtime for behavior/ mood, dated 01/22/26, and discontinued 01/28/26; - An order for haloperidol 2 mg/ml 0.5 ml orally every 6 hours as needed for agitation/restlessness, dated 01/30/26; - No documentation of consents or education of risks and benefits for the psychotropic medication use were provided to the resident and/or their representative. During an interview on 02/11/25 at 9:15 A.M., the Corporate Compliance Officer said psychotropic medication consent forms were discussed during a meeting with the administration and had not yet been initiated. During an interview on 02/12/26 at 6:37 P.M., the Administrator and Director of Nursing (DON) said they would expect residents or their representatives to be given informed consents for the use of psychotropic medications.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on observation, interview, and record review, the facility failed to provide adequate supervision when leaving residents unattended with an unlabeled, unknown liquid material, and failed to provide adequate supervision when leaving the locked unit without staff for 14 residents out of 14 residents. The facility census was 64.The facility did not provide a policy regarding adequate supervision. Observation of the facility during the initial tour on 02/09/26, showed a locked unit with 14 residents. Review of the facility's Matrix (information used to identify pertinent care categories for residents in long-term care facilities) showed:- The 14 cognitively impaired residents that resided on the locked unit had a diagnosis of Alzheimer's (brain disorder with progressive mental deterioration)/dementia (a disorder marked by memory loss, personality changes, and impaired reasoning that interferes with daily functioning), exhibited behaviors, and needed increased monitoring. 1. Observation of the locked unit on 02/09/26 at 11:50 A.M., showed:- One unknown Certified Nurse Assistant (CNA) worked on the unit;- The CNA brought residents to the dining room one at a time, leaving those in the dining room unsupervised while he/she went to get the next resident;- A cart with 15 uncovered cups sat in the dining room. On the cart next to the cups was an unlabeled bucket of an unknown liquid substance which smelled strongly of bleach;- A resident stood next to the cart and other residents passed back and forth in front of the cart with no staff monitoring in the dining area. Observation of the dining room on the locked unit on 02/11/26 at 11:55 A.M., showed:- A cart in the dining room with an unlabeled bucket of an unknown liquid substance which smelled strongly of bleach. A rag floated in the bucket;- CNA F washed the hands of each resident in the dining room with the rag from the bucket;- Resident #10 and Resident #15 complained of his/her hands burning. During an interview on 02/11/26 at 12:01 P.M., CNA F said he/she did not know what was in the bucket. Kitchen staff delivered it every day before each meal, and he/she wiped the resident's hands with it. CNA F said he/she thought it was soap and water, but it wasn't labeled. Observation of the dining room on the locked unit on 02/12/26 at 11:45 A.M., showed:- A cart in the dining room with an unlabeled bucket of an unknown liquid substance which smelled strongly of bleach. A rag floated in the bucket;- CNA G wiped the dining room tables with the rag from the unknown substance in the bucket. During an interview on 02/12/26 at 11:50 A.M., CNA G said the bucket was filled with soap and water to wipe the dining room tables down before and after each meal. The bucket came from the kitchen before each meal. During an interview on 02/12/26 at 2:00 P.M., the Dietary Services Manager (DSM) said the liquid in the bucket was bleach water for wiping the tables down before and after the meals. It was plain water with a couple of capfuls of bleach. The bucket was sent with each meal. The CNAs should be aware of what the bucket held and how to use it. The mixture was not supposed to be used on a resident's skin. 2. Observation on 02/10/26 at 5:30 P.M. to 5:32 P.M., showed no staff on the locked unit. Observation on 02/11/26 from 11:55 A.M. until 12:10 P.M., of the locked unit showed:- CNA F went from resident to resident and attempted to redirect the residents to the dining room tables to prepare for lunch;- The residents got up and walked off from the dining room tables;- Certified Medication Technician (CMT) J tried to assist with the residents. During an interview on 02/11/26 at 12:01 P.M., CNA F said the facility regularly staffed only one CNA on the locked unit. It was very difficult to monitor all the residents when the CNA was providing care to a resident in his/her room. Every resident on the unit had dementia and/or behaviors and was constantly on the move. CNA F said mealtimes were very difficult for one staff. During