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	265451	A. BUILDING _____ B. WING _____	04/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRAIRIE VIEW SKILLED NURSING	606 WEST MISSOURI STREET BLOOMFIELD, MO 63825

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 623 SS=D	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8)	F 623		

§483.15(c)(3) Notice before transfer.
Before a facility transfers or discharges a resident, the facility must-
(i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman.
(ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and
(iii) Include in the notice the items described in paragraph (c)(5) of this section.

§483.15(c)(4) Timing of the notice.
(i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged.
(ii) Notice must be made as soon as practicable before transfer or discharge when-
(A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section;
(B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section;
(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;
(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Claudia Harris RN BSN CHPN LNHA	Administrator	4/17/25

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.

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(E) A resident has not resided in the facility for 30 days.

§483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:
(i) The reason for transfer or discharge;
(ii) The effective date of transfer or discharge;
(iii) The location to which the resident is transferred or discharged;
(iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;
(v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;
(vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and
(vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act.

§483.15(c)(6) Changes to the notice.

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F 623	Continued From page 2	F 623		

If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available.

§483.15(c)(8) Notice in advance of facility closure
In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(k).
This REQUIREMENT is not met as evidenced by:
Based on interview and record review, the facility failed to provide a written copy of the notice of transfer or discharge to the resident and/or the resident's responsible party for three residents (Residents #14, #37, and #48) out of six sampled residents. The facility census was 46.

Review of the facility's policy titled, "Transfer or Discharge, Facility-Initiated," dated October 2022, showed:
- Facility-initiated transfers and discharges, when necessary, must meet specific criteria and require resident/representative notification and orientation, and documentation as specified in this policy;
- The resident and representative are notified in writing of the specific need for transfer or discharge;
- Notice of transfer is provided to the resident/representative as soon as practicable before the transfer and to the long-term care

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F 623	Continued From page 3	F 623		

(LTC) ombudsman when practicable;
- Notices are provided in a form and manner that the resident can understand, taking into account the resident's educational level, language, communication barriers, and physical or mental impairments;
- Nursing notes will include documentation of appropriate orientation and preparation of the resident prior to transfer or discharge.

1. Review of Resident #14's medical record showed:
- Admitted on 02/17/25;
- The resident transferred to the hospital on 03/05/25, and returned to the facility on 03/06/25;
- No documentation of the written notification with the reason for the hospital transfer provided to the resident and/or the responsible party.

2. Review of Resident #37's medical record showed:
- Admitted on 07/26/24;
- The resident transferred to the hospital on 03/18/25, and returned to the facility on 03/23/25;
- No documentation of the written notification with the reason for the hospital transfer provided to the resident and/or the responsible party.

3. Review of Resident #48's medical record showed:
- Admitted on 01/06/25;
- The resident transferred to the hospital on 01/18/25, and returned to the facility on 01/24/25;
- No documentation of the written notification with the reason for the hospital transfer provided to the resident and/or the responsible party.

During an interview on 04/02/25 at 8:59 A.M., the Social Service Director (SSD) said there should

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F 623	Continued From page 4 be a transfer/discharge notice given to the resident and/or the resident representative when a resident was sent to the hospital. During an interview on 04/02/25 at 9:28 A.M., Licensed Practical Nurse (LPN) A said when a resident was sent to the hospital, he/she verbally told the resident and /or the resident's representative of the reason for the transfer/discharge to the hospital. The SSD completed the transfer/discharge form. During an interview on 04/02/25 at 9:35 A.M., the Director of Nursing (DON) said when a resident was sent to the hospital, he/she verbally told the resident and/or the resident's representative of the reason for the transfer/discharge to the hospital. The SSD completed the transfer/discharge form. During an interview on 04/03/25 at 11:06 A.M., the Administrator said there should be a transfer/discharge notice given to the resident and/or the resident representative when a resident was sent to the hospital.	F 623		
F 625 SS=D	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to	F 625		

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return and resume residence in the nursing facility;
(ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any;
(iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and
(iv) The information specified in paragraph (e)(1) of this section.

§483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section.
This REQUIREMENT is not met as evidenced by:
Based on interview and record review, the facility failed to inform the resident and the family or legal representative of their bed-hold policy at the time of the transfer to the hospital for three residents (Residents #35, #37, and #48) out of six sampled residents. The facility census was 46.

Review of the facility's policy titled, "Transfer or Discharge, Facility-Initiated," dated October 2022, showed:
- Facility-initiated transfers and discharges, when necessary, must meet specific criteria and require resident/representative notification and orientation, and documentation as specified in this policy;
- The resident and representative are notified in writing of the notice of the facility bed-hold and policies;
- Notices are provided in a form and manner that

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the resident can understand, taking into account the resident's educational level, language, communication barriers, and physical or mental impairments;
- Nursing notes will include documentation of the appropriate orientation and preparation of the resident prior to the transfer or discharge.

