

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/22/2024
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265247	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 10/04/2024
NAME OF PROVIDER OR SUPPLIER KIRKSVILLE MANOR CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1705 EAST LAHARPE KIRKSVILLE, MO 63501		
(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 557 SS=E	Respect, Dignity/Right to have Prsnl Property CFR(s): 483.10(e)(2) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(2) The right to retain and use personal possessions, including furnishings, and clothing, as space permits, unless to do so would infringe upon the rights or health and safety of other residents. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to treat four residents (Resident #2 #1 #12 and #18) with dignity and respect, in a review of 18 sampled residents. Staff did not speak respectfully to residents and did not promptly respond to an incontinent resident when he/she required staff assistance. The facility census was 49. Review of the facility's policy titled Dignity, dated February 2021, showed the following: -Residents are treated with dignity and respect at all times; -Staff speak respectfully to residents at all times; -Demeaning practices and standards of care that compromise dignity are prohibited. Staff are expected to promote dignity and assist residents by promptly responding to a resident's request for toileting assistance; -Staff are expected to treat cognitively impaired residents with dignity and sensitivity; for example: a. Addressing the underlying motives or root causes for behavior; b. Not challenging or contradicting the resident's beliefs or statements.	F 557			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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 557	Continued From page 1 1. Review of Resident #2's annual Minimum Data Set (MDS) a federally mandated assessment instrument, dated 8/9/24, showed the following: -The resident had severe cognitive impairment; -He/She had adequate hearing; -He/She had the ability to express ideas and wants; -He/She had clear comprehension to understand others; -He/She required maximum assistance with upper and lower body dressing, bathing, and bed mobility; -He/She was dependent on staff for transfers, personal hygiene, toilet use, and locomotion; -He/She was always incontinence of bladder and bowel. Review of the resident's Care Plan, updated 8/10/24, showed the following: -The resident was dependent on staff for meeting emotional, intellectual, physical, and social needs related to physical limitations; -All staff conversed with the resident while providing care; -The resident was able to use the call light when he/she needed assistance, staff to keep call light within his/her reach at all times when he/she was in the room; -The resident was totally dependent on two staff for repositioning and turning in bed every two hours and as necessary; -The resident required total assistance by one to two staff with personal hygiene; -Encourage the resident to discuss any feelings or concerns with remining in long-term care. During an interview on 9/27/24 at 11:20 A.M., the resident said the following:	F 557			

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F 557	Continued From page 2 -A staff member told the resident his/her taxes paid for the resident to live at the facility; -How could this be considered his/her home with the way staff treated him/her?; -The staff would come in the room, turn off the call light and never come back to provide assistance. During an interview on 9/27/24 at 11:20 A.M., Resident #1, Resident #2's roommate, said the following: -He/She was in the room in bed the day Certified Nurse Aide (CNA) E made the comment about how his/her taxes paid for their stay at the facility; -Resident #1 was upset with the comment because he/she paid income taxes too. 2. Review of Resident #1's Care Plan, updated 8/14/24, showed the following: -The staff helped make the resident's room as home like as possible; -The resident was able to use the call light when he/she needed assistance, staff kept the call light within reach at all times when the resident was in his/her room and answered the call light in a timely manner; -The resident needed assistance with two staff members and a mechanical lift for all transfers to the wheelchair and back to bed. Review of the resident's admission MDS, updated 8/14/24, showed the following: -The resident was cognitively intact; -He/She required maximum assistance with upper body dressing, bathing, personal hygiene, and bed mobility; -He/She was dependent on staff for transfers, lower body dressing, toilet use, and locomotion; -He/She experienced frequent incontinence of	F 557			

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F 557	Continued From page 3 bladder and bowel. During an interview on 9/27/24 at 11:20 A.M., Resident #1 said the following: -He/She was upset about how he/she was treated in the facility; -The staff came into the room and shut off his/her call light and said they would be back, but they never did come back until he/she activated the call light again; -CNA E told the resident that he/she used the call light too much; -Staff left a reusable incontinence pad behind his/her back making the chair uncomfortable and everyone else could see it which was embarrassing; -The resident asked the staff to move it and the staff said, they would fix it later when the staff had more time; -Staff walked by the room while the call light was activated but would not stop; -He/She was concerned about how Resident #2 was treated by staff when staff told Resident #2 their taxes paid for the resident's stay at the facility. Observation in the resident's room on 9/27/24 at 11:20 A.M., showed a reusable incontinence pad positioned behind the resident's back and visible from across the room. 3. Review of Resident #12's quarterly MDS, dated 9/12/24, showed the following: -The resident had severe cognitive impairment; -He/She required maximal assistance for upper and lower body dressing, personal hygiene, bed mobility, and transfers; -He/She was dependent on staff for toilet use; -He/She was always incontinent of bladder and	F 557			

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F 557	Continued From page 4 bowel. Review of the resident's care plan, updated 9/16/24, showed the following: -The resident needed assistance with one staff member and wheeled walker for all transfers, ambulating, and toileting, he/she attempted to transfer and ambulate without assist; -The resident had a potential for falls and injuries due to diagnosis of impaired cognition and making poor decisions. Observation in the hallway across from the nurses station on 10/1/24 at 9:40 A.M., showed the following: -The resident stood up from his/her wheelchair and looked down the hallway; -Certified Medication Technician (CMT) B walked into the hallway past the resident; -Resident #15 told CMT B the resident was wet and CMT B nodded in acknowledgement; -CMT B told Resident #12 to sit down and continued to walk down the hall. During an interview on 10/1/24 at 8:55 A.M., Licensed Practical Nurse (LPN) A said the following: -The resident will stand up from his/her wheelchair, so staff are supposed to try to determine if the resident's needs were met; -The resident was incontinent, so LPN A assisted the resident to provide peri care and change clothes; -LPN A said he/she did not know CMT B walked by the resident without stopping to address the resident; -LPN A said CMT B should have at least stopped and addressed the resident.	F 557			

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F 557	Continued From page 5 4. Review of Resident #18's Care Plan, updated 7/24/24, showed the following: -Help make the resident's room as home like as possible; -Encourage and allow the resident to make choices related to cares and schedule; -Keep the resident's call light within reach at all times when he/she was in the room and answer it in a timely manner; -Encourage the resident to verbalize feelings and give realistic feedback; -He/She had diagnoses of unspecified psychosis, depression, and anxiety which he/she took antipsychotic, antidepressant, and antianxiety medications daily; -Encourage participation in self-calming behaviors such as breathing exercises, meditation, or guided imagery. Review of the resident's quarterly MDS, dated 7/25/24, showed the following: -The resident was cognitively intact; -He/She had verbal behaviors towards others; -He/She was dependent on toilet use and locomotion; -He/She was frequently incontinent of bladder and occasionally incontinent of bowel. During an interview on 10/4/24 at 5:50 A.M., Certified Nurse Aide (CNA) J said the following: -He/She told Resident #16 not to use the call light so much; -The resident did not like being alone in his/her room, so the resident would turn on the call light, then tell staff he/she did not need anything, but as soon as staff left the room, the resident activated the call light again; -The resident did this several times a shift, every shift.	F 557			

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F 557	Continued From page 6 During an interview on 10/10/24 at 10:18 P.M., the resident's family member said a staff member told the resident that he/she was using the call light too much. This upset the resident. 5. During an interview on 10/2/24 at 6:20 P.M., Staff O said the following: -CNA E was rude to the residents; -CNA E told residents to stop using their call light so much, they should quit being lazy and do things themselves; -He/She notified administration and the corporate office, but nothing was done about it. During an interview on 10/1/24 at 12:45 P.M., the Director of Nursing (DON) said the following: -The expectation was staff treated the residents with dignity and respect; -She was unaware of staff telling residents they used their call lights too much and the residents felt they were not being treated with dignity and respect. During an interview on 9/27/24 at 1:45 P.M., the Administrator said the following: -No one reported a staff member told a resident they used the call light too much, said their tax dollars paid for the resident's stay, or did not treat any resident without dignity and respect; -His expectation was staff report to the charge nurse or administration when a resident was not treated with dignity and respect so the issue could be addressed immediately; -Communication between staff members was an issue the facility was trying to improve. MO242619	F 557			

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F 677 F 677 SS=E	Continued From page 7 ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to provide four residents (Resident #2, #3, #16, and #8), of 18 sampled residents, with assistance with activities of daily living (ADL). Staff did not ensure Resident #2 had glasses to see when eating, left his/her hair wet after bathing, and did reposition or check for incontinence. Staff failed to check Residents #3, #16, and #8 for incontinence and reposition the residents timely. The facility census was 49. Review of the facility's Activities of Daily Living (ADL), Supporting policy, dated March 2018, showed the following: -Appropriate care and services will be provided for residents who are unable to carry out ADLs independently, with the consent of the resident and in accordance with the plan of care, including appropriate support and assistance with: -a. Hygiene (oral care); -b. Mobility (transfer); - c. Elimination (toileting). 1. Review of Resident #2's annual MDS, dated 8/9/24, showed the following: -The resident had severe cognitive impairment; -He/She required maximum assistance with upper and lower body dressing, bathing, and bed mobility; -He/She was dependent on transfers, personal	F 677 F 677			

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F 677	Continued From page 8 hygiene, toilet use, and locomotion; -He/She was always incontinence of bladder and bowel. Review of the resident's Care Plan, updated 8/10/24, showed the following: -The resident had an ADL self-care performance deficit related to left hemiplegia (paralysis on one side of the body); -He/She was totally dependent on one staff to provide shower; -He/She was totally dependent on two staff for repositioning and turning in bed every two hours and as necessary; -He/She required assistance of one staff to eat. Observation on 9/27/24 at 10:02 A.M., showed the resident sat in a Geri chair in front of a television in his/her room with eyes closed. During an interview on 9/27/24 at 11:06 A.M., the resident said the following: -The staff did not ensure he/she had his/her glasses on when he/she ate breakfast so the resident could see what he/she was eating; -The staff left his/her hair wet after a bath so he/she was cold and did not have a blanket; -The resident had to yell at staff to get him/her a blanket because the call light was not in reach; -The staff left the resident to sit in his/her Geri chair all day, which happened frequently. Observation on 9/27/24 at 11:06 A.M., showed the following: -The resident was not wearing glasses; -His/her hair was still wet; -The call light was in a chair behind the resident and out of reach.			F 677			

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F 677	Continued From page 9 Observation in the dining room on 9/27/24 at 12:20 P.M., showed staff brought the resident to the dining room table in the Geri chair. During an interview on 9/27/24 at 12:20 P.M., the resident said staff did not check him/her for incontinence or reposition him/her before staff brought him/her to the dining room that day. Observation in the dining room on 10/1/24 at 9:10 A.M., showed the resident sat in a Geri chair at the dining room table, feeding himself/herself breakfast. The resident was not wearing glasses. The resident had difficulty getting the food onto his/her silverware. Food fell on the table and his/her clothing protector. During an interview on 10/1/24 at 9:20 A.M. and 10:20 A.M., Licensed Practical Nurse (LPN) C said the resident was supposed to have glasses on for meals. 2. Review of Resident #3's quarterly MDS, dated 8/7/24, showed the following: -The resident had severely impaired cognitive skills for daily decision making; -He/She was dependent on staff for toileting hygiene and transfers; -He/She was always incontinent of bladder and bowel. Review of the resident's Care Plan, updated 8/13/24, showed the following: -The staff checked the resident for incontinence during routine rounds and as needed; -The resident was incontinent of bowel and bladder, he/she was unable to let staff know, the staff anticipated the resident's needs during routine rounds, as needed and per family request;	F 677			

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F 677	Continued From page 10 -He/She needed two staff assistance and Hoyer lift for all transfers and toileting; -The staff performed the resident's perineal care as needed, made sure the resident was clean, dry and odor free; -He/She had a potential for decrease in cognition due to diagnoses of dementia and Alzheimer's disease (brain disorder that causes a gradual decline in memory, thinking, and other cognitive abilities that eventually interferes with daily life). Observation in the common area on 9/27/24 at 9:15 A.M., showed the resident sat in a wheelchair in common area in front of the television, leaned down, and placed his/her head on his/her knees. Observation in the common area on 9/27/24 at 10:05 A.M., showed the resident continued to sit in a wheelchair in front of the television, leaned down with his/her head on his/her knees in the same spot as 9:15 A.M. Observation in the common area on 9/27/24 at 11:03 A.M., showed the resident continued to sit in a wheelchair in front of the television, leaned down with his/her head on his/her knees in the same spot as 9:15 A.M. Observation in the dining room on 9/27/24 at 12:40 P.M., showed staff brought the resident from the common area over to the dining room table in his/her wheelchair. Staff did not reposition the resident or check him/her for incontinence. The resident's hair was disheveled. Observation in the dining room on 10/4/24 at 7:10 A.M., showed staff brought the resident in a wheelchair to the dining room table.	F 677			