meals, he/she was constantly redirecting residents one after another. Today he/she was very thankful for CMT J for helping, but that was not the norm. If a resident should require more than one person for assistance, he/she had to call the float staff. Sometimes help came, and sometimes it took a long time, or no one came. Observation of the dining room on the locked unit on 02/12/26 at 11:54 A.M., showed:- CNA G assisted Resident #64 to the bathroom in the resident's room;- The dining room was left unsupervised for four minutes while Resident #64 and CNA G were in (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the resident's room. During an interview on 02/12/26 at 11:50 A.M., CNA G said there was usually only one CNA assigned to the locked unit. He/She said it would be good to have a second person working the unit. It got really busy at lunch times and if the only CNA was in a resident's room, there was no way staff knew what was going on outside the room. During an interview on 02/10/26 at 5:45 P.M., the Director of Nursing (DON) said there was usually one staff member assigned to the locked unit. There was usually a float staff member that could work where needed, and there was always a nurse that could assist if needed, but neither stayed on the locked unit. She was not aware of any instances when the single staff member left the unit unsupervised. There should always be staff on the unit with the residents. If the unit staff member needed a break, then they were expected to find another staff member to take over prior to leaving.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide routine and emergency medications and biologicals for one resident (Resident #12) out of 16 sampled residents. The facility census was 64.Review of the facility policy titled, Medication and Treatment Orders, revised July 2016, showed:- Medications and biologicals that are required to be refilled must be reordered from the issuing pharmacy not less than three days prior to the last dosage being administered to ensure that refills are readily available;- Orders not specifying the number of doses, or duration of medication, shall be subject to automatic stop orders;- Medications not specifically limited to duration of use and number of doses when ordered will be controlled by automatic stop orders. 1. Review of Resident #12's medical record showed:- admitted on [DATE];- Diagnoses of Alzheimer's disease (brain disorder with progressive mental deterioration), dementia (the impaired ability to remember, think, or make decisions that interferes with doing everyday activities) with mood disturbance, and depression (a mood disorder that causes a persistent feeling of sadness and loss of interest);- An order for Seroquel (an antipsychotic (psychiatric medications that treat symptoms of psychosis - such as hallucinations, delusions, and severe paranoia) medication) 25 milligram (mg) 0.5 tablet by mouth two times a day related to dementia with mood disturbance, dated 10/07/25, and discontinued 01/19/26;- An order for buspirone (an anxiety medication) 5 mg by mouth two times a day related to dementia with mood disturbance, dated 10/17/25;- An order for memantine (a medication for memory) 5 mg by mouth two times a day related to Alzheimer's disease, dated 10/17/25, and discontinued date 01/19/26. Review of the resident's Medication Administration Record (MAR) for November 2025 - January 2026, showed:- Seroquel not administered the morning of 11/03/25, the night of 11/05/25, the morning and night of 11/07/25, and the morning and night of 11/08/25, the night of 12/12/25, the morning and the night of 12/13/25;- Buspirone not administered the morning of 11/02/25, the morning of 11/03/25, the night of 01/06/26, the morning and the night of 01/07/26, and the night of 01/08/26;- Memantine not administered the morning and the night of 01/06/26, the morning and night of 01/07/26, and the morning of 01/08/26. Review of the resident's progress Notes showed:- On 11/02/25 at 09:45 A.M., buspirone medication on order;- On 11/03/25 at 7:00 A.M., buspirone medication out and on order;- On 11/03/25 at 7:01 A.M., Seroquel medication out on order;- On 11/05/25 at 3:57 P.M., Seroquel medication ordered;- On 11/07/25 at 6:57 A.M., Seroquel medication on order;- On 11/07/25 at 9:12 P.M., Seroquel medication ordered;- On 11/08/25 at 7:01 A.M., Seroquel medication out and ordered;- On 11/08/25 at 3:06 P.M., Seroquel medication ordered and waiting on pharmacy;- On 12/12/25 at 2:24 P.M., Seroquel medication out and waiting on pharmacy;- On 12/13/25 at 8:26 A.M., Seroquel medication unavailable;- On 12/13/25 at 4:54 P.M., Seroquel medication on order;- On 01/06/26 at 2:42 P.M., memantine and buspirone medications on order;- On 01/07/26 at 6:42 A.M., memantine medication on order;- On 01/07/26 at 6:43 A.M., buspirone