STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265251	A. BUILDING _____ B. WING _____	10/10/2024

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VILLA AT BLUE RIDGE, THE	701 BLUE RIDGE ROAD COLUMBIA, MO 65201

(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 607 SS=E	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(5)(ii)(iii) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, §483.12(b)(4) Establish coordination with the QAPI program required under §483.75. §483.12(b)(5) Ensure reporting of crimes occurring in federally-funded long-term care facilities in accordance with section 1150B of the Act. The policies and procedures must include but are not limited to the following elements. §483.12(b)(5)(ii) Posting a conspicuous notice of employee rights, as defined at section 1150B(d)(3) of the Act. §483.12(b)(5)(iii) Prohibiting and preventing retaliation, as defined at section 1150B(d)(1) and (2) of the Act. This REQUIREMENT is not met as evidenced by: Based on interview and record review, facility staff failed to check the Certified Nurse Assistant (CNA) Registry for employee prior to hire to ensure they did not have a Federal Indicator (a marker given by the federal government to individuals who have committed abuse and/or	F 607		

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

Tina Hyatt — Administrator — 11-1-24

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 607	Continued From page 1 neglect) for five employees (Dietary Aide D, Nurse Aide E, Housekeeping F, Dietary Cook G, and Registered Nurse H) out of a sample of ten employees. Facility staff failed to complete a thorough investigate of an injury of unknown origin for one resident (Resident #61) out of one sampled resident. The facility census was 83. 1. Review of the Facility's Screening Abuse and Neglect Manual, undated, showed: -The facility will not hire an employee or engage an individual who was found guilty of abuse, neglect, exploitation, or mistreatment or misappropriation of property by a court of law; or who has a finding in the State nurse aide registry concerning abuse, neglect, exploitation, mistreatment of residents or misappropriation of resident property, or has had a disciplinary action in effect taken against his/her professional license; -The Certified Nurse Assistant (CNA) Registry-ALL applicants must be checked before hire; -Keep a copy of the result page in the employee's personnel file. 2. Review of Dietary Aide D's employee file showed a hire date of 01/05/24. The employee file did not contain documentation of the Dietary Aide's CNA's registry check. 3. Review of Nurse Aide E's employee file showed a hire date of 08/26/24. The employee file did not contain documentation of the Nurse Aide's CNA's registry check. 4. Review of Housekeeping F's employee file showed a hire date of 10/01/24. The employee file did not contain documentation of the	F 607		

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F 607	Continued From page 2 Housekeeping's CNA's registry check. 5. Review of Dietary Cook G's employee file showed a hire date of 11/19/23. The employee file did not contain documentation of the Dietary Cook's CNA's registry check. 6. Review of Registered Nurse H's employee file showed a hire date of 05/20/24. The employee file did not contain documentation of the Registered Nurse's CNA's registry check. During an interview on 10/10/24 at 10:05 A.M., the assistant business office manager (ABOM) said it is his/her responsibility to do background checks prior to hiring. He/She said he/she was not aware he/she should be running the nurse aide registry checks on all staff. He/She said he/she was recently educated on the CNA registry checks and he/she was only running them on CNA's to check for certification. During an interview on 10/10/24 at 4:36 P.M., the Assistant Director of Nursing (ADON) said it is the responsibility of the ABOM to run all background checks prior to hire including nurse aide registry. He/She said the nurse aide registry should be done prior to hire and quarterly. He/She was not aware they were not being done. He/She said he/she recently educated the ABOM and he/she must have only ran the CNA's instead of all staff. He/She said they should be done so the facility can ensure no one is hired who has charges against them. During an interview on 10/10/24 at 5:19 P.M., the Administrator said it is the responsibility of the ABOM to run all background checks prior to hire including nurse aide registry. He/She was not	F 607		

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F 607	Continued From page 3 aware they were not being done. He/She said they should be ran prior to hire and quarterly. He/She is not sure why he/she was not doing them. He/She said it is important for the CNA registry checks to be completed to ensure all employees hired are free from charges of abuse and neglect. 7. Review of the Facility's Reporting Abuse and Neglect Manual, undated, showed: -All allegations of abuse, neglect, exploitation, mistreatment, injuries of unknown source and misappropriation of resident property by facility employees, contracted employees, volunteers, contract services, consultants, physicians, visitors, family members, or other individuals will be reported immediately but no later than the following timeframes. If the abuse is alleged or the allegation results in serious bodily injury, the allegation must be reported within 2 hours after the allegation was made. If the allegation does not allege abuse or result in serious bodily injury, the report must be made within 24 hours after the allegation was made. Review of the Facility's Event Investigation, undated, showed: -To investigate the cause of all marks, discolorations, skin breaks and injuries which have not been witnessed. To identify any injuries after a resident sustains an event; -Complete a Report of Event Form as soon as possible whenever there is an unusual, unexpected and/or unidentified event that si not consistent with the routine operation of the facility, the routine care of the resident and/or adversely effects or has the potential to adversely affect a	F 607		

