STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265773	A. Building B. Wing	02/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Worth County Convalescent Center	503 East Fourth Grant City, MO 64456

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to assure staff followed acceptable standards of practice for one sampled resident (Residents #4) of 12 sampled residents when facility licensed staff did not follow wound care orders correctly which placed the resident at risk for decline in physical health. The facility failed to ensure the setting on the low air loss mattress was correct for Resident #24. Additionally, the facility failed to ensure staff administered insulin correctly which affected three sampled residents (Resident #2, #7 and 11) of 12 sampled residents. The facility census was 33. The facility did not provide a policy for the Drive Low Air Loss Mattress (LAL mattress, is a therapeutic mattress designed to help prevent and treat pressure ulcers by controlling pressure and keeping the skin cool and dry). 1.Review of Resident #24's care plan dated 7/3/23 showed it did not address the use of a LAL mattress. Review of the resident's Quarterly MDS, dated [DATE] showed: - Cognitive skills severely impaired. - Dependent on staff assistance for toilet use, and showers. - Required substantial to maximum assistance with transfers. - Always incontinent of bowel and bladder. - Weight - 115 pounds. - At risk for pressure ulcers. No pressure ulcers noted. - Diagnoses included stroke, depression, anxiety and diabetes mellitus. Review of the resident's POS showed: - There was no order for a LAL mattress or for the settings. - Start date: 7/19/24 - Admit to Hospice. Observation on 2/23/26 at 10:55 A.M., showed the resident lay in bed with the LAL mattress pressure set on 350 pounds. (continued on next page)

