STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265761	A. BUILDING _____ B. WING _____	C 06/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LINCOLN COMMUNITY CARE CENTER	205 TIMBERLINE DRIVE LINCOLN, MO 65338

(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 569 SS=E	Notice and Conveyance of Personal Funds CFR(s): 483.10(f)(10)(iv)(v) §483.10(f)(10)(iv) Notice of certain balances. The facility must notify each resident that receives Medicaid benefits- (A) When the amount in the resident's account reaches $200 less than the SSI resource limit for one person, specified in section 1611(a)(3)(B) of the Act; and (B) That, if the amount in the account, in addition to the value of the resident's other nonexempt resources, reaches the SSI resource limit for one person, the resident may lose eligibility for Medicaid or SSI. §483.10(f)(10)(v) Conveyance upon discharge, eviction, or death. Upon the discharge, eviction, or death of a resident with a personal fund deposited with the facility, the facility must convey within 30 days the resident's funds, and a final accounting of those funds, to the resident, or in the case of death, the individual or probate jurisdiction administering the resident's estate, in accordance with State law. This REQUIREMENT is not met as evidenced by: Based on record review and interview, facility staff failed to refund resident funds within 30 days of discharge for 17 residents (Resident # 255, #256, #257, #258, #259, #260, #260, #262, #263, #264, #265, #266, #267, #268, #269, #270, and #271) out of 41 sampled residents. The facility census was 55. 1. Review of the facility's refunds policy, undated, showed the policy did not contain direction for staff on resident refunds after discharge. 2. Review of the facility's aging report (report	F 569		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Jennifer Howard | TITLE: Administrator | (X6) DATE: 7-12-24

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 569	Continued From page 1 showing outstanding invoices and balances), dated 6/18/24, showed the following residents had money in the facility's operating account: -Resident #255 was discharged on 05/12/23: with a balance of $3,503.61; -Resident #256 was discharged on 09/22/21: with a balance of $3,658.59; -Resident #257 was discharged on 03/14/22: with a balance of $5,492.79; -Resident #258 was discharged on 10/12/21: with a balance of $4,727.14; -Resident #259 was discharged on 04/21/24: with a balance of $6,550.37; -Resident #260 was discharged on 01/25/22: with a balance of $3,283.09; -Resident #262 was discharged on 07/23/22: with a balance of $744.01; -Resident #263 was discharged on 12/05/23: with a balance of $6,309.85; -Resident #264 was discharged on 10/08/21: with a balance of $2,214.05; -Resident #265 was discharged on 06/25/23: with a balance of $15,619.10; -Resident #266 was discharged on 12/01/21: with a balance of $1,172.78; -Resident #267 was discharged on 06/18/21: with a balance of $4,465.88; -Resident #268 was discharged on 04/04/23: with a balance of $3,406.52; -Resident #269 was discharged on 04/18/24: with a balance of $10,614.34; -Resident #270 was discharged on 07/18/22: with a balance of $605.21; -Resident #271 was discharged on 02/01/23: with a balance of $7,714.63. During an interview on 6/19/24 at 3:20 P.M., the Business Office Manager (BOM) said the facility	F 569		

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F 569	Continued From page 2 aging report has not been balanced for a while. He/She said they have plans to get with an outside company to help with year end reports, but they have not done that yet. He/She said, "I don't know anything about aging reports." He/She said he/she did not get trained on resident credits and third-party liability credits. He/She said he/she does not know a time frame of when to contact Medicaid about credit balances. He/She said he/she has not contacted Medicaid about credit balances in residents accounts. During an interview on 6/20/24 at 12:54 P.M., the administrator said resident balances should be refunded within 30 days of discharge. She said Medicaid should be notified within three days of resident discharge or death and Medicaid should let facility know how to take care of the credit balance. The administrator said she was not aware there were balances in the account for discharged or deceased residents.	F 569		
F 657 SS=E	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff.	F 657		

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F 657	Continued From page 3 (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, facility staff failed to ensure care plans were reviewed and revised to include appropriate fall interventions for six (Resident #10,#12, #13, #19, #35, and #42) out of eight sampled resident's. Staff failed to ensure care plans reflected the use of side rails for one (Resident #42) out of eight sampled residents. The facility census was 55. 1. Review of the facility's Care Plans, Comprehensive Person-Centered, revised December 2016, showed: -Identifying problem areas and their causes, and developing interventions that are targeted and meaningful to the resident, are the endpoint of an interdisciplinary process; -Care plan interventions are chosen only after careful data gathering, proper sequencing of events, careful consideration of the relationship between the resident's problem areas and their	F 657		

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F 657	Continued From page 4	F 657		

causes, and relevant clinical decision making;
-When possible, interventions address the underlying sources(s) of the problem area(s), not just addressing only symptoms or triggers.

