STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265763	A. Building B. Wing	02/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Knox County Nursing Home District	55774 State Highway 6 Edina, MO 63537

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 0692 Level of Harm - Actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to monitor or identify weight loss, failed to complete assessments or notify the resident's provider or dietitian of significant weight loss, failed to ensure staff adequately monitored consumption of supplements ordered for weight loss and failed to re-evaluate the resident's care plan or initiate interventions to prevent further weight loss for one resident (Resident #13), in a sample of two residents investigated for nutrition concerns. Review of the resident's weight records showed the resident experienced a seven pound (lb.) weight loss, a 5.6 percent (%) significant weight loss in 30 days. The resident had also developed a pressure ulcer. The resident experienced significant weight loss with no staff identification, evaluation, notification or intervention. The facility census was 39. Review of the Resident Assessment Instrument (RAI) manual, updated October 2025, showed the following:-Weight loss can result in debility and adversely affect health, safety, and quality of life;-Weight loss may be an important indicator of a change in the resident's health status or environment;-If significant weight loss is noted, the interdisciplinary team should review for possible causes of changed intake, changed caloric need, change in medication (e.g., diuretics), or changed fluid volume status;-Weight should be monitored on a continuing basis, weight loss should be assessed and care planned at the time of detection and not delayed until the next MDS assessment;-Diagnosis and issues that can contribute to pressure ulcers included dehydration, recent weight loss or malnutrition, and recent decline in functional abilities. Review of the facility policy, Weight Assessment and Intervention, dated 08/28/23, showed the following:-Resident weights are monitored for undesirable or unintended weight loss or gain;-Residents are weighed upon admission and at intervals established by the interdisciplinary team;-Weights are recorded in each unit's weight record chart and in the individual's medical record;-Unless notified of significant weight change, the dietitian will review the unit weight record monthly to follow individual weight trends over time;-The threshold for significant, unplanned and undesired weight loss, will be based on the following criteria [where percentage of body weight loss equals (usual weight- actual weight)/(usual weight) x 100]: One month - 5% weight loss is significant; greater than 5% is severe;-If the weight change is desirable, this is documented;-Undesirable weight change is evaluated by the treatment team whether the criteria for significant weight change have been met. The evaluation includes: -The resident's target weight range (including rationale if different from ideal body weight); -The resident's calorie, protein, and other nutrient needs compared with the resident's current intake; -The relationship between current medical condition or clinical situation and recent fluctuations in weight; -Whether, and to what extent, weight stabilization or improvement can be anticipated;-The physician and the multidisciplinary team identify conditions and medications that may be causing anorexia, weight loss or increasing the risk of weight loss. -Care planning for weight loss or impaired nutrition is a multidisciplinary effort and includes the physician, nursing staff, the dietitian, the consultant pharmacist, and the resident or resident's legal surrogate: -Individualized care plans shall address to the extent possible: -The identified causes of weight loss; -Goals and benchmarks for improvement; and -Time frames and parameters for monitoring and reassessment;-Interventions for undesirable weight loss are based on careful consideration of: (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 0692 Level of Harm - Actual harm Residents Affected - Few	-Resident choice and preferences; -Nutrition and hydration needs of the resident; -Functional factors that may inhibit independent eating; -Environmental factors that may inhibit appetite or desire to participate in meals; -Chewing and swallowing abnormalities and the need for diet modifications; -Medications that may interfere with appetite, chewing, swallowing, or digestion; -The use of supplementation and/or feeding tubes. 1. Review of Resident #13's face sheet showed he/she had a representative. Review of the resident's Care Plan, dated 09/08/23, showed the following:-Nutritional Status: The resident will follow diet as ordered: Low concentrated sweets (LCS)/no added salt (NAS) with ground meats with Liquids: Regular;-Cue the resident to eat small bites alternating with sips;-House supplement Ensure (protein liquid supplement) in between meals;-Long Term Goal, the resident will comply with his/her diet and have no complications related to the diet order;-Administer my medications/treatments/labs as ordered by physician;-Ask the resident if he/she has his/her teeth in-obtain them if not. He/She is unable to eat without his/her dentures being in;-Be alert for symptoms of impending dehydration, such as decreased urine output, a change in mental status, confusion, a drop in blood pressure from baseline, constipation, impaction, dizziness, fatigue/lethargy. Please report to the physician;-Dietician to evaluate my nutritional status per protocol;-Educate the resident on why he/she is on a diet with No added salt/ Low concentrated sweets and a ground meat texture and what foods he/she should have;-Encourage the resident to report any oral problems, such as sores, lesions, swelling or redness to nursing staff;-The resident enjoys eating most meals in the dining room;-Resident enjoys eating any kind of pudding, mash potatoes and gravy, etc.; he/she likes foods that are soft textured;-He/She likes to drink coffee, sweetened iced tea, and water;-He/She feeds himself/herself but needs set up assist with meal trays;-He/she also requires cues to take small bites of food and to alternate between bites and sips;-He/She will maintain current weight through review date;-Offer food alternatives when appropriate for any meal served;-Provide him/her with fresh ice water at least daily and as needed;-Encourage to drink fluids any time you are in my room;-The resident has full dentures. Review of the resident's Physician's Orders, dated 05/23/25, showed orders for the following:-House supplement Ensure two times daily; the order did not specify an amount to be given; -Diet: heart healthy: no added salt, ground meat texture (may have chopped meats for breakfast), regular consistency liquids: Regularly cue resident to eat small bites alternating with sips. Review of the resident's annual Minimum Data Set (MDS), a federally mandated assessment completed by staff, dated 08/26/25, showed the following:-Impaired vision, can see large print, has corrective lenses;-Cognitively intact;-Diagnoses included hemiplegia (paralysis on one side of the body), anxiety, chronic obstructive pulmonary (respiratory) disease, chronic pain syndrome, cerebral infarction (stroke);-Set up or clean up assistance from staff for eating; -124 lbs.;-No weight loss;-Mechanically altered diet;-Therapeutic diet;-No natural teeth, edentulous;-Section V of the MDS triggered nutritional status and dental care; the facility staff did not mark to proceed to care plan nutritional status or dental status. Review of the resident's Physician's Orders, dated 10/01/25, showed Diet: LCS/NAS; Ground meats; Liquids: regular, cue resident to eat small bites alternating with sips. Review of the resident's quarterly MDS, dated [DATE], showed the resident weighed 126 lbs. and did not have significant weight loss. The resident continued a mechanically altered diet and a therapeutic diet. Review of the resident's Weight Record, dated January 2026, showed the following:-On 01/07/26, the resident weighed 124.5 lbs.;-On 01/14/26, the resident weighed 125 lbs.;-On 01/21/26, the resident weighed 125.5 lbs. Review of the resident's Care Plan, last updated 01/22/26, showed an update to the goal date, no new interventions or changes to the nutrition plan of care. Review of the resident's Nurses Notes, dated 02/01/26 at 9:14 A.M. and 2:34 P.M., showed staff documented the resident had mental status changes and respiratory issues. The resident was sent to the emergency room and admitted with Influenza A (viral infection). Review of the resident's Nurses Notes, dated 02/03/26 at 12:32 P.M., showed staff documented the resident returned from the hospital. Review of the resident's Weight Record, dated 02/03/26, showed staff documented the resident weighed 117.5 lbs., (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	which was a seven-pound weight loss from the weight obtained on 01/07/25; this was a 5.6% significant weight loss in 28 days. Review of the resident's Care Plan showed no evidence the resident's nutrition care plan was re-evaluated after a significant, unplanned weight loss and no new interventions were initiated. Review of the resident's medical record, including Nurses Progress Notes and Physician Orders, showed no evidence the physician, dietitian, consultant pharmacist or representative were notified of the resident's significant unplanned weight loss. Review of the resident's Weight Record, dated 02/05/26, showed the resident weighed 118.0 lbs., a six and a half pound weight loss since 01/07/26, which was a 5.2% significant weight loss in 30 days. Review of the resident's Care Plan showed no evidence the resident's nutrition care plan was re-evaluated after a significant, unplanned weight loss and no new interventions were initiated. Review of the resident's medical record including, Nurses Progress Notes and Physician Orders, showed no evidence the physician, dietitian, consultant pharmacist or representative was notified of the resident's significant, unplanned weight loss. Review of the resident's Weight Record, dated 02/11/26, showed the resident weighed 117.5 lbs., a seven- and one-half pound weight loss, from the weight obtained 01/14/26, which was a 6% significant weight loss in 29 days. Review of the resident's Care Plan showed no evidence of the resident's nutrition care plan was re-evaluated after a significant, unplanned weight loss and no new interventions were initiated. Review of the resident's medical record, including Nurses Progress Notes and Physician Orders, showed no evidence the physician, dietitian, consultant pharmacist or representative was notified of the resident's significant, unplanned weight loss. Review of the Registered Dietitian's Note, dated 02/13/26, showed the following:-Significant weight loss at 30 days of 6%;-Currently receiving a LCS/NAS diet with ground meat-small bites alternation with sips of liquids;-Also getting Ensure two times daily between meals. One Ensure providing 220 calories and nine grams of protein; -Current weight of 118 lbs., continue to monitor. Review of the resident's Care Plan showed no evidence of the resident's nutrition care plan was re-evaluated after a significant, unplanned weight loss and no new interventions were initiated. Review of the resident's medical record, including Nurses Progress Notes and Physician Orders, showed no evidence the physician, consultant pharmacist or representative was notified of the resident's significant, unplanned weight loss. Review of the resident's Weight Record, dated 02/18/26, showed the resident weighed 118.5 lbs., which was a seven lbs. weight loss since the weight on 01/21/26; a 5.6% weight loss in 29 days. Review of the resident's Care Plan showed no evidence the resident's nutrition care plan was re-evaluated after a significant, unplanned weight loss and no new interventions were initiated. Review of the resident's medical record, including Nurses Progress Notes and Physician Orders, showed no evidence the physician, consultant pharmacist or representative was notified of the resident's significant, unplanned weight loss. Review of the resident's Nurses Notes, dated 02/22/26 at 5:31 P.M., showed staff documented the resident had a wound located on the upper portion of the right gluteal crevice (the crease on the right side of the body where the buttocks meet the upper thigh) inferior (below or closer to the feet than the reference point) to the coccyx (tailbone) area. The area was oval shaped with regular edges. The wound had yellow slough (dead tissue) to the wound bed, with no depth. Review of the resident's quarterly MDS, dated [DATE], showed the following:-Cognitively intact;-New diagnosis of dementia;-Other behaviors one to three days;-Rejection of care one to three days;-Wandering one to three days;-119 lbs., significant, unplanned weight loss;-Significant weight loss not on physician prescribed weight loss;-Mechanically altered therapeutic diet;-New antipsychotic medication, taken routinely;-No unhealed pressure ulcers; (Documentation in the resident's medical record showed on 02/22/26 the resident had developed a pressure ulcer). Observation on 02/23/26 at 12:03 P.M. to 12:30 P.M. (continuously monitoring in the resident's room), showed the resident sat in his/her room in his/her recliner. The resident appeared to have dry lips with a scab on his/her bottom lip. The resident's face appeared sunken, and skin looked dry. Staff delivered the resident's lunch tray. The resident said, I cannot see well and the staff member opened the resident's items on the tray. Staff served stroganoff, green bean casserole that (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	was watery, and another brown porous round scoop of food that was unidentified, pumpkin pie, water and milk. The staff member said he/she didn't know what the unidentified substance was and left the room. The resident took two bites and sat back in his/her recliner. The resident would occasionally pick up his/her fork like he/she was going to eat and would set his/her fork back down. At 12:30 P.M. the resident said he/she was finished eating. During the meal, no staff came in the resident's room to cue or assist the resident. The resident consumed less than 10% of his/her meal. The resident said the food was ok, not great. Observation on 02/24/26 at 5:45 A.M. showed the resident self-propelled down the hall in his/her wheelchair. The resident requested a sweater from staff, the resident appeared confused about where he/she was going. The resident was complaining of his/her eyes and lips being dry. The resident went to the nursing desk complaining of his/her eyes being dry, and Licensed Practical Nurse (LPN) O said he/she could not get his/her eye drops until day shift During an observation on 02/24/26 at 5:55 A.M., the resident put Chapstick on all the dry areas of his/her face and his/her nose. Review of the resident's Quarterly Nutrition Assessment, completed by the Dietary Manager, dated 02/24/26 at 12:45 P.M., showed the resident had a 5% weight change in the past month. The resident leaves 25% uneaten at most meals. Will refer to the Registered Dietitian related to weight changes. The resident feeds himself/herself and makes his/her own food choices at meals. Will continue to monitor diet and weight. Review of the resident's Care Plan showed no evidence the resident's nutrition care plan was re-evaluated after a significant, unplanned weight loss and no new interventions were initiated. Review of the resident's medical record, including Nurses Progress Notes and Physician Orders, showed no evidence the physician, consultant pharmacist or representative was notified of the resident's significant, unplanned weight loss. During an interview on 02/24/26 at 3:35 P.M., the resident's power of attorney (POA) said the resident has had a change. The facility has not had a care plan meeting recently. The facility did not notify him/her of the weight loss; the resident looked like he/she had lost quite a bit of weight. He/She felt facility staff needed to assist the resident to eat and cue him/her, or even feed him/her if needed, especially with his/her new confusion. He/She wanted the resident to be well nourished and for staff to assist him/her to be well nourished. 2. During an interview on 02/26/26 at 12:57 P.M., Certified Medication Technician (CMT) J said he/she, or staff that pass medications were responsible for administering ordered supplements. The resident needed a lot of encouragement. The resident will drink some of his/her Ensure supplement. Staff do not record consumptions. Sometimes the resident was more confused than others. He/She did not know if the resident consumed his/her supplements. During an interview on 02/24/26 at 3:20 P.M., Licensed Practical Nurse (LPN) E said he/she was not sure what all residents had weight loss. The restorative aide weighs the residents, and the IDT team reviewed them and added interventions. He/She called the physicians for orders when the IDT team ask him/her too. During interview on 02/25/26 at 1:41 P.M., the Dietary Manager said the following:-Weight loss was significant if a resident had a 5% weight loss in one month, 7.5% weight loss in three months and 10% weight loss in six months;-The kitchen documented consumption of meals for new admissions, residents on Medicare part A services, and residents with weight loss;-On 02/01/26, the kitchen staff started consumption logs that remained in the kitchen until complete. Prior to that, staff had a form they completed daily and would give it to the charge nurse; -Resident #13 had been sick at the beginning of the month and had not bounced back;-Resident #13 has not been getting his/her consumptions monitored because she was not aware the resident had lost weight; he/she just found out about the resident's significant weight loss on 02/24/26. They were completing the resident's MDS and found the note from the Registered Dietitian (RD) that the resident had a significant weight loss;-She just initiated the form today to monitor the resident's meal consumptions. During an interview on 02/26/26 at 1:10 P.M., the Director of Nursing (DON) said the following:-The facility monitored monthly weights on each resident. Residents with weight concerns are usually weighed weekly. The Interdisciplinary Team (IDT) team decided how often a resident was weighed; -If a resident has a 3 lbs. weight change or a 5% weight change in 30 days, that would be considered a (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	significant weight change;-With a significant weight loss, the charge nurse was expected to notify the physician right away (within a couple of days) to obtain new orders or interventions;-The resident was weighed on 02/03/26; on 02/04/26, the IDT met, but the resident had gone to the emergency room that day, so the IDT did not discuss his/her weights, and the significant weight loss was missed. There were no notes about his/her weight loss in the IDT meeting, but it did get documented in the resident's chart;-The weight loss was missed; if it would have been noted, staff would have reviewed the resident's care plan, notified the physician and the dietitian and started monitoring consumptions on the resident;-When a resident has wounds many times the RD will request a high protein supplement for wound healing;-The facility had IDT meetings at least every other week. During interview on 03/03/26, at 1:33 P.M., the RD said the following:-Significant weight loss was 5% in one month;-If a resident has a significant weight loss, she expected the facility to notify her, the physician, consultant pharmacist and representative; -The physician would review possible causes of weight loss and might give a new order for an intervention, possibly labs, or a referral to try to determine the cause of the weight loss and how to slow it down. The pharmacist would look for possible side effects of medications, and the representative should be updated;-She was not made aware of the resident's weight loss on 02/03/26; she would have expected staff to call her;-On 02/13/26, he/she noticed the weight loss during his/her record review; at that time, she reviewed with staff to ensure the resident was getting his/her Ensure as ordered;-She did not increase the supplement because the supplements were large, and she didn't think the resident would drink another one;-Any additional Ensure would likely keep the resident from eating food;-She thought the weights were reported in IDT and to the physician, consultant pharmacist and representative, as soon as the weight was verified as correct, and when there was a significant weight loss;-Before adding supplements, there should be some discussion about illness, medications, see if the resident needed assistance/cueing, ensure there was no chewing or swallowing problems, etc.;-When a significant weight loss was found, she expected facility staff to call her immediately (within a day or two). Staff should call the physician and representative within a day or two;-The facility was expected to monitor consumptions for new admissions, residents receiving Medicare Part A services, and residents with significant weight loss;-Facility staff should document an interview, and/or assessments, something when a weight loss is found;-If staff did not recognize the weight loss, review in IDT for possible new orders or interventions, notify the physician, consultant pharmacist and representative, then we dropped the ball;-She did not know the facility was not having weekly IDT meetings;-She is also consulted on residents with pressure ulcers, and usually a high protein supplement was added to aide in wound healing. During an interview on 03/10/26, at 1:54 P.M., the Nurse Practitioner that works with the resident's physician said the following:-Weight loss can have different goals depending on the goals of the resident;-Staff are expected to notify her or the physician if the resident has weight loss so we could look at possibly adding in medications or supplements, depending on the situation;-Staff are expected to follow the nutrition policy;-When a significant weight loss occurs, staff are expected to notify the physician, dietitian, and the representative; -Staff are expected to find the cause of the weight loss and identify contributing factors;-For a resident with weight loss, the resident should have increased monitoring, like weekly weights and monitoring consumptions;-Staff would be expected to attempt interventions to stabilize the resident or attempt to prevent further weight loss;-This resident has had a significant weight loss and problems with his/her weight.

