STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265804	A. Building B. Wing	11/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Manor at Elfindale, The	1707 West Elfindale Street Springfield, MO 65807

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards when staff failed to use effective hair restraints; failed to consistently date opened foods and properly close frozen foods to prevent freezer burn; stored a measuring cup in the thickener container, and did not close the container; failed to clean the fans inside of the refrigerator; and failed to clean the deflector shield in the ice machine located in the kitchen. The facility census was 94.1. Review of the 2013 Food Code, issued by the Food and Drug Administration (FDA), showed food employees shall wear hair restraints such as hats, hair coverings or nets, beard restraints, and clothing that covers body hair, that are designed and worn to effectively keep their hair from contacting exposed food; clean equipment, utensils, and linens; and unwrapped single-service and single-use articles.Review showed the facility did not provide a policy regarding the use of hair net restraints.Observations on 09/15/25, beginning at 9:05 A.M., showed the Dietary Manager (DM) in the kitchen with facial hair observed on his/her chin. The DM prepared mashed potatoes. The DM did not wear a hair net over the exposed hair.Observations on 09/17/25, beginning at 10:35 A.M., showed the DM in the kitchen with facial hair observed on his/her chin. The DM did not wear a hair net over the exposed hair.During an observation and interview on 09/17/25, at 1:37 P.M., Culinary [NAME] (CC) A was in the kitchen, wearing a beard net that covered his/her beard. CC A had a mustache that was not covered by a hair net. He/she was peeling potatoes. He/she said staff were expected to wear a hair net when in the kitchen, and hair nets should cover all facial hair, including the beard and mustache.During an interview on 09/17/25, at 1:44 P.M., Culinary Aide (CA) B said hair nets should be wore when staff are in the kitchen. The hair nets should cover all hair, including any facial hair.During an interview on 09/17/25, at 1:44 P.M., CA B said hair nets should be wore when staff are in the kitchen. The hair nets should cover all hair, including any facial hair.During an interview on 09/17/25, at 1:48 P.M., CC C said hair nets should be on while in the kitchen. The hair nets should cover all hair, including beards and mustaches.During an interview on 09/17/25, at 1:51 P.M., CA D said staff should put on hair nets as soon as they walk into the kitchen. The hair nets should cover all hair, including facial hair. Staff should wear a beard net if they have a beard or mustache.During an interview on 09/18/25, at 8:51 A.M., the DM said staff should be wearing a hair net as soon as they step into the kitchen. The hair nets should cover any facial hair and the hair on top of the head.During an interview on 09/18/25, at 9:05 A.M., the Administrator said staff should be wearing hairnets when in the kitchen. The hair nets should cover the hair on top of the head. 2. Review of the 2013 Missouri Food Code showed food shall be protected from contamination by storing the food in a clean, dry location, and where it is not exposed to splash, dust, or other contaminationReview showed the facility did not provide a policy on storing opened foods or dating open foods.Observations on 09/15/25, beginning at 9:05 A.M., showed the following:-A box of hamburger patties in the walk-in freezer. The patties were in a bag, inside of the box. The bag was opened, and the patties exposed, some patties had white substance on them. There were approximately 15 patties in the bag;-One large container of garlic, opened and approximately 1/3 of the item remaining. It had no open date or use by date.Observations on 09/17/25, beginning at 10:35 (continued on next page)

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

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	the cleaning schedule for September 2025 showed the following:-The night shift was to wipe down the ice machine ice reflector guard on Fridays;-The week of 09/01/25, no staff initialed completing this task;-The week of 09/08/25, no staff initialed completing this task.During an interview on 09/17/25, at 1:37 P.M., CC A said the DM drained the ice machine and cleaned the inside. He/she believes the DM did this one time per week. They have a cleaning list they are expected to complete daily and weekly. The ice guard shouldn't have black spots on the inside.During an interview on 09/17/25, at 1:44 P.M., CA B said the kitchen staff clean the ice machine. It was included in the cleaning schedule, but he/she was not sure how often it's done.During an interview on 09/17/25, at 1:48 P.M., CC C said maintenance cleaned the inside of the ice machine. They have a schedule. He/she was not sure how often this was completed. The ice machine should be clean.During an interview on 09/17/25, at 1:51 P.M., CA D said maintenance cleans the inside of the ice machine, but he/she doesn't know how often.During an interview on 09/18/25, at 8:51 A.M., the DM said every six months maintenance drains the ice machine, takes all of the ice out, and sanitizes everything. He/she was not aware of any black or brown substance on the deflector shield. He/she monitored the cleaning schedules. Staff were to initial as they complete tasks.During an interview on 09/18/25, at 9:05 A.M., the Administrator said the ice machine was on a schedule for maintenance to clean.During an interview on 09/18/25, at 3:17 P.M., the Maintenance Director said he/she cleaned the inside of the ice machine. He/she descaled the inside by removing the ice and running a chemical through the machine. This was on the cleaning list to do every two to three months. He/she had not noticed any black spots on the deflector shield.