1. Review of Resident #35's medical record showed:
- Admitted on 10/18/24;
- The resident transferred to the hospital on 12/28/24, and returned to the facility on 12/31/24;
- No documentation the resident and/or the resident's representative was informed in writing of the facility's bed-hold policy at the time of the transfer on 12/28/24.

2. Review of Resident #37's medical record showed:
- Admitted on 07/26/24;
- The resident transferred to the hospital on 01/15/25, and returned to the facility on 01/18/25;
- The resident transferred to the hospital on 02/09/25, and returned to the facility on 02/12/25;
- No documentation the resident and/or the resident's representative was informed in writing of the facility's bed-hold policy at the time of the transfer on 01/15/25 and 02/09/25.

3. Review of Resident #48's medical record showed:
- Admitted on 01/06/25;
- The resident transferred to the hospital on 01/18/25, and returned to the facility on 01/24/25;
- No documentation the resident and/or the resident's representative was informed in writing of the facility's bed-hold policy at the time of the transfer on 01/18/25.

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F 625	Continued From page 7 During an interview on 04/02/25 at 8:59 A.M., the Social Service Director (SSD) said there should be a bed-hold policy notice given to the resident and/or the resident representative when a resident was sent to the hospital. During an interview on 04/02/25 at 9:32 A.M., Licensed Practical Nurse (LPN) A said when a resident was sent to the hospital, he/she verbally told the resident and/or the resident's representative of the bed-hold policy. The SSD completed the bed-hold policy form. During an interview on 04/02/25 at 9:35 A.M., the Director of Nursing (DON) said when a resident was sent to the hospital, he/she verbally told the resident and/or the resident's representative of the bed-hold policy. The SSD completed the bed-hold policy form. During an interview on 04/03/25 at 11:06 A.M., the Administrator said there should be a bed-hold policy notice given to the resident and/or the resident representative when a resident was sent to the hospital.	F 625		
F 699 SS=D	Trauma Informed Care CFR(s): 483.25(m) §483.25(m) Trauma-informed care The facility must ensure that residents who are trauma survivors receive culturally competent, trauma-informed care in accordance with professional standards of practice and accounting for residents' experiences and preferences in order to eliminate or mitigate triggers that may cause re-traumatization of the resident. This REQUIREMENT is not met as evidenced	F 699		

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by:
Based on interview and record review, the facility failed to identify, assess, and provide supportive interventions for one resident (Resident #35) with a diagnosis of post traumatic stress disorder (PTSD - a mental health condition triggered by a terrifying event - either experiencing it or witnessing it; symptoms may include flashbacks, nightmares and severe anxiety, as well as uncontrollable thoughts about the event) out of one sampled resident. The facility's census was 46.

Review of the facility's policy titled, "Behavioral Health Services," dated February 2019, showed:
- The facility will provide and residents will receive behavioral health services as needed to attain or maintain the highest practical physical, mental, or psychosocial well-being in accordance with comprehensive assessment and plan of care;
- Behavioral health services are provided to residents as needed as part of the interdisciplinary (involving two or more departments or professions), person-centered approach to care;
- Residents who exhibit signs of emotional/psychosocial distress receive services and support that address their individual needs and goals for care;
- Residents who do not display symptoms of, or have not been diagnosed with, mental, psychiatric, psychosocial adjustment, substance abuse or PTSD will not develop behavioral disturbances that cannot be attributed to a specific clinical condition that makes the pattern unavoidable;
- Staff training regarding behavioral health services includes, but is not limited to:
a. Recognizing changes in behavior that

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indicates psychological distress;
b. Implementing care plan interventions that are relevant to the resident's diagnosis and appropriate to his/her needs;
c. Monitoring care plan interventions and reporting changes in condition;
d. Protocols and guidelines related to the treatment of mental disorders, psychosocial adjustment difficulties, and history of PTSD.

1. Review of Resident #35's medical record showed:
- Admitted on 10/18/24;
- Diagnoses of PTSD, major depressive disorder (MDD - long-term loss of pleasure or interest in life), and anxiety (persistent worry and fear about everyday situations) disorder.

Review of the resident's March and April 2025 Physician's Order Sheets (POS), showed:
- An order for risperidone (an antipsychotic medication - a medication used to treat psychosis, a collection of symptoms that affect your ability to tell what is real and what is not) 0.25 milligram (mg) by mouth two times a day related to PTSD for 14 days, dated 03/13/25 and completed on 03/27/25;
- An order for fluoxetine (an antidepressant medication) 40 mg two capsules by mouth in the morning related to depression, dated 03/13/25;
- An order for clonazepam (an antianxiety medication) 0.5 mg by mouth two times a day related to anxiety disorder, dated 11/14/24.

Review of the resident's Preadmission Screening and Resident Review (PASARR - a federal program to prevent inappropriate admission and retention of people with mental disabilities in nursing facilities), dated 10/22/24, showed:

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- Diagnoses of PTSD and MDD;
- No behaviors and triggers documented.