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F 0697 Level of Harm - Actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. Based on observation, interview and record review, the facility failed to implement interventions to address pain and notify the physician of effectiveness of interventions regarding pain for one resident (Resident #15), in a review of 13 sampled residents. The facility failed to administer available ordered pain medications to address the resident's pain on occasions when other medication was not effective. Staff reported the resident's increased pain was preventing him/her from sleeping and attending activities. The facility census was 39.Review of the facility policy, Pain Assessment and Management, revised 09/08/23, showed the following:-"Pain management" is defined as the process of alleviating the resident's pain based on his or her clinical condition and established treatment goals;-Pain management is a multidisciplinary care process that includes the following:a) Recognizing the presence of pain;b) Developing and implementing approaches to pain management;c) Identifying and using specific strategies for different levels and sources of pain;d) Monitoring for the effectiveness of interventions; ande) Modifying approaches as necessary;-Possible Behavioral Signs of Pain, including:a) behavior such as resisting care, irritability, depressed mood, or decreased participation in usual physical and/or social activities;b) loss of function or inability to perform ADLs due to the presence of pain;c) insomnia;- Review the medication administration record to determine how often the individual requests and receives; PRN pain medication, and to what extent the administered medications relieve the resident's pain;-Assessing Pain:-Assess the resident at admission and during ongoing assessments to help identify the resident who is experiencing pain or for whom pain may be anticipated during specific procedures, care, or treatment;-Monitor the resident for the presence of pain and the need for further assessment when there is a change of condition;-Assess the resident whenever there is a suspicion of new pain or worsening of existing pain;-Identifying the Causes of Pain:-Residents may experience pain from several different causes simultaneously;-In addition, common procedures such as moving the resident or physical therapies, can cause the resident pain;-Review the resident's treatment record or recent nurses' notes to identify any situations or interventions where an increase in the resident's pain may be anticipated, for example:a) bathing, dressing, or other ADLs;b) ambulation or physical therapy.-Implementing Pain Management Strategies:-Non-pharmacological interventions may be appropriate alone or in conjunction with medications. Some non-pharmacological interventions include:a) exercise - range of motion exercises to prevent muscle stiffness and contractures; and;b) cognitive or behavioral - relaxation, music, diversions, activities, etc.-The medication regimen is implemented as ordered. Results of the interventions are documented and communicated directly to the provider when appropriate. Ongoing communication between the prescriber and the staff is necessary for the optimal use of pain medications.-Monitoring and Modifying Approaches:-Monitor the resident's pain each shift for acute pain or significant changes in levels of chronic pain and at least weekly; -Monitor the following factors to determine if the resident's pain is being adequately controlled:a) The resident's response to interventions and level of comfort over time;-Contact the prescriber immediately if the resident's pain or medication side effects are not adequately controlled;-If pain has not been adequately controlled, the multidisciplinary team, including the physician, shall reconsider approaches and adjust as indicated;-If there is a pattern (time of day) that the resident reports or appears to be in increased pain, consider the possibility of drug diversion and communicate the pattern to the nursing supervisor;-Document the resident's reported level of pain with adequate detail (i.e., enough information to gauge the status of pain and the effectiveness of interventions for pain) as necessary and in accordance with the pain management program;-Reporting:-Report the following information to the physician or practitioner:a) Prolonged, unrelieved pain despite care plan interventions. 1. Review of Resident #15's undated face sheet showed his/her diagnoses included pain (in right shoulder), rhabdomyolysis (a serious, potentially life-threatening medical condition involving the rapid breakdown of damaged skeletal muscle tissue), reduced mobility, muscle weakness and history of (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	falling. Review of the resident's Care Plan, revised 09/22/25, showed the following:-Encourage him/her to become involved with physical activities;-Monitor for pain and report to charge nurse any pain that is stated or he/she appears to be having;-Monitor/document/report to physician any changes, potential for improvement, reasons for self-care deficit, expected course, declines in function;-He/She will be monitored for increased pain; if he/she receives pain medication, he/she will be reassessed within one hour of having pain medication for effectiveness;-Monitor for symptoms of muscle pain; if noted, please contact physician/nurse practitioner;-Notify charge nurse with any status changes; charge nurse to notify physician;-Encourage him/her to participate in activities that promote exercise, physical activity for strengthened and improved mobility. Review of the resident's progress notes, dated 11/18/25 at 2:50 P.M., showed staff documented the resident rarely attends activities per his/her choice. Review of the resident's December 2025 physician order sheets (POS), showed the following:-Acetaminophen (pain reliever) 325 milligram (mg), two tablets orally every six hours as needed (PRN); order date 11/22/23;-Acetaminophen-codeine (Schedule III narcotic controlled substance pain reliever for mild to moderate pain) 300-30 mg, one to two tablets orally, five times per day PRN; order date 10/07/25. Review of the resident's December 2025 Medication Administration Record (MAR) showed the following:-On 12/01/25 at 2:24 A.M., Licensed Practical Nurse (LPN) D documented administering acetaminophen 325 mg, two tablets; reason: pain (no documentation of a pain score at the time of administration); result: not effective (no documentation of a pain score at the time of follow up and no documentation of notification to the charge nurse when the administration was not effective);-No documentation of staff offering or administering acetaminophen-codeine, or the resident declining the medication after the acetaminophen was not effective;-On 12/29/25 at 5:14 A.M., LPN D documented administering acetaminophen 325 mg, two tablets; reason: pain (no documentation of a pain score at the time of administration); result: not effective (no documentation of a pain score at the time of follow up and no documentation of notification to the charge nurse when the administration was not effective);-No documentation of staff offering or administering acetaminophen-codeine, or the resident declining the medication after the acetaminophen was not effective. Review of the resident's January 2026 POS, showed the following:-Acetaminophen 325 mg, two tablets orally every six hours PRN; order date 11/22/23;-Acetaminophen-Codeine 300-30 mg, one to two tablets orally, five times per day PRN; order date 10/07/25. Review of the resident's January 2026 MAR showed the following:-On 01/25/26 at 2:56 A.M., Certified Medication Technician (CMT) H administered acetaminophen 325 mg, two tablets; reason: pain (no documentation of a pain score at the time of administration); result: somewhat effective (no documentation of a pain score at the time of follow up and no documentation of notification to charge nurse when the administration was only somewhat effective);-No documentation of staff offering or administering acetaminophen-codeine, or the resident declining the medication after the acetaminophen was only somewhat effective. Review of the resident's February 2026 POS, showed the following:-Acetaminophen 325 mg, two tablets orally every six hours PRN; order date 11/22/23;-Acetaminophen-Codeine 300-30 mg, one to two tablets orally, five times per day PRN; order date 10/07/25. Review of the resident's February 2026 MAR showed the following:-On 02/17/26 at 6:48 A.M., CMT H documented administering acetaminophen 325 mg, two tablets; reason: pain (no documented pain score at the time of administration); result: somewhat effective (no documented pain score at the time of follow up and no documentation of notification to the charge nurse when the administration was only somewhat effective);- No documentation of staff offering or administering acetaminophen-codeine, or the resident declining the medication after the acetaminophen was only somewhat effective.-On 02/23/26 at 3:16 A.M., Licensed Practical Nurse (LPN) D documented administering acetaminophen 325 mg, two tablets; reason: pain (no documented pain score at the time of administration); result: not effective (no documented pain score at the time of follow up and no documentation of notification to the charge nurse when the administration was not effective);-No documentation of acetaminophen-codeine being offered, administered or declined as an additional intervention for the resident's pain after the (continued on next page)

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	265763	A. Building B. Wing	02/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Knox County Nursing Home District	55774 State Highway 6 Edina, MO 63537