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. Based on observation, record review, and interview, the facility staff failed to ensure the facility was maintained in a sanitary and comfortable fashion when the outside of the ice machine had drips of lime down the side, the ice machine vent had fuzzy lint present, and one knob was missing from the cook stove. The facility census was 94.1. Review showed the facility did not provide a policy regarding cleaning the ice machine. Review of the cleaning schedule for September 2025 showed the following:-The September cleaning schedules showed the night shift was to wipe down the ice machine and ice reflector guard on Fridays;-The week of 09/01/25, no staff initialed completing this task;-The week of 09/08/25, no staff initialed completing this task.Observations on 09/15/25, at 9:05 A.M., and on 09/17/25, at 10:35 A.M., showed three drips of a white substance down the left side of the ice machine.During an interview on 09/17/25, at 1:37 P.M., [NAME] A said the Dietary Manage (DM) cleans the outside of the ice machine one time per week. It was on the cleaning schedule.During an interview on 09/17/25, at 1:44 P.M., Culinary Assistant (CA) B said anyone can clean the outside of the ice machine. The kitchen staff have that on the cleaning list.During an interview on 9/17/25, at 1:48 P.M., [NAME] C said he/she was unsure who was responsible for cleaning the outside of the ice machine.During an interview on 9/17/25, at 1:51 P.M., CA D said maintenance cleaned the outside of the ice machine. He/she was not sure how often, but it was probably on a cleaning list.During an interview on 9/18/25, at 8:51 A.M., DM said the kitchen staff were responsible for wiping down the outside of the ice machine. This was on the cleaning schedule that he/she monitors.During an interview on 09/18/25, at 9:05 A.M., the Administrator said maintenance cleans the outside of the ice machine. It was on a cleaning schedule.During an interview on 09/18/25, at 3:17 P.M., the Maintenance Director said kitchen staff can wipe down the ice machine. He/she also does it when it's descaled.2. Observations on 09/15/25, beginning at 9:05 A.M., and on 09/17/25, at 10:35 A.M., showed the vent on the left side of the ice machine, had fuzzy lint present.During an interview on 09/17/25, at 1:37 P.M., CC A said cleaning the vents on the ice machine was part of the entire cleaning process and the DM did this one time per week.During an interview on 09/17/25, at 1:44 P.M., CA B said he/she didn't know who was responsible for cleaning the vents on the outside of the ice machine. They should not have lint on them.During an interview on 09/17/25, at 1:48 P.M., [NAME] C said he/she was not sure who cleaned the vents on the outside of the ice machine.During an interview on 09/17/25, at 1:51 P.M., CA D said maintenance cleaned the vents on the ice machine. He/she was not sure how often this was completed.During an interview on 09/18/25, at 8:51 A.M., the DM said maintenance cleaned the vents when he/she descaled the ice machine.During an interview on 09/18/25, at 9:05 A.M., the Administrator said maintenance was responsible for cleaning the outside of the ice machine.During an interview on 09/18/25, at 3:17 P.M., the Maintenance Director said maintenance cleaned the vents on the ice machine. 3. Observations on 09/15/25, beginning at 9:05 A.M., and on 09/17/25, at 10:35 A.M., showed no knob on the seventh control post of the stove missing.During an interview on 09/17/25, at 1:37 P.M., [NAME] A said the knob for the burner had been missing awhile. He/she was still able to turn the burner on and off.During an interview on 09/17/25, at 1:48 P.M., [NAME] C said the knob had been missing a while. The burner still turns on and off without it.During an interview on 09/18/25, at 8:51 A.M., the DM said the knob had been missing awhile. He/she had looked for a replacement, but the stove was older, and he/she hadn't been able to locate one.During an interview on 09/18/25, at 9:05 A.M., the Administrator said he/she would get a knob for the stove.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted Based on record review and interview, the facility failed to complete the baseline care plans for all residents within 48 hours of admission and failed to document resident and/or representative was provided a copy of the baseline care plan when staff did not complete a full baseline care plans within 48 hours of admission for two residents (Residents #37 and #95) and failed to document representative or resident notification of the care plan for the residents. A sample of 19 residents was selected for review in a facility with a census of 94. Review showed the facility did not provide a policy related to Baseline Care Plans.1. Review of Resident #37's facility face sheet (admission information) showed the following information:-admission date of 09/04/25;-Diagnoses included history of head and face injury with fracture, diabetes type 2, depression, reduced mobility;-Resident was cognitively intact.Review of the resident's admission (baseline) care plan, created 09/10/25, showed the following information:-Staff care planned related to resident personal preferences (such as activities, etc.);-Staff care planned related to resident's history prior to being admitted to the facility;-Staff did not care plan regarding other care needs (such as diabetes or depressions) of the resident;-The care plan did not have a signature of the resident or a resident representative confirming receipt of a copy of the baseline care plan or a summary of the baseline care plan.2. Review of Resident #95's facility face sheet showed the following information:-admission date of 09/03/25;-Diagnoses included history of leg fracture, heart disease, and weakness;-Resident was cognitively intact.Review of the resident's admission (baseline) care plan, created 09/09/25, showed the following information:-Staff care planned related to the resident's personal preferences (such as activities, etc.);-Staff care planned related to part of the resident's history prior to being admitted to the facility;-Staff care planned the resident was at risk for poor nutrition;-Staff did not care plan related to other care needs (such as leg fracture and weakenss) of