Review of the resident's behavioral note charting, dated 10/19/24 - 02/08/25, showed:
- Anger and hostility;
- Yelling and profanity;
- Refusal of medications;
- Threatening behavior toward staff.

Review of the resident's Trauma Screening Questionnaire (TSQ), undated, showed:
- Difficulty falling or staying asleep;
- Irritability or outbursts of anger;
- Being jumpy or being startled at something unexpected;
- No documentation of when or who completed the questionnaire.

Review of the resident's care plan, revised 11/07/24, showed:
- Takes an antidepressant related to PTSD;
- No documentation the resident had past trauma or any triggers that would cause the resident to have behaviors.

During an interview on 03/31/25 at 11:55 A.M., the resident said he/she had PTSD due to being in combat during the Vietnam War and witnessed people killed. Loud sounds, noises, and closed-in spaces made him/her upset and irritable. He/She did not like to eat in the dining room because of the closed-in space and preferred to eat in his/her room.

During an interview on 04/03/25 at 9:58 A.M., the Minimum Data Set (MDS - a federally mandated assessment instrument completed by the facility staff) Coordinator said he/she completed the TSQ

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F 699	Continued From page 11 form and placed in a binder, but not in the resident's medical record. The questionnaire should be dated and signed upon completion. The resident's care plan should have interventions in place related to past trauma and PTSD triggers. During an interview on 04/03/25 at 11:01 A.M., the Administrator said she would expect the TSQ to be signed and dated by the person who completed the form. She would expect the care plan to include interventions addressing the resident's triggers related to PTSD.	F 699		
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(f). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility.	F 755		

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§483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and

§483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.
This REQUIREMENT is not met as evidenced by:
Based on observation, interview, and record review, the facility failed to ensure staff reconciled narcotics (a process that allows one staff to reconcile the exact narcotic inventory on hand with another staff) at each shift change for two out of two sampled medication carts. The facility also failed to implement procedures to ensure medications were accurately administered, documented, disposed of, and reconciled for one resident (Resident #12) outside of the 12 sampled residents This practice had the potential to affect all residents. The facility census was 46.

Review of the facility's policy titled, "Controlled Substances," last revised November 2022, showed:
- Controlled substance inventory is monitored and reconciled to identify loss or potential diversion in a manner that minimizes the time between loss/diversion and detection/follow-up;
- The system of reconciling the receipt, dispensing, and disposition of controlled substances includes the following:
    a. Records of personnel access and usage;
    b. Medication administration records;
    c. Declining inventory records;
    d. Destruction, waste, and return to pharmacy records;

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRAIRIE VIEW SKILLED NURSING	606 WEST MISSOURI STREET BLOOMFIELD, MO 63825

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 755	Continued From page 13 - Nursing staff count the controlled medication inventory at the end of each shift, using these records to reconcile the inventory count; - The nurse coming on duty and the nurse going off duty make the count together and document and report any discrepancies to the Director of Nursing (DON) Services; - The DON Services documents irreconcilable discrepancies in a report to the Administrator. 1. Review of the 200/300 Hall Medication Cart Narcotic Count Log for Controlled Substances showed: - For day/evening/night shifts for 12/01/24 - 12/31/24, 16 missed out of 84 opportunities to reconcile the narcotic counts; - For day/evening/night shifts for 01/01/25 - 01/31/25, 25 missed out of 84 opportunities to reconcile the narcotic counts; - For day/evening/night shifts for 02/01/25 - 02/28/25, 37 missed out of 84 opportunities to reconcile the narcotic counts; - For day/evening/night shifts for 03/01/25 - 03/31/25, 15 missed out of 84 opportunities to reconcile the narcotic counts. 2. Review of the 100/400 Hall Medication Cart Narcotic Count Log for Controlled Substances showed: - For day/evening/night shifts for 12/24/24 - 12/31/24, 6 missed out of 24 opportunities to reconcile the narcotic counts; - For day/evening/night shifts for 01/01/25 - 01/31/25, 12 missed out of 86 opportunities to reconcile the narcotic counts; - For day/evening/night shifts for 02/01/25 - 02/28/25, 31 missed out of 79 opportunities to reconcile the narcotic counts; - For day/evening/night shifts for 03/01/25 -	F 755		

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F 755	Continued From page 14	F 755		

03/31/25, 41 missed out of 84 opportunities to reconcile the narcotic counts.

3. Review of Resident #12's medical record showed:
- An admission date of 01/24/24;
- An order for morphine sulfate (a narcotic pain medication) 100 milligrams (mg) per five milliliters (ml) 0.25 ml by mouth every 4 hours as needed for pain, dated 01/24/24.

Review of the resident's Controlled Drug Receipt/Record/Disposition form for Bottle #2 of morphine sulfate 30 ml showed:
- Zero doses signed out as administered by staff.

