STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265730	A. Building B. Wing	02/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Eastview Manor Care Center	1622 East 28th Street Trenton, MO 64683

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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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. Based on interview and record review, the facility staff failed to follow facility policy and ensure the residents physician was verbally notified on 01/21/2026 of a resident fall with a head injury and on 1/24/2026 when staff found the resident unresponsive for about a minute and with seizure like activity for about 45 seconds before becoming responsive again. The staff notified the residents physician on 01/25/26 at 12P.M., approximately 16 hours after the change in condition occurred. The facility census was 82.Review of the facility policy titled Notification of Changes, dated 05/14/24, showed:- The purpose of this policy is to ensure the facility promptly informs the resident, consults the resident's physician, and notifies, consistent with his or her authority, the resident's representative when there is a change requiring notification.- Circumstances requiring notification included accidents resulting in injury and accidents with the potential to require physician intervention.Review of the facility policy titled Incidents and Accidents, dated 5/18/24, showed:- Accidents refer to any unexpected or unintentional incident, which results or may result in injury or illness to a resident.- The purpose of incident reporting can include assuring that appropriate and immediate interventions are implemented, and corrective actions are taken place to prevent recurrences and improve the management of resident care.- The nurse will contact the resident's practitioner to inform them of the incident/accident, report any injuries or other findings, and obtain orders, if indicated, which may include transportation to the hospital dependent upon the nature of the injury.- Documentation should include the date, time, nature of the incident, location, initial findings, immediate interventions, notifications, and orders obtained or follow-up interventions.Review of the facility policy titled Notifying Clinicians, dated 06/26/24, showed:- The purpose of this policy is to ensure the Clinicians are properly notified of a Residents Change in Condition and overall, health and/or mental status;- The Clinician shall be notified of Changes in Conditions, Emergent Situations, Routine Diagnostics, and concerns of the resident's overall health status;- Examples: Falls, incidents, skin tears, out of range vital signs, abnormal labs, altered mental status, new wounds, changes in wounds, anything regarding a change in the resident's baseline or condition;- The nurse will implement 911 for immediate transfer for physician evaluation, when there is an accident involving the resident which results in an injury and has the potential for requiring physician intervention;- The nurse will initiate verbal communication with the clinician when a condition or incident arises with the resident which would warrant an immediate implementation of a change in plan of care to include physician advisement or initiation of physician orders to avoid a delay in treatment that may cause worsening in condition;- If you are unable to reach the physician, you shall notify nursing administration and they can assist in contacting a physician if/when needed;- Ensure that there is documentation of time, phone number dialed and to whom you spoke with when you reached out to the physician's office. Documenting if you reached anyone, or if the number of attempts made and if messages were left;- After-hours, the licensed nurse will notify the (continued on next page)

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

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

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	residents physician or the on-call physician for all changes is conditions, incidents or accidents, and emergency responses after-hours to ensure the physician is kept informed and to give guidance;- In the event the licensed nurse cannot reach the physician for guidance, the licensed nurse must call the Medical Director for guidance;- In the event the licensed nurse cannot reach the physician or the Medical Director, the licensed nurse must call the Director of Nursing for further guidance;- If the licensed nurse cannot get ahold of the physician in an event where the resident needs to be sent to the hospital via 911, the nurse will send the resident to the hospital and continue attempts to notify the physician of the situation.Review of Resident #2's admission Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 11/15/25, showed:- Cognitively Intact;- Required the use of a wheelchair and supervision or physical assistance from nursing staff for toileting, bathing, and hygiene;- Required anticoagulant (medications that prevent or reduce blood clot formation) and antiplatelet (medications that reduce platelet clustering and inhibit blood clot formation in arteries) medications which increase the risk for bleeding;- Diagnoses include Heart Failure, Diabetes, and