2. Review of Resident #10's Admission Minimum Data Set (MDS) a federally mandated assessment tool, dated 05/21/24, showed staff assessed the resident as:

-Moderate cognitive impairment;
-Supervision and touching assistance with sit to stand position;
-Used wheelchair.

Review of the resident's fall incident report, dated 05/23/24, showed the resident got tangled in bed sheet while trying to transfer and fell.

Review of the resident's care plan, dated 06/03/24, showed the plan did not contain documentation of the residents fall or fall interventions.

3. Review of Resident #12's Quarterly MDS, dated 04/16/24, showed staff assessed the resident as:

-Severe cognitive impairment;
-Supervision and touch assistance with sit to stand position.

Review of the resident's fall incident report, dated 03/16/24, showed staff documened they found the resident face forward, got a hematoma to head, a bloody nose, and a bruise on right side of face.

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F 657	Continued From page 5 Review of the resident's care plan, dated 02/27/24, showed the plan was not updated to contain documentation of the residents fall or fall interventions. 4. Review of Resident #13's Quarterly MDS, dated 04/25/24, showed staff assessed the resident as: -Moderate Cognitive impairment; -Upper and lower extremity impairment on both sides; -Dependent with transfers and positioning in bed. Review of the resident's fall incident report, dated 05/18/24, showed staff documented they found the resident on the floor. Review of the resident's care plan, dated 05/28/24, showed the plan did not contain documentation of the residents fall or fall interventions. 5. Review of Resident #19's Quarterly MDS, dated 05/15/24, showed staff assessed the resident as: -Moderate Cognitive impairment; -Upper and lower extremity impairment on one side; -Dependent with transfers and positioning in bed. Review of the resident's fall incident report, dated 03/03/24, showed staff documented the resident fell. Review of the resident's care plan, dated	F 657		

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F 657	Continued From page 6 04/18/24, showed the plan did not contain fall interventions. 6. Review of Resident #35's Quarterly MDS, dated 04/09/24, showed staff assessed the resident as: -Severe Cognitive impairment; -One fall with since last MDS. Review of the resident's fall incident report, dated 02/21/24, showed the resident slide out of his/her wheelchair and found on the floor. Review of the resident's fall incident report, dated 5/04/24 at 12:45 P.M., showed staff documented they found the resident on the floor on his/her right side. Review of the resident's fall incident report, 05/04/24 at 6:45 P.M., showed staff documented the resident found face down on the ground. Review of the resident's fall incident report, 06/16/24 at 5:55 P.M., showed staff documented they found the resident on the bathroom floor in front of the toilet. Review of the resident's care plan, dated 04/19/24, showed the plan did not contain documentation of the residents fall or fall interventions. 7. Review of Resident #42's Quarterly MDS, dated 03/06/24, showed staff assessed the resident as:	F 657		

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F 657	Continued From page 7 -Modified Cognitive impairment; -Setup assistance with transfers. Review of the resident's nurse's note, dated, 05/17/24 at 4:02 P.M., showed staff documented the resident found on floor beside bed. Review of the resident's care plan, dated 03/18/24, showed the plan did not contain documentation of the residents fall or fall interventions. 8. During an interview on 06/20/24 at 11:14 A.M., Registered Nurse (RN) A said care plans should be updated with interventions after falls. He/She said it is the responsibility of the nurses to initiate the initial interventions after a fall and then the Director of Nursing (DON)/MDS Coordinator updates the care plan. During an interview on 06/20/24 at 11:48 A.M., the DON/MDS coordinator said when a fall happens the charge nurse does a fall incident report at that time, and an intervention is put in at the same time. The DON said she double checks that it is appropriate and then it is added to the care plan. The DON said if there are falls not updated, it might be because she is behind or she was not notified about it. The DON said every fall should be documentation and have an updated intervention. During an interview on 06/20/24 at 12:50 A.M., the Administrator said falls should be updated and interventions added to the care plan within a 24-48 hour time frame. The administrator said she would expect the nurse be responsible for coming up with a intervention, then as a team we	F 657		

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F 657	Continued From page 8 go over to make sure it is acceptable, and it is then put on the care plan. 9. Review of Resident #42's Quarterly MDS, dated 03/06/24, showed staff assessed the resident as: -Modified Cognitive impairment; -Does not use bed rails; -Supervision or limited assist of one as needed with bed mobility and transfers; -Setup assistance from chair/bed-to-chair transfer. Review of the resident's care plan, dated 03/18/24, showed the plan did not contain documentation of the resident's bed rails. Review of the resident's bed rail assessment, dated 4/01/24, showed bed rails were not indicated for resident and the resident had not expressed a desire to have side rails. Observation on 06/17/24 at 11:45 A.M., showed the resident in bed with bilateral raised bedrails. Observation on 06/18/24 at 10:06 A.M., showed resident in bed with bilateral raised bedrails. Observation on 06/19/24 at 9:12 A.M., showed resident in bed with bilateral raised bedrails. During an interview on 06/20/24 at 11:14 A.M., RN A said if the resident has the bars on his/her bed he/she would expect them to be care planned. During in interview on 06/20/24 at 11:47 A.M., the	F 657		