the resident;-The care plan did not have a signature of the resident or a resident representative confirming receipt of a copy of the baseline care plan or a summary of the baseline care plan.3. During an interview on 09/19/25, at 9:13 A.M., Life Enrichment Aide P said for care and needs for a specific resident, facility nurses have access to the information. For what residents like and don't like he/she must learn through experience with the resident. He/She was able to look through the electronic medical records (EMR) at times, but he/she did not know of a specific area to look for care needs.During an interview on 09/19/25, at 9:19 A.M., Certified Nurse Aide (CNA) Q said for a newer resident, he/she would have to talk to a nurse about the resident needs. For a resident in memory care, staff can't always ask them directly. This staff would need to get information from therapy or other staff. For charting on resident needs and activities, he/she does not have direct access to things like resident being continent or not, requiring assistance with transfers or not, etc. He/She did have access to some things in the EMR and could see some basic info on the residents. However, that is not always available for new admissions. He/She thought he/she might be able to see care plans, but is unsure. During an interview on 09/19/25, at 9:39 A.M., CNA R said for resident needs and care information, he/she usually discusses information with the resident. For more specific resident information, he/she will ask the nurses. During an interview on 09/19/25, at 9:50 A.M., Certified Medication Tech (CMT) O said the Kardex (located in the resident electronic medical records) is available for information on residents and will tell the resident story, plus limitations and expectations. The Kardex is in the EMR and he/she believed all staff were able to access this information. As far as care plans, he/she doesn't ever access them. The Kardex is where he/she goes for resident information. During an interview on 09/19/25, at 10:26 A.M., the Minimum Data Set (MDS - a federally mandated assessment tool completed by facility staff) Coordinator A said resident allergies are listed on the face sheet in the EMR. Resident preferences are listed on Care Plans. Nurses and department heads can put information on the Care Plans. Floor nurses can put in information in the Care Plan, but often (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	information is put in by the MDS Coordinators after inter-disciplinary (IDT) or other meetings. For the full Care Plan, it can take up to 21 days for staff to complete them. That Care Plan should include resident medication and allergies and likes and dislikes. Sometimes pain issues are addressed there as well. Care Plans should include special medications, or resident is continent or not, plus unique concerns and problems. For new residents, staff build the Care Plan as we go along. Staff usually complete care plans after the first MDS assessment at 8 to 10 days after admission. For rehabilitation residents, staff should complete Baseline Care Plans immediately The nurses build up the Baseline Care Plan based on some guided questions. General questions answered for the baseline include all of the assistance with daily tasks questions and specialty items. Things like IV therapy, oxygen use, transfusions, specific medications, pain, or fall history should all be on a resident Baseline Care Plan. Staff have up to 21 days to complete comprehensive Care Plans, but staff should have completed Baseline Care Plans by 24 hours. During an interview on 09/19/25, at 10:50 A.M., the Administrator said the facility policy for completing Care Plans is based on Centers for Medicaid and Medicare Services (CMS) guidelines.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 interview, and record review, the facility failed to develop and implement a complete comprehensive person-centered care plan for all residents when staff did not care plan relating to a wound for one resident (Resident # 5), did not care plan oxygen usage for one resident (Resident #101), and did not care plan regarding a fracture for one resident (Resident #38). The facility census was 94.Review of facility policy titled Comprehensive Care Plans, dated November 2016, showed the following:-It is the policy of the facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, and mental, and psychosocial needs that are identified in the resident's comprehensive assessment;-The care planning process will include an assessment of the resident's strengths and needs;-The comprehensive care plan will describe, at a minimum services that are to be furnished to attain or maintain the resident's highest physical, mental, and psychosocial wellbeing; any services that would otherwise be furnished; any specialized services the facility will provide; and the resident's goals for admission, desired outcomes, and preferences for future discharge; -The comprehensive care plan will be prepared by an interdisciplinary team;-The comprehensive care plan will include measurable goals and timeframes to meet the resident's needs as identified in the resident's comprehensive assessment;-Team members responsible for carrying out interventions in the care plan will be notifies of their roles and responsibilities for carrying out the interventions.1. Review of the Resident #5's face sheet (a document that gives a resident's information at a quick glance) showed the following:-An admission date of 10/18/24;-Diagnoses included congestive heart failure (CHF - a long-term condition in which the heart can't pump blood well enough to meet the body's needs) and chronic kidney disease (CKD - disease characterized by progressive damage and loss of function in the kidneys).Review of the resident's quarterly Minimum Data Set (MDS - a federally mandated comprehensive assessment instrument completed by facility staff), dated 07/31/25, showed the following information: -Cognitively intact;-Independent with activities of daily living (ADL - basic self-care tasks essential for independence)-Used