| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 265800 | A. Building<br>B. Wing | 05/21/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Gower Convalescent Center, Inc | 323 South Highway 169<br>Gower, MO 64454 |

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) |
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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.<br><br>Based on observation, interview, and record review, the facility failed to store, prepare, and distribute food in accordance with professional standards for food safety when the facility staff thawed sausage in the refrigerator on a wire rack shelf above a box of sausage rolls and ground beef, when [NAME] B did not wash hands between glove changes while preparing and serving food, and additionally when [NAME] C sat two frozen chicken strips on a package of hamburger buns that still contained hamburger buns while waiting for the air fryer to heat up. This had the potential to affect all resident's. The facility census was 67.Review of the facilities Storage-Refrigerated Foods policy, not dated, showed: Place meat, poultry and seafood items on the lowest shelf to minimize leakage onto other stored foods. Review of the facilities Glove-ology flyer, not dated, showed:-Washing hands thoroughly before and after wearing or changing gloves was the most important thing to reduce surface bacteria, sweat, dirt and grim build-up on skin and under nails;-Glove use in itself did not guarantee food safety;-Always wash hands before and after using disposable gloves.Observation of the kitchen on 05/20/26 at 8:00 A.M. showed ground sausage in a steam table pan stored above a box of sausage rolls and ground beef in the walk in refrigerator.Observation on 05/20/26 at 11:15 A.M. showed [NAME] C used a gloved hand to take two frozen chicken strips out of the freezer and placed them on a package of hamburger buns that still contained hamburger buns while waiting for the air fryer to warm up.Observation on 05/20/26 at 12:35 P.M. showed [NAME] B prepared a plate of food then took of his/her gloves, put on a new pair of gloves without washing his/her hands, touched his/her stomach with the gloved hands, then prepared another plate of food without changing gloves or washing hands.During an Interview on 05/20/26 at 11:17 A.M. [NAME] A said Frozen chicken strips should not be placed on a package of hamburger buns.During an Interview on 05/20/26 at 11:20 A.M. [NAME] C said He/she probably should not have sat the frozen chicken strips on the package of hamburger buns.During an Interview on 05/20/26 at 12:54 P.M. [NAME] B said he/she was not sure if hands should be washed between each glove change while handling food.During an Interview on 05/20/26 at 12:56 P.M. [NAME] A said hands were supposed to be washed each time gloves were changed.During an Interview on 05/20/26 at 12:58 P.M. [NAME] C said hands were supposed to be washed each time gloves were changed.During an Interview on 05/21/26 at 8:17 A.M. [NAME] A said as long as the thawing ground sausage was in a steam table pan it was okay to store above the bottom shelf since nothing would be able to drip on what was stored below the sausage.During an Interview on 05/21/26 at 12:07 P.M. the Administrator said:-Hands should be washed when changing gloves while working in the kitchen;-It was cross contamination to place frozen chicken strips on a bag of hamburger buns that still contained hamburgers;-Raw meat should not defrost on a shelf above other food. |

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

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| F 0552<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Ensure that residents are fully informed and understand their health status, care and treatments.<br><br>**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 three Residents (Resident #8, Resident #9, and Resident #19) of the 17 sampled residents. The facility census was 67.The facility did not provide a Psychotropic Medications policy.<br><br>1. Review of Resident #8's Quarterly Minimum Data Set (MDS), a federally mandated assessment completed by facility staff, dated 04/24/26, showed:- Moderate cognitive impairment;- Independent with activities of daily living (ADL's);- Diagnoses: Alzheimer's disease, anxiety disorder, and bipolar disorder (mental health condition characterized by extreme, cyclical shifts in mood, energy, and activity levels).<br><br>Review of the resident's Comprehensive care plan, dated 04/20/26, showed:- The Resident was at risk for adverse consequences related to receiving antidepressant medication Sertraline, anticonvulsant medication Gabapentin for pain, Lorazepam for anxiety as needed and Melatonin for sleep;- The Resident was to have consistent approach amongst caregivers.