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F 657	Continued From page 9 DON/MDS coordinator said anyone who had bedrails should have them care planned. He/She said it is his/her responsibility, as the MDS coordinator, to add it to the care plan. He/She was not aware they were not care planned. During an interview on 06/20/24 at 12:37 P.M., the administrator said it is the responsibility of the MDS coordinator to make sure anyone who has bed rails has them care planned. He/She is not sure why they are not care planned.	F 657		
F 658 SS=E	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, facility staff failed to maintain professional standards of practice when staff did not complete neurological assessments after unwitnessed falls for two residents (Resident #35, and #42) of 14 sampled residents. Staff failed to get physician orders to self-administer eye drops for two residents (Resident #33 and #39) of 14 sampled residents. The facility census was 55. 1. Review of the facility's policy titled, "Falls-Clinical Protocol," revised 09/12, showed the nurse shall assess and document/report the following: -Vital signs; -Neurological status;	F 658		

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F 658	Continued From page 10 -Falls should be identified at witnessed or unwitnessed events. Review of the nurse's "Fall Reports," showed the report directed staff neurological checks must be initiated if not witnessed. Review of the facility's "Neurological Evaluation Flow Sheet," showed staff are directed to: -Complete checks-Every 15 minutes for one hour, every 30 minutes for two hours, every one hour for two hours and every shift for 72 hours; -Glasgow coma scale (is a clinical scale used to reliably measure a person's level of consciousness after a brain injury) to include eyes open, best verbal response, best motor response, pupils, reflexes, movement and vital signs. 2. Review of Resident #35's Quarterly Minimum Data Set (MDS), a federally mandated assessment tool, dated 04/09/24, showed staff assessed the resident as: -Moderate cognitive impairment; -One fall with injury since last MDS; -Diagnosis of dementia. Review of the resident's nurse's note, dated, dated 02/21/24, showed staff documented the resident attempted to transfer from his/her wheelchair to his/her recliner and found between the wheelchair and recliner. Review of the resident's fall incident report, dated 02/21/24, showed the report did not contain neurological exams after the resident had an unwitnessed fall.	F 658		

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F 658	Continued From page 11 Review of nurse's note dated, 02/21/24 at 6:50 P.M., showed staff documented the resident found face down on the floor by a certified nurse aid (CNA), with his/her neck under the wheels of his/her roommate's wheelchair. The resident was sent out to the hospital at 7:15 P.M. His/Her x-rays were negative and the resident would be return with a family member, no documentation of resident's return date or time. Review of nurse's note dated, 05/04/24 at 12:56 P.M., showed staff documented the resident fell out of his/her wheelchair reaching for a brownie on the floor. Review of the resident's fall incident report, 05/04/24 at 12:45 P.M., showed staff did not document neurological exams were initiated after the resident had a fall witnessed by another resident. Review of the resident's fall incident report, 05/04/24 at 6:45 P.M., showed staff did not document neurological exams were initiated after the resident had an unwitnessed fall and was found face down on the ground with his/her head under an occupied wheelchair. Abrasion noted on left great toe and left forehead. Review of the resident's fall incident report, 06/16/24 at 5:55 P.M., showed the report did not contain documentation of neuro checks after the resident had an unwitnessed fall and found on the bathroom floor. Review of the resident's nurse's note, dated, 06/16/24 at 5:55 P.M., showed staff documented the resident was found on his/her bathroom floor	F 658		

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F 658	Continued From page 12 after attempting to self-transfer to the toilet. Review of resident's medical record, dated 06/20/24, showed staff did not document a fall assessment or neurological exams were initiated after the resident had an unwitnessed fall. 3. Review of Resident #42's Quarterly MDS, dated 03/06/24, showed staff assessed the resident as: -Modified Cognitive impairment; -Does not use bed rails; -Supervision or limited assist of one as needed with bed mobility and transfers; -Setup assistance from chair/bed-to-chair transfer. Review of nurse's note dated, 02/16/24 at 12:03 A.M., showed staff documented resident was found laying on the floor in front of refrigerator in room with abrasion to right elbow. Review of resident's fall assessment, dated 02/16/24, showed the record did not contain documentation neurological exams were initiated after the resident had a fall witnessed by another resident. Review of nurse's note dated, 05/17/24 at 4:02 P.M., showed staff documented the resident was found sitting on buttocks beside her bed. Review of resident's medical record, dated 06/20/24, showed staff did not document a fall assessment or neurological exams were initiated after the resident had an unwitnessed fall after he/she was found on floor beside bed.	F 658		

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F 658	Continued From page 13	F 658		

4. During an interview on 06/20/24 at 11:14 A.M., Registered Nurse (RN) A said if a resident has a fall, and it is not witnessed then the policy is to initiate neurological checks. He/She said there is a form they fill out with the exact timing, but he/she knows it says to check the resident every 15 min for an hour, every 30 minutes for an hour, and that the assessment is done for 72 hours. He/She said after every fall a fall report and nurse's note are completed by the nurse. He/She said he/she would not consider another resident as a witness. He/She said he/she would only consider a staff member or a family member as a reliable witness.

