STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265859	A. Building B. Wing	05/14/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cotton Point Living Center	609 South Railroad Street Matthews, MO 63867

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview and record review, the facility failed to maintain sanitary conditions for ice intended for resident consumption. The facility failed to ensure the ice machine drain line maintained a required air gap (empty space that ensures dirty sewer water can never flow backward into the ice machine and contaminate the ice) to prevent potential contamination, failed to maintain sanitary conditions surrounding the ice machine, and failed to prevent contamination of communal ice during resident use. These deficient practices had the potential to affect all residents who consumed ice from the facility ice machine. The facility census was 47.Review of the facility's policy titled, Sanitization, revised November 2022, showed:- Ice machines and ice storage containers are drained, cleaned, and sanitized per manufacturer's instructions;- Ice chest and coolers used to store and transport ice are cleaned regularly, especially prior to use or when contaminated or visibly soiled;- Did not address the air gap required for the ice machine. 1. Observations on 05/11/26 at 10:32 A.M., and 3:21 P.M., and 05/13/26 at 10:09 A.M., of the ice machine room on Birch Boulevard showed:- Two plastic containers with a buildup of dust were located on top of the ice machine;- Dirt, debris and a blue ice scoop were observed on the floor beneath the ice machine;- A round white plastic pipe connected from the back of the ice machine extended through the wall into the furnace room and rested directly on a floor drain located next to the furnace;- Water dripped from the pipe onto the floor drain;- Dirt and debris were observed on the floor in the furnace room; and- The ice machine drain line lacked an air gap to prevent direct contact between the pipe and the floor drain. 2. Observations on 05/13/26 at 8:20 P.M., showed:- A cart labeled dirty cups only containing several dirty cups was located next to a cart labeled clean cups only containing clean cups in the dining room;- Resident #26 removed a dirty cup from the dirty cup cart;- Resident #26 walked to the ice chest located near the nurse's station and opened the lid;- Resident #26 poured liquid from the dirty cup into the communal ice chest;- Resident #26 handled the communal ice scoop with bare hands and scooped ice into the dirty cup two times;- Licensed Practical Nurse (LPN) A remained at the nurse's station and did not intervene or redirect Resident #26; and- No staff assisted Resident #26 with obtaining ice.3. Observations on 05/14/26 at 8:02 A.M., and 11:03 A.M., showed a cart labeled dirty cups only containing dirty cups was located next to a cart labeled clean cups only containing clean cups in the dining room.During an interview on 05/13/26 at 8:25 P.M., LPN A said residents were instructed not to obtain their own ice and were expected to ask staff for assistance due to infection control concerns. Resident #26 should have requested staff assistance before accessing the communal ice chest.During interviews on 05/13/26 at 9:27 P.M., and on 05/14/26 at 8:24 A.M., the Administrator said the ice machine drain line should have maintained an air gap to prevent backflow contamination and should not have been in direct contact with the floor drain. Residents should not obtain their own ice and staff should intervene, redirect, and assist residents with ice handling.During an interview on 05/14/26 at 7:55 A.M., the Housekeeping Supervisor said the floors in the ice machine room and furnace room should have remained clean and free of dirt and debris. Ice scoops should not be stored on the floor beneath the ice machine.During an interview on 05/14/26 at 8:22 A.M., the Maintenance Supervisor said the ice machine drain line should have maintained an air gap to prevent contamination (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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Cotton Point Living Center	609 South Railroad Street Matthews, MO 63867