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F 677	Continued From page 11 Observation in the dining room on 10/4/24 at 9:10 A.M., showed staff took the resident in the wheelchair from the dining room table to the common area and sat the resident in front of the television. Staff did not reposition the resident or check him/her for incontinence. During an interview on 10/4/24 at 12:40 P.M., CNA L said staff did not check the resident for incontinence prior to going to the dining room table. 3. Review of Resident #16's quarterly MDS, dated 9/4/24, showed the following: -The resident had severe cognitive impairment; -He/She was dependent on staff for toileting hygiene and transfers; -He/She was always incontinent of bladder and bowel. Review of the resident's Care Plan, updated 9/5/24, showed the following: -The resident ate all meals in the dining room, he/she needed to sit up for one hour after all meals before laying down; -He/She was always incontinent of bladder and bowel due to history of cerebrovascular accident (CVA, stroke) and not always knowing when he/she needed to use the toilet; -The staff assisted the resident with perineal cleansing as needed and checked with routine rounds; -The resident required two staff assist with Hoyer lift for all transfers; -He/She was at risk for skin breakdown due to diagnoses of dementia and bowel and bladder incontinence; -The staff assisted the resident with position	F 677			

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NAME OF PROVIDER OR SUPPLIER KIRKSVILLE MANOR CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1705 EAST LAHARPE KIRKSVILLE, MO 63501		
(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 677	Continued From page 12 changes, he/she needed assistance with two staff for repositioning when he/she was in the wheelchair; -The staff kept the resident's skin clean and dry, performed perineal care after each incontinence episode. Observation in the dining room on 10/4/24 at 7:29 A.M., showed the staff brought the resident to the dining room in his/her wheelchair. Observation on 10/4/24 at 9:20 A.M., showed the resident sat in the wheelchair in his/her room, next to the bed. The resident's eyes were closed. Observation on 10/4/24 at 10:35 A.M., showed the resident sat in the wheelchair in his/her room, next to the bed with his/her eyes closed. During an interview on 10/4/24 at 12:20 P.M., CNA M said he/she did not check the resident for incontinence or reposition the resident between breakfast and lunch because CNA M was busy with another resident causing CNA M to be behind on getting everyone checked for incontinence and getting them up for lunch. This happened at least twice a week. 4. Review of Resident #8's Admission MDS, dated 6/30/24, showed the following: -The resident had severely impaired cognitive skills for daily decision making; -He/She was dependent on staff for toileting hygiene and transfers; -He/She was always incontinent of bladder and bowel. Review of the resident's Care Plan, dated 7/10/24, showed the following:	F 677			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 677	Continued From page 13 -The resident had an ADL self-care performance deficit; -The staff were to anticipate the residents needs during routine rounds and as needed. Observation on 10/4/24 at 7:15 A.M., showed staff brought the resident to the dining room table in a Geri chair. Observation on 10/4/24 at 9:10 A.M., showed staff took the resident back to his/her room and left the resident sitting in the Geri chair without repositioning the resident or checking him/her for incontinence. During an interview on 10/4/24 at 12:40 P.M., CNA L said staff did not transfer the resident to bed or check the resident for incontinence after breakfast. 5. During an interview on 10/4/24 at 12:20 P.M., CNA M said the residents who were incontinent, needed assistance with toileting, or had dementia were supposed to be checked for incontinence and turned before meals but some days it did not get done until after lunch because he/she was busy caring for other residents. During an interview on 10/4/24 at 12:30 P.M., CNA K said, the staff were supposed to provide incontinence care before meals but some days the staff were too busy, so it was done after lunch. During an interview on 10/4/24 at 12:40 P.M., CNA L said ideally, the residents should be checked every two hours but that day there was not enough time to get everyone cared for before lunch.	F 677			

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F 677	Continued From page 14 During an interview on 10/4/24 at 2:02 P.M., the Director of Nursing said the following: -The expectation was staff checked residents for incontinence and repositioned them during routine rounds and more often when needed; -The routine rounds did not have a specific time frame, but it would be at least before meals and at bedtime; -She felt like there was enough staff to care for the residents. MO241170 MO243016	F 677			

Missouri Department of Health and Senior Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 04161	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 10/04/2024
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NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE

KIRKSVILLE MANOR CARE CENTER

**1705 EAST LAHARPE
KIRKSVILLE, MO 63501**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
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 F677	A4075		
A8030	19 CSR 30-88.010(29) Dignity/Privacy Each resident shall be treated with consideration, respect, and full recognition of his or her dignity and individuality, including privacy in treatment and care of his or her personal needs. All persons, other than the attending physician, the facility personnel necessary for any treatment or personal care, or the department or Department of Mental Health staff, as appropriate, shall be excluded from observing the resident during any time of examination, treatment, or care unless consent has been given by the resident. II/III This regulation is not met as evidenced by: Class II* Refer to F557 *The higher classification merited due to the violation's effect on the residents.	A8030		

Missouri Department of Health and Senior Services

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE *Administrator*

(X6) DATE *10/31/24*

PLAN OF CORRECTION

Provider/Supplier Name:	Kirksville Manor Care Center	
Street Address, City, Zip:	1705 E. LaHarpe St Kirksville, Mo 63501	
Date of Survey:	October 4, 2024	
PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER		265247
ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION: (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLETION DATE
F557	All residents have the potential to be affected by the deficient action. An all-staff in-service will be held by 11/15/24, to include education on Residents Rights, and the policy for Dignity. Assured residents #1 and #2 that all staff will be educated on how to speak to residents. In-serviced all staff on call light use and placement. All staff will attend to resident needs when answering the light, if more than 1 aide is required, call light will remain on until needs are met. All staff will be in-serviced on how to position the re-usable incontinence pad in wheelchairs. All staff will be in-serviced on addressing the residents at the time the need has occurred and not walk on by for resident #12 and all other residents. Staffing Coordinator will draft scheduling of routine of breaks for day shift CNA's to ensure residents are cared for timely. Social Services designee will monitor all residents with emphasis on Dignity by asking residents how staff have been speaking to them and if call lights are being placed within reach. SSD will keep a log of residents asked and results founded with documentation three times a week for 1 month. DON will report during QRTLY QAPI meeting to ensure facility compliance.	11/15/2024

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:	Kirksville Manor Care Center	
Street Address, City, Zip:	1705 E. LaHarpe St Kirksville, Mo 63501	
Date of Survey:	October 4, 2024	
PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER		265247
ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION: (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLETION DATE
F677	All residents have the potential to be affected by deficient action. An all-staff in-service will be held by 11/15/24, to educate ADL's and Repositioning of dependent residents with focus on ensuring eyeglasses are placed, hair is dried after shower and repositioning and incontinence care are completed. This affected residents #2, # 3, #16, and #8. Admin staff have monitored timeliness of cares since receiving POC for improvement. Staffing Coordinator / Quality Assurance leader will use placement cards to ensure staff compliance in repositioning of dependent residents. Admin staff that include DON, Staffing Coordinator / Quality Assurance leader, Infection Control Nurse, MDS Coordinator, and Social Services by keeping a log of residents monitored and will monitor staff three times a week for one month. All admin staff will assist in this monitoring by keeping a log of the residents checked throughout the day and the results found. DON will report in the QRTL Y QAPI meeting to ensure facility compliance.	11/15/2024

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:	Kirksville Manor Care Center	
Street Address, City, Zip:	1705 E. LaHarpe St Kirksville, Mo 63501	
Date of Survey:	October 4, 2024	
PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER		265247
ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION: (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLETION DATE
A4075	See F677	11/15/2024
A8030	See F557	11/15/2024

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NAME OF PROVIDER OR SUPPLIER

KIRKSVILLE MANOR CARE CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE

1705 EAST LAHARPE

KIRKSVILLE, MO 63501

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{F 557} SS=E	Respect, Dignity/Right to have Prsnl Property CFR(s): 483.10(e)(2) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(2) The right to retain and use personal possessions, including furnishings, and clothing, as space permits, unless to do so would infringe upon the rights or health and safety of other residents. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to maintain resident dignity and self determination for four residents (Resident #1, #8, #2, and #7) when staff failed to provide grooming assistance to include basic haircuts. The facility census was 51. Review of the facility's policy titled, Resident Rights, dated February 2021, showed the following: -Employees will treat all residents with kindness, respect, and dignity; -Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include a dignified existence, to be treated with respect, kindness and dignity, and self-determination, and to exercise his/her rights as a resident of the facility. During an interview on 12/10/24 at 1:30 P.M., the Director of Nursing (DON) said the facility did not have a policy specific to hair cuts. 1. Review of Resident #1's care plan, revised 9/4/24, showed coping was impaired, provide assistance with activities of daily living (ADLs) as	{F 557}		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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 557}	Continued From page 1 needed, include resident in determining next steps in care. Review of the resident's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument, dated 9/5/24 showed the following: -Diagnoses included multiple sclerosis, anxiety, and depression; -Cognitively intact; -The resident had the ability to express ideas and wants; -The resident was understood and had clear comprehension to understand others; -The resident required supervision or touching assistance with personal hygiene. Observation on 11/21/24 at 8:30 A.M., showed the resident sat in his/wheelchair in the dining room awaiting breakfast, his/her hair was approximately shoulder length. Observation on 11/26/24 at 8:00 A.M., showed the resident sat in the dining room eating breakfast, his/her was approximately shoulder length. During interviews on 11/21/24 at 12:00 P.M. and 11/26/24 at 2:00 P.M., the resident said the following: -He/She was embarrassed by how long his/her hair was, it made him/her feel sloppy; -He/She had not received a hair cut for over 6 months, he/she always kept his/her hair trimmed before coming to the facility to live; -The facility did not have a beautician/professional hairstylist to provide haircuts to the residents; -He/She was going to have family and friends visit over the holidays and felt embarrassed by how	{F 557}			

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{F 557}	Continued From page 2 his/her hair looked. 2. Review of Resident #8's quarterly MDS, dated 9/4/24, showed the following: -Diagnoses included stroke, dementia, and hemiplegia (loss of strength or paralysis on one side); -Cognitively impaired; -The resident had clear speech and was usually able to express ideas and wants; -The resident had clear comprehension and understood others; -The resident was dependent on staff for personal hygiene. Review of the resident's Care Plan, revised 9/4/24 showed the following: -The resident required extensive assistance of two staff members with ADLs; -Encourage the resident to make routine daily decisions; -The resident was able to make own needs known if given time, due to cognition. Observation on 11/19/24 at 8:30 A.M. showed the resident's hair was trimmed short. During an interview on 11/25/24 at 9:35 A.M., the resident's family member said the following: -The resident always kept his/her hair trimmed very short. The resident took pride in his/her appearance before he/she was admitted to the facility; -The resident's hair had grown out very long and was wavy and curly. The family member paid for a beautician to come to the facility to give the resident a haircut; -The facility currently didn't have a beautician.	{F 557}			

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{F 557}	Continued From page 3 3. Review of Resident #2's Care Plan, revised 4/17/24, showed the following: -The resident was dependent on staff to help with his/her ADL tasks related to decreased mobility and tremors. Staff to anticipate his/her needs. -Allow the resident to make decisions independently. Assist with gathering facts and information if necessary. Invite the resident to make routine daily decisions, and give the resident plenty of time to make decisions. Review of the resident's quarterly MDS, dated 9/25/24, showed the following: -Diagnoses included aphasia (a disorder that affects how you communicate), seizure disorder and depression. -Cognitively intact; -The resident was usually able express ideas and wants; -The resident had clear comprehension and understood others; -The resident required substantial to maximal assistance with personal hygiene. During an interview on 11/21/24 at 1:45 P.M. the resident said he/she did not like his/her hair long as it made him/her feel "embarrassed and messy". During an interview on 11/21/24 at 1:50 P.M. the resident's family member said he/she paid a beautician to cut the resident's hair recently, as it was too long. The resident liked his/her hair neat and trimmed shorter. The resident would not have worn his/her hair long like it was prior to the hair cut. Observation on 11/26/24 at approximately 12:30 P.M. showed the resident sat in his/her Geri chair	{F 557}			