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F 607	Continued From page 4 resident or visitor. Examples of when a form should be completed: -Bruises/skin tear of unknown origin; -The charge nurse is responsible for completion of the Report of Event form and forwarding to the Director of Nursing (DON) as soon as possible. 8. Review of Resident #61's Annual Minimum Data Set (MDS), a federally mandated assessment tool used by staff, dated 06/15/24, showed staff assessed the resident as follows: -Cognition intact; -Substantial assistance with lower body dressing; -Upper extremity impairment on one side; -Diagnoses of Parkinson's disease; -Used wheelchair. Observation on 10/08/24 at 9:24 A.M., showed the resident in his/her recliner. He/She had a red left cheek, small amount of swelling under the left eye and on his/her left brow, laceration to the right forehead in his/her hairline, and resident's left wrist and hand appeared swollen. Resident was unable to answer questions, but grimaced and guarded left wrist when touched. Review of the resident's medical record, showed the record did not contain documentation staff investigated the injuries to the resident. During an interview on 10/10/24 at 4:36 P.M., the Assistant Director of Nursing (ADON) said he/she was called to the resident's room because the resident had a redden cheek, scratch to his/her forehead and a swollen wrist. He/She said when he/she asked the resident if he/she fell the resident nodded yes but was unable to answer any other questions. He/She said he/she asked	F 607		

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F 607	Continued From page 5 dayshift staff if they knew where the resident got the injuries and staff were unsure. He/She said he/she never contacted night shift about the injuries. He/She said he/she told the charge nurse to contact the doctor and get an order for an X-ray, which came back clear. He/She said he/she is supposed to investigate when there is an injury of unknown origin. He/She said there was no proof that there was an injury, and that the resident didn't injury himself/herself. He/She said he/she did not do a formal investigation or fill out a report on the situation. During an interview on 10/10/24 at 5:19 P.M., the administrator said he/she expects the charge nurse who finds an injury of unknown origin to initiate the investigation, notify the physician, notify the responsible party, notify the ADON or DON and then he/she should notify the administrator. He/She would expect there to be an investigation that narrows down time frames and has staff interviews. He/She said he/she would expect there to be documentation of what was investigated. He/She was not made aware of the injury of unknown origin and he/she is not sure why it was not investigated and documented.	F 607		
F 638 SS=F	Qrtly Assessment at Least Every 3 Months CFR(s): 483.20(c) §483.20(c) Quarterly Review Assessment A facility must assess a resident using the quarterly review instrument specified by the State and approved by CMS not less frequently than once every 3 months. This REQUIREMENT is not met as evidenced by: Based on interview and record review, facility staff failed to assess residents using the quarterly	F 638		

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Minimum Data Set (MDS), a federally mandated assessment completed by staff, no less frequently than once every 92 days as directed by the Resident Assessment Instrument (RAI) manual for 19 residents (Resident #6, #9, #12, #20, #26, #28, #29, #31, #32, #33, #41, #44, #46, #51, #57, #63, #69, #70, and #71) out of 20 sampled. The facility census was 83.

1. Review of the Resident Assessment Manual (RAI), dated 10/1/17, showed the Quarterly assessment is an Omnibus Budget Reconciliation Act of 1987 (OBRA) non-comprehensive assessment for a resident that must be completed at least every 92 days following the previous OBRA assessment of any type. It is used to track a resident's status between comprehensive assessments to ensure critical indicators of gradual change in a resident's status are monitored. As such, not all MDS items appear on the Quarterly assessment. The Assessment Reference Date (ARD) must be not more than 92 days after the ARD of the most recent OBRA assessment of any type.

1. Review of Resident #6's medical record showed a quarterly MDS dated 5/10/24. Staff did not document a quarterly MDS in August 2024.

2. Review of Resident #9's medical record showed a quarterly MDS dated 05/30/24. Staff did not document a quarterly MDS in August 2024.

3. Review of Resident #12's medical record showed a admission MDS dated 05/07/24. Staff did not document a quarterly MDS in August 2024.

4. Review of Resident #20's medical record

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showed a admission MDS dated 05/07/24. Staff did not document a quarterly MDS in August 2024.

5. Review of Resident #26's medical record showed a quarterly MDS dated 05/07/24. Staff did not document a quarterly MDS in August 2024.

6. Review of Resident #28's medical record showed a quarterly MDS dated 4/28/24. Staff did not document a quarterly MDS in July 2024.

7. Review of Resident #29's medical record showed a quarterly MDS dated 05/18/24. Staff did not document a quarterly MDS in August 2024.

8. Review of Resident #31's medical record showed a admission MDS dated 05/07/24. Staff did not document a quarterly MDS in August 2024.

9. Review of Resident #32's medical record showed a quarterly MDS dated 05/08/24. Staff did not document a quarterly MDS in August 2024.