a walker for mobility;-Resident was at risk for pressure ulcers;-Resident had one stage 3 pressure ulcer (full-thickness loss of skin, in which subcutaneous fat may be visible in the ulcer and granulation tissue and epibole (rolled wound edges) are often present). Review of resident's July 2025 Physician Order Sheet (POS) showed an order, dated 07/29/25, to cleanse area to left second toe, apply skin prep, and leave open to air, one time a day for scabbed area to left second toe. Staff to discontinue when resolved.Review of the resident's pressure ulcer record, dated 07/29/25, showed the resident had a facility acquired stage 3 pressure wound to the left toe. Summary indicated the area started as a dry scab. The wound area to the left second toe was approximately 0.4 centimeters (cm) by 0.4 cm by 0.2 cm. The area is 100% pink with scant bloody drainage. The surrounding skin was pink dry and intact. Treatment orders in place and will continue to monitor.Review of the resident's pressure ulcer record, dated 08/05/25, showed resident had a facility acquired stage 3 pressure wound to the left toe. Summary indicated the area started as a dry scab. The wound area to the left 2nd toe is approximately 0.4 cm by 0.4 cm by 0.1 cm. The area is 100% pink with scant yellow drainage. The surrounding skin is pink dry and intact.Review of the resident's pressure ulcer record, dated 09/16/25, showed resident had a facility acquired stage 3 pressure wound. The area to the left 2nd toe was approximately 0.3 cm by 0.3 cm. The area was a dry intact dark brown scab. The surrounding skin was dry, intact and blanches without pain.Review of the resident's care plan, revised on 4/07/25, showed staff did not update the care plan to address the wound to the resident's left toe.2. Review of the Resident #101's face sheet showed the following:-An admission date of 10/23/2024;-Diagnoses included CHF and chronic obstructive pulmonary disease (COPD - a group of lung diseases that block airflow and make it difficult to breathe).Review of the resident's quarterly (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	MDS, dated [DATE], showed the following information: -Moderate cognitive impairment;-Dependent with transfers, showers, dressing, and toileting;-Used a wheelchair for mobility;-Did not use oxygen or a continuous positive airway pressure (CPAP - a machine to deliver air pressure to help you breathe during sleep). Review of the resident's current POS showed the following:-An order, dated 09/08/25, for oxygen at 2 liters per minute via nasal canula as needed for shortness of breath to maintain oxygen saturation above 90% related to respiratory failure;-An order, dated 09/08/25, for CPAP to be applied and checked on during the night.Review of the resident's progress note, dated 09/04/25, showed the resident had audible wheezing noted with accessory muscle use also noted. Oxygen saturation was 91% on room air. Staff applied oxygen applied at 4 liters.Review of the resident's progress note, dated 09/08/25, showed resident was on oxygen at 2 liters per minute via nasal cannula.Review of the resident's care plan, dated 11/15/24, showed the following:-At risk for altered respiratory function related to COPD and asthma;-Resident will display optimal breathing patterns daily;-Assess respiratory status such as depth, rate, presence of breath sounds, dyspnea,shortness of breath, and cough as needed;-Check oxygen saturation as required;-Head of bed elevated as needed;-Maintain a clear airway and encourage to cough to clear secretions as needed.(Staff did not care plan related to the resident's oxygen or CPAP usage.)During an interview on 09/18/25, at 3:11 P.M., MDS Coordinator B said the resident should have his/her CPAP and oxygen included on the care plan. 3. Review of Resident #38 's face sheet showed the following:-admission date of 03/14/23;-Diagnoses included atrial fibrillation (irregular heartbeat), vascular dementia (brain disorder that occurs when blood flow to the brain is reduced leading to cell damage and memory loss), unspecified fall, weakness, depression (feelings of sadness), and anxiety (excessive and persistent worry or fear).Review of the resident's quarterly MDS, dated [DATE], showed the following:-Moderate cognitive impairment;-Partial assistance with toileting, showers, upper and lower body dressing;-Set up with personal hygiene.Review of the resident's progress note, dated 05/07/25, showed the following:-On 05/07/25, at 10:41 A.M., certified nurse aides (CNA) observed the resident on the floor and called the nurse. Resident on her stomach, complaining of pain to left hip/leg. Resident was able to roll him/herself onto his/her back. Resident was unable to straighten left leg. Nurse noted shortening and outward rotation. Resident was unable to sit up or stand. Resident assisted to bed with two CNAs and a gait belt. Resident rated pain 10/10 and was asking for pain medication. Resident given as needed medications. Staff notified family and Nurse Practitioner (NP) and order obtained to have left hip X-ray done; -On 05/07/25, at 11:10 A.M., X-ray technician in the facility and completed the X-ray. Tech states to call the doctor and not wait for the x-ray results as this is a bad fracture, and the resident needed to go to the hospital;-On 05/07/25, at 11:44 A.M., called emergency medical services to requested ambulance for transport;-On 05/07/25, at 12:01 P.M., resident left via ambulance;-On 05/07/25, at 9:29 P.M., resident admitted to the hospital, waiting for orthopedic to see if resident a candidate for surgery. Review of the resident's care plan, last updated 07/14/25, showed the following:-ADL self care performance deficit related to musculoskeletal impairment. Needs assistance with washing back and hard to reach areas. Required assist with reposition self in bed. Used a walker. Requires assistance with toileting and transfers;-History and/or has potential for falls related to incontinence. Anticipate and meet resident's needs as needed. Call light in reach and encourage use. Continue to anticipate resident needs. Educate resident to turn the light on in the bathroom prior to sitting on the toilet. Maintain clutter free environment. Place items frequently used by resident within easy reach. Therapy to screen/evaluate for skilled services upon return;(Staff did not update the care plan to reflect the fall with fracture.) During an interview on 09/18/25, at 9:43 A.M., Licensed Practical Nurse (LPN) H said they have a risk management meeting and any falls are discussed in this meeting. The MDS Coordinators are involved in this meeting so they would know when to update the care plans for falls and additional interventions. 