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{F 557}	Continued From page 4 (large padded wheelchair that usually reclines) in the dining room. The resident's hair was approximately shoulder length. 4. Review of Resident #7's Care Plan, dated 8/29/24, showed the following: -Diagnoses included dementia, major depressive disorder and anxiety; -The resident liked his/her hair shampooed on shower days, unless he/she had been to the beauty shop. Encourage the resident to brush his/her hair, hand the resident a brush; -The resident needed assistance of one staff with personal hygiene. Review of the resident's quarterly MDS, dated 10/14/24, showed the following: -Severe cognitive impairment; -The resident was able to express ideas and wants; -The resident had clear speech was understood and understood others; -The resident required substantial to maximal assistance with personal hygiene. Observation on 11/19/24 at 9:00 A.M., showed the resident sat in his/her Geri chair in the dining room. The resident's hair hung down close to the resident's chin level and was over the resident's eyes. During an interview on 11/21/24 at 3:00 P.M., the resident said he/she needed a haircut, his/her hair was always in his/her face. The resident always kept his/her hair neat and trimmed short. He/She felt messy with long hair. Observation on 11/26/24 at 9:00 A.M., showed the resident sat in his/her Geri chair in the dining	{F 557}			

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{F 557}	Continued From page 5 room. The resident's hair hung down close to the resident's chin and was over the resident's eyes. 5. During an interview on 11/21/24 at 3:45 P.M., Certified Nurse Assistant (CNA) I said the following: -He/She had some experience with cutting hair; -He/She volunteered to cut some of the resident's hair on his/her weekends off. Many of the resident's had requested a haircut; -He/She wasn't able to keep up with the residents haircuts and work full time; -Resident #7 had requested his/her hair be cut several times. The resident's hair often hung in his/her face. The resident normally liked it short; -The facility had a beautician, but he/she quit months ago. During an interview on 11/26/24 at 2:15 P.M., the DON said the following: -He/She expected the residents to have their hair trimmed to their liking or preference; -It was a dignity issue if a resident's hair was left long, if their preference was for it to be kept trimmed short; -The facility's beautician/professional hairstylist quit a few months ago; -The facility had an aide who had some experience with hair cuts. He/She trimmed some of the resident's hair on the weekends when he/she was not working the floor. During an interview on 11/26/24 at 11:02 A.M., the Administrator said the following: -The facility had an aide who cut hair at the facility on weekends; -He would expect the resident's to have haircuts to their liking or preference.	{F 557}			

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{F 557}	Continued From page 6 MO244120	{F 557}			
{F 677} SS=E	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to provide three residents (Resident #7, #8 and #2), of nine sampled residents, with assistance with activities of daily living (ADL) when staff failed to check for incontinence. The facility failed to ensure Resident #7's hair was groomed and pulled back out of the resident's face during meals and throughout the day. The facility also failed to ensure Resident #2 received routine showers. The facility census was 51. Review of the facility's Activities of Daily Living (ADL), Supporting policy, dated March 2018, showed appropriate care and services will be provided for residents who are unable to carry out ADLs independently, with the consent of the resident and in accordance with the plan of care, including appropriate support and assistance with hygiene (dressing, bathing and grooming) and toileting. 1. Review of Resident #7's care plan, dated 8/29/24, showed the following: -Diagnoses included dementia, major depressive disorder and anxiety; -The resident required substantial assistance with personal hygiene, the resident wore incontinence	{F 677}			

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NAME OF PROVIDER OR SUPPLIER KIRKSVILLE MANOR CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1705 EAST LAHARPE KIRKSVILLE, MO 63501		
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{F 677}	Continued From page 7 briefs day and night; -Check the resident during each routine rounds and as needed, dependent with changing incontinence briefs and with changing clothes; -The resident needed one assist with grooming. Review of the resident's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument, dated 10/14/24 showed the following: -Severe cognitive impairment; -Always incontinent of bowel and bladder; -Dependent with toilet hygiene; -The resident required substantial to maximal assistance with personal hygiene. Observation on 11/19/24 at 8:15 A.M., showed the resident sat in his/her geri chair (large padded wheelchair that usually reclines) in the dining room eating breakfast. The resident's hair hung down close to the resident's chin level and covered the resident's eyes, food was present in the resident's hair. Observation on 11/19/24 at 9:45 A.M., showed the resident sat in his/her geri chair in his/her room. There was a foul strong odor of urine in the resident's room. Observation on 11/19/24 at 10:45 A.M., showed the following: -Certified Nurse Aide (CNA) N and CNA H transferred the resident to bed; -A strong odor of urine permeated the room; -CNA N and CNA H removed the resident's incontinence brief. The resident's brief was saturated with urine and the resident's skin was red where the brief was located with imprints of the brief in the resident's skin.	{F 677}			

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{F 677}	Continued From page 8 During an interview on 11/19/24 at 10:55 A.M. CNA H said the following: -Staff assisted the resident out of bed at approximately 7:45 A.M. that morning; -Staff tried to check and change residents that were incontinent every two hours, but it usually was three hours or more before staff changed many of the incontinent residents; -The facility was short staffed and there was so many mechanical lifts it was hard to get it all done in a timely manner. During an interview on 11/21/24 at 3:00 P.M., the resident said he/she needed a haircut, his/her hair was always in his/her face. He/She felt messy with long hair. 2. Review of Resident #8's quarterly MDS, dated 9/4/24, showed the following: -Severe cognitive impairment; -Dependent on staff for toilet hygiene; -Always incontinent of bladder and bowel. Review of the resident's Care Plan, updated 9/5/24, showed the following: -Always incontinent of bladder and bowel due to history of stroke; -Assist with perineal cleansing as needed, check on routine rounds and as needed (PRN): -Keep skin clean and dry, perform peri care after each incontinence episode. Observation on 11/19/24 at 8:15 A.M., showed the resident sat in a geri chair in the dining room eating breakfast. Observation on 11/19/24 at 9:15 A.M. showed the resident in his/her and sitting in a geri chair.	{F 677}			

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{F 677}	Continued From page 9 During an interview on 11/19/24 at 9:15 A.M., the resident said he/she was wet and needed to be changed. There was an odor of urine and feces noted in the resident's room. Observation on 11/19/24 at 10:00 A.M., showed the resident remained in his/her room in a geri chair. An odor of urine and feces persisted in the room. Observation on 11/19/24 at 10:30 A.M., showed the following: -CNA J and CNA K entered the resident's room and transferred the resident to bed with a mechanical lift; -CNA J and CNA K removed the resident's incontinence brief. The incontinence brief was saturated with urine and soiled with feces. The resident's skin was red where it touched the brief with imprints from the incontinence brief on the resident's skin. During an interview on 11/19/24 at 10:40 A.M. CNA J and CNA K said the following: -Staff assisted the resident out of bed at 7:30 A.M. that morning; -The resident had not been checked for incontinence or changed since 7:30 A.M. -The resident was always wet with urine and soiled with feces when they changed him/her; - It was difficult to get residents changed in a timely manner because of the high level of care needed for each resident, multiple mechanical lift transfers, and not enough staff to provide care. 3. Review of Resident #2's care plan, revised 4/17/24, showed the following: -The resident was dependent on staff to help with his/her ADL tasks related to decreased mobility	{F 677}			

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{F 677}	Continued From page 10 and tremors. Staff to anticipate needs; -Assist the resident with using the bed pan during routine rounds, as needed (PRN) and per the resident's request. -Check during routine rounds of care for episodes of incontinence of bowel and bladder. Review of the resident's quarterly MDS, dated 9/25/24, showed the following: -Diagnoses included aphasia (a disorder that affects communication), seizure disorder and depression. -Cognitively intact; -Always incontinent of bowel and bladder; -Dependent on staff for toilet hygiene and with showering. Review of the facility's shower schedule showed the resident was to receive a shower on Monday and Thursday of each week. Review of the facility shower sheets showed staff did not provide the resident a shower on 11/18/24. Observation on 11/19/24 at 11:00 A.M., showed the following: -The resident lay in bed, his/her hair was oily and dirty. CNA J and CNA K entered the resident's room and said they were going to check to see if the resident was dry and get the resident up for the day; -CNA J and CNA K removed the resident's incontinence brief. The brief was saturated with urine and the resident's skin was red where it was in contact with the brief. There were imprints from the incontinence brief in the skin. During an interview on 11/19/24 11:10 A.M., CNA	{F 677}			

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{F 677}	Continued From page 11 J and CNA K said they checked the resident around 6:45 A.M. for incontinence and the resident was dry at that time, the resident had not been checked for incontinence since. During an interview on 11/19/24 at 1:30 P.M. the resident's family member said the following: -The resident didn't always receive routine showers; -His/Her hair was oily and dirty because the resident didn't receive his/her scheduled shower yesterday; -The facility was short staffed at times, and things got missed. 4. During an interview on 11/26/24 at 2:15 P.M., the Director of Nursing (DON) said the following: -She would expect all incontinent residents be checked for incontinence every two hours and changed if wet or soiled at that time, three to four hours was too long a period for incontinence checks; -She would expect each resident to have at least two showers a week; -She was not aware any showers had been missed. During an interview on 11/26/24 at 11:02 A.M., the Administrator said the following: -He would expect incontinent residents be checked for incontinence every two hours or as needed to assure they were clean and dry; -He would expect showers be provided two to three times a week depending on the resident's preference; -He was unaware of any missed showers. MO243356	{F 677}			

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F 684 F 684 SS=J	Continued From page 12 Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to provide care and treatment following a fall with injury for one resident (Resident #9) with a personal history of a stroke and who was on Xarelto (anticoagulant or blood thinning medication) of nine sampled residents. The resident complained of right sided rib pain at the time of the fall and continued to complain of pain 9 out of 10 (on a scale from 0 to 10 with ten being the worst pain) to the right side. Approximately 2-1/2 hours after the resident was found, the resident's family member arrived at the facility to check on the resident and requested the resident be re-evaluated by staff due to the resident's severe pain, along with shortness of breath. Approximately 10-3/4 hours after the resident was found, the resident continued to complain of pain of 7 out of 10. Staff described the resident as very tearful and in a lot of pain when repositioned, and the physician was not notified. On 10/22/24, the resident's physician gave orders to send the resident to the emergency room (ER) for evaluation, nonemergent, due to a high blood potassium level. In the emergency department the resident was found to have a large right sided	F 684 F 684			

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F 684	Continued From page 13 hemothorax (when a collection of blood accumulates in the chest cavity, often caused by trauma or injury, symptoms can include difficulty breathing and pain) with multiple displaced rib fractures and a right scapular fracture (a rare injury that occurs when the shoulder blade is directly or indirectly impacted by a significant amount of force such as a fall or blow to the shoulder). At the time of the fall, the on-call physician, who was not the resident's primary care physician, was notified that the resident had "slipped" from the wheelchair and there was no injury and the notification was facility procedure. The physician was not notified the resident was in pain after the fall and continued to have pain throughout the night, the use of an anticoagulant medication, the resident's shortness of breath or that the fall was unwitnessed. The facility census was 51. The administrator was notified on 11/21/24 at 12:30 P.M.. of the Immediate Jeopardy (IJ) which began on 10/21/24. The IJ was removed on 11/21/24, per onsite verification. Review of the facility's policy, Acute Condition Changes, dated March 2018, showed the following: -The physician will help identify individuals with a significant risk for having acute changes of condition during their stay; -The nurse shall assess and document/report baseline information to include current level of pain and recent changes in pain level, onset, duration and the severity, all active diagnoses, and current medications; -Direct care staff, including nursing assistants will be trained in recognizing subtle but significant changes in the resident and how to communicate	F 684			