<br><br>Review of the Physician's Order Sheet, dated 05/21/26, showed:- Order for lorazepam 0.5mg (milligram) by mouth as needed (an anti-anxiety medication) began on 03/12/26;- Order for sertraline 50mg by mouth at bedtime (an antidepressant medication) began on 3/12/26.<br><br>Review of the resident's medical record on 05/21/26 showed the facility did not have any record of a consent form for the resident regarding the use of psychotropic medications and the risks and benefits.<br><br>2. Review of Resident #9's Quarterly MDS, dated [DATE], showed:- Cognitively intact;- Minimal staff assistance with ADL's;- Diagnoses included: Emphysema (long term lung condition that causes shortness of breath), heart failure, and high blood pressure.<br><br>Review of the resident's comprehensive care plan, dated 05/07/26, showed:- The Resident was at risk for adverse consequences related to receiving antidepressant medication Sertraline, anticonvulsant medication Gabapentin for pain, Lorazepam for anxiety as needed and Melatonin for sleep;- The Resident was to have consistent approach amongst caregivers.<br><br>Review of the Physician's Order Sheet, dated 05/21/26, showed:- Order for lorazepam 0.5mg (milligram) by mouth as needed (an anti-anxiety medication) began on 09/24/25;- Order for buspirone 15mg by mouth three times a day (an anti-anxiety medication) began on 7/12/23;- Order for venlafaxine 150mg by mouth daily (an antidepressant medication) began on 01/04/24;- Order for lithium 300mg by mouth every other day (a mood stabilizer medication) began on 01/01/24;- Order for mirtazapine 45mg by mouth at bedtime (an antidepressant medication) began on 01/28/26;- Order for quetiapine 100mg by mouth at bedtime and 50mg by mouth daily (an antipsychotic medication) began on 01/03/25.<br><br>Review of the resident's medical record on 05/21/26 showed the facility did not have any record of a consent form for the resident regarding the use of psychotropic medications and the risks and benefits.<br>(continued on next page) |

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| F 0552<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During an interview on 5/20/26 at 2:42 P.M., the Director of Nursing (DON) said she had called the person responsible for getting the consents signed and was told they have not all been completed and signed. She said they informed consents should have been signed and dated.<br><br>During an interview on 05/21/26 at 11:48 A.M., the DON said psychotropic consents should be obtained for new psychotropic medications and should be done with any increase or decrease as well.<br><br>3. Review of Resident #19's Quarterly MDS, dated [DATE] showed:-Cognitive skills intact;-Two falls with no injury;-Diagnoses included high blood pressure, anxiety and hip fracture;-In the last seven days, the resident received seven anti-anxiety medications, seven antidepressant medications, and seven anticoagulants; -No antipsychotic medications were received.<br><br>Review of the resident's drug regimen review, dated 04/09/26 showed:-The pharmacist recommended to decrease Alprazolam (used to treat anxiety) o.5 milligrams (mg.) twice daily to 0.35 mg in the morning and continue the 0.5 mg. dose at bedtime; -On 05/06/26 the physician declined due to the resident had been on this regimen for years and the resident's spouse was in the process of dying. Review of the resident's care plan, dated 05/07/26 showed:-The resident was at risk for adverse consequences related to receiving an antidepressant (Citalopram) for depression, Trazodone to help the resident sleep and an antianxiety medication, (Alprazolam). 5/6/26 a gradual dose reductions (GDR) were declined for Alprazolam and Citalopram; -Approaches included: assess resident's functional status prior to initiation of drug's use to serve as a baseline. Attempt gradual dose reduction yearly (after the first year) unless clinically contraindicated;-Attempt to give the lowest dose possible;-Monitor the resident's behavior and response to medication, review for continued need at least quarterly and Pharmacy consultant review. Review of the resident's POS dated May 2026 showed an order with a start date of 12/01/2025 give Alprazolam 0.5 mg. twice daily for anxiety.<br><br>Review of the resident's undated Psychotropic Medication Informed Consent showed:-Medication drug class, Benzodiazepine;-Medication, Alprazolam 0.5 mg. given twice daily to decrease anxiety symptoms; -Reason for use of the medication, documented diagnosis of generalized anxiety;-Per note on 01/30/26, the resident was being seen by Behavioral Health Solution and order were per the physician; -Non-pharma-logical interventions included: Encourage resident to socialize with peers;-Enjoys one on one interactions, not large groups and likes to watch television; -The informed consent was not signed by the resident or responsible party or by a staff member and was not dated. During an interview on 05/20/26 at 2:42 P.M., the DON said she had called the person responsible for getting the consents signed and was told they have not all been completed and signed. She said they informed consents should have been signed and dated.