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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 - Some	from the floor drain.During an interview on 05/14/26 at 10:49 A.M., the Director of Nursing (DON) said residents should not independently obtain ice from the communal ice chest and staff should intervene, redirect, or assist residents with obtaining ice.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide restorative services for one resident (Resident #9) out of two sampled residents and one resident (Resident #17) outside the sample. The facility census was 47.Review of the facility's policy titled, Restorative Nursing, revised July 2017, showed:- Residents will receive restorative nursing care as needed to help promote optimal safety and independence;- Residents may be started on a restorative nursing program upon admission, during the course of stay or when discharged from rehabilitative care;- Restorative goals may include, but are not limited to supporting and assisting the residents in:a) Adjusting or adapting to changing abilities;b) Developing, maintaining or strengthening his/her physiological and psychological resources;c) Maintaining his/her dignity, independence and self-esteem; andd) Participating in the development and implementation of his/her plan of care. 1. Review of Resident #9's quarterly Minimum Data Set (MDS - a federally mandated assessment instrument completed by staff), dated 04/06/26, showed:- Independent for bed mobility, transfers, toileting and mobility;- Required minimal assistance/supervision for dressing, personal hygiene, and showers. Review of the resident's May 2026 physicians order sheet (POS) showed:- An order to receive restorative therapy (RT) three times per week for bilateral (left and right) upper extremity therapy, passive range of motion (the movement of a joint or body part entirely by an external force) and active range of motion (the movement of a joint or body part entirely on your own) and stretching, dated 04/17/26. Review of the resident's medical record showed:- No documentation the resident received RT three times per week from 04/17/26 - 05/14/26;- 12 missed out of 12 opportunities. During an interview on 05/13/26 at 9:38 A.M., Resident #9 said he/she did things on his/her own and did not need therapy other than help with showering on occasion. He/She was unsure what RT was and if he/she received it. 2. Review of Resident #17's quarterly MDS, dated [DATE], showed:- Independent for bed mobility, bathing, and transfers;- Required minimal assistance/supervision for dressing and toileting;- Required partial or moderate assistance with personal hygiene;- Wheelchair for mobility;- Impairment of both sides to the lower extremities. Review of the resident's May 2026 POS showed:- An order to receive RT three times per week. Seated bilateral lower extremity therapy exercises with green band and 2-pound (lb.) ankle weights, two sets x 15 repetitions, sit to stand and stand to sit, ambulation in parallel bars, and NuStep (seated exercise machine) on level five for 10 minutes, dated 02/03/26. Review of the resident's medical record showed:- No documentation the resident received RT three times per week 02/03/26 - 05/14/26;- 45 missed out of 45 opportunities. During an interview on 05/13/2026 at 10:30 A.M., the Restorative Nursing Aide (RNA) F said if there were no notes under the restorative progress notes in the resident's electronic medical record (EMR), then there were no notes. He/She tried to do RT as ordered but got pulled to the floor often and it did not always get done. When a resident refused restorative, the RNA told a nurse and was unsure if they charted the refusal or not. He/She knew there should be more documentation related to RT. During an interview on 05/14/26 at 1:38 P.M., the Assistant Director of Nursing (ADON) said residents should receive RT services as ordered. She would expect the RNA to document when RT was being done and if a resident refused. During an interview on 05/14/26 at 2:00 P.M., the Administrator said he would expect the RNA to be doing RT on residents as ordered and letting him, the Director of Nursing (DON), or the therapy department know if a resident was not getting the ordered therapy.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on observation, interview, and record review, the facility failed to monitor and consistently implement interventions, including adequate supervision consistent with resident needs, goals, and current professional standards of practice, in order to eliminate or reduce the risk of falls and accidents, failed to document an assessment after a fall, to notify the provider and the on-call nurse after a fall, and to update the care plan with new interventions to prevent additional falls for one resident (Resident #49) out of two sampled residents. The facility census was 47.Review of the facility policy titled, Falls and Fall Risk, Managing, dated March 2018, showed:- Based on previous evaluations and current date, the staff will identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling and to try to minimize complications from falling;- A fall is unintentionally coming to rest on the ground, floor or other lower level, but not as a result of an overwhelming force (a resident pushes another resident). An episode where a resident lost his/her balance and would have fallen, if not for another person or if he or she had not caught him/herself, is considered a fall. A fall without injury is still a fall. Unless there is evidence suggesting otherwise, when a resident is found on the floor, a fall is considered to have occurred;- The staff will monitor and document each resident's response to interventions intended to reduce falling or the risks of falling;- The nurse shall assess and document/report the following: a. Vital signs; b. Recent injury; c. Musculoskeletal function, observing for change in normal range of motion, weight bearing, etc.; d. Change in cognition or level of consciousness; e. Neurological status; f. Pain; g. Frequency and number of falls since last physician visit; h. Precipitating factors, details on how fall occurred; i. All current medications, especially those associated with dizziness or lethargy; j. All active diagnoses. 