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F 684	Continued From page 14 these changes to the nurse; -Before contacting a physician about someone with an acute change of condition, the nursing staff will collect pertinent details to report to the physician; for example, the history of present illness. Phone calls should be made by an adequately prepared nurse who has collected and organized pertinent information, including the resident's current symptoms and status. Review of the facility's policy, Pain Assessment and Management, dated March 2022, showed the following: -The purpose of this procedure is to help the staff identify pain in the resident and to develop interventions that are consistent with the resident's goals and needs and that address the underlying causes of pain; -The pain management program is based on a facility-wide commitment to appropriate assessment and treatment of pain, based on professional standards of practice, the comprehensive care plan and the resident's choice related to pain management; -Pain management is a multidisciplinary care process that includes assessing the potential for pain, recognizing the presence of pain, addressing the underlying causes of the pain; -Report to the physician significant changes in the resident's level of pain. 1. Review of Resident #9's care plan dated 10/17/24 showed the following: -The resident required assistance of two staff for bed mobility, for pulling up in bed, repositioning in bed, dressing, toileting, and transfers (Date initiated, 10/17/24); -The resident will attempt to do things without assistance, staff to anticipate needs during	F 684			

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F 684	Continued From page 15 routine rounds, as needed and per request (Date initiated, 10/17/24); -The resident was up in the wheelchair, leaned forward, and fell to the floor. Experienced right rib pain. Interventions for staff to continue to educate about not leaning forward in wheelchair, keep call light within reach at all times. (Date initiated, 10/21/24 and revised on 11/6/24). Review of the resident's admission Minimum Data Set (MDS), a federally mandated assessment instrument, dated 10/21/24, showed the following: -Moderate cognitive impairment; -The resident had pain occasionally and received as needed (PRN) pain medications; -Pain rarely affected sleep; -Pain occasionally affected day to day activities; -No range of motion impairment to upper extremities; -Range of motion impairment in both lower extremities; -Wheelchair used for mobility; -Substantial to maximum assistance required from a staff member to move from sitting to lying position, and for chair/bed to chair transfer; -The resident had one fall since admission with no evidence of injury. Review of the resident's physician order sheet (POS) dated October 2024 showed the following: -Diagnoses included acquired absence of left leg above knee, acquired absence of right leg above the knee, malignant neoplasm of the frontal lobe (a cancerous tumor in the frontal lobe of the brain), muscle wasting and atrophy (decrease in muscle mass and strength) and diabetes; -An order for Xarelto 20 milligram (mg) daily.	F 684			

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F 684	Continued From page 16 Review of the resident's Nursing Note dated 10/21/24 at 5:25 P.M. showed the following: -Registered Nurse (RN) A was called to the resident's room by Certified Nurse Assistant (CNA) E. The resident was found lying on the floor on his/her back in front of his/her wheelchair. The resident said he/she was up in his/her wheelchair, leaned forward and fell out of the wheelchair. This fall was not witnessed; -The resident complained of right-side rib pain, but no apparent injury was noted. Staff transferred the resident from the floor to the wheelchair with the assist of two staff members and a mechanical lift. Staff assisted the resident to the dining room. Neurology checks (quick assessment that evaluates the health of someone's nervous system through a series of tests) started, and vital signs (measurements of the body's basic function including temperature, pulse rate, respiration rate and blood pressure) obtained; -On call physician notified of the fall at 5:40 P.M. and no new orders received. Family notified of the fall. Review of the resident's Medication Administration Record (MAR), dated 10/21/24 at 8:30 P.M., showed the resident complained of pain in his/her right rib area and rated it a "9" on a scale from 0 to 10 with ten being the worst pain. Staff administered Tramadol (medication used to treat moderate to severe pain) 50 mg and the medication was noted as effective. Review of the resident's Nursing Note, dated 10/21/24 at 9:17 P.M., showed the resident was tearful and said he/she wanted to go home at times. The resident complained of right sided rib pain. Upon palpation resident was tender to touch	F 684			

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F 684	Continued From page 17 on the right side and 3 to 4 inches below the axilla (armpit). There was no documentation of the physician being notified. Review of the resident's Nursing Note, dated 10/22/24 at 4:12 A.M., showed the resident complained of pain in his/her right side and rated it a "7" on a 0 to 10 scale with ten being the worst. Staff administered two Tylenol Extra Strength 500 mg tablets (analgesic used to treat mild to moderate pain) and it was noted to be effective. Review of the resident's MAR, dated 10/22/24 at 7:12 A.M., showed the resident complained of right-side rib pain and rated it a "6" on a scale from 0 to 10. Staff administered Tramadol 50 mg one tablet for right sided rib pain, and it was ineffective. No further treatment for pain was initiated when the Tramadol did not effectively relieve the pain. Review of the resident's Nursing Note, dated 10/22/24 at 8:21 A.M., completed by Licensed Practical Nurse (LPN) C, showed the on-call physician's office called and gave an order to send the resident to the emergency department for evaluation due to a critical potassium level and to send the resident nonemergent. Notified the resident's family member of the order. At that time the family member voiced concerns about the fall from the night before and said the resident was still in a lot of pain. LPN C was unaware of the fall. The family member reported the resident was complaining of arm, shoulder, side, and back pain. The resident rated his/her pain a "10". Message sent to the physician to see if he/she wanted any x-rays while at the hospital. After receiving an order from the physician on	F 684			

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F 684	Continued From page 18 10/22/24 at 8:21 A.M. to send the resident to the hospital, Emergency Medical Services (EMS) was contacted to transport the resident. Review of the resident's Nursing Note dated 10/22/24 at 9:15 A.M., showed staff spoke with the ER nurse regarding the fall and complaint of pain, along with high potassium level. The ER nurse said they were in the process of doing x-rays for the resident. Review of the resident's Hospital Discharge Summary, dated 10/25/24 at 1:30 P.M., showed the following: -The resident presented through the emergency room department with complaints related to a fall out of his/her wheelchair. The resident was found to have a large right sided traumatic hemothorax with multiple displaced rib fractures and a right scapula fracture. Evacuation hemothorax was achieved through tube thoracotomy (a surgical procedure that involves making an incision in the chest wall and inserting a tube to drain fluid or air from the pleural space); -It was easy to identify that this injury pattern would be quite disruptive to the resident's quality of life and there would be a long road to any meaningful recovery if meaningful recovery was achievable. Aggressive pain control measures were taken; -The resident will discharge back to the facility with hospice arrangements. During an interview on 11/19/24 at 3:00 P.M., Certified Nurse Assistant (CNA) E said the following: -He/She found the resident on the floor on his/her back. The resident had fallen out of his/her wheelchair and CNA E notified RN A.	F 684			

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F 684	Continued From page 19 During an interview on 11/21/24 at 5:15 P.M., CNA F said the following: -On 10/21/24 he/she worked 11:00 P.M. to 7:00 A.M.; -He/She was notified of the resident having a fall in report; -At 4:00 A.M., the resident was tearful and complained of right rib pain. The resident had a lot of pain when staff turned him/her, it was not normal for the resident to have rib pain. CNA F reported that to the charge nurse. During an interview on 11/19/24 at 12:50 P.M., RN A said the following: -On the evening of 10/21/24, CNA E found the resident on the floor. The resident complained of right sided rib pain after the fall. He/She touched the resident's side and the resident had discomfort; -He/She notified the physician on call (not the resident's primary physician) the resident had a fall and had some rib soreness. He/She did not receive any orders. He/She did not communicate to the physician the resident was on a blood thinning medication; -The resident had increased pain at bedtime, but RN A didn't feel it required urgent care or the physician being notified. If the resident had a rib fracture nothing really could be done for it; -RN A scheduled a mobile x-ray for the following day. During an interview on 11/20/24 at 7:54 A.M., LPN C said the following: -He/She worked the 7:00 A.M. to 3:00 P.M. shift on 10/22/24; -He/She received no information during shift change report regarding the resident or a fall from	F 684			

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F 684	Continued From page 20 the staff on the previous shift; -The resident's family member reported the morning of 10/22/24 the resident was crying out in pain and hurt all over since the fall; -The resident had been sent out for a critical potassium level. LPN C called the hospital and requested the resident have x-rays due to pain from the fall. During an interview on 11/20/24 at 5:30 P.M., the resident's family member said the following: -On the evening of 10/21/24, RN A called him/her and said the resident fell out of his/her wheelchair onto the floor. RN A said he/she had checked the resident over and didn't have any concerns; -On 10/21/24 approximately 8:00 P.M., the resident's family member arrived at the facility to check on the resident. The resident complained of right sided rib pain and had concerns his/her ribs were broken. He/She questioned RN A about the resident's increased pain. RN A said he/she would schedule a mobile x-Ray for the next day; - On 10/22/2024 when the resident's family member arrived at the facility, the resident was crying out in pain, hurting all over and having some difficulty breathing. The family member reported the pain to LPN C and LPN C was not aware the resident had fallen the evening before; -The resident was diagnosed with multiple rib fractures and a right shoulder fracture. He/she felt the resident should have been evaluated in the emergency room the night of the fall. The resident was in a lot of pain throughout the night; -Due to the extent of the injuries after the fall, the resident elected to go on hospice and return to the facility with no surgical intervention. During an interview on 11/19/24 at 2:15 P.M., the Director of Nursing (DON) said the following:	F 684			

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F 684	Continued From page 21 -She would expect any resident who sustained a fall and was on a blood thinning medication be sent out for evaluation due to a risk of bleeding; -She would expect all staff to notify the administrative staff member on call of a resident fall. RN A did not notify the administrative staff on call of the fall; -RN A did not provide the physician on call with enough information regarding the resident and the fall or make the physician aware the resident was on blood thinning medication; -The post fall assessment was not thorough and there was no evidence the night charge nurse evaluated the resident following the fall for any increased pain or change in status; -The resident had increased pain and should have been sent out for evaluation at the time of the fall. During an interview on 11/26/24 at 11:02 A.M., the Administrator said the following: -He would expect staff to follow the facility policy regarding a change in condition and pain assessment; -He would expect staff to assess a resident for pain following a fall and relay any concerns or an increase in pain to the physician. During an interview on 11/20/24 at 11:10 A.M., the Physician Q (on call physician) said the following: -He was the physician on call on 10/21/24, but had not seen or evaluated the resident in the past; -He was notified the resident slipped from the wheelchair and it was procedure to notify the physician on call, but was told no injury had occurred; -The nurse described the resident as having some "tenderness", but nothing more;	F 684			

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F 684	Continued From page 22 -He would expect staff to notify him that the fall was unwitnessed, the resident was on a blood thinning medication or any continued or an increase in pain; -Communication played a role and if he had received all the details regarding the fall and the resident's history and use of a blood thinner, he would have sent the resident out for evaluation at the time of the fall. NOTE: At the time of the abbreviated survey, the violation was determined to be at the immediate jeopardy level "J". Based on observation, interview and record review completed during the onsite visit, it was determined the facility had implemented corrective action to remove the IJ violation at the time. A final revisit will be conducted to determine if the facility is in substantial compliance with participation requirements. At the time of exit, the severity of the deficiency was lowered to the "G" level. This statement does not denote that the facility has complied with State law (Section 198.026.1 RSMo.) requiring that prompt remedial action to be taken to address Class I violation(s). MO244074	F 684			
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §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	F 689			

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F 689	Continued From page 23 supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on interview and record, review the facility failed to develop a care plan with interventions to prevent falls for one resident (Resident #9) of nine sampled residents, who was at risk for falls and was admitted to the facility after having falls at home. The resident sustained a fall while at the facility on 10/21/22. Staff failed to complete a thorough post fall assessment or notify the Director of Nursing (DON), as directed by facility policy, at the time of the fall. The facility failed to communicate the resident's fall to the oncoming shift at shift change. The facility failed to communicate pertinent information regarding the fall to the on-call physician, who was not familiar with the resident which delayed evaluation and treatment. As a result of the fall, the resident sustained a large right sided hemothorax (when a collection of blood accumulates in the chest cavity, often caused by trauma or injury, symptoms can include difficulty breathing and pain) with multiple displaced rib fractures (broken ribs where the pieces of bone have moved so that a gap has formed around the fracture, complications can include punctured lungs and damage to other organs) and a right scapular fracture (a rare injury that occurs when the shoulder blade is directly or indirectly impacted by a significant amount of force such as a fall or blow to the shoulder). The facility census was 51. Review of the facility's policy titled, Care Plans-Baseline, December 2016 showed the following: -A baseline plan of care to meet the resident's immediate needs shall be developed for each	F 689			

