STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265415	A. Building B. Wing	03/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
New Haven Care Center	9503 Highway 100 New Haven, MO 63068

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, facility staff failed to maintain professional standards of care when they failed to utilize the electronic medication administration record (eMAR), while administering insulin to three residents (Resident # 2, 18 and 20), and failed to document insulin dosages for five residents (#2, #18, #20, #24 and #30). Staff failed to administer extended release medication per pharmacy recommendations for one resident (Resident 8), who was unable to swallow pills, and failed to obtain a physician's order for oxygen for one resident (Resident #63) out of 30 sampled residents. The facility census was 69 . 1. Review of Medication Administration policy, undated, directed staff to utilize the MAR to select medications from the resident's medication slot. Verify the drug name, dose and route on the medication label with the MAR/physician order. Document administration and any essential information on the MAR immediately after administering the medication. Consult Pharmacy to determine if crushing is appropriate for the medication ordered. Review of National Institutes of Health (NIH) The Five Rights of Medication Administration, dated September 4, 2023, showed right patient, right drug, right route, right time and right dose. 2. Review of Resident #2's admission Minimum Data Set (MDS), dated [DATE], showed staff assessed the resident as cognitively intact with a diagnosis of diabetes mellitus. Review of the resident's Physician's Order Sheet (POS), showed an order dated 12/23/24, to administer Insulin Lispro 100 units/milliliter (Units/ml) by sliding scale every A.M., afternoon, and at supper. Review of the eMAR, dated March 2025, showed staff documented they administered the resident's Lispro Insulin and did not document the units of insulin administered on: -March 8 at 8:32 A.M., and 11:30 A.M.; -March 9 at 7:38 A.M., 10:48 A.M. and 15:46 P.M.; -March 10 at 8:00 A.M., 10:58 A.M. and 3:44 P.M.; -March 11 at 7:38 A.M. and 10:44 A.M.; -March 12 at 7:49 A.M., 10:47 A.M. and 4:30 P.M.; (continued on next page)

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

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-March 13 at 7:16 A.M., 12:00 P.M. and 4:00 P.M.; -March 14 at 7:15 A.M. and 11:10 A.M.; -March 15 at 7:30 A.M. and 4:03 P.M.; -March 16 at 7:18 A.M. and 10:44 A.M.; -March 17 at 7:35 A.M., 10:51 A.M. and 3:41 P.M.; -March 18 at 7:29 A.M., 11:05 A.M. and 3:44 P.M.; -March 19 at 6:36 A.M., 10:35 A.M. and 3:42 P.M.; -March 20 at 7:50 A.M., 11:09 AM. and 3:55 P.M.; -March 21 at 7:09 A.M. and 10:54 A.M. Observation on 03/20/25 at 10:55 A.M., showed Licensed Practical Nurse (LPN) A administered three units of insulin for a blood sugar of 192 milligrams/deciliter (mg/dL) after he/she referenced a handwritten sliding scale note from the medication's box. Observation showed the LPN did not use the eMAR to verify the correct insulin dosage. The dosage was selected from the sliding scale table showing an insulin dose for specific blood sugar ranges. 3. Review of Resident #18's Quarterly MDS, dated [DATE], showed staff assessed the resident as cognitively intact with a diagnosis of diabetes mellitus. Review of the resident's POS , dated 10/16/24, showed an order to administer Insulin Aspart 100 Units/ml by sliding scale every A.M., Afternoon, P.M., and at bedtime. Review of the eMAR, dated March 2025, showed staff documented they administered the resident's Insulin Aspart and did not document the units of insulin administered on: -March 8 at 7:02 A.M., 10:42 A.M. and 3:41 P.M.; -March 9 at 7:37 A.M., 10:48 A.M., 3:47 P.M. and 9:00 P.M.; -March 10 at 7:35 A.M., 10:57 A.M. 3 :45 P.M. and 8:38 P.M.; -March 11 at 7:27 A.M., 11:01 A.M., 3:55 P.M. and 9:30 P.M.; -March 12 at 7:38 A.M., 11:33 A.M., 4:30 P.M. and 8:22 P.M.; -March 13 at 11:30 A.M., 4:00 P.M. and 9:07 P.M.; -March 14 at 7:15 A.M., 11:00 A.M., 3:16 P.M. and 9:00 P.M.; -March 15 at 8:18 A.M., 10:46 A.M., 4:00 P.M. and 9:00 P.M.; (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-March 16 at 11:00, 3:44 P.M. and 7:18 P.M.; -March 17 at 11:00 A.M., 15:49 P.M. and 7:46 P.M.; -March 18 at 11:00 A.M., 3:43 P.M. and 8:45 P.M.; -March 19 at 6:47 A.M., 10:39 A.M., 3:41 P.M. and 8:31P.M.; -March 20 at 7:45 A.M., 11:09 AM. and 3:52 P.M. and 8:00 P.M.; -March 21 at 7:04 A.M. and 10:34 A.M. Observation on 03/20/25 at 10:40 A.M., showed LPN A administered five units of insulin after he/she referenced a handwritten sliding scale note from the medication's box. Observation showed the LPN did not use the eMAR to verify the correct insulin dosage. The dosage was selected from the sliding scale table showing an insulin dose for specific blood sugar ranges. 