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	265547	A. BUILDING _____ B. WING _____	03/21/2025

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F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to follow physician's orders for one resident (Resident #26) out of 15 sampled residents and one resident (Resident #25) outside the sample. The facility's census was 57. Review of the facility's policy titled, "Transcription of Orders/Following Physician's Orders," last reviewed May 2024, showed: - The purpose of this policy is to outline procedures in accurately transcribing physician's orders and to ensure that all physicians' orders are followed. To ensure a process is in place to monitor nurses in accurately transcribing and following physician's orders; - Upon receiving a physician's order via telephone, fax, written order, verbal order, transcribed order or other, it will be documented in residents' electronic medical records in orders section; - The Nurse or Certified Medication Technician (CMT) in charge of medication administration must review all their designated Medication Administration Record (MAR) and Treatment Administration Record (TAR) prior to the end of their shift to ensure that all medications/treatments scheduled to be given on their shift were administered according to physicians' orders and that all necessary interventions were taken in the event of an	F 658		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Thomas L Dial	Administrator	04/02/2025

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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F 658	Continued From page 1 omission. Review of the facility's policy titled, "Administration of Insulin Policy," last reviewed May 2024, showed: - It is the policy of this facility to provide timely administration of insulin in order to meet the needs of each resident and to prevent adverse effects on a resident's condition; - All insulin will be administered in accordance with physician's orders; - Insulin administration will be coordinated with mealtimes and bedtime snacks unless otherwise specified in the physician order; - Monitor blood sugar as ordered by the physician Review of the facility's policy titled, "Blood Glucose Monitoring Policy," last reviewed June 2024, showed: - It is the policy of this facility to perform blood glucose monitoring to diabetic residents as per physician's orders. 1. Review of Resident #20's March 2025 Physician's Order Sheet (POS), showed: - Diagnoses of diabetes mellitus (elevated levels of glucose in the blood), acute hepatitis C (inflammation of the liver caused by infection) and schizophrenia (significant disruptions in thought processes, perceptions, emotions, and behaviors); - An order for Novolog (fast-acting insulin) per sliding scale if blood sugar (BS) 151-200= 3 units, 201-250=6 units, 251-300=9 units; 301-350=12 units, 351-400=15 units, over 400 call the physician, subcutaneously (injection under the skin) before meals and bedtime, dated 01/20/22; - An order for Novolog 7 units subcutaneously	F 658		

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three times a day, dated 05/19/21.

Observation of the resident's medication administration on 03/19/25 at 8:23 A.M., showed:
- The resident finished breakfast;
- Licensed Practical Nurse (LPN) G did not check the resident's BS and did not administer the sliding scale Novolog insulin;
- LPN G administered Novolog 7 units subcutaneously;
- LPN G failed to check the resident's BS before administering insulin as ordered;
- LPN G failed to administer the resident's insulin before breakfast as ordered.

2. Review of Resident #29's March 2025 POS, showed:
- Diagnoses of diabetes mellitus, chronic obstructive pulmonary disease (COPD- persistent airflow obstruction and chronic inflammation of the airways and lungs), major depressive disorder (persistent feelings of sadness, hopelessness, and loss of interest or pleasure in activities), and anxiety;
- An order for insulin lispro (Humalog - a fast-acting insulin) per sliding scale if BS 150-200=2 units; 201-250=3 units; 251-300=6 units; 301-250=9 units; 351-400=12 units; 401-450=15 units, over 450 call the physician, subcutaneously four times a day, dated 11/21/2024.

Observation of the resident's medication administration on 03/19/25 at 8:37 A.M., showed:
- LPN G did not check the resident's BS;
- LPN G administered Humalog 3 units subcutaneously;
- LPN G failed to check the resident's BS before administering insulin as ordered.

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During an interview on 03/19/25 at 8:23 A.M., LPN G said he/she did not perform the glucose monitoring for Resident #20 and Resident #25 prior to administering the insulin as ordered.

During an interview on 03/21/25 at 9:00 A.M., LPN A said he/she would check the resident's BS 30 minutes before the fast-acting insulin was administered as ordered.

During an interview on 03/21/25 at 9:05 A.M., the Director of Nursing (DON) said physician orders should be followed. Blood sugars should be checked prior to administering insulin as ordered.

During an interview on 03/21/25 at 3:27 P.M., the Administrator said he/she would expect nurses and staff to follow physician orders. Staff should obtain BS and then administer insulin as ordered.

F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2)	F 689		

§483.25(d) Accidents.
The facility must ensure that -
§483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and

§483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents.
This REQUIREMENT is not met as evidenced by:
Based on observation, interview, and record review, the facility failed to provide protective oversight when facility staff left the medication carts unattended and unlocked on three separate occasions. This had the potential to affect all

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residents in the facility. The facility census was 57.

Review of the facility's policy titled, "Medication Storage Policy," last reviewed May 2024, showed:
- It is the policy of this facility to ensure all medications housed on our premises will be stored in the medication rooms according to the manufacturer's recommendations and sufficient to ensure proper sanitation, temperature, light, ventilation, moisture control, segregation, and security.
- All drugs and biologicals will be stored in locked compartments (i.e. medication carts, cabinets, drawers, refrigerators, medication rooms) under proper temperature controls;
- Only authorized personnel will have access to the keys to locked compartments;
- During a medication pass, medications must be under the direct observation of the person administering medications or locked in the medication storage area/cart;
- Schedule II (medications with a high potential of abuse) drugs and back-up stock of Schedule III (medications with a moderate to low potential of abuse), Schedule IV (medications with a low potential of abuse), and Schedule V (medications with a lower potential of abuse than Schedule IV medications) medications are stored under double-lock and key.

1. Observation on 03/19/25 at 8:21 A.M., showed:
- Licensed Practical Nurse (LPN) G left the unlocked and unattended medication cart for two minutes;
- A resident paced in front of and around the unlocked medication cart.