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F 689	Continued From page 24 resident within forty-eight (48) hours of admission; -The baseline care plan will be used until the staff can conduct the comprehensive assessment and develop an interdisciplinary person-centered care plan; -The interdisciplinary team will review the healthcare practitioner's orders (e.g., dietary needs, medications, routine treatments, etc.) and implement a baseline care plan to meet the resident's immediate care needs including, but limited to initial goals based on admission orders, physician orders, dietary orders, therapy services and social services. Review of the facility's policy titled, Assessing Falls and Their Causes, dated March 2018, showed the following: -The purposes of this procedure was to provide guidelines for assessing a resident after a fall and to assist staff in identifying causes of the fall; -Review the resident's care plan to assess for any special needs of the resident, identify current medications and active medical conditions; -Falls are the leading cause of morbidity and mortality among the elderly in nursing homes, falling maybe related to underlying clinical or medical conditions, overall functional decline, medication side effects or environmental risk factors; -If a resident has just fallen, or is found in the floor without a witness to the event, evaluate for possible injuries to the head, neck, spine, and extremities; -If an assessment rules out significant injury or condition change, notify the practitioner routinely by fax, or phone the next day; -Observe for delayed complications of a fall for approximately 48 hours after an observed or	F 689			

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F 689	Continued From page 25 suspected fall, and document findings in the medical record; -Document any observed signs or symptoms of pain, swelling, bruising or deformity, and/or decreased mobility, and any changes in level of responsiveness/consciousness or overall function. Note the presence or absence of significant findings; -After an observed or probable fall, clarify details of the fall, such as when fall occurred and what the individual was trying to do at the time if the fall; -Distinguish falls as rolling, sliding, or dropping from bed or chair to floor; -Within 24 hours of the fall, begin to try to identify the likely cause of the incident; -When a resident falls, record in the medical record the condition in which the resident was found, assessment data, including vital signs and any obvious injuries. Interventions or treatment administered, notification to the physician and family, as indicated, completion of falls risk assessment, appropriate interventions to prevent future falls; -Report to the attending physician (timing of notification may vary, depending on whether injury was involved), the DON and the nursing supervisor on duty 1. Review of Resident #9's Nursing Note, dated 10/14/24 at 9:13 P.M., showed the following: -The resident was admitted from the hospital emergency room; -The resident transfers with assist of two staff and slides from wheelchair to bed and has bilateral amputation of lower extremities. History of falls which was the reason the resident was in the emergency room today.	F 689			

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F 689	Continued From page 26 Review of the resident's Care Plan, dated 10/17/24, showed the following: Diagnoses included acquired absence of left leg above knee, acquired absence of right leg above the knee, malignant neoplasm of the frontal lobe (a cancerous tumor in the frontal lobe of the brain), muscle wasting and atrophy (decrease in muscle mass and strength) and diabetes; -The resident required assist of two for bed mobility, for pulling up in bed, repositioning in bed, dressing, toileting, and transfers (Date initiated, 10/17/24); -The resident will attempt to do things without assistance, staff to anticipate my needs during routine rounds, as needed and per request (Date initiated, 10/17/24) -The care plan did not address the resident's risk for falls or include interventions to prevent falls. Review of the resident's Fall Risk Evaluation, dated 10/20/24, showed the following: -Upon admission and quarterly, at a minimum, thereafter, observe the resident status in the 11 clinical condition parameters listed below by assigning the corresponding score which best describes the resident. If the total score is 10 or greater, the resident should be considered at HIGH RISK for potential falls. Prevention protocol should be initiated immediately and documented on the care plan; -Staff documented the resident had no falls in the past three months, was bedbound/continent, had a change of condition in the last 14 days, had a recent hospitalization, took one to two medications that increased the likelihood for falls, and had multiple predisposing diseases that increased the likelihood for falls; -The resident's score was 17 showing the resident was at high risk for falls, the section of	F 689			

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F 689	Continued From page 27 the evaluation "Risk for Falls" including options for interventions, was not completed by staff. Review of the resident's admission Minimum Data Set (MDS), a federally mandated assessment instrument, dated 10/21/24, showed the following: -Moderate cognitive impairment; -The resident had pain occasionally and received as needed (PRN) pain medications; -Pain rarely affected sleep; -Pain occasionally affected day to day activities; -No range of motion impairment to upper extremities; -Range of motion impairment in lower extremities; -Wheelchair used for mobility; -Substantial to maximum assistance required from a staff member to move from sitting to lying position, rolling left to right, and for chair/bed to chair transfer; -The resident had one fall since admission with no evidence of injury. Review of the resident's Occupational Therapy Evaluation, dated 10/17/24, showed the following: -The resident will increase sitting balance during Activities of Living (ADL) to fair and using righting reactions 75% of the time to reduce the risk of falls, facilitate upright posture and increase participation with functional tasks; -Sitting during meals percentage baseline was less than 25% and was poor (sits unsupported with minimal assist and unable to weight shift). Review of the resident's Nursing Note, dated 10/21/24 at 5:25 P.M., showed the following: -Registered Nurse (RN) A was called to the resident's room by Certified Nurse Assistant (CNA) E. The resident was found on the floor on	F 689			

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F 689	Continued From page 28 his/her back in front of his/her wheelchair. The resident said he/she was up in his/her wheelchair, leaned forward and fell out of the wheelchair; -The resident complained of right-side rib pain, but no apparent injury was noted. Staff transferred the resident from the floor to the wheelchair with the assist of two staff members and a mechanical lift. The resident was assisted to the dining room; -Staff notified the call physician at 5:40 P.M. and no new orders were received. Review of the resident's Unwitnessed Fall Report dated 10/21/24 at 6:07 P.M., showed the following: -RN A was called to the resident's room, the resident was on the floor on his/her back in front of the wheelchair. The resident said he/she leaned forward in the wheelchair and fell out; -The resident was assisted to the wheelchair by two staff members and use of a mechanical lift and brought to the dining room. No apparent injury noted. The resident complained of right-sided rib tenderness; -Level of pain was a "5" on a 0 to 10 scale with 10 being the worse; -The section for environmental factors and situational factors was not completed; -Predisposing factors: weakness/fainted and trunk control and balance issue. Review of the resident's medical record showed staff did not document on 10/21/24 (11:00 P.M. to 7:00 A.M.) that the 11-7 shift charge nurse assessed the resident post fall for any delayed complications, pain or injury. Review of the resident's hospital Discharge Summary, dated 10/25/24 at 1:30 P.M., showed	F 689			

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F 689	Continued From page 29 the following: -The resident presented through the emergency room department with complaints related to a fall out of his/her wheelchair. The resident was found to have a large right sided traumatic hemothorax with multiple displaced rib fractures and a right scapula fracture. Evacuation hemothorax was achieved through tube thoracostomy. -It was easy to identify that this injury pattern would be quite disruptive to the resident's quality of life and there would a long road to any meaningful recovery if meaningful recovery was achievable. Aggressive pain control measures were taken. -The resident will discharge back to the facility with hospice arrangements. Review of the resident's care plan, revised 11/6/24, showed fall on 10/21/24, right rib pain. Up in wheelchair and leaned forward and fell to floor. Interventions for staff to continue to educate about not leaning forward in wheelchair. During an interview on 11/20/24 at 5:30 P.M., the resident's family member said the following: -The resident was admitted directly to the facility from the emergency room after a fall at home. The resident had fallen multiple times at home trying to transfer; -On the evening of 10/21/24, RN A called him/her and said the resident fell out of his/her wheelchair onto the floor. RN A said he/she had checked the resident over and didn't have any concerns; -On 10/21/24 approximately 8:00 P.M. the family member arrived at the facility to check on the resident. The resident complained of right sided rib pain and had concerns his/her ribs were broken. He/She questioned RN A about the resident's increased pain. RN A said he/she	F 689			

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F 689	Continued From page 30 would schedule a mobile x-ray for the next day; -The following day (10/22/24) when the family member arrived at the facility the resident was crying out in pain, hurting all over and having some difficulty breathing. The family member reported the pain to Licensed Practical Nurse (LPN) C and he/she was not aware the resident had fallen the evening before; -The resident ended up with multiple rib fractures and a right shoulder fracture. He/she felt the resident should have been evaluated in the emergency room the night of the fall. The resident was in a lot of pain throughout the night; -Due to the extent of the injuries after the fall, the resident elected to go on hospice and return to the facility with no surgical intervention. During an interview on 11/19/24 at 3:00 P.M., CNA E said the following: -He/She was not aware the resident had a history of falls. He/She didn't know of any fall interventions that were in place to prevent falls for the resident; -He/She found the resident on the floor on his/her back. The resident fell out of his/her wheelchair and CNA E notified RN A. During an interview on 11/20/24 at 1:36 P.M., CNA P said the following: -The resident was typically in bed, the resident was so weak he/she wasn't sure the resident could hold himself/herself up if in the wheelchair for very long. CNA P was afraid to even leave the resident in the wheelchair while he/she changed the bed linens on shower day; -CNA P made a comment to one of the charges nurse that he/she was concerned with leaving the resident in his/her wheelchair unsupervised because the resident was so weak;	F 689			

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F 689	Continued From page 31 -CNA P wasn't sure if the resident had a history of falls. During an interview on 11/20/24 at 7:54 A.M., LPN C said the following: -He/She was not aware the resident had a fall in the past or prior to admission. He/She could not recall any fall prevention interventions that were in place for the resident prior to his/her fall on 10/21/24; -He/She worked the 7:00 A.M. to 3:00 P.M. shift on 10/22/24; -The off-going nurse provided no information at shift change to LPN C regarding the resident or a fall. If any resident had a recent fall, he/she evaluated the resident at the start of his/her shift to assure there was no post fall concerns. This was not done as LPN C was not aware of the resident's fall; -The resident's family member reported that morning the resident was crying out in pain and hurt all over since the fall; -The resident had been sent out for a critical potassium level, LPN C called the hospital and requested the resident have x-rays due to pain from the fall. During an interview on 11/20/24 at 9:00 A.M., LPN B said on 10/21/24 he/she worked the 11:00 P.M. to 7:00 A.M. shift. LPN B did not recall if the resident had a fall prior to his/her shift. He/She could not recall if the resident had any pain throughout his/her shift. During an interview on 11/20/24 at 10:00 A.M. with Physical Therapy Assistant (PTA) O said the following: -The resident was very weak and required a mechanical lift for transfers;	F 689			

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F 689	Continued From page 32 -The resident's core strength was very poor. The resident was often slumped over in bed and required assistance to sit up in bed due to his/her weakness; -The resident was not safe to sit in his/her wheelchair unsupervised due being visibly weaker prior to the fall. PTA O thought the nursing staff were aware of this, but was not sure if it was communicated to them. During an interview on 11/19/24 at 2:15 P.M., the DON said the following: -The resident was admitted to the facility from the emergency room following a fall at home. A fall care plan and interventions should have been put in place upon admission; -She would expect the Fall Risk Evaluation be completed accurately. The fall incident report should be thorough and attempt to find the root cause of the fall; -She was not aware that therapy staff had concerns with the resident being up in the wheelchair unsupervised. That information was not relayed to her, she would expect for therapy to relay that information to the nursing staff; -The facility also had a weekly meeting with therapy to discuss the residents and any concerns or recommendations; -She would expect staff to report any falls to the oncoming shift at change of shift and documentation of the resident's status following the fall; -She would expect all staff notify the administrative staff member on call of a resident fall. RN A didn't notify the administrative staff on call of the fall; -The post fall assessment was not thorough and there was no evidence the night charge nurse evaluated the resident following the fall for any	F 689			

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F 689	Continued From page 33 increased pain or changes in status; -The resident had an increase of pain and should have been sent out for evaluation at the time of the fall; -She would expect for the baseline care plan be completed at admission by the admitting nurse. During an interview on 11/26/24 at 11:02 A.M. the Administrator said the following: -He would expect staff to follow the facility policy regarding falls; -He would expect staff to assess a resident for pain following a fall and relay any concerns or an increase in pain to the physician. During an interview on 11/20/24 at 11:10 A.M. the Physician Q (on call physician on) said the following: -He was the physician on call on 10/21/24, but had not seen or evaluated the resident in the past; -He was notified the resident slipped from the wheelchair and it was procedure to notify the physician on call, but was told no injury had occurred; -The nurse described the resident as having some "tenderness", but nothing more.	F 689			
F 725 SS=E	MO244074 Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial	F 725			

