STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	26E256	A. Building B. Wing	10/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Johnson County Care Center	122 East Market Street Warrensburg, MO 64093

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 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. Based on interview and record review, the facility failed to provide sufficient proof of the Registered Nurse (RN) eight consecutive hours a day coverage during the Fiscal Year (FY) Quarter Four 2024 Payroll Based Journal (PBJ- a report that provides staffing dataset information submitted by nursing homes on a quarterly basis) for all the dates triggered within the quarter equaling nine total days; during FY Quarter One 2025 PBJ for all the dates triggered within the quarter equaling two total days; during FY Quarter Two 2025 PBJ for all the dates triggered within the quarter equaling 18 total days; and during FY Quarter Three 2025 PBJ for all the dates triggered within the quarter equaling 45 total days. This deficient practice had the potential to affect all residents within the facility. The facility census was 75 residents.Review of the facility's undated policy titled Policy for Staffing showed:-Followed the Missouri regulatory requirements at the minimal operation.-RN at least eight hours a day.-Used the services of a RN for at least eight hours a day, seven days a week.1. Review of the facility's PBJ FY Quarter Four 2024 PBJ data report showed the facility had no RN coverage for the following dates:-7/7/24.-7/21/24.-8/3/24.-8/11/24.-8/17/24.-8/31/24.-9/14/24.-9/15/24.-9/28/24.--Requested documentation of RN Coverage for the listed dates and the facility was unable to produce documentation of RN coverage for eight hours per day. 2. Review of the PBJ FY Quarter One 2025 PBJ data report showed the facility had no RN coverage for the following dates:-10/5/24.-7/21/24.--Requested documentation of RN Coverage for the listed dates and the facility was unable to produce documentation of RN coverage for eight hours per day. 3. Review of the PBJ FY Quarter Two 2025 PBJ data report showed the facility had no RN coverage for the following dates:-1/14/25.-1/21/25.-1/31/25.-2/5/25.-2/6/25.-2/7/25.-2/11/25.-2/12/25.-2/13/25.-2/17/25.-2/25/25.-2/26/25.- documentation of RN Coverage for the listed dates and the facility was unable to produce documentation of RN coverage for eight hours per day. 4. Review of the PBJ FY Quarter Three 2025 PBJ data report showed the facility had no RN coverage for the following dates:-4/3/25.-4/8/25.-4/9/25.-4/16/25.-4/22/25.-4/23/25.-4/25/25.-4/30/25.-5/1/25.-5/2/25.-5/6/25.-5/7/25.-5/10 documentation of RN Coverage for the listed dates and the facility was unable to produce documentation of RN coverage for eight hours per day. 5. During an interview on 10/14/2025 at 9:50 A.M., the Administrator said:-He/She oversaw staffing at this time, since the Director of Nursing just started about two months ago. -He/She knew that the facility had not met the eight-hour RN requirement. -The facility had been trying to hire RN's.-The facility had just hired a DON two months ago. -It was the policy of management not to use agency staff. -He/She was trying to staff the facility as best as could be, but it was very difficult to hire RN's due to the lack of RN's in the area. -He/She had recently gotten fully staffed for RN's to ensure that there was a RN for eight hours per day seven days a week. During an interview on 10/14/25 at 10:56 A.M. the DON said:-He/She was not doing staffing at this time. -He/She knew that the facility had just gotten fully staffed with RN's.-He/She did not know that the facility was not meeting the RN requirement prior to being hired.

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to establish and maintain a comprehensive infection prevention and control program designed to help prevent the development and transmission of Legionella (A [NAME] of pathogenic Gram-negative bacteria that includes the species L. pneumophila, causing legionellosis, all illnesses caused by Legionella, including a pneumonia-type illness called Legionnaires' disease and a mild flu-like illness called Pontiac fever) and/or other water-borne pathogens (a bacterium, virus, or other microorganism that can cause disease) that included specific assessments and contents, in accordance with State of Missouri rules and Centers for Disease Control (CDC) and Centers for Medicare and Medicaid Services (CMS) standards and guidelines. This deficient practice had the potential to affect all residents, visitors, volunteers, and staff who resided, visited, used, or worked in the facility. The facility failed to ensure appropriate hand hygiene was performed during medication administration for one sampled resident (Resident #69) and two supplemental residents (Resident #25 and Resident #68); the facility failed to ensure appropriate hand hygiene was performed during wound care for one sampled resident (Resident #2) out of 18 sampled residents and two supplemental residents; and the facility failed to ensure Tuberculosis (TB a chronic bacterial infection caused by Mycobacterium tuberculosis bacteria) testing was completed following facility policy, Center for Disease Control (CDC) guidelines, and State regulation for eight sampled employees (Employee A, B, D, E, G, H, J, and K) of 10 sampled employees. The facility census was 75 residents with a licensed capacity for 87 residents at the time of the survey 1. Review of the facility's Legionella program paperwork towards the back of a binder entitled Disaster Manual, last reviewed 8/23/24 and provided by the Administrator, showed the following:-There was no 31-page (pg.) Centers for Disease Control (CDC) toolkit including a completed brief 8 question assessment on page 2, with the rest consisting of educational guidelines for creating a water management program with control measures such as physical controls, temperature management, disinfectant level control, visual inspections, and environmental testing for pathogens.-There was no facility-specific risk assessment that considered the American Society of Heating, Refrigerating, and Air Conditioning Engineers (ASHRAE) industry standard #188.-There was a hand-drawn diagram of the facility's water system with no accompanying written explanation of the water flow throughout the facility that identified and indicated specific potential risk areas of growth within the building with assessments of each individual area's potential risk level.-No testing protocols and acceptable ranges for control measures with a method of monitoring them specifically at this facility was present.-There were no facility-specific interventions or action plans for when control limits are not met.-There was no documentation included of any site log book being maintained with any dated cleanings, sanitizings, descalings, and inspections mentioned. Observation on 10/7/25 at 12:47 P.M. during the initial facility Life Safety Code (LSC) kitchen inspection with the Dietary Manager (DM) showed there was a three-sink area, a chemical dish-washing machine, a hand-washing sink, and a steam table (also referred to as a hot food table, is specifically designed to hold food at steady, safe serving temperatures, and not designed to cook or warm foods from a raw state). Observation on 10/8/25 between 10:03 A.M. and 1:33 P.M. during the initial facility LSC walk-through inspection showed the following:-The water main supply entered in the basement and first spread out through their kitchen, ice machine, hot water heater, laundry rooms, bathrooms, boiler room, and Janitor's Closet with a mop hopper (mop hoppers/service sinks are used in janitorial and maintenance areas to fill and empty mop buckets, clean mops, and dispose of dirty water). -On the first floor there were gender specific public restrooms located on the west wall along (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	with a Beauty Shop with a sink.-The second floor contained at least 17 resident rooms with private or shared bathrooms and sinks, two Shower Rooms, a Janitor's Closet with a mop hopper, and a Medication Room with a sink.-The third floor contained at least 17 resident rooms with private or shared bathrooms and sinks, two Shower Rooms, a Janitor's Closet with a mop hopper, and a Medication Room with a sink.-The building was equipped with a complete fire sprinkler system with sprinkler heads located throughout the facility. During an interview on 10/10/25 at 9:51 A.M. the Maintenance Supervisor (MS) said the following:-His/Her responsibilities with the Legionella program included doing the pathogen testing throughout the building.-He/She was trained on the requirements by his/her predecessor. During an interview on 10/10/25 at 10:55 A.M. the Administrator said the following:-The Maintenance Supervisor oversaw the Legionella program.-They learned about the CMS and CDC requirements from corporate staff and other maintenance people. 2. Review of the facility's undated policy titled Medication Management and Monitoring showed staff were to wash hands before and after each administration of medication. Review of Resident #68's admission Record showed he/she admitted to the facility with a diagnosis of Diabetes Mellitus (DM II- a complex disorder of carbohydrate, fat, and protein metabolism that is primarily a result of a deficiency or complete lack of insulin secretion in the pancreas or resistance to insulin). Observation on 10/9/25 at 9:25 A.M. of the resident's medication administration pass completed by Licensed Practical Nurse (LPN) A showed:-LPN A did not wash or sanitize his/her hands prior to the start of the medication pass.