1. Review of Resident #49's quarterly Minimum Data Set (MDS - a federally mandated assessment instrument completed by facility staff), dated 04/24/26, showed:- Cognition intact;- Partial to moderate assistance of staff for toileting and sitting to standing position;- Substantial to maximal assistance of staff for sitting to lying and lying to sitting positions;- Resident used a wheelchair. Review of the resident's medical record showed:- No documentation of a fall on 05/08/26;- No documentation of an assessment of the fall on 05/08/26;- No documentation the resident's provider and the on-call nurse were notified of the fall on 05/08/26. Review of the resident's care plan, last updated on 04/24/26, showed:- At risk for falls;- History of falls;- Works with the restorative program for strengthening and balancing;- Monitor, document, and report as needed to the physician for signs and symptoms of pain, change in condition, or new onset of confusion;- Physical therapy (PT) consult for strength and mobility as needed;- Did not address the fall on 05/08/26 with new interventions. Observation on 05/11/26 at 12:43 P.M., of the resident showed:- Resident sat at a table in the dining room with a plate of food in front of him/her;- Resident did not touch his/her food;- Medical Records (MR) staff asked the resident why he/she was not eating;- The resident told the MR staff he/she did not feel well, had a fall over the weekend, and didn't feel like eating. During an interview on 05/11/26 at 12:45 P.M., the resident said he/she was not eating because of soreness from a fall he/she had over the weekend. He/She fell on Friday and reported the incident to staff. During an interview on 05/11/26 at 12:17 P.M., Certified Nurse Assistant (CNA) I said if a resident fell, he/she immediately would assist the resident and call for help. The charge nurse was always informed so the resident could be assessed immediately. During an interview on 05/11/26 at 12:21 P.M., Certified Medication Technician (CMT) J said if a resident fell, he/she stayed with the resident and called for help. The charge nurse was always informed so the resident could be assessed immediately. During an interview on 05/12/26 at 8:37 A.M., Restorative Nurse Aide (RNA) F said if a resident fell, he/she would call for help. The charge nurse was always informed so the resident could be assessed immediately. During an interview on 05/12/26 at 9:15 A.M., the MDS Coordinator was unaware of the resident's fall. During an interview (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	on 05/13/26 at 10:20 A.M., CNA K said the resident had mentioned he/she was sore but did not mention anything about a fall. During an interview on 05/13/26 at 2:20 P.M., the Assistant Director of Nursing (ADON) said the resident had left the facility by ambulance. During an interview on 05/14/26 at 2:12 P.M., the Director of Nursing (DON) said she would expect staff to call the on-call nurse, notify the resident's family, and notify the physician of a fall. If there was an injury, the resident should be sent out by the physician's order to be evaluated. She expected staff to document any resident's fall and then follow-up, whether it be vitals, neurological checks, etc. During an interview on 05/14/26 at 2:17 P.M. the Administrator said he would expect staff to assess the resident after a fall, to follow-up, to notify the provider and the guardian if the resident had one, and to try to send the resident out to be evaluated. The facility always had an on-call physician and an on-call nurse. He expected staff to document resident falls and follow-up after a fall. During an interview on 05/19/26 at 11:40 A.M., Licensed Practical Nurse (LPN) L said when he/she arrived on the day shift on 05/08/26, the resident was on the floor. LPN L had other staff in there with him/her assisting with the resident, but he/she could not remember who it was. The resident was assessed, assisted to the wheelchair, and then assisted to the resident's bed. He/She did check the resident out to make sure the resident was not hurt, but failed to document anything about the fall, to notify the provider, or the on-call nurse.Complaint #3000359