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F 725	Continued From page 34 well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.71. §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to provide sufficient nursing staff to meet residents' needs for five sampled residents (Resident #7, #8, #2, #6, and #1). The facility failed to have adequate staffing to check and provide incontinence care to residents in a timely manner, to provide routine showers to ensure good personal hygiene, to answer call lights in a timely manner and to assist residents out of bed for meals, and ensure all residents were served meals. The facility census was 51. Review of the facility policy titled, Staffing, dated October 2017, showed the following: -Our facility provides sufficient numbers of staff with skill and competency necessary to provide	F 725			

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F 725	Continued From page 35 care and services for all residents in accordance with the resident's care plan and the facility assessment; -Licensed nurses and certified nursing assistants are available 24 hours a day to provide direct resident care services; -Staffing numbers and the skill requirements of direct care staff are determined by the needs of the residents based on each resident's plan of care. Review of the Facility Assessment Tool, updated on 8/1/24, showed the following: -The persons involved in completing the assessment included the Administrator, Director of Nursing (DON) and Governing Body with the corporation; -The Quality Assurance Team and Quality Assurance Performance Committee reviewed the assessment on 10/16/24; -Assistance with toileting showed 47 residents out of 50 were independent; -Assistance with transfers showed 31 residents required assist of 1-2 staff and 13 were dependent on staff; -Licensed Practical Nurses (LPN) providing direct care showed 6-10 daily; -Nurse Aides 13-20 daily. Review of the facility's list of residents who required a two person transfer or mechanical lift transfer dated, 11/19/24, showed a total of 27 residents. 1. Review of Resident #7's Care Plan, dated 8/29/24, showed the following: -Diagnoses included dementia, major depressive disorder and anxiety; -The resident required substantial assistance with	F 725			

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F 725	Continued From page 36 personal hygiene, the resident wore incontinence briefs day and night; -Check the resident during each routine rounds and as needed, dependent with changing incontinence briefs and with changing clothes; -The resident needed assistance of one staff with grooming. Review of the resident's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument, dated 10/14/24 showed the following: -Severe cognitive impairment; -Always incontinent of bowel and bladder; -Dependent with toilet hygiene; -The resident required substantial to maximal assistance with personal hygiene. Observation on 11/19/24 at 9:45 A.M., showed the resident sat in his/her geri chair (large padded wheelchair that usually reclines) in his/her room. There was a strong, foul odor of urine in the resident's room. Observation on 11/19/24 at 10:45 A.M., showed the following: -Certified Nurse Aide (CNA) N and CNA H transferred the resident to bed; -A strong odor of urine permeated the room; -CNA N and CNA H removed the resident's incontinence brief. The resident's brief was saturated with urine and the resident's skin was red where the brief was located with imprints of the brief in the resident's skin. During an interview on 11/19/24 at 10:55 A.M., CNA H said the following: -Staff assisted the resident out of bed at approximately 7:45 A.M. that morning; -Staff tried to check and change residents that	F 725			

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F 725	Continued From page 37 were incontinent every two hours, but it was usually three hours or more before staff changed many of the incontinent residents; -The facility was short staffed and there was so many mechanical lifts it was hard to get it all done in a timely manner. 2. Review of Resident #8's quarterly MDS, dated 9/4/24, showed the following: -Severe cognitive impairment; -Dependent on staff for toilet hygiene; -Always incontinent of bladder and bowel. Review of the resident's Care Plan, updated 9/5/24, showed the following: -Always incontinent of bladder and bowel due to history of stroke; -Assist with perineal cleansing as needed, check on routine rounds and as needed (PRN): -Keep skin clean and dry, perform peri care after each incontinence episode. Observation on 11/19/24 at 8:15 A.M., showed the resident sat in a geri chair in the dining room eating breakfast. Observation on 11/19/24 at 9:15 A.M., showed the resident in his/her room, sitting in a geri chair. During an interview on 11/19/24 at 9:15 A.M., the resident said he/she was wet with urine and needed to be changed. There was a strong odor of urine and feces noted in the resident's room. Observation on 11/19/24 at 10:00 A.M., showed the resident remained in his/her room in a geri chair. An odor of urine and feces persisted in the room.	F 725			

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F 725	Continued From page 38 Observation on 11/19/24 at 10:30 A.M., showed the following: -CNA J and CNA K entered the resident's room and transferred the resident to bed with a mechanical lift; -CNA J and CNA K removed the resident's incontinence brief. The incontinence brief was saturated with urine and soiled with feces. The resident's skin was red where it touched the brief with imprints from the incontinence brief on the resident's skin. During an interview on 11/19/24 at 10:40 A.M., CNA J and CNA K said the following: -Staff assisted the resident out of bed at 7:30 A.M. that morning; -Staff had not checked he resident for incontinence or changed the resident since 7:30 A.M. -The resident was always wet with urine and soiled with feces by the time staff were able to change him/her; -It was difficult to get residents changed in a timely manner because of the high level of care needed for each resident, multiple mechanical lift transfers, and not enough staff to provide care. 3. Review of Resident #2's Care Plan, revised 4/17/24, showed the following: -The resident was dependent on staff to help with his/her activities of daily living (ADL) tasks related to decreased mobility and tremors. Staff to anticipate needs; -Assist the resident with using the bed pan during routine rounds, as needed (PRN) and per the resident's request. -Check during routine rounds for episodes of incontinence of bowel and bladder.	F 725			

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F 725	Continued From page 39 Review of the resident's quarterly MDS, dated 9/25/24, showed the following: -Diagnoses included aphasia (a disorder that affects communication), seizure disorder and and depression. -Cognitively intact; -Always incontinent of bowel and bladder; -Dependent on staff for toilet hygiene and with showering. Review of the facility's shower schedule showed the resident was to receive a shower on Monday and Thursday of each week. Review of the facility shower sheets showed staff did not provide the resident a shower on 11/18/24. Observation on 11/19/24 at 11:00 A.M., showed the following: -The resident lay in bed, his/her hair was oily and appeared dirty. CNA J and CNA K entered the resident's room and said they were going to check to see if the resident was dry and get the resident up for the day; -CNA J and CNA K removed the resident's incontinence brief. The brief was saturated with urine and the resident's skin was red where it was in contact with the brief. There were imprints from the incontinence brief in the resident's skin. During an interview on 11/19/24 11:10 A.M., CNA J and CNA K said they checked the resident around 6:45 A.M. for incontinence and the resident was dry at that time. Staff had not checked the resident for incontinence from 6:45 A.M. until 11:00 A.M.. The facility was short staffed and they could not get all care provided to residents in a timely manner.	F 725			

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F 725	Continued From page 40 During an interview on 11/19/24 at 1:30 P.M., the resident's family member said the following: -The resident didn't always receive routine showers; -The resident's hair was oily and dirty because the resident didn't receive his/her scheduled shower on 11/18/24; -The facility was short staffed at and resident care got missed. 4. Review of Resident #6's admission Baseline Care Plan, dated 10/30/24, showed the following: -Diagnoses included displaced intertrochanteric fracture of the left femur (a break in the thigh bone which is displaced), history of falling, muscle weakness, need for assistance with personal care, muscle weakness, pain, diabetes and unsteadiness on feet; -Independent with eating once the meal was placed in front of the resident; -Partial to moderate assistance needed with toileting, bathing, to roll from left to right, lying to sitting on the side of the bed; -Substantial to moderate assistance with dressing lower body, putting on and taking off footwear and personal hygiene. Review of the resident's comprehensive admission Care Plan, dated 11/1/24, showed the following: -The resident was a fall risk, evaluate fall risk at admission. -The Care Plan did not address staff assistance required for ADLs or any other care areas. Review of the resident's admission MDS, dated 11/6/24, showed the following: -Cognitively intact;	F 725			

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F 725	Continued From page 41 -Understood and understands others; -Limited range of motion impairment to the lower extremity on one side; -Used a walker and wheelchair for mobility; -Independent with eating once setup help provided; -Independent with toilet hygiene; -Required substantial to maximum assistance from staff with toilet transfers and walking 10 feet; -Occasionally incontinent of bowel and bladder. During an interview on 11/19/24 at 1:00 P.M., the resident said the following: -The resident had only been at the facility for a few weeks; -There was not enough staff to care for him/her or the other residents; -He/She often waited two hours for his/her call light to be answered, as a result he/she was incontinent of urine waiting for someone to assist him/her, this upset the resident; -He/she had missed being served a meal four or five times; -He/She asked staff to walk him/her over three hours ago and staff said they didn't have time, not enough staff; -He/She was going back home tomorrow because he/she was not receiving care like he/she should at facility because of the lack of staff. 5. Review of Resident #1's Care Plan, revised 9/4/24, showed the following: -Coping was impaired, provide assistance with activities of daily living (ADLs) as needed, include resident in determining next steps in care; -Required assistance of two staff with all transfers and use of mechanical lift.	F 725			

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F 725	Continued From page 42 Review of the resident quarterly MDS, dated 9/5/24, showed the following: -Diagnoses included multiple sclerosis, anxiety, and depression; -Cognitively intact; -The resident had the ability to express ideas and wants; -The resident was understood and had clear comprehension to understand others; -The resident required supervision or touching assistance with personal hygiene; -Dependent with toileting; -Dependent with chair/bed to chair transfer; -Frequently incontinent of bowel and bladder. During an interview on 11/19/24, Resident #1 said the following: -At times there was not enough staff to get him/her out of bed. He/She had to remain in bed all day; -Sometimes he/she had to wait long periods for a bedpan and would become incontinent waiting for staff at assist and this upset him/her. During an interview on 11/19/24 at 10:40 A.M., CNA J said it was difficult for staff to get residents changed in a timely manner because of the high level of care needed for each resident, multiple residents required mechanical lifts for transfers which required two staff members and there was not enough staff to provide the care residents required. During an interview on 11/19/24 at 10:55 A.M., CNA H said the following: -Staff tried to check and change residents that were incontinent every two hours, but it usually was three hours or more before staff could check and change many of the incontinent residents	F 725			

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F 725	Continued From page 43 due to not having enough staff; -The facility was short staffed and there were so many residents who required the mechanical lift for transfers it was very hard to get it all done in a timely manner. During an interview on 11/19/24 at 3:00 P.M., CNA E said the following: -Several residents didn't get up for supper because there was not enough staff to get them out of bed. The facility had almost 30 residents who required a mechanical lift for transfers, there wasn't enough staff available to get all of the residents up for meals and back to bed in a timely manner; -Staff did not get incontinent residents didn't get changed in a timely manner and many resident showers weren't completed because of being short staffed. During an interview on 11/20/24 at 12:00 P.M., CNA G said the following: -Residents who were incontinent went long periods without being checked or changed because of being short staffed; -The residents refused to get out of bed sometimes because they didn't want to stay up for a long period because there was not enough staff available to get them back to bed; -Staff did not provide residents with oral care, or wash residents' faces and hands routinely and did not get room trays passed timely because of being short staffed; -Staff had gone to the Administrator and Director of Nursing (DON) multiple times about not having enough staff to meet the needs of the residents, but nothing changed. During an interview on 11/26/24 at 1:15 P.M.,	F 725			

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F 725	Continued From page 44 CNA I said the following: -The facility was short staffed and residents were not getting the care they needed; -Staff were unable to get residents checked and changed every two hours, the residents also went long periods without being repositioned because of being short staffed; -Staff were unable to pass ice water to residents, complete oral care or wash the residents' hands and faces in the morning because of being short staffed; -Staff also missed completing resident showers and residents had to wait long periods for assistance because of being short staffed. During an interview on 11/19/24 at 12:45 P.M. Licensed Practical Nurse (LPN) M said the following: -The facility didn't have enough staff to meet the needs of the residents; -The facility had almost 30 residents who were a mechanical lift transfer, this required two staff members for each transfer and was very time consuming; -Residents weren't repositioned, checked for incontinence and changed in a timely manner, showers were missed, water and snacks didn't get passed as a result of being short staffed. During an interview on 11/20/24 at 7:54 A.M., LPN C showed the following: -The facility was short staffed and as a result room trays were missed getting passed; some residents remained in bed for meals because staff didn't have time to get them up; -Some residents chose not to get up for meals because they would have to sit up for a long period, waiting for assistance back to bed; -Staff couldn't care for the residents properly with	F 725			