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F 0697 Level of Harm - Actual harm Residents Affected - Few	acetaminophen was not effective;-On 02/24/26 at 12:30 A.M., LPN D documented administering acetaminophen 325 mg, two tablets; reason: pain (no documented pain score at the time of administration); result: not effective (no documented pain score at the time of follow up and no documentation of notification to the charge nurse when the administration was not effective);-No documentation of acetaminophen-codeine being offered, administered or declined as an additional intervention for the resident's pain after the acetaminophen was documented as not effective. Review of the resident's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument to be completed by the facility staff, dated 02/17/26, showed the following:-He/She had severely impaired cognition;-He/She received PRN pain medications or was offered and declined in the past five days;-He/She had pain or hurting in the past five days;-He/She had occasional pain in the past five days;-He/She rated his/her pain a five as his/her worst pain on a pain scale of 0-10 in the last five days;-Over the past five days, pain occasionally limited his/her day to day activities;-Over the past five days, pain made it occasionally hard for him/her to sleep. Observation on 02/24/26 at 6:10 A.M., showed Certified Nurse Assistant (CNA) A gave a verbal report to CNA I and said the following:-The resident didn't sleep well and had been up all night with his/her back hurting bad;-The resident was given Tylenol for pain and staff placed warm towels on his/her back for pain relief, but his/her back was still hurting. During an interview on 02/25/26 at 2:10 P. M., the resident said the following:-He/She had pain, and the Tylenol (acetaminophen) was not helping;-He/She had pain when he/she walks;-He/She has had the pain for a while;-Nothing (pain medication or heat packs) helped with the pain;-Pain rating depends on what he/she was doing; on his/her best day, his/her acceptable pain score would be a two, which would be not so bad and the worst that his/her pain gets was a ten;-Pain prevents him/her from doing things he/she would like to do;-Pain prevents him/her from sleeping;-He/She has pain with walking and trying to do things. During an interview on 02/26/26 at 11:10 A.M., the resident's family representative said the following:-The resident has frequent pain;-The resident has had back pain for a very long time;-The resident sometimes might not be able to tell you that he/she was having pain;-He/She has not been contacted by the facility regarding the resident's pain. During an interview on 02/25/26 at 12:10 P.M. and 02/26/26 at 10:45 A.M., Restorative Aide (RA) H, who was also CMT H, said the following:-The resident's pain had stopped him/her from doing things;-The resident has complained of back pain for a while;-If the resident complained of pain, he/she reported it to the charge nurse;-The resident doesn't do as much as he/she used to do; he/she just likes to sit in his/her chair; -Sometimes that resident doesn't even want to get out of his/her recliner to go to activities;-He/She was aware the resident has a Tylenol 3 (acetaminophen-codeine) order but has never had to give it. During an interview on 02/25/26 at 2:25 P.M., CMT G said the following:-The resident sometimes complains of back pain;-The resident sometimes complains of pain everywhere;-The resident usually rates his/her pain as very bad and he/she takes that as a seven or eight on the 0-10 pain scale; -If the pain medication was not effective, he/she reported that to the charge nurse. During an interview on 02/25/26 at 2:16 P.M. and 03/03/26 at 1:30 P.M., Licensed Practical Nurse (LPN) E said the following:-The resident has pain;-The resident complained of back pain more at night than during the day;-The resident had trouble sleeping at night due to pain;-The resident has an order to Tylenol and Tylenol 3;-He/She would call the physician if the medications were not effective;-He/She has never had to call the physician;-He/She has had to administer the Tylenol 3 because the regular Tylenol was not effective, and it helped the resident;-The resident can voice if the medication is effective or not and he/she will be sleeping if the medication was effective. During an interview on 02/25/26 at 3:50 P.M. and 02/26/26 at 10:38 A.M., LPN D said the following:-The resident complains of pain in his/her back;-He/She gave the resident Tylenol last night (02/24/26) and it wasn't working so he/she tried warm, wet towels wrapped in a Ziploc as another intervention because he/she had nothing else to give;-He/She usually doesn't document a pain score at the time of administration; he/she just documents the reason for the administration;-He/She will go ask the resident, or have the aide ask (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	the resident, within two hours of the administration, if the Tylenol was effective or not, but the resident will usually let someone know if it was or wasn't;-When he/she charted not effective, his/her next step was to use the warm towels;-He/She did not notify the physician;-The resident's back pain has been going on for several months;-He/She has never given the resident the Tylenol 3, but probably would have tried it had he/she known about it;-Another staff member reminded him/her on 02/25/26 that the resident had an order for Tylenol 3;-The resident's pain has affected her activity and sleep until he/she gets his/her pain medication;-The resident's pain was mostly at night. During an interview on 02/26/26 at 1:10 P.M., the Director of Nursing (DON) said the following:-The resident often complained of headaches and back pain;-A lot of the resident's back pain was in the evening;-She would expect staff to check if there are other orders available if the first pain medication (acetaminophen) administered was somewhat effective or not effective;-She would expect the acetaminophen-codeine order to then be given and would expect staff to try other interventions such as repositioning;-If the resident still had no relief, she would expect staff to notify the physician. During an interview on 03/10/26 at 1:54 P.M., the Nurse Practitioner said the following:-She would expect staff to notify her or the physician if pain was unresolved;-She would expect staff to try the acetaminophen with codeine if acetaminophen did not resolve the pain (as long as it did not exceed the maximum daily amount);-She was not notified or aware of any unresolved pain with the resident.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to assess limited range of motion/risk of limited range of motion and provide direction to staff or interventions such as restorative nursing services to assist three residents (Resident #5, #6, and #25) in a review of 13 sampled residents, with mobility and/or limited range of motion to ensure the resident did not develop new or worsen existing limited range of motion which could cause pain, skin issues, and decline in the resident's abilities. The facility census was 39. Review of the facility's policy Resident Mobility and Range of Motion last reviewed, 6/8/23, showed the following:-Residents will not experience an avoidable reduction in range of motion (ROM);-Residents with limited range of motion will receive treatment and services to increase and/or prevent a further decrease in ROM;-Residents with limited mobility will receive appropriate services, equipment and assistance to maintain or improve mobility unless reduction in mobility is unavoidable;- As part of the resident's comprehensive assessment, the nurse will identify the resident's:-Current range of motion of his or her joints;-Current mobility status (per current 11:DS assessment tool), including his or her ability to: -Move to and from the lying position; -Turn and move side-to-side in bed; -Change body positions; -Transfer to and from bed or chair; and -Walk.-Limitations in movement or mobility;-Opportunities for improvement; -Previous treatment and services for mobility;-As part of the comprehensive assessment, the nurse will also identify conditions that place the resident at risk for complications related to ROM and mobility, including: -(1) pain; -(2) skin integrity issues; -(3) muscle wasting and atrophy; -(4) gait and balance issues that may lead to falls or fractures; -(5) contractures; -(6) other complications that could cause or contribute to immobility, impaired ROM or injury from falls; -During the resident's assessment, the nurse will identify the underlying factors that contribute to his or range of motion or mobility problems, if any, including; -(1) immobilization (bedfast, chair or wheelchair usage); -(2) neurological conditions (e.g., cerebral palsy, cerebral vascular accident); -(3) conditions in which movement may lead to pain, and or; - (4) conditions that limit or immobilize movement of limbs or digits (e.g., splints);- The care plan will be developed by the interdisciplinary team based on the comprehensive assessment, and will be revised as needed;-The care plan will include specific interventions, exercises and therapies to maintain, prevent avoidable decline in, and/or improve mobility and range of motion;-Interventions may include therapies, the provision of necessary equipment, and/or exercises andwill be based on professional standards of practice and be consistent with state laws and practice acts;-The care plan will include the type, frequency, and duration of interventions, as well as measurable goals and objectives. The resident and representative will be included in determining-these goals and objectives;-Documentation of the resident's progress toward the goals and objectives will include attempts to address any changes or decline in the resident's condition or needs. Review of the facility's policy Restorative Nursing and Therapy Services, last reviewed 6/8/23, showed the following:-Residents will receive restorative nursing care as needed to help promote optimal safety and independence;-Restorative nursing care consists of nursing interventions that may or may not be accompanied by formalized rehabilitative services;-Residents may be started on a restorative nursing program upon admission, during the resident's stay or when discharged from rehabilitative care;-Restorative goals and objectives are individualized and resident-centered, and are outlined in the resident's plan of care;-The resident or representative will be included in determining goals and the plan of care;-Restorative goals may include, but are not limited to supporting and assisting the resident in; -(1) Adjusting or adapting to changing abilities; -(2) Developing, maintaining, or strengthening his/her physiological and psychological resources; -(3) Maintaining his/her dignity, independence and self-esteem; and -(4) Participating in the development and implementation of his/her plan of care. 1. Review of Resident #6's undated face sheet showed the following diagnoses: Hemiplegia (paralysis), (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	unspecified affecting right dominant side, muscle weakness, hemiplegia and hemiparesis (a neurological condition characterized by partial weakness, reduced strength, or impaired motor function on one side of the body) following unspecified cerebrovascular disease (a group of conditions that impair blood flow to the brain) affecting right dominant side, reduced mobility, need for assistance with personal care, personal history of transient ischemic attack (TIA) (stroke), personal history of traumatic brain injury, and cerebral infarction (ischemic stroke). Review of the resident's Functional Maintentance Nursing Program form, dated 10/14/25, showed the following:-He/She will not develop new contractures: stretching right knee/ankle to prevent contracture;-Transfer: sit to stand at bar; standing 30 seconds; He/She will maintain ability to transfer with standby/minimum assistance. Review of the resident's care plan, revised 10/14/25, showed the following:-He/she will not develop new contractures;-He/She will stretch his/her right knee/ankle to prevent contractures;-Arrange restorative therapy schedule so there is no conflict with activities that he/she enjoys attending;-He/She will be encouraged to participate in restorative therapy;-He/She will be assessed, and an individualized treatment plan will be created;-He/She will be ready for restorative therapy at the designated hour;-Monitor progress - therapist and nursing to collaborate care and services to maximize his/her accomplishments;-He/She will maintain ability to transfer with stand by assist/minimum assistance; he/she will sit to stand at bar for 30 seconds. Review of the resident's progress notes, dated 12/04/25 at 2:59 P.M., showed the following:-He/She continues on the restorative program;-Progressing in the following areas: ambulating, active range of motion (AROM), passive range of motion (PROM), and transferring;-Goals: He/She will not develop new contractures; He/She will remain to transfer with standby/minimum assistance with verbal/tactile cues;-He/She required the following assistance: one staff with transfers and activities of daily living (ADL's);-Continue plan of care. Review of the resident's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument to be completed by the facility staff, dated 12/23/25, showed the following:-He/She had moderately impaired cognition;-He/She required substantial/maximum assistance for upper body dressing;-He/She was dependent on staff for lower body dressing;-He/She was dependent on staff for putting on/taking off footwear;-He/She was dependent on staff for toileting hygiene;-He/She required partial/moderate assistance for personal hygiene;-He/She required partial/moderate assistance for rolling left to right;-He/She required partial/moderate assistance for sitting to lying;-He/She required substantial/maximum assistance sit to stand;-He/She had impairment to one side (right side) upper extremity;-He/She had impairment to one side (right side) lower extremity;-He/She used a wheelchair for mobility;-He/She received zero minutes of restorative therapy in the past 7 days;-He/She had no rejection of cares. Review of the restorative therapy binder and resident's electronic health record (EHR) for January 2026 showed the following:-On 01/01/26; No documentation of any restorative therapy received;-On 01/02/26; No documentation of any restorative therapy received;-On 01/03/26; No documentation of any restorative therapy received;-On 01/04/26; No documentation of any restorative therapy received;-On 01/05/26; in bed all day - No documentation of any restorative therapy received;-On 01/06/26; in bed all day - No documentation of any restorative therapy received; -On 01/07/26; No documentation of any restorative therapy received;-On 01/08/26; in bed - No documentation of any restorative therapy received;-On 01/09/26; No documentation of any restorative therapy received;-On 01/10/26; No documentation of any restorative therapy received;-On 01/11/26; No documentation of any restorative therapy received;-On 01/12/26; No documentation of any restorative therapy received;-On 01/13/26; 126 minutes of restorative therapy included: upper extremity (left) 25 minutes, upper extremity (right) 26 minutes (couldn't move arm today), lower extremity (left) 27 minutes; lower extremity (right) 28 minutes; standing at bar in shower room [ROOM NUMBER] times (1 minute each time) and resting in between each standing 20 minutes-On 01/14/26; No documentation of any restorative therapy received. Review of the resident's progress notes, dated 01/15/26 at 8:58 A.M., showed the following:-He/She continues on the restorative program;-Progressing in the following areas: (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	ambulating, active range of motion (AROM), passive range of motion (PROM), and transferring;-Goals: He/She will not develop new contractures; He/She will remain to transfer with standby/minimum assistance with verbal/tactile cues;-He/She required the following assistance: one staff with transfers and activities of daily living (ADL's);-Continue plan of care. Review of the restorative therapy binder and resident's electronic health record (EHR) for January 2026 showed the following:-On 01/15/26; No documentation of any restorative therapy received;-On 01/16/26; No documentation of any restorative therapy received;-On 01/17/26; No documentation of any restorative therapy received;-On 01/18/26; No documentation of any restorative therapy received;-On 01/19/26; No documentation of any restorative therapy received;-On 01/20/26; No documentation of any restorative therapy received;-On 01/21/26; No documentation of any restorative therapy received;-On 01/22/26; OOF No documentation of any restorative therapy received;-On 01/23/26; No documentation of any restorative therapy received;-On 01/24/26; No documentation of any restorative therapy received;-On 01/25/26; No documentation of any restorative therapy received;-On 01/26/26; No documentation of any restorative therapy received;-On 01/27/26; refused. Would not get out of bed; No documentation of any restorative therapy received;-On 01/28/26; No documentation of any restorative therapy received;-On 01/29/26; No documentation of any restorative therapy received;-On 01/30/26; refused ; No documentation of any restorative therapy received;-On 01/31/26; No documentation of any restorative therapy received;-Restorative therapy documented as received for 1 out of 31 days 01/01/26 through 01/31/26. Review of the restorative therapy binder and the resident's electronic health record for February 2026, showed the following:-On 02/01/26; No documentation of any restorative therapy received;-On 02/02/26; No documentation of any restorative therapy received;-On 02/03/26; No documentation of any restorative therapy received;-On 02/04/26; No documentation of any restorative therapy received;-On 02/05/26; No documentation of any restorative therapy received;-On 02/06/26; 126 minutes of restorative therapy included: upper extremity (left) 27 minutes, upper extremity (right) 26 minutes, lower extremity (left) 26 minutes; lower extremity (right) 24 minutes; standing balance 23 minutes;-On 02/07/26; No documentation of any restorative therapy received;-On 02/08/26; No documentation of any restorative therapy received;-On 02/09/26; refused. In bed and needed to go to the bathroom;-On 02/10/26; No documentation of any restorative therapy received;-On 02/11/26; No documentation of any restorative therapy received;-On 02/12/26; No documentation of any restorative therapy received;-On 02/13/26; No documentation of any restorative therapy received;-On 02/14/26; No documentation of any restorative therapy received;-On 02/15/26; No documentation of any restorative therapy received;-On 02/16/26; No documentation of any restorative therapy received;-On 02/17/26; in bed two times; No documentation of any restorative therapy received;-On 02/18/26; No documentation of any restorative therapy received;-On 02/19/26; No documentation of any restorative therapy received;-On 02/20/26; No documentation of any restorative therapy received;-On 02/21/26; No documentation of any restorative therapy received;-On 02/22/26; No documentation of any restorative therapy received;-On 02/23/26; No documentation of any restorative therapy received;-On 02/24/26; No documentation of any restorative therapy received;-On 02/25/26; No documentation of any restorative therapy received;-On 02/26/26; No documentation of any restorative therapy received;-Restorative therapy documented as received for 1 out of 26 days 02/01/26 through 02/26/26. Observation of the resident on 02/25/26 at 4:32 P.M., showed his/her right hand curled up tightly into a ball with the thumb sticking up in between the second and third finger; 1/4 fingernails pushing down into the palm of the hand. During an interview on 02/25/26 at 2:00 P.M., the resident said the following:-The Restorative Aide gets pulled to work the floor a lot, so he/she never gets therapy several times a week - more like once a week, if that;-When he/she does get restorative therapy, it does help him/her;-He/She does not have a brace, splint, or washcloth for his/her hand. During an interview on 02/25/26 at 12:10 P.M. and 02/26/26 at 10:45 A.M., Restorative Aide (RA) H said the following:-Restorative therapy orders are all for six days a week;-If a resident refuses restorative therapy, the form should say (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	refused;-He/She gets pulled from RA duties to work the floor a lot;-The facility used to have another RA and now it's just him/her working in the RA position, so that is the reason there are gaps in restorative therapy/documentation;-He/She doesn't have time to go back and ask the resident again to do restorative therapy if they are busy or unavailable at the time he/she attempts. During an interview on 02/25/25 at 2:16 P.M., Licensed Practical Nurse (LPN) E said the following:-RA H is unable to get to all of the residents for restorative therapy because RA H gets pulled to work the floor a lot;-The facility lost their other RA a few weeks ago and they are training another certified nurse aide for the RA position. During an interview on 02/25/26 at 2:25 P.M., Certified Medication Technician (CMT) G said the following:-RA H gets pulled to work the floor a lot;-He/She is sure that RA H has trouble getting to all residents for restorative therapy. During an interview on 02/26/26 at 1:10 P.M., the Director of Nursing (DON) said the following:-Every resident should be receiving daily restorative therapy to prevent worsening or to increase mobility; -She encourages all staff to do range of motion with each resident daily before getting them up and 2-3 times a day;-The facility implemented a new tracking system with a new paper form to better track how often each resident is receiving restorative therapy and to track how each resident is doing;-The MDS Coordinator gets copies of all the restorative therapy forms, and they get scanned into the resident's electronic health record (EHR);-She would expect that all restorative therapy forms be scanned into the EHR beginning January 2026;-Restorative Aide (RA) H does a lot of group restorative therapy;-There is a new RA that will begin training next week because RA H cannot get all resident's restorative therapy done;-There was a second RA that left in January leaving RA H as the only RA. 2. Review of Resident #25's Face Sheet showed the following: -The resident admitted to the facility on [DATE]; -The resident had diagnoses of stroke, hemiplegia and hemiparesis affecting left non-dominant side, cellulitis of left lower limb, unspecified abnormalities of gait and mobility, contracture of left hand and left shoulder, and unspecified pain. Review of the resident's care plan, last reviewed/revised on 09/24/25, showed the following:-Need restorative therapy related to maintaining lower body strength to continue to participate in ADL tasks and transfers. Standing lower extremity exercises at bar: toe raises, marching, leg kicks, and weight shifts;-Arrange restorative therapy schedule so there is no conflict with activities that I enjoy attending;-Have supplies and equipment readily available;-I will be assessed, and an individualized treatment plan will be created;-I will be encouraged to participate in restorative therapy.-I will be praised for all my accomplishments.-I will be ready for restorative therapy at the designated hour.-Monitor progress. Therapist and nursing to collaborate care and services to maximize my accomplishments.- I will ambulate with contact guard assistance with LBQC (quad cane);- I will ambulate to meals with restorative aid when possible;-Resting hand splint to be applied in the morning and removed at bedtime, remove for cares, monitor for redness or skin irritation and notify OT with any questions. Twice a day-PRN. Review of the physician's orders dated January 2026, showed the following:-Restorative Therapy to treat as needed (PRN);-Resting hand splint to be applied in the morning and removed at bedtime, remove for cares, monitor for redness or skin irritation and notify OT with any questions. Twice a day-PRN. Review of the restorative therapy binder and resident's electronic health record (EHR) for January 2026 showed the following:-On 01/01/26; No documentation of any restorative therapy received;-On 01/02/26; No documentation of any restorative therapy received;-On 01/03/26; No documentation of any restorative therapy received;-On 01/04/26; No documentation of any restorative therapy received;-On 01/05/26; No documentation of any restorative therapy received;-On 01/06/26; 45 minutes of activities exercise;-On 01/07/26; No documentation of any restorative therapy received;-On 01/08/26; Ambulated 50 feet;-On 01/09/26; No documentation of any restorative therapy received;-On 01/10/26; No documentation of any restorative therapy received;-On 01/11/26; No documentation of any restorative therapy received;-On 01/12/26; No documentation of any restorative therapy received;-On 01/13/26; No documentation of any restorative therapy received;-On 01/14/26; No documentation of any restorative therapy received;-On 01/15/26; 20 minutes of ambulation;-On 01/16/26; No documentation of any restorative therapy (continued on next page)

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	265763	A. Building B. Wing	02/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Knox County Nursing Home District	55774 State Highway 6 Edina, MO 63537

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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 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	received;-On 01/17/26; No documentation of any restorative therapy received;-On 01/18/26; No documentation of any restorative therapy received;-On 01/19/26; No documentation of any restorative therapy received;-On 01/20/26; 23 minutes of ambulation-On 01/21/26; No documentation of any restorative therapy received;-On 01/22/26; No documentation of any restorative therapy received;-On 01/23/26; No documentation of any restorative therapy received;-On 01/24/26; No documentation of any restorative therapy received;-On 01/25/26; No documentation of any restorative therapy received;-On 01/26/26; 30 minutes of activities exercise-On 01/27/26; Ambulated 40 feet, right upper extremity AROM 26 minutes, right lower extremity AROM 28 minutes, left upper extremity PROM 20 minutes, left lower extremity PROM 28 minutes;-On 01/28/26; 33 minutes of ambulation;-On 01/29/26; No documentation of any restorative therapy received;-On 01/30/26; No documentation of any restorative therapy received;-On 01/31/26; No documentation of any restorative therapy received. Review of the resident's Quarterly Minimum Data Set, (MDS, a federally mandated assessment instrument completed by facility staff) dated 02/05/26, showed the following: -Cognitively intact; -No behaviors or rejection of cares;-Lower extremity impairment in range of motion on one side; -Upper extremity impairment in range of motion on one side; -Required partial/moderate assistance for toileting hygiene, personal hygiene, sit to lying, lying to sitting. -Required substantial/maximal assistance for dressing, shower transfers and showers; -Required supervision for sit to stand, toilet transfers, and walking; -Used a wheelchair;-Restorative therapy marked as 2 days a week. Review of the resident's February 2026 physician orders showed the following;-Restorative Therapy to treat PRN;-Resting hand splint to be applied in the morning and removed at bedtime, remove for cares, monitor for redness or skin irritation and notify OT with any questions. Twice a day-PRN. Review of the resident's February 2026 Medication Administration Record (MAR) showed no documentation staff applied the splint during the month of February. Review of the facility's form titled Functional Maintenance Nursing Program Effective date 11/18/25 for the resident showed the following:-Plan-ambulation three times per week with hemi cane;-Plan- sit to stand transfers/balance. Review of the restorative therapy binder and resident's electronic health record (EHR) for February 2026 showed the following:-On 02/01/26; No documentation of any restorative therapy received;-On 02/02/26; No documentation of any restorative therapy received;-On 02/03/26; No documentation of any restorative therapy received;-On 02/04/26; No documentation of any restorative therapy received;-On 02/05/26; No documentation of any restorative therapy received;-On 02/06/26; No documentation of any restorative therapy received;-On 02/07/26; No documentation of any restorative therapy received;-On 02/08/26; No documentation of any restorative therapy received;-On 02/09/26; No documentation of any restorative therapy received;-On 02/10/26; 45 minutes of activities exercise;-On 02/11/26; No documentation of any restorative therapy received;-On 02/12/26; No documentation of any restorative therapy received;-On 02/13/26; No documentation of any restorative therapy received;-On 02/14/26; No documentation of any restorative therapy received;-On 02/15/26; No documentation of any restorative therapy received;-On 02/16/26; No documentation of any restorative therapy received;-On 02/17/26; No documentation of any restorative therapy received;-On 02/18/26; No documentation of any restorative therapy received;-On 02/19/26; No documentation of any restorative therapy received;-On 02/20/26; No documentation of any restorative therapy received;-On 02/21/26; No documentation of any restorative therapy received;-On 02/22/26; No documentation of any restorative therapy received;-On 02/23/26; No documentation of any restorative therapy received. Observation on 02/23/26 at 12:00 P.M. showed the resident's contracted left hand sat on a half tray clamp on a side table; the resident was not wearing a splint. Observation on 2/24/26 at 6:25 A.M. showed the resident's contracted left hand sat on a half tray clamp on a side table; the resident was not wearing a splint. Observation on 2/24/26 at 12:21 P.M. showed the resident's contracted left hand sat on a half tray clamp on a side table; the resident was not wearing a splint. Review of the restorative therapy binder and resident's electronic health record (EHR) for February 2026 showed the following:-On 02/24/26; No documentation of any restorative therapy received;-On 02/25/26; No (continued on next page)