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to maintain a medication error rate of five percent (%) or less. There were four errors out of 27 opportunities for errors, resulting in an error rate of 14.81%. This affected three residents (Residents #9, #30, and #36) out of five sampled residents. The facility census was 47.Review of the facility's policy titled, Administering Medications, revised April 2019, showed:- Medications are administered in a safe and timely manner and as prescribed;- Medications are administered in accordance with prescriber orders, including any required time frame. Review of the facility's policy titled, Medication and Treatment Orders, revised July 2016, showed:- Drugs and biologicals that are required to be refilled must be reordered from the issuing pharmacy not less than three days prior to the last dosage being administered to ensure that refills are readily available. 1. Review of Resident #9's medical record showed:- admitted on [DATE];- Diagnoses of hyperlipidemia (high cholesterol), occlusion and stenosis of unspecified carotid artery (narrowing of an artery increasing risk of stroke), essential hypertension (high blood pressure), other specified disorders of the veins (complications with veins or blood flow), Alzheimer's disease and cerebrovascular disease (a group of conditions than can affect blood flow to the brain and cause potential neurological problems). Review of the resident's physician order sheet (POS), dated May 2026, showed:- An order for rosuvastatin (a cholesterol medication) calcium 40 milligrams (mg) by mouth every day for hyperlipidemia, dated 07/04/25. Observation on 05/13/26 at 8:50 A.M., of the resident's medication administration showed:- Licensed Practical Nurse (LPN) C prepared the resident's medications for administration;- LPN C did not administer the resident's rosuvastatin calcium medication dose. Review of the resident's May 2026 medication administration record (MAR) showed:- The last administration date for rosuvastatin calcium was 05/06/26;- Dates 05/07/26 - 05/14/26 documented as unavailable in-house;- Eight missed out of eight opportunities. 2. Review of Resident #30's medical record showed:- admitted on [DATE];- Diagnoses of hyperlipidemia, unspecified atrial flutter (abnormal beating pattern of the heart), essential hypertension, and nonrheumatic mitral valve prolapse (condition where the mitral valve in the heart does not close properly and could cause complications). Review of the resident's POS, dated May 2025, showed:- An order for Eliquis (a blood thinner) 5 mg by mouth twice a day for deep vein thrombosis (a blood clot) prevention, dated 05/21/25. Observation on 05/13/26 at 8:41 A.M., of the resident's medication administration showed:- LPN C prepared the resident's medications for administration;- LPN C did not administer the resident's Eliquis medication dose. Review of the resident's May 2026 MAR showed:- The last administration date for Eliquis was the morning dose on 05/05/26;- The evening dose on 05/05/26 and the morning and evening doses 05/06/26 - 05/14/26 documented as unavailable in-house;- 19 missed out of 19 opportunities. During an interview on 05/13/26 at 8:43 A.M., LPN C said Resident #30 was out of Eliquis and the electronic medical record (EMR) showed the medication had been ordered on 05/05/26. LPN C said he/she was unsure why it had not come in yet. During an interview on 05/14/26 at 9:23 A.M., the Assistant Director of Nursing (ADON) said staff should be ordering medications at least seven days prior to the resident running out. Anyone who re-orders medications should follow up within a day or two and/or let the ADON know if it had not been received. If a resident was missing a dose of medication due to the medicine not being in the facility, he/she would expect staff to contact the pharmacy immediately. During an interview on 05/14/26 at 1:45 P.M., the Administrator said he would expect nursing to ensure residents do not run out of medications or miss doses. If a resident was out of medication, he would expect staff to check the overflow medications and then contact the pharmacy immediately and let the Director of nursing (DON) or ADON know. During an interview on 05/19/26 at 11:49 A.M., Pharmacy Staff M said Resident #9's rosuvastatin calcium was last ordered on 03/31/26, and Resident #30's Eliquis was last ordered on 04/07/26. During an interview on 05/19/26 at 1:40 P.M., the Physician said the facility did not (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	notify him/her that Resident #9 had missed several doses of rosuvastatin calcium and Resident #30 had missed multiple doses of Eliquis. He/She would expect the facility to be aware of when residents needed medication refills, to make sure the residents did not miss any doses, and someone to contact him/her when this issue occurred. He/She said missing medication doses could potentially have ill effects on the residents.3. Review of Resident #36's medical record