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F 725	Continued From page 45 the number of staff they have, only the basics are done; -Residents don't receive oral care, hair doesn't get brushed, and showers are often missed During an interview on 11/19/24 at 2:35 P.M., Certified Medication Technician (CMT) L said the following: -The facility had almost 30 residents who required the mechanical lift for transfers, this required two staff members, because of this many other things didn't get done because there was not enough staff available; -The residents complained about waiting long periods for staff to assist with getting out of bed and back to bed in a timely manner because of being short staffed. Staff could not complete showers like they were supposed to because of being short staffed. During an interview on 11/20/24 at 12:30 P.M., the Administrator said the following: -He was new as an administrator, and this was the first time he had completed the facility assessment; -He was not familiar with the form/process; -He completed the assessment with assistance from the Corporate Administrator. He did not know the assessment required involvement by the Quality Assurance Team or other disciplines; -For Assistance with Activities of Daily Living (ADL), he documented there were 47 residents independent with toileting. That was completed incorrectly; -The facility currently had 27 residents who required transfer with mechanical lifts, who would be dependent with transfers. He did not feel the number he documented was correct, he documented 13 and thought it should be much	F 725			

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F 725	Continued From page 46 higher. During interviews on 11/20/24 at 12:15 P.M. and 11/26/24 at 2:15 P.M., the DON said following: -The facility had enough staff to meet the needs of each resident; -Nursing staff didn't work efficiently and manage their time well; -She did not feel the facility was short staffed; -The facility had enough staff to transfer 27 residents who were a mechanical lift; Staff needed to be prepared and have all the supplies needed prior to the transfer and work efficiently, but she felt it could be done; -The facility did not have 47 residents who were independent with toileting and there were more residents dependent with transfers then what the facility assessment indicated; -She thought the issue with residents not being served a meal tray was an issue with meal cards, she thought this had been addressed with the new dietary manager. During interviews on 11/20/24 at 12:15 P.M. and 11/26/24 at 11:02 A.M., the Administrator said the following: -He did not feel the facility was short staffed, the issue was nursing staff not working efficiently; -The facility had enough staff to transfer 27 residents who were a mechanical lift; -The facility had plenty of staff to meet the needs of the resident.	F 725			
F 838 SS=E	MO244120, MO745734 Facility Assessment CFR(s): 483.71(a)(1)(3)(b)(1)(c)(1)-(5) §483.71 Facility assessment.	F 838			

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F 838	Continued From page 47 The facility must conduct and document a facility-wide assessment to determine what resources are necessary to care for its residents competently during both day-to-day operations (including nights and weekends) and emergencies. The facility must review and update that assessment, as necessary, and at least annually. The facility must also review and update this assessment whenever there is, or the facility plans for, any change that would require a substantial modification to any part of this assessment. §483.71(a) The facility assessment must address or include the following: §483.71(a)(1) The facility's resident population, including, but not limited to: (i) Both the number of residents and the facility's resident capacity; (ii) The care required by the resident population, using evidence-based, data-driven "methods" that considering the types of diseases, conditions, physical and behavioral health needs, cognitive disabilities, overall acuity, and other pertinent facts that are present within that population, consistent with and informed by individual resident assessments as required under § 483.20; (iii) The staff competencies and skill sets that are necessary to provide the level and types of care needed for the resident population; (iv) The physical environment, equipment, services, and other physical plant considerations that are necessary to care for this population; and (v) Any ethnic, cultural, or religious factors that may potentially affect the care provided by the facility, including, but not limited to, activities and food and nutrition services.	F 838			

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F 838	Continued From page 48 §483.71(a)(2) The facility's resources, including but not limited to the following: (i) All buildings and/or other physical structures and vehicles; (ii) Equipment (medical and non- medical); (iii) Services provided, such as physical therapy, pharmacy, behavioral health, and specific rehabilitation therapies; (iv) All personnel, including managers, nursing and other direct care staff (both employees and those who provide services under contract), and volunteers, as well as their education and/or training and any competencies related to resident care; (v) Contracts, memorandums of understanding, or other agreements with third parties to provide services or equipment to the facility during both normal operations and emergencies; and (vi) Health information technology resources, such as systems for electronically managing patient records and electronically sharing information with other organizations. §483.71(a)(3) A facility-based and community-based risk assessment, utilizing an all-hazards approach as required in §483.73(a) (1). § 483.71(b) In conducting the facility assessment, the facility must ensure: § 483.71(b)(1) Active involvement of the following participants in the process: (i) Nursing home leadership and management, including but not limited to, a member of the governing body, the medical director, an administrator, and the director of nursing; and (ii) Direct care staff, including but not limited to,	F 838			

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F 838	Continued From page 49 RNs, LPNs/LVNs, NAs, and representatives of the direct care staff, if applicable. (iii) The facility must also solicit and consider input received from residents, resident representatives, and family members. §483.71(c) The facility must use this facility assessment to: §483.71(c)(1) Inform staffing decisions to ensure that there are a sufficient number of staff with the appropriate competencies and skill sets necessary to care for its residents' needs as identified through resident assessments and plans of care as required in § 483.35(a)(3). §483.71(c)(2) Consider specific staffing needs for each resident unit in the facility and adjust as necessary based on changes to its resident population. §483.71(c)(3) Consider specific staffing needs for each shift, such as day, evening, night, and adjust as necessary based on any changes to its resident population. §483.71(c)(4) Develop and maintain a plan to maximize recruitment and retention of direct care staff. §483.71(c)(5) Inform contingency planning for events that do not require activation of the facility's emergency plan, but do have the potential to affect resident care, such as, but not limited to, the availability of direct care nurse staffing or other resources needed for resident care. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility	F 838			

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F 838	Continued From page 50 failed to review and update the facility wide assessment to determine what resources were necessary to care for residents competently during their day to day operations and emergencies as required. The facility census was 51. Review of the facility policy titled, Facility Assessment, dated October 2018, showed the following: -A facility assessment is conducted annually to determine and update capacity to meet the needs of and competently care for our residents during day-to-day operations. Determining our capacity to meet the needs of and care for our residents during emergencies is included in this assessment; -The team responsible for conducting and reviewing and updating the facility-wide assessment includes the administrator, a representative of the governing body, the medical director, the director of nursing (DON), the infection preventionist and also the director from environmental services, physical operations, dietary services physical operations, dietary services, social services, activity services and rehabilitative services; -The facility assessment includes a detailed review of the resident population, which includes need for assistance with activities of daily living (ADL); -The facility assessment is reviewed and updated annually and as needed. 1. Review of the Facility Assessment Tool, updated on 8/1/24, showed the following: -The persons involved in completing the assessment included the Administrator, Director of Nursing (DON) and Governing Body with the	F 838			

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F 838	Continued From page 51 corporation; -The Quality Assurance Team and Quality Assurance Performance Committee reviewed the assessment on 10/16/24; -Assistance with toileting showed 47 residents out of 50 were independent; -Assistance with transfers showed 31 residents required assist of 1-2 staff and 13 were dependent. During an interview on 11/20/24 at 12:15 P.M., the DON said she did not have any involvement with completing the facility assessment. The facility did not have 47 residents who were independent with toileting and more residents were dependent with transfers then what the facility assessment indicated. During an interview on 11/20/24 at 12:30 P.M., the Administrator said the following: -He was new as an administrator, and this was the first time he had completed the facility assessment; -He was not familiar with the form/process; -He completed the assessment with assistance from the Corporate Administrator. He did not know the assessment required involvement by the Quality Assurance Team or other disciplines; -For Assistance with Activities of Daily Living (ADL), he documented there were 47 residents independent with toileting. That was completed incorrectly; -The facility currently had 27 residents who required transfer with mechanical lifts, who would be dependent with transfers. He did not feel the number he documented was correct, he documented 13 and thought it should be much higher.	F 838			

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F 880	Continued From page 52	F 880			
F 880	Infection Prevention & Control	F 880			
SS=E	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 reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections;				

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F 880	Continued From page 53 (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 and interview, the facility failed to ensure proper signage on the entrance of the building, notifying visitors of Coronavirus Disease 2019 (COVID-19) outbreak in the building and failed to post transmission based precaution signage outside of one COVID-19 positive room for (Resident #5) in nine sampled residents. The facility census was 51.	F 880			

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F 880	Continued From page 54 Review of the facility policy titled, COVID-19 Prevention, Response and Reporting, dated 5/29/24, showed the following: -It is the policy of this facility to ensure that appropriate interventions are implemented to prevent the spread of COVID-19 and promptly respond to any suspected or confirmed COVID-19 infections; -The Infection Preventionist will assess facility risk associated with COVID-19 through surveillance activities of COVID-19 infection in the community and illness present in the facility; -Threat detected-the facility will respond promptly and implement emergency and/or outbreak procedures; -The facility will establish a process to identify and manage individuals with suspected or confirmed -SARS-CoV-2 infection ensuring everyone is aware of the recommended infection prevention and control (IPC) practices in the facility by posting visual alerts (signs, posters) at the entrance and in strategic places to include instructions about current IPC recommendations. Review of the Centers for Disease Control and Prevention's Infection Control Guidance for SARS-CoV-2 (Severe Acute Respiratory Syndrome, virus that causes COVID-19)/COVID-19 infections revised 6/24/24 showed the following: -This guidance applies to all U.S. settings where healthcare is delivered, including nursing homes. The recommendations in this guidance continue to apply after the expiration of the federal COVID-19 Public Health Emergency; -Establish a Process to Identify and Manage Individuals with Suspected or Confirmed SARS-CoV-2 Infection; -Ensure everyone is aware of recommended IPC	F 880			

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F 880	Continued From page 55 practices in the facility. Post visual alerts (e.g., signs, posters) at the entrance and in strategic places (e.g., waiting areas, elevators, cafeterias). These alerts should include instructions about current IPC recommendations (e.g., when to use source control and perform hand hygiene). Dating these alerts can help ensure people know that they reflect current recommendations. -Establish a process to make everyone entering the facility aware of recommended actions to prevent transmission to others if they have any of the following three criteria: -A positive viral test for SARS-CoV-2; -Symptoms of COVID-19, or close contact with someone with SARS-CoV-2 infection (for patients and visitors) or a higher-risk exposure (for healthcare personnel (HCP). 1. Observation on 11/26/24 at 7:45 A.M., showed there was no signage on the front entrance of the building stating there was a COVID-19 positive resident in the building. Review of Resident #5's Facesheet, undated showed the following: -Admission: 11/20/24; -Diagnoses included fracture (break) of the right femur (thigh bone). Review of the resident's nursing note dated 11/24/24 at 8:12 A.M., showed Rapid COVID test positive for COVID. Review of the resident's nursing note dated 11/24/24 at 8:15 A.M., showed the resident was placed in isolation for COVID precautions. Observation on 11/26/24 at 8:00 A.M., showed the following:	F 880			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265247	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R-C 11/26/2024
NAME OF PROVIDER OR SUPPLIER KIRKSVILLE MANOR CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1705 EAST LAHARPE KIRKSVILLE, MO 63501		
(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 56 -There was a three-drawer cart sitting outside of the resident's room with gloves, gowns, N95 masks, surgical masks, and shoe covers; -There was no signage posted on the resident's door or wall by his/her door stating what precautions to take before entering his/her room; -There was no sign posted to alert staff or visitors to check with the nurse before entering the room. During an interview on 11/26/24 at 8:45 A.M., Licensed Practical Nurse (LPN) C said the following: -He/She found out yesterday the resident tested positive for COVID-19 on 11/24/24; -The resident had wheezes (high pitched, musical sound that occurs when air passes through narrowed or blocked airways in the lungs) in his/her lungs and a cough. During an interview on 11/26/24 at 8:55 A.M., the Infection Control Nurse said the following: -He/She received information through a text that the resident tested positive for COVID-19 over the weekend (11/23/24 or 11/24/24), he/she thought the resident was symptomatic, but wasn't sure; -He/She had been working the floor and didn't get signage posted at the entrance alerting visitors that there was COVID in the building or signage on the resident's door alerting visitors to check with the nurses before entering the room. During an interview on 11/26/24 at 2:15 P.M., the Director of Nursing said the following: -She worked on 11/24/24, the resident showed symptoms of COVID-19 and had a cough. She completed a rapid response COVID-19 test on the resident and it indicated the resident was positive;	F 880			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 880	Continued From page 57 -She would expect the facility to post signage alerting staff and visitors of a COVID-19 outbreak in the facility at the entrance of the facility; -She did alert all staff working that the resident tested positive; -She would expect the facility to post signage notifying staff and visitors of precautions required upon entering a COVID-19 positive room. During an interview on 11/26/24 at 1:00 P.M., the Administrator said he would expect the facility to follow their policy regarding COVID-19.	F 880			