Observation on 04/02/25 at 10:28 A.M., of the 100/400 Medication Cart showed:
- Bottle #2 of morphine sulfate 30 ml bottle in a box with tape on the top of the box, and no tape on the bottom of the box;
- Bottle #2 of morphine sulfate 30 ml opened, labeled with resident's last name, and with 29.5 ml in the 30 ml bottle.

During an interview on 04/02/25 at 10:30 A.M., Certified Medication Technician (CMT) B said he/she thought the box of the resident's Bottle #2 of morphine was unopened so when the counts were done for each shift, the staff only counted opened boxes. The staff didn't look at boxes to see if they had been opened since it had tape on top of the box. to see if those bottles have been opened. If there was ever a discrepancy, it was reported to the DON.

During an interview on 04/02/25 at 10:31 A.M., the DON said she boxes of medications that were taped should be unused and therefore a full

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F 755	Continued From page 15 bottle. She was unsure why Resident #12's morphine bottle had been opened in Box #2. During an interview on 04/03/25 at 9:15 A.M., CMT B said narcotics were counted every shift with the on-coming and off-going staff members. During an interview on 04/03/25 at 9:18 A.M., the DON said she expected two staff, the on-coming and the off-going, to count the narcotics on each cart for each shift. The Administrator was made aware of Resident #12's Box #2 of the opened morphine bottle and the unaccounted missing doses. An audit was done, and other discrepancies were found. During an interview on 04/03/25 at 9:30 A.M., the Administrator said narcotics should be reconciled with two staff members, the on-coming and off-going staff. The DON reported the narcotic discrepancy and an audit was completed.	F 755		
F 759 SS=D	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to maintain a medication error rate of less than five percent (%). There were 28 opportunities with three errors made, resulting in an error rate of 10.71% for one resident (Resident #27) out of four sampled residents. The facility's census was 46.	F 759		

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F 759	Continued From page 16	F 759		

Review of the facility's policy titled, "Insulin Administration," last revised September 2014, showed:
- Three key characteristics of insulin are: onset of action - how quickly the insulin reaches the bloodstream and begins to lower blood glucose, peak effects - the time when the insulin is at its maximum effectiveness, and duration of effect - the length of time during which the insulin is effective;
- Rapid-acting insulin - onset of 10-15 minutes (min), peak of 0.5-3 hours (hrs.), duration of 3-6 hrs.;
- Regular/short-acting insulin - onset of 0.5-1 hr., peak of 2.5-5 hrs., duration of 8-12 hrs.;
- Steps in the procedure to administer insulin: wash hands, check blood glucose per the physician order or facility protocol, check and re-check the type of insulin on the vial matches the type of insulin ordered, and check the order for the amount of insulin.

1. Review of Resident #27's Physician Order Sheet (POS), dated April 2025, showed:
- An order to obtain fasting blood sugars (FSBS-a blood sugar check before eating) before meals, dated 01/27/24;
- An order for Humalog (fast-acting insulin) 3 unit subcutaneously (injection under the skin) with meals, dated 03/07/25;
- An order for Humalog as per sliding scale if blood sugar 151 - 200 = 3 units; 201 - 250 = 6 units; 251 - 300 = 9 units; 301 - 350 = 12 units; 351 - 400 = 14 units; 401 - 999 = 16 units and call the physician, subcutaneously before meals, dated 01/26/24.

Observation of the resident's medication

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F 759	Continued From page 17 administration on 04/01/25 at 8:26 A.M., showed: - Certified Medication Technician (CMT) B did not check the resident's blood sugar; - CMT B administered the scheduled Humalog 3 units plus Humalog 6 units for a blood sugar of 228 that was obtained at 5:00 A.M.; - CMT B failed to check the resident's blood sugar, failed to administer the correct dose of insulin, and failed to administer the insulin before the resident ate breakfast as ordered. During an interview on 04/01/25 at 8:20 A.M., CMT B said he/she used the resident's blood glucose reading completed at 5 A.M., to determine how much sliding scale Humalog to administer now. During an interview on 04/01/25 at 8:27 A.M., Resident #27 said he/she had already eaten breakfast. His/Her blood sugar was checked at 5:15 A.M. The insulin was administered 1.5 hours after his/her blood sugar was checked. Breakfast was served between 7: 00 A.M. - 7:45 A.M. During an interview on 04/01/25 at 9:10 A.M., CMT B said he/she started administering insulin at 6:15 A.M., using the blood sugar readings obtained from the night shift staff at 5 A.M. During an interview on 04/01/25 10:12 A.M., the Director of Nursing (DON) and the Administrator said staff should check blood sugars for short-acting insulin administration at no more than one hour before it was administered.	F 759		
F 760 SS=D	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its-	F 760		

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F 760	Continued From page 18	F 760		

§483.45(f)(2) Residents are free of any significant medication errors.
This REQUIREMENT is not met as evidenced by:
Based on observation, interview, and record review, the facility failed to ensure that one resident (Residents #27) out of one sampled resident was free from significant medication errors when staff did not check blood sugars prior to administering insulin (a medication that regulates blood sugar levels). The facility's census was 46.