2. Observation on 03/19/25 at 8:37 A.M. showed:

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F 689	Continued From page 5 - LPN G left the unlocked and unattended medication cart, left the keys to the narcotic box on top of the medication cart, and left the bottom drawer of the cart partially open; - Two residents in the hallway near the unlocked and unattended medication cart. 3. Observation on 03/21/25 at 8:07 A.M., showed: - The unlocked and unattended medication cart sat near the nurses' station; - Two residents and several staff were near and around the unlocked and unattended cart; - At 8:08 A.M., Certified Medication Technician (CMT) D walked up to the unlocked cart, locked it, and took it into the medication stock room. During an interview on 03/21/25 at 8:10 A.M., CMT D said he/she should have locked the medication cart before walking away from it. During an interview on 03/21/25 at 9:00 A.M., LPN A said medication carts and keys should be secured before walking away from medication cart. During an interview on 03/21/25 at 9:25 A.M., the Director of Nursing (DON) said medication carts should never be left unattended and unlocked. He/she expected staff to keep keys out of reach of the residents. During an interview on 03/21/25 at 3:28 P.M., the Administrator said staff should never leave a medication cart unlocked and unattended.	F 689		
F 698 SS=D	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis.	F 698		

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The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences.
This REQUIREMENT is not met as evidenced by:
Based on interview and record review, the facility failed to provide documentation of ongoing assessments, monitoring, and communication between the facility and the dialysis (a process for removing waste and excess water from the blood) center for one resident (Resident #51) out of one sampled resident. The facility census was 57.

Review of the facility's policy titled, "Dialysis," revised 03/18/22, showed:
- Ensure that residents who require dialysis and such services as ordered by the physician;
- The facility will ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences;
- The facility will ensure that each resident receives care and services for the provision of hemodialysis (a procedure that acts as an artificial kidney, filtering blood to remove waste and excess fluid when the kidneys cannot) and/or peritoneal (lining of the the stomach) dialysis consistent with professional standards of practices including the:
1. Ongoing assessment of the resident's condition and monitoring for complications before and after dialysis treatment received at a certified dialysis facility;
2. Ensure the resident has transportation to and from an off-site certified dialysis facility for dialysis

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treatments.
3. Ongoing assessments and oversight of the resident before and after dialysis treatments;
4. Ongoing communication and collaboration with dialysis clinic, regarding dialysis care and services.

1. Review of Resident #51's medical record showed:
- Admitted on 02/11/25;
- Diagnoses of end stage renal disease (the kidneys can no longer adequately filter waste and excess fluid from the blood) and dependence on renal dialysis (relying on a machine to filter the blood and remove waste due to kidney failure), dated 02/11/25.

Review of the resident's March 2025 Physician's Order Sheet (POS), showed:
- Renal (kidney) diet, regular texture, thin/regular consistency, dated 02/12/25;
- Cover the dialysis port (soft tubes used to allow blood to travel through the dialysis machine where it is cleaned as it passes through a special filter) to the left upper arm with a large border gauze every day, dated 02/11/25;
- An order for acetaminophen (medication used to treat minor aches and pain) tablet 325 milligram (mg) two tablets by mouth every Monday, Wednesday and Friday for pain before leaving for dialysis, dated 03/12/25;
- An order for Lidocaine-Prilocaine (a numbing medication) External Cream 2.5-2.5 % apply to the area of the dialysis port topically every day shift every Monday, Wednesday, and Friday for dialysis. Apply to the length of the dialysis access 45 to 60 minutes prior to dialysis, dated 03/12/25;
- No order for dialysis.

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Review of the resident's Progress Note, dated 03/19/25, showed:
- The resident received dialysis on Monday, Wednesday and Friday.

Review of the resident's Care Plan, revised 02/12/25, showed:
- Renal diet with regular texture and thin liquids;
- Dialysis due to renal failure;
- Renal insufficiency related to kidney disease end stage.

Review of the resident's Dialysis Communication Log showed:
- The facility did not have a communication log between the dialysis center and the facility for the resident.

Observation on 03/18/25 at 9:38 A.M., and 03/19/25 at 12:23 P.M., of a note posted on the kitchen wall showed:
- Resident #51 needed to eat early or have a lunched packed on Tuesdays, Thursdays and Saturdays.

During an interview on 03/19/25 12:18 P.M., the Business Office Manager (BOM) said he/she was the temporary administrator at the time the resident was admitted. He/She was not aware of a communication log between the facility and the dialysis facility.

During an interview on 03/19/25 at 3:35 P.M., the Minimum Data Set (MDS - a federally mandated assessment instrument completed by the facility staff) Coordinator said he/she knew the resident had an order for dialysis when the resident was admitted. The facility had trouble getting transportation for Tuesday, Thursday and

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F 698	Continued From page 9 Saturday, so the order was probably discontinued, and did not get put back on the resident's POS for dialysis to be on Monday, Wednesday and Friday. During an interview on 03/20/25 at 2:05 P.M., Licensed Practical Nurse (LPN) A said the facility did what was ordered prior to dialysis such as the Lidocaine cream and the ordered acetaminophen. If the resident required a snack taken with them to dialysis, the dietary staff provided the snack. The facility did not perform any vital signs or anything else prior to the resident going to dialysis. The facility did not send any documentation with the resident to dialysis. During an interview on 03/21/25 at 2:15 P.M., the Assistant Director of Nursing (ADON) said she thought the dialysis was on the resident's POS. Dialysis was supposed to be sending the facility documentation to the facility, however the facility had not received any documentation. During an interview on 03/21/25 at 3:31 P.M., the Administrator said there should be an order for dialysis. She was not here when the resident was admitted, but there should always be an order for dialysis. There should be a communication log showing the communication between the dialysis center and the facility.	F 698		
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	F 755		

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§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.

§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 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 three out of three sampled medication carts. This practice had the potential to affect all residents. The facility census was 57.

Review of the facility's policy titled, "Controlled

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Substance Administration and Accountability Policy", last reviewed 06/14/24, showed:
- The charge nurse or other designee conducts a daily visual audit of the required documentation of controlled substances. Spot checks are performed to verify;
- Inventory verification: for areas without automated dispensing systems, two licensed nurses account for all controlled substances and access keys at the end of each shift.