Missouri Department of Health and Senior Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 04161	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R-C 11/26/2024
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NAME OF PROVIDER OR SUPPLIER KIRKSVILLE MANOR CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1705 EAST LAHARPE KIRKSVILLE, MO 63501
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A4046	19 CSR 30-85.042(37) Nursing Staff Sufficient/Qualified All facilities shall employ nursing personnel in sufficient numbers and with sufficient qualifications to provide nursing and related services which enable each resident to attain or maintain the highest practicable level of physical, mental and psychosocial well-being. Each facility shall have a licensed nurse in charge who is responsible for evaluating the needs of the residents on a daily and continuous basis to ensure there are sufficient, trained staff present to meet those needs. I/II This regulation is not met as evidenced by: Class II Refer to F725.	A4046		
{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: This deficiency is uncorrected. For previous examples, please see the Statement of Deficiencies dated 10/4/24. 1. Class I* Refer to F684. *Higher classification merited due to the violation's effect on the resident. NOTE: At the time of the complaint investigation,	{A4075}		

Missouri Department of Health and Senior Services
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE



TITLE


(X6) DATE

12/20/24

Missouri Department of Health and Senior Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 04161	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R-C 11/26/2024
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{A4075}	Continued From page 1 the violation was determined to be at an imminent danger class I level. Based on observation, interview and record review completed during the onsite visit, it was determined the facility had implemented corrective action to address and lower the violation at the time. A final revisit will be conducted to determine if the facility is in substantial compliance with participation requirements. At the time of exit, the severity of the deficiency was lowered to the class II level. 2. Class II Refer to F677.	{A4075}			
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. I/II This regulation is not met as evidenced by: Class II Refer to F880.	A4086			
{A8030}	19 CSR 30-88.010(29) Dignity/Privacy Each resident shall be treated with consideration,	{A8030}			

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{A8030}	Continued From page 2 respect, and full recognition of his or her dignity and individuality, including privacy in treatment and care of his or her personal needs. All persons, other than the attending physician, the facility personnel necessary for any treatment or personal care, or the department or Department of Mental Health staff, as appropriate, shall be excluded from observing the resident during any time of examination, treatment, or care unless consent has been given by the resident. II/III This regulation is not met as evidenced by: This deficiency is uncorrected. For previous examples, please see the Statement of Deficiencies dated 10/4/24. Class II* Refer to F557. *The higher classification merited due to the extent of the violation.	{A8030}			

PLAN OF CORRECTION		
Provider/Supplier Name:	Kirksville Manor Care Center	
Street Address, City, Zip:	1705 E. LaHarpe Kirksville, MO 63501	
Date of Survey:	11-26-24	
PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER		265247
ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION: (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLETION DATE
F557	The facility failed to maintain resident dignity and self-determination for four residents (Resident #1, Resident #8, Resident #2, and Resident #7) when staff failed to provide grooming assistance, including basic haircuts. To address this, an outside beautician aide was hired for one day a week and immediate grooming assistance was provided by a Beautician Aide to the affected residents, their care plans were updated accordingly, and ads were placed in the local area for a licensed hairdresser. This Beautician Aide will provide services 1 day a week on a weekly basis until a licensed hairdresser has been hired. A facility-wide assessment will be conducted by the Social Service Designee to identify other residents at risk, ensuring all receive adequate grooming services and conduct resident interviews on preferences. Policies regarding resident grooming and personal care will be reviewed and updated to ensure compliance with CFR 483.10(e)(2), and all direct care staff will undergo mandatory training before 1/08/25 on the importance of maintaining resident dignity by ensuring residents' hair is combed and pulled out of their face, checking routinely for incontinence and ensuring showers are not missed. A check list will be reviewed weekly by the Activities Director and SSD to document grooming assistance, with compliance reviewed monthly by the Quality Assurance Committee. The grooming check list will be checked by the IDT team weekly for the first three months and monthly thereafter. Quarterly resident and family satisfaction surveys will be mailed to residents and resident families, focusing on personal care and grooming services.	1/08/2025

F677	Immediate actions taken for the residents found to have been affected include: Incontinence care has been provided to resident #7, #8, and #2. Resident #7's hair has been groomed. A shower has been given to resident #2. Identification of other residents having the potential to be affected was accomplished by: All residents have the potential to be affected as all residents have care plans. Actions taken/systems put into place to reduce the risk of future occurrence include: Policies regarding ADL assistance have been reviewed and/or updated to ensure compliance with CFR 483.24(a)(2). All clinical staff will be educated on appropriate ADL care to be provided to residents to include incontinence care, hair grooming, and showers on 1/3/25 by the corporate nurse. How the corrective actions will be monitored to ensure the practice will not recur: The Director of Nursing and/or designee will complete walking rounds 5 times a week for 4 weeks then weekly for 3 months, and then monthly thereafter to ensure residents have received the necessary services to include incontinence care, hair grooming, and showers. All deficiencies will be corrected immediately. The Director of Nursing and/or designee will review shower schedule daily for 4 weeks then weekly for 1 month to ensure showers are being completed and/or refuses documented. All deficiencies will be corrected immediately. Audit findings will be discussed by the QA committee monthly and monitoring will be adjusted as determined by the QA committee. The QA committee will review this plan of correction until such time consistent substantial compliance has been met as determined by the QA committee.	1/08/2025
F684	The facility failed to provide appropriate care and treatment following a fall with injury for Resident #9. Medical evaluations and treatment were provided, and the resident was transported to the emergency room. The DON or designee (s) will complete a pain assessment on all residents to identify any unmet pain needs/change in pain. The residents' physicians will be updated with the results of the pain assessment if indicated. The DON or designee(s) will complete an assessment on all residents with falls in the last week to assess for any change in condition/pain. The residents' physicians will be updated with the results of the assessment if indicated. The documentation will be updated to include the incident and follow-up care. A facility-wide	1/08/2025

	assessment will be conducted by the DON, or designee to identify other residents at risk, ensuring care plans are up to date with clear protocols for handling falls. Policies regarding incident reporting and response will be reviewed and updated to ensure compliance with CFR 483.25. All licensed staff will undergo mandatory training on 1/03/25 on the importance of timely and appropriate care following incidents by the DON or designee. The DON or designee will re-educate all licensed nurses, CMT's, and all direct care staff on appropriate pain management, change of condition and high-risk medications ie: anticoagulants with falls. Education will include review of facility policy and procedure surrounding pain/ pain management, follow up to pain intervention, and notification to physicians of ineffective pain intervention. A check list will aid in documentation and review of incidents and care provided, with compliance reviewed monthly by the Quality Assurance Committee. An audit completed by the DON or designee will check the handling of incidents weekly at an IDT meeting for the first three months and monthly thereafter. Quarterly resident and family satisfaction surveys will be mailed to residents and families focusing on the quality of care and incident response.	
F689	The facility failed to develop a care plan with interventions to prevent falls for Resident #9, who was at risk for falls and sustained a significant injury following a fall at the facility. Immediate corrective actions included conducting a thorough post-fall assessment, notifying the Director of Nursing (DON), and communicating the resident's fall and condition to the on-call physician and incoming shift. A facility-wide assessment conducted by the MDS Coordinator or designee with oversight by DON will identify other residents at risk, ensuring all have appropriate fall prevention plans. Policies regarding fall prevention, incident reporting, and response will be reviewed and updated to ensure compliance with CFR 483.25(d)(1)(2). MDS Coordinator will train on the importance of baseline care plans and fall prevention. All nursing staff will undergo mandatory training on the importance of fall prevention, all licensed staff will undergo proper incident reporting by using the SBAR form and proper follow up. An audit by the DON or designee will document and review incidents and fall prevention measures 2 times a week for 1 month, with compliance being reviewed monthly by the Quality Assurance	1/08/2025

	Committee. The check list tool will be developed by the DON or designee to check the handling of falls and preventative measures and discussed at IDT meetings weekly for the first three months and monthly thereafter. Quarterly resident and family satisfaction surveys will be mailed to residents and resident families focusing on safety and fall prevention measures.	
F725	The facility failed to provide sufficient nursing staff to meet residents' needs, including incontinence care, routine showers, timely response to call lights, and assistance with meals. Immediate measures taken by administration staff will help ensure sufficient nursing staff to meet residents' needs and provide necessary care and assistance to the affected residents. Onsite education with an emergency meeting held by the Administrator and DON with all staff by assuring each person in the building assist with answering call lights that they walk by with the possibility of freeing time for the direct care staff to provide care to dependent residents. The facility has assessed the safety and ability of each resident's transfer, to promote the highest level of independence during transfers. Policies regarding staffing levels and responsibilities will be reviewed and updated to ensure compliance with CFR 483.35(a)(1)(2). Strategies will be implemented to recruit and retain sufficient nursing staff, including competitive pay, benefits, and professional development opportunities. To ensure compliance, the Director of Nursing and/or designee will review the staffing schedule daily to ensure there is adequate staff to meet the acuity level of care within the facility. The facility is advertising, hiring for positions as applicants apply for and working with an agency to try and fill positions for additional staff as the need arises. All staff will undergo mandatory training on the importance of meeting resident needs in a timely and compassionate manner. Audits will be completed by DON or designee to review care provided, by using resident interviews and placement cards with compliance reviewed weekly for 3 weeks during IDT meetings then monthly by Quality Assurance. Quarterly resident and family satisfaction surveys will be mailed to residents and resident families focusing on the sufficiency the care provided to them. Ongoing residents will be assessed and reviewed based on their quarterly MDS schedule and as needed with significant changes.	1/08/2025

F838	The facility failed to review and update the facility-wide assessment to determine necessary resources for resident care. A comprehensive review and update of the facility-wide assessment were conducted by the Corporate Administrator, Administrator, Corporate Nurses, DON, Therapy, and MDS coordinator, documenting the updated assessment to reflect current resources and resident needs completed by 1/08/2025. The facility-wide assessment will identify other residents at risk, ensuring all residents' needs are met through adequate resource allocation and planning. Policies regarding the facility-wide assessment will be reviewed and updated to ensure compliance with CFR 483.71(a)(1)(3)(b)(1)(c)(1)-(5). All administrative staff including the DON, Admissions Nurse, Staffing Coordinator, Wound Nurse, MDS Coordinator, RA department and Social Services will undergo mandatory training on the importance of conducting and updating the facility-wide assessment. An audit will be conducted by MDS coordinator with oversight by Administrator or designee using the Census and Conditions Report in PCC form will ensure the facility-wide assessment is updated timely and accurately for nursing care, with compliance reviewed monthly by the Quality Assurance Committee. The audit will be used to check the accuracy and completeness of the assessment quarterly by the IDT team. Quarterly resident and family satisfaction surveys will be mailed to residents and resident families focusing on the adequacy of facility resources and planning.	1/08/2025
F880	The facility failed to ensure proper signage on the entrance of the building and transmission-based precaution signage outside a COVID-19 positive room. Immediate placement of appropriate signage at the entrance and outside Resident #5's room was completed, with documentation of corrective actions taken. The Infection Control Nurse or designee will complete a facility-wide assessment will identify other residents at risk, ensuring all are protected through proper infection control measures. Policies regarding infection prevention and control will be reviewed and updated to ensure compliance with CFR 483.80(a)(1)(2)(4)(e)(f). An annual review and updates of the Infection Prevention and Control Program (IPCP) will be established. All Staff will undergo mandatory training on infection prevention and control, including signage protocols with a focus on if the infection preventionist is not in the building charge nurse is responsible for posting outbreak signage at the front entrance and "see Nurse" at	1/08/2025

	the resident's room. Infection Control Nurse or designee will do daily checks for any new infection control measures needed this will ensure compliance with infection control measures, with compliance reviewed monthly by the Quality Assurance Committee. Chart reviews, charge nurse follow up, by Infection Control Nurse or designee will check infection control measures weekly for the first three months and monthly thereafter. Quarterly resident and family satisfaction surveys will be conducted, focusing on infection control measures.	

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.

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A8030	See F557	1/08/2024
A4075	See F677 and F684	1/08/2024
A4046	See F725	1/08/2024
A4086	See F880	1/08/2024

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