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

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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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to inform residents and/or their responsible parties, in advance of the risks and benefits of proposed care, when the facility failed to obtain written consent before beginning psychotropic medications (medications that affect the mind, emotions, and behavior) for four (Resident #3, Resident #4, Resident #5, and Resident #30) of the 12 sampled residents. The facility census was 33. Review of the facility's Resident Participation - Assessment/Care Plans policy, revised 2016, showed the residents/representatives have the right to be informed, in advance (by the physician, practitioner, or professional) of the risks and benefits of the care or treatment proposed. 1. Review of Resident #3's Care Plan, revised on 10/12/25, showed:- The resident had depression related to stroke and inability to be active and relied on nursing staff to anticipate and meet needs;- The resident had an alteration in neurological status/impaired brain function related to stroke and relied on staff to assess for effects of psychotropic medications, cue and reorient as needed, and review medications and record possible causes of cognitive deficit. Review of the resident's Quarterly Minimum Data Set (MDS) a federally mandated assessment tool completed by facility staff, dated 02/04/26, showed:- Resident had severe cognitive impairment;- High-risk drug classes including anti-psychotic and anti-convulsant were ordered;- Diagnoses of Dementia, Psychotic Disorder, and Stroke. Review of the resident's physician order summary report, dated 02/24/26, showed Quetiapine Fumarate (anti-psychotic) and Divalproex Sodium (anti-convulsant), for mood disorders, started on 10/16/24. Record review of the resident's Medical Records showed no documentation of informed consents with the resident or family for the use of anti-psychotic or anti-convulsant medications for the resident could be located. 2. Review of Resident #4's Care Plan, revised on 09/05/24, showed: - The resident had depression related to health problems and relied on nursing staff to anticipate and meet needs;- The resident used psychotropic medications related to major depressive disorder and staff were required to educate the resident about risks, benefits, and the side effects and/or toxic symptoms of the psychoactive medication drug being given. Review of the resident's, Annual MDS, dated [DATE], showed:- Resident was cognitively intact; - High-risk drug classes including anti-psychotic, anti-depressant, and anti-convulsant medications were used;- Diagnoses of depression, muscle wasting and atrophy, and wound infection. Review of the resident's physician order summary report, dated 02/24/26, showed Aripiprazole (anti-psychotic) and Sertraline (anti-depressant), for mood disorders, ordered on 08/15/24. Record review of Resident's Medical Records showed no documentation of informed consents with the resident or family for the use of anti-psychotic or anti-depressant medications for the resident were (continued on next page)

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

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	located in the clinical record. 3. Review of Resident #5's Care Plan, revised on 07/11/25, showed: - The resident had depression related to stroke and relied on nursing staff to anticipate and meet needs;- The resident had a mood problem related to stroke and staff were required to educate the resident about expectation of treatment, concerns with side effects and potential adverse effects evaluation and maintenance. Review of the resident's, Annual MDS, dated [DATE], showed:- Resident was cognitively intact; - High-risk drug classes including anti-psychotic and anti-depressant are ordered;- Diagnoses of dementia, depression, and stroke. Review of the resident's Order Summary Report, dated 02/24/26, showed Sertraline (anti-depressant) ordered on 03/04/24 and Quetiapine Fumarate (anti-psychotic) ordered on 07/11/25, for mood disorders. Record review of Resident's Medical Records showed no documentation of informed consents by the resident or family for the use of anti-psychotic or anti-depressant medications for the resident. During an Interview on 02/26/2026 at 8:57 A.M. the Director of Nursing (DON) said the residents should have written consents for the psychotropic medications and the facility is getting the proper form to document the written consents. During an Interview on 02/26/2026 at 8:58 A.M. the Administrator said the residents should have written consents for the psychotropic medications in their medical record. 4. Review of Resident #30's care plan, dated 12/11/24 showed it did not address the resident's use of psychotropic medication. Review of the resident's Annual MDS, dated [DATE] showed: - Cognitive skills for daily decision making moderately impaired. - No behaviors. - Antipsychotics were provided to the resident on a regular basis. - A gradual dose reduction (GDR) was documented by the physician as clinically contraindicated on12/16/25. - Diagnoses included non-traumatic brain dysfunction, Alzheimer's disease, stroke and depression. Review of the resident's POS dated February 2026 showed a start date of 12/16/25 for Seroquel 50 milligrams, one tablet at bedtime related to dementia. Review of the electronic medical chart on 2/25/26 showed no consents or education of risks and benefits for psychotropic medication use for the resident or family were found. The resident was not capable of an interview regarding the medication consents. During an interview on 2/26/26 at 8:57 A.M., the DON said the facility should have a written consent for the psychotropic medications prior to the start of the medications.