1. Review of the 100/200/400 Hall Medication Cart Narcotic Count Log for Controlled Substances showed:
- For day/evening/night shifts for 12/27/24 - 01/17/25, 57 missed out of 88 opportunities to reconcile the narcotic counts;
- For day/evening/night shifts for 01/18/25 - 02/12/25, 76 missed out of 104 opportunities to reconcile the narcotic counts;
- For day/evening/night shifts for 02/13/25 - 03/05/25, no documentation of the Narcotic Count Log with 132 missed out of 132 opportunities to reconcile the narcotic counts;
- For day/evening/night shifts for 03/06/25 - 03/21/25, 49 missed out of 80 opportunities to reconcile the narcotic counts.

2. Review of the 300 Hall Medication Cart Narcotic Count Log for Controlled Substances showed:
- For day/evening/night shifts for 12/27/24 - 01/17/25, 59 missed out of 88 opportunities to reconcile the narcotic counts;
- For day/evening/night shifts for 01/18/25 - 02/08/25, 50 missed out of 88 opportunities to reconcile the narcotic counts;
- For day/evening/night shifts for 02/09/25 - 02/12/25, no documentation of the Narcotic Count

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Log with 16 missed out of 16 opportunities to reconcile the narcotic counts;
- For day/evening/night shifts for 02/13/25 - 03/09/25, 54 missed out of 88 opportunities to reconcile the narcotic counts;
- For day/evening/night shifts for 03/07/25 - 03/21/25, 37 missed out of 58 opportunities to reconcile the narcotic counts.

3. Review of the Nurses' Treatment Medication Cart Narcotic Count Log for Controlled Substances showed:
- For 6 A.M. - 6 P.M. shift for 01/01/25-01/31/25, 31 missed out of 122 opportunities to reconcile the narcotic counts;
- For 6 A.M. - 6 P.M. shift for 02/01/25-02/28/25, 16 missed out of 112 opportunities to reconcile the narcotic counts;
- For 6 A.M. - 6 P.M. shift for 03/01/25-03/21/25, 16 missed out of 92 opportunities to reconcile the narcotic counts.

During an interview on 03/21/25 at 9:44 A.M., Certified Medication Technician (CMT) D said he/she counted the narcotics when on-coming and off-going each shift.

During an interview on 03/21/25 at 9:45 A.M., Licensed Practical Nurse (LPN) A said two nurses counted the narcotics on the nurses' medication/treatment cart at the beginning and end of each shift.

During an interview on 03/21/25 at 9:50 A.M., the Director of Nursing (DON) said the off-going and on-coming staff should count the narcotics on each cart after each shift.

During an interview on 03/21/25 at 3:26 P.M., the

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F 755	Continued From page 13 Administrator said the narcotics should be counted with two staff members, the on-coming and off-going staff, for each shift.	F 755		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that-- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and	F 758		

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F 758	Continued From page 14 §483.45(a)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(a)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility staff failed to ensure that as needed (PRN) orders for antipsychotic (medications that treat psychotic disorders) medications were limited to 14 days for one resident (Resident #46) of five sampled residents. The facility census was 57. Review of the facility's policy titled, "Use of Psychotropic (medications that affect the mind, emotions, and behavior) Medication Policy," dated 06/26/24, showed: - PRN orders for all psychotropic medications shall be used only when the medication is necessary to treat a diagnosed specific condition that is documented in the clinical record and for a limited duration (14 days); - If the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond the 14 days, he/she shall document their rationale in the resident's medical record and indicate the duration for the PRN order.	F 758		

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F 758	Continued From page 15 1. Review of Resident #46's medical record showed: - A diagnosis of anxiety (an intense, excessive, and persistent worry and fear about everyday situations); - An order for haloperidol (an antipsychotic medication) 5 milligram (mg) by mouth every 12 hours PRN for anxiety and agitation, dated 12/21/24; - The haloperidol order did not indicate the duration for the PRN order; - The prescribing practitioner did not document the appropriateness for the PRN antipsychotic medication to be extended beyond 14 days and did not document the duration for the PRN order. Review of the resident's haloperidol PRN Medication Administration Records (MARs) showed: - For January 2025, the resident received the medication five times; - For February 2025, the resident received the medication eight times; - For March 2025, the medication was discontinued on 03/04/25. Review of the resident's Monthly Medication Regimens (MMRs) showed: - On 01/10/25, and on 02/09/25, the Pharmacist recommended a review of the psychotropic haloperidol PRN order(s) for addition of a stop date (14 days) or have the physician or psychiatry provide a progress note for the continued use. During an interview on 03/21/25 at 2:20 P.M., the Assistant Director of Nursing (DON) said she was responsible for retrieving the pharmacy recommendations. Once she received the recommendations, if it needs a physician's order,	F 758		

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F 758	Continued From page 16 then she contacted the primary care physician (PCP) and received the orders. The physician order should link with the recommendation if there a new order was written. She did not know how she missed this particular recommendation. There should be a 14 day stop date for PRN medications. During an interview on 03/21/25 at 2:23 P.M., the Director Of Nursing (DON) said she knew the psychiatric physician always put a 14 stop date on the PRN medications. She thought all of the PRN medications should be written that way.	F 758		
F 759 SS=D	Free of Medication Error Rts 5 Prnt 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 38 opportunities with five errors made, resulting in an error rate of 13.15% for two residents (Residents #20 and #25) out of four sampled residents. The facility's census was 57. Review of the facility's policy titled, "Administration of Insulin Policy," last reviewed May 2024, showed: - It is the policy of this facility to provide timely administration of insulin in order to meet the needs of each resident and to prevent adverse effects on a resident's condition;	F 759		