<br><br>During an interview on 05/21/26 at 7:53 A.M., the MDS/Care Plan Coordinator said ff a new order was received for psychotropic medication, he/she filled out the risks and benefits with the resident and/or the family. He/She would either get a verbal consent from the family or if the resident was alert and oriented, explain it to the resident and get a signature. It should also be care planned. He/She thought the Charge Nurse (CN) would get the consents signed. |

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| F 0567<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Honor the resident's right to manage his or her financial affairs.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to implement policies and procedures to ensure resident trust accounts (RTF) were credited with interest monthly for three residents (Resident #33, #49, and #55) and failed to obtain written authorization for the disbursement of funds from the RTF for two residents (Resident #49 and #55). The facility census was 67.Request for facility policy on the Management of the RTF not provided.1. Review of Resident #33's Annual Minimum Data Set (MDS), a federally mandated assessment, dated 04/01/26, showed: - He/she had severe cognitive impairment;- Diagnoses: non-traumatic brain dysfunction, Alzheimer's disease and anxiety disorder.Review of the Resident's January - March 2026 Quarterly RTF statement, showed:- He/She had a balance of $433.22 on 01/01/26 and a balance of $563.22 on 03/31/26;- Resident did not receive any credits for interest for the quarter;- On 03/31/26 had a charge for $20.00 for a haircut without a signed receipt from the resident or guardian authorizing this service.2. Review of Resident #49's Annual MDS, dated [DATE], showed: - He/She was cognitively intact;- Diagnoses: hypertension, anxiety disorder, and depression.Review of the Resident's January - March 2026 Quarterly RTF statement, showed:- He/She had a balance of $2,247.32 on 01/01/26 and a balance of $1,802.32 on 03/31/26;- He/She did not receive any credits for interest for the quarter;- He/She had a withdrawal of $700.00 for clothing on 02/03/26 with no signed receipt on file with the Business Office Manager (BOM).3. Review of Resident #55's Quarterly MDS, dated [DATE], showed: - He/She was moderately cognitively impaired;- Diagnoses: Alzheimer's Disease.Review of the Resident's January - March 2026 Quarterly RTF statement, showed:- He/She had a balance of $511.89 on 1/1/26 and a balance of $621.89 on 03/31/26;- He/She did not receive any credits for interest for the quarter.During an interview on 05/21/26 at 9:25 A.M., the BOM said:- The bank pays out interest every six months and we credit it to the active residents at the end of June and the end of December. She did not know that residents should be credited with interest into their account on a monthly basis.- If a resident discharges before the end of the month credit in June or December they will not receive any interest that has accrued during that period which could amount to five months of interest. - She did not have any signed receipts for work conducted in the salon for residents and did not have a signed receipt for the clothing disbursement to Resident #49. That transaction was done based on a verbal request from the resident and the resident's family member. During an interview on 05/21/26 at 2:35 P.M., the Administrator said:- She was not sure how often residents should be credited with interest from funds in the RTF.- There should be signed receipts or authorizations for resident transactions that involve the RTF account. |

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| F 0568<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Properly hold, secure, and manage each resident's personal money which is deposited with the nursing home.<br><br>Based on record review and interview, the facility failed to maintain a system to ensure the resident trust fund (RTF) account was managed in accordance with proper accounting principles by not maintaining a monthly written reconciliation of all monies held in the resident trust fund account. The facility managed funds for 9 residents. The facility census was 67.Request for facility policy on the Management of the RTF not provided.1. Review of the monthly bank statements from April 2025 through March 2026 did not contain a written record of a reconciliation of the RTF account with the bank statements. During an interview on 05/21/26 at 9:25 A.M., the Business Office Manager (BOM) said:- She reconciles the RTF account monthly but does not record the reconciliation or have paperwork showing the account funds reconcile with the bank statements.During an interview on 05/21/26 at 2:35 P.M., the Administrator said:- There should be a written record of the monthly reconciliation of the RTF account done by the BOM. |