medication on order;- On 01/07/26 at 2:48 P.M., memantine and buspirone medication on order;- On 01/08/26 at 7:02 A.M., memantine medication on order;- On 01/08/26 at 2:30 P.M., buspirone on order. During an interview on 02/12/26 at 2:40 P.M., Licensed Practical Nurse (LPN) E said if a resident ran out of a medication or it wasn't in the medication cart, there was a locked medication stock supply that had certain medications in it. The paper list of locked medications might not be accurate, so he/she did not go by that. He/She looked up Resident #12's Seroquel and it was not in the locked medication stock supply. If the medication was not in there, then the nurse would call the physician and/or pharmacy for further instructions. During an interview on 02/12/26 at 5:40 P.M., the Director of Nursing (DON) said medications should be ordered before they ran out and the pharmacy delivered medications daily except on the weekend. If medications ran out, the facility had a locked medication stock supply the nursing staff could access for certain medications. If that option did not work, then he/she did not (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	know what the next step was. During a phone interview on 02/24/26 at 11:47 A.M., the Pharmacist said they did daily deliveries to the facility. If a medication was ordered before 1:00 P.M., then a medication would likely be delivered the same day, and if ordered after 1:00 P.M., then it would be delivered the next day. The pharmacy always had an on-call pharmacist that could be called. If it was an important medication, such as a seizure medication, then the pharmacy would send it as soon as possible as a high priority. The facility had a locked medication supply with a lot of different medications that could be utilized if a resident's medication supply was out. Seroquel should be in the locked medication supply. The facility should document the reason for not administering a medication and call the pharmacy if they were out of a medication and needed it as soon as possible. The facility should not document a medication was not given because it was ordered or out. During a phone interview on 02/24/26 at 3:55 P.M., the Pharmacist said the facility had staff issues because they weren't following through with the ordering of medications. For example, on 11/07/25, a resident's Seroquel medication was requested and delivered, but staff still marked it as not administered on 11/08/25, even though the facility had it. The Pharmacist said he/she talked to the Administrator about the staff not ordering the resident medications in a timely manner. During a phone interview on 02/25/26 at 1:29 P.M., the Pharmacist said Resident #12's buspirone medication was ordered and delivered on 11/11/25, ordered and delivered on 01/06/26, ordered on 01/22/26 and not delivered because it was ordered too soon, ordered and delivered on 02/03/26, and ordered on 02/09/26 and not delivered because it was ordered too soon. The resident's memantine medication was ordered and delivered on 12/05/25, ordered and delivered on 01/06/26, and ordered on 01/07/26 and not delivered because the medication was delivered the day before on 01/06/26. The resident's Seroquel medication was ordered and delivered on 11/07/25, ordered and delivered on 12/11/25, ordered and delivered on 01/12/26, and ordered and delivered on 02/03/26. There should be no reason the facility documented the resident's medications weren't administered because they were out or on order.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview and record review, the facility failed to ensure medications and biologicals were labeled and stored in accordance with currently accepted practices for one medication cart out of two medication carts and one medication storage room out of one medication storage room which affected five residents (Residents #9, #19, #37, #39, and #58). This had the potential to affect all residents. The facility census was 64. Review of the facility policy titled, Medication Labeling and Storage, undated, showed:- The nursing staff is responsible for maintaining medication storage and preparation areas in a clean, safe, and sanitary manner;- If the facility has discontinued, outdated or deteriorated medications or biologicals, the dispensing pharmacy is contacted for instructions regarding returning or destroying these items;- Labeling of medications and biologicals dispensed by the pharmacy is consistent with applicable federal and state requirements and currently accepted pharmaceutical practices;- The medication label includes, at a minimum, the medication name (generic and/or brand), prescribed dose, strength, expiration date, when applicable, resident's name, route of administration, and appropriate instructions and precautions;- For over the counter (OTC) medications