10. Review of Resident #33's medical record showed a quarterly MDS dated 05/03/24. Staff did not document a quarterly MDS in August 2024.

11. Review of Resident #41's medical record showed a quarterly MDS dated 5/24/24. Staff did not document a quarterly MDS in August 2024.

12. Review of Resident #44's medical record showed a quarterly MDS dated 05/08/24. Staff did not document a annual MDS in August 2024.

13. Review of Resident #46's medical record showed a annual MDS dated 05/30/24. Staff did

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F 638	Continued From page 8 not document a quarterly MDS in August 2024. 14. Review of Resident #51's medical record showed a quarterly MDS dated 05/03/24. Staff did not document a quarterly MDS in August 2024. 15. Review of Resident #57's medical record showed a quarterly MDS dated 05/31/24. Staff did not document a quarterly MDS in August 2024. 16. Review of Resident #63's medical record showed a quarterly MDS dated 05/09/24. Staff did not document a quarterly MDS in August 2024. 17. Review of Resident #69's medical record showed a quarterly MDS dated 5/3/24. Staff did not document a quarterly MDS in August 2024. 18. Review of Resident #70's medical record showed a quarterly MDS dated 04/24/24. Staff did not document a quarterly MDS in July 2024. 19. Review of Resident #71's medical record showed a quarterly MDS dated 5/1/24. Staff did not document a quarterly MDS in August 2024. 20. During an interview on 10/10/24 at 2:52 P.M., the MDS Coordinator said the previous MDS Coordinator was gone a lot and got behind on MDS's so he/she is now trying to catch up. He/She said if the MDS says "In progress" that means it is one he/she is actively working on. During an interview on 10/10/24 at 4:37 P.M., the Assistant Director of Nursing (ADON) said the previous MDS Coordinator was supposed to have them completed, but they were not, so the current MDS trying to get caught up. The ADON said the Director of Nursing (DON) is responsible for	F 638		

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F 638	Continued From page 9 oversite on MDS. During an interview on 10/10/24 at 5:19 P.M., the administrator said she would expect the DON to help MDS if needed. The DON however has had to work the floor to cover RN hours, so he/she has not been available much. The administrator said she was not aware they were far behind and the corporate who over sees the facility hasn't reported anything about this to her.	F 638		
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 meet professional standards of care one resident (Resident #31) , when staff failed to provided the resident's treatment as ordered and facility staff failed to provide consistent documentation in regard to choice of code status (the level of medical interventions a resident wishes to have if their heart or breathing stops) for two resident's (#3 and #30) out of three sampled resident. The facility census was 83. 1. Review of the facility's Physician Orders Policy, undated, showed a current lists of orders must be maintained in the clinical record of each resident to avoid confusion and errors.	F 658		

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2. Review of Resident #31's admission Minimum Data Set (MDS), a federally mandated assessment tool, dated 05/07/24, showed staff assessed the resident as:

-Moderate cognitive impairment;
-Lower extremity impairment on one side;
-Dependent on staff for lower body dressing;
-Diagnosis of Parkinson's and Diabetes.

Review of the resident's Physician Order Sheet (POS), dated October 2024, showed an order dated 08/15/24, for Tubi grip (a tubular bandage that provides support and compression for a variety of injuries and conditions) to bilateral lower extremity every shift, off at bedtime for generalized edema.

Observation on 10/07/24 at 3:30 P.M., showed the resident in his/her wheelchair without Tubi grips on his/her legs.

Observations on 10/08/24 at 1:25 P.M., showed the resident in his/her wheelchair without Tubi grips on his/her legs.

Observations on 10/09/24 at 10:00 A.M., showed the resident in his/ her wheelchair without Tubi grips on his/her legs.

During an interview on 10/10/24 at 2:45 P.M., Licensed Practical Nurse (LPN) A said he/she expects staff to carry out orders as prescribed by the physician. He/She said it is okay to use nursing judgement in certain cases, but nurses should document the reason for not carrying out the order and should notify the physician. He/She said if a resident refuses care or treatments nurses should make more than one attempt and

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should document the refusals and notify the physician of the situation.

During an interview on 10/10/24 at 3:02 P.M., LPN R said the resident often refuses to wear his/her tubi grips. LPN R said the tubi grips were on him/her this morning, and it is the nurses responsibility to put them to the resident. LPN R said he/she does not know why they are not on her currently. LPN R said if a resident refuses a treatment it should be documented on the Treatment Administration Record.

During an interview on 10/10/24 at 4:37 P.M., the Assistant Director of Nursing (ADON) said if a resident has an order for a treatment, the expectation is for it to be followed. If a resident refuses, try a different staff but if not done it should be documented.

During an interview on 10/10/24 at 5:19 P.M., the administrator said all physician orders should be followed and if resident refuses any order or treatment, it should be documented in progress notes each time.