4. During an interview on 09/18/25, at 1:44 P.M., Certified Nurse Assistant (CNA) E said a care plan informs staff how to care for a resident. The care plan should include if a resident had a wound or utilized oxygen (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Manor at Elfindale, The	1707 West Elfindale Street Springfield, MO 65807

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	or a CPAP.During an interview on 09/18/25, at 1:49 P.M., Certified Medication Technician (CMT) J said a care plan was used to tell staff how to care for a resident. Care plans should include information on wounds, oxygen, and CPAP usage.During an interview on 09/18/25, at 3:11 P.M., MDS Coordinator B said staff have an interdisciplinary team (IDT) meeting daily and discuss resident changes such as falls and skin issues. The care plan is updated during the IDT meeting. The nurses tell him/her of resident changes in oxygen or medication and they would appear on the electronic charting system dashboard. During an interview on 09/18/25, at 3:30 P.M., CMT O said a care plan showed how to care for the resident, what they like, and preferences including activities. Oxygen use should be included on the care plan, but he/she was unsure of including CPAP use. He/she would want a wound to be included on the care plan. During an interview on 09/18/25, at 3:46 P.M., Licensed Practical Nurse (LPN) M said a care plan showed how staff should care for a resident. A care plan should include information on diagnoses, assistance needs, mental status, oxygen, CPAP use, and wounds. The facility has care plan meetings with the family to update care plan. Nurses complete a 24-hour report sheet that informs staff of any resident changes including medication changes. He/she would notify the Assistant Director of Nursing (ADON) about any updates needed to the care plan. During an interview on 09/19/25, at 9:50 A.M., the ADON said a care plan was used to identify what interventions were needed to care for the resident. Staff should be able to look at the care plan and know how to care for that resident. Wounds, CPAP use, and oxygen should be included in the care plan. The nurses fill out a risk assessment on residents and the MDS Coordinators use those to make care plans. Care plans are reviewed during IDT meetings for any updates and to ensure interventions are appropriate.During an interview on 09/19/25, at 10:41 A.M., the Administrator said he/she expected care plans to be updated so staff can care for the residents.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. Based on observation, record review, and interview, the facility failed to provide respiratory care per standards of practice when staff failed to obtain orders for the use of oxygen and care plan the use of oxygen for one resident (Resident #3). The facility census was 94.Review showed the facility did not provide a policy regarding oxygen therapy.1. Review of Resident #3's face sheet (a general information sheet) showed the following:-admission date of 03/06/25;-Diagnoses included sleep apnea (a potentially serious sleep disorder in which breathing repeatedly stops and starts), respiratory failure with hypoxia (low levels of oxygen) and hypercapnia (high levels of carbon dioxide in blood), congestive heart failure (CHF - a long-term condition that happens when the heart can't pump blood well enough to give the body a normal supply), and chronic kidney disease.Review of the resident's significant change Minimum Data Sheet (MDS - a federally mandated comprehensive assessment instrument completed by facility staff),dated 07/30/25, showed the resident did not use oxygen.Review of the resident's current Physician Order Sheet (POS) showed no order for oxygen.Review of the resident's care plan, updated 08/11/25, showed staff did not care plan related to oxygen use. Review of the resident's progress note, dated 09/12/2025, showed the resident's oxygen saturation was 82% on room air, Staff applied oxygen at 3 liters per minute (lpm) to bring saturation to 90%. Staff notified hospice of the change in condition and made a visit with resident. (Staff did not document physician notification or obtaining an order for oxygen use.) Review of the resident's progress note, dated 09/13/25, showed the resident had no signs or symptoms of pain or distress and vital signs stable on oxygen via nasal cannula.Review of the resident's oxygen saturation readings, dated September 2025, showed the resident was wearing oxygen on 09/13/25 and 09/14/25.Review of the resident's progress note, dated 09/15/25, showed the resident's respirations were slightly labored with minimal activity and on oxygen on as needed.Observation on 09/15/25 at 9:33 A.M., showed the resident asleep in recliner with oxygen in place at 3 lpm via nasal cannula.Observation on 09/18/25, at 3:43 P.M., showed the resident in bed with oxygen in place via nasal cannula at 3 lpmDuring an interview on 09/18/25, at 1:44 P.M., Certified Nurse Assistant (CNA) E said he/she had observed the resident wearing oxygen when he/she cared for them. The nurse reported the resident's oxygen saturation was low and he/she needed oxygen. The care plan tells the staff what the resident needs are and oxygen use should be included.During an interview on 09/18/25, at 1:49 P.M., Certified Medication Technician (CMT) J said care plans tell staff how to care for residents and should include oxygen.During an interview on 09/18/25, at 3:11 P.M., MDS