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F 0568 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Properly hold, secure, and manage each resident's personal money which is deposited with the nursing home. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to establish and maintain a system that assured a full and complete, separate accounting, according to generally accepted accounting principles, of each resident's personal funds entrusted to the facility on the resident's behalf when monthly personal funds reconciliation showed an accumulating reimbursement deficit to the account due to monthly bank charges owed by the facility. This affected four of 12 sampled residents (Resident #3, #4, #7, and #12). The facility census was 33.Based on record review and interview, the facility failed to establish and maintain a system that assured a full and complete, separate accounting, according to generally accepted accounting principles, of each resident's personal funds entrusted to the facility on the resident's behalf when monthly personal funds reconciliation showed an accumulating deficit to the account due to monthly bank charges. This affected four of 12 sampled residents (Resident #3, #4, #7, and #12). The facility census was 33.Review of the facility's policy on management of the Resident Trust Fund (RTF) not provided;1. Review of Resident #3's Quarterly Minimum Data Set (MDS, a federally required assessment tool completed by facility staff), dated 1/2/26, showed:- Resident not cognitively screened;- Diagnoses: hypertension, diabetes, stroke, dementia, quadriplegia (paralysis of all four limbs), seizure disorder, traumatic brain injury, and psychotic disorder;2. Review of Resident #4's Annual MDS, dated [DATE], showed:- Resident was cognitively intact;- Diagnoses: anemia, hypertension, and GERD (Acid reflux);3. Review of Resident #7's Annual MDS, dated [DATE], showed:- Resident was cognitively intact;- Diagnoses: heart failure, hypertension, urinary tract infection, diabetes, dementia, and anxiety disorder;4. Review of Resident #12's Quarterly MDS, dated [DATE], showed:- Resident was not cognitively screened;- Diagnoses: hypertension, diabetes, Alzheimer's Disease, and depression;5. Review of the Resident RTF Account, dated February 2025 through January 2026 showed:- RTF charged a fee of $2.00 each month during the period for Paper Statement Fee;- No entries during the period showing reimbursement to the RTF Account for the bank charge of Paper Statement Fee;- Reconciliation of the RTF Account by the facility contained a running balance of money owed to the RTF by the facility which showed a current balance of $84.00 owed;- Interest was credited to the RTF monthly based on the ending account balance each month, which did not include the funds accrued, that the facility owed to the RTF account;- Residents #3, #4, #7 and #12 had funds in the interest bearing RTF as of 1/31/26;During an interview on 2/25/26 at 9:54 A.M., Administrator said:- We keep a running tally of the bank statement fees that are charged to the Resident Trust Fund and that total is money that the facility owes back to the resident trust account since the residents are not responsible to pay bank fees. It was last year sometime since we reconciled the account and put money back into the resident trust fund.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to develop and implement a comprehensive person-centered plan which included measurable objectives and timeframes to address resident needs and preference when the care plans did not include Resident #29's preference for life saving measures or address Resident #34's desire to return to the community. The deficient practice affected two of the 12 sampled residents. The facility census was 33. Review of the facility's Resident Care Plan Policy and Procedure policy, dated [DATE], showed:- The purpose is the care plan shall be used in developing the resident's daily care routines and will be available to caregivers and other staff who have the responsibility for providing care or services to the resident;- Care plans for each resident will be developed upon admission and updated quarterly;- Completed care plans are placed in the resident's chart;- Aides are responsible for reporting to the charge nurse any change in the resident's condition and the care plan goals that have not been met;- Change in a resident's condition must be reported to the Director of Nursing so that a review of the resident's assessment and care plan can be made;- Documentation must be consistent with the resident's care plan. Review of the facility's Care Planning - Interdisciplinary Team policy, revised [DATE], showed:- Our facility's care planning/Interdisciplinary team is responsible for the development of an individualized comprehensive care plan for each resident;- A comprehensive care plan for each resident is developed within seven days of completion of the resident assessment. Review of the facility's Goals and Objectives, Care Plans policy, revised [DATE], showed:- Care plans shall incorporate goals and objectives that lead to the resident's highest obtainable level of independence;- Care plan goals and objectives are defines as the desired outcome for a specific resident problem;- Care plan goals and objectives are derived from information contained in the resident's comprehensive assessment and are resident oriented, behaviorally stated, are measurable, and contain timetables to meet the resident's needs;- Goals and objectives are entered on the resident's care plan so that all disciplines have access to such information and are able to report whether or not the desired outcomes are being achieved;- Goals and objectives are reviewed and/or revised when there has been a significant change in the resident's condition, when the desired outcome has not been achieved, when the resident has been