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	265763	A. Building B. Wing	02/26/2026

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Knox County Nursing Home District	55774 State Highway 6 Edina, MO 63537

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	documentation of any restorative therapy received;-On 02/26/26; No documentation of any restorative therapy received; During an interview on 02/25/26 at 12:50 P.M., and 2/26/26 at 8:47 A.M., the resident said the following:-RA H works as a CNA frequently and does not get restorative therapy completed;-He/She used to get restorative therapy two days a week;-He/She use to wear a brace on the left hand;-The brace had been missing for a long time;-He/She would wear the brace if he/she had one;-He/She was unsure how long it had been since she wore the brace;-He/She felt like her mobility has declined without restorative therapy being done very often;-He/She was getting restorative therapy two days a week for 15 minutes when RA H was able to do therapy every day. During an interview on 2/25/26 at 2:20 P.M., LPN E said he/she was unaware that the resident had ever had a brace. Observation on 02/26/26 at 8:47 A.M. showed the resident's contracted left hand sat on a half tray clamp on a side table; the resident was not wearing a splint. During an interview on 02/26/26 at 10:00 A.M. CNA F said he/she was unaware the resident had a hand brace.During an interview on 02/26/26 at 10:10 A.M. CMT G said he/she vaguely remembered the resident having a brace a long time ago. It does not show up on the Medication Administration Record (MAR). During an interview on 02/26/26at 10:15 A.M. LPN D said he/she remembers the resident having a brace a long time ago and was unsure why the resident quit wearing it. 3. Review of Resident #5's face sheet shows diagnosis of dementia, arthritis, abnormalities of gait and mobility, and contracture of the right hand.Review of the resident's Functional Maintenance Nursing Program, dated 04/17/23, showed the following:-Passive Range of Motion (PROM) to the right finger extension, elbow check and extension and forearm pronation (refers to rotating the forearm so the palm faces downward or backward) and supination (the rotational movement of the forearm that turns the palm upward or forward, positioning the radius and ulna bones parallel to each other) as the resident allows;-Splinting applied to Right Upper Extremity (RUE): Right hand resting hand splint on at bedtime and off in the morning:a. Skin will be free of redness, swelling and/or breakdown;b. Patient will tolerate splint according to wear schedule for contracture prevention/positioning and/or pain management. Review of the resident's Physician's Orders, dated 01/17/24, showed ASO Brace PRNSpecial Instructions: ASO (Ankle Stabilizing Orthosis) brace is a specialized, lace-up ankle support device designed to provide superior, consistent, and long-lasting stability for the ankle joint) brace on right ankle when weight bearing only. Not to be worn when non-weight bearing. Review of the resident's Care Plan, dated 08/27/24, showed the resident needs ASO (ankle stabilizing orthosis; a brace, commonly used lace-up ankle support that provides stabilization, mimicking the support of professional athletic taping) brace as needed (PRN) on the right ankle when weight bearing only. Not to be worn when non-weight bearing. Certified Nurse Assistant (CNA) to don and doff.The care plan did not address the resident's severe contractures of his/her right hand, directives for range of motion, splinting, or care of the resident's right hand. Review of the resident's annual Minimum Data Set (MDS), a federally mandated assessment completed by staff, dated 11/11/25, showed the following:-Severe cognitive impairment;-No behaviors or rejection of care;-Limited range of motion in one lower extremity;-Dependent on staff for oral hygiene, toileting hygiene, shower/bathe, upper body dressing, lower body dressing, putting on/taking off footwear, personal hygiene, roll left and right, sit to lying, lying to sitting on side of bed, sit to stand, chair/bed-to-chair transfer, toilet transfer, tub/shower transfer, and wheelchair mobility;-Diagnoses include dementia, Alzheimer's, and profound intellectual disabilities;-No therapy or restorative services;-No range of motion. Review of the resident's quarterly MDS, dated [DATE], showed the following:-Severe cognitive impairment;-Limited range of motion in one lower extremity;-No therapy or restorative services;-No range of motion. Observation on 02/24/26, at 6:30 A.M., showed the following:-The resident in his/her bed;-CNA A and CNA B provided personal cares;-The resident's right hand was bent at the wrist 90+ degrees, with his/her fingers closed in a tight fist;-The resident's feet turned outward (not in a typical resting position);-The resident did not have a washcloth or splint on the resident's right hand. During an interview on 02/24/26 at 6:40 A.M., CNA A said the facility has a Restorative Nursing Aide (RNA) that does range of motion for residents. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The resident's right hand has severe contractures. He/She thought the resident received range of motion from the restorative aide. Review of the resident's record including his/her physician orders, and nurses notes showed the resident was not on a restorative program. The resident's record did not show any range of motion or splinting completed, offered, or declined. During an interview on 02/26/26, at 11:30 A.M., RA H said the following:-For contractures some of the residents are on restorative therapy but not all;-Residents with contractures she would try to loosen the contracture and prevent them from getting worse;-Resident #5 has a contracture of his/her hand on his/her affected side. The resident was not on a restorative program, did not have range of motion activities documented, and had no splint;-Resident #13, was on restorative and then went to the hospital. The resident did not get put back on restorative and must have been missed; -Resident #25 used to have a splint but it went missing a couple of weeks ago. The resident told him/her it was missing, and she has not had time to track it down. She does not know why the resident cannot bend his/her left leg. -Resident #25 goes to almost all activities and she does not have time to go back and ask again;-She does not always get to complete her restorative duties because she gets pulled a lot to help others, pass medications or work on the floor as a CNA. During an interview on 02/26/26 at 1:10 P.M. the Director of Nursing (DON) said the following:-Residents with contractures would have restorative nursing for range of motion two to three times a week. They encourage all staff to do ROM on residents with contractures, but documented would be restorative nursing;-She did not know if all residents with contractures or potential for contractures are on restorative nursing;-The facility had two staff to do restorative nursing until January, the facility was trying to hire an additional RA;-RA H does restorative therapy daily;-RA H does help with CNA work;-Staff should do ROM before getting residents out of bed;-RA H should continue to work with Resident #25 daily;-RA H should work around Resident #25's activity schedule;-Resident #25 should be utilizing the hand brace;-She was unaware that resident #25's brace was missing;-Resident #25's brace should have been replaced as soon as staff knew it was missing;-She does not know if Resident #5 or Resident #13 received restorative nursing for their contractures. During an interview on 03/10/26 at 1:54 P.M., the Nurse Practitioner said the following:-She would expect the facility to do everything they can to prevent or worsening of existing contractures, depending on the resident's condition- if they had a progressive disease, it would make it more difficult;-She would expect contractures to be on the care plan.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure medications were labeled in accordance with currently accepted professional standards of practice, and per facility policy, when staff failed to date a multi-use Lantus insulin pen (long-acting, injectable medication to treat diabetes (inability to regulate blood sugar) with an open date when first accessed for one resident (Resident #12), failed to date a multi-use Ozempic (injectable insulin-like medication used to treat diabetes) pen with an open date for one resident (Resident #16), when first accessed and failed to discard an open, in-use vial of Humalog insulin (rapid-acting, injectable medication used to treat diabetes) for one resident (Resident #1), per the manufacturer's recommendations for expiration and discarding time frame. The facility failed to keep a pharmacy medication card of Ativan (narcotic schedule IV controlled substance) behind two locked doors for one resident (Resident #13) when staff left it on the medication room counter (behind one lock only) and failed to keep the keys for two medication carts secured, when staff left the keys in the narcotic control logbook located on top of the medication carts. The medication carts were placed in an open area between the nurses station and a living area, where two residents self-propelled in wheelchairs by the carts, and were unattended by staff responsible for the medication carts. The facility census was 39. Review of the facility policy, Insulin Administration, dated [DATE], showed the following:-Purpose: To provide guidelines for the safe administration of insulin to residents with diabetes;-Preparation: The nursing staff will have access to specific instructions (from the manufacturer if appropriate) on all forms of insulin delivery system(s) prior to their use;-Steps in the Procedure: Check expiration date, if drawing from an open multi-dose vial (or pen). If opening a new vial, record expiration date and time on the vial (or pen) (follow manufacturer recommendations for expiration after opening). Review of the facility policy, Medication Labeling and Storage, dated [DATE], showed the following:-The facility stores all medications in locked compartments. Only authorized personnel have access to keys;-Medication Storage: 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, the dispensing pharmacy is contacted for instructions regarding returning or destroying these items;-Medications are stored in an orderly manner in cabinets, drawers, carts or automatic dispensing systems. Each resident's medications are assigned to an individual cubicle, drawer or other holding area;-Controlled substances and other drugs subject to abuse are separately locked in permanently affixed compartments;-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. Go by manufacturer's expiration date unless contraindicated. Review of the facility policy, Administering Medications, dated [DATE], showed the expiration/beyond use date on the medication label is checked prior to administering. When opening a multi-dose container, the date opened is recorded on the container. Review of the facility policy, Security of Medication Cart, dated [DATE], showed the policy did not address securing the keys to the medication cart.1. Review of Resident #12's undated face sheet showed a diagnosis of diabetes mellitus (too much sugar in the blood stream). Review of the resident's February 2026 physician order sheet showed an order for Lantus insulin, administer 55 units subcutaneously twice daily.Observation on [DATE] at 6:06 A.M. of the licensed nurse treatment cart, showed it contained an open in use Lantus insulin pen labeled for the resident with no open date (staff had not labeled the pen with an open date when first opened per facility policy).Observation on [DATE] at 7:02 A.M., showed the following:-Licensed Practical Nurse (LPN) E removed the resident's open, and in-use Lantus insulin pen from the medication cart; the pen did not have a documented open date on the insulin pen;-LPN E dialed up the 55-unit dose from the (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	resident's Lantus insulin pen;-LPN E administered the resident's Lantus insulin. During an interview on [DATE] at 7:15 A.M., LPN E said the following:-All insulin pens should be dated with an open date;-Without the open date, you do not know how long the pen has been in use;-Insulin pens are only to be in use for 28 days after they have first been opened;-He/She did not check the pen for an open date prior to the preparation or administration of the resident's insulin;-He/She had no way of knowing if the insulin pen was expired or not. 2. Review of Resident #1's undated face sheet showed a diagnosis of diabetes mellitus.Review of the resident's [DATE] through February 2026 physician order sheets showed an order for Humalog insulin per sliding scale (an amount to be determined based on a procedure prior to the administration) three times daily.Observation on [DATE] at 6:06 A.M., of the licensed nurse treatment cart, showed it contained an open, in use vial of Humalog insulin labeled for the resident, in a pharmacy box with a date of [DATE] written on the box. During an interview on [DATE] at 6:10 A.M., LPN D said the [DATE] date written on the box of the resident's Humalog insulin would be the date the insulin vial was opened or first used.Review of the manufacturer's guideline for use for Humalog insulin showed it was good for 28 days after it was opened. (Based on this information, the vial should have been disposed of on [DATE]).3. Review of Resident #16's undated face sheet showed a diagnosis of diabetes mellitus.Review of the resident's February 2026 physician orders showed the resident had an order for Ozempic 2 milligrams (mg) to be administered every Monday.Observation on [DATE] at 6:06 A.M., of the licensed nurse treatment cart, showed it contained an open, in use vial of Ozempic labeled for the resident, in a pharmacy box. Neither the pen nor pharmacy had an open date (staff had not labeled the pen with an open date per facility policy when first opened).4. Observation on [DATE] at 5:27 A.M., of the locked medication room, showed a pharmacy medication card of 60, 1/2 tablets of Ativan, labeled for Resident #13, located on the medication room counter and not behind an additional locked cabinet or door. During an interview on [DATE] at 5:30 A.M., LPN D said the pharmacy had just delivered the medications and he/she was waiting for the day shift Certified Medication Technician (CMT) to arrive to place the Ativan card on the active cart. He/She was aware all narcotics should be kept behind two locked doors. The medication room had a lock box for narcotics, but he/she had not placed the card in the lock box.Review of a pharmacy delivery sheet showed LPN D signed for the Ativan medication card on [DATE] at 3:00 A.M. 5. Observation on [DATE] at 5:43 A.M., showed the following:-The south and central CMT medication cart and the west CMT medication cart sat beside one another in between the nursing desk and the resident sitting/living area. One resident self-propelled about the area in his/her wheelchair, another resident sat in his/her wheelchair in the area and two staff came and went from the area, walking by the medication carts to go up and down the halls to care for residents and perform duties. No staff was at the nursing desk at this time;-The medication cart keys for the south and central CMT medication cart and the west CMT medication cart were stored in the narcotic count binder on top of the medication cart and were visible in the folded binder. The keys were not secured by staff and left accessible to anyone walking by. Observation on [DATE] at 6:05 A.M. showed the following:-CMT G walked up to the south and central CMT medication cart, removed the medication cart keys from the narcotic count binder, and then opened the narcotic binder on the west CMT medication cart and removed the keys from the binder, placing the keys in his/her pocket;-CMT G then unlocked the south and central CMT medication cart with the keys, opened the locked narcotic box with the keys and began the narcotic count by him/herself;-LPN D walked up to CMT G, handed him/her Resident #13's Ativan medication card to be added to the cart and then completes the narcotic count with CMT G.During an interview on [DATE] at 6:10 A.M., LPN D said the following:-He/She was responsible for the south and central CMT medication cart and the west CMT medication cart but did not need to access them during her shift; there were no resident scheduled medications for his/her shift; he/she only worked out of the licensed nurse treatment cart during his/her shift;-He/She placed the medication cart keys in the narcotic count binders because he/she knew CMT G would be coming in soon and was going to be doing the count with him/her after he/she (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	arrived. He/She could not remember when he/she placed the keys in the narcotic binders. He/She should keep all keys on his/her person and hand them over to the on-coming shift instead of leaving them out in the open. During interview on [DATE] at 2:24 P.M. and [DATE] at 1:35 P.M. the administrator said the following:-All insulin, or insulin-like products like Ozempic, should be dated with an open date, when first opened, to determine when the product is expired, so the medication could be discarded by the manufacturer's suggested discard date. Without the date, you can't tell if the medication would be expired or not;-Keys to the medication cart should not be left in the narcotic book on the medication cart and should be kept on the person responsible for the keys and handed off to the next person assuming the cart;-Narcotics should be always locked up and behind two locks.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. Based on observation, interview, and record review, the facility failed to ensure staff served the correct portion size of food items to residents with a physician's order for a mechanical soft diet. The facility census was 39.Review of the facility policy, Portion Control-Portion Sizes, dated 2004, showed the following:-Policy: Foods shall be served according to standard portion sizes;-Purpose: To ensure adequate servings of foods and to provide equal sized portions for those residents not requiring special dietary modification;-Procedure: Portion control equipment, such as numbered dippers/scoops, spoodles, ladles of varying ounce capacities, is used at all meals; 1. Review of a list of the residents' orders, dated 2/22/26-2/23/26, provided by the Dietary Manager, showed six residents had a physician's order for a mechanical soft diet. Review of the Diet Spreadsheet for lunch on 2/23/26 showed residents on a mechanical soft diet were to receive the following:-Ground baked turkey with gravy (4-ounce serving with gravy), or;-Ground beef stroganoff over noodles (6-ounce serving of beef stroganoff /4-ounce serving of noodles). Observation on 2/23/26 between 11:26 AM. to 12:00 P.M., during the lunch meal service, showed Dietary Staff K served residents on a mechanical soft diet either a 3-ounce serving of ground baked turkey (instead of a 4-ounce serving) or a 4-ounce serving of ground beef stroganoff over noodles (instead of a 6-ounce serving of beef stroganoff over a 4-ounce serving of noodles). During an interview on 2/24/26 at 9:24 A.M., Dietary Staff K said he/she usually referred to the diet spreadsheet when selecting serving utensils, but he/she didn't check the spreadsheet prior to serving lunch yesterday. Meat portions were typically 3-ounce servings, so he/she selected a 3-ounce utensil to serve the ground turkey. He/She used a 4-ounce scoop for the stroganoff, and it should have been a 6-ounce scoop. During an interview on 2/24/26 at 9:28 A.M., the Dietary Manager said the following:-Staff should refer to the diet spreadsheet or the recipe when selecting serving utensils;-Staff should serve food items with the correct utensils. During an interview on 2/27/26 at 9:59 A.M., the Consultant Dietitian said staff should utilize correct serving utensils to serve the correct portion sizes of food items to residents on a mechanical soft diet.