During an interview on 06/20/24 at 11:47 A.M., the Director of Nursing (DON) said if there is a fall, he/she expects the nurse to fill out a fall report in the electronic medical record. He/She said if the fall is unwitnessed or if the resident hit his/her head he/she expects the nurses to initiate neurological exams. He/She considers staff or an alert and oriented resident to be a reliable witness to a fall. He/She said not initiating neurological exams puts the residents at risk for a brain bleed and it could result in death. He/She said he/she is not sure of the exact time frames for the fall protocol on neurological exams but said there is a form with time frames that the nurses use. He/She was not aware staff were not initiating neurological exams on residents who had unwitnessed falls.

During an interview on 06/20/24 at 12:37 P.M., the Administrator said it is his/her expectation that when a resident falls that the nurse assesses for injury and initiates neuros for any unwitnessed falls or falls with head injury. He/She said there is a neurological evaluation sheet that the nurses

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use that has all the time frames and areas to assess. He/She said he/she would consider staff or an alert and oriented resident as a reliable source for a witness to a fall. He/She said staff should be documenting who the witness is on the nurse's fall report sheet in the electronic medical record. He/She said he/she was not aware staff were not completing neurological exams following unwitnessed falls or falls with head injuries and was not aware they were not documenting the name of the witness. He/She said it is important to perform neurological exams because injuries to the head could be potentially life threatening.

5. Review of the facility's policy titled, "Administering Medications," revised 12/12, showed the policy directed staff as follows:

-Only persons licensed or permitted by this state to prepare, administer, and document the administration of medications may do so;
-Medications must be administered in accordance with the orders, including any required time frame;
-Residents may self-administer their own medications only if the Attending Physician, in conjunction with the Interdisciplinary Care Team, has determined that they have the decision-making capacity to do so safely.

6. Review of Resident #33's Quarterly MDS, dated 06/03/24, showed the staff assessed the resident as cognitively intact.

Review of the resident's care plan, dated 03/07/24, showed the record did not contain direction for self-administration of eye drops.

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F 658	Continued From page 15 Review of the resident's Physicians Order Sheet (POS), dated June 2024, showed an order for: -Dorzolamide eye drops, instill one drop in both eyes one time a day; -Latanoprost eye drops, instill one drop in both eyes one time a day. -Did not contain an order for self-administration. Observation on 06/17/24 at 11:14 A.M., showed the eye drops on the resident's bed side table. Observation on 06/18/24 at 9:54 A.M., showed the eye drops on the resident's bed side table. Observation on 06/19/24 at 8:41 A.M., showed the eye drops on the resident's bed side table. During an interview on 06/20/24 at 9:01 A.M., Certified Medication Technician (CMT) D said the resident has two eye drops he/she self-administers. He/She said the resident is cognitive. During an interview on 06/20/24 at 11:14 A.M., RN A said he/she believes this resident self-administers eye drops. He/She said he/she should have orders to self-administer the eye drops. During an interview on 06/20/24 at 12:37 P.M., the administrator said the resident has orders to self-administer two sets of eye drops. He/She said he/she does not have an order to self-administer the third eye drop. 7. Review of Resident #39's Quarterly MDS, dated 04/02/24, showed the staff assessed the	F 658		

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F 658	Continued From page 16 resident as cognitively intact. Review of the resident's care plan, dated 01/11/24, showed the record did not contain direction on the self-administration of eye drops. Review of the resident's POS, dated June 2024, showed an order for: -Propylene glycol eye drops, instill one drop in both eyes one time a day. -Did not contain an order for self-administration. Observation on 06/17/24 at 2:20 P.M., showed lubricating eye drops on the resident's bed side table. Observation on 06/19/24 at 2:37 P.M., showed lubricating eye drops on the resident's bed side table. Observation on 06/20/24 at 8:30 A.M., showed lubricating eye drops on the resident's bed side table. During an interview on 06/20/24 at 9:01 A.M., CMT D said the resident does not self-administer eye drops. He/She is unsure why the resident has eye drops at bedside. During an interview on 06/20/24 at 11:14 A.M., RN A said the resident does not have an order to self-self-administer eye drops. He/She was not aware the resident had eye drops at bed side. He/She is not sure why the resident has them. During an interview on 06/20/24 at 12:37 P.M., the administrator said he/she was not aware the resident had the eye drops at bed side.	F 658		