3. Review of the facility's policies showed staff did not provide a documentation of advance directives policy.

4. Review of Resident #3's Quarterly MDS, dated 09/15/24, showed facility staff assessed the resident as moderate cognitive impairment.

Review of the resident's care plan, dated 07/09/24, showed staff documented the resident as a full code status.

Review of the resident's POS, dated October

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F 658	Continued From page 12 2024, showed a physician order for full code status. Review of the resident's face sheet, showed the resident's code status as do not resuscitate (DNR). Review of the resident's advance directive, dated 09/16/24, showed the resident had a signed DNR. Observation on 10/10/24 at 1:35 P.M., showed the resident's door had a red sticker next to his/her name. 5. Review of Resident #30's Quarterly MDS, dated 8/28/24, showed staff assessed the resident as cognitively intact. Review of the resident's care plan, dated 8/24/24, showed staff documented the resident as a full code status. Review of the resident's facesheet showed staff documented the resident as a full code status. Review of the resident's POS, 08/22/24, showed anorder for a DNR status. Observation on 10/10/24 at 5:06 P.M., showed the resident's door with a red dot on it. 6. During an interview on 10/10/24 at 1:37 P.M., housekeeper B said he/she is not sure what the colored stickers meant next to the resident's names on their door. He/She said he/she thinks they signify which bed each resident is in. He/She said he/she works in housekeeping and had not received an education on the meaning of the door	F 658		

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VILLA AT BLUE RIDGE, THE	701 BLUE RIDGE ROAD COLUMBIA, MO 65201

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F 658	Continued From page 13 stickers. During an interview on 10/10/24 at 1:39 P.M., nurse aide (NA) C said the red dot next the residents name on his/her door indicates DNR and green sticker indicates full code. During an interview on 10/10/24 02:45 P.M., LPN A said the red sticker on the resident's door means they are a DNR and the green means they are a full code. He/She said he/she would expect the advance directives placed in the resident charts to match their orders, what the resident has signed off on, the face sheet, and what is marked on the resident's door. He/She said having them not match or be incorrect could cause a full code to get missed and not be resuscitated and a DNR could be resuscitated against their choice. He/She said the Social Services director oversees obtaining and maintaining resident code statuses. He/She said he/she was not aware some residents had code statuses that did not match. During an interview on 10/10/24 at 3:22 P.M., the social services director said he/she is responsible for obtaining and maintain resident code statuses. He/She said he/she obtains the residents code status upon admission and keeps them up to date as they change. He/She said he/she oversees making sure code status changes are updated by the physician as they change. He/She said he/she does quarterly audits to make sure resident code status match records. He/She said there are five areas he/she checks during audits. He/She checks the resident's face sheet, care plan, the resident's door, orders, and make sure there is an updated copy at the nurse's station. He/She said he/she was not aware there were	F 658		

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F 658	Continued From page 14	F 658		

some residents whose code status didn't match. He/She said he/she did an audit last July and it is time for another audit.

During an interview on 10/10/24 at 4:36 P.M., the assistant director of nursing (ADON) said the social services director is responsible for maintaining and updating advance directives. He/She said it is his/her expectation that resident code statuses are accurate and consistently match all areas of their medical record. He/She said he/she was not aware there were some residents whose medical records had inconsistent code statues. He/She said the concern with the inconsistency is that the resident may not get their wishes carried out if something were to happen.

During an interview on 10/10/24 at 5:10 P.M. CNA I said the dots on the door are there so you know the code status of the residents. Red is DNR and Green is revive them.

During an interview on 10/10/24 at 5:15 P.M. Charge Nurse J said the dots on the door show the code status. Red is DNR and green is full code. He/She said it is the responsibility of someone in administration to make sure the dots are on the door. Social Services usually comes around and checks them.

During an interview on 10/10/24 at 5:19 P.M., the administrator said the social services director is responsible for maintaining and ensuring each resident's advanced directives are correct and consistent throughout their medical record. He/She said he/she was not aware there were some residents whose records were not consistent. He/She said the concern is that in the

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F 658	Continued From page 15 event of an emergency staff would not know which is correct and the residents wishes would not be upheld. He/She said code statuses can be found on the resident's face sheet, orders, care plan, color codes dots on the doors and in a advance directive binder.	F 658		
F 661 SS=D	Discharge Summary CFR(s): 483.21(c)(2)(i)-(iv) §483.21(c)(2) Discharge Summary When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following: (i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results. (ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative. (iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter). (iv) A post-discharge plan of care that is developed with the participation of the resident and, with the resident's consent, the resident representative(s), which will assist the resident to adjust to his or her new living environment. The post-discharge plan of care must indicate where the individual plans to reside, any arrangements that have been made for the resident's follow up care and any post-discharge medical and non-medical services. This REQUIREMENT is not met as evidenced	F 661		