readmitted to the facility, and at least quarterly. Review of the facility's Care Plans, Comprehensive Person-Centered policy, revised [DATE], showed:- A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial, and functional needs is developed and implemented for each resident;- The interdisciplinary team in conjunction with the resident and his/her family or legal representative, develops and implements a comprehensive, person-centered care plan for each resident;- Each resident's comprehensive, person-centered care plan will be consistent with the resident's rights to participate in the development and implementation of his or her plan of care;- The comprehensive, person-centered care plan will include measurable objectives and timeframes, describe services to be furnished and provided, include the resident's stated goals and desired outcomes, and include the resident's stated preference and potential for future discharge, including his or her desire to return to the community. 1. Review of Resident #34's, admission MDS, dated [DATE], showed:- The resident is cognitively (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	intact; - The resident requires partial assistance with showering, bathing, and putting on footwear and only required setup assistance with most other activities of daily living (ADL's);- Diagnoses of heart failure, chronic lung disease, and kidney failure. Review of the resident's Care Plan, revised on [DATE], showed the care plan was incomplete and did not address the resident's wishes to discharge to the community.During an interview on [DATE] at 1:54 P.M., the resident said his/her goal was to return to the community and would like to be able to things outside of the facility. During an interview on [DATE] at 8:56 A.M., the Administrator said the resident's care plan should accurately reflect the resident's needs, wishes and goals of each resident. 2. Review of Resident #29's care plan dated [DATE] showed it did not address the resident's code status (preference for life saving measures). Review of the resident's face sheet showed Do Not Resuscitate (DNR, a medical instruction that indicates cardiopulmonary resuscitation (CPR), should not be performed if a person's heart stops beating or the person stops breathing). Review of the resident's Quarterly MDS, dated [DATE] showed: - Cognitive skills intact. - No behaviors. - Upper extremity and lower extremity impaired on one side. - Diagnoses included stroke, depression, and hemiparesis (muscle weakness or paralysis on one side of the body)/hemiplegia (paralysis affecting one side of the body). Review of the physician orders dated February 2026 showed a start date of [DATE] to Do Not Resuscitate. During an interview on [DATE] at 8:57 A.M. the Director of Nursing (DON) said: - He/She was also the MDS/Care Plan Coordinator. - The care plans provide direction to the staff and should address the resident's code status.

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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. 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. (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 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 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. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. - 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: (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- 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. 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. (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 02/24/2026 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 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 (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are free from significant medication errors. Based on observations, interviews, and record review, the facility failed to ensure staff provided a safe and effective administration system that was free of significant medication errors when staff failed to prime insulin pens prior to administering insulin which affected three of the 12 sampled residents, (Resident #2, #7 and #11). The facility census was 33. The facility did not provide a policy for administration of insulin or the use of insulin pens. 1. Review of Resident #2's Physician Order Sheet (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. - 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. 2. Review of Resident #11'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 times 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. - 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 8 units and administered it in his/her abdomen. During an interview on 2/26/26 at 7:44 A.M, LPN A said: (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- He/She should have cleaned the port with an alcohol wipe before he/she attached the needle. - He/She primed new insulin pens with two units, but after that he/she did not prime the insulin pens. During an interview on 2/26/26 at 8:57 A.M., the DON said: - Staff should clean the insulin ports with an alcohol wipe and then attach the needle. - Staff should prime the insulin pen with two units of insulin each time before it is used. 3. Review of Resident #7's Physician Order Sheet (POS) dated February 2026 showed:- Start date: 01/28/25 - Blood sugar per glucometer twice daily for diabetes mellitus. - Lispro insulin injection 12 units two times daily with meals for diabetes mellitus. Review of the resident's Medication Administration Record (MAR) dated February 2026 showed:- 02/26/26 - Blood sugar documented by staff as 128.- 02/26/26 - Staff documented Humalog insulin 12 units was administered. Observation on 02/26/26 at 7:04 A.M., showed:- 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 let the resident administer to their lower right abdomen. During an interview on 2/26/26 at 8:57 A.M., the DON said: - Staff should clean the insulin ports with an alcohol wipe and then attach the needle. - Staff should prime the insulin pen with two units of insulin each time before it is used. Intake 270849