-While popping out the pills into the medication cup, LPN A dropped a pill on the floor.-LPN A picked up the pill from the floor, threw the pill away, and continued popping out pills into a medication cup without washing or sanitizing his/her hands after touching the floor.-LPN A finished putting the pills into the cup, mixed the pills in pudding, and assisted the resident in taking the medication.-LPN A returned to the medication cart without washing or sanitizing his/her hands. 3. Review of Resident #69's admission Record showed he/she admitted to the facility with the following diagnoses:-DM II.-Epilepsy (a chronic neurological disorder characterized by recurrent, unprovoked seizures, which are caused by abnormal, excessive electrical activity in the brain), Intractable (resistant to conventional anti-epileptic drug treatment), With Status Epilepticus (a prolonged or recurrent seizure that lasts for more than five minutes or consists of multiple seizures without regaining consciousness between them). Observation on 10/9/25 at 9:40 A.M. of the resident's medication administration pass completed by LPN A showed:-LPN A did not wash or sanitize his/her hands prior to the start of the medication pass.-LPN A popped the resident's pills into a medication cup, then placed them in a bag to be crushed, crushed the medications, returned the medications to the medication cup, mixed the medications in pudding, and assisted the resident in taking the medications.-LPN A returned to the medication cart without washing or sanitizing his/her hands. 4. Review of Resident #25's admission Record showed he/she admitted to the facility with the following diagnoses:-Schizophrenia (a disorder that affects a person's ability to think, feel, and behave clearly).-Moderate Intellectual Disabilities. Observation on 10/9/25 at 9:46 A.M. of the resident's medication administration pass completed by LPN A showed:-LPN A did not wash or sanitize his/her hands prior to the start of the medication pass.-LPN A popped the resident's medications into a medication cup.-LPN A gave the resident (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	his/her medications and returned to the medication cart without washing or sanitizing his/her hands. During an interview on 10/9/25 at 9:50 A.M. LPN A said he/she would not have done anything differently during the medication pass. 5. During an interview on 10/14/25 at 9:48 A.M. LPN A said:-Hand hygiene should be completed before and after each resident during medication administration.-He/She could not remember if he/she had done appropriate hand hygiene during Resident #68's, Resident #69's, and Resident #25's medication administration.-He/She had been told by some staff person that he/she could not have hand sanitizer on his/her medication cart, which made it hard to remember to perform hand hygiene appropriately.-He/She should have sanitized his/her hands after picking up the dropped pill from the floor and continuing Resident #68's medication pass.-He/She should have sanitized his/her hands before and after each medication pass. During an interview on 10/14/25 at 10:07 A.M. LPN B said:-Hand hygiene should be completed before and after each resident during medication administration.-Hand hygiene should be performed after picking anything up from the floor.-LPN A had not performed appropriate hand hygiene during Resident #68's, Resident #69's, and Resident #25's medication administration.-LPN A should have sanitized his/her hands before and after each resident and after he/she had picked up the dropped pill.-Hand sanitizer was not allowed to be kept on the medication carts.-When staff were not allowed to keep hand sanitizer on the medication carts it made it difficult for staff to remember to perform appropriate hand hygiene. During an interview on 10/14/25 at 12:02 P.M. the Director of Nursing (DON) said:-Hand hygiene should be performed before and after each resident during medication administration.-LPN A had not performed hand hygiene appropriately during Resident #68's, Resident #69's, and Resident #25's medication administration.-LPN A should have washed his/her hands after picking up the pill from the ground and before resuming Resident #68's medication administration.-He/She had not told staff that they could not keep hand sanitizer on the medication carts.-Staff were to keep hand sanitizer in the medication carts in order to perform appropriate hand hygiene during medication administration. 6. Review of the facility's Policy for Handwashing, undated, showed:-All staff must apply proper hand washing before, after, and between care deliveries with the following procedure:--Turn on water.--Wet hands.--Dispense five milliliter (ml) of soap (about the size of a silver dollar) into the palm of one hand.--Rub hands together vigorously for at least 30 seconds. Pay particular attention to nails. Use a nail brush if desired.--Rinse thoroughly under running water, rubbing hands together vigorously.--Dry with a clean paper towel.--Turn off the water using the paper towel as a barrier between the handle and your clean hand.--Dispose of paper towel in the trash can.-Hand hygiene is the primary means of preventing the transmission of infection. Situations that require hand hygiene include:--Before and after assisting a resident with personal cares.--Before and after changing a dressing.--Upon and after coming into contact with a resident's intact skin.--After handling soiled or used linens, dressings, bedpans, catheters, and urinals-Alcohol-based hand rubs can be used when hands are not visibly soiled for routine decontamination of hands. Review of Resident #2's admission Record showed the resident was admitted to the facility on [DATE] with diagnoses that included unspecified wound, left foot, and osteomyelitis (infection of the bone tissue, often leading to inflammation, pain, and damage to the bone). Review of the resident's Wound care plan, initiated 10/13/19, showed:-The resident was at risk for infection related to foot wound(s).-The resident would receive daily dressing changes as ordered.-Nurses would report signs (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	and symptoms of infection such as elevated temperature, loss of appetite, flushed or pale appearance, nausea, vomiting, or foul odor from wounds. Review of the resident's Physician's Orders dated July, 2025 showed:-Clean the right foot plantar (bottom/sole of foot) area with wound cleanser. Apply foam dressing and Kerlex (gauze bandaging with a crinkle weave) daily starting on 9/19/24.-Clean the left foot plantar area with wound cleanser. Apply A & D ointment (a topical skin protectant used to soothe minor skin irritations, and protect chafed or chapped skin. It is available over-the-counter and is characterized by its thick, emollient, and moisture-sealing properties. to dry areas) Apply foam dressing and Kerlex daily for foot dryness starting 10/10/24. Review of the resident's quarterly Minimum Data Set (MDS - a federally mandated assessment instrument completed by facility staff for care planning), dated 9/12/25 showed the resident:-Was cognitively intact.-Had a venous or arterial ulcer (a sore that develops, typically on the feet or lower legs, due to poor blood flow in the veins and/or arteries).-Had other open lesions (damaged tissue) on the foot.-Received dressings to the feet. During an interview on 10/8/25 at 12:00 P.M. the resident said:-He/She had been diagnosed with osteomyelitis several years ago and had very poor circulation which caused him/her to have lots of wounds off and on to both feet.-He/She had infected wounds on his/her feet over the past several years but currently was not taking any antibiotic for his/her wounds. Observation on 10/9/25 at 3:03 P.M of the resident's wound care. showed:-Items to be used during wound care were sitting on a table next to LPN B who was sitting at the foot of the resident's bed.-Prior to starting the wound care LPN B applied hand sanitizer to his/her hands and put on exam gloves.-He/She took socks off the resident's left and right feet and threw them onto the floor.-LPN B picked up scissors and cut the Kerlex wrap off the resident's left foot and then touched the resident's left foot with both gloved hands.-With the same gloved hands and without sanitizing the scissors LPN B cut and then removed the Kerlex from the resident's right foot. -Observation of the right foot showed black eschar (a layer of dead, crusty tissue that forms over a wound) approximately 1/3 inch thick. There was puffiness and a reddish pink coloring to the inside of the resident's right ankle and foot with two open areas approximately 1/4 inch in size on the swollen portion of the foot and ankle. There was an open area approximately ¾ inch in diameter in the mid-section of the arch on the right foot.-LPN B said the foot looked about like it did the last time he/she saw it over two months ago, but he/she hadn't seen the open area on the resident's arch and didn't know when that started because he/she normally didn't do the resident's wound care.-LPN B removed and discarded the exam gloves, used hand sanitizer and put on clean exam gloves.-LPN B applied wound cleanser to a pad and cleaned the eschar on the resident's right foot. -LPN B took off his/her gloves, used hand sanitizer, and put on a new pair of exam gloves before placing a padded foam dressing over the eschar.