High Blood Pressure.Review of the resident's care plan, dated 01/21/26, directed staff to follow the facility fall protocol if a fall occurs. Review of progress notes for the month of January 2026 showed:- On 01/21/26 at 7:42 A.M., Registered Nurse (RN) A documented that on 01/21/26 at 1:45 A.M., He/She heard the resident call for help and found the resident lying on the floor with his/her head against the sink cabinet. RN A observed a moderate amount of bleeding from a four-centimeter laceration to the left side of the resident's head and cleaned the wound and applied two Steri-Strips (sterile, breathable, hypoallergenic adhesive tapes reinforced with polyester filaments, designed to securely close small, shallow wounds or surgical incisions). RN A found five other abrasions and a kiwi sized area on the resident and included that it had been important to state the resident had been on blood thinners, at that time. No documentation regarding notification to the physician about the resident's condition. - 01/21/26 at 7:58 A.M., showed RN A documented Skin is jaundice. Skin cold/clammy to touch. Skin is fragile, and described the skin issues the resident had received overnight. No documentation regarding notification to the physician about the resident's condition. - On 01/24/26 at 8:00 P.M., Licensed Practical Nurse (LPN) B documented the resident had become unresponsive for about a minute then had seizure like activity for about 45 seconds before becoming responsive again. LPN B wrote that the DON and Assistant Director of Nursing (ADON) had been notified and to monitor, and that the resident required three staff to transfer and was resting in bed. No documentation regarding notification to the physician about the resident's condition. - On 01/25/26 at 12:00 P.M., LPN A documented she notified the Nurse Practitioner (NP) to inform them that the resident had went unresponsive last evening with a 30-45 second period seizure type activity, had been jaundiced in color, and had swollen areas to his/her right hip and right abdomen. The physician gave an order to send the resident to a local emergency room for evaluation and treatment; - On 01/25/26 at 5:12 P.M., LPN A documented the resident had been admitted to the local hospital. During an interview on 01/28/26 at 10:10 A.M., RN A said:- On the night shift, on 01/21/26, he/she had heard someone calling for help and found Resident #2 on the floor with abrasions and a laceration to the head.- He/She did not call the physician but sent a text a message to the NP and Administrator the following around 5:23 A.M. - He/She would call the provider if an incident was emergent but at the time it was his/her understanding that he/she could notify them via text when it wasn't emergent. We have to notify the DON prior to sending someone out;- He/She did not feel it was warranted to send the resident out at that time. - When a resident falls as the nurse, she should assess the resident, treat or render first aid, and notify the provider and send out if the resident needs to be (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	sent out. The facility has a chain of command to follow before sending the resident out.During an interview on 01/28/26 at 10:20 A.M., the Administrator said when a resident is injured or has a change in condition, they are to call the residents physician. During an interview on 01/28/26 at 12:13 P.M., the DON said the nurses should have notified Resident #2s physician provider as quickly as possible.- The nurses should notify the ADON, the DON, the Administrator, the guardians, and the regional administration in addition to the provider.- Nursing should document notification to the physician in the resident's medical record. During an interview on 01/28/26 at 1:04 P.M. LPN A said:- When a resident falls or has an incident, the nurse should assess the resident, get the resident's vital signs, fill out the risk management section in the electronic medical record, update the resident's care plan and initiate interventions if needed.- The nurse would also notify the resident's primary care provider, guardian if not their own person, DON, ADON, Administrator, and resident care coordinator.- On Sunday night, 01/24/26, a code blue was called for the resident, LPN A had been going off shift but responded and ran to the resident's room where the resident was having seizure like activity for about 30-45 seconds, then the resident responded he/she was okay.- On Monday, 01/25/26, the resident's hip and abdomen looked swollen, and his/her nursing judgement indicated the resident needed to be sent out to the emergency room.During an interview on 02/06/26 at 10:30 A.M., the Nurse Practitioner (NP) said: - The nurse should have notified her when Resident #2 fell and sustained injury and when the resident had changes in his/her condition. - She expected the facility nurses to notify her of any injuries, acute occurrences, or anything urgent that needs addressed right away.- Non-injury or routine issues can be a message, but with Resident #2 she would have expected the nurse to call her right away;During an interview on 02/09/26 at 12:35 P.M., the facility Medical Director said the nurse should have called the residents physician about the fall with injury and the resident should have been sent out to the hospital.During an interview on 02/09/26 at 1:52 P.M., LPN B said:- LPN A and LPN B had been called to the resident's room by therapy for seizure like activity. The resident wasn't totally unresponsive, but was responsive to painful stimuli;- The resident had no previous activity like that before;- The resident was acting fine afterwards that he/she just monitored the resident all night every 30 to 60 minutes. - - He/she should have notified the residents physician of the change in condition. During an interview on 02/10/26 at 12:04 P.M., the resident's primary physician said he/she or the FNP should have been called when the resident fell. Intake 2725241