Coordinator D said oxygen should be included on the care plan. He/she was not informed the resident was utilizing oxygen.During an interview on 09/18/25, at 3:46 P.M., Licensed Practical Nurse (LPN) M said oxygen was considered a medication and should have an order for use. A care plan would tell staff how to care for a resident and oxygen use should be on it. During an interview on 09/19/25, at 9:00 A.M., Registered Nurse (RN) L said oxygen was a medication and they should have an order for use. He/she remembered the resident using oxygen when he/she cared for them. There were no standing orders for oxygen use from the physician. Staff do not know what the oxygen is indicated for or the flow rate of oxygen if there is no order. During an interview on 09/19/25, at 9:10 A.M., RN K said oxygen should have orders and be included on the care plan. The resident had been using oxygen intermittently and should have had an order. During an interview on 09/19/25, at 9:50 A.M., the Assistant Director of Nursing (ADON) said oxygen required an order, but a nurse can initiate it based on nursing judgement. The physician should be called within 15 to 20 minutes of application of oxygen to obtain an order. The care plan is used to identify what interventions are needed to care for a resident and oxygen should be included. He/she was unaware the resident utilized oxygen.During an interview on 09/19/25, at 10:41 A.M., the Administrator said there should be an order for oxygen if a resident was using it. He/she expected care plans to be updated so staff can care for the residents.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. Based on observation, record review, and interviews, the facility failed to ensure a medication error rate of less than 5% when staff made three errors out of 31 opportunities resulting in an 9.67% error rate when facility staff failed to administer one medication and administered a medication that did not indicate a dosage to one resident (Resident #47) and failed to prime an insulin pen to ensure an accurate dose to one resident (Resident #52) during medication pass observations. The facility had a census of 94.1. Review of the facility procedure titled Safe Administration Practiced, Long-Term Care, dated 05/19/25, showed the following:-Be sure to administer daily ,weekly, and monthly medications within two hours of the scheduled administration time;-Consult the practitioner if there are unresolved concerns related to prescribed medications;-Documentation associated with safe medication administration would include medication name, strength, and dose.Review of resident #47's face sheet showed the following:-admission date of 08/28/24;-Diagnoses included high blood pressure and pulmonary fibrosis (chronic lung disease that causes lung tissues to become scarred and damaged, making it harder to breathe).Review of the resident's current POS showed the following:-An order, dated 08/28/24, for B-Complex (supplement) tablet, give one tablet by mouth one time a day related to vitamin B deficiency;-An order, dated 09/27/24, for Allegra (allergy medication) allergy tablet, give one tablet by mouth one time a day related to allergies (no dosage listed);-An order, dated 09/27/24, for fexofenadine HCl (generic brand for Allegra) tablet 180 milligrams (mg), give one tablet by mouth as needed for allergies. Up to once a day.Review of the resident's September 2025 Medication Administration Record (MAR) showed an order, dated 09/27/24, for Allegra allergy tablet, give 1 tablet by mouth one time a day (no dosage listed). The MAR showed the medication was documented as administered seventeen days in the month without a listed dosage.Observation of a medication pass on 09/17/25, at 9:50 A.M., showed Certified Medication Tech (CMT) N sanitized his/her hands and started to prepare medications to administer to the resident. The order for the resident's Allegra was noted to be an incomplete order with no dosage listed on the MAR. The CMT pulled the Allegra card from the medication cart, and it had a dosage of 180 mg and a sticker stating PRN at the top of the card. The CMT placed the Allegra in the medication cup to administer. The B complex vitamin was not in the medication cart and unavailable for administration at the ordered time. The CMT reported the facility was waiting for the medication to be delivered from the pharmacy and indicated a note stating medication was not available in the MAR. The CMT then entered the resident's room and administered the medications.During an interview and observation on 09/17/25, at 11:46 A.M., CMT N said the dose of the medication should be indicated on the order and included on the MAR. The Allegra had a standard dose, so it was not indicated in the order. The CMT then looked up the medication on his/her phone and reported the standard dosage as 180 mg.During an interview on 09/18/25, at 1:49 PM., CMT J said the CMT should write a progress note and alert the nurse if a medication was not available. He/she would consider it to be a medication error if the medication is not given at the ordered time. He/she would not give a medication that did not have a dosage listed. He/she would not know if it was the correct dosage to administer if it did not indicate it on the order. It would be a medication error if a medication was administered without a dosage.During an interview on 09/18/25, at 3:30 P.M., CMT O said a medication order should include the resident's name, medication name, dosage, time, and route. He/she would notify the nurse if a medication did not have a listed dose. He/she would not give the dose if it did not include a dosage because it would be a medication error. He/she would contact the pharmacy if a medication was not available and put a note indicating why it was not given. He/she is unsure if this would be a medication error as it had never occurred.During an interview on 09/18/25, at 3:46 P.M., Licensed Practical Nurse (LPN) M said a medication order should have medication name, dosage, how many pills to be administered, route, how many times a day, and a