-LPN B discarded his/her gloves, used hand sanitizer and put on clean gloves before opening a package of calcium alginate (a highly absorbent fiber derived from seaweed, primarily used for moderate to heavily oozing wounds). He/She cut a piece of calcium alginate to fit the mid-arch wound without sanitizing the scissors. He/She placed the dressing into the open wound on the mid-arch section of the right foot.-Without sanitizing his/her hands LPN B used Kerlex to wrap the bandaging in place on the right foot. -LPN B took off and discarded his/her gloves and used tape to secure the Kerlex and then put on gloves without first using sanitizer and opened the second padded foam bandage which he/she placed on the left foot and then wrapped the left foot with Kerlex.-LPN B took off and discarded his/her gloves and used tape to secure the Kerlex on the left foot.-LPN B applied hand sanitizer, sanitized the scissors and placed socks on each of the resident's feet.-LPN B said the resident's room sink didn't work and normally he/she would wash his/her hands before starting wound care and before leaving the room.-The resident said the sink had been dripping over the past several months. Maintenance had fixed it a couple of times, but it was dripping so he/she turned it off with the valve below the sink. The water couldn't be turned on at the faucets because it was turned off under the sink.-LPN B did not sanitize his/her hands after putting on the resident's socks or wash his/her hands before leaving the room. During an interview on 10/9/25 at 3:20 P.M. LPN B (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	said:-Nurses were supposed to wash their hands before starting and after finishing wound care, but the water was turned off to the resident's faucet so he/she used hand sanitizer and put on gloves before doing wound care for Resident #2.-Nurses were supposed to sanitize their hands before and after cleaning and dressing wounds and to sanitize equipment before and after using it.-Nurses should sanitize their hands after touching skin and after any dirty step in the wound care process. During an interview on 10/10/25 at 1:04 P.M. LPN A said:-Nurses were supposed to wash their hands before and after doing wound care, but the resident's sink had not worked for the three weeks he/she had been employed there, so he/she used hand sanitizer before starting and after finishing the resident's wound care.-Nurses should sanitize their hands before and after cleaning, treating, and dressing wounds and after each dirty step in the wound care process or after touching anything that could be dirty. During an interview on 10/14/25 at 10:18 A.M. the DON said:-He/She expected nurses to wash their hands before and after wound care.-Nurses should always use hand sanitizer after each dirty task in the wound care process and before cleaning, treating, and dressing wounds. During an interview on 10/14/25 at 12:20 P.M. the MDS Coordinator, also the Infection Control Nurse, said:-Nurses should wash their hands before and after completing wound care.-Nurses should sanitize their hands after touching anything that could potentially be dirty and after every dirty task in the wound care process. During an interview on 10/14/25 at 1:00 P.M. the Maintenance Supervisor said:-Resident #2 kept turning the faucets off in his/her room with too much force. That had caused the valve stems to go bad more than once in the past several months. -He/She always tried to keep multiple valve stems on hand at the facility, and had recently ordered several, but it was taking longer for the parts to arrive from overseas.-The resident's sink could be turned on and off by the valve below the sink. 7. Review of the facility's Policy for TB-Employee Version, undated, showed:-To ensure early detection of tuberculosis for potential employees, all potential employees shall be asked to participate in TB testing or a chest X-ray for possible infection.-If a potential employee has no documentation of a prior two-step Mantoux Tuberculin Skin Test (TST), administer the first step at least two to three days prior to employment. -The previous two-step TB test is acceptable if performed no longer than six months from the hire date.-Read results of the first tuberculin injection within 48 to 72 hours of injection. Results must be read and documented in millimeters (mm) prior to or on the employee start date.-If results are negative, administer second step within one to three weeks of the first TST administration and read results within 48 to 72 hours.-A chest X-ray should be provided for employees whose skin test reactions indicate positive results. Treatment for TB infection should be provided according to results. Review of the Centers for Disease Control (CDC) website on 10/10/25 showed:-A person who does not return within 72 hours after administration of tuberculin will need to be rescheduled for another skin test.-Induration (hard, raised swelling at injection site) of five or more millimeters (mm) is considered positive for individuals with compromised autoimmune systems or those on immunosuppressive therapy; those with recent contact with an infectious TB case; or those with fibrotic changes on a chest X-ray consistent with past TB.-Induration of 10 mm or more is positive for people coming from countries where TB is common; those who misuse drugs; workers, including health care workers, and residents in high risk congregate settings; and individuals with clinical conditions like diabetes, kidney failure and certain cancers. Review of employee files who were hired within the past year and still currently employed as of 10/9/25, showed: -Review of Employee A's file showed he/she:--Was hired as a Nurse Assistant (NA) on 4/16/25.--Received his/her first Mantoux TST injection on 4/14/25. It was read with negative results on 4/16/25.--Received the second Mantoux TST more than 21 days later, on 5/28/25. There was no date documented for results.-Review of Employee B's file showed he/she:--Was hired as a NA on 1/30/25.--Received his/her first TST months later, on 5/10/25. It was read with negative results on 5/12/25.--Received the second TST more than 21 days later, on 7/2/25. It was read on 7/5/25 with negative results.-Review of Employee D's file showed he/she:--Was hired as a Certified Medication Technician (CMT) on 5/19/25.--Received his/her first TST on 5/16/25. It (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	was read with negative results on 5/19/25.--Received the second TST more than 21 days later, on 6/19/25. It was read more than 72 hours later, on 6/25/25.-Review of Employee E's file showed he/she:--Was hired as a Certified Nursing Assistant (CNA) on 9/18/25.--Received his/her first TST on 9/17/25. It was read with negative results on 9/19/25.--Received the second TST on 10/1/25. There was no documentation of results.-Review of Employee G's file showed he/she:--Was hired as a Registered Nurse (RN) on 2/17/25.--Received his/her first TST on 2/19/25. It was read with negative results on 2/21/25.--Received the second TST on 3/7/25. There was no documentation of second step results.-Review of Employee H's file showed he/she:--Was hired as a Dishwasher on 9/23/25.--Received his/her first TST on 9/19/25. It was read with negative results on 9/22/25.--Received the second TST on 10/1/25. There was no documentation of second step results.-Review of Employee J's file showed he/she:--Was hired as a Transportation Driver on 7/7/25.--Received his/her first TST on 7/7/25. It was read with negative results less than 24 hours later, on 7/8/25.--Received the second TST on 7/21/25. It was read more than 72 hours later, on 7/30/25.-Review of Employee K's file showed he/she:--Was hired as a Housekeeper on 6/12/25.--Received his/her first TST on 6/12/25. There was no documentation of first step results.--Received the second TST on 6/25/25. It was read on 6/27/25 with negative results. 8. During an interview on 10/9/25 at 11:50 A.M. the Business Office Manager said:-He/She was responsible for new employee background screenings and the DON and LPN D were responsible for TB testing for newly hired and current staff.-TB documentation was kept in the nursing office until the employee no longer worked at the facility and then their TB information was given to him/her to be placed in the employee's file. During an interview on 10/14/25 at 10:18 A.M. the DON said:-LPN D was responsible for keeping track of when staff were due for their two-step and annual TB tests.-Either he/she or LPN D administered the first step Mantoux TST on the employee's first day of orientation. -New employees were told when the first step needed to be read, when the second step would be done, and that they couldn't work on the floor until results of the first TST step had been read.-Results should be recorded on the Employee TST form kept on LPN D's desk.-Either he/she or LPN D usually administered the second step TST when due. The employees were told any nurse could read it and it needed to be read in two to three days. -The nurse who read it should record the second step results on the Employee TST form.-He/She tried to read the TB results Monday through Friday and other nurses read the results on evenings, and weekends.-Nurses have been told where to go to record results of the TST tests.-He/She tried to have the second step done one week after the first step if possible-He/She was new to the facility within the past few months and noticed the TB results were either read too late or weren't read at all and needed to be started all over again.-He/She, as the DON, was responsible for auditing and ensuring TB tests were completed according to facility policy.