4. Review of Resident #20's Quarterly MDS, dated [DATE], showed staff assessed the resident as cognitively intact with a diagnosis of diabetes mellitus. Review of the resident's POS, dated 11/14/24, showed an order to administer Insulin Aspart 100 units/ml twice a day at breakfast and midday by sliding scale. Review of the eMAR, dated March 2025, showed staff documented they administered the resident's Insulin Aspart and did not document the units of insulin administered: -March 8 at 7:05 A.M. and 10:47 A.M.; -March 9 at 7:38 A.M. and 10:23 A.M.; -March 10 at 7:36 A.M. and 12:52 P.M.; -March 11 at 7:29 A.M. and 11:07 A.M.; -March 12 at 8:45 A.M.; -March 13 at 7:15 A.M. and 12:00 P.M.; -March 14 at 7:18 A.M. and 11:05 A.M.; -March 15 at 7:30 A.M. and 10:47 A.M.; -March 16 at 6:43 A.M. and 11:00 A.M.; -March 17 at 7:37 A.M. and 11:08 A.M.; -March 18 at 7:27 A.M. and 11:00 A.M.; -March 19 at 6:42 A.M. and 10:33 A.M.; (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-March 20 at 8:00 A.M. and 11:08 A.M.; -March 21 at 7:11 A.M. and 10:38 A.M. Observation on 03/20/25 at 10:48 A.M,. showed LPN A administered five units of insulin after he/she referenced a handwritten sliding scale from the medication's box. Observation showed the LPN did not use the eMAR to verify the correct insulin dosage. The dosage was selected from the sliding scale table showing an insulin dose for specific blood sugar ranges. 5. During an interview on 03/20/25 at 10:40 A.M., LPN A said he/she does not use the eMAR when administering insulin because he/she knows what everyone gets and it is easier. The LPN said there is a cheat sheet in the medication box and he/she would check the computer if he/she has any questions. The LPN said he/she documents in the eMAR after he/she administers everyone's insulin. 6. Review of Resident #24's Quarterly MDS, dated [DATE], showed staff assessed the resident as severely cognitively impaired and diagnosis of diabetes mellitus. Review of the resident's POS, dated 08/13/24, showed an order to administer Lispro Insulin 100 units/ml per sliding scale three times a day at midday, afternoon and at bedtime. Review of the eMAR, dated March 2025, showed staff documented they administered the resident's Insulin Aspart and did not document the units of insulin administered for: -March 8 at 10:49 A.M.; -March 9 at 10:50 A.M., 3:47 P.M. and 7:13 P.M.; -March 10 at 10:45 A.M. and 8:49 P.M.; -March 11 at 10:50 A.M.; -March 12 at 2:44 P.M.; -March 13 at 3:55 P.M.; -March 14 at 10:44 A.M., 3:18 P.M. and 8:49 P.M.; -March 15 at 10:57 A.M., 3:43 P.M. and 8:46 P.M.; -March 16 at 10:53 A.M., 3:36 P.M. and 8:35 P.M.; -March 17 at 11:04 A.M., 3:31 P.M. and 8:01 P.M.; -March 18 at 10:42 A.M.; -March 19 at 10:53 A.M., 3:37 P.M. and 7:25 P.M.; -March 20 at 11:10 A.M. and 3:49 P.M.; (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-March 21 at 10:45 A.M. Observation on 03/20/25 at 11:17 A.M., showed, showed RN B used the eMAR to administered 15 units of Lispro Insulin for a blood sugar of 302 mg/dL. Observation showed the RN did not document the administration in the eMAR. 7. Review of Resident #30's Quarterly MDS, dated [DATE], showed staff assessed the resident as cognitively intact and with a diagnosis diabetes mellitus. Review of the resident's POS, dated 08/13/24, showed an order to administer Insulin Aspart 100 units/ml per sliding scale three times a day in the morning, midday and evening. Review of the eMAR, dated March 2025, showed staff documented they administered the resident's Insulin Aspart and did not document the units of insulin administered for: -March 8 at 10:30 A.M. and 3:45 P.M.; -March 9 at 7:14 A.M. and 3:49 P.M.; -March 10 at 7:29 A.M., 10:46 A.M. and 3:38 P.M.; -March 11 at 7:07 A.M., 10:53 A.M. and 4:04 P.M.; -March 12 at 8:06 A.M., 10:45 A.M. and 3:35 P.M.; -March 13 at 11:27 A.M. and 4:00 P.M.; -March 14 at 10:48 A.M. and 3:21 P.M.; -March 15 at 11:00 A.M. and 3:44 P.M.; -March 16 at 11:04 A.M. and 3:38 P.M.; -March 17 at 7:19 A.M., 11:06 A.M. and 3:41 P.M.; -March 18 at 7:15 A.M., 10:46 A.M. and 3:42 P.M.; -March 19 at 6:43 A.M., 10:35 A.M. and 3:47 P.M.; -March 20 at 7:11 A.M., 11:10 A.M. and 4:01 P.M.; -March 21 at 7:15 A.M. Observation on 03/20/25 at 11:20 A.M., showed RN B used the eMAR to administer five units of Lispro Insulin for a blood sugar of 235 mg/dL. Observation showed the RN did not document the dose administered in the eMAR. 8. During an interview on 03/20/25 at 11:26 A.M., RN B said he/she doesn't usually watch medication administration but did notice today that LPN A did not have a computer with him/her while (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	administering insulin so he/she took one to him/her. RN B said the eMAR should always be used to check orders and document the dosages administered. He/She said staff should not administer medication from memory. RN B said most residents have an insulin cheat sheet inside the medication box but he/she does not use it. RN B said he/she does not know how others do it. During an interview on 03/20/25 at 11:56 A.M., the Assistant Director of Nursing (ADON) said staff should not administer medications without first verifying the medication and dosage with the