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

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

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 2/24/26 at 12:57 P.M., showed the resident was not in bed, but the LAL mattress was pressure set on 350 pounds. Observation on 2/25/26 at 9:30 A.M. showed the resident lay in bed with the LAL mattress pressure set on 350 pounds. Observation on 2/26/26 at 7:24 A.M., showed the resident was not in bed, but the LAL mattress pressure set was set on 350 pounds. During an interview on 2/26/26 at 7:44 A.M., Licensed Practical Nurse (LPN) A said He/She did not know who was responsible to check the settings on the LAL mattress but thought it was probably housekeeping. During an interview on 2/26/26 at 8:57 A.M., the Administrator said if the resident was on Hospice, then Hospice should monitor to ensure the LAL mattress is on the correct setting. The facility did not provide a policy for the use of insulin pens. 2. Review of Resident #2's care plan, dated 7/7/22 showed the resident had Diabetes Mellitus as evidenced by increased blood sugar levels and need for insulin. Diabetes medication as ordered by the physician. Review of the resident's Quarterly MDS, dated [DATE] showed: - Cognitive skills for daily decision making intact. - Independent with eating, toilet use, showers, dressing and transfers. - Always continent of bowel and bladder. - Diagnosis included diabetes mellitus. Review of the resident's POS dated February 2026 showed: - Start date: 2/14/23 - Blood sugar per glucometer twice daily for diabetes mellitus. - Humalog insulin injection 12 units three times daily with meals for diabetes mellitus. Review of the resident's Medication Administration Record (MAR) dated February 2026 showed: - 2/25/26 - Blood sugar documented by staff as 184. - 2/25/26 - Staff documented Humalog insulin 12 units was administered. Observation on 2/25/26 at 6:40 A.M., showed: - The resident checked his/her blood sugar and reported to LPN A it was 184. - The Humalog insulin pen did not have a label to indicate which resident it belonged to and was (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	not dated when opened. - Unknown staff had handwritten the resident's first name and 12 u on the lid. - LPN A did not clean the port before he/she attached the needle and did not prime it with two units. - LPN A dialed the insulin pen to 12 units and administered it in his/her right arm. 3. Review of Resident #11's care plan dated 6/14/25 showed the resident had Diabetes Mellitus. Diabetes medication as ordered by the physician. Review of the resident's Quarterly MDS dated [DATE] showed: - Cognitive skills intact. - Supervision/touch assistance with dressing,, personal hygiene and transfers. - Independent with eating. - Occasionally incontinent of bowel and bladder. - Diagnosis included diabetes mellitus. Review of the resident's POS dated February 2026 showed: - Start date: 12/13/25 - Check blood sugars before meals and at bedtime related to diabetes mellitus. - Start date: 7/7/25 - Humalog insulin pen, 8 units three tines a day for diabetes mellitus. Review of the resident's MAR dated February 2026 showed: - 2/25/26 - Staff documented the blood sugar as 154. - 2/25/26 - Staff documented eight units was administered in the resident's abdomen. Observation on 2/25/26 at 11:14 A.M., showed: - LPN A Obtained the resident's blood sugar which was 116. - The Humalog insulin pen did not have a label to indicate which resident it belonged to and was not dated when opened. - Unknown staff had handwritten the resident's initials on the lid and wrote 8U on the lid. - LPN A did not clean the port before he/she attached the needle and did not prime it with two units. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- LPN A dialed the insulin pen to 8 units and administered it in his/her abdomen. During an interview on 2/26/26 at 7:44 A.M, LPN A said: - The insulin pens should be dated when opened and should have a label on then to indicate which resident it belonged to. - The insulin pens should not be used if they do not have a date when they were opened or a label to indicate which resident it belonged to. During an interview on 2/26/26 at 8:57 A.M., the DON said: - The Pharmacy label is placed on the box of insulin pens but there are labels in the drawer of the medication cart for staff to use to label the insulin pens with the resident's name, date opened and expiration date and type of insulin. - The insulin pens should have a label on them to indicate which resident it belonged to. - The insulin pens should be dated when opened. - The insulin pens should not be used if they have not been dated or labeled because there was no way to determine how long the insulin pen had been opened. Review of the facility's Physician Orders policy, dated 08/31/2016, showed:- The purpose is to ensure the physicians orders are followed as written for safety and well-being of the resident;- Physician orders should be followed as written. Review of the facility's Wound Care Clean Dressing Change policy, revised on 01/03/2018, showed:- The facility is committed to prevention of infections and promoting wound care;- The procedure included applying prescribed medication to wound/wound area, if ordered. 4. Review of Resident #4's Care Plan, revised on 09/05/24, showed: - The resident had two pressure ulcers related to decreased mobility and relied on nursing staff to administer treatments as ordered, monitor for effectiveness, and assess and document status of the wound;- The resident had a nutritional problem and chronic pain related to wound healing and relied on staff to anticipate and meet needs. Review of the resident's, Annual MDS, dated [DATE], showed:- Resident was cognitively intact; - Dependent on nursing staff for transfers and showers;- Diagnoses of: stage three pressure ulcers (severe, full-thickness skin injury extending through the outer skin layer into the subcutaneous fat, appearing as a deep crater, often with visible fat, slough, and possible tunneling) to both buttocks, muscle wasting and atrophy, and wound infection. Review of the resident's Physician Order Sheet, located in the resident's electronic medical record, showed:- Order entered on 01/20/2026, that Licensed nursing staff were to clean the right and left buttocks wounds with wound cleanser, use skin prep to peri-wound area, apply collagen powder and cover with bordered gauze one time a day on Monday, Wednesday, and Friday for wound treatment;- Order entered on 02/06/2026, that Licensed nursing staff were to apply protect zinc spray after skin prep to peri-wounds with dressing changes and daily. One time a day for wound treatment. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 02/23/2026 at 10:50 A.M., the Resident said:- He/She had sores on his/her bottom and the staff would change the dressings but they are supposed to look at the wounds every day shift but they don't.- Nursing staff would change the dressings every other day during the week, every shower day, but they are supposed to check the dressings every day shift;- Nursing staff are supposed to put spray on it; - The dressing gets bunched up sometimes and the nursing staff have had to change it on an off scheduled day;- He/She has been dealing with the sores for over a year and they used to be really bad but he/she stays on his/her side a lot; During an interview on 02/24/2026 at 11:03 A.M., the Resident said he/she felt like the only nurse that did his/her wound spray was Licensed Practical Nurse (LPN) A, who does the spray. During an interview on 02/24/2026 at 2:45 P.M., Nurse Practitioner (NP) A said:- The resident had been admitted with the wounds and she had had his/her left side healed and right side improved greatly. When she sees him/her weekly the wounds improve and when she doesn't see him/her weekly he/she doesn't seem to stay off the wound, offload enough;- The resident gets confused about the spray, because the zinc peri-wound spray is applied only when the dressing is changed and the skin prep spray is ordered for application more often. Observation on 02/25/2026 at 2:30 P.M., showed:- Registered Nurse (RN) C perform the morning dressing change on the resident;- RN C knocked, provided privacy, washed hands, and applied applicable Enhanced Barrier Precautions;- RN C removed the intact dressings and the affected areas looked like road rash with some bloody drainage noted to the removed dressings, the resident's skin, and on the bed mat beneath the resident;- RN C cleaned the areas with wound cleanser saline wash and four by four bandages with new ones for each buttock area;- RN C then applied the collagen powder and bordered gauze to each wound with the affected area appearing to extend beyond the bordered gauze, peri-wound area;- RN C changed the bed pad due to the blood soiling, covered the resident up and lowered the bed to it's lowest position, dated and initialed the dressings, and left the room;- Outside the room, RN C was asked about the skin prep spray and the zinc spray to the peri-wound as ordered with each dressing change. RN C said he/she didn't do it and believed the sprays are only done with the morning and night dressing changes;- This was the morning dressing change due to the dayshift nurse postponing the procedure for observation. RN C said he/she would have to check the order but did not return to the room. During an interview on 02/26/2026 at 7:30 A.M., the Resident said RN C did not return to apply the spray to the peri-wound, they hardly ever do the spray and they are supposed to each shift. He/She again said that LPN A is about the only one who does the spray. During an interview on 02/26/2026 at 7:32 A.M., LPN A said:- When licensed staff are doing the resident's dressing changes the nurse should definitely apply the skin prep spray and the zinc spray;- The nurses should be spraying the wounds each shift. During an interview on 02/26/2026 at 8:57 A.M., the Director of Nursing (DON) said:- RN C should have completed the entire ordered treatment for the resident;- RN C should have used the ordered sprays for the wound;- Nursing staff should be performing the treatments as ordered and according to the schedule ordered;- The products and sprays ordered by the providers help extend the life of the applied treatment and should be applied. Observation on 02/26/2026 at 7:04 A.M., showed:- LPN A prepared to administer insulin to resident #7. LPN A had already drawn up the 12 units and had already attached the needle to the pen;- LPN A (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	had not primed the insulin pen and had not cleaned the port before applying the needle to the pen;- There was no open date written on the insulin pen. During an interview on 02/26/2026 at 7:07 A.M., LPN A said:- He/She did not prime the insulin pen. He/She believed nursing should only prime a pen when it is first opened and not any times following when the pen is used after the initial opening;- His/Her procedure for setting up the insulin pen is to just screw on the needle and dial in the amount of required insulin, that's it;- The insulin pen should be dated when opened;- LPN A did not say the port needed cleaned first. During an interview on 02/26/2026 at 8:56 A.M, the Director of Nursing (DON) said:- The insulin pens should have a label on them to indicate who they belong to;- The insulin pens should not be used if they have not been dated when opened or labeled because there is no way to know how long the pens have been open;- The insulin pens should have the port cleaned with an alcohol wipe before the licensed staff attached the needle;- The insulin pens should be primed with two units of insulin before use each time. #2708494