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F 759	Continued From page 17 - All insulin will be administered in accordance with physician's orders; - Insulin administration will be coordinated with mealtimes and bedtime snacks unless otherwise specified in the physician order; - Monitor blood sugar as ordered by the physician. Review of the facility's policy titled, "Blood Glucose Monitoring Policy," last reviewed June 2024, showed: - It is the policy of this facility to perform blood glucose monitoring to diabetic residents as per physician's orders. 1. Review of Resident #20's March 2025 Physician's Order Sheet (POS), showed: - Diagnosis of diabetes mellitus (elevated levels of glucose in the blood); - An order for Novolog (fast-acting insulin) per sliding scale if blood sugar (BS) 151-200= 3 units, 201-250=6 units, 251-300=9 units, 301-350=12 units, 351-400=15 units, over 400 call the physician, subcutaneously (injection under the skin) before meals and bedtime, dated 01/20/22; - An order for Novolog 7 units subcutaneously three times a day, dated 05/19/21. Review of the resident's Medication Administration Record (MAR), dated March 2025, showed: - On 03/18/25 at 5:00 A.M., the night nurse documented the glucose reading as 147. At 7:00 A.M., Licensed Practical Nurse (LPN) G documented the glucose reading as 147; - On 03/19/25 at 5:00 A.M., the night nurse documented the glucose reading as 150. At 7:00 A.M., LPN G documented the glucose reading as 150;	F 759		

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F 759	Continued From page 18 - On 03/20/25 at 5:00 A.M., the night nurse documented the glucose reading as 187. At 7:00 A.M., LPN G documented the glucose reading as 187. Observation of the resident's medication administration on 03/19/25 at 8:23 A.M., showed: - The resident finished breakfast; - LPN G did not check the resident's BS; - LPN G administered Novolog 7 units subcutaneously for a BS of 150 received at 5:00 A.M.; - LPN G failed to check the resident's BS, failed to administer the correct dose of insulin, and failed to administer the insulin before the resident ate breakfast as ordered. 2. Review of Resident #25's POS, dated March 2025, showed: - Diagnosis of diabetes mellitus; - An order for insulin lispro (Humalog - a fast-acting insulin) per sliding scale if BS 150-200=2 units; 201-250=3 units; 251-300=6 units; 301-250=9 units; 351-400=12 units; 401-450=15 units, over 450 call the physician, subcutaneously four times a day, dated 11/21/2024. Review of the resident's MAR, dated March 2025, showed: - On 03/18/25 at 5:00 A.M., the night nurse documented the glucose reading as 203. At 7:00 A.M., LPN G documented the glucose reading as 203; - On 03/19/25 at 5:00 A.M., the night nurse documented the glucose reading as 235. At 7:00 A.M., LPN G documented the glucose reading as 235; - On 03/20/25 at 5:00 A.M., the night nurse	F 759		

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F 759	Continued From page 19	F 759		

documented the glucose reading as 241. At 8:00 A.M., LPN G documented the glucose reading as 241.

Observation of the resident's medication administration on 03/19/25 at 8:37 A.M., showed:
- LPN G did not check the resident's BS;
- LPN G administered Humalog 3 units subcutaneously per the sliding scale for a BS of 235 that was taken at 5:00 A.M.;
- LPN G failed to check the resident's BS, and failed to administer the correct dose of insulin.

During an interview on 03/19/25 at 8:23 A.M., LPN G said he/she did not perform the glucose monitoring for Resident #20 and Resident #25 prior to administering the insulin as ordered. The BS readings for the residents were obtained at 5:00 A.M., by the night nurse. He/She used those BS readings to administer the insulin to the residents during their medication pass.

During an interview on 03/21/25 at 8:10 A.M., Certified Medication Technician (CMT) D said BS were checked again for the sliding scale insulins. BS were checked at 5:00 A.M., for the long-acting insulin administration. Fast-acting insulin should be administered 30 minutes before each meal if ordered that way.

During an interview on 03/21/25 at 9:00 A.M., LPN A said he/she would check the resident's BS 30 minutes before the fast-acting insulin was administered. LPN A said he/she always verified insulin was administered prior to the resident eating breakfast if it was ordered that way. LPN A would not administer fast-acting insulin off of a 5:00 A.M. BS reading.

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F 759	Continued From page 20 During an interview on 03/21/25 at 9:05 A.M., the Director of Nursing (DON) said blood sugars should be checked prior to administering insulin. It was not appropriate to use a glucose reading from two or more hours prior to administering the insulin. During an interview on 03/21/25 at 3:27 P.M., the Administrator said he/she would expect nurses and staff to obtain BS and then administer insulin.	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- §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 two residents (Residents #20 and #25) out of two sampled residents were 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 57. Review of the facility's policy titled, "Administration of Insulin Policy," last reviewed May 2024, showed: - It is the policy of this facility to provide timely administration of insulin in order to meet the needs of each resident and to prevent adverse effects on a resident's condition; - All insulin will be administered in accordance with physician's orders; - Insulin administration will be coordinated with mealtimes and bedtime snacks unless otherwise	F 760		

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F 760	Continued From page 21 specified in the physician order; - Monitor blood sugar as ordered by the physician. Review of the facility's policy titled, "Blood Glucose Monitoring Policy," last reviewed June 2024, showed: - It is the policy of this facility to perform blood glucose monitoring to diabetic residents as per physician's orders. 1. Review of Resident #20's March 2025 Physician's Order Sheet (POS) showed: - Admission date of 02/15/17; - Diagnosis of diabetes mellitus (elevated levels of glucose in the blood); - An order for Novolog (fast-acting insulin) per sliding scale if blood sugar (BS) 151-200= 3 units, 201-250=6 units, 251-300=9 units; 301-350=12 units, 351-400=15 units, over 400 call the physician, subcutaneously (injection under the skin) before meals and bedtime, dated 01/20/22; - An order for Novolog 7 units subcutaneously three times a day, dated 05/19/21; - An order for Tresiba (long-acting insulin) FlexTouch Pen 25 units subcutaneously in the morning, dated 06/13/24; - An order for metformin (diabetic medication) 1,000 milligrams (mg) by mouth twice daily, dated 5/19/21. Observation of the resident's medication administration on 03/19/25 at 8:23 A.M., showed: - Licensed Practical Nurse (LPN) G did not check the resident's BS; - LPN G administered Novolog 7 units subcutaneously; - LPN G failed to check the resident's blood sugar prior to the administration of the insulin.	F 760		

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F 760	Continued From page 22	F 760		

2. Record review of Resident #25's POS, dated March 2024, showed:
- Admission date of 09/28/20;
- Diagnosis of diabetes mellitus;
- An order for Lantus (long-acting insulin) 30 units in the morning subcutaneously, dated 11/20/24;
- An order for Lantus 45 units at bedtime subcutaneously, dated 11/20/23;
- An order for insulin lispro (Humalog - a fast-acting insulin) per sliding scale if BS 150-200=2 units; 201-250=3 units; 251-300=6 units; 301-350=9 units; 351-400=12 units; 401-450=15 units, over 450 call the physician, subcutaneously four times a day, dated 11/21/2024.