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	26E256	A. Building B. Wing	10/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to have parameters listed in the medication orders for Acetaminophen (a widely used over-the-counter medication that relieves pain and reduces fever) containing medications for three sampled residents (Resident #1, #6, and #78) of out of 18 sampled residents. The facility census was 75 residents. Review of policy entitled Medication Management and Monitoring dated 2019 showed that it was the responsibility of nursing professionals was to be aware of action, correct dosage and route, frequency, and other considerations as required for the administration of medications.1. Review of Resident #78's admission Record showed the resident was admitted to the facility on [DATE].Review of Medication Review Report dated 2/29/24 showed the following order:-Acetaminophen 325 milligram (mg) give two tablets by mouth every four hours as needed for pain or increased body temperature. -The order failed to have the parameters of not to exceed three grams of Acetaminophen in 24 hours from all sources. 2. Review of Resident #6's admission Record showed the resident was admitted to the facility on [DATE]. Review of Medication Review Report dated 3/4/25 showed the following orders:-Acetaminophen Extra Strength 500 mg tablet give two tablets by mouth every six hours as needed for pain. -The order failed to have the parameters of not to exceed three grams of Acetaminophen in 24 hours from all sources. 3. Review of Resident #1's admission Record showed the resident was admitted to the facility on [DATE]. Review of Medication Review Report dated 2/29/24 showed the following orders:- Acetaminophen 325 mg give two tablets by mouth every six hours as needed for pain.-The order failed to have the parameters of not to exceed three grams of Acetaminophen in 24 hours from all sources. 4. During an interview on 10/14/2025 at 9:22 A.M., Licensed Practical Nurse (LPN) B said: -Acetaminophen should have had parameters of not to exceed 3 grams (g) in 24 hours from all sources.-If the order did not have the parameters, he/she would have called the doctor and gotten the parameters.-He/She was unsure who audited the orders to ensure medications that needed parameters had them. -All orders with Acetaminophen should have had parameters. -The parameters were needed to be on the order because too much Acetaminophen could be toxic. During an interview on 10/14/2025 at 9:26 A.M., LPN A said: -Acetaminophen should have had parameters of no to exceed 3 g in 24 hours from all sources.-If the order did not have the parameters, he/she would have called the doctor and gotten the parameters.-He/She was unsure who audited the orders to ensure medications that needed parameters had them. -All orders with Acetaminophen should have had parameters. During an interview on 10/14/25 at 11:25 A.M., the Director of Nursing (DON) said:-It was his/her expectation that all orders that contained Acetaminophen would have the parameter of not to exceed 3 g of Acetaminophen in 24 hours from all sources. -It was his/her expectation that all nurses would have ensured that this parameter was added to all orders that contained Acetaminophen. -It was his/her expectation that when the parameter was missing on an order the nurse that discovered it would have contacted the doctor and received the order to add the parameter. -It was ultimately his/her responsibility to ensure that all medications that contained Acetaminophen had the parameter on all the orders.-He/She had only been a DON for two months. -He/She though pharmacy audited all the medications.-He/She would audit all medications with Acetaminophen to ensure parameters were in place.

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F 0728 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that nurse aides who have worked more than 4 months, are trained and competent; and nurse aides who have worked less than 4 months are enrolled in appropriate training. Based on interview and record review the facility failed to ensure 10 Nurse Assistants (NA A, NA B, NA C, NA D, NA E, NA F, NA G, NA H, NA I, and NA J) out of 24 were not Certified Nursing Assistants (CNAs) within four months of hire. The facility census was 75 residents.A policy on NA training was requested but was not received from the facility. 1. Review of an undated hire record sheet showed:-NA A was hired on 2/6/25.-NA B was hired on 4/16/25.-NA C was hired on 3/17/25.-NA D was hired on 3/2/25.-NA E was hired on 6/11/24.-NA F was hired on 1/30/25.-NA G was hired on 2/27/24.-NA H was hired on 3/31/25.-NA I was hired on 1/3/25.-NA J was hired on 4/18/25.During an interview on 10/10/2025 at 2:23 P.M., NA A said:-He/She had started CNA class last week. -He/She was hired in February 2025. -The class was an on-line class and nurses observed him/her and did the checkoffs for the skill being observed.-He/She and three other NA's were in the class (NA F, NA H, and NA J)During an interview on 10/14/2025 at 9:50 A.M., the Administrator said:-He/She oversaw staffing and the NA program.-A NA could only be an NA for four months. -If a NA was not a CNA after four months that person should have been moved to a different department or terminated. -Some were NA's longer than four months due to lack of staff. -He/She should have done audits and tracked the status of the NA's. -He/She was trying to hire more staff to include NA's and CNA's but it was difficult due to the availability of qualified people.During an interview on 10/14/25 at 10:10 A.M., NA H said:-He/She had worked at the facility for nine months. -He/She was a NA, not a CNA. -He/She had been in the CNA class for a couple of weeks. -No one at the facility had ever said why it had taken so long to get in the class to become certified.During an interview on 10/14/25 at 10:35 A.M., the Director of Nursing (DON) said:-He/She was not in charge of the NA program at this time.-He/She had only been the DON for two months.-He/She was unaware of how many NA's had been NA's longer than four months.-He/She did not know that NA's could only be NA's for four months before they had to become certified, moved to another department, or terminated.