diagnosis. He/she would call the physician to ascertain the medication dosage prior to administering. He/she would not give a medication without a dosage as it would be an (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	error. He/she would contact the pharmacy if a medication was unavailable at the administration time. It might be a medication error if not given on time. During an interview on 09/19/25, at 9:00 A.M., Registered Nurse (RN) L said a medication order should include the medication name, dosage, time to administer, and the form. He/she would call the physician to get the correct dose if it was missing on an order. He/she would not give a medication without a listed dose. It would be a medication error if a medication was given without a dosage listed. It would be a medication error if a medication was not given at the right time. He/she would call the pharmacy to obtain medication as soon as possible. During an interview on 09/19/25, at 9:10 A.M., RN K said a medication order should contain the resident name, drug, route, and time. He/she would call the physician for clarification if a medication did not indicate the dose. It is a medication error if a medication is given without the dose listed. He/she would contact the pharmacy and have the medication sent right away if it was not available for administration. It would be a medication error if a medication was not given at the ordered time. During an interview on 09/19/25, at 9:50 A.M., the Assistant Director of Nursing (ADON) B said medication orders should include the name, dosage, route, and time to administer. Staff should call and clarify with the physician any medication that does not include a dosage. If a medication was administered without a dose indicated, it would be a medication error. Staff should call the pharmacy and look in the overflow medications for any medication not available. It would be a medication error if a medication was not administered at the ordered time.During an interview on 09/19/2025 at 10:41 A.M., the Administrator said staff should have complete orders, including dosage, prior to administering medication. Staff should order a medication and administer it on time for any medication that is unavailable. 2. Review of the facility procedure titled Insulin Pen Use, dated 05/19/25, showed staff should prime the insulin pen by pointing it up in the air, dialing one or two units on the insulin pen, and then fully press the plunger. A drop of insulin should appear at the needle tip. Repeat the priming procedure until a drop appears.Review of the Humalog (fast acting insulin) Kwikpen packet insert, dated March 2023, showed the following: -Prime before each injection;-To prime turn the dose knob to select 2 units, hold pen with the Needle pointing up, tap the cartridge holder gently to collect air bubbles at the top, and push the dose knob in until it stops, and a 0 is seen in the dose window. A stream of insulin should be seen from the needle. If a stream of insulin is not seen, repeat steps no more than 4 times;-Priming ensures the pen is ready to dose and removes air that may collect in the cartridge during normal use;-If you do not prime before each injection, you may get too much or too little insulin.Review of Resident #52's face sheet (a document that gives a resident's information at a quick glance) showed the following:-admission date of 01/31/25;-Diagnoses included diabetes (chronic condition that affects how the body uses glucose (blood sugar)) and dementia (group of thinking and social symptoms that interfere with daily functioning). Review of the resident current Physician Order Sheet (POS) showed an order, dated 01/31/24, for Humalog (fast acting insulin) injection solution 100 unit per milliliter, inject subcutaneously with meals per the following sliding scale: -If blood glucose reading is 0 milligrams/deciliter (mg/dL) to 175 mg/dL, administer 0 units of insulin;-If blood glucose reading is 176 mg/dL to 200 mg/dL, administer 1 unit of insulin;-If blood glucose reading is 201 mg/dL to 250 mg/dL, administer 2 units of insulin;-If blood glucose reading is 251 mg/dL to 299 mg/dL, administer 3 units of insulin;-If blood glucose reading is 300 mg/dL to 399 mg/dL, administer 4 unites of insulin; 40-If blood glucose reading is 400 mg/dL or higher, notify the physician.Observation of insulin administration on 09/18/25, at 11:00 A.M., showed Licensed Practical Nurse (LPN) G returned to the medication cart after obtaining the resident's blood sugar. The blood sugar reported as 232 mg/dL. The LPN reported the resident would need 2 units of insulin per physician order. The nurse obtained the insulin pen from the cart and placed a needle on the end of the pen. LPN G dialed the pen to a line in between 2 and 4 on the pen which indicated 3 units of medication. He/she then asked the surveyor if this indicated 2 units of insulin. The surveyor asked the LPN how many units the pen was dialed to, and he/she reported it was two units. The surveyor then asked where 3 were on the pen if the line in between 2 and 4 units indicated 2 units to him/her. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	LPN G adjusted the dial to 2 units and reported he/she guessed it was 2 units. The LPN did not prime the pen to expel any air out of the needle and then proceeded to the resident's room and administered the medication.During an interview on 09/18/25, at 3:46 P.M., LPN M said an insulin pen should be primed prior to administering. I would be a medication error if an insulin pen was not primed. He/she would ask another nurse or nurse manager if he/she was unsure of an insulin dosage.During an interview on 09/19/25, at 9:00 A.M., RN L the insulin pen should be primed with two units prior to dialing dose amount. If an insulin pen was not primed it would have air in the needle. It would be an error to not prime an insulin pen.During an interview on 09/19/25, at 9:10 A.M., RN K said an insulin pen should be primed with two units prior to dialing it to the correct dosage. It would be an error If staff do not prime the pen, as