Review of the facility's policy titled, "Insulin Administration," last revised September 2014, showed:
- Three key characteristics of insulin are: onset of action - how quickly the insulin reaches the bloodstream and begins to lower blood glucose, peak effects - the time when the insulin is at its maximum effectiveness, and duration of effect - the length of time during which the insulin is effective;
- Rapid-acting insulin - onset of 10-15 minutes (min), peak of 0.5-3 hours (hrs.), duration of 3-6 hrs.;
- Regular/short-acting insulin - onset of 0.5-1 hr., peak of 2.5-5 hrs., duration of 8-12 hrs.;
- Steps in the procedure to administer insulin: wash hands, check blood glucose per the physician order or facility protocol, check and re-check the type of insulin on the vial matches the type of insulin ordered, and check the order for the amount of insulin.

1. Review of Resident #27's Physician Order Sheet (POS), dated April 2025, showed:
- An admission date of 01/26/24;
- A diagnosis of diabetes mellitus (elevated levels

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of glucose in the blood);
- An order to obtain fasting blood sugars (FSBS-a blood sugar check before eating) before meals, dated 01/27/24;
- An order for Humalog (fast-acting insulin) 3 unit subcutaneously (injection under the skin) with meals, dated 03/07/25;
- An order for Humalog as per sliding scale if blood sugar 151 - 200 = 3 units; 201 - 250 = 6 units; 251 - 300 = 9 units; 301 - 350 = 12 units; 351 - 400 = 14 units; 401 - 999 = 16 units and call the physician, subcutaneously before meals, dated 01/26/24;
- An order for Lantus (long-acting insulin 66 units subcutaneously in the morning, dated 03/08/25.

Observation of the resident's medication administration on 04/01/25 at 8:26 A.M., showed:
- Certified Medication Technician (CMT) B did not check the resident's blood sugar;
- CMT B administered Humalog 9 units;
- CMT B failed to check the resident's blood sugar prior to the administration of the insulin.

During an interview on 04/01/25 at 8:20 A.M., CMT B said he/she used the resident's blood glucose reading completed at 5 A.M., to determine how much sliding scale Humalog to administer now.

During an interview on 04/01/25 at 8:27 A.M., Resident #27 said he/she had already eaten breakfast. His/Her blood sugar was checked at 5:15 A.M. The insulin was administered 1.5 hours after his/her blood sugar was checked. Breakfast was served between 7: 00 A.M. - 7:45 A.M.

During an interview on 04/01/25 at 9:10 A.M., CMT B said he/she started administering insulin

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F 760	Continued From page 20 at 6:15 A.M., using the blood sugar readings obtained from the night shift staff at 5 A.M. During an interview on 04/01/25 10:12 A.M., the Director of Nursing (DON) and the Administrator said staff should check blood sugars for short-acting insulin administration at no more than one hour before it was administered.	F 760		
F 801 SS=D	Qualified Dietary Staff CFR(s): 483.60(a)(1)(2) §483.60(a) Staffing The facility must employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, taking into consideration resident assessments, individual plans of care and the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.71. This includes: §483.60(a)(1) A qualified dietitian or other clinically qualified nutrition professional either full-time, part-time, or on a consultant basis. A qualified dietitian or other clinically qualified nutrition professional is one who- (i) Holds a bachelor's or higher degree granted by a regionally accredited college or university in the United States (or an equivalent foreign degree) with completion of the academic requirements of a program in nutrition or dietetics accredited by an appropriate national accreditation organization recognized for this purpose. (ii) Has completed at least 900 hours of supervised dietetics practice under the supervision of a registered dietitian or nutrition professional.	F 801		

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(iii) Is licensed or certified as a dietitian or nutrition professional by the State in which the services are performed. In a State that does not provide for licensure or certification, the individual will be deemed to have met this requirement if he or she is recognized as a "registered dietitian" by the Commission on Dietetic Registration or its successor organization, or meets the requirements of paragraphs (a)(1)(i) and (ii) of this section.
(iv) For dietitians hired or contracted with prior to November 28, 2016, meets these requirements no later than 5 years after November 28, 2016 or as required by state law.

§483.60(a)(2) If a qualified dietitian or other clinically qualified nutrition professional is not employed full-time, the facility must designate a person to serve as the director of food and nutrition services.
(i) The director of food and nutrition services must at a minimum meet one of the following qualifications-
(A) A certified dietary manager; or
(B) A certified food service manager; or
(C) Has similar national certification for food service management and safety from a national certifying body; or
D) Has an associate's or higher degree in food service management or in hospitality, if the course study includes food service or restaurant management, from an accredited institution of higher learning; or
(E) Has 2 or more years of experience in the position of director of food and nutrition services in a nursing facility setting and has completed a course of study in food safety and management, by no later than October 1, 2023, that includes

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topics integral to managing dietary operations including, but not limited to, foodborne illness, sanitation procedures, and food purchasing/receiving; and
(ii) In States that have established standards for food service managers or dietary managers, meets State requirements for food service managers or dietary managers, and
(iii) Receives frequently scheduled consultations from a qualified dietitian or other clinically qualified nutrition professional.
This REQUIREMENT is not met as evidenced by:
Based on observation, interview, and record record review, the facility failed to employ a qualified director of food and nutrition services. The facility did not have a Dietary Manager (DM) with a background or required years of experience in food preparation, food service and/or food storage. This deficient practice had the potential to affect all residents in the facility. The facility census was 46.