in bulk containers (if permitted by state law) the label contains the medication name, strength, quantity, accessory instructions, lot number, and expiration date (if applicable);- Multi-dose vials that have been opened or accessed (e.g., needle punctured) are dated and discarded within 28 days unless the manufacturer specifies a shorter or longer date for the open vial;- Multi-dose vials that are not opened or accessed are discarded according to the manufacturer's expiration date;- If medication containers have missing, incomplete, improper or incorrect labels, contact the dispensing pharmacy for instructions regarding returning or destroying these items. Observation of the 100 Hall medication cart on 02/12/26 at 10:20 A.M., showed:- Resident #39's hydralazine (blood pressure medication) 25 mg with 18 tablets expired on 06/30/25;- Resident #9's furosemide (medication to get rid of excess fluid) 20 mg as needed with 12 tablets expired 07/08/25. Review of Resident #9's Medication Administration Record (MAR), dated February 2026, showed:- The resident received one dose of furosemide on 02/01/26, 177 days after the expiration date. Review of the Resident #9's medical record showed:- No documentation of any adverse reactions to the expired furosemide dose. Observation of the medication room on 02/12/26 at 10:45 A.M., showed: - Three bottles of Vitamin E (a supplement medication) 180 mg expired 09/2025;- One bottle of Geri-Dryl (an antihistamine medication) 25 mg expired 11/2025;- Three bottles of Alkums Antacid regular strength Calcium Carbonate 500 (heart burn medication) mg expired 11/25;- Nine boxes of Alginaid arginine (medication for wound management) powder expired 12/14/25;- One bottle of Thiamine B1 (vitamin medication) 100 mg expired 11/25;- One bottle of Zinc (mineral medication) 50 mg expired 01/26;- Two boxes of Bisacodyl (stool softener) 5 mg expired 12/25;- Resident #37's divalproex (an anticonvulsant medication) 500 mg delayed release with 56 tablets, expired 10/01/25;- Resident #58's one bottle of cholecalciferol (Vitamin D supplement) 50 mcg expired 01/26;- A discharged resident's amiodarone (medication to control heart rhythm and rate) 200 mg tablets with no expiration date; - A discharged resident's pantoprazole (heart burn medication) 40 mg delayed release tablets with no expiration date;- Resident #19's undated lorazepam (antianxiety medication) 2.1mg/milliliter (ml) open bottle with 28 ml left in the bottle;- Two vials of Afluria (flu vaccine) 5 ml multidose vial, opened and undated, expired 06/30/24;- Four vials of stock Aplisol tuberculin (purified protein derivative to test for tuberculosis infection) one ml vial, opened and undated;- One vial of Afluria 5 mg, opened and undated, expired 06/30/25;- Five vials of Afluria 5 mg multidose vial, unopened, expired 06/30/25. During an interview on 02/12/26 at 10:25 A.M., Certified Medication Technician (CMT) J said the pharmacy was here last week and there was no schedule for the nurses and CMTs to check the medication carts for expired medications, but they did look at the medication carts when possible, for (continued on next page)

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	265716	A. Building B. Wing	02/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hubble Creek	1115 K Land Drive Jackson, MO 63755

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	expired medications. During an interview on 02/12/26 at 11:00 A.M, Licensed Practical Nurse (LPN) D said multidose medications should be labeled with the date it was opened. During an interview on 02/12/26 at 2:40 P.M., LPN E said nursing staff looked at the medication carts for expired medications when they could, but it was not a scheduled task. CMTs were usually good about finding expired medications and letting the nurses know. During an interview on 02/12/26 at 5:40 P.M., the Director of Nursing (DON) said nursing staff looked at the medication carts and room for expired medications, but it was not on a scheduled time frame. The pharmacy rounded once a month and delivered medications to the facility every day except the weekends. Expired medications should not be administered to the residents and staff should be checking the medications before administering. Medications should be labeled with the date it was opened.