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to protect one resident's right, (Resident #4), to be free from abuse when Resident #3 hit Resident #4 on the left side of his/her ear. This affected one of the four sampled residents, (Resident #4). The facility census was 84. On 2/6/26 the Administrator was notified of the past noncompliance that began on 02/02/26. The facility administration immediately conducted aninvestigation and corrective actions were implemented that included in-service for all staff regarding abuse prevention, incidents and accidents and behavioral monitoring. The noncompliance was corrected on 02/04/2026.Review of the facility's policy for Abuse and Neglect, revised 6/12/24 showed:It is the policy of this facility to report all allegations of abuse/neglect/exploitation or mistreatment, including injuries of unknown sources and misappropriation of resident property are reported immediately to the Administrator of the facility and to other agencies in accordance with current state and federal regulations within prescribed time frames. Abuse is the willful infliction of injury.Physical abuse is purposefully beating, striking, wounding, or injuring any resident. Physical abuse also includes, but is not limited to, hitting, slapping, punching, biting, and kicking.The facility will develop and operationalize policies and procedures for screening and training employees, protection of residents and for the prevention, identification, investigation, and reporting of abuse, neglect, mistreatment, and misappropriation of property. The purpose is to assure that the facility is doing all that is within its control to prevent occurrences. The facility will identify, correct and intervene in situations in which abuse, neglect is more likely to occur. The facility will protect residents from harm during an investigation.The facility is committed to protecting the residents from abuse by anyone including other residents.Employees are trained through orientation and ongoing training on issues related to abuse prohibition practices, such as dealing with aggressive residents. Sensitivity to resident rights and resident needs and what constitutes physical, sexual, verbal and mental abuse. The facility will identify and correct by providing interventions in which abuse is more likely to occur.The facility desires to prevent abuse, neglect, and theft by establishing a resident sensitive and resident secure environment. Assess the environment circumstances which may make abuse, neglect, or misappropriation of resident items more likely to occur. As part of the resident social history assessment, staff will identify residents with increased vulnerability for abuse or who have needs and behaviors that might lead to conflict. Residents who allegedly mistreat another resident will be removed from contact with the resident during the course of the investigation. Review of Resident #4's Annual Minimum Data Set (MDS), a federally mandated assessment tool, completed by facility staff, dated 11/20/25 showed: Cognitive skills intact. No behaviors. Supervision or touch assistance with eating and transfers. Diagnoses included anxiety, depression, psychotic disorder and Schizophrenia. Review of the resident's care plan, initiated on 2/2/26 showed the resident was involved in a resident-on-resident altercation on 2/2/26 resulting in him/her being struck with a closed hand by another resident. The primary care physician, psychiatrist and guardian were notified. Medication and labs were ordered and reviewed. Already received counseling. Neuro checks were initiated per facility protocol. Skin checks completed and no new areas noted. Room moves completed. The residents no longer reside on the same hall. Review of Resident #4's progress notes, showed on 2/2/26 at 5:00 A.M. the resident was involved in an incident as the victim. The resident confirmed he/she felt safe and did not need to talk to anyone. The resident was able to name a staff member who he/she felt safe with to share any thoughts and feelings. The resident denied any aftereffects from the incident.During an interview on 2/6/26 at 8:34 A.M., the resident (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	said he/she was at the nurse's desk waiting to put his/her Cheez its back in the snack room. Resident #3 had been banging his/her cup on the glass at the nurse's station and said he/she wanted a cup of ice. Resident #4 stood behind Resident #3 and when he/she turned around, asked Resident #4 if he/she was enjoying the show. Resident #4 replied, he/she did not care about his/her pathetic ass show Resident #3 went to hit Resident #4, and Certified Nurse Aide (CNA) A was in between them and when Resident #3 went to hit Resident #4, he/she had to reach around CNA A so instead of a full punch, Resident #3 hit Resident #4 on the left side of his/her face by his/her ear with a closed hand. Resident #3 then called Resident #4 a name and Resident #4 responded and said name calling did not hurt. Resident #4 turned and walked away. Resident #4 said he/she did not have any red marks or injuries, no pain and he/she felt safe in the facility but felt better since the room change. 