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Knox County Nursing Home District	55774 State Highway 6 Edina, MO 63537

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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 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. Based on observation, interview, and record review, the facility failed to provide food items to conserve flavor and appearance. The facility census was 39.Review of the facility policy, Protecting Nutrients, dated 2004, showed the following:-Policy: All food shall be prepared to protect nutrients;-Purpose: To provide a food supply containing adequate nutrients;-Standardized recipes shall be followed;-Exceptions to following recipes shall only be made by the Food Service Supervisor and/or Dietitian/Consultant;-Substitution of ingredients shall only be made by the Food Service Supervisor and/or Dietitian/Consultant;-Foods shall not be prepared or portioned too far in advance of serving. 1. Review of the Resident Council meeting minutes, dated 12/5/25, showed when asked about the menus and food, several resident said they didn't like the menus or the food. Review of the Resident Council meeting minutes, dated 1/5/26, showed the residents in attendance reported the following:-Food and menus were no better; -The cucumbers and onions had nothing but pure vinegar on them;-The grilled sandwiches were usually burnt;-Sometimes the chicken strips were very hard. Review of the Resident Council meeting minutes, dated 2/6/26, showed the residents in attendance reported the following:-Old Business: Sandwiches were still burned, especially at the evening meal;-The peeling was left on the potatoes which made them tough to chew; -One resident did not like sauces on everything. 2. During interview on 02/23/26 at 10:25 A.M., Resident #2 said the food was not good and did not have any flavor. During interview on 02/23/26 at 11:00 A.M., Resident #7 said the food did not taste good. During an interview on 02/23/26 at 11:23 A.M., Resident #9 said he/she did not like the food. The food was not seasoned and did not taste good most of the time. The vegetables were usually hard and not cooked all the way or sometimes the vegetables were mushy. During interview on 02/23/26 at 12:00 P.M., Resident #25 said the food did not taste very good. During interview on 2/24/26 at 11:55 A.M., Resident #2 said the food did not taste good. 3. Review of the Diet Spreadsheet (Week 3, Day 16) for lunch on 2/23/26 included baked turkey or beef stroganoff over noodles and green bean casserole. Observation on 2/23/26 at 12:01 P.M., of the sample test tray for the lunch meal, showed the following:-Half of the slice was dark brown, and the other half was white. The turkey appeared freezer burnt. The texture of the turkey was stringy and chunky and lacked flavor;-The green bean casserole was runny and thin, had no seasoning, and lacked flavor. Observation on 02/23/26 at 11:23 A.M., showed staff brought a tray into Resident #9's room. The tray contained turkey and green bean casserole. The turkey was dark on one side and light on the other side. The resident said, What is that? That doesn't look like turkey, and the green bean casserole is runny and doesn't look like casserole. The resident took a bite of the turkey and green bean casserole and said they did not taste good. During an interview on 02/23/26 at 12:15 P.M., Resident #26 said the food was lukewarm, was not cooked well, and had no seasoning. The turkey he/she received today was very processed and did not taste good. It did not look appetizing. During interview on 02/23/26 at 12:30 P.M., Resident #13 said the food at the lunch meal was not great. The green bean casserole was not good. 4. During interviews on 2/23/26 at 12:37 P.M. and on 2/24/26 at 9:24 A.M., Dietary Staff K said the turkey was more like a turkey roast that contained both dark and white meat pressed together in the same roast and held together with netting. Another dietary staff cooked the roast the day before, and he/she reheated the roast and sliced it prior to the meal. The green bean casserole contained green beans, butter, soup, milk and onion. The mixture started out thick and got thinner during the cooking process. He/She was unsure how the casserole became so thin. Staff should use recipes during food preparation. During an interview on 2/24/26 at 9:28 A.M., the Dietary Manager said the baked turkey was a netted turkey roast comprised of 15% thigh meat and the rest was breast meat. The roast was supposed to look light and dark, and it was not freezer burnt. Staff baked the turkey roast the day before service. Staff reheated the roast in the oven prior to serving on 02/23/26. The baked turkey was not available, so the vendor substituted the turkey roast in its place. Staff should use a recipe when preparing food items.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to follow current infection control standards for four sampled residents (Resident #6, #25, #13 and #5) in a review of 13 sampled residents and two additional residents (Resident #12 and #29). The facility failed to follow infection control practices for Enhanced Barrier Precaution (EBP) when staff did not wear personal protective equipment (PPE) during personal care for one resident (Resident's #6) who required EBP use, failed to ensure staff washed their hands and changed their gloves after they became soiled during direct care and before touching the resident and/or clean items for one resident (Resident # 6), and failed to follow infection control practices while performing wound care for two resident's (Resident's #25 and # 13) when staff failed to change their gloves and perform hand hygiene after removing soiled bandage and prior to touching clean items. The facility failed to ensure infection control practices during medication administration and procedures for three residents (Resident #16, #12 and #29), in a review of staff performing 10 resident medication administrations and procedures. The facility census was 39.Review of the facility's policy Dressings, Dry/Clean, dated 3/31/23 showed the following:-The purpose of this procedure is to provide guidelines of dry, clean dressings;-Establish a clean field;-Place the clean equipment on the clean field;-Place a biohazard or plastic bag nearby or use a waste basket below the clean field;-Position resident and adjust clothing to provide access to the affected area;-Wash and dry your hands thoroughly;-Put on gloves, remove soiled dressing;-Pull glove over dressing and discard into plastic or biohazard bag;-Clean hands and apply new gloves;-Open dry, clean dressing;-Label tape or dressing with date, time and initials and place on clean field;-Using clean technique, open gauze or dressing supplies;-Wash and dry hands thoroughly;-Put on clean gloves;-Assess the wound and surrounding skin;-Cleanse the wound with ordered wound cleanser;-Use dry gauze to pat the wound dry;-Apply the ordered dressing and secure per order;-Discard disposable items into the designated container;-Remove gloves and discard into designated container, wash and dry hands. A facility policy regarding EBP was requested but not received. 1. Review of Resident #6's undated face sheet showed his/her diagnoses included urinary tract infection (UTI), prostate cancer and need for assistance with personal care. Review of the resident's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument to be completed by the facility staff, dated 12/23/25, showed the following:-He/She had moderately impaired cognition;-He/She was dependent on staff for toileting hygiene;-He/She required partial/moderate assistance for personal hygiene;-He/She was frequently incontinent of bowel;-He/She had a urinary catheter. Review of the resident's care plan, revised 02/04/26, showed the following:-He/She has bowel incontinence and wears disposable briefs;-He/She had a urinary catheter;-He/She needs assistance from 1-2 staff with perineal cares after toileting or being incontinent of bowel;-Provide perineal care after toileting, being incontinent, and as needed (PRN);-Provide catheter care at least twice daily and after every episode of bowel incontinence;-Enhanced barrier precautions: The resident has an indwelling medical device (urinary catheter); in addition to standard precautions, the following steps must be taken: The use of gowns and gloves are required for high contact care activities;-Don gown and gloves upon entering his/her room for high-contact care activities and doff gown and gloves upon exiting;-Enhanced barrier precautions should be maintained specifically when anticipating close physical contact while assisting with transfers, mobility, and any high contact activity;-Please remember to wash hands upon entering his/her room. If hands become soiled and between glove changes, wash hands. When cares are complete, please wash hands before exiting his/her room. Review of the resident's physician order sheet (POS) showed the following:-Urinary catheter, change every 30 days and as needed; once a day on the 5th of the month; order date 11/04/25;-Ensure perineal care and catheter care are being done shiftly and as needed; twice a day; order date 09/16/25. Observation on 0/25/26 (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	at 4:32 P.M., showed the following:-Enhanced Barrier Precaution signs and personal protective equipment (PPE) displayed outside of resident's room/door;-Certified Nurse Aide (CNA) N entered the resident's room, washed his/her hands, and donned gloves, but no gown;-CNA N pulled the resident's pants and brief down and provided catheter care; -CNA N assisted the resident to turn on his/her right side and cleaned feces from the resident's bottom,-The cloth pad under the resident was soiled with feces; -CNA N doffed his/her soiled gloves and donned new gloves without washing hands between glove change, -CNA N placed a clean brief under the resident, touching the soiled pad under the resident with his/her gloves and the resident's clean brief;-CNA N removed the soiled brief from under the resident and doffed his/her left soiled glove into the trash;-CNA N used his/her bare left hand and soiled gloved right hand to fasten the clean brief and assist with pulling up the resident's pants;-CNA N doffed his/her right soiled glove without washing hands or applying gloves;-CNA N held the catheter bag at his/her waist and assisted the resident with a bed to wheelchair transfer, touching the catheter bag, wheelchair and the resident with soiled, bare hands; -CNA N folded the soiled pad from the resident's bed and placed it in a black trash bag and tied it up;-CNA N placed a clean pad on the resident's bed and pulled up the resident's bed linens;-CNA N exited the room without washing hands and carried the trash and dirty linen bags to the shower room down the hallway. During an interview on 02/25/26 at 4:50 P.M., CNA N said the following:-Enhanced Barrier Precautions and personal protective equipment should be used for the resident because he/she had a catheter;-He/She should have worn a gown and gloves; -He/She should have changed gloves and washed his/her hands in between dirty and clean tasks and before leaving the room. 2. Review of Resident #25's Face Sheet showed the resident had diagnoses of stroke, hemiplegia (severe or total paralysis affecting one side of the body, caused by brain damage, stroke or injury) and hemiparesis (weakness, rather than complete paralysis, affecting one side of the body, commonly caused by a stroke) affecting left non-dominant side, and cellulitis (serious bacterial skin infection) of left lower limb. Review of the resident's care plan, last revised 01/16/26, showed the following: -The resident has a wound on the posterior (back) of his/her left knee; -Assess condition of surrounding skin. Report emergence of skin excoriation; -Assess location, size (length, width, and depth), presence/absence of granulation tissue and epithelization of wound and chart it under wound; -Observe and report signs of localized infection (e.g., localized pain, redness, swelling, tenderness, loss of function, heat at the infected area). Report to charge nurse/physician. -Perform dressing change per physician order. -Position for comfort with physical support as necessary. -Record the amount, type, consistency, color, and odor of drainage from the wound. -The care plan did not address infection control practice or using enhanced barrier precautions (EBP). Review of the resident's quarterly Minimum Data Set, (MDS, a federally mandated assessment instrument completed by facility staff) dated 02/05/26, showed the following: -Cognitively intact; -Lower extremity impairment in range of motion on one side; -Upper extremity impairment in range of motion on one side; -Required partial/moderate assistance for toileting hygiene, personal hygiene;-Frequently incontinent of bladder; -Occasionally incontinent of bowel; -Pressure ulcer not documented; -Skin tear documented; -Application of ointments/medications other than to feet; -Application of non-surgical dressing other than to feet. Review of the physician order sheet, dated February 2026, showed a treatment order for the resident's left knee: Apply Calmoseptine to peri wound, calcium alginate with silver to wound bed, cover with Opti foam dressing, change daily and PRN. Ordered 2/16/26. Observation on 2/25/26 at 9:00A.M., showed the following:-LPN E entered the room, donned EBP and gathered supplies;- LPN E removed a bandage from the resident's left knee and with the same gloves, he/she measured the resident's wound; -With same gloves, he/she applied calcium alginate (absorbent wound dressing) to the wound and Calmoseptine (barrier cream) around the open area and covered the area with a new bandage;- With the same gloves, he/she removed a black permanent marker from his/her pocket and dated the bandage and put the marker back in his/her pocket;-With the same gloves, he/she pulled up the resident's pants, positioned a wheelchair near the resident and held it in place while the resident pivoted and sat (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	been trained to clean the tip of an insulin pen with an alcohol wipe prior to applying the needle tip. During an interview on 02/25/2026 at 1:35 P.M., the administrator said staff should be cleaning the tip of an insulin pen with an alcohol wipe prior to applying the needle tip. 10. Review of the facility policy, Administering Medications through a Small Volume (Handheld) Nebulizer, dated 06/13/23, showed the following:-The purpose of this procedure is to safely and aseptically administer aerosolized particles of medication into the resident's airway;-Steps in Procedure:-When treatment is complete, turn off nebulizer and disconnect T-piece, mouthpiece and medication cup;-Rinse and disinfect the nebulizer equipment according to facility protocol, or: -a. wash pieces with warm, soapy water; -b. rinse with hot water; -c. place all pieces in a bowl and cover with rubbing alcohol. Soak for five minutes; -d. rinse all pieces with sterile water; and -e. allow to air dry on paper towel;-When equipment is completely dry, store in a plastic bag with the resident's name and the date on it. 11. Review of Resident #29's February 2026 physician order sheet showed an order for budesonide (a long-acting inhaled medication used to treat respiratory illness) nebulizer treatments twice daily for cough. Observation on 02/24/26 at 9:14 A.M. showed the following:-Certified Medication Technician (CMT) J removed the resident's budesonide medication from the medication cart, entered the resident's room, removed the resident's nebulizer treatment supplies from a cloth bag, added the medication to the medication cup, handed the resident the handheld administration pieces and turned the nebulizer on to begin administering the medication;-CMT J left the room, leaving the resident self-administering the medication. Observation on 02/24/26 at 9:20 A.M. showed the following:-CMT J returned to the resident's room. The resident had completed his/her nebulizer treatment and CMT J took the handheld administration pieces from the resident and placed them in a cloth bag on the resident's table;-CMT J did not disconnect the T-piece, mouthpiece and medication cup, and rinse and disinfect the nebulizer equipment according to facility policy. During an interview on 02/24/2026 at 10:06 A.M., CMT J said the following:-Nebulizer pieces are washed/cleaned during night shift; -They are not cleaned/rinsed in between or after each use. During an interview on 02/26/26 at 1:10 P.M., the DON said the following:-She would expect staff to change their gloves and wash their hands in between dirty and clean tasks;-She would expect staff to use Enhanced Barrier Precautions and wear personal protective equipment (gown and gloves) during catheter care. During an interview on 02/25/2026 at 1:35 P.M., the administrator said she expected staff to disconnect the nebulizer treatment device pieces and rinse or clean them and allow them to air dry after each use.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Knox County Nursing Home District	55774 State Highway 6 Edina, MO 63537

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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 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to have an adequate audible system for the residents to signal nursing staff for assistance and failed to ensure staff responded to call lights timely for three residents (Resident's #25, #9 and #20) in a sample of 13 residents. The facility census was 39. Review of the facility policy, Resident Call System, last updated December 2023, showed the following:-Residents are provided with a means to call staff for assistance through a communication system that directly calls a staff member or a centralized workstation;-Each resident is provided with a means to call staff directly for assistance from his/her bed, from toileting/bathing facilities and from the floor;-Call system communication may be audible or visual. The system may be wired or wireless;-The resident call system should always remain functional. If audible communication is used, the volume is maintained at an audible level that can be easily heard;-Calls for assistance are answered as soon as possible, but no later than five minutes, urgent requests for assistance are addressed immediately. 1. Review of the facility's daily census report, provided by the facility, dated 02/23/26, showed the following:-Central hall with nine residents;-South hall with 14 residents;-West hall with 17 residents. Observation of the facility on 02/24/26 at 5:30 A.M. showed the following:-A centralized nursing station with a call light computer monitor;-All three resident room halls extended off the nursing station. Observation on 02/24/26 at 5:50 A.M., of the call light monitor at the nurses' desk, showed room [ROOM NUMBER]'s call light was on. There was no audible sound heard at the nurses desk. A sign on the computer monitor said, the volume must be on at all times. Observation on 02/23/26 at 12:00 P.M. showed the call light in room [ROOM NUMBER] was on for 11 minutes. There was no audible indication to alert staff the call light was on from the middle of the west hall Observation on 02/24/26 at 5:28 A.M. showed the call light in room [ROOM NUMBER] was on for 14 minutes. There was no audible indication to alert staff the call light was on from the middle of the central hall. Observation on 02/24/26 at 5:33 A.M. showed the call light in room [ROOM NUMBER] was on for 15 minutes. There was no audible indication to alert staff the call light was on outside the room on the west hall. Observation on 02/24/26 at 5:37 A.M. showed the call light in room [ROOM NUMBER] was on for 11 minutes. There was no audible indication to alert staff call light was on in the middle of the central hall. Observation on 02/24/26 at 6:07 A.M., showed a call light on above the door for room [ROOM NUMBER]. There was no audible sound heard at the resident's room to indicate a call light was on the hall. Observation on 02/24/26 at 12:03 P.M., showed the call light in room [ROOM NUMBER] was on for 10 minutes. There was no audible indication to alert staff the call light was on the central hall. 2. Review of Resident #25's undated Face Sheet showed the resident had diagnoses of stroke, hemiplegia (severe or total paralysis affecting one side of the body, caused by brain damage, stroke or injury) and hemiparesis (weakness, rather than complete paralysis, affecting one side of the body, commonly caused by a stroke) affecting the left non-dominant side, cellulitis (serious bacterial skin infection) of left lower limb, unspecified abnormalities of gait and mobility. Review of the resident's care plan, dated 02/04/26, showed the following: -Left sided weakness from stroke;-Always keep call light within reach;-Use call light for assistance;-Assist of one staff for ambulation with a quad cane;-Assist of one staff, gait belt, wheelchair or quad cane for transfers;-Assist of one staff for showers;-Assist of one to two staff to reposition;-Assist of one to two staff for dressing;-Assist of one to two staff for toileting and peri care afterwards. Review of the resident's Quarterly Minimum Data Set, (MDS, a federally mandated assessment instrument completed by facility staff) dated 02/05/26, showed the following: -Cognitively intact; -Lower extremity impairment in range of motion on one side; -Upper extremity impairment in range of motion on one side; -Required partial/moderate assistance of staff with toileting hygiene, personal hygiene; rolling side to side, sit to lying, lying to sitting;-Required substantial/maximum assistance of staff with dressing, shower transfers and showers;-He/She used a wheelchair;-Frequently incontinent of (continued on next page)