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F 658	Continued From page 17 8. During an interview on 06/20/24 at 11:47 A.M., the DON/MDS coordinator said he/she is not aware of anyone who self-administers eye drops. He/She said if a resident self-administers medications, they must have an order for it, and it should be care planned. During an interview on 06/20/24 at 12:37 P.M., the Administrator said anyone who is allowed to self-administer anything, should have orders to self-administer it and it should be care planed. He/She said he eye drops not aware of. Should not happen, they are supposed to acknowledge he has them but not for administering, just that they have looked at them and reordered them. her orders would need reflect that. Staff would just acknowledge them being there. was not aware that they are at bedside and that they are signing off on them, they should not be.	F 658		
F 679 SS=E	Activities Meet Interest/Needs Each Resident CFR(s): 483.24(c)(1) §483.24(c) Activities. §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. This REQUIREMENT is not met as evidenced by: Based on interview and record review, facility staff failed to provide an ongoing program of	F 679		

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activities designed to meet three residents (Resident #4, #16 and #24) out of 14 sampled residents interest on the weekends. The facility census was 55.

1. Review of the facility's policy titled, "Activity Programs," revised 6/18, showed it directed staff as follows:

-The activities program is ongoing and includes facility-organized group activities, independent individual activities and assisted individual activities;
-Activities are scheduled seven days a week and residents are given an opportunity to contribute to the planning, preparation, conducting, cleanup and critique of the programs;
-Our activity programs consist of individual, small group and large group activities that are designed to meet the needs and interests of each resident. Activity programs include activities that promote self-esteem, comfort, pleasure, education, creativity, success, and independence.

Review of the facility's activity calendar, dated March 2024, showed:

-Saturday, 03/02/24; 01:30 P.M., Social coloring;
-Sunday, 03/03/24; 03:00 P.M., Baptist services;
-Saturday, 03/09/24; 01:30 P.M., Funny videos;
-Sunday, 03/10/24; 03:00 P.M., Baptist services;
-Saturday, 03/16/24; 01:30 P.M., Social Coloring;
-Sunday, 03/17/24; 02:00 P.M., Yoder's and 3:00 P.M., Baptist services;
-Saturday, 03/23/24; 01:30 P.M., Bingo with Cliff;
-Sunday, 03/24/24; 03:00 P.M., Non-denominational Christian Church services;
-Saturday, 03/30/24; 01:30 P.M., Social Coloring;
-Sunday, 03/31/24; 03:00 P.M., Methodist

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F 679	Continued From page 19 services. Review of the facility's activity calendar, dated April 2024, showed: -Saturday, 04/06/24; 01:30 P.M., Social coloring; -Sunday, 04/07/24; 03:00 P.M., Baptist services; -Saturday, 04/13/24; 01:30 P.M., Funny videos; -Sunday, 04/14/24; 03:00 P.M., Baptist services; -Saturday, 04/20/24; 01:30 P.M., Social Coloring; -Sunday, 04/21/24; 02:00 P.M., Yoder's and 3:00 P.M., Baptist services; -Saturday, 04/27/24; 01:30 P.M., Funny videos; -Sunday, 04/28/24; 03:00 P.M., Non-denominational Christian Church services. Review of the facility's activity calendar, dated May 2024, showed: -Saturday, 05/04/24; 01:30 P.M., Movie in activity room; -Sunday, 05/05/24; 03:00 P.M., Methodist services; -Saturday, 05/011/24; 01:30 P.M., Movie in activity room; -Sunday, 05/12/24; 03:00 P.M., Baptist services; -Saturday, 05/18/24; 01:30 P.M., Movie in activity room; -Sunday, 05/19/24; 02:00 P.M., Yoder's and 3:00 P.M., Baptist services; -Saturday, 05/25/24; 01:30 P.M., Movie in activity room; -Sunday, 05/26/24; 03:00 A.M., Baptist services. Review of the facility's activity calendar, dated June 2024, showed: -Saturday, 06/01/24; 01:30 P.M., Social Word Search;	F 679		

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F 679	Continued From page 20 -Sunday, 06/02/24; 03:00 P.M., Non-denominational Christian Church services; -Saturday, 06/08/24; 01:30 P.M., Movie in activity room; -Sunday, 06/09/24; 03:00 P.M., Methodist services; -Saturday, 06/15/24; 01:30 P.M., Social Word Search; -Sunday, 06/16/24; 02:00 P.M., Yoder's and 3:00 P.M., Baptist services; -Saturday, 06/22/24; 01:30 P.M., Movie in activity room; -Sunday, 06/23/24; 03:00 A.M., Baptist services; -Saturday, 06/29/24; 1:30 P.M., Social Word Search; -Sunday, 06/30/24; 3:00 P.M., Baptist services. 2. Review of Resident #4's Quarterly Minimum Data Set (MDS), a federally mandated assessment tool, dated 04/08/24, showed staff assessed the resident as follows: -Cognitively intact; -Independent with ADL's. Review of the resident's care plan, dated 05/07/24, showed staff documented the resident enjoys going to most facility activities of manicures, playing bingo, and music events. During an interview on 6/18/24 at 10:40 A.M., the resident said he/she does not think they have activities on the weekends, sometimes they have church. He/She said he/she would attend activities on the weekends if they had them. 3. Review of Resident #16's Quarterly MDS, dated 04/18/24, showed staff assessed the	F 679		