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure consistent and accurate wound assessments by a trained professional and failed to obtain a physician's order prior to treatment of an open wound for one sampled resident (Resident #2) out of 18 sampled residents. The facility census was 75 residents.Review of the facility's Skin Integrity Management policy, dated 2007 showed:-Ulcers and wounds will be assessed accurately to determine the wound or ulcer type.-Non-pressure ulcers will be assessed weekly. All wounds will be documented using the Wound Tracking form.-After assessing a wound proper documentation is necessary to include the resident's name, vital signs, wound location and size, and description of any drainage, odor, necrotic tissue, infection, and any follow-up.-Do not stage (a system used by healthcare providers to classify the depth of tissue damage caused by pressure) a non-pressure ulcer.Review of the Missouri Nurse Practice Act (NPA), updated 8/28/24, showed:-A Licensed Practical Nurse (LPN) can't perform the initial, comprehensive wound assessment.-An LPN can't independently modify care plans or wound care treatments.-Wound care must be done under the supervision of a Registered Nurse (RN) or licensed prescriber.-An LPN can collect data and document information about the wound such as size, appearance, and the presence of any drainage; monitor for change; implement the care plan; and perform wound care according to physician orders.-LPNs require specialized training and certification to perform comprehensive wound care.Review of the National Pressure Ulcer Advisory Panel website on 10/14/25 showed:-The term unstageable was used to describe a type of PU with full thickness tissue loss in which the base of the ulcer is covered by slough (yellow, tan, gray, green or brown) and/or eschar (tan, brown or black) in the wound bed.-The term was not used to describe a wound caused by poor blood circulation. 1.Review of Resident #2's admission Record showed the resident was admitted to the facility on [DATE] with diagnoses that included unspecified wound, left foot and osteomyelitis (infection of the bone tissue, often leading to inflammation, pain, and damage to the bone). Review of the resident's Wound care plan, initiated 10/13/19, showed:-The resident was at risk for infection related to wound(s) on the foot.-The resident would receive daily dressing changes as ordered.-Licensed nurses will document feet wounds with dressing changes, related to appearance, measurements, drainage, and odor and notify the physician as needed.-Nurses will report signs and symptoms of infection such as elevated temperature, loss of appetite, flushed or pale appearance, nausea, vomiting, or foul odor from wound.-Weekly wound assessments will be conducted by a wound clinic or clinical nurse as the resident allows.Review of the resident's July, 2025 physician orders showed:-Clean his/her right foot plantar (bottom/sole of foot) with wound cleanser. Apply foam dressing and Kerlix (gauze bandaging with a crinkle weave) daily starting on 9/19/24.-Clean his/her left foot plantar area with wound cleanser. Apply A & D ointment to dry areas. Apply foam dressing and Kerlix daily for foot dryness starting 10/10/24.Review of the resident's electronic medical record (EMR) showed no initial, comprehensive assessments completed by an RN or a physician for any wounds and no documentation showing the dates when any wounds were initially discovered.Review of the resident's Weekly Wound Tracking form, for 7/2/25 through 7/9/25 showed:-On 7/2/25 the resident:--Had a stasis ulcer (chronic, open wound on the lower leg due to poor blood circulation) on his/her right plantar measuring 3.5 centimeters (cm) by 3.2 cm. The wound was also marked as unstageable and was described as starting to granulate (tissue that fills in when a wound starts to heal). There was no date showing when the wound was first identified. --The resident also had a callus on his/her left plantar foot area measuring 1.0 cm by 1.0 cm, also marked as unstageable. It was described as dry skin and treatment consisted of foam dressing and Kerlix, no date was indicated for when the left foot callus was first identified. -On 7/9/25 the right plantar wound measured 3.2 cm by 3.0 cm with dark granulation. It was treated with foam dressing and Kerlix. A second wound (wound #2), measuring 1.5 cm by 1.5 cm was documented for the right (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	plantar. Edges had granulation. Treatment consisted of Calcium Alginate and foam dressing. The date it was first identified was not indicated. -On 7/9/25 the left plantar measurements, description and treatment had not changed from the previous week.-There was no documentation of wound assessment due on 7/16/25.Review of the resident's nursing notes for 7/15/25 through 7/17/25 did not show why the resident did not have the wound assessment.Review of the resident's Weekly Wound Tracking for 7/24/25 through 7/30/25 showed:-On 7/24/25:--The resident only had one wound which was reclassified from stasis to callus and continued to be identified as unstageable. There was no documentation for wound #2 or documentation that wound #2 had healed. --On 7/24/25 The left plantar measurements, wound description, and treatment had not changed from the previous week. --On 7/24/25 a second wound was documented on the left foot. There was no documentation when the second left foot wound was first identified. It was classified as a callus and also as unstageable. It measured 1.5 cm by 1.2 cm and was described as being dry skin. Treatment consisted of foam dressing and Kerlix wrap.-On 7/30/25 the right plantar wound increased to 3.0 cm by 3.0 cm by 0.5 cm deep. It was described as dark and the treatment consisted of foam dressing and Kerlix.-On 7/30/25 the left plantar documentation showed the resident had two wounds similar to the previous week's wound type, size, description and treatment.Review of the resident's EMR on 10/10/25 showed there was no further wound tracking documentation after 7/30/25. Review of the resident's quarterly Minimum Data Set (MDS - a federally mandated assessment instrument completed by facility staff for care planning), dated 9/12/25 showed the resident:-Was cognitively intact.-Rejected cares daily.-Had no pressure ulcer or diabetic foot ulcer.-Had a venous or arterial ulcer (a sore that develops, typically on the feet or lower legs, due to poor blood flow in the veins and/or arteries).-Had other open lesions (damaged tissue) on the foot.-Received dressings to the feet.Observation on 10/8/25 at 11:58 A.M. showed:-The resident was in bed with socks covering dressings to both feet. The inside of the resident's right sock appeared stained with an approximate one-half to one inch stain as if the wound could have seeped.-When asked why his/her feet were bandaged the resident replied he/she had been diagnosed with osteomyelitis several years ago and he/she had very poor circulation which caused him/her to have lots of wounds to the feet.Observation during the resident's wound care on 10/9/25 at 3:03 P.M. showed:-Black eschar (a layer of dead, crusty tissue over a wound) approximately 1/3 inch thick on the right foot metatarsalgia pad (padded area just below the toes). The inner right foot was puffy and pinkish red. There were two tiny open areas on the inside of the resident's right foot.-LPN B said the eschar was not something new and the inside of the resident's foot and ankle was always swollen.-The resident had an approximately three-fourths inch open wound to the mid arch area of his/her right foot.-LPN B said the mid-arch open wound was new since he/she last treated the wound a couple of months ago, so he/she didn't know how long it had been there. He/She would use calcium alginate (a highly absorbent fiber derived from seaweed used for medical dressings for wounds with a steady discharge) and will get the physician's order as soon as he/she was done with the treatment.-LPN B opened the calcium alginate packet after cutting it to fit the wound and placed it into the wound and used Kerlix wrap to secure it.During an interview on 10/9/25 at 3:20 P.M. LPN B said:-He/She was texting the doctor now for the calcium alginate order.-The physician just wanted nurses to go ahead and treat any new wounds when they were doing wound treatments and then get the order instead of having to wait to get the order and have to redress the resident's wounds. -He/She had been responsible for doing weekly wound assessments, but hadn't done them since August, 2025 or before. -He/She had been measuring wounds weekly, writing a description of the wounds, and documenting the treatments, but had stopped doing the wound care assessments because he/she was told it put him/her into too much overtime. -RNs at the facility did not do wound care assessments.-He/She did not have any specialized training related to wound care.-The resident has had wounds on his/her feet for several years and he/she thought the resident came into the facility with them. The resident stopped going to the wound care clinic about three or more years ago. -He/She didn't know what the cause of the wounds were.