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	bladder; -Occasionally incontinent of bowel; During an interview on 02/23/26 at 12:00 P.M. and 02/24/26 at 6:25 A.M. and 1:30 P.M., the resident said the following:-Call lights take a long time to be answered;-It took 30 minutes or longer at night and early morning;-Call light response time depended on who was working. He/She has had to wait 45 minutes for staff to assist him/her in the bathroom;-Staff were just slow to answer the call lights. Review of the facility call light log report for the resident's room, dated 02/19/26 through 02/22/26 showed the following:-On 02/19/26 at 5:26 A.M. the resident's call light was on for 24 minutes;-On 2/19/26 at 9:38 P.M., the resident's call light was on for 35 minutes;-On 2/20/26 at 6:11 P.M., the resident's call light was on for 27 minutes;-On 2/21/26 at 6:35 P.M., the resident's call light was on for 19 minutes;-On 2/22/26 at 8:33 A.M., the resident's call light was on for 19 minutes;-On 2/22/26 at 9:34 P.M., the resident's call light was on for 24 minutes. 3. Review of Resident #9's admission MDS, dated [DATE], showed the resident was cognitively intact, had limited range of motion in one upper extremity, used a cane, and required partial/moderate assistance from staff to shower/bathe. During an interview on 02/23/26 at 11:23 A.M., the resident said, If you press your call light at 12:00 A.M. forget it, don't bother, they don't come for a long time. The resident said he/she had never timed it, but it took forever for staff to respond to the call light. During the day, staff usually answered the call light pretty timely, but during the evenings and nights, especially in the middle of the night, you can't get help if you try, so he/she tried to make sure he/she went to the bathroom before night shift. After supper was another time, he/she had just given up and taken himself/herself to the bathroom even though he/she was supposed to wait for help, so he/she didn't fall. Review of the facility call light log report for the resident's room, dated 02/19/26 through 02/22/26, showed the following:-On 02/22/26 at 10:58 A.M., the resident's call light was on for 23 minutes; -On 02/22/26 at 5:53 P.M., the resident's call light was on for 47 minutes. 4. Review of Resident #20's annual MDS, dated [DATE], showed the resident was cognitively intact. The resident was dependent on staff for toileting hygiene, transfers and bed mobility. The resident was frequently incontinent of bowel and bladder. During the resident group interview on 02/24/26 at 1:30 P.M., the resident said he/she had to wait 30 minutes at times for staff to respond to his/her call light, and sometimes staff shut the light off and said they would be back but don't return. Review of the facility call light log report for the resident's room, dated 02/19/26 through 02/22/26, showed the following:-On 02/20/26, at 12:44 P.M., the resident's call light was on for 26 minutes;-On 02/20/26, at 6:57 P.M., the resident's call light was on for 30 minutes;-On 02/20/26, at 8:30 P.M., the resident's call light was on for 25 minutes;-On 02/21/26, at 12:44 P.M., the resident's call light was on for 31 minutes. 5. During an interview on 02/24/26 at 6:34 A.M., Certified Nurse Assistant (CNA) A said he/she worked on the night shift. Staff do not know if a call light was going off down on the other two halls unless they walk up to the nurse's desk to look down the hall and see if a light was on above the room door, or to hear the call light beep. The beep volume was so low, you could not hear it down the hall, especially if staff were doing rounds or were in a room. During an interview on 02/25/26 at 2:45 P.M., CNA N said he/she worked day shift, usually (6:00 A.M. to 2:30 P.M.). When a call light went off, it turned the light on above the room door, and there should be an audible sound at the nurse's desk. Sometimes people turn down the audible sound at the desk and then staff don't know if a light was on for the other halls unless staff walked up to the desk. During an interview on 02/25/26 at 9:32 A.M., the Administrator said the following:-The call light reports showed some call light times were too long;-She expected staff to ideally answer call lights within five minutes;-Unanswered call lights for 20 minutes were not acceptable;-The computer call light monitor at the nurses desk can be turned up and down;-Staff are not supposed to turn the volume down;-The audible system should be loud enough it can be heard down the halls, so staff know there was a resident needing help on another hall;-The audible system should also be loud enough it could be heard at the nurse's desk.

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F 0569 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify each resident of certain balances and convey resident funds upon discharge, eviction, or death. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to convey the remaining resident balance to the state or the probate jurisdiction administering the resident's estate within 30 days of death for one resident (Resident #43) and failed to return resident funds to two discharged residents (Residents #44 and #42), within five days following discharge. The facility census was 39. Review of the undated facility policy, Resident Funds - Cash on hand, showed the following:-Any cash, up to $50, on deposit with the facility is refunded to the resident, the resident representative, or the resident's estate, upon discharge, eviction, or death as applicable;-Policy Interpretation and Implementation: The resident's personal funds and a final accounting of funds are returned to the resident, the resident's representative or to the resident's estate (individual or probate jurisdiction per state law), as applicable, within 30 days from the date of the resident's death or eviction from the facility, or death. 1.Review of Resident #43's electronic medical record showed the resident expired on [DATE]. Observation of a petty cash envelope held in the business office, labeled for the resident, on [DATE] at 9:02 A.M., showed the resident had $28.29 in cash in the envelope. Review of the transaction log, held in the envelope, showed the resident had a balance of $28.29 in petty cash. The facility had not refunded the resident's representative the account balance within 30 days of the resident's death. 2. Review of Resident #44's electronic medical record showed the resident discharged home on [DATE]. Observation of a petty cash envelope held in the business office, labeled for the resident, on [DATE] at 9:02 A.M., showed the resident had $45.28 in cash in the envelope. Review of the transaction log, held in the envelope, showed the resident had a balance of $45.28 in petty cash. The facility had not refunded the resident the account balance within five days of the resident's discharge. 3. Review of Resident #42's electronic medical record showed the resident discharged home on [DATE]. Observation of a petty cash envelope held in the business office, labeled for the resident, on [DATE] at 9:02 A.M., showed the resident had $20.00 in cash in the envelope. Review of the transaction log, held in the envelope, showed the resident had a balance of $20.00 in petty cash. The facility had not refunded the resident the account balance within five days of the resident's discharge. 4. During an interview on [DATE] at 8:21 A.M., the Administrative Assistant said she became responsible for resident petty cash when she assumed her role in [DATE]. She was not aware of deadlines for returning resident money to a resident, a resident's responsible party or to the estate. During interview on [DATE] at 9:51 A.M., the Administrator said the following:-The facility had not returned the petty cash for Resident #42, #43 or #44 after they passed away or discharged ;-The facility was waiting for a family member for each of the residents to come to the facility to sign for the balance of petty cash;-The facility had not considered sending a check to each of these residents or resident representatives refunding them their petty cash balance;-She was not aware of the regulation deadlines for returning resident petty cash or resident funds.

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident when there is a significant change in condition **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to complete a significant change in status assessment (SCSA) Minimum Data Set (MDS), a federally mandated assessment instrument required to be completed by facility staff, for two residents (Residents #13 and #1), in a review of 13 sampled residents, within 14 days after the facility determined, or should have determined, there had been a significant change in the resident's physical or mental condition which had an impact on more than one area of the resident's health status and required interdisciplinary review and/or revision of the care plan. The facility census was 39. Review of the Long-Term Care Facility Resident Assessment Instrument (RAI) User's Manual, version 3.0 showed a significant change is a decline or (improvement) in a resident's status that:-Will not normally resolve itself without intervention by staff or by implementing standard disease-related clinical interventions and is not self-limiting;-Impacts more than one area of the resident's health status;-Requires interdisciplinary review and/or revision to the care plan;-The manual also showed a SCSA was appropriate if there was a consistent pattern of changes, with either two or more areas of decline, or two or more areas of (improvement). This may include two changes within a particular domain (e.g., two areas of activities of daily living (ADL) decline or (improvement));-Decline in two or more of the following: -Resident's decision-making ability has changed; -Presence of a resident mood item not previously reported by the resident or staff and/or an increase in the symptom frequency, increase in the number of areas where behavioral symptoms are coded as being present and/or the frequency of a symptom increases for items in Section E (Behavior); -Changes in frequency or severity of behavioral symptoms of dementia that indicate progression of the disease process since the last assessment; -Any decline in an activity of daily living (ADL) physical functioning area (e.g., self-care or mobility) (at least one) where a resident is newly coded as partial/moderate assistance, substantial/maximal assistance, dependent, resident refused, or the activity was not attempted since last assessment and does not reflect normal fluctuations in that individual's functioning;-Resident's incontinence pattern changes or there was placement of an indwelling catheter; -Emergence of unplanned weight loss problem (5% change in 30 days or 10% change in 180 days); -Emergence of a condition/disease in which a resident is judged to be unstable;-Improvement in two or more of the following: -Any (improvement) in an ADL physical functioning area (at least one) where a resident is newly coded as independent, setup or clean-up assistance, or supervision or touching assistance since last assessment and does not reflect normal fluctuations in that individual's functioning.During an interview on 02/26/26 at 10:30 A.M., the Administrator said the facility did not have a specific policy related to significant change MDSs. The facility staff would follow the RAI manual.1. Review of Resident #13's annual Minimum Data Set (MDS), a federally mandated assessment completed by staff, dated 08/26/25, showed the following:-Impaired vision, can see large print, has corrective lenses;-Cognitively intact;-Diagnoses: stroke with hemiplegia (paralysis of one side of the body), anxiety, chronic respiratory disease, chronic kidney disease stage 4, endothelial corneal dystrophy (progressive, typically inherited, non-inflammatory disease where the innermost layer of the cornea (endothelium) fails. These cells stop pumping out excess fluid, leading to corneal swelling, thickening, and, eventually, cloudy vision, glare, and discomfort, especially in the morning, chronic pain syndrome, irregular heartbeat, stroke, left foot drop;-Mild depression symptoms;-No behaviors or rejection of care;-Independent with oral hygiene, roll left and right, sit to lying, lying to sitting on side of bed, and wheelchair mobility 150 feet;-Set up or clean up assistance from staff for eating, and upper body dressing,-Requires supervision/touching assistance from staff members for toileting hygiene, sit to stand, chair/bed-to-chair transfer, and toilet transfers;-Requires partial/moderate assistance from staff for shower/bathe, personal hygiene, and tub/shower transfer,-Occasionally incontinent of bowel and bladder;-Pain meds as needed (PRN);-Pain frequently, effects sleep rarely, limited day to day (continued on next page)

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	activities frequently, mild pain, -Weighs 124 pounds (lbs.);-No pressure wounds;-No significant weight loss;-No antipsychotic medication. Review of the resident's quarterly MDS, dated [DATE], showed the following:-New diagnosis of pneumonia;-No signs or symptoms of depression (improvement);-Pain frequently effects sleep (decline);-Rates pain a five on a scale of 0 to 10 where 10 is the worst pain;-Weighs126 lbs. Review of the resident's Physician's Orders, dated 02/22/26, showed a new treatment order for the resident's right gluteal crevice: cleanse the site using 2 centimeter (cm) x 2 cm gauze and normal saline, pat dry and apply calcium alginate (highly absorbent dressing for draining wounds) to the wound bed and cover with a border dressing. Change daily or as needed for soiling. Review of the resident's Nurses Notes, dated 02/22/26 at 5:31 P.M., showed staff documented the following:-Wound is located on the upper portion of the right gluteal crevice;-The area is oval shaped with regular edges;-The wound has yellow slough (dead, necrotic tissue) to the wound bed, there is no depth (unstageable pressure ulcer);-The peri wound (area around wound) has mild maceration (white skin from prolonged moisture) and erythema (reddening);-The resident does report mild pain to the site;-The resident has limited mobility; he/she was wheelchair bound and since recent illness is incontinent of bowel and bladder. Review of the resident's quarterly MDS, dated [DATE], showed the following:-Cognitively intact;-Diagnosis, new dementia (decline);-Other behaviors one to three days (decline);-Rejection of care one to three days (decline);-Wandering one to three days (decline); -Set up or clean up assistance from staff for oral hygiene (decline);-Requires partial/moderate assistance from staff for toileting hygiene (decline), upper body dressing (decline), roll left and right (decline), sit to lying (decline), lying to sitting on side of bed (decline), sit to stand (decline), chair/bed-to-chair transfer (decline), and toilet transfer (decline);-Pain frequently, effects sleep frequently, occasionally effects day to day activities (decline);-Rates his/her pain a five (on a 00-10 scale with 10 being worst pain);-Weight 119 lbs.;-Significant weight loss not on physician prescribed weight loss (decline);-New antipsychotic medication, taken routinely;The resident had a pressure ulcer that is not coded that had been found on 02/22/26. Observation on 02/25/26 at 8:52 A.M., showed the following:-The resident was in the shower room being assisted to a standing position by Certified Nurse Assistant (CNA) I;-Observation showed an open wound to the resident's right side of his/her tailbone; the open area was bleeding with red granulated tissue exposed (Stage III pressure ulcer);-Licensed Practical Nurse (LPN) E measured the open area and said the wound measured 0.5 cm in length and 0.4 cm in width and was open just past the dermis, so not enough depth to measure. Staff did not complete a comprehensive Significant Change in Status Assessment after the resident had a new diagnosis of dementia, a decline in several Activities of Daily Living (ADL's), weight loss, new pressure ulcer, new antipsychotic pain medication, and increase in pain and new behaviors.2. Review of Resident #1's annual MDS, dated [DATE], showed the following:-Cognition moderately impaired; -Acute change in mental status from baseline;-Walker and wheelchair use;-Requires supervision/touching assistance from staff members for oral hygiene,-Requires partial/moderate assistance from staff for personal hygiene, roll left and right, wheel 50 feet with two turns, and wheel 150 feet;-Requires substantial/maximal assistance from staff for toileting hygiene, shower/bathe, upper body dressing, lower body dressing, putting on/taking off footwear, sit to lying, lying to sitting on side of bed, sit to stand, chair/bed-to-chair transfer, toilet transfer, and tub/shower transfer;-Frequently incontinent of bowel and bladder;-Diagnoses include heart failure, high blood pressure, diabetes mellitus (inability to regulate blood sugar), chronic obstructive pulmonary disease (respiratory illness), chronic kidney disease stage 3, hypoxemia (oxygen levels low in arterial blood), pulmonary embolism (blood clot to the lungs), cognitive communication deficit, -Risk of pressure ulcers;-One unhealed Stage II pressure ulcer (a partial-thickness skin injury with exposed dermis). Review of the resident's quarterly MDS, dated [DATE], showed the following:-Cognitively intact (improvement);-New physical and verbal behaviors directed towards others one to three days (decline);-Rejection of care one to three days;-Wheelchair (no walker use-decline);-Independent with roll left and right (improvement), sit to lying (improvement), lying to sitting on side of bed (improvement), sit to stand (improvement),-Set up (continued on next page)

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	or clean up assistance from staff for oral hygiene (improvement)-Requires supervision/touching assistance from staff members for chair/bed-to-chair transfer (improvement), toilet transfer (improvement), tub/shower transfer (improvement),-Requires partial/moderate assistance from staff for toileting hygiene (improvement), upper body dressing (improvement), lower body dressing (improvement), putting on/taking off footwear(improvement), -Dependent on staff to wheel 50 feet with two turns (decline), and wheel 150 feet (decline);-Occasionally incontinent of bowel (improvement);-New diagnoses of pneumonia and urinary tract infection;-Pressure ulcer healed (improvement). The facility staff failed to complete a Significant Change in Status Assessment after several improvements in ADL's and cognition and decline in mobility and behaviors. Review of the resident's quarterly MDS, dated [DATE], showed the following:-Cognitively intact;-Verbal behaviors one to three days;-Rejection of care one to three days;-Wheelchair (no walker use-decline);-Requires supervision/touching assistance from staff members for oral hygiene (decline), toileting hygiene (improvement), -Requires partial/moderate assistance from staff for shower/bathe (improvement), sit to stand (decline), chair/bed-to-chair transfer (decline), toilet transfer (decline);-No scheduled pain meds, did receive PRN (as needed) pain medication- or offered and declined;-Pain is present, occasionally, rarely effects sleep, occasionally effects day-to-day activities-Rates pain at a five on 0-10 scale. The facility staff failed to complete a Significant Change in Status Assessment after several changes in ADL's and cognition, and decline in mobility, pain, and behaviors. 3. During an interview on 03/10/26 at 11:56 A.M., the MDS Coordinator said the following:-She was new to the position; she started in September;-She tried to follow the RAI manual to complete the MDS's but does not know everything in the manual yet;-She did not know that a SCSA should be completed when a resident improves, so for Resident #1, she did not know that would trigger a SCSA;-With Resident #13, the resident had been sick and did not bounce back, but he/she didn't know to do a SCSA if a resident did not return to the same level of function within 14 days;-She did not code the wound on the last MDS for Resident #13 because the documentation did not say what the wound was, just that it was open.