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F 679	Continued From page 21 resident as follows: -Moderate cognitive impairment; -Unclear Speech; -Communication problem related to Expressive Aphasia. Review of the resident's care plan, dated 5/21/24, showed staff documented the resident enjoys going to all facility group activities. During an interview on 6/18/24 at 9:58 A.M., the resident was asked if there are activities on the weekends; the resident shook his/her head no. The resident was asked if he/she would like activities on the weekend; the resident shook his/her head yes. 4. Review of Resident #24's Annual MDS, dated 08/15/24, showed staff assessed the resident as follows: -Cognitively intact; -Activity preferences to be very important to do things with groups of people. During an interview on 06/18/24 at 3:48 P.M., the resident said there are usually no activities on the weekend besides church services on Sunday. He/She said activities on the weekends are randomly scheduled. He/She said he/she loves activities and would attend if they had them on the weekends. 5. During interview on 6/20/24 at 11:17 A.M., Certified Nurses Aide (CNA) B said there are no staff led activities on the weekends. He/She said that it would be the CNA's responsibility to start	F 679		

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any activities on the weekends if they have time. He/She said there is a TV in the activities room if the residents want to put a movie on.

During an interview on 06/18/24 at 11:14 A.M., Registered Nurse (RN) A said it is the activities director job to develop activities. He/She said to his/her knowledge the facility does not have anyone designated to perform activities on the weekends. He/She said staff are responsible for turning on movies for the residents who sit in the living room during the day. He/She said the residents have church on Sundays and once a month on Sunday a volunteer group comes in to sing to the residents.

During an interview on 06/20/24 at 11:31 A.M., the Activity Director said on Saturdays the residents can do word searches, cross word puzzles, and watch tv in the activities room. He/She said Sundays they have church service in the afternoon. He/She said there is no staff led activities on the weekends.

During an interview on 06/20/24 at 11:47 A.M., the Director of Nursing (DON) said they offer movies and church on the weekends as activities. He/She said it is his/her understanding that staff starts the movie for the residents, aides get residents up for church and families come in on the weekends to help. He/She said he/she is not sure there are initiated activities for dependent residents. He/She said he/she feels like it would depend on who is working, if residents get activities initiated. He/She said some take the initiative more than others and there isn't anyone specifically assigned to that task.

During an interview on 06/20/24 at 12:37 P.M.,

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F 679	Continued From page 23 the administrator said they do not have a designated person who does activities on the weekends or weekend staff led activities. He/She said usually the south hall charge nurse initiates inviting residents to play games or starting movies on the weekends. He/She said he/she was not aware they had to have staff led activities on the weekend and he/she thought they could just initiate it tuning on movies and getting the games out.	F 679		
F 909 SS=E	Resident Bed CFR(s): 483.90(d)(3) §483.90(d)(3) Conduct Regular inspection of all bed frames, mattresses, and bed rails, if any, as part of a regular maintenance program to identify areas of possible entrapment. When bed rails and mattresses are used and purchased separately from the bed frame, the facility must ensure that the bed rails, mattress, and bed frame are compatible. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, facility staff failed to complete entrapment assessments for four residents (Residents #16, #24, #36 and #42) out of four sampled residents who use side rails, to ensure the environment remained safe and free of accident hazards. The facility census was 55. 1. Review of the facility's policy titled, "Proper Use of Side Rails," revised 12/16, showed an assessment will be made to determine the resident's symptoms, risk of entrapment and reason for using side rails. When used for mobility or transfer, an assessment will include a review of the resident's:	F 909		

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F 909	Continued From page 24 -Risk of entrapment from the use if side rails; -That the bed's dimensions are appropriate for the resident's size and weight. Review of the facility's policy titled, "Bed Safety," revised 12/07, showed to try and prevent death/injury from the beds and related equipment (including the frame, mattress, side rails, headboard, footboard, and bed accessories), the facility shall promote the following approaches: -Inspection by maintenance staff of all beds and related equipment as part of our regular bed safety program to identify risks and problems including potential entrapment risks; -Review that gaps within the bed system are within the dimensions established by Food and Drug Administration (FDA) (Note: the review shall consider situations that could be caused by the resident's weight, movement or bed position). 2. Review of Resident #16's Quarterly Minimum Data Set (MDS), a federally mandated assessment tool, dated 4/18/24, showed staff assessed the resident as: -Moderate cognitive impairment; -Unclear Speech; -Upper extremity impairment on one side, lower extremity impairment on both sides; -Substantial to maximal assistance with rolling left to right, lying to sitting on side of bed, and chair/bed to chair transfer. Review of the resident's medical record showed the entrapment assessment did not contain the appropriate measurements for the resident's size and weight.	F 909		

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3. Review of Resident #24's Quarterly MDS, dated 05/10/24, showed staff assessed the resident as:

-Moderate cognitive impairment;
-Substantial maximal assistance for bed mobility to roll left and right;
-Substantial maximal assistance from chair/bed-to-chair transfer.