Observation of the resident's medication administration on 03/19/25 at 8:37 A.M., showed:
- LPN G did not check the resident's BS;
- LPN G administered Humalog 3 units subcutaneously;
- LPN G failed to check the resident's blood sugar prior to the administration of the insulin.

During an interview on 03/19/25 at 8:23 A.M., LPN G said he/she did not perform the glucose monitoring for Resident #20 and Resident #25 prior to administering the insulin as ordered.

During an interview on 03/21/25 at 9:00 A.M., LPN A said he/she would check the resident's BS 30 minutes before the fast-acting insulin was administered.

During an interview on 03/21/25 at 9:05 A.M., the Director of Nursing (DON) said blood sugars should be checked prior to administering insulin.

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F 760	Continued From page 23 During an interview on 03/21/25 at 3:27 P.M., the Administrator said he/she would expect nurses and staff to obtain BS and then administer insulin.	F 760		
F 880 SS=F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be	F 880		

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reported.
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.
(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and
(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.

§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.

§483.80(e) Linens.
Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.

§483.80(f) Annual review.
The facility will conduct an annual review of its IPCP and update their program, as necessary.
This REQUIREMENT is not met as evidenced by:
Based on observation, interview, and record review, the facility failed to implement Enhanced Barrier Precautions (EBP) during urinary catheter (a flexible tube placed in the body to drain and collect urine) care for two residents (Residents #2 and #58) out of two sampled residents. The

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F 880	Continued From page 25 facility failed to put interventions in place to ensure the facility's Legionella (a type of bacteria that can cause serious lung infection) testing was completed in a timely manner. The facility census was 57. Review of the facility's policy titled, "Enhanced Barrier Precautions," last reviewed 05/18/24, showed: - EBP of gown and gloves must be used for high-contact resident care activities for residents with any of the following: infection or colonization with a Centers for Medicare and Medicaid (CDC)-targeted multidrug-resistant organism (MDRO) when contact precautions do not otherwise apply; or wounds and/or indwelling medical devices even if the resident is not known to be infected or colonized with a MDRO; - High contact resident care activities include, but are not limited to, dressing, bathing/showering, transferring, providing hygiene, changing linens, changing briefs or assisting with toileting, indwelling device care or use, or wound care; - Wounds that require EBP are chronic wounds, including, but not limited to pressure ulcers (a localized area of skin damage that develops when prolonged pressure is applied to a specific area of the body), diabetic foot ulcers, unhealed surgical wounds, and venous stasis (a chronic wound on the lower leg that develops due to impaired blood flow in the veins, leading to blood pooling and tissue breakdown) ulcers. These are wounds that generally require a dressing. Any wound care requires EBP; - Indwelling medical devices include, but are not limited to, central lines, urinary catheters, feeding tubes, and tracheostomies; - Make gowns and gloves available immediately near or outside of the resident's room;	F 880		

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(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 880	Continued From page 26	F 880		

- Ensure access to alcohol-based hand rub in every resident room (ideally both inside and outside of the room);
- Position a trash can inside the resident room and near the exit for discarding personal protective equipment (PPE) after removal, prior to exit of the room, or before providing care for another resident in the same room.

Review of the facility's policy titled, "Legionella Surveillance Policy," last reviewed June 2024, showed:
- It is the policy of this facility to establish primary and secondary strategies for the prevention and control of Legionella infections;
- Legionella surveillance is one component of the facility's water management plans for reducing the risk of Legionella and other opportunistic pathogens in the facility's water systems;
- Primary prevention strategies: diagnostic testing and investigation for the source of Legionella. For diagnostic testing, the facility shall use McGeer criteria (designed to identify and track health-associated infections in long-term care facilities) when diagnosing pneumonia; residents with health-care associated pneumonia or who have failed antibiotic therapy for community-acquired pneumonia shall be tested for Legionella using both culture of lower respiratory secretions and the Legionella urinary antigen test. For the investigation for a facility source of Legionella, this may include culturing of the facility water for Legionella.

1. Observation on 03/20/25 at 9:50 A.M., of Resident #56's wound care showed:
- No EBP signage posted or PPE outside of the resident's room;
- Licensed Practical Nurse (LPN) A did not put on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X3) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265547	A. BUILDING _____ B. WING _____	03/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREENVILLE HEALTH CARE CENTER	117 SYCAMORE STREET GREENVILLE, MO 63944

(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 880	Continued From page 27 an isolation gown and entered the resident's room; - LPN A performed the wound dressing; - LPN A removed the gloves, performed hand hygiene, and exited the room. 2. Observation on 03/20/25 at 11:05 A.M. of Resident #2's catheter care showed: - No EBP signage posted outside of the resident's room; - Certified Nurse Aide (CNA) E and CNA F did not put on an isolation gown and entered the resident's room; - CNA E performed the resident's catheter care; - CNA E removed the gloves, did not perform hand hygiene, and put on clean gloves; - CNA E and CNA F rolled the resident from side to side and placed clean pants and a Hoyer (a mechanical device used to safely transfer individuals with limited mobility) sling under the resident; - CNA E and CNA F removed the gloves, did not perform hand hygiene, gathered the trash, and exited the resident's room; - CNA F assisted the resident to the main dining room. 3. Observation on 03/21/25 at 10:44 A.M., of Resident #56's catheter care showed: - No EBP signage posted outside of the resident's room; - CNA B and CNA C did not put on an isolation gown and entered the resident's room; - CNA B performed the resident's catheter care; - CNA B and CNA C removed the gloves, performed hand hygiene, gathered the trash, and exited the residents room. During an interview on 03/21/25 at 2:07 P.M.,	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265947	A. BUILDING _____ B. WING _____	03/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREENVILLE HEALTH CARE CENTER	117 SYCAMORE STREET GREENVILLE, MO 63944