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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. Based on observations, interviews, and record review, the facility failed to ensure staff properly labeled and dated opened insulin pens, which affected five of the 12 sampled residents, (Resident #2, #7, #11, #29, and #34), staff preset medications for Resident #10, #22 and #31. Additionally, staff taped seven Lorazepam (used to treat anxiety) tabs into the medication card which affected Resident #30. Resident #24 had an undated opened bottle of Morphine Sulfate (an Opioid used to treat moderate to severe pain) which was filled on 7/19/24. The facility census was 33. Review of the facility's policy for Drug/Medication Administration for Oral Medications, dated 7/29/13 showed: - The facility is committed to providing a safe environment for residents and staff. Medications will be administered in a safe and professional manner. - The purpose is to provide a uniform set of guidelines for giving and charting of medications and treatments. To determine standard medication administration times to e observed by the nursing staff in administration of medications ordered by the physician. - The seven rights will be observed. Right resident, right medications, right dose, right time, right route, the right to refuse and right to be educated. - You cannot pre-pour medications-this is not an acceptable standard of practice. Pour medications just prior to administering. 1. The facility did not provide a policy for the use of Insulin pens. 2. Observation and Interview on 2/24/26 at 8:40 A.M., showed in the top drawer of the medication cart: - Three paper cups with medications in them with the resident's first name on them. Resident #20 had one blue oblong pill, one white round pill and one white oblong pill. Resident #31 had one white capsule, one oblong white pill, two small round white pills, and two round red pills. Resident #22 had one pink oblong pill, two white oblong pills, one round tan pill and one round pink pill. Licensed Practical Nurse (LPN) A said he/she should not have preset the medication. - Unknown staff handwrote Resident #34's first initial and last name on the lid of the Lantus insulin pen and did not have a date when it was opened. - Unknown staff handwrote Resident #11's first and last initial and 8 on the lid of the Lispro insulin pen and did not have a date when it was opened. - Unknown staff handwrote Resident 2's first name and 12 U on the lid of the Lispro insulin pen and did not have a date when it was opened. - Unknown staff handwrote Resident #11's first and last initial and 24 on the lid of the Lantus insulin pen and did not have a date when it was opened. - Unknown staff handwrote Resident #7's first and last initial and 34 on the lid of the Lispro insulin (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	pen and did not have a date when it was opened. - Unknown staff handwrote Resident #7's first and last initial on the lid of the Lispro Insulin pen and did not have a date when it was opened. - Unknown staff handwrote Resident #29's first and last initial on the lid of the Novolog insulin flexpen and did not have a date when it was opened. - Unknown staff handwrote Resident #34's first initial and last name and 5 on the lid of the Lantus insulin pen and did not have a date when it was opened. - The Director of Nursing (DON) said the pharmacy label was placed on the box of insulin pens when they arrived from the pharmacy and the staff have labels in the drawer of the medication cart which they are supposed to place on the insulin pens with the resident's name, date opened and expiration date. 3. Observation and interview on 2/24/26 at 9:17 A.M., showed: - Resident #30 had a bubble pack (a type of medication packaging where each dose of medication is sealed in its own small plastic bubble attached to a backing card) of Lorazepam and had seven dates where the bubble had been punctured and the medication taped in. - LPN A said the staff should not have taped the medication, it should have been destroyed by two nurses. 4. The facility did not provide a policy for how long Morphine Sulfate was to be used after opened. 5. Observation and interview on 2/24/26 at 9:25 A.M., showed: - Resident #24 had an undated opened bottle of Morphine Sulfate that was filled by the pharmacy on 7/19/24. - Review of the Narcotic Log Sheet showed staff opened the bottle of Morphine Sulfate on 7/23/24. It was not signed out from 7/30/24 until 2/18/25 and has been used on a regular basis and has not been used since 1/18/26. - LPN A said the Morphine Sulfate should have been dated when it was opened. During an interview on 02/26/2026 at 7:21 A.M., LPN A said he/she had pre-popped all of the morning medications and shouldn't have done it, it was a bad habit, and it's hard to get all the meds done without pre-popping. During an interview on 2/26/26 at 8:57 A.M. the DON said: - The insulin pens should have a label on them to indicate which resident they belonged to. - The insulin pens should not have been used if they had not been dated when opened because there was no way to know how long they had been opened. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Staff should not preset the medications. - Medication should not be taped into the bubble pack. - If the Morphine Sulfate was filled on 7/19/24, the pharmacy said it would be good until the expiration date.