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to maintain a copy of the Pre-admission Screening and Resident Review (PASARR) Level II assessment for one resident (Resident #5), in a sample of two residents with mental illness. The facility also failed to take information and recommendations on the resident's Level II PASARR and incorporate the information into the resident's care plan, and assessment data to adequately meet the resident's needs. The facility census was 39. Review of the facility's policy admission Criteria, undated, showed the following:-All new admissions and readmissions are screened for mental disorders (MD), intellectual disabilities (ID) or related disorders (RD) per the Medicaid Pre-admission Screening and Resident Review (PASARR) process;-The facility conducts a Level I PASARR screen for all potential admissions, regardless of payer source, to determine if the individual meets the criteria for a MD, ID or RD; -If the level I screen indicates that the individual may meet the criteria for a MD, ID, or RD, he or she is referred to the state PASARR representative for the Level II (evaluation and determination) screening process;-The admitting nurse notifies the social services department when a resident is identified as having a possible (or evident) MD, ID or RD; -The social worker is responsible for making referrals to the appropriate state-designated authority;--Upon completion of the Level II evaluation, the state PASARR representative determines if the individual has a physical or mental condition, what specialized or rehabilitative services he or she needs, and whether placement in the facility is appropriate;-The state PASARR representative provides a copy of the report to the facility;-The interdisciplinary team determines whether the facility can meet the needs and services of the potential resident that are outlined in the evaluation;-Once a decision is made, the state PASARR representative, the potential resident and his or her representative are notified. During an interview on 02/26/26 at 1:30 P.M., the Administrator said the facility did not have another policy on use or retention of the PASARR. 1. Review of Resident #5's medical record showed no documentation of a Level II PASRR assessment. State Agency (SA) staff contacted Central Office Medical Review Unit (COMRU) for the resident's PASRR Level II assessment. (COMRU sent SA staff the resident's PASRR Level II assessment) Review of the resident's PASRR, dated 08/19/2015, showed the following:-Diagnoses include Alzheimer's dementia, major depressive disorder, intellectual disability, convulsions and epilepsy (seizure disorder);-The resident had a brain injury after stuffing corn up his/her nose, and the corn being left there for an extended period, the intellectual disability occurred after brain surgery in 1951 (age 4);-He/She never attended school and never worked;-He/She speaks very little/short answers and at times hollers out, but speech is garbled;-Oriented to person and confused;-Coherent, poor concentration, poor judgment and poor insight;-Does not make good decisions, follow simple directions, follow complex directions, stay on task, but can express some needs/wants;-Resident is childlike;-Resident needs structured socialization activities to diminish toward isolation and withdrawal, physician services, medically related social services, dietary services;-This assessment was completed at this facility. Review of the resident's annual Minimum Data Set (MDS), a federally mandated assessment completed by staff, dated 11/11/25, showed the following:-PASARR II based on intellectual disability;-Unclear speech, mumbled words;-Severe cognitive impairment; -No behaviors or rejection of care;-Diagnoses include dementia, Alzheimer's, seizure disorder, depression, panic disorder, profound intellectual disabilities, -Received antipsychotic, antidepressant, opioid, and anticonvulsant medication;-Gradual dose reduction attempted 04/11/25 and physician documented clinically contraindicated on 04/10/25. Review of the resident's quarterly MDS, dated [DATE], showed this review had new verbal behaviors directed towards others daily and other behaviors not directed towards others daily. Review of the resident's record showed no documentation of a PASARR. Review of the resident's Care Plan, dated 01/26/26, showed the resident's care plan did not (continued on next page)

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	265763	A. Building B. Wing	02/26/2026

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Knox County Nursing Home District	55774 State Highway 6 Edina, MO 63537

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	have any information from his/her PASARR. During an interview on 02/25/26 at 3:15 P.M., the Social Services Director (SSD) said the following:-She was responsible for submitting the Level I and Level II PASARR;-She was not sure what was on a Level II PASARR;-She knew the resident had one, but was not aware the facility did not have a copy of the resident's PASSAR;-She did not know that someone needed to review the level II PASARR.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities Based on interview and record review, the facility failed to conduct a Level 1 Pre-admission Screening and Resident Review (PASARR) screening for one resident (Resident #27) in a review of two sampled residents with mental illness. The facility census was 39. Review of the undated facility policy, admission Criteria, showed the following:-All new admissions and readmissions are screened for mental disorders (MD), intellectual disabilities (ID) or related disorders (RD) per the Medicaid PASARR process;-The facility conducts a Level I PASARR screen for all potential admissions, regardless of payer source, to determine if the individual meets the criteria for a MD, ID or RD.;If the level I screen indicates that the individual may meet the criteria for a MD, ID, or RD, he or she is referred to the state PASARR representative for the Level II (evaluation and determination) screening process;The admitting nurse notifies the social services department when a resident is identified as having a possible (or evident) MD, ID or RD.;The social worker is responsible for making referrals to the appropriate state-designated authority;Upon completion of the Level II evaluation, the state PASARR representative determines if the individual has a physical or mental condition, what specialized or rehabilitative services he or she needs, and whether placement in the facility is appropriate;The state PASARR representative provides a copy of the report to the facility;The interdisciplinary team determines whether the facility can meet the needs and services of the potential resident that are outlined in the evaluation;Once a decision is made, the state PASARR representative, the potential resident and his or her representative are notified. 1. Review of Resident #27's undated face sheet showed the following:-admission date 08/18/23;-His/Her diagnoses included major depressive disorder (a serious mental health condition characterized by persistent sadness, loss of interest in activities and low energy lasting at least two weeks) and borderline personality disorder (a serious, long-term mental health condition marked by extreme instability in moods, self-image, behavior, and relationships.) Review of the resident's electronic health record (EHR) showed no documentation of a completed Level 1 PASARR. Review of the resident's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument, dated 02/17/26, showed no documentation a PASARR had been completed. During an interview on 02/25/26 at 3:15 P.M., the Social Services Director (SSD) said the following:-She was responsible for submitting the Level 1 PASARR;-She was not aware a Level 1 submission had to be completed on all admissions;-She thought Level 1 PASARR submissions only had to be completed on Medicaid residents (not on private pay residents).

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. Based on observation, interview and record review, the facility failed to follow their policy on assessment of wounds and pressure ulcers (an injury to the skin and underlying tissue resulting from prolonged pressure on the skin), failed to adequately assess and identify a pressure ulcer, failed to stage (measure the severity of damage caused by unrelieved pressure) a pressure ulcer correctly, failed to initiate interventions to prevent a pressure ulcer from worsening and failed to re-evaluate and attempt new interventions for one resident's (Resident #25) pressure ulcer, in a review of two resident's with pressure ulcers. The facility identified Resident #25's wound as a skin tear (separation of skin layers, often leaving a skin flap) when it was a deep tissue injury (pressure ulcer caused from prolonged pressure, damaging underlying tissue, leaving skin intact but discolored) that evolved to an unstageable pressure injury and then a Stage II pressure ulcer and failed to further evaluate and put interventions into place to prevent the resident's wheelchair cushion from causing pressure to his/her posterior left knee, causing the worsening of the wound which also required an antibiotic after the wound became infected. The facility census was 39. Review of the facility policy, Pressure Injuries Overview, last revised 06/08/23, showed the following: -The purpose of this procedure is to provide information regarding definitions and clinical features of pressure injuries; -Pressure Ulcer/Injury (PU/PI) refers to localized damage to the skin and/or underlying soft tissue usually over a bony prominence or related to a medical or other devices; -A pressure injury will present as intact skin and may be painful; -A pressure ulcer will present as an open ulcer, the appearance of which will vary depending on the stage and may be painful; -Pressure ulcer/injuries occur as a result of intense and/or prolonged pressure or pressure in combination with shear; -Avoidable means that the resident developed a pressure ulcer/injury and that one or more of the following was not completed; 1. Evaluation of the resident's clinical condition and risk factors; 2. Definition or implementation of interventions that are consistent with resident needs, resident goals, and professional standards of practice; 3. Monitoring or evaluation of the impact of the interventions; 4. Revision of the interventions as appropriate; -Staging (National Pressure Injury Advisory Panel Classification System): -Stage 1 Pressure Injury: Non-blanchable erythema of intact skin;-Intact skin with a localized area of non-blanchable erythema (redness), which may appear differently in darkly pigmented skin; -Presence of blanchable erythema or changes in sensation, temperature, or firmness may precede visual changes; -Color changes do not include purple or maroon discoloration; these may indicate deep tissue pressure injury;-Stage 2 Pressure Injury: Partial-thickness skin loss with exposed dermis; -Partial-thickness loss of skin with exposed dermis (the thick, middle layer of skin);-The wound bed is viable (the ability to live, grow and develop successfully), pink or red, moist, and may also present as an intact or ruptured serum-intact blister; -Adipose (fat) is not visible and deeper tissues are not viable; -Granulation tissue (connective tissue that forms at the base of wounds during the phase of healing), slough (non-viable tissue) and eschar (dead tissue) are not present; -This stage should not be used to describe moisture-associated skin damage including continence-associated dermatitis, intertriginous dermatitis, medical adhesive-related skin injury, or traumatic wounds (skin tears, burns, abrasions). Stage 3 Pressure Injury: Full-thickness skin loss; -Full-thickness loss of skin, in which adipose is visible in the ulcer and granulation tissue and epibole (rolled wound edges) are often present; -Deep Tissue Pressure Injury (DTPI): Persistent, non-blanchable, deep red, maroon or purple discoloration;-This injury results from intense and/or prolonged pressure and shear forces at the bone-muscle interface. Review of the facility policy, Prevention of Pressure Injuries, last revised 06/28/23, showed the following: -The purpose of this procedure is to provide information regarding identification of pressure injury risk factors and interventions for specific risks; -Review the residents' care plan and identify the risk factors as well as the interventions designed to reduce or eliminate those considered modifiable; -Assess the resident on admission (within eight hours) for existing pressure injury risk factors. Repeat the risk (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	assessment weekly and upon any changes in condition; Use a standardized pressure injury screening tool to determine and document risk factors; -Supplement the use of a risk assessment tool with assessment of additional risk factors; -During the skin assessment, inspect the presence of erythema, temperature of skin and soft tissue and edema; -Inspect the skin daily when performing or assisting with personal care or ADLs; -Teach residents who can change positions independently the importance of repositioning. Provide support devices and assistance as needed. Remind and encourage residents to change positions; -Select appropriate support surfaces based the resident's risk factors, in accordance with current clinical practice; -Review and select medical devices with consideration to the ability to minimize tissue damage, including size, shape, its application and ability to secure the device; -Monitor regularly for comfort and signs of pressure related injury; -For prevention measures associated with specific devices, consult current clinical practice guidelines; -Evaluate, report, and document potential changes in the skin; -Review the interventions and strategies for effectiveness on an ongoing basis. 1. Review of NPUAP (National Pressure Ulcer Advisory Panel) guidelines, dated September 2016, showed the following definitions: -Stage I pressure ulcer is intact skin with localized area of non-blanchable (when you press on the area of redness the redness does not go away) erythema (redness). Presence of blanchable erythema changes in sensation, temperature, or firmness may precede visual changes; -Stage II pressure ulcer is a partial-thickness loss of skin with exposed dermis (the thick layer of living tissue below the top layer of skin that forms the true skin). The wound bed is viable, visible and deeper tissue are not visible. Granulation tissue (new connective tissue), slough (dead tissue in the process of separating from the body, which is usually light colored, soft, moist, or stringy), and eschar (dead tissue that sheds or falls off from health skin) are not present; -Stage III pressure ulcer is a full thickness loss of skin, where adipose (fat) is visible in the ulcer and granulation tissue and rolled wound edges are often present. Slough and eschar may be visible, but do not obscure the extent of tissue loss. The depth of tissue damage varies by the location on the body. Undermining and tunneling may occur. Fascia (a thin sheath of fibrous tissue), muscle, tendon, ligament, cartilage or bone are not exposed; -Stage IV pressure ulcer is a full-thickness skin and tissue loss with exposed or directly palpable fascia, muscle, tendon, ligament, cartilage or bone in the ulcer. Slough and or eschar may be visible, but do not obscure the extent of tissue loss. Rolled edges, undermining and or tunneling often occur. Depth varies by location; -Unstageable pressure ulcer is a full thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because it is obscured by slough or eschar; -Deep Tissue Pressure Injury is an intact or non-intact skin with localized area of persistent non-intact skin with localized area of persistent non-blanchable deep red, maroon, purple discoloration or epidermal separation revealing a dark wound bed or blood-filled blister. This injury results from intense and/or prolonged pressure and shear forces at the bone-muscle interface. The wound may evolve rapidly to reveal the actual extent of tissue injury or may resolve without tissue loss. If necrotic tissue, subcutaneous tissue, granulation tissue, fascia, muscle, or other underlying structures are visible, this indicates a full thickness pressure ulcer (unstageable, Stage III or Stage IV pressure ulcer). 2. Review of the facility Roster Matrix (a document used by skilled nursing facilities to list all current residents and track their care needs), completed by staff, showed Resident #25 had a Stage II pressure ulcer. 4. Review of Resident #25's Face Sheet showed the resident had diagnoses of stroke, hemiplegia (severe or total paralysis affecting one side of the body, caused by brain damage, stroke or injury) and hemiparesis (weakness, rather than complete paralysis, affecting one side of the body, commonly caused by a stroke) affecting left non-dominant side, cellulitis (serious bacterial skin infection) of left lower limb, unspecified abnormalities of gait and mobility. Review of the resident's care plan, dated 03/24/22, showed the following:-At risk for pressure ulcers;-Daily observation of skin with routine care;-Monitor, encourage, and assist with repositioning every two to four hours;-Need full skin evaluation weekly with shower and as needed;-Place pressure-reducing mattress on my bed and cushion in my wheelchair to decrease pressure;-Report any redness or skin (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	breakdown to charge nurse and physician. Review of the resident's Physician's Orders, dated November 2023, showed an order for weekly skin assessments with special instructions to include any skin issues, rash, bruise, skin tear, open areas, discoloration, edema, etc.; order date of 11/17/23. Review of the resident's progress notes, dated 11/27/25 at 6:50 A.M., showed the Certified Nurse Assistant (CNA) was giving the resident a shower this morning and found an open area to his/her the resident's left posterior (the back of) knee fold. This nurse assessed the area, resident reported that it happened last night when staff removed his/her Opti foam (dressing designed for advanced wound care and pressure injury prevention) patch. Resident had obtained a 1 centimeter (cm) by 0.3-centimeter skin tear to his/her left posterior knee fold. This nurse cleansed the area with wound wash, skin prep (a waterproof skin barrier used to protect intact skin) applied to peri wound (skin area beyond the wound edge), triple antibiotic ointment (TAO) and covered with a non-adherent bandage. Called the resident's Nurse Practitioner (NP), informed him/her of the area and new treatment orders received (as applied). Change daily and as needed.Review of the resident's wound management detail report, dated 11/27/25 at 6:59 A.M., showed the following:-Wound type- skin tear;-Wound location- left posterior knee fold;-Wound measurements- 1.0 cm x 0.3 cm, total flap loss: entire wound bed is exposed;-Color of alteration in skin- pink;-No exudate (drainage) present;-Wound healing status- stable. Review of the resident's care plan showed no documentation of a review or update after discovery of the wound.Review of the resident's weekly skin assessment, dated 12/01/25, showed skin intact, no action needed, documented by Licensed Practical Nurse (LPN) E, indicating the area was healed. Review of the resident's progress notes, dated 12/05/25 at 12:17 P.M., showed the resident's NP saw the resident, per resident request, to look at the back of his/her left leg where his/her chair and cushion have rubbed. Review of the resident's medical record showed no evidence staff completed a risk assessment per facility policy, that the resident's wheelchair or cushion had been examined for root cause or evaluation/adjustment or that the resident's care plan had been updated with new interventions.Review of the resident's weekly skin assessments, dated 12/8/25, 12/15/25 and 12/22/25, showed skin intact, no action needed, documented by LPN E.Review of the resident's progress notes dated 12/29/25 at 7:21 A.M, documented by LPN E, showed CNA reported area behind left knee was open, this nurse assessed area to find that old area has reopened, measured 1 cm by 0.7cm by 0.2 cm depth. Called the resident's NP and informed. New orders received, apply Calmoseptine (moisture barrier) to peri wound and collagen with silver (wound care product for chronic or infected wounds) to wound bed, cover with Opti foam and change daily and PRN. Review of the resident's wound management detail report, dated 12/29/26 at 7:29 A.M., showed the following:-Wound type- skin tear;-Wound location- left posterior knee fold;-Wound measurements: 1.0 cm x 0.7 cm, total flap loss: entire wound bed was exposed;-Color of alteration in skin- pink;-No exudate present;-Wound healing status- declining. Review of the resident's medical record showed no evidence of staff completing a risk assessment per facility policy, a root cause or evaluation had been conducted to determine why the area had reopened, or the resident's care plan had been updated with the new wound or new interventions.Review of the resident's weekly skin assessment, dated 12/29/25, showed the resident had an open area to his/her left knee fold, no documentation under any action needed, documented by LPN E. Review of the resident's wound management detail report, dated 12/31/25 at 10:37 A.M., showed the following:-Wound type- skin tear;-Wound location- left posterior knee fold;-Wound measurements- 1.0cm x 0.5cm, total flap loss: entire wound bed was exposed;-Color of alteration in skin- pink;-No exudate present;-Wound healing status- stable. Review of the resident's weekly skin assessment, dated 01/05/26, showed skin intact, no action needed, documented by LPN E, indicating the area was healed.Review of the resident's wound management detail report, dated 01/08/26 at 11:20 A.M., showed the following:-Wound type- skin tear;-Wound location- left posterior knee fold;-Wound measurements- 0.5cm x 0.5cm, total flap loss: entire wound bed was exposed;-Color of alteration in skin- pink;-No exudate present;-Wound healing status- stable. Review of the resident's weekly skin assessment, dated 01/12/26, showed the resident had a skin (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	tear to his/her left knee; already treating per wound orders, documented by LPN M. Review of the resident's medical record showed no evidence staff completed a risk assessment with the change in condition to the area behind the resident's left knee. There was no documentation of a root cause or evaluation had been conducted to determine why the area had reopened.Review of the resident's care plan, last revised 01/16/26, showed the following: -The resident has a wound on the posterior of his/her left knee; -Assess condition of surrounding skin. Report emergence of skin excoriation; -Assess location, size (length, width, and depth), presence/absence of granulation tissue and epithelization of wound and chart it under wound; -Observe and report signs of localized infection (e.g., localized pain, redness, swelling, tenderness, loss of function, heat at the infected area). Report to charge nurse/physician; -Perform dressing change per physician order; -Position for comfort with physical support as necessary;-Record the amount, type, consistency, color, and odor of drainage from the wound; -The care plan did not address pressure caused by the resident's wheelchair cushion to the area of the wound. Review of the resident's weekly skin assessment, dated 01/19/26, showed the resident had an open area to his/her left knee fold; actions- barrier cream, offload, Opti foam; documented by LPN E. Review of the resident's wound management detail report, dated 01/22/26 at 1:58 P.M., showed the following:-Wound type- skin tear;-Wound location- left posterior knee fold;-Wound measurements- 1.0 cm x 0.5 cm, total flap loss: entire wound bed is exposed;-Color of alteration in skin- pink;-No exudate present;-Wound healing status- stable. Review of the resident's medical record showed no evidence staff completed a risk assessment with the change in condition to the area behind the resident's left knee and no documentation staff made the DON or NP aware of the worsening wound. Review of the resident's weekly skin assessment, dated 01/26/26, showed skin intact, no action needed, documented by LPN E, indicating the area was healed.Review of the resident's weekly skin assessment, dated 02/02/26, showed the resident had an open area to his/her left knee fold; actions-nothing noted; documented by LPN E.Review of the resident's medical record showed no evidence staff completed a risk assessment with the change in condition to the area behind the resident's left knee. There was no documentation staff determined a root cause or staff completed an evaluation to determine why the area had reopened. There was no documentation staff updated the resident's care with new interventions and no documentation of an assessment of surrounding wound skin to include the size (length, width, and depth), presence/absence of granulation tissue and epithelization of wound charted under wound section of the electronic medical record, as directed by the resident's care plan and no documentation the DON or NP were made aware. Review of the resident's Quarterly Minimum Data Set (MDS), a federally mandated assessment instrument, completed by facility staff, dated 02/05/26, showed the following: -Cognitively intact; -Lower extremity impairment in range of motion on one side; -Upper extremity impairment in range of motion on one side; -Required partial/moderate assistance for toileting hygiene, personal hygiene, sit to lying, lying to sitting;-Required substantial/maximal assistance for dressing, shower transfers and showers; -Required supervision for sit to stand, toilet transfers, and walking; -Pressure ulcer not documented; -Skin tear documented; -Pressure reducing device for chair; -Application of ointments/medications other than to feet; -Application of non-surgical dressing other than to feet. Review of the resident's weekly skin assessment, dated 02/09/26, showed the resident had an open area to his/her left knee fold; actions included barrier cream and offload; documented by LPN E.Review of the resident's wound management detail report, dated 02/12/26 at 11:25 A.M., showed the following:-Wound type- skin tear;-Wound location- left posterior knee fold;-Wound measurements- 0.5cm x 1.0cm, total flap loss: entire wound bed exposed;-Color of alteration in skin- red (change in condition of the wound);-No exudate present;-Wound healing status- stable. Review of the resident's medical record showed no documentation staff completed a risk assessment with the change in condition to the area behind the resident's left knee.Review of the resident's progress notes, dated 02/16/26 at 6:12 A.M., showed staff informed the resident's NP of wound changes and measurements, new orders given for calcium alginate with silver to replace the collagen. Review of (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the resident's weekly skin assessment, dated 02/16/26, showed the resident had a skin tear to his/her left knee fold; no actions noted, documented by LPN E.Review of the resident's medical record showed no documentation of an assessment of surrounding wound skin to include the size (length, width, and depth), presence/absence of granulation tissue and epithelization of wound charted under wound section of the electronic medical record, as directed by the resident's care plan. Review of the resident's Physician's Orders, dated February 2026, showed an order to measure the resident's skin tear weekly on Thursday, order date of 02/19/26. Review of the resident's medical record showed no evidence staff measured the resident's skin tear as ordered on 02/19/26. Review of the resident's weekly skin assessment, dated 02/23/26, showed the resident had a skin tear on the back of his/her left knee fold; action- barrier cream and offload, documented by LPN E. Review of the resident's medical record showed no documentation of an assessment of surrounding wound skin to include the size (length, width, and depth), presence/absence of granulation tissue and epithelization of wound charted under wound section of the electronic medical record, as directed by the resident's care plan. Review of the resident's progress notes, dated 02/24/26 at 2:25 P.M., showed the nurse called the resident's NP and reported purulent drainage (thick, often foul-smelling fluid that signals a likely wound infection) from the wound on the left knee fold, new orders given for Keflex (antibiotic) 500 milligrams (mg) twice daily (BID) for seven days. Observation on 02/24/26 at 6:25 A.M., showed the resident up in his/her wheelchair. The resident's left leg extended out without a pedal or leg rest for his/her foot to rest on; his/her posterior left leg rubbed the wheelchair cushion and edge of the wheelchair seat. Observation on 02/24/26 at 12:21 P.M., showed the resident in his/her wheelchair with his/her left leg extended, with direct pressure on the back of the left knee from the wheelchair cushion. There was no pedal or leg rest for the resident's foot or leg to rest on.Observation and interview on 02/25/26 at 9:00 A.M., showed the following: -LPN E performed a dressing change to the resident's left posterior thigh; -There was no skin tear to the left posterior knee;-There was a large deep purple area on the posterior side of the resident's left thigh. When LPN E applied fingertip pressure, the darkest areas did not turn white (indicating a deep tissue injury), the outer, lighter areas, were slow to blanch (blanching is when an area turns white with fingertip pressure and when pressure is released, a return of color, or blood flow, to the area occurs which demonstrates healthy perfusion of blood), with an open ulcer with red tissue;-LPN E applied calcium alginate to the open area, and Calmoseptine to the peri wound (purple area) and covered the wound with Opti foam;-LPN E said this was the area he/she has been identifying as a skin tear to the posterior left knee, it started as a skin tear and had evolved;-The reason he/she classified it as a skin tear was because when it opened the skin came off on the dressing. He/She did not know if the adhesive pulled the skin off or if the skin was dead because of pressure and came off with the dressing. During an interview on 02/24/26 at 6:25 A.M. and 02/25/26 at 9:10 A.M., the resident said the following: -He/She has a wound on the back of his/her left knee; -He/She has had the purple sore area, where his/her leg rubs on the cushion and seat of his/her wheelchair, for many months;-The wound was getting worse; -He/She needed a new cushion for his/her wheelchair because the current cushion rubbed on the back of his/her leg. He/She had complained about the cushion rubbing to someone but could not remember who or when; -He/She was told by someone that it was too soon to get a new cushion;-His/Her wheelchair caused the wound and sore area on the back of his/her leg because it rubbed all the time, causing constant pressure;-He/She had had his/her current wheelchair and cushion for about two to three years, no one had changed the cushion or leg rest; -The wound had opened in December;-He/She does not like the footrest that came with the chair; his/her leg does not bend at the knee and will not stay on the footrest properly;-The footrest does not extend or elevate, so his/her leg was suspended in the air, unsupported when he/she was in his/her chair, which put pressure on his/her wound;-It is very sore and has been for several months; -Therapy has not evaluated him/her for an appropriate foot/leg rest to elevate his/her leg to remove pressure or a different cushion for his/her wheelchair;-If staff could get him/her a leg rest to remove the pressure (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265763	A. Building B. Wing	02/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Knox County Nursing Home District	55774 State Highway 6 Edina, MO 63537