Review of the resident's medical record showed the entrapment assessment did not contain the appropriate measurements for the resident's size and weight.

4. Review of Resident #36's annual MDS, dated 03/13/23, showed staff assessed the resident as:

-Severe cognitive impairment;
-Partial/moderate assistance from staff with rolling left and right;
-Supervision from staff with transferring from chair/bed-to-chair transfers;
-Supervision from staff for toilet transfers.

Review of the resident's medical record showed, the entrapment assessment did not contain the appropriate measurements for the resident's size and weight.

5. Review of Resident #42's Quarterly MDS, dated 03/06/24, showed staff assessed the resident as:

-Modified cognitive impairment;

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F 909	Continued From page 26 -Supervision or limited assist of one as needed with bed mobility and transfers; -Setup assistance from chair/bed-to-chair transfer. Review of the resident's medical record showed the entrapment assessment did not contain the appropriate measurements for the resident's size and weight. 6. During an interview on 06/19/24 at 1:02 P.M., the Maintenance Director said he/she is responsible for completing the entrapment assessments. He/She said he/she does the measurements on admission, monthly, and if the resident changes rooms or beds. He/She said that he/she uses a tape measure and measures the distance of the railing with the mattress, while the resident is not in bed. He/She said he/she did not know he/she was supposed to do the measurements with the resident in the bed. During in interview on 06/20/24 at 11:47 A.M., the Director of Nursing/MDS coordinator said rails need to be monitored for safety. He/She expects any resident with siderail to have entrapment assessments completed. He/She said the maintenance director is responsible for completing entrapment assessments. He/She said the facility does not usually use side rails. During an interview on 06/20/24 at 12:37 P.M., the administrator said it is the responsibility of the maintenance director to complete entrapment assessments monthly. He/She said the measurements are done without the resident in the bed. He/She said he/she was not aware that they should be done with the resident in the bed.	F 909		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265761	A. BUILDING _____ B. WING _____	C 06/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LINCOLN COMMUNITY CARE CENTER	205 TIMBERLINE DRIVE LINCOLN, MO 65338

(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 909	Continued From page 27 He/She said entrapment assessments are done upon admission, at least monthly, with changes of condition, bed changes, and with readmission after hospitalization.	F 909		

Missouri Department of Health and Senior Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	04803	A. BUILDING: _____ B. WING _____	C 06/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LINCOLN COMMUNITY CARE CENTER	205 TIMBERLINE DRIVE LINCOLN, MO 65338

(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
A4074	19 CSR 30-85.042(65) Protective Oversight, Voluntary Leave Each resident shall receive twenty-four- (24-) hour protective oversight and supervision. For residents departing the premises on voluntary leave, the facility shall have, at a minimum, a procedure to inquire of the resident or resident's guardian of the resident's departure, of the resident's estimated length of absence from the facility, and of the resident's whereabouts while on voluntary leave. I/II This regulation is not met as evidenced by: Class II Refer to F909	A4074		
A4101	19 CSR 30-85.042(92) Activity Program The facility shall designate an employee to be responsible for the activity program. The designated person shall be capable of identifying activity needs of residents, designing and implementing programs to maintain or increase, or both, the resident's capability in activities of daily living. Facilities shall provide activity programs on a regular basis. Each resident shall have a planned activity program which includes individualized activities, group activities, and activities outside the facility as appropriate to his/her needs and interests. II/III This regulation is not met as evidenced by: Class III Refer to F679	A4101		
A4116	19 CSR 30-85.042(102) Clinical Records Accurate/Accessible The facility must maintain clinical records on each	A4116		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	04803	A. BUILDING: _____ B. WING _____	C 06/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LINCOLN COMMUNITY CARE CENTER	205 TIMBERLINE DRIVE LINCOLN, MO 65338

(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
A4116	Continued From page 1 resident in accordance with accepted professional standards and practices. These records shall be complete, accurately documented, readily accessible on each nursing unit, and systematically organized. II/III This regulation is not met as evidenced by: Class III Refer to F658	A4116		
A9001	19 CSR 30-88.020(1) Personal Funds/Money - Oversight No operator is required by this rule or by section 198.090, RSMo, to hold, manage, safeguard, or account for any personal funds or money in trust unless some other governmental agency placing residents in the facility makes this a requirement. The record keeping and other requirements of this section apply only to those personal possessions and funds which the facility accepts to hold in trust for the resident as provided in the facility ' s policy. This regulation is not met as evidenced by: Class III Refer to F569	A9001		