-It was best practice to do (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	weekly wound assessments to make sure staff were tracking the wounds to see if they were getting better or worse, but nobody was assessing the resident's wounds lately because the resident refused to go to the wound care clinic and he/she had been told to not come in on his/her day off to do the assessments.Note: At 3:33 P.M. during the interview LPN B's phone dinged. LPN B said he/she just got the physician approval for the calcium alginate.During an interview on 10/10/2025 at 10:45 A.M. the Director of Nursing (DON) said:-LPN B was doing all the weekly wound care assessments on residents. -The resident refused to go to the wound care clinic and wasn't cooperative with his/her treatment. -He/She told LPN B not to come in anymore on his/her day off to do the wound assessments. He/She didn't mean LPN B shouldn't do them. He/She expected LPN B to have been doing wound assessments on the days he/she worked unless the resident refuses the assessment. -The Weekly Wound Tracking showed wounds were unstageable as well as stasis ulcers. -He/She had only been at the facility a couple of months and wasn't sure what the wounds were.During an interview on 10/10/2025 at 1:04 P.M. LPN A said:-He/She was newer to the facility and noticed an open area on the resident's foot as well as eschar the one time he/she provided the resident's wound treatment. The resident refused most of his/her treatments. -He/She didn't fully assess wounds because he/she was an LPN and it was out of his/her scope of practice to classify them. He/She could measure the wound and describe the tissue condition, but a nurse had to identify the type of wound and document if it was healed. -The resident's foot was nowhere near being healed.The RNs have the credentials to classify wounds and stage pressure ulcers.-He/She didn't know what type of wounds the resident had. The Weekly Wound Tracking form showed the resident had unstageable wounds. He/She didn't know if that was a PU or another type of wound.-He/She thought wound assessments had to be done weekly and nurses were to look at the wound daily during treatments, but the resident refused more than half of them.During an interview on 10/10/2025 at 1:38 P.M. LPN B said:-A year ago the resident had an open area on his/her foot pad.-He/She marked it as unstageable because it wasn't a stage I, 2, 3, or 4. -He/She hadn't received any training on staging PU or classifying wounds. -The previous DON went over the Weekly Wound Assessment form over a year ago. He/She thought he/she was told if it wasn't a PU it was unstageable. -The right foot had a callus on the foot pad with no depth or drainage in Sept, 2024. He/She thought it also was from poor circulation. -The residents' feet frequently had open wounds related to poor circulation.There was now depth to the eschar on the right foot. -The left foot had gotten better since a year ago. The right foot was worse due to the open area and the tiny pinhole spots on the side of his/her foot. -The right foot swelling has been there for many years. -He/She might have called the wounds unstageable since they were just calluses and you can't stage calluses. Weekly skin assessments were completed on the Treatment Administration Record (TAR). The resident usually had his/her feet bandaged up so staff can't see them unless the resident was getting wound care.-Assessing wounds was within the scope of practice of an LPN.During an interview on 10/10/2025 at 2:14 P.M. Nurse Aide (NA) A said he/she had never filled out a shower sheet for the resident because the resident leaves his/her feet bandaged when he/she sponge bathes. During an interview on 10/14/2025 at 10:18 A.M. the DON said:-He/She was unable to find any skin assessments for the resident where it showed skin areas of concern on a body diagram. He/She asked nurses about it and they said they just mark the skin assessments weekly on the TAR for the skin they are able to see as the resident's feet were always bandaged. He/She couldn't find any wound assessments that showed a body diagram and the exact location of wounds on the resident's feet. It would be best to have a diagram to show the location on the foot of all new wounds.-The first of August he/she told LPN B not to come in on his/her day off to do wound assessments and LPN B thought he/she wasn't supposed to assess the resident any longer. -He/She didn't realize LPN B wasn't assessing the resident's wounds. He/She expected LPN B to do the assessment on his/her regular work day. There should not be any gaps in doing the resident's weekly wound assessments.-Since 7/30/25 he/she had conversations with nurses about the resident's feet, but LPN B didn't mention the area that he/she found open when doing wound care (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	on 10/9/25. He/She realized the nurses needed more oversight in regards to wound treatments and assessments.-He/She didn't think it was out of an LPNs scope of practice to do skin assessments. One nurse should do the assessments for consistency and they should be done weekly. Staging is for PUs. LPN B didn't see the wounds as pressure ulcers. They are stasis ulcers. Unstageable means it isn't a PU. It doesn't meet the Stage 1 through 4 criteria used for PUs.-Either he/she or the MDS coordinator should be designated to audit wound assessments to ensure they are being done.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to complete thorough and timely fall investigations and failed to update care plans for two sampled residents (Resident #3 and #19) who fell multiple times out of 18 sampled residents. The facility census was 75 residents. Review of the facility's undated policy titled Fall Policy and Procedure showed:-The purpose of the policy was to ensure appropriate medical and multi-disciplinary assessment of falls and fall risk factors; to coordinate management of acute and recurrent falls; and to provide measures to help prevent falls.-The licensed nurse performed an assessment within a time frame appropriate to the clinical circumstance, right after the fall occurred and coordinated other indicated evaluation and management of injuries or underlying causative conditions.-Licensed nurses were responsible for providing adequate documentation of evaluation and management of the fall.-The incident report was for internal management only and should not be considered as part of the resident's medical record.-The safety committee coordinated fall risk assessments and fall managements.Review of the facility's undated policy titled Policy and Procedures for Fall Investigation showed licensed nurses completed the fall investigation form upon each fall on the provided form.Review of the facility's undated policy titled Upon a Fall Incident showed:-Staff were to conduct an immediate investigation of the accident/incident.-The investigation report was to be submitted to the Director of Nursing (DON) no later than 24 hours after the occurrence of the accident/incident.-The Quality Assurance (QA) team completed a summary of investigation for unwitnessed falls that addressed the following:--What happened.--Physical and mental assessments.--Interviewing process that included all potential witnesses.--Reviewing the pattern and history.--Summary for determining the causation and developing the interventions.-Staff were to complete an incident report for witnessed falls that included the following:--The surroundings of the occurrence including medical devices or equipment that may have been involved in the incident.--The causation of the witnessed incident.--Time that the attending physician was notified and response.--Date and time that the resident's family or responsible party was notified.--The condition of the injured resident including the resident response and reaction.--The disposition of the injured resident.--Signature and title of the person completing the report.--The date, time, and place the accident/incident took place.1. Review of Resident #19's admission Record showed he/she admitted to the facility with the following diagnoses:-Parkinsonism (a clinical syndrome characterized by a group of movement disorders that mimic Parkinson's Disease (a progressive neurological disorder that affects movement, balance, and coordination), Unspecified.-Tremor, Unspecified.-Hallucinations, Unspecified.Review of the resident's Quarterly Minimum Data Set (MDS- a federally mandated assessment instrument completed by facility staff for care planning) dated 7/7/25 showed:-The resident was cognitively intact.-The resident did not have any falls since admission or the prior assessment.Review of the resident's care plan dated 9/5/25 showed:-The resident had potential for falls related to repeated falls.-The resident had to be reminded to not use the wheelchair as a walker.-The resident had poor balance and was unable to ambulate at times.-The resident had poor safety awareness.-The resident had been having increased hallucinations and medications were changed which caused him/her to be more unsteady on his/her feet.-The interventions that were in place included:--Monitor for medication side effects and keep the physician informed of any problems.--No foot pedals on wheelchair.--Ensure the resident had shoes on the right feet.--The resident was to only ambulate with the restoration aide (RA) due to decline.--The resident was to work with the RA for ambulation and strengthening.-NOTE: The care plan was not updated to show the resident had falls on 9/23/25 and 9/28/25 with new interventions as of 10/13/25.Review of the resident's Incident Audit Report dated 10/9/25 showed:-The report was created on 10/9/25.-The resident had an unwitnessed fall on 9/23/25.-The nurse had been called to the hallway outside of the (continued on next page)