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| F 0695<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide safe and appropriate respiratory care for a resident when needed.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to provide proper respiratory care when staff failed to document the date when oxygen tubing was replaced for four residents (Resident #9, #11, #31, and #44), failed to ensure clean concentrator filters for one resident (Resident #11), and failed to provide proper storage for tubing (Residents #44) resulting in possible exposure to bacteria during oxygen usage and possible adverse effects. This affected four of 17 sampled residents. The facility census was 67.<br><br>Review of facility Policy for Administration of Medications and Cleaning a Nebulizer Machine, dated as revised on 07/27/2021, showed:- After each treatment - discard any leftover medication;- Rinse the nebulizer medication cup and mouthpiece or mask with warm running water and place on a paper towel to air dry;- When dry, connect to the tubing and run nebulizer machine for 10 to 20 seconds;- Place dry equipment and tubing in a plastic container;- Weekly - replaced used tubing, mask, or mouthpiece with new tubing, mask, or mouthpiece.<br><br>No facility policy provided for oxygen administration or oxygen supplies.<br><br>1. Review of Resident #9's Quarterly Minimum Data Set (MDS), a federally mandated assessment completed by facility staff, dated 05/19/26, showed:- Cognitively intact;- Required minimal staff assistance with activities of daily living (ADL's);- Diagnoses: Emphysema (long term lung condition that causes shortness of breath), heart failure, and high blood pressure.<br><br>Review of the resident's Comprehensive care plan, dated 05/07/26, showed:- The Resident required oxygen at two liters per minute via nasal cannula continuously due to shortness of breath with activity, emphysema (long term lung condition that causes shortness of breath), and chronic bilateral pleural effusions (an accumulation of excess fluid in the pleural spaces (the thin cavities between the lungs and the chest wall) on both sides of the chest).<br><br>Review of the resident's physician orders, dated 01/30/26, showed:- Administer oxygen at two liters via nasal canula and adjust to keep blood oxygen levels above 90%;- Change all oxygen tubing, humidifier bottles, and nebulizer tubing and plastic bags once weekly on Wednesday and ensure all items are dated and excess tubing is stored in the new plastic storage bags;- The day shift CMT to clean oxygen humidifier bottle and change the distilled water each day;- The evening CMT to check oxygen humidifier bottle and fill with distilled water as needed;- The night nurse to check oxygen humidifier bottle to ensure it is not empty and fill with distilled water as needed.<br><br>Observation of the resident's room, on 05/18/2026 at 10:10 A.M., showed:- Oxygen on and operating at two liters per minute via nasal cannula;- No storage bag for the oxygen tubing on the concentrator;- There had been no date written on the oxygen tubing and no date written on the humidifier bottle;- Nebulizer mask and tubing sat on the trash can.<br><br>Observation of the resident's room, on 05/19/2026 at 8:00 A.M., showed:- The oxygen tubing remained undated with no storage bag;- The nebulizer tubing undated, with no storage bag, sitting open on nebulizer.<br><br>Observation of the resident's room, on 05/20/2026 at 8:30 A.M., showed:- The oxygen humidifier bottle and tubing had been changed and dated 5/18;- The oxygen tubing had a blue cover down the (continued on next page) |