showed:- admitted on [DATE];- Diagnosis of type two diabetes mellitus (a metabolic disease). Review of the resident's POS, dated May 2026, showed:- An order for Humalog (a fast-acting insulin used to treat diabetes) KwikPen inject as per sliding scale: if blood sugar 140 - 169 = 33 units subcutaneously (beneath the skin) with meals related to type 2 DM, dated 05/07/26. Observation on 05/13/26 at 11:02 A.M., of Resident #32's blood sugar showed:- LPN B checked the resident blood sugar with a blood sugar reading of 159;- LPN B told the resident his/her blood sugar reading was 159;- LPN B entered the resident's blood sugar reading as 139 on the MAR; - LPN B told the resident he/she would get zero units of insulin;- LPN B did not administer the resident's Humalog 33 units as ordered for a blood sugar of 159. During an interview on 05/14/2025 at 1:18 P.M., LPN B said he/she must have gotten nervous while checking the blood sugar and entered the wrong blood sugar reading. He/She normally double checked the reading before entering it into the resident's electronic medical record (EMR). During an interview on 05/14/26 at 9:23 A.M., the ADON said he/she would expect staff checking insulin to double check the reading versus what was being administered to eliminate the room for error. During an interview on 05/14/26 at 1:45 P.M., the Administrator said he would expect nursing to review blood sugar readings before it was entered into the resident's EMR to eliminate the room for error.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure two residents (Resident #30 and #36) were free from significant medication errors when staff did not administer medications as ordered by the physician and did not document the correct blood sugar reading. The facility census was 47.Review of the facility's policy titled, Administering Medications, revised April 2019, showed:- Medications are administered in a safe and timely manner and as prescribed;- Medications are administered in accordance with prescriber orders, including any required time frame. Review of the facility's policy titled, Medication and Treatment Orders, revised July 2016, showed:- Drugs and biologicals that are required to be refilled must be reordered from the issuing pharmacy not less than three days prior to the last dosage being administered to ensure that refills are readily available. 1. Review of Resident #30's medical record showed:- admitted on [DATE];- Diagnoses of hyperlipidemia (high cholesterol), unspecified atrial flutter (abnormal beating pattern of the heart), essential hypertension (high blood pressure), and nonrheumatic mitral valve prolapse (condition where the mitral valve in the heart does not close properly and could cause complications). Review of the resident's physician order sheet (POS), dated May 2026, showed:- An order for Eliquis (a blood thinner) 5 milligrams (mg) by mouth twice a day for deep vein thrombosis (a blood clot) prevention, dated 05/21/25. Observation on 05/13/26 at 8:41 A.M., of the resident's medication administration showed:- Licensed Practical Nurse (LPN) C prepared the resident's medications for administration;- LPN C did not administer the resident's Eliquis medication dose. Review of the resident's May 2026 medication administration record (MAR) showed:- The last administration date for Eliquis was the morning dose on 05/05/26;- The evening dose on 05/05/26 and the morning and evening doses 05/06/26 - 05/14/26 documented as unavailable in-house;- 19 missed out of 19 opportunities. During an interview on 05/13/26 at 8:43 A.M., LPN C said Resident #30 was out of Eliquis and the electronic medical record (EMR) showed the medication had been ordered on 05/05/26. LPN C said he/she was unsure why it had not come in yet. During an interview on 05/14/26 at 9:23 A.M., the Assistant Director of Nursing (ADON) said staff should be ordering medications at least seven days prior to the resident running out. Anyone who re-orders medications should follow up within a day or two and/or let the ADON know if it had not been received. If a resident was missing a dose of medication due to the medicine not being in the facility, he/she would expect staff to contact the pharmacy immediately. During an interview on 05/14/26 at 1:45 P.M., the Administrator said he would expect nursing to ensure residents do not run out of medications or miss doses. If a resident was out of medication, he would expect staff to check the overflow medications and then contact the pharmacy immediately and let the Director of nursing (DON) or ADON know. During an interview on 05/19/26 at 11:49 A.M., Pharmacy Staff M said Resident #30's Eliquis was last ordered on 04/07/26. During an interview on 05/19/26 at 1:40 P.M., the Physician said the facility did not notify him/her that Resident #30 had missed multiple doses of Eliquis. He/She would expect the facility to be aware of when residents needed