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F 661	Continued From page 16 by: Based on interview and record review, facility staff failed to complete a comprehensive discharge summary or post discharge plan of care form for one resident (Resident #77) of two discharged residents. The facility census was 83. 1. Review of the facility's Discharge/Transfer of Resident Policy, undated, showed to provide a safe departure from the facility and to provide sufficient information for aftercare of the resident staff will complete a discharge summary and post discharge plan of care form. 2. Review of Resident #77s medical record, showed the resident discharged on 07/09/24. The record did not contain a comprehensive discharge summary or post discharge plan of care of the resident's stay in the facility. During an interview on 10/10/24 at 10:00 A.M., the Social Services Director (SSD) said he/she is responsible for resident discharges. The SSD said he/she should have put a discharge summary and other discharge information in the resident's medical record, but just didn't do it. During an interview on 10/10/24 at 4:37 P.M., the Assistant Director of Nursing (ADON) said when a resident is discharged the SSD is made aware, and they are responsible to set up home health, or therapy if needed. The SSD would do discharge education and put the discharge summary in the medical record. During an interview on 10/10/24 at 5:19 P.M., the administrator said when a resident discharges from the facility she would expect there to be a doctor's order, Home Health set up if needed,	F 661		

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F 661	Continued From page 17 and verify they have a safe place to go after they leave the facility. The administrator said SSD is responsible for putting the discharge information into the resident's medical record.	F 661		
F 698 SS=D	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on interview and record review, facility staff failed to ensure one (Resident #55) of one sampled residents received care and services for the provision of hemodialysis (the clinical purification of blood by dialysis, as a substitute for the normal function of the kidney) consistent with professional standards of practice when staff failed to provide orders, ongoing assessments of the resident's condition, and monitoring for complications after dialysis treatments. The facility census was 83. 1. Review of the Facility's Care of a Resident Receiving Dialysis policy, undated, showed staff are directed to: -Feel for thrill (vibration that is felt on the skin overlying an dialysis shunt (connection from a hemodialysis access point to a major artery)) sensation daily; -Inspect access site for redness, swelling, or warmth; -Watch for bleeding after dialysis;	F 698		

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F 698	Continued From page 18 -Monitor for signs of infection; -Nurse will maintain dressing to access site at all times. Site to be checked every shift and dressing reapplied or reinforced as needed; -Nurses will check the thrill daily and document daily. This will be documented on the resident's treatment record; -Communication between the Facility and Dialysis unit; -The Dialysis Communication Record will be sent with the resident on each dialysis visit; -All care concerns in the last 24 hours will be addressed, including last medications given and facility contact person; -The dialysis unit will complete the lower portion of the report to include weight prior to and after dialysis, any labs completed, medication given, follow up information and any new physician orders; -The lower portion will be signed by the dialysis nurse and returned to the facility; -These records will be maintained in the medical record. 2. Review of Resident #55's Quarterly Minimum Data Set (MDS), a federally mandated assessment tool, dated 07/20/24, showed facility staff assessed the resident as: -Cognitively intact; -Diagnoses of End Stage Renal Disease, Type 2 Diabetes Mellitus and Congestive Heart Failure; -Received dialysis. Review of the resident's care plan, dated 08/21/24, showed staff assessed the resident with right-sided dialysis shunt. Review showed staff documented:	F 698		

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F 698	Continued From page 19 -The resident will not have signs or symptoms of infection; -Staff will check for thrill over shunt once daily; -Staff will not take blood pressure or blood from the right-side extremity; -The plan of care did not direct staff on monitoring or care of a resident on dialysis. Review of the resident's physician's order sheet (POS), dated October 2024, showed the POS did not contain an order for dialysis or care of the right-side shunt. Review of the resident's medical record, from January 2024-October 2024, showed the record it did not contain documentation staff assessed the resident prior to or upon return from dialysis appointments, monitored daily vital signs, monitored risk for infection, monitored the resident's shunt, monitored intake, and output, monitored daily weights, and the record did not contain completed communication forms. During an interview on 10/09/24 at 2:49 P.M., Charge Nurse L said he/she only puts documentation in the residents chart if the dialysis clinic calls to say there are issues. He/She said he/she will add a note in progress notes or if he/she sees any issues. He/She said there are no other documentation that is required for them to do with residents on dialysis. He/She said the facility only has one dialysis resident. During an interview on 10/10/24 at 2:45 P.M., Licensed Practical Nurse (LPN) A said he/she is not sure what the policy says about dialysis. He/She said staff should be assessing the resident before and after dialysis. He/She said some of the assessments would be checking	F 698		