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| F 0695<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | length of the tubing, but no storage bag present;- The nebulizer tubing was dated 5/18, and the tubing was twisted under the wheel of the bedside table and the nebulizer mask had been hanging from the nebulizer machine tubing nub.<br><br>During an interview on 05/21/26 at 8:30 A.M., the resident said he/she would expect the nursing staff to maintain his/her oxygen supplies properly.<br><br>2. Review of Resident #31's Quarterly MDS, dated [DATE], showed:- Cognitively intact;- Required moderate assistance from staff for toileting, showering, and dressing;- Diagnoses: chronic respiratory failure and anxiety.<br><br>Review of he resident's Comprehensive care plan, dated 03/06/26, showed:- Required one person assistance with bathing, transfers, and dressing;- Required supplemental oxygen for COPD diagnosis;- The nursing staff were required to administer oxygen as ordered and change tubing weekly per protocol.<br><br>Review of the resident's physician orders, dated 05/21/26, showed:- Oxygen at two liters via nasal canula and adjust to keep blood oxygen levels above 90%;- Change nebulizer tubing and plastic bag weekly on Wednesday and date both items;- Replace nebulizer tubing every Wednesday evening.<br><br>Observation of the resident's room, on 05/18/2026 at 9:00 A.M., showed:- Oxygen on at two liters per minute via nasal cannula;- No bag for storing the oxygen tubing and the tubing and humidifier bottle had been undated;- The nebulizer mask and tubing sat on the nebulizer machine undated and with no storage bag;- The portable oxygen tank tubing undated.<br><br>Observation of the resident's room, on 05/21/26 at 8:10 A.M., showed:- Oxygen on at two liters per minute via nasal cannula;- The oxygen tubing and humidifier dated;- The portable oxygen tank tubing dated but were not stored in a bag;- The nebulizer mask and tubing dated but were on the nebulizer and not in a storage bag.<br><br>During an interview on 05/21/26 at 8:10 A.M., the resident said he/she would expect the nursing staff to maintain his/her oxygen supplies properly.<br><br>During an interview on 05/20/2026 at 3:20 P.M., Licensed Practical Nurse (LPN) A said:- Oxygen and nebulizer tubing should be dated when changed by the Certified Medication Technicians (CMT), usually weekly. They change them when doing the breathing treatments;- The tubing and nebulizer mask should be kept in a plastic bag after being rinsed off and dried on paper towels;- The humidifier bottle gets rinsed daily, rinsed in baby soap weekly, and changed monthly. They should be dated when changed;- The oxygen concentrator filters should be cleaned.<br><br>During an interview on 05/20/2026 at 3:28 P.M., CMT B said:- The oxygen tubing and nebulizer mask and tubing should be dated when changed by the CMT's;- The humidifier bottle should be dated when changed monthly, and rinsed daily, baby soap rinsed weekly;- Maintenance is always working on the filters, they are the ones who clean them on the concentrators and air conditioners.<br><br>During an interview on 05/21/2026 at 8:00 A.M., CMT C said:- The oxygen tubing and nebulizer tubing should be changed weekly by the med techs on this side in the afternoon and on the other side usually in the morning on Wednesdays;- The oxygen and nebulizer tubing should be dated when its changed;- The facility used the blue sleeve to protect the oxygen tubing from touching the floor on the residents (continued on next page) |

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| F 0695<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | who wear it all the time;- The nebulizer tubing and mask should be stored in a bag when not being used, unless it's being cleaned and laid out to dry on paper towels. Then it goes in the bag;- Storage bags should be used for oxygen tubing used on the portable tanks.<br><br>During an interview on 05/21/26 at 7:57 A.M., the Director of Nursing (DON) said the nebulizer mask should be stored in a bag after it has been cleaned and is dry and should be dated as well.<br><br>3. Review of Resident #11's Quarterly MDS, dated [DATE], showed:<br><br>-The resident was not cognitively intact;<br><br>-The resident required oxygen therapy;<br><br>-Diagnoses of acute pulmonary edema (build up of fluid in the lungs), heart failure (a condition where the heart is too weak to effectively pump blood), wheezing (a high pitched whistling sound that occurs when breathing).<br><br>Review of Resident #11's care plan, dated 04/20/2026, showed:<br><br>-The resident required supplemental oxygen as needed to keep oxygen saturation (a measurement of the cells in blood that carry oxygen) above 90%;<br><br>-Staff were to change the oxygen tubing weekly.<br><br>Observation on 05/18/2026 at 4:10 P.M. showed:<br><br>-An oxygen concentrator sitting in the resident's room with the oxygen tubing coiled up sitting on top of the concentrator;<br><br>-No date on the oxygen tubing indicating when the oxygen tubing was changed;<br><br>-The oxygen concentrator filter had a layer of dust built up on it.<br><br>Observation on 05/19/2026 at 2:17 P.M. showed:<br><br>-Oxygen tubing covered with a CPAP hose cover, the part of the oxygen tubing that went into the resident's nose was not covered and the oxygen tubing was still coiled up and sitting on top of the oxygen concentrator;<br><br>-The oxygen concentrator filter had a layer of dust built up on it.<br><br>During an Interview on 05/21/2026 at 9:17 A.M. the Infection Control Nurse said:<br><br>-The CPAP hose cover acted as a barrier so the oxygen tubing would not touch the floor while in use;<br>(continued on next page) |