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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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and rubbing and get his/her leg healed, he/she would go dancing, it has been so sore for so long. 5. During an interview on 02/25/26 at 9:00 A.M., 9:10 A.M. and 2:20 P.M. and 03/11/26 at 11:10 A.M., LPN E said the following: -He/She was the wound nurse and had received on the job wound training;-The resident's left leg was paralyzed from a stroke, and it rubbed on the wheelchair because the resident could not bend his/her leg, and the resident did not have a footrest to support his/her leg;-The resident had a red area on the back of his/her left knee that was calloused from the wheelchair cushion rubbing his/her posterior knee; -The sore and calloused area has been there for several months;-Opti foam was used to the area and when staff removed the Opti foam, it caused a skin tear; -The pad and the seat on the chair put pressure on the back of his/her thigh where the deep purple area was located;-The wound on the left posterior knee measured 1.0 cm x 1.0 cm, and the open area was shiny and bright red; -The peri wound measured 7 cm x 5 cm, was dark purple in color and was slow to blanche, the darkest part did not blanche at all; -He/She had reported to the Nurse Practitioner months ago the posterior leg was hard and purple and obtained an order for Opti foam for cushioning and protection;-He/She had not contacted therapy, and was not sure if the wound was caused by pressure from the wheelchair or from friction;-With a new wound, the charge nurse should notify the DON who will assess the wound with him/her, then contact the NP who will evaluate the wound within 24 hours to stage the wound; -Interventions included dressing changes and encourage the resident to sit in recliner or lay in bed;-He/She did not know if the wound assessments or staging was documented anywhere, he/she was not allowed to stage wounds;-The MDS coordinator was responsible for completing the risk assessments. During an interview on 02/26/26 at 1:10 P.M., 03/09/26 at 2:40 P.M. and 3/12/26 at 9:02 A.M., the Director of Nurses (DON) said the following: -She felt the resident's wound was a pressure ulcer caused from the resident's leg rubbing on the edge of the wheelchair cushion and seat of the wheelchair;-She did wound assessments every Thursday with the charge nurse; if there was a new wound identified, she will assess the new wounds when notified by the charge nurse;-She knew the wheelchair was causing pressure and had just encouraged the resident to sit in his/her recliner.-Interventions for the resident's wound included dressing changes and encouraging the resident to sit in the recliner; -She had not reevaluated the resident's interventions;-The Nurse Practitioner (NP) does the wound staging. -The resident sits in the chair and cannot bend his/her knee and did not have a leg rest that would elevate to support his/her leg;-The only note she can see from the Nurse Practitioner was dated for 12/05/25;-She did not know how often the Nurse Practitioner has visualized the wound or when the last time she saw the wound. During an interview on 03/10/26 at 1:54 P.M., the Nurse Practitioner said the following:-She would consider the area on the resident a wound and not a skin tear;-She believed the pressure from the resident's leg against the cushion caused the wound;-She had ordered a new cushion, and it somehow fell through the cracks;-Elevated footrests or a cradle would be beneficial to alleviate the pressure;-She or the physician does the wound staging, a nurse can do it, but the facility likes her to do it;-She believed the wound was a Stage II pressure ulcer obtained at the facility.

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	265763	A. Building B. Wing	02/26/2026

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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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. Based on observation, interview and record review, the facility failed to ensure one resident (Resident #12), in a review of two sampled residents who received insulin injections, were free from significant medication errors. Staff failed to prime (remove the air from the needle and cartridge) the resident's Humalog insulin pen (prefilled pen of rapid acting insulin (medication injected under the skin used to treat diabetes) and Lantus insulin pen (prefilled pen of long-acting insulin) needle, as instructed by the manufacturer, during the preparation of the medication, potentially affecting the amount of insulin dispensed with each dose. Further observation showed staff did not hold the insulin pen against the resident's skin after the administrations for the manufacturer's suggested time to ensure the proper dose was administered. The facility census was 39. Review of the facility policy, Insulin Administration, dated 11/15/23, showed the following:-Purpose: To provide guidelines for the safe administration of insulin to residents with diabetes;-Nursing staff will have access to specific instructions (from the manufacturer if appropriate) on all forms of insulin delivery system(s) prior to their use;-The forms of insulin delivery include pens containing insulin cartridges to deliver insulin subcutaneously (under the skin) through a needle;-The policy did not direct how to prepare or administer insulin using a pen device. Review of the facility policy, Administering Medications, dated 06/09/23, showed the policy did not direct how to prepare or administer insulin using a pen device. 1. Review of the manufacturer instructions for the Humalog insulin pen administration showed the following:-Prime the Pen (Safety Check): Dial 2 units. Hold the pen with the needle up, tap it to bring air bubbles to the top, and push the knob in until 0 appears;-A stream of insulin must appear at the tip. Repeat up to four times if necessary to see a stream; -Turn the dial to the precise, prescribed unit count;-Insert the needle into the skin (abdomen, thigh, or upper arm), fully depress the knob, and hold for 5-10 seconds to ensure the full dose;-Remove the needle; minor fluid drops are typical. 2. Review of the manufacturer instructions for the Lantus insulin pen, for the steps to prepare and administer insulin showed the following:-Prime/Safety Test: Dial 2 units. With the needle pointing up, press the injection button until 0 appears and a drop of insulin is visible. Repeat if necessary; -Turn the dose selector to your required unit count.-Insert the needle into the skin (abdomen, thigh, or upper arm) at a 90-degree angle;-Press the injection button all the way down and hold it for a slow count of 10 to ensure the full dose is delivered;-Take the needle out of the skin. Use the outer cap to remove the needle from the pen and discard it in a sharps container. 3. Review of Resident #12's face sheet showed a diagnosis of diabetes mellitus (too much sugar in the blood stream). Review of the resident's February 2026 physician order sheet showed the following: -Humalog insulin, administer 20 units three times daily; -Humalog insulin, administer per sliding scale (a dose amount to be based on the result of a blood sugar check (finger stick procedure to determine the amount of sugar in the blood)), three times daily; for a blood sugar result of 201 to 250, administer six units;-Lantus insulin, administer 55 units subcutaneously twice daily. Observation on 02/24/2026 at 7:02 A.M., showed the following:-Licensed Practical Nurse (LPN) E performed the resident's blood sugar check and determined six units of sliding scale Humalog insulin needed to be prepared;-LPN E removed the resident's Humalog insulin pen and Lantus insulin pen from the medication cart,;-LPN E dialed up the 55 unit dose from the resident's Lantus insulin pen without priming the insulin pen;-LPN E dialed up 26 units of Humalog insulin from the insulin pen without priming the insulin pen; -LPN E administered the resident's Lantus insulin in his/her right abdomen and did not hold the pen in place for ten seconds;-LPN E administered the resident's Humalog in the resident's left abdomen and did not hold the pen in place for five to ten seconds. During an interview on 02/25/2026 at 1:46 P.M., LPN E said the following:-He/She had never been trained to prime insulin pens;-He/She had never been trained to hold the insulin pen against the resident's skin after the administration for any amount of time. During an interview on 02/25/2026 at 1:35 P.M., the administrator said she expected staff to prime insulin pens prior to dialing up the ordered dose and to hold the pen against the skin after the administration as the manufacturer's instructions instruct.