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation and interview, the facility failed to prepare and serve food in accordance with professional standards for food service safety when facility staff failed to properly monitor food storage temperatures. This had the potential to affect all residents in the facility. The facility census was 33.Review of facility policy, Food Storage (Dry, refrigerated, and frozen), revised November 2022, showed:- Keep potentially hazardous foods out of the temperature danger zone of 41 degrees to 135 degrees;- Follow and adhere to the guidelines regarding proper storage temperatures;- Set refrigerators to the proper temperature ensuring the internal temperature of the food is 41 degrees or lower;- Conduct random temperature checks of food items;- Keep freezer at a temperature that ensures products will remain frozen (0 degrees);- Check freezer temperature regularly;Observation in the kitchen on 02/23/26 at 9:26 A.M., showed:Main Kitchen Area:- Chest Freezer, Two Stand-up Freezers, Two large 2-Door Refrigerators, and One Stand-up Refrigerator were missing any refrigerator or freezer temperature logs;- Chest Freezer thermometer was buried beneath many frozen food items and after a few minutes of digging, was produced by the Dietary Manager (DM).During an interview on 02/23/26 at 9:28 A.M., the Dietary Manager (DM) said: - Kitchen staff were supposed to look at the thermometer but after truck deliveries the thermometer would get shoved around and covered up;- Dietary staff did not currently have temperature checks sheets. They used have temperature check sheets but the sheets didn't get filled out a lot so they stopped;- She would ask the dietary aides if they checked the temperatures and they say they did;- The Dietician would check the thermometers when he/she would come to visit the facility monthly.During an interview on 02/26/26 at 8:53 A.M., the Activities Coordinator said:- She had been a dietary aide before and currently helps out in the kitchen when needed;- The kitchen staff should always check the refrigerator and freezer temperatures and then record the temperatures;- Kitchen staff would always monitor and record the temperatures when she worked in there and should still.During an interview on 02/26/26 at 8:57 A.M., the Director of Nursing (DON) said refrigerator and freezer temperature checks should be completed daily and recorded on the temperature logs by dietary staff.Copies of the past year of temperature logs were produced after the DON interview on 02/26/26 and showed:- June 2025, none of the refrigerator or freezer temperatures varied by one degree, recorded daily, for the entire month and no initials provided for any documented reading;- July 2025, none of the refrigerator or freezer temperatures varied by one degree, recorded weekly, for the entire month and no initials provided for any documented reading;- September 2025, only temperatures documented for the first through the forth, no variance in the temperatures recorded, and no initials provided for the documented readings;- November 2025, no documented readings for the fifth both shifts, no reading for the 17th through the 30th for am shift and none for pm shift on the 13th through the 17th, or 18th through the 30th;- No log provided for December 2025;- January 2026, none of the refrigerator or freezer temperatures varied by one degree, recorded weekly, for the entire month and no initials provided for any documented reading;- February 2026, no documented readings until the 22nd.

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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. Based on interview and record review, the facility failed to follow policy and screen six out of 10 employees for tuberculosis (TB - an infection disease characterized by the growth of nodules in the tissues, especially the lungs) prior to employment. The facility census was 33 residents. Review of facility policy, Employee Screening for Tuberculosis (TB) Policy and Procedure, revised 5/16/23, showed:- Each newly hired employee will complete a 2-step tuberculosis test prior to offer of employment and prior to employee's duty assignment. - Screening includes a baseline test, individual risk assessment and symptom evaluation.- All employees will complete a 1-step annual test following the new hire 2-step testing. - All potential employees will complete baseline testing prior to hire and before entering the facility. 1. Review of facility Human Resources and TB records, showed:- Certified Nursing Assistant (CNA) (A) was hired on 1/23/25 and TB baseline was established on 1/25/25, two days after the date of hire;- Dietary [NAME] (A) was hired on 6/9/25 and TB baseline was established on 6/20/25, 11 days after the date of hire;- Nursing Assistant (NA) (A) was hired on 7/25/25 and TB baseline was established on 7/30/25, 5 days after the date of hire;- Registered Nurse (RN) (A) was given 1st step TB test on 9/25/25 and it was read less than 48 hours later on 9/26/25;- RN (B) was given 1st step TB test on 10/3/25 and it was read over 72 hours later on 10/7/25. - CNA (B) was hired on 11/13/25 and TB baseline was established on 1/11/26, 59 days after the date of hire;- CNA (C) was hired on 12/18/25 with baseline established on 5/26/22 from another facility. No updated TB test on file with the current facility;During an interview on 2/25/25 at 9:10 A.M., the Director of Nursing (DON) said any TB test read outside the window of 48 hours to 72 hours from the initial injection is invalid and must be re-taken.During an interview on 2/25/25 at 1:15 P.M., the Administrator said:- Annual tests completed previously by new hires are good for up to one year prior to the date of hire at this facility.- TB tests shall be read between 48 to 72 hours from when the individual is injected. If this is not done the test is invalid and must be taken again.- She was not sure why CNA (B) did not have a TB test completed and on file prior to the employee starting work at the facility.- She was certain that CNA (C) was test prior to starting work at the facility but was unable to find the documentation.