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| F 0695<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | -He/she believed that the oxygen filters were cleaned monthly but was not sure;<br><br>-The resident's oxygen tubing should have been kept in a bag to keep it clean since the resident only used the oxygen as needed.<br><br>During an Interview on 05/21/2026 at 9:25 A.M. the MDS Coordinator said:<br><br>-Oxygen tubing was changed weekly and the filters on the oxygen concentrators were cleaned at the same time the tubing was changed;<br><br>-He/she was not sure if the oxygen tubing should have been kept in a bag to keep it clean or if it was okay for the oxygen tubing to be coiled up and sat on the top of the oxygen concentrator.<br><br>During an Interview on 05/21/2026 at 11:49 A.M. the Director of Nursing (DON) said:<br><br>-Oxygen tubing should be changed weekly on Wednesday's and labeled with the date it was changed;<br><br>-The oxygen filters were cleaned either monthly or weekly;<br><br>-She was not sure if there was any documentation in the resident's medical record when oxygen tubing was changed and oxygen concentrator filters were cleaned.<br><br>4. Review of Resident #44's Quarterly MDS, dated [DATE] showed:<br><br>Cognitive skills severely impaired.<br><br>Dependent on the assistance of staff for toilet use, lower extremity dressing, personal hygiene, and transfers.<br><br>Required substantial to maximum assistance with showers and upper extremity dressing.<br><br>Always incontinent of urine.<br><br>Frequently incontinent of bowel.<br><br>Diagnoses included high blood pressure, diabetes mellitus, anxiety and depression.<br><br>Review of the resident's care plan revised 3/31/26 showed it did not address the use of oxygen.<br><br>Review of the resident's POS, dated May 2026 showed asStart date: 10/20/25 - Oxygen - titrate to keep oxygen saturation (amount of oxygen in the blood) greater than 90%.<br><br>Review of the resident's Treatment Administration Record (TAR), dated May 2026, showed:<br><br>Oxygen - titrate to keep oxygen saturation greater than 90%.<br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 265800 | A. Building<br>B. Wing | 05/21/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Gower Convalescent Center, Inc | 323 South Highway 169<br>Gower, MO 64454 |

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

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| F 0695<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | No oxygen saturation was documented.<br><br>Observation on 5/18/26 at 2:28 P.M. showed the oxygen tubing was not dated and the humidified water bottle was not dated. The oxygen tubing was draped over the oxygen concentrator and was not in a protective bag.<br><br>Observation on 5/19/26 at 1:54 P.M., showed the oxygen tubing was not dated and the humified water bottle was not dated. The oxygen tubing remained draped over the oxygen concentrator and was not in a protective bag.<br><br>During an interview on 5/21/26 at 7:53 A.M., the MDS/Care Plan Coordinator said:<br><br>The resident used the oxygen as needed. The oxygen tubing should be changed weekly and dated when changed, even if the oxygen was only used as needed.<br><br>There should be an order for the oxygen tubing and the humified water bottles to be changed.<br><br>The oxygen saturation should be documented.<br><br>The oxygen tubing and the humidified water bottle should be dated.<br><br>During an interview on 5/21/26 at 8:33 A.M., CNA A said the resident used the oxygen at night and as needed, but does not use it continuously.<br><br>During an interview on 5/21/26 at 8:56 A.M., Certified Medication Technician (CMT) A said:<br><br>The resident used the oxygen in the mornings when his/her oxygen saturation was low.<br><br>He/She would let the Charge Nurse (CN) know what the oxygen saturation was.<br><br>The oxygen and nebulizer tubing should be changed weekly and dated with the staff's initials.<br><br>The humidified water bottle should be changed monthly and dated.<br><br>During an interview on 5/21/26 at 11:48 A.M., the Administrator and the DON said:<br><br>The oxygen tubing should be changed weekly and dated. The CMTs change them weekly on Wednesdays.<br><br>The humidified water bottles are not dated and should be changed monthly.<br><br>The nurses should document the oxygen saturation on the TARs. |