Review of the facility's policy titled, "Dietician," dated November 2022, showed:
- If a qualified dietitian is not employed full-time (35 or more hours per week), a director of food and nutrition services will be designated. The individual will:
a. Be a certified dietary manager, or;
b. Be a certified food service manager, or;
c. Be nationally certified for food service management and safety, or;
d. Have an associate's (or higher degree) in food service management or hospitality, if the course study includes food service or restaurant management, from an accredited institution, or;
e. Has two or more years of experience in the position of director of food and nutrition services

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in a nursing facility setting and has completed a course of study in food safety and management, by no later than October 1, 2023, that includes topics integral to managing dietary operations including, but not limited to, foodborne illness, sanitation procedures, food purchasing/receiving, and meet any state requirements for food service or dietary managers;

f. Receive frequently scheduled consultations from a qualified dietitian or other clinically qualified nutrition professional.

Review of the facility's current employee list, dated 03/31/25, showed:
- The DM's hire date of 01/16/24;
- No full-time dietitian.

During an interview on 03/31/25 at 9:13 A.M., the DM said upon hire in January 2024, the prior Administrator enrolled him/her in the required courses to become a certified dietary manager (CDM) within a year of his/her hire date. He/She was enrolled for the required courses, but failed to complete the certification requirement. Administration did not follow up with him/her about the progress or status of the requirement. He/She had no previous long-term care experience as a DM prior to accepting this position. The facility did not have a full-time dietitian.

During an interview on 04/03/24 at 10:11 A.M., the Registered Dietician (RD) said he/she gave the facility management guidance and information regarding what course of study the dietary employee should be enrolled in to complete the dietary requirement.

During an interview on 04/03/24 at 11:32 A.M.,

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F 801	Continued From page 24 the Administrator said she had been in her position at the facility since January 2025, but would expect the employee enrolled in the required dietary courses to follow up with management on his/her status. She would also expect the person enrolled in the required courses to have the certification completed in a timely manner.	F 801		

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A4055	19 CSR 30-85.042(46) Safe/Effective Medication System There shall be a safe and effective system of medication distribution, administration, control, and use. I/II This regulation is not met as evidenced by: Class II Refer to F755, F759 and F760	A4055		
A4108	19 CSR 30-85.042(98)(B) Clinical Records - assessment/interventions Facilities shall ensure that the clinical record contains sufficient information to- (B) Reflect the initial and ongoing assessments and interventions by each discipline involved in the care and treatment of the resident; and II/III This regulation is not met as evidenced by: Class III Refer to F699	A4108		
A5015	19 CSR 30-85.052(15) Food Service Supervisor All facilities shall employ a food service supervisor who shall have overall supervisory responsibility for dietary services. II This regulation is not met as evidenced by: Class II Refer to F801	A5015		

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A8008	Continued From page 1	A8008		
A8008	19 CSR 30-88.010(8) Informed Services/Charges - Alz Disclosure Prior to or at the time of admission and during his or her stay in the facility, each resident and/or his or her next of kin, legally authorized representative or designee shall be fully informed, in writing, of services available in the facility and of related charges, including any charges for services not covered by the facility's basic per diem rate or federal or state programs. Information shall include procedures to be followed by the facility in cases of medical emergency, including transfer agreements and costs. All residents who receive treatment in an Alzheimer's special care program or unit and their next of kin, legally authorized representatives or designees shall be given a copy of the Alzheimer's Special Care Services Disclosure Form at the time of admission. Residents also shall be informed of services outside the facility which may reasonably be made available to the resident and of any reasonable estimate of any foreseeable costs connected with those services. II/III This regulation is not met as evidenced by: Class III Refer to F625	A8008		
A8016	19 CSR 30-88.010(16) Reasons to Transfer/Discharge A resident may be transferred or discharged only for medical reasons or for his or her welfare or that of other residents, or for nonpayment for his or her stay. II	A8016		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00629	A. BUILDING: _____ B. WING _____	04/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRAIRIE VIEW SKILLED NURSING	606 WEST MISSOURI STREET BLOOMFIELD, MO 63825

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A8016	Continued From page 2 This regulation is not met as evidenced by: Class II Refer to F623	A8016		

PLAN OF CORRECTION

Provider/Supplier Name:	Prairie View Skilled Nursing
Street Address, City, Zip:	606 West Missouri Street, Bloomfield, MO 63825
Date of Survey:	3/31/25 – 4/3/25

PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	

ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION: (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLETION DATE
	This plan of correction is submitted as required under state law. The submission of this plan does not constitute an admission on the part of Prairie View Skilled Nursing as to the accuracy of the surveyors' findings or the conclusions drawn therefrom. This plan of correction does not constitute an admission on the part of the facility that the findings cited are accurate, that the findings constitute a deficiency or the scope and severity regarding any of the deficiencies cited are correctly applied. The facility submits this plan of correction with the intention that it be inadmissible by any third party or any civil action or criminal action against the facility or any employee, agent, officer, director or shareholder of the facility. Any changes to the facility policies and procedures should be considered to be subsequent remedial measures as that concept is employed in Rule 407 of the Federal Rules of Evidence and should be inadmissible in any proceeding on that basis.	
F623	The facility will continue to provide a written copy of the notice of transfer or discharge to the resident and/or the resident's responsible party which: describes the need for the transfer or discharge; is provided as soon as practicable; is in a manner that the resident can understand, and; provides for the notification and orientation, and documentation in the resident's medical record. Medical records review of Residents #14, #37, and #48 will be conducted by the Administrator and/or designee to verify the proper notice of transfer/discharge was signed and returned by the resident or responsible party for their respective hospital transfers on 3/05/25, 3/18/25, and 1/18/25. All licensed nurses will be inserviced by the Administrator and/or designee regarding the proper steps for implementation and documentation of Notice Requirements before Transfer/Discharge of a resident.	5/17/25

Maci Harris RN BSN CHPN LNHA Administrator 4/17/25

	Ongoing monitoring will be conducted by the Administrator and/or designee to verify that with each hospital transfer, proper documentation is in the medical record regarding the provision of a written notice of transfer/discharge form to the resident and/or responsible party. Any identified discrepancies in following this requirement will be addressed through the disciplinary process and reviewed through the QA/QAPI Committee.	
F625	The facility will continue to inform the resident and/or the family and/or the legal representative in writing of its bed-hold policy at the time of a transfer to the hospital. Medical records review of Residents #35, #37, and #48 will be conducted by the Administrator and/or designee to verify the proper notice of bed-hold policy was signed and returned by the resident or responsible party for their respective hospital transfers on 12/28/24, 1/15/25 and 2/09/25, and 1/18/25. All licensed nurses will be inserviced by the Administrator and/or designee regarding the requirement of providing a written bed-hold notification and orientation at the time of transfer for hospitalization or therapeutic leave. This will include the requirement for proper documentation of said notice within the medical record. Ongoing monitoring will be conducted by the Administrator and/or designee to verify that with each hospital transfer or therapeutic leave, proper notification of bed-hold policy is provided to the resident and/or responsible party in writing and documented in the medical record. Any identified discrepancies will be addressed through the disciplinary process and reviewed through the QA/QAPI Committee.	5/17/25
F699	The facility will continue to identify, assess, and provide supportive interventions for any resident who is a trauma survivor with culturally competent, trauma-informed care in accordance with professional standards of practice and accounting for residents' experiences and preferences in order to eliminate or mitigate triggers. The TSQ for resident #35 will be reviewed and/or corrected for accuracy with completion date and signature indicated. TSQ will be maintained in the resident's medical record. Resident's care plan will be reviewed, corrected, and updated by the Interdisciplinary Team and documented by the facility Care Coordinator. Consultant RAI Coordinator will conduct an audit of all current residents' TSQ assessments for accuracy, completion and inclusion within their respective medical records. In addition, said audit will verify care plan updates as necessary.	5/17/25

	Consultant RAI Coordinator will inservice facility Care Coordinator for proper assessment, documentation and care planning for any resident identified as a trauma survivor with culturally competent, trauma-informed care in accordance with professional standards of practice which accounts for residents' experiences and preferences in order to eliminate or mitigate triggers. Ongoing monitoring will be conducted by the Consultant RAI Coordinator to verify that a TSQ assessment is completed with each new admission; that any resident's assessment that indicates a history of trauma or of being a trauma survivor will receive culturally competent, trauma-informed care in accordance with professional standards of practice and accounting for residents' experiences and preferences in order to eliminate or mitigate triggers that may cause re-traumatization; and that the facility Care Coordinator, together with the Interdisciplinary Team, has initiated appropriate interventions for the resident's care through the care plan process. Any discrepancies will be immediately corrected by the facility Care Coordinator at the RAI Consultant's instruction and referred to the QA/QAPI Committee.	
F755	The facility will continue to provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident; and facility will continue to have an established system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. The Director of Nurses and/or designee will inservice all licensed nurses and Certified Medication Technicians regarding facility policy, "Controlled Substances," and the policy/procedure/practice requiring nursing staff to count the controlled medication inventory at each shift change as follows: - The nurse/CMT coming on duty and the nurse/CMT going off duty conduct the count together and document and report discrepancies to the Director of Nurses. In addition, it will be emphasized that this shift-to-shift count is a mandatory occurrence. The bottle #2 of morphine sulfate 30 ml. and labeled with the resident's last name, with tape on the top of the box but no tape on the bottom of the box, with the security top popped from the top, identified by the surveyor at the time of survey as containing 29.5 mls., with no corresponding dose(s) documented as being administered, was inspected by the facility pharmacist and the appropriate hospice company's nurse and both provided statements to the facility that the bottle contained 30 mls. as initially dispensed by the pharmacy. Bottle #2 was destroyed and replaced for assurance of no discrepancies. The Director of Nurses conducted an audit of the narcotics on both facility	5/17/25