PLAN OF CORRECTION

Provider/Supplier Name:	Lincoln Community Care Center	Page #1
Street Address, City, Zip:	205 Timberline Drive, Lincoln MO 65338	
Date of Survey:	6-20-2024	

PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	

ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION: (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLETION DATE
F569/A9001	-Lincoln Community Care Center signed a service	8-4-24
	agreement with Clifton/Larson/Allen LLP tax/accountants to	
	provide a reconciliation of aging accounts receivable and to train	
	Business Office Manager and Assistant to perform reconciliation	
	of accounts receivable which may affect all residents.	
	- The Administrator in-serviced the Business Office	
	Manager and the Assistant Business Office Manager with the	
	policy and procedure for refunds of resident funds and	
	accounting and records of resident funds.	
	-The business office will refund all funds owed to persons or	
	insurances the full amount of funds owed per audit.	
	-The Business Office Manager will print off the Aging Accounts	
	Receivable report monthly for review by the Administrator and	
	will be reviewed monthly in QAPI x 6 months for compliance	
	and document.	
F657	-Administrator in-serviced Care Plan Coordinator on fall	8-4-24
	care plans with interventions. Care Plan Coordinator is to talk to	
	ADON or charge nurse to obtain any information	
	regarding a resident fall daily during week, interventions will be	
	discussed by IDT team in morning meeting and care planned.	
	All residents have the potential to be affected by fall careplans.	
	-Care plan coordinator updated care plans on resident # 10,	
	#12, #13, #19, #35 and #42 to reflect fall and fall interventions.	
	-Administrator in-serviced Care Plan Coordinator on side rail	
	care plans. Care plan is to talk to ADON or charge nurse to	
	obtain information regarding any resident orders for side rails.	
	-Care plan coordinator updated resident #42 care plan and	
	other residents that have a signed consent and Dr order for	
	side rail use.	
	-Administrator will monitor x2 falls to ensure care plan	
	placement for fall and fall intervention weekly x 4 weeks then	
	monthly x 6 months. Administrator will monitor side rail use on	
	x 2 care plans weekly x 4 weeks then monthly x 6	
	for compliance and document.	

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:	Lincoln Community Care Center	Page # 2
Street Address, City, Zip:	205 Timberline Drive, Lincoln MO 65338	
Date of Survey:	6-20-2024	

PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	

ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION: (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLETION DATE
F658/A4116	-Administrator in-serviced all charge nurses on fall and neuro	8-4-24
	check protocol. Neuro checks to be initiated will all unwitnessed	
	falls.	
	-Administrator in-serviced all nursing personnel on reporting	
	any medications that are found in a residents room immediately	
	to the charge nurse to ensure there is an order to keep	
	medication at bedside, if no order, medication is to be removed.	
	- ADON to review report sheets daily, during week, and	
	interview charge nurses to obtain report on any	
	residents that have fallen. ADON then will track completion of	
	neuro check sheets.	
	-Care plan coordinator added eye drops at bedside to care	
	plan for resident # 33, only resident with Dr order for bedside	
	medications. Medication removed from # 39 room.	
	-Administrator in-serviced Care Plan Coordinator on including	
	medications at bedside in care plans if Dr orders.	
	-ADON to monitor random rooms weekly x 4 weeks then	
	monthly x 6 months for medications at bedside for compliance.	
	-Administrator will monitor random neuro check forms	
	for completeness weekly x 4 then monthly x 6 months for	
	compliance.	
F679/A4101	-Administrator in-serviced Activity Director on staff directed	8-4-24
	activities on the weekend that support resident interest, well-	
	being, independence and interaction with community.	
	-July Activity calendar reflects staff directed activities on the	
	weekends for the entirety of the month.	
	-The Administrator will review the activity calendar prior to the	
	end of the month to ensure staff directed activities are included	
	on weekends x 6 months and will review monthly at QAPI x 1	
	year	

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PLAN OF CORRECTION

Provider/Supplier Name:	Lincoln Community Care Center	Page # 3
Street Address, City, Zip:	205 Timberline Drive, Lincoln MO 65338	
Date of Survey:	6-20-24	

PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	

ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION: (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLETION DATE
F909/A4074	-Administrator in-serviced Maintenance on bed rail entrapment assessments, which have the potential to affect all residents,	8-4-24
	with the resident in bed upon admission, significant changes,	
	bed/room moves, re-admission and bi-monthly.	
	-Resident #16, #24 , # 36 and #42 bed rail assessments	
	completed by maintenance with resident present in bed.	
	All residents will have bed rail assessments done.	
	-Administrator to monitor bed rail entrapment assessment log	
	weekly x 4 weeks then monthly x 6 months for compliance and	
	document.	

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