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| F 0675<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Honor each resident's preferences, choices, values and beliefs.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record review, the facility failed to ensure one of the 17 sampled residents, (Resident #10) received care which would allow the resident to achieve his/her highest practicable well-being. The facility census was 67. Review of the facility's Resident Rights Policy revised 8/25 showed:-As a resident, you have the right to a dignified existence, self-determination, and communication with access to people and services inside and outside the facility. -The facility must treat you with respect and dignity and care for you in a manner and in an environment that promotes maintenance or enhancement of your quality of life, while recognizing your individuality. -The right to reside and receive services in the facility with reasonable accommodation of your needs and preferences except when to do so would endanger your health or safety or the health or safety of other residents.-You have the right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and support for daily living safely. The facility must provide a safe, clean, comfortable, and homelike environment. -Housekeeping and maintenance services necessary to maintain a sanitary, orderly and comfortable interior. 1.Review of Resident #10's Comprehensive Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 03/03/26 showed:- Cognitive skills intact;- Upper and lower extremity impaired on one side;- Dependent on the assistance of staff for toilet use, showers, lower extremity dressing; - Required substantial to maximum assistance with upper extremity dressing, personal hygiene and transfers;- Occasionally incontinent of urine;- Always continent of bowel;- No falls;- Diagnoses included high blood pressure, diabetes mellitus, stroke, hemiplegia (paralysis affecting one side of the body) and hemiparesis (muscular weakness on one side of the body). Review of the resident's care plan, revised 04/0/26 showed:- Since his/her stroke in November 2025, the left side of the resident's body is flaccid. The ability to walk, dress, toilet, and maintain personal hygiene has deteriorated. He/She had a recent fall which caused a fractured pelvis and a brain bleed. Approaches included placing a pillow on his/her lap to keep the left arm positioned. Follow Occupational Therapy/Physical Therapy/Speech Therapy (OT/PT/ST) recommendations. He/She had a blue splint to wear on the left hand every night. Place the sling on the left arm before transferring due to hemiplegia. Preferred to use the bedside commode or the bedpan. Provide one or two staff assistance for transfers, dressing, toileting, bathing and bed mobility. - The resident experienced occasional bladder incontinence related to left hemiplegia and limited mobility, which usually occurred at night. Approaches included adapting the environment to maximize independence: grab bars, bedside commode, bedpan. Provide one or two staff assistance for toileting. Observation and interview on 05/18/26 at 2:03 P.M., showed:- The resident sat in a wheelchair in his/her room. - He/She had been in the current room for about three weeks, and he/she was unable to use the bathroom in his/her room because they had been working on it. They were supposed to put a grab bar on the wall by the toilet and were not sure what else. - There was a bedpan in a plastic bag on the floor. It had various tools on one side of the bathroom. Did not have a bedside commode in the bathroom. - If he/she had to go to the bathroom, the staff took him/her to the 100 or the 200 halls to use the bathroom. It was especially hard when the resident had diarrhea. - He/She would prefer to use the bathroom in his/her room. At night he/she used the bedpan. - No one has told the resident when the bathroom would be fixed. During an interview on 05/19/26 at 2:50 P.M., the Director of Nursing (DON) said she was not sure when the resident was moved rooms. She was not aware the grab bar had not been installed in the resident's bathroom. Normally, they make sure the room is completely ready before the resident is moved. They had recently just remodeled the resident's room. She thought the resident had moved to the room on 05/11/26. During an interview on 5/19/26 at 2:53 P.M., the Maintenance Director said:-He/She was verbally notified on Friday, 05/15/26 about the resident needing a grab bar in the bathroom. -It has not been installed yet because he/she had to order one and it had been ordered. -At 3:35 P.M., he/she (continued on next page) |