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F 880	Continued From page 28 CNA B said he/she did not know what EBP was and had not had any training on EBP. During an interview on 03/21/25 at 2:08 P.M., CNA C said he/she was not aware of EBP and had not had any training on EBP. During an interview on 03/21/25 at 2:20 P.M., the Infection Preventionist (IP) said he/she just received information from corporate to implement EBP last week. He/She had not provided education to the staff yet. The IP had completed the corporate-wide training last week. During an interview on 03/21/25 at 2:26 P.M., the Regional Director of Operations said he/she just had a meeting about EPB corporate wide several weeks ago. The training information went out to the facilities on 03/07/25. He/She expected for EBP to be implemented throughout the facilities. Residents with chronic wounds and indwelling medical devices should have EBP. Corporate had ordered magnets for the resident doorframes and the CDC guideline sheets were being used for now. The PPE cart should be outside the residents' doors of who were on EBP. The cart should have gloves, gowns, masks, and hand sanitizer for use. 4. Review of the facility's Legionella results, dated 02/10/25, showed: - Sampled potable (drinkable) water collected on 12/23/24; - Sampled potable water received on 12/24/24; - Sampled potable water processed on 12/24/24; - Sampled potable water analyzed on 01/06/25; - Facility received the laboratory results on 02/10/25; - Legionella identified in the central bath, bath	F 880		

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	265547	A. BUILDING _____ B. WING _____	03/21/2025

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F 880	Continued From page 29	F 880		

house west. Room #202, Room #300, and Room #406.

Review of the corporate maintenance supervisor's email, dated 02/28/25 at 10:03 A.M., showed:
- A list of the specific items that needed to be ordered to complete the Legionella retesting at the facility;
- Did not address any specific instructions for the facility retesting for Legionella.

During an interview on 03/21/25 at 10:16 A.M., the Administrator said she took the Administrator position for the facility on 03/01/25. This was the first she had been made aware of the Legionella report. She had never seen the lab results or its findings until it was brought to her attention on 03/21/25.

During an interview on 03/21/25 at 10:30 A.M., the Maintenance Supervisor did not have a contact person, nor did he/she speak with a representative from the lab company regarding the lab results. He/She received the Legionella report from the previous acting Administrator sometime in February. There were no instructions in the email, dated 02/28/25, from the testing company. He/She contacted the corporate maintenance director and was not offered any guidance or instructions on what to do next after the lab results were received.

During an interview on 03/21/25 at 10:48 A.M. and 2:14 P.M., the Business Office Manager (BOM) said he/she was the acting Administrator at the time the facility received the laboratory results for the Legionella testing. A couple of days after receiving the lab results, he/she

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	265547	A. BUILDING _____ B. WING _____	03/21/2025

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F 880	Continued From page 30 contacted the city office and was prompted to contact the local health department. The local health department was contacted and he/she was prompted to call the Department of Health and Senior Services (DHSS). He/She contacted the corporate maintenance supervisor before calling DHSS due to following the corporate chain of command policy. The corporate maintenance supervisor told him/her to order the test kits and retest the facility for any inaccuracies. The lab test kits were ordered last Thursday, 03/13/25 and arrived at the facility a couple of days ago. He/She did not contact DHSS or report the laboratory results that were received on 02/10/24 because the facility was going to retest for inaccuracies.	F 880		

Missouri Department of Health and Senior Services

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	15550	A. BUILDING _____ B. WING _____	03/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREENVILLE HEALTH CARE CENTER	117 SYCAMORE STREET GREENVILLE, MO 63944

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A4056	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	A4056		
A4061	19 CSR 30-85.042(52) Drug Regimen Review-Monthly At least monthly a pharmacist or a registered nurse shall review the drug regimen of each resident, irregularities shall be reported in writing to the resident's physician, the administrator, and the director of nurses. There must be written documentation which indicates how the reports were acted upon. I/III This regulation is not met as evidenced by: Class III Refer to F758	A4061		
A4075	19 CSR 30-85.042(66) Nursing Care per Res Condition Each resident shall receive personal attention and nursing care in accordance with his/her condition and consistent with current acceptable nursing practice. I/II This regulation is not met as evidenced by: Class II Refer to F658, F689 and F606	A4075		

Missouri Department of Health and Senior Services

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	15550	A. BUILDING _____ B. WING _____	03/21/2025

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A4086	19 CSR 30-85.042(77) Infection Control/Communicable Disease Residents shall be cared for by using acceptable infection control procedures to prevent the spread of infection. The facility shall make a report to the division within seven (7) days if a resident is diagnosed as having a communicable disease as determined by the Missouri Department of Health and listed in the Code of State Regulations pertaining to communicable diseases, specifically 19 CSR 20-20.020, as amended. (II) This regulation is not met as evidenced by: Class II Refer to F880	A4086		

PLAN OF CORRECTION

Provider/Supplier Name:	Greenville Health Care center
Street Address, City, Zip:	117 Sycamore Street Greenville, Mo 63944
Date of Survey:	3/21/25

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
F 658	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i)	4/23/2025
	1.) Resident # 20 and resident #25 had no adverse effects from the deficient practice.	
	2.) All residents have the potential to be affected by the deficient practice.	
	3.) All LPNs, RNs, and insulin certified CMT's will be in-serviced on the facilities policies for "Administration of insulin", "Blood Glucose monitoring", and "Transcription of Orders/Following Physicians Orders" The DON/Designee will provide all LPNs, RNs, and insulin certified CMTs with Diabetes Mellitus training which will include a pre/post test.	
	4.) The Director of Nursing/Designee will initially complete a blood glucose validation checklist on all LPNs, RNs, and insulin certified CMTs. Then 4 random blood glucose validation checklists will be completed weekly x 8 weeks and then ongoing as needed to ensure compliance. The competencies will be reviewed monthly during the facilities QAPI meeting.	
	5.) Date Completed: 4/23/25	
	Cross Reference State Tag A4075	4/23/25
F689	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2)	
	1.) No residents were affected by this deficient practice.	
	2.) All residents have the potential to be affected by this deficient practice.	
	3.) The DON/Designee will in-service all LPNs, RNs, and CMTs on the facilities policies: "Accidents and Supervision" and "Medication Storage"	
	4.) The DON/Designee will complete the Medication Cart/room audit 5 times weekly on varying shifts for 8 weeks, and ongoing as needed to ensure compliance. The results will be reviewed during the monthly QAPI meeting.	
	5.) Date Completed: 4/23/2025	
	Cross Reference State Tag A4075	
F698	Dialysis CFR(s): 483.25(l)	4/23/25

