STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	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

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 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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 (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 [DATE]; - The resident transferred to the hospital on [DATE], and returned to the facility on [DATE]; - 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 [DATE]; (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 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- The resident transferred to the hospital on [DATE], and returned to the facility on [DATE]; - 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 [DATE]; - The resident transferred to the hospital on [DATE], and returned to the facility on [DATE]; - 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 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.

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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 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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 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 [DATE]; - The resident transferred to the hospital on [DATE], and returned to the facility on [DATE]; - 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 [DATE]; - The resident transferred to the hospital on [DATE], and returned to the facility on [DATE]; - The resident transferred to the hospital on [DATE], and returned to the facility on [DATE]; - 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 [DATE]; (continued on next page)

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	265451	A. Building B. Wing	04/03/2025

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- The resident transferred to the hospital on [DATE], and returned to the facility on [DATE]; - 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. 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.

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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 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 [DATE]; - 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; (continued on next page)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- 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: - 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 form and placed in a binder, but not in the resident's medical record. The questionnaire should be dated (continued on next page)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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.

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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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 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; - 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: (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- 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 - 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 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. (continued on next page)

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	265451	A. Building B. Wing	04/03/2025

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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.

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	265451	A. Building B. Wing	04/03/2025

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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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. Based on observation, interview, and record review, the facility failed to 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. 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 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. (continued on next page)

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	265451	A. Building B. Wing	04/03/2025

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. 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 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. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	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

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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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.

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F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician. 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 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. (continued on next page)

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F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 04/03/24 at 11:32 A.M., 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.