medication refills, to make sure the residents did not miss any doses, and someone to contact him/her when this issue occurred. He/She said missing medication doses could potentially have ill effects on the residents.2. Review of Resident #36's medical record showed:- admitted on [DATE];- Diagnosis of type two diabetes mellitus (a metabolic disease). Review of the resident's POS, dated May 2026, showed:- An order for Humalog (a fast-acting insulin used to treat diabetes) KwikPen inject as per sliding scale: if blood sugar 140 - 169 = 33 units subcutaneously (beneath the skin) with meals related to type 2 DM, dated 05/07/26. Observation on 05/13/26 at 11:02 A.M., of the resident's blood sugar showed:- LPN B checked the resident blood sugar with a blood sugar reading of 159;- LPN B told the resident his/her blood sugar reading was 159;- LPN B entered the resident's blood sugar reading as 139 on the MAR; - LPN B told the resident he/she would get zero units of insulin;- LPN B did not administer the resident's Humalog 33 units as ordered for a (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	blood sugar of 159. During an interview on 05/14/2025 at 1:18 P.M., LPN B said he/she must have gotten nervous while checking the blood sugar and entered the wrong blood sugar reading. He/She normally double checked the reading before entering it into the resident's electronic medical record (EMR). During an interview on 05/14/26 at 9:23 A.M., the ADON said he/she would expect staff checking insulin to double check the reading versus what was being administered to eliminate the room for error. During an interview on 05/14/26 at 1:45 P.M., the Administrator said he would expect nursing to review blood sugar readings before it was entered into the resident's EMR to eliminate the room for error.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265859	A. Building B. Wing	05/14/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cotton Point Living Center	609 South Railroad Street Matthews, MO 63867

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure three residents (Residents #9, #13, and #15) out of five sampled residents received the influenza (a highly contagious respiratory illness) immunization. The facility census was 47.Review of the facility's policy titled, Influenza, Prevention and Control of Seasonal, dated August 2014, showed:- The Infection Preventionist (IP) will promote and administer the seasonal influenza vaccine;- Unless contraindicated, all residents and staff will be offered the vaccine. 1. Review of Resident #9's medical record showed:- admitted on [DATE];- Diagnoses of chronic obstructive pulmonary disease (COPD - a lung disease) and Alzheimer's disease (a progressive and irreversible brain disorder);- No documentation of the education provided to the resident or representative regarding the benefits and potential side effects of the influenza vaccine;- No documentation of the consent or refusal for the influenza vaccine;- No documentation the resident received the influenza vaccine. 2. Review of Resident #13's medical record showed:- admitted on [DATE];- Diagnoses of major depressive disorder (a mental health disorder) and hypertension;- No documentation of the education provided to the resident or representative regarding the benefits and potential side effects of the influenza vaccine;- No documentation of the consent or refusal for the influenza vaccine;- No documentation the resident received the influenza vaccine. 3. Review of Resident #15's medical record showed:- admitted on [DATE];- Diagnoses of COPD and generalized anxiety disorder (a mental health condition);- No documentation of the education provided to the resident or representative regarding the benefits and potential side effects of the influenza vaccine;- No documentation of the consent or refusal for the influenza vaccine;- No documentation the resident received the influenza vaccine. During an interview on 05/14/26 at 2:05 P.M., the Assistant Director of Nursing (ADON) said she and another staff member share the duties of the Infection Preventionist. She was responsible for staff prevention and the Infection Preventionist was responsible for resident prevention. She and the IP were new to the facility, but she would expect the immunization forms to either be signed for consent or refusal and documented. During an interview on 05/14/26 at 2:10 P.M., the Director of Nursing (DON) said she was new to the facility and would expect the facility to have the immunization forms documented on the residents of the facility. During an interview on 05/14/26 at 2:14 P.M., the Administrator said it was the DON's responsibility to monitor the infection program, however this task had been delegated to the ADON at this time. The IP was responsible for obtaining the residents' consents or refusals for immunizations. He would expect the immunizations forms to be documented.