	1.) Resident #51 had no adverse effects from the deficient practice. Resident #51 now has a Physician order for dialysis and a contract with the dialysis provider.	
	2.) All residents who receive dialysis have the potential to be affected by this deficient practice.	
	3.) The DON/designee will in-service the LPNs, and RNs on the facilities polices: "Transcription of Orders/Following physician's orders", "hemodialysis." The DON/Designee will in-service all RNs and LPNs on completing the dialysis communication form and sending with the resident to each treatment. The DON/Administrator will be in-serviced on the facilities "Contract Administration" policy.	
	4.) The DON/Designee will complete an audit 3 times a week of the dialysis communication form to x 8 weeks and ongoing to ensure compliance. The audit will be discussed during the monthly QAPI meeting.	
	5.) Date Completed: 4/23/25	
	Cross Reference State Tag A4075	
F755	Pharmacy Services/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3)	
	1.) No residents were identified as being affected by this deficient practice.	
	2.) All residents have the potential to be affected by this deficient practice.	
	3.) The DON/Designee will in-service all LPNs, RNs, and CMTs on the facilities "Controlled Substance Administration and Accountability" policy.	
	4.) The DON/Designee will audit the narcotic count logs 5 times weekly on varying shifts x 8 weeks, and ongoing to ensure compliance. The results will be reviewed during the monthly QAPI meeting.	
	5.) Date Completed: 4/23/25	
	Cross Reference State Tag A4055	
F758	Free from Unnecessary Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5)	4/23/25
	1.) Resident #46 had no adverse effects from the deficient practice.	
	2.) All residents have the potential to be affected by this deficient practice.	
	3.) The DON/Designee will in service all LPNs, RN's and CMTs on the facilities "Controlled Substance Administration and Accountability" policy.	
	4.) The DON/Designee will audit PRN antipsychotic medications to ensure they are discontinued after 14 days weekly x 8 weeks then ongoing to monitor compliance. The audits will be reviewed during the monthly QAPI meeting.	
	5.) Date Completed: 4/23/25	
	Cross reference State tag A4061	
F759	Free Medication Error Rates 5 Percent or More CFR(s): 483.45(f)(1)	
	1.) Residents #21 and #25 had no adverse effects due to the deficient practice.	
	2.) All Residents have the potential to be affected by this deficient practice.	

	3.) All LPNs, RNs, and insulin certified CMT's will be in-serviced on the facilities policies for "Administration of insulin", "Blood Glucose monitoring", and "Transcription of Orders/Following Physicians Orders" The DON/Designee will provide all LPNs, RNs, and insulin certified CMTs with Diabetes Mellitus training which will include a pre/post test.	
	4.) The Director of Nursing/Designee will initially complete a blood glucose validation checklist on all LPNs, RNs, and insulin certified CMTs. Then 4 random blood glucose validation checklists will be completed weekly x 8 weeks and then ongoing as needed to ensure compliance. The competencies will be reviewed monthly during the facilities QAPI meeting.	
	5.) Date Completed: 4/23/25	
	Cross Reference State Tag A4055	
F760	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2)	4/23/25
	1.) Residents #21 and #25 had no adverse effects due to the deficient practice.	
	2.) All Residents have the potential to be affected by this deficient practice.	
	3.) All LPNs, RNs, and insulin certified CMT's will be in-serviced on the facilities policies for "Administration of insulin", "Blood Glucose monitoring", and "Transcription of Orders/Following Physicians Orders" The DON/Designee will provide all LPNs, RNs, and insulin certified CMTs with Diabetes Mellitus training which will include a pre/post test.	
	4.) The Director of Nursing/Designee will initially complete a blood glucose validation checklist on all LPNs, RNs, and insulin certified CMTs. Then 4 random blood glucose validation checklists will be completed weekly x 8 weeks and then ongoing as needed to ensure compliance. The competencies will be reviewed monthly during the facilities QAPI meeting.	
	5.) Date Completed: 4/23/25	
	Cross Reference State Tag: A4055	
F880	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f)	4/23/25
	1.) Residents #2 and #56 had no adverse effects from the deficient practice.	
	2.) All residents have the potential to be affected by this deficient practice.	
	3.) The DON/Designee will in service all staff on the facilities "EBP" Policy. The Administrator will be in serviced on the facilities "Legionella Surveillance" policy.	
	4.) The DON/Designee will audit all residents who require "EBP" to ensure they have the proper PPE equipment and signage posted weekly x 8 weeks, and then ongoing to ensure compliance. The Administrator will ensure that new samples are collected and sent in to determine the need for more aggressive treatment of Legionella bacteria previously present within the facility. The Administrator will initiate a mitigation plan if there are still positive results following new sample results	

	once they come back from the lab, utilizing the CDC Healthcare Facility Water Management Program Checklist. The audit forms and results of legionnaires testing will be reviewed during monthly QAPI meeting to ensure ongoing compliance. 5.) Date Completed: 4/23/25 Cross Reference State Tag A4086	

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:	Greenville Health Care center
Street Address, City, Zip:	117 Sycamore Street Greenville, Mo 63944
Date of Survey:	3/21/25