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| F 0675<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | placed a toilet safety rail over the toilet for the resident to use. -At 3:39 P.M., he/she brought a copy of the order for the grab bar. He/She said it had not been ordered yet; it was still in his/her cart to be ordered online. During an observation and interview on 05/19/26 at 3:40 P.M., the resident said:-He/She did not know if the toilet safety rail would work or not because it did not seem very stable.-He/She did not like having to leave his/her room to get the 100 or 200 halls to go to the bathroom, especially when he/she had diarrhea. It made him/her feel terrible and very embarrassed. -He/She had had an accident waiting for the staff to take him/her to the bathroom and it was so embarrassing. He/She hated not being able to clean him/herself up after going to the bathroom, but having diarrhea on top of it, was just so embarrassing! During an interview on 05/20/26 at 10:29 A.M., the Maintenance Director said:-He/She was aware the resident had been moved to a different room but was not aware of when the transfer took place.-If he/she had been aware, the maintenance staff would have checked the room to ensure it was ready and everything was set up for the resident. During an interview on 05/21/26 at 7:53 A.M., the MDS/Care Plan Coordinator said:-The resident had a stroke and had fallen with fractures prior to being admitted to the facility. -He/She thought the resident had moved to a different room in the last week. -He/She was not aware there was not a grab bar in the resident's bathroom for the resident to use. The resident should be able to use the bathroom in his/her room. During an interview on 05/21/26 at 8:33 A.M., Certified Nurse Aide (CNA) A said:-To get the resident up and out of bed would take two staff, otherwise the resident is a one person assist. It takes two staff to toilet the resident. -He/She did not know until this week the resident was unable to use the bathroom in his/her room. They take the resident to the bathroom on 100 or 200 halls. The resident does well with the gait belt (a special belt placed around the resident's waist to provide a handle to hold onto during a transfer) and using the grab bar to stand and pivot onto the toilet. -The bathroom in the resident's room is tight for space, and the toilet is not working, at least that's what the resident said. -He/She did not know if there was a grab bar on the wall in the resident's room or not. During an interview on 05/21/26 at 8:56 A.M., Certified Medication Technician (CMT) A said:-The resident is not able to use his/her left side. The therapist thought the resident would have an easier time getting in and out of bed if the resident was in room [ROOM NUMBER] due to the resident's left side not working. -He/She thought the staff took the resident into the big bathrooms on the 100 and 200 halls because the resident's bathroom didn't have enough space. During an interview on 05/21/26 at 9:12 A.M., CNA B said:-The resident is a two person assist, especially when toileting because of how he/she pivots. The resident is not able to move his/her left side at all. -He/She thought the resident moved last week or the week before that. -The resident is unable to use the bathroom in his/her room because it does not have a grab bar for the resident to use. He/She was aware the resident was not able to use his/her bathroom in his/her room.-He/She thought they filled out a maintenance request for the grab bar last Thursday.-They take the resident to the big bathrooms on the 100 or 200 halls to use the toilet. -During an interview on 05/21/26 at 9:26 A.M., the Maintenance Director said:-The request for the grab bars was filled out on 05/19/26. As far as he/she is aware, the resident's toilet is working in the resident's bathroom. During an interview on 05/21/26 at 11:45 A.M., the Speech Therapist (ST) said:-He/She was not aware of any grab bars in the resident's bathroom. -He/She thought the staff took the resident to the bigger bathrooms on the 100 or 200 halls because the resident was a two person assist.-The resident can hold onto the grab bar with his/her right hand but did not think the resident had enough strength to hold onto it with his/her left hand. During an interview on 05/21/26 at 11:48 A.M., the DON and the Administrator said:-The aides take the resident to the big bathroom on the 100 or 200 halls. -The resident's room should have been set up before the resident moved into it. They were not aware that the room was not ready. It was not made clear to the DON or the Administrator. -They had just remodeled room [ROOM NUMBER]. If they had known it was not ready, they would not have moved the resident. -She had observed the staff taking the resident to the bigger bathrooms but was not aware that the resident was uncomfortable with it. |