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F 698	Continued From page 20 vitals, weights and blood sugars. He/She said he/she was not aware of a dialysis communication for until today. During an interview 10/10/24 at 9:13 A.M., the Assistant Director of Nursing (ADON) said he/she would expect there to be an order for dialysis and assessing the shunt site. He/She said staff should be doing the assessments and vital signs on the resident monthly. He/She said they do not do assessments before or after dialysis, but staff should be doing them because the resident could have blood sugars that are too high or too low and they would not know if they didn't do assessments. He/She said they have a communication form staff have not been using. He/She said he/she the new hires were not educated on them when they started. He/She said the DON is responsible for ensuring these are getting done, but the DON has been staffing the night shift as the charge nurse. During an interview on 10/10/24 at 5:19 P.M., the administrator said they only have one resident on dialysis. He/She said he/she would expect there to be orders for dialysis and taking care of the shunt, He/She said staff should be assessing at the shunt daily. He/She said he/she expects staff to be using the communication form before the resident leaves for dialysis, he/she should take the form to the dialysis clinic and then facility staff should be filling it out when he/she returns. He/She said he/she was not aware staff were not using the communication forms and that there were not orders in for dialysis and assessments of the shunt.	F 698		
F 727 SS=E	RN 8 Hrs/7 days/Wk, Full Time DON CFR(s): 483.35(b)(1)-(3)	F 727		

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F 727	Continued From page 21 §483.35(b) Registered nurse §483.35(b)(1) Except when waived under paragraph (e) or (f) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. §483.35(b)(2) Except when waived under paragraph (e) or (f) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis. §483.35(b)(3) The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. This REQUIREMENT is not met as evidenced by: Based on interview and record review, facility staff failed to provide the services of a Registered Nurse (RN), for at least eight consecutive hours per day, seven days a week. The facility census was 83. 1. Review of the facility's policies showed the facility did not provide a policy for RN coverage. 2. Review of the facility's RN staff schedule, dated July 2024, showed the facility did not have an RN in the building for the dates of: -Thursday 07/04/24; -Friday 07/05/24; -Sunday 07/07/24; -Saturday 07/13/24; -Sunday 07/14/24; -Saturday 07/20/24; -Sunday 07/21/24; -Friday 07/26/24; -Saturday 07/27/24;	F 727		

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F 727	Continued From page 22 -Sunday 07/28/24; -Monday 07/29/24; -Tuesday 07/30/24. 3. Review of the facility's RN staff schedule, dated August 2024, showed the facility did not have an RN in the building for the dates of 08/03/24 through 08/31/24. 4. Review of the facility's RN staff schedule, dated September 2024, showed the facility did not have an RN in the building for eight consecutive hours per day for the month of September. 5.Review of the facility's RN staff schedule, dated October 2024, showed the facility did not have an RN in the building for the dates of 10/01/24 through 10/08/24. 6. During an interview 10/10/24 at 9:13 A.M., the Director of Nursing (DON) said he/she works 12-hour shifts on nights to cover the nursing holes. He/She said he/she is the only RN on staff. He/She said he/she knows the requirement is to have an RN eight hours a day seven days a week. He/She said he/she is on call for them if they need him/her and he/she is not scheduled. He/She said they are currently trying to hire another RN. During an interview on 10/10/24 at 4:36 P.M., the Assistant Director of Nursing (ADON) said he/she is responsible for scheduling. He/She said he/she only has one RN on staff full time, and it is the DON. He/She said he/she knows the requirement is to have an RN on staff eight consecutive hours daily. He/She said they have utilized agency in the past, but it costs too much.	F 727		

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F 727	Continued From page 23 During an interview on 10/10/24 at 5:19 P.M., the administrator said the ADON does all of their scheduling. He/She said they only have one full time RN and that is the DON. He/She said he/she is aware the requirement is to have an RN eight consecutive hours seven days a week.	F 727		
F 759 SS=D	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, facility staff failed to ensure a medication error rate of less than 5% out of 31 opportunities observed. Two errors occurred, resulting in a 6.45% error rate, which affected one resident (Residents #60) of 6 sampled residents. The facility census was 83. 1. Review of the facility's policy Medication Administration, revised 2/17/13, showed: -The complete act of administration entails removing an individual dose from a previously dispensed, properly labelled container, verifying it with the physician's orders, giving the individual dose to the priper resident, and promptly recording the information; -If there is doubt concerning the administration, the physician's order must be verified before the medication is adminstered; -Certain medications should never be crushed.	F 759		

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F 759	Continued From page 24 Refer to pharmacy manual if you are unsure a medication can be crushed. Review of the website dailymed.nlm.nih.gov, updated 04/18/23, showed Metoprolol succinate extended-release (ER)(used to lower blood pressure), tablets are scored and can be divided; however, do not crush or chew the whole or half tablet. 2. Review of Resident #60's Quarterly Minimum Data Set (MDS), a federally mandated assessment tool, dated 07/01/24, showed staff documented the resident diagnosis of Dementia/Alzheimers, hypertension, hip fracture and adequate vision. Review of the the resident's Physician Order Sheet (POS), October 2024, the physician ordered: -Latanoprost drops (used to reduce increased pressure in the eye in people with either open-angle glaucoma or ocular hypertension) 0.0005%, one drop to left eye once daily; -Metoprolol Succinate tablet ER 24 hr; 50 mg (milligrams) 1.5 tabs once a day A.M. Observation on 10/10/24 at 6:40 A.M., showed Certified Medical Technician (CMT) K placed Metoprolol Succinate ER in a medicine cup and crushed the tablets. During an interview on 10/10/24 at 6:45 A.M., CMT K said he/she realizes now the metopropol should not have been crushed because it is extended release. During an interview on 10/10/24 at 5:00 P.M., the	F 759		