2. Review of Resident #3's Annual MDS, dated [DATE] showed: Cognitive skills intact. No behaviors. Supervision or touch assistance with transfers. Diagnoses included depression, bipolar, and Schizophrenia. Review of the resident's care plan revised, 2/5/26 showed: -The resident was involved in a resident on resident on 2/2/26 where he/she made closed hand contact to another resident. Placed on protective oversight by staff. Primary Care Physician (PCP), Psych and Guardian notified. Medication and lab review completed. New one tome order received for Thorazine (used to treat mental health conditions), 50 milligrams (mg.) intramuscular (IM) injection via verbal order form the physician. New order received to continue the Thorazine 50 mg. IM every eight hours as needed for 14 days. Labs were drawn. Urinalysis with culture and sensitivity was obtained. Referral sent for psych counseling and consent obtained. Placed on Hot Rack charting twice weekly. Skin checks completed and no new areas noted. Room moves completed. Residents no longer reside on the same hall. - The resident is on antibiotic therapy related to a urinary tract infection. Administer antibiotic medication as ordered by the physician. Monitor/document side effects and effectiveness every shift. Report pertinent lab results to the physician. Review of the resident's Physician Order Sheet (POS) dated February 2026 showed an order with a start date of 2/4/26 for Macrobid oral capsule 100 mg., twice daily for five days for urinary tract infection (UTI). Observation and interview on 2/6/26 at 10:28 A.M., showed Resident #3 was in his/her room lying on the bed. Resident #3 declined to talk to the surveyor. CNA A was1:1 with the resident. CNA A said the resident had been placed on 1:1 since the morning of the incident. During an interview on 2/6/26 at 10:45 A.M., CNA A said Resident #3 had not had any further behaviors. The incident actually started about 1:30 A.M., when Resident #3 wanted to call a taxi to take him/her to St. Louis. Registered Nurse (RN) A informed Resident #3 not to get upset if no one answered because of the time of day. Resident #3 was upset because the numbers did not work. Resident #3 went back to his/her room then returned about 10 minutes later still mad. Resident #4 had come out of his/her room at that time to put his/her snacks back in the snack room. The next thing CNA knew, Resident #3 threw a punch at Resident #4 and connected with the left side of Resident #4's ear. Resident #4 did not fight back, just turned and walked away and went back to his/her room. During an interview on 2/6/26 at 1:21 P.M., Licensed Practical Nurse (LPN) A said he/she was not working when it happened. Resident #3 was placed on one on one after the incident. During an interview on 2/6/26 at 2:45 P.M., the Director of Nursing (DON) said RN A called at approximately 3:20 A.M. and informed her of the incident. The Administrator was already in the building and was aware of the situation. Resident #4 went to put his/her Cheez-its back in the snack room and when Resident #3 asked Resident #4 if he/she was liking the show, Resident #4 informed Resident #3 he/she was not interested in his/her pathetic ass show. CNA A intervened between the two residents, Resident #3 had to reach around CNA A, so it was not like a full-on hit. The staff were in-serviced over Crisis Prevention Intervention (CPI), resident (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	behaviors, accidents/incidents and abuse/neglect. An in-service regarding abuse, intensive monitoring, behavioral emergencies and incidents and accidents was provided to all staff on 2/2/26 and 2/4/26. During an interview on 2/6/26 at 3:39 P.M., RN A said the incident between Resident #3 and Resident #4 occurred between 3:10 A.M. and 3:15 A.M., Resident #3 was upset because he/she thought the staff were lying to him/her. Resident #3 was waiting for a cab to leave and was upset. Resident #4 just happened to be in the wrong place at the wrong time. Resident #4 went to put his/her crackers back in the snack room. CNA A was between the two residents when Resident #3 took a swing at Resident #4. The punch caught Resident #4 on the left side of her head by his/her ear. The two residents were immediately separated. The DON, Administrator, physicians and guardians were notified. Resident #3 received an order for Thorazine (antipsychotic medication), and he/she was placed 1on 1 supervision. Typically, Resident #3 is more verbally aggressive and not physically aggressive. Residents have the right to not be hit by others and free from abuse. Intake 2731647