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
A4075	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i)	4/23/2025
	1.) Resident # 20 had no adverse effects from the deficient practice. Resident # 25 in not listed on the resident sample provided.	
	2.) All residents have the potential to be affected by the deficient practice.	
	3.) All LPNs, RNs, and insulin certified CMT's will be in-serviced on the facilities policies for "Administration of Insulin", "Blood Glucose monitoring", and "Transcription of Orders/Following Physicians Orders" The DON/Designee will provide all LPNs, RNs, and insulin certified CMTs with Diabetes Mellitus training which will include a pre/post test.	
	4.) The Director of Nursing/Designee will initially complete a blood glucose validation checklist on all LPNs, RNs, and insulin certified CMTs. Then 4 random blood glucose validation checklists will be completed weekly x 8 weeks and then ongoing as needed to ensure compliance. The competencies will be reviewed monthly during the facilities QAPI meeting.	
	5.) Date Completed: 4/23/25	
	Cross Reference F658	4/23/25
A4075	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2)	
	1.) No residents were affected by this deficient practice.	
	2.) All residents have the potential to be affected by this deficient practice.	
	3.) The DON/Designee will in-service all LPNs, RNs, and CMTs on the facilities policies: "Accidents and Supervision" and "Medication Storage"	
	4.) The DON/Designee will complete the Medication Cart/room audit 5 times weekly on varying shifts for 8 weeks, and ongoing as needed to ensure compliance. The results will be reviewed during the monthly QAPI meeting.	
	5.) Date Completed: 4/23/2025	
	Cross Reference F689	
A4075	Dialysis CFR(s): 483.25(l)	4/23/25

	1.) Resident #51 had no adverse effects from the deficient practice. Resident #51 now has a Physician order for dialysis and a contract with the dialysis provider.	
	2.) All residents who receive dialysis have the potential to be affected by this deficient practice.	
	3.) The DON/designee will in-service the LPNs, and RNs on the facilities polices: "Transcription of Orders/Following physician's orders", "hemodialysis." The DON/Designee will in-service all RNs and LPNs on completing the dialysis communication form and sending with the resident to each treatment. The DON/Administrator will be in-serviced on the facilities "Contract Administration" policy.	
	4.) The DON/Designee will complete an audit 3 times a week of the dialysis communication form to x 8 weeks and ongoing to ensure compliance. The audit will be discussed during the monthly QAPI meeting.	
	5.) Date Completed: 4/23/25	
	Cross Reference F698	
A4055	Pharmacy Services/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3)	
	1.) No residents were identified as being affected by this deficient practice.	
	2.) All residents have the potential to be affected by this deficient practice.	
	3.) The DON/Designee will in-service all LPNs, RNs, and CMTs on the facilities "Controlled Substance Administration and Accountability" policy.	
	4.) The DON/Designee will audit the narcotic count logs 5 times weekly on varying shifts x 8 weeks, and ongoing to ensure compliance. The results will be reviewed during the monthly QAPI meeting.	
	5.) Date Completed: 4/23/25	
	Cross Reference F755	
A4061	Free from Unnecessary Psychotropic Meds/PRN Use CFR(s): 483.45(e)(3)(e)(1)-(5)	4/23/25
	1.) Resident #46 had no adverse effects from the deficient practice.	
	2.) All residents have the potential to be affected by this deficient practice.	
	3.) The DON/Designee will in service all LPNs, RN's and CMTs on the facilities "Controlled Substance Administration and Accountability" policy.	
	4.) The DON/Designee will audit PRN antipsychotic medications to ensure they are discontinued after 14 days weekly x 8 weeks then ongoing to monitor compliance. The audits will be reviewed during the monthly QAPI meeting.	
	5.) Date Completed: 4/23/25	
	Cross reference F758	
A4055	Free Medication Error Rates 5 Percent or More CFR(s): 483.45(f)(1)	
	1.) Residents #21 and #25 had no adverse effects due to the deficient practice.	
	2.) All Residents have the potential to be affected by this deficient practice.	

	3.) All LPNs, RNs, and insulin certified CMT's will be in-serviced on the facilities policies for "Administration of insulin", "Blood Glucose monitoring", and "Transcription of Orders/Following Physicians Orders" The DON/Designee will provide all LPNs, RNs, and insulin certified CMTs with Diabetes Mellitus training which will include a pre/post test.	
	4.) The Director of Nursing/Designee will initially complete a blood glucose validation checklist on all LPNs, RNs, and insulin certified CMTs. Then 4 random blood glucose validation checklists will be completed weekly x 8 weeks and then ongoing as needed to ensure compliance. The competencies will be reviewed monthly during the facilities QAPI meeting.	
	5.) Date Completed: 4/23/25	
	Cross Reference F759	
A4055	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2)	4/23/25
	1.) Residents #21 and #25 had no adverse effects due to the deficient practice.	
	2.) All Residents have the potential to be affected by this deficient practice.	
	3.) All LPNs, RNs, and insulin certified CMTs will be in-serviced on the facilities policies for "Administration of insulin", "Blood Glucose monitoring", and "Transcription of Orders/Following Physicians Orders" The DON/Designee will provide all LPNs, RNs, and insulin certified CMTs with Diabetes Mellitus training which will include a pre/post test.	
	4.) The Director of Nursing/Designee will initially complete a blood glucose validation checklist on all LPNs, RNs, and insulin certified CMTs. Then 4 random blood glucose validation checklists will be completed weekly x 8 weeks and then ongoing as needed to ensure compliance. The competencies will be reviewed monthly during the facilities QAPI meeting.	
	5.) Date Completed: 4/23/25	
	Cross Reference F760	
A4086	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f)	4/23/25
	1.) Residents #2 and #56 had no adverse effects from the deficient practice	
	2.) All residents have the potential to be affected by this deficient practice.	
	3.) The DON/Designee will in service all staff on the facilities "EBP" Policy. The Administrator will be in serviced on the facilities "Legionella Surveillance" policy.	
	4.) The DON/Designee will audit all residents who require "EBP" to ensure they have the proper PPE equipment and signage posted weekly x 8 weeks, and then ongoing to ensure compliance. The Administrator will ensure that new samples are collected and sent in to determine the need for more aggressive treatment of Legionella bacteria previously present within the facility. The Administrator will initiate a mitigation plan if there are still positive results following new sample results	

	once they come back from the lab, utilizing the CDC Healthcare Facility Water Management Program Checklist. The audit forms and results of legionnaires testing will be reviewed during monthly QAPI meeting to ensure ongoing compliance.	
	5.) **Date Completed: 4/23/25**	
	Cross Reference F880	

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.