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Assitant Director of Nurses (ADON) said the policy for crushing medications has to have an order and the medication has to be mixed with something. He/She said extended release tablets should not be crushed. He/She said the risk is the full dose would be adminstered at one time. He/She said if they read the orders, they should know how to administer the medications.

During an interview on 10/10/24 at 5:53 P.M., the administrator said extended release medication typically are not crushed because it would not be dispersed properly. He/She said medication errors should be reported to the Charge Nurse. Medication errors are discussed at QAPI meetings.

Observation on 10/10/24 at 6:50 A.M., showed CMT K administered one drop of Latanoprost eye drops to the resident's left and right eyes.

During an interview on 10/10/24 at 8:36 A.M., CMT K said he/she gave two drops, one in each eye to the resident and afterward noticed the order was changed. The resident used to have a prescription for both eyes. He/She said he/she should have looked at the medication administration record more closely.

During an interview on 10/10/24 at 8:29 A.M., Charge nurse L said it is expected that staff follow medication orders as written. The eye drops, for example, are prescribed for the left eye only for a reason.

During an interview on 10/10/24 at 5:00 P.M., the ADON said they should know how to administer the medications. A nurse should be notified right away. The charge nurse should fill out a med

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F 759	Continued From page 26 error form.	F 759		
F 761 SS=C	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, facility staff failed to store medications and biologics in a safe manner when medication and treatment carts were left unlocked in public areas accessible to residents. The census was 83.	F 761		

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F 761	Continued From page 27 1. Review of the facility's "Storage of Medications" Policy, undated, showed: -All medications must be stored at or near the nurse's station in a locked cabinet, a locked medication room, or one or more locked medication carts; -All poisonous substances and other hazardous compounds such as sterilization solutions, irrigation solutions, antiseptics, diagnostic reagents, etch, must be kept in a separate locked container away from medications and may not be accessible to residents. 2. Observation at 10/10/24 8:20 A.M., showed the 200 hall medication cart left unlocked and unattended in hall. Observation at 10/10/24 8:33 A.M., showed the 200 hall medication cart unlocked and unatteneded while staff was in resident room. Observation at 10/10/24 9:15 A.M., showed the 200 hall medication cart unlocked and unattended in hall. During an interview on 10/10/24 at 9:30 A.M., Certified Medication Technician (CMT) K said medication carts are supposed to be locked each time they leave it, but he/she is getting asked for a lot more as needed medications than ususal this morning. 3. Observation at 10/10/24 9:17 A.M., showed the 300 hall treatment cart unlocked and unattended in the hall. Observation at 10/10/24 11:53 A.M., showed the	F 761		

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F 761	Continued From page 28 300 hall treatment cart unlocked and unattended. 4. During an interview on 10/10/24 at 8:29 A.M., Charge Nurse L said the carts are supposed to be locked unless you are right in from of it. During an interview on 10/10/24 at 11:30 A.M., the Assistant Director of Nurses said medication and treatment carts should always be locked or residents could get into them, or there could be misplacment of drugs. . During an interview on 10/10/24 at 11:55 A.M., the adminstrator said it is not ok for medication and treament carts to be unlocked and unattended. There is the potential for harm to residents.	F 761		
F 849 SS=D	Hospice Services CFR(s): 483.70(n)(1)-(4) §483.70(n) Hospice services. §483.70(n)(1) A long-term care (LTC) facility may do either of the following: (i) Arrange for the provision of hospice services through an agreement with one or more Medicare-certified hospices. (ii) Not arrange for the provision of hospice services at the facility through an agreement with a Medicare-certified hospice and assist the resident in transferring to a facility that will arrange for the provision of hospice services when a resident requests a transfer. §483.70(n)(2) If hospice care is furnished in an LTC facility through an agreement as specified in paragraph (o)(1)(i) of this section with a hospice, the LTC facility must meet the following requirements:	F 849		