eMAR. The ADON said if staff does this it puts the residents at risk for medication errors. The ADON said staff do not document the units of insulin administered for residents who receive insulin via sliding scale because the doses are listed in the eMAR instructions by the blood sugar ranges. The ADON said he/she did not know the eMAR had a designated field to document the administered dose. During an interview on 3/20/25 at 12:00 P.M., the administrator said he/she expects staff to follow the facility policy for medication administration. He/She said he/she did not know staff did not document the units of insulin administered for resident who received it via sliding scale. He/She said he/she did not the eMAR had a designated field to document the administered dose. He/She said now that he/she knows, staff will be expected to complete this. 8. Review of the Merck Pharmaceutical Manual, Professional Version, online, undated, showed ER Potassium chloride tablets should be swallowed whole; do not crush or chew or allow to dissolve in the mouth. For patients with difficulty swallowing, the tablets may be broken in half and each half taken separately with a glass of water. These formulations can be made into an aqueous solution by placing the whole dose in a glass or cup containing 120 ml of water. Allow two minutes for tablets to dissolve and then stir for approximately 30 seconds. Swirl the suspension and drink immediately. To ensure administration of the entire dose, add 30 ml of water to the glass or cup, swirl, and consume immediately; repeat with a final 30 ml water. 9. Review of Resident #8's admission MDS, dated [DATE], showed staff assessed the resident as severely cognitively impaired and received a mechanically altered diet. Review of the resident's care plan, dated 03/18/25, showed staff identified the resident received a mechanically altered diet. Review of the resident's POS, dated March 2025, showed an order to administer one 20 milliequivalents (mEq) tablet of extended release potassium chloride by mouth three times daily. Observation on 03/18/25 at 11:40 A.M., showed LPN C crushed a 20 mEq tablet of extended release potassium chloride, added it to applesauce, and administered it to the resident. During an interview on 03/18/25 at 11:45 A.M., LPN C said he/she believed it is okay to crush the potassium chloride tablet for this resident. The LPN said he/she did not know if the pharmacy or resident's physician had been consulted. During an interview on 03/20/25 at 11:56 A.M., the ADON said extended release potassium chloride should not be crushed. If a resident can not swallow the pill, the pharmacy should be notified that liquid is needed, or it should be dissolved in water. The ADON said the pharmacy can send a liquid version, but he/she did not know if the pharmacy had been contacted. During an interview on 03/21/25 at 2:40 P.M., the DON said staff should not crush extended release (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	potassium chloride. The DON said he/she did not know staff were crushing the medication and administering it that way to the resident. 10. Review of the facility's policy titled Oxygen Administration , revised 07/22/24, showed: -Oxygen is administered under orders of a physician, except in the case of an emergency; -The resident's care plan shall identify the interventions for oxygen therapy, based upon the resident's assessment and orders, such as, but not limited to: -The type of oxygen delivery system; -When to administer, such as continuous or intermittent and /or when to discontinue; -Equipment setting for the prescribed flow rates; -Monitoring for complications associated with the use of oxygen. 11. Review of Resident # 63's admission MDS, dated [DATE], showed staff assessed the resident as cognitively intact and did not require oxygen. Review of the resident's care plan, reviewed on 3/21/25, showed it did not address oxygen use for the resident. Review of resident's POS, dated 3/20/25, showed it did not contain an order for oxygen. Observation on 03/18/25 at 2:02 P.M., showed the resident in his/her room with oxygen on at three liters per minute. Observation on 03/20/25 09:37 A.M., showed a concentrator in the room with bagged tubing. Observation on 03/21/25 at 1:08 P.M., showed the resident with an oxygen concentrator in his/her room with oxygen tubing hung on the wall. During an interview on 03/18/25 at 2:05 P.M., the resident said he/she used the oxygen when needed. During an interview on 03/21/25 at 2:14 P.M., the administrator said if the resident does not have an order for a current treatment staff should contact the DON and physician. During an interview on 03/21/25 at 2:25 P.M., LPN C said all residents who use oxygen should have an order, even if it is as needed. LPN C said he/she did not know the resident did not have an order for oxygen. During an interview on 03/21/25 at 2:40 P.M., the DON said all residents who use oxygen should have an order. The DON said he/she did not know the resident did not have an order for oxygen.