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, interview, and record review, the facility failed to follow infection control precautions by not changing gloves, performing hand hygiene, and by not following enhanced barrier precautions (EBP - an infection control intervention for nursing homes designed to reduce the transmission of multidrug-resistant organisms (MDROs)) for one resident (Resident #54) out of two sampled residents. The facility also failed to use proper infection control techniques to wash residents' hands during a lunch service. The facility census was 64.Review of the facility policy titled, Urinary Catheter (a flexible tube inserted into the bladder to drain urine) Care, dated August 2022, showed: - Use a clean washcloth with warm water and soap or a bathing wipe to cleanse and rinse the catheter from the insertion site to approximately four inches outward. Review of the facility policy titled, Enhanced Barrier Precautions, dated December 2024, showed: - EBP apply when a resident is infected or colonized with a Centers for Disease Control (CDC) targeted MDRO, but does not have a wound or indwelling medical device, and does not have secretions or excretions that cannot be covered or contained; - EBP apply when a resident is not known to be infected or colonized with any MDRO, has a wound or indwelling medical devices, and does not have secretions or excretions that are unable to be covered or contained; - Indwelling medical devices include central lines, urinary catheter, feeding tubes, and tracheotomies; - Examples of secretions or excretions include wound drainage, fecal incontinences or diarrhea, or other discharges from the body that cannot be contained and pose an increased potential for extensive environmental contamination and risk of transmission of a pathogen; - EBPs employ targeted gown and glove use during high contact resident care activities; - Examples of high-contact resident care activities requiring the use of a gown and gloves include dressing, bathing, showering, providing hygiene or grooming, changing briefs, assisting with toileting, transferring, providing bed mobility, changing linens, device care, and wound care. Review of the facility policy titled, Handwashing/Hand Hygiene, undated, showed hand hygiene is indicated: - Immediately before touching a resident: - Before performing an aseptic technique (procedure that healthcare providers use to prevent the spread of germs that cause infection) task; - After contact with blood, body fluids, or contaminated surfaces; - After touching a resident's environment; - Before moving from work on a soiled body site to a clean body site on the same resident; (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Immediately after glove removal; - Did not address resident hand hygiene. 1. Review of Resident #54's medical record showed: - An admission date of 02/09/23; - Diagnoses of neuromuscular dysfunction of the bladder (refers to what happens when an injury or disease interrupts the electrical signals between the nervous system and bladder function) and obstructive and reflux uropathy (a blockage in the urinary tract causing urine to back up and flow backward from the bladder to the kidneys); - An order to change the catheter every month starting on the 22nd of each month related to neuromuscular dysfunction of the bladder, dated 09/22/25; - An order for EBP related to Foley catheter (a type of catheter), dated 01/23/26; - An order to perform catheter care every shift for prevention, dated 09/03/25. Observation on 02/09/26 at 2:13 P.M., of Resident #54's incontinent and catheter care showed: - EBP signage on the door and PPE hung on the door; - Certified Nurse Assistant (CNA) L and CNA M put on gloves, did not perform hand hygiene, did not put on a gown, and entered the room; - CNA M pulled wipes from the container and handed them to CNA L; - CNA L cleaned the resident's front peri area, did not change gloves, and did not perform hand hygiene; - CNA L rolled the resident onto his/her right side facing CNA L; - CNA L did not change gloves, did not perform hand hygiene, pulled wipes from the container, and handed them to CNA M; - CNA M cleaned the resident's buttocks and rectal area, changed gloves, and did not perform hand hygiene; - CNA L and CNA M changed the bed linens and rolled the resident side-to-side; - CNA M did not change gloves, did not perform hand hygiene, cleaned the insertion site of the catheter, and cleaned the catheter by wiping toward the insertion site; - CNA L and CNA M changed gloves, did not perform hand hygiene, assisted the resident with putting clothes on, and pulled the resident up in the bed; - CNA M did not remove gloves, did not perform hand hygiene, and exited the resident's room with the (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	bagged up trash and soiled linens from the room; - CNA L did not change gloves, did not perform hand hygiene, adjusted the resident's blanket, and hung the catheter bag on the bedframe; - CNA L did not change gloves, did not perform hand hygiene, picked up the resident's cup from the bedside table and exited the resident's room; - CNA L did not change gloves, did not perform hand hygiene, and entered the resident's room with the resident's cup full of ice; - CNA L did not change gloves, did not perform hand hygiene, poured tea