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F 849	Continued From page 29 (i) Ensure that the hospice services meet professional standards and principles that apply to individuals providing services in the facility, and to the timeliness of the services. (ii) Have a written agreement with the hospice that is signed by an authorized representative of the hospice and an authorized representative of the LTC facility before hospice care is furnished to any resident. The written agreement must set out at least the following: (A) The services the hospice will provide. (B) The hospice's responsibilities for determining the appropriate hospice plan of care as specified in §418.112 (d) of this chapter. (C) The services the LTC facility will continue to provide based on each resident's plan of care. (D) A communication process, including how the communication will be documented between the LTC facility and the hospice provider, to ensure that the needs of the resident are addressed and met 24 hours per day. (E) A provision that the LTC facility immediately notifies the hospice about the following: (1) A significant change in the resident's physical, mental, social, or emotional status. (2) Clinical complications that suggest a need to alter the plan of care. (3) A need to transfer the resident from the facility for any condition. (4) The resident's death. (F) A provision stating that the hospice assumes responsibility for determining the appropriate course of hospice care, including the determination to change the level of services provided. (G) An agreement that it is the LTC facility's responsibility to furnish 24-hour room and board care, meet the resident's personal care and	F 849		

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F 849	Continued From page 30 nursing needs in coordination with the hospice representative, and ensure that the level of care provided is appropriately based on the individual resident's needs. (H) A delineation of the hospice's responsibilities, including but not limited to, providing medical direction and management of the patient; nursing; counseling (including spiritual, dietary, and bereavement); social work; providing medical supplies, durable medical equipment, and drugs necessary for the palliation of pain and symptoms associated with the terminal illness and related conditions; and all other hospice services that are necessary for the care of the resident's terminal illness and related conditions. (I) A provision that when the LTC facility personnel are responsible for the administration of prescribed therapies, including those therapies determined appropriate by the hospice and delineated in the hospice plan of care, the LTC facility personnel may administer the therapies where permitted by State law and as specified by the LTC facility. (J) A provision stating that the LTC facility must report all alleged violations involving mistreatment, neglect, or verbal, mental, sexual, and physical abuse, including injuries of unknown source, and misappropriation of patient property by hospice personnel, to the hospice administrator immediately when the LTC facility becomes aware of the alleged violation. (K) A delineation of the responsibilities of the hospice and the LTC facility to provide bereavement services to LTC facility staff. §483.70(n)(3) Each LTC facility arranging for the provision of hospice care under a written agreement must designate a member of the	F 849		

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F 849	Continued From page 31 facility's interdisciplinary team who is responsible for working with hospice representatives to coordinate care to the resident provided by the LTC facility staff and hospice staff. The interdisciplinary team member must have a clinical background, function within their State scope of practice act, and have the ability to assess the resident or have access to someone that has the skills and capabilities to assess the resident. The designated interdisciplinary team member is responsible for the following: (i) Collaborating with hospice representatives and coordinating LTC facility staff participation in the hospice care planning process for those residents receiving these services. (ii) Communicating with hospice representatives and other healthcare providers participating in the provision of care for the terminal illness, related conditions, and other conditions, to ensure quality of care for the patient and family. (iii) Ensuring that the LTC facility communicates with the hospice medical director, the patient's attending physician, and other practitioners participating in the provision of care to the patient as needed to coordinate the hospice care with the medical care provided by other physicians. (iv) Obtaining the following information from the hospice: (A) The most recent hospice plan of care specific to each patient. (B) Hospice election form. (C) Physician certification and recertification of the terminal illness specific to each patient. (D) Names and contact information for hospice personnel involved in hospice care of each patient. (E) Instructions on how to access the hospice's	F 849		

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F 849	Continued From page 32 24-hour on-call system. (F) Hospice medication information specific to each patient. (G) Hospice physician and attending physician (if any) orders specific to each patient. (v) Ensuring that the LTC facility staff provides orientation in the policies and procedures of the facility, including patient rights, appropriate forms, and record keeping requirements, to hospice staff furnishing care to LTC residents. §483.70(n)(4) Each LTC facility providing hospice care under a written agreement must ensure that each resident's written plan of care includes both the most recent hospice plan of care and a description of the services furnished by the LTC facility to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, as required at §483.24. This REQUIREMENT is not met as evidenced by: Based on interview and record review, facility staff failed to document collaboration of care with hospice providers for development and implementation of a coordinated plan of care and communication between the facility and local hospice provider for two (Resident #49 and #82) out of three sampled residents who received hospice services. The facility census was 83. 1. Review of the facility's Nursing Facility Services Agreement, dated October 15, 2009, showed, Coordination of Care: -General. Hospice and facility shall communicate with one another regularly and as needed for each particular hospice patient. Each party is responsible for documenting such communications in its respective clinical records	F 849		

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F 849	Continued From page 33 to ensure that the needs of hospice patients are met 24 hours per day. -Design of plan of care. In accordance with applicable federal and state laws and regulations, Facility staff shall coordinate with hospice in developing a plan of care for each hospice patient. Hospice retains primary responsibility for development of the Plan of Care. 2. Review of Resident's #49's Quarterly Minimum Data Set (MDS), a federally mandated assessment, dated 09/26/24, showed: -Received hospice care; -Diagnosis of