	medication carts on 4/3/25, during the survey, with any additional discrepancies identified and corrected. The Director of Nurses and/or designee will inservice all licensed nurses and Certified Medication Technicians regarding facility policy/procedure/practice that if any additional bottle of any narcotic is accidentally opened prior to determining the presence of a primary bottle, the responsible nurse will immediately report this as a medication error to the Director of Nurses with proper documentation of the error provided to the Director of Nurses by the responsible nurse. The documentation will be reviewed by the Director of Nurses with the Administrator. Ongoing monitoring will be conducted by the Director of Nurses through daily and/or weekly observational rounds with emphasized focus on narcotics maintained at the facility. Any discrepancies will be addressed through the disciplinary process and reviewed by the QA/QAPI Committee.	
F759	The facility will continue to maintain a medication error rate less than five percent. Director of Nurses and/or designee will re-educate CMT B regarding proper blood glucose monitoring timeliness as it relates to administration of insulin; and accurate documentation of insulin administration as it is ordered. Director of Nurses and/or designee will conduct an inservice for all licensed nurses and Certified Medication Technicians certified to administer insulin regarding the facility policy, Insulin Administration. This will include review of the proper guidelines for timely blood glucose monitoring as it relates to insulin administration with regard to insulin pharmacokinetics; accuracy and documentation of administration vs. glucose level assessment times and with regard to meal times and physician orders. In addition, the QA/QAPI Committee will conduct a weekly audit of insulin administration times for all current residents who receive insulin injections to verify timeliness of insulin administrations as related to blood glucose monitoring. Any licensed/certified staff authorized to administer insulin that is identified to be improperly administering/documenting the timeliness of insulin administration as related to blood glucose monitoring, will be counseled for proper technique/time. The facility will conduct this weekly audit until full compliance is achieved. Results and/or any ongoing/future issues will be reported to the QA/QAPI Team at the monthly meeting.	5/17/25
F760	The facility will continue to ensure that residents are free of any significant medication errors. Director of Nurses and/or designee will re-educate CMT B regarding proper blood glucose monitoring prior to insulin administration.	5/17/25

	Director of Nurses and/or designee will conduct an inservice for all licensed nurses and Certified Medication Technicians certified to administer insulin regarding the facility policy, Insulin Administration. This will include review of the proper guidelines for timely blood glucose monitoring as it relates to insulin administration with regard to insulin pharmacokinetics; accuracy and documentation of administration vs. glucose level assessment times and with regard to meal times and physician orders. In addition, the QA/QAPI Committee will conduct a weekly audit of insulin administration times for all current residents who receive insulin injections to verify timeliness of insulin administrations as related to blood glucose monitoring. Any licensed/certified staff authorized to administer insulin that is identified to be improperly administering/documenting the timeliness of insulin administration as related to blood glucose monitoring, will be counseled for proper technique/time. The facility will conduct this weekly audit until full compliance is achieved. Results and/or any ongoing/future issues will be reported to the QA/QAPI Team at the monthly meeting.	
F801	The facility will continue to employ sufficient staff with the appropriate competencies and skill sets to carry out the functions of the food and nutrition service. Since the dietary manager did not complete the required certification class in a timely manner, he/she was re-enrolled in the certification class. As of 4/16/25, the dietary manager has completed the required class and is scheduled for certification testing on 4/19/25. The Administrator will conduct ongoing monitoring to verify that the dietary manager successfully obtains the required certification as a dietary manager.	5/17/25

The Administrator signing and dating the first page of the CMS-2567/State Form is indicating their approval of the plan of correction being submitted on this form.

PLAN OF CORRECTION

Provider/Supplier Name:	Prairie View Skilled Nursing
Street Address, City, Zip:	606 West Missouri Street, Bloomfield, MO 63825
Date of Survey:	3/31/25-4/3/25

PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER		
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A4055	Refer to F755, F759 and F760	5/17/25
A4108	Refer to F699	5/17/25
A5015	Refer to F801	5/17/25
A8008	Refer to F625	5/17/25
A8016	Refer to F623	5/17/25

Maci Harris RN BSN CHAN LNHA Administrator 4/17/25

The Administrator signing and dating the first page of the CMS-2567/State Form is indicating their approval of the plan of correction being submitted on this form.