the resident would be getting air instead of medication. The smaller unlabeled lines on the insulin pen indicate odd numbers. The line located between two and four on the insulin pen would indicate three units. The nurse should contact the nurse manager for any medication or insulin pen questions.During an interview on 09/19/25, at 9:50 A.M., the ADON B said staff should prime the insulin pen with two units prior to dialing the indicated amount. The pen would administer air and not the indicated dose if not primed first which would be a medication error. The smaller lines on the insulin pen would indicate odd numbers and the even numbers are printed to select correct dose. The nurse should ask nursing management or another nurse if they have a question regarding medication.During an interview on 09/19/25, at 10:41 A.M., the Administrator staff should follow professional standards when administering insulin.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. Based on observation, interview, and record review, the facility staff failed ensure all residents were free of significant medication errors when staff failed to prime one resident's (Resident #52) insulin pen prior to insulin administration to ensure accurate dosing. The facility census was 94.Review of the facility procedure titled Insulin Pen Use, dated 05/19/25, showed staff should prime the insulin pen by pointing it up in the air, dialing one or two units on the insulin pen, and then fully press the plunger. A drop of insulin should appear at the needle tip. Repeat the priming procedure until a drop appears.Review of the Humalog (fast acting insulin) Kwikpen packet insert, dated March 2023, showed the following: -Prime before each injection;-To prime turn the dose knob to select 2 units, hold pen with the Needle pointing up, tap the cartridge holder gently to collect air bubbles at the top, and push the dose knob in until it stops, and a 0 is seen in the dose window. A stream of insulin should be seen from the needle. If a stream of insulin is not seen, repeat steps no more than 4 times;-Priming ensures the pen is ready to dose and removes air that may collect in the cartridge during normal use;-If you do not prime before each injection, you may get too much or too little insulin.1. Review of Resident #52's face sheet (a document that gives a resident's information at a quick glance) showed the following:-admission date of 01/31/25;-Diagnoses included diabetes (chronic condition that affects how the body uses glucose (blood sugar)) and dementia (group of thinking and social symptoms that interfere with daily functioning). Review of the resident current Physician Order Sheet (POS) showed an order, dated 01/31/24, for Humalog (fast acting insulin) injection solution 100 unit per milliliter, inject subcutaneously with meals per the following sliding scale: -If blood glucose reading is 0 milligrams/deciliter (mg/dL) to 175 mg/dL, administer 0 units of insulin;-If blood glucose reading is 176 mg/dL to 200 mg/dL, administer 1 unit of insulin;-If blood glucose reading is 201 mg/dL to 250 mg/dL, administer 2 units of insulin;-If blood glucose reading is 251 mg/dL to 299 mg/dL, administer 3 units of insulin;-If blood glucose reading is 300 mg/dL to 399 mg/dL, administer 4 unites of insulin; 40-If blood glucose reading is 400 mg/dL or higher, notify the physician.Observation of insulin administration on 09/18/25, at 11:00 A.M., showed Licensed Practical Nurse (LPN) G returned to the medication cart after obtaining the resident's blood sugar. The blood sugar reported as 232 mg/dL. The LPN reported the resident would need 2 units of insulin per physician order. The nurse obtained the insulin pen from the cart and placed a needle on the end of the pen. LPN G dialed the pen to a line in between 2 and 4 on the pen which indicated 3 units of medication. He/she then asked the surveyor if this indicated 2 units of insulin. The surveyor asked the LPN how many units the pen was dialed to, and he/she reported it was two units. The surveyor then asked where 3 were on the pen if the line in between 2 and 4 units indicated 2 units to him/her. LPN G adjusted the dial to 2 units and reported he/she guessed it was 2 units. The LPN did not prime the pen to expel any air out of the needle and then proceeded to the resident's room and administered the medication.During an interview on 09/18/25, at 3:46 P.M., LPN M said an insulin pen should be primed prior to administering. I would be a medication error if an insulin pen was not primed. He/she would ask another nurse or nurse manager if he/she was unsure of an insulin dosage.During an interview on 09/19/25, at 9:00 A.M., Registered Nurse (RN) L the insulin pen should be primed with two units prior to dialing dose amount. If an insulin pen was not primed it would have air in the needle. It would be an error to not prime an insulin pen.During an interview on 09/19/25, at 9:10 A.M., RN K said an insulin pen should be primed with two units prior to dialing it to the correct dosage. It would be an error If staff do not prime the pen, as the resident would be getting air instead of medication. The smaller unlabeled lines on the insulin pen indicate odd numbers. The line located between two and four on the insulin pen would indicate three units. The nurse should contact the nurse manager for any medication or insulin pen questions.During an interview on 09/19/25, at 9:50 A.M., the Assistant Director of Nursing (ADON) B said staff should prime the insulin pen with two units prior to dialing the indicated amount. The pen would administer air and not the indicated dose if not primed first which (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	would be a medication error. The smaller lines on the insulin pen would indicate odd numbers and the even numbers are printed to select correct dose. The nurse should ask nursing management or another nurse if they have a question regarding medication.During an interview on 09/19/25, at 10:41 A.M., the Administrator staff should follow professional standards when administering insulin.