into the resident's cup, and placed the lid on the cup; - CNA L removed gloves, did not perform hand hygiene, and exited the resident's room. During an interview on 02/12/26 at 4:55 P.M., CNA H said hand hygiene should be performed prior to putting on gloves. He/She the catheter should be cleaned by wiping around the insertion site and then wiping from the insertion site and away. He/She knew which residents were on EBP by the sign on the door, the PPE hanging on the door, and staff were told during report at the start of the shift. During an interview on 02/12/26 at 5:01 P.M., CNA N said hand hygiene should be performed when entering and leaving residents' rooms and when changing gloves. He/She knew what residents were on EBP by the sign on the door, the PPE hanging on the door, and any of his/her residents with wounds or catheters. During an interview on 02/12/26 at 5:06 P.M., Licensed Practical Nurse (LPN) C said residents on EBP had signs on the door and it was told in shift change report. Hand hygiene should be performed when entering residents' room and after removing gloves. Catheters should be cleaned by wiping around the insertion site and then down the catheter. During an interview on 02/12/26 at 6:30 P.M., the Administrator and the Director of Nursing (DON) said they would expect staff to wear gowns and gloves while performing high-contact care on residents with EBP. During an interview on 02/12/26 at 6:30 P.M., the DON said she would expect staff to change gloves and perform hand hygiene when going from dirty to clean care. She would expect staff to clean the urinary catheter from the insertion site and away from the body. During an interview on 02/12/26 at 6:30 P.M., the Corporate Compliance Officer said residents with MDROs, indwelling medical devices, and wounds should be on EBP. 2. Observations during the lunch service in the main dining room on 02/09/26 from 11:49 A.M. - 12:10 P.M., showed: - CNA T removed a rag from a bucket of soapy water, and washed a resident's hands with the rag; - CNA T placed the rag in the bucket and washed another resident's hands with the same rag; (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- CNA T placed the rag in the bucket and washed another resident's hands with the same rag; - CNA T placed the rag in the bucket and washed another resident's hands with the same rag; - CNA T placed the rag in the bucket and washed another resident's hands with the same rag; - CNA T placed the rag in the bucket and washed another resident's hands with the same rag; - CNA T placed the rag in the bucket and washed another resident's hands with the same rag; - CNA T placed the rag in the bucket and washed another resident's hands with the same rag; - CNA T placed the rag in the bucket and washed another resident's hands with the same rag; - CNA T placed the rag in the bucket and washed another resident's hands with the same rag. Observation during the lunch service in the main dining room on 02/10/26 from 11:50 A.M. - 12:05 P.M., showed: - CNA T removed a rag from a bucket of soapy water and washed a resident's hands with the rag; - CNA T placed the rag in the bucket and washed another resident's hands with the same rag; - CNA T placed the rag in the bucket and washed another resident's hands with the same rag; - CNA T placed the rag in the bucket and washed another resident's hands with the same rag; - CNA T placed the rag in the bucket and washed another resident's hands with the same rag; - CNA T placed the rag in the bucket and washed another resident's hands with the same rag. Observation during the lunch service in the main dining room on 02/11/26 from 11:46 A.M. - 12:00 P.M., showed: - CNA T removed a rag from a bucket of soapy water and washed a resident's hands with the rag; - CNA T placed the rag in the bucket and washed another resident's hands with the same rag; - CNA T placed the rag in the bucket rag and washed another resident's hands with the same rag; - CNA T placed the rag in the bucket and washed another resident's hands with the same rag; - CNA T placed the rag in the bucket and washed another resident's hands with the same rag; - CNA T placed the rag in the bucket and washed another resident's hands with the same rag; - CNA T placed the rag in the bucket and washed another resident's hands with the same rag. During an interview on 02/11/26 at 1:38 P.M., CNA T said that he/she used a rag in a bucket of soap (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and water to wash the residents' hands before meals. He/She used the same rag on each resident but washed it in the bucket of soapy water between each resident. During an interview on 02/12/26 at 6:40 P.M., the Administrator and Corporate Compliance Officer said that it was not appropriate for staff to use the same rag to clean multiple residents' hands.