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	26E256	A. Building B. Wing	10/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Johnson County Care Center	122 East Market Street Warrensburg, MO 64093

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	resident's room.-The Nursing Assistant (NA) saw the resident stand at the foot of his/her bed and then left his/her room and started running down the hall.-The resident tripped over his/her feet and fell to the floor.-The resident had a laceration above his/her left eye.-The resident had been sent to the local hospital.-The resident returned to the facility with five stitches to his/her injury above his/her left eye.-The immediate action taken was the resident was sent to the hospital.-The resident had poor safety awareness and needed to ambulate with assistance due to decline in cognition.-There was no Root Cause Analysis (RCA- a systematic problem-solving method used to identify the fundamental causes of a problem to prevent its recurrence) completed for the fall.Review of the resident's Incident Audit Report dated 10/9/25 showed:-The report was created on 10/9/25.-The resident had an unwitnessed fall on 9/28/25.-Staff had entered the resident's room and found the resident lying on his/her left side on a floor mat.-The resident was resting with his/her eyes closed.-The resident said he/she was unsure of how he/she ended up on the floor.-The immediate action taken was that the resident was assisted to bed.-The contributing factors of the fall included:--Confusion.--Incontinence.--Recent Illness.-There was no RCA completed for the fall.2. Review of Resident #3's admission Record showed he/she was admitted to the facility with a diagnosis of Unspecified Dementia (a progressive organic mental disorder characterized by chronic personality disintegration, confusion, disorientation, stupor, deterioration of intellectual capacity and function, and impairment of memory control, judgement, and impulses), Unspecified Severity, Without Behavioral Disturbance, Psychotic Disturbance, Mood Disturbance, and Anxiety.Review of the resident's care plan dated 7/3/25 showed:-The resident was at high risk for falls related to gait/balance problems.-The resident wore a personal alarm which was worn to alert the resident to try not to stand on his/her own due to poor safety awareness.-The resident preferred to use a wheelchair for locomotion due to a history of numerous falls at a previous facility.-The following interventions were in place:--Answer call light promptly.--Anticipate and meet the resident's needs.--Assist the resident with all transfers.--Decrease obstacles in room.--Eliminate potential hazards.--Ensure night light was working.--Keep corridors clutter free,--Keep corridors/room well lit.--Keep personal items within reach.--Maximize time out of bed to increase tolerance.--Non-skid socks.--Remind the resident to use call light for assistance.--Review medications with physician.-All of the interventions in the resident's care plan were placed in the care plan on 12/26/22.- The care plan was not updated to show the resident had falls on 10/3/25 and 10/4/25 with new interventions as of 10/13/25.Review of the resident's Quarterly MDS dated [DATE] showed:-The resident severely cognitively impaired.-The resident had falls since the prior assessment.-The resident had two falls with injury since the prior assessment.Review of the resident's Incident Audit Report dated 10/9/25 showed:-The report was created on 10/9/25.-The resident had an unwitnessed fall on 10/3/25.-The nurse had been called to the resident's room.-The resident was found lying beside his/her bed on the floor.-The resident had said that he/she was trying to get out of bed when he/she fell.-The immediate action taken was to notify the resident's hospice company.-A predisposing environmental factor was that the resident had a fall alarm.-The predisposing physiological factors of the fall included:--Confusion.--Incontinence.-There was no RCA completed for the fall.Review of the resident's Incident Audit Report dated 10/9/25 showed:-The report was created on 10/9/25.-The resident had an un-witnessed fall on 10/4/25.-The nurse had been called into the resident's room.-The NA found the resident lying on the floor beside his/her bed.-The resident said that he/she was trying to get into bed and fell out of his/her wheelchair.-The resident had a small bruise on the right side of his/her forehead.-No other injuries were noted.-The immediate action taken was to notify the resident's hospice company and initiate neurological checks (a series of questions and tests used to evaluate the health and function of the brain, spinal cord, and nerves).-The predisposing physiological factors of the fall included:--Confusion.--Incontinence.-There was no RCA completed for the fall.3. During an interview on 10/14/25 at 9:43 A.M. Licensed Practical Nurse (LPN) A said:-The nurses were responsible for the initial fall documentation.-He/She was unsure of who was (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	responsible for fall investigations.-He/She was unsure if there was a time frame in which the fall investigations needed to be completed.-He/She guessed that fall investigations needed to be completed within 72 hours of the fall.-He/She was unsure of who was responsible for completing care plans.-Care plans needed to be updated after every fall.-He/She was unsure of the current fall interventions that were in place for Resident #3 and Resident #19.During an interview on 10/14/25 at 10:57 A.M. LPN B said:-Nurses were responsible for completing the fall investigations.-The fall investigations needed to be completed as close to the time as the fall as possible.-The fall investigations for Resident #19 and Resident #3 should have been completed before 10/9/25.-The MDS Coordinator updated the care plans.-He/She was unsure if the MDS Coordinator would know to update a resident's care plan after fall if the fall investigation had not been completed.-He/She was unsure if care plans needed to be updated after each fall.-He/She was unsure if Resident #3's and Resident #19's care plans needed to be updated at that point in time.During an interview on 10/14/25 at 11:35 A.M. the DON said:-He/She had changed the way the staff were to complete fall investigations when he/she started working at the facility.-The nurses had to complete a five-to-six-page form and turn it into him/her after each resident fall.-There was also a form in the Electronic Medical Record (EMR) system that the nurses could fill out as well.-The nurses were responsible for completing the fall investigations.-He/She would be the person responsible for ensuring that all fall investigations were complete and thorough.-He/She had not been on top of that recently.-The MDS Coordinator and charge nurses could update care plans.-Care plans should be updated after every fall.-The MDS Coordinator and himself/herself was responsible for ensuring care plans were updated after each fall.-He/She was unsure if there was a time frame in place for when fall investigations and care plan updates needed to be completed after a resident fall.-He/She would have expected Resident #3's and Resident #19's fall investigations to have been completed prior to 10/9/25.-He/She was unsure why the fall investigations had not been completed.-He/She would have expected Resident #3's and Resident #19's care plans to have been updated by that point in time.During an interview on 10/14/25 at 12:19 P.M. the MDS Coordinator said:-Resident #3's and Resident #19's fall investigations were created and completed on 10/9/25.-He/She had completed Resident #3's and Resident #19's fall investigations.-He/She had been working with the floor nurses related to fall investigations.-Resident #3's and Resident #19's fall investigations should have been completed immediately after the fall.-Resident #3's and Resident #19's fall investigations were completed late.-He/She thought he/she had updated Resident #3's and Resident #19's care plans after they fell.-He/She was unsure if the floor nurses had the ability to update care plans, but he/she would not expect them to update the care plans because it was his/her responsibility to complete them.-Resident #3's and Resident #19's care plans should have been updated by that point in time.-He/She was unsure of what specific interventions were put into place after Resident #19's fall.-The interventions that were put into place after Resident #3's fall included:--Ensuring the resident's fall alarm was working.--Placing fall mats beside the resident's bed.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. Based on observation, interview, and record review, the facility failed to ensure appropriate care for one sampled resident (Resident #10) with a Gastrostomy (G-Tube- an opening into the stomach from the abdominal wall, made surgically for the introduction of food) out of 18 sampled residents. The facility census was 75 residents.Review of the facility's undated policy titled Tube Feeding Protocol showed:-The head of bed (HOB) would be elevated at least 30 degrees.-If at any time during the tube feedings the resident's HOB was lower than the 30 degrees, staff were to stop the tube feeding until the HOB was re-elevated to at least 30 degrees.1. Review of Resident #10's admission Record showed the resident admitted to the facility with the following diagnoses:-Cerebral Palsy (a group of conditions that affect movement and posture caused by damage that occurs to the developing brain, most often before birth).-Gastrostomy Status.Review of the resident's care plan dated 7/24/25 showed:-The resident was fully dependent on staff for repositioning and turning in bed.-The resident required tube feeding and his/her HOB needed to be elevated at 45 degrees continuously, as tolerated, due to the resident sliding down in bed.Review of the resident's Quarterly Minimum Data Set (MDS- a federally mandated assessment instrument completed by facility staff for care planning) dated 9/12/25 showed:-The resident was severely cognitively impaired.-The resident had a G-Tube.-The resident received 51% or more of his/her proportion of total calories through tube feeding.Review of the resident's Order Summary Report dated October 2025 showed an order for Jevity (a high protein, fiber-fortified liquid formula used to provide complete, balanced nutrition for people who require tube feeding or supplemental nutrition) 1.5 calorie via G-Tube at 30 milliliters (ml)/hour for 22 hours a day.Observation on 10/7/25 at 10:39 A.M. showed:-The resident's tube feeding was currently running.-The resident's HOB was at 30 degrees.-The resident had slid down in bed and was lying at an approximate 20-degree angle.Observation on 10/8/25 at 9:03 A.M. showed:-The resident's tube feeding was currently running.-The resident's HOB was at 30 degrees.-The resident had slid down in bed and was lying at an approximate 20-degree angle.Observation on 10/8/25 at 3:08 P.M. of the resident showed:-The resident was slumped over in the bed towards his/her right side and was sitting at a less than 30-degree angle.-Licensed Practical Nurse (LPN) C had come into the resident's room to give him/her some medication through his/her G-Tube.-LPN C had startled the resident awake and the resident sat back up in bed at a 30-degree angle.During an interview on 10/8/25 at 3:20 P.M. LPN C said:-The resident's HOB needed to be at 30 degrees at all times.-The resident had some ability to move around in bed and the staff would need to monitor the resident frequently due to the resident sliding down in bed.Observation on 10/9/25 at 11:30 A.M. showed the resident's HOB was less than 30 degrees.Observation on 10/10/25 at 9:00 A.M. showed the resident was lying flat in bed.Observation on 10/10/25 at 12:45 P.M. showed the resident was lying flat in bed.During an interview on 10/14/25 at 9:45 A.M. LPN A said:-He/She was unsure of the specific angle that a resident needed to be positioned at when tube feeding was running.-A resident should never lie flat in the bed when tube feeding was running.-When a resident with tube feeding was not positioned correctly it put the resident at risk of aspiration (unintentional inhalation of foreign materials, such as food, liquids, or gas, into the respiratory tract).-If he/she were to walk into a resident's room with tube feeding running and the resident was not positioned correctly, then he/she would reposition the resident and assess the resident for aspiration.During an interview on 10/14/25 at 10:01 A.M. LPN B said:-A resident's HOB needed to be raised to 30 degrees when tube feeding was running.-A resident should never lie flat in bed with tube feeding running.-It was important to keep a resident's HOB elevated when tube feeding was running to decrease the resident's risk of aspiration.-If nursing staff were to walk into a resident's room with tube feeding running and the resident was not positioned correctly, then staff should reposition the resident.During an interview on 10/14/25 at 11:45 A.M. the Director of Nursing (DON) said:-A resident's HOB needed to be elevated to at least a 30-degree angle (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	when tube feeding was running.-If a resident with tube feeding running was not positioned correctly it would put them at an increased risk for aspiration.-He/She would have expected the nursing staff to have checked on the resident more frequently to make sure that the resident was positioned correctly throughout the week.

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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, interview, and record review the facility failed to ensure a medication error rate under five percent (%) for one sampled resident (Resident #69) out of 18 sampled residents. Two medication errors were detected out of 31 observed opportunities resulting in an error rate of 6.45%. This deficient practice had the ability to affect all residents. The facility census was 75 residents.Review of the facility's undated policy titled Crushing Medication Policy showed:-Medications that were not to be crushed may be opened and sprinkled into pudding or applesauce if clinically appropriate.-If medications were not able to be crushed or opened up, staff were to place them whole into a medication cup along with the crushed medication, then mixed together with pudding or applesauce.Review of How to Take Your Depakote (a medication used as a mood stabilizer or anti-convulsant (used to control seizures) which can come in a various oral formulations, including delayed-release tablets, extended-release (ER) tablets, and sprinkle capsules) Product dated in 2025 created by Depakote.com showed:-Depakote products were to be taken exactly as the doctor prescribed.-Depakote tablets or Depakote ER Tablets should be swallowed whole and should not be crushed or chewed.1. Review of Resident #69's admission Record showed he/she admitted to the facility with the following diagnoses:-Epilepsy (a chronic neurological disorder characterized by recurrent, unprovoked seizures, which are caused by abnormal, excessive electrical activity in the brain), Intractable (resistant to conventional anti-epileptic drug (AED) treatment), With Status Epilepticus (a prolonged or recurrent seizure that lasts for more than five minutes or consists of multiple seizures without regaining consciousness between them).-Generalized Idiopathic Epilepsy (GIE- a group of epilepsy syndromes characterized by seizures that affect the entire brain).Review of the resident's Order Summary Report dated October 2025 showed:-An order for Depakote Oral Tablet Delayed Release 125 milligrams (mg), give one tablet by mouth two times a day for seizures, give the 125 mg with 500 mg tablet to equal 625 mg dose.-An order for Depakote Oral Tablet Delayed Release 500 mg, give one tablet by mouth two times a day for seizures, give 500 mg with 125 mg tablet to equal 625 mg dose.Observation on 10/9/25 at 9:40 A.M. of the resident's medication administration pass completed by Licensed Practical Nurse (LPN) A showed:-LPN A grabbed the resident's medication packets.-LPN A popped all of the resident's medications into a medication cup.-LPN A then placed all of the medications into a plastic bag and crushed all of the medications, to include the 125 mg and 500 mg doses of Depakote Delayed Release Tablets.-LPN A then emptied the contents back into the medication cup and mixed the crushed medications in pudding.-LPN A then assisted the resident in taking the medication.During an interview on 10/9/25 at 9:50 A.M. LPN A said he/she would not have done anything differently during the resident's medication administration.During an interview on 10/14/25 at 9:40 A.M. LPN A said:-Depakote tablets could not be crushed.-Depakote tablets could not be crushed because it could affect how the resident would receive the dose.-Not crushing Depakote tablets was a standard of practice and the facility did not need to have an order to not crush the resident's Depakote.-The resident did not get crushed medications.-He/She did not remember crushing the resident's medication on 10/9/25.During an interview on 10/14/25 at 10:04 A.M. LPN B said:-Depakote tablets could not be crushed.-There were different forms of Depakote and for resident's who could not take whole medications, the facility could order sprinkle form.-Not crushing Depakote tablets was a standard of practice and the facility did not need to have an order to not crush the resident's Depakote.-Depakote tablets could not be crushed because it affected how the resident received the dose.-The resident did not normally get crushed medications.-He/She was unsure why LPN A crushed the resident's medications.During an interview on 10/14/25 at 11:55 A.M. the Director of Nursing (DON) said:-Depakote tablets could not be crushed.-Depakote tablets could not be crushed because it could affect how the resident would receive the dose.-The resident's medication order should state that the medication should not be crushed.-He/She was unsure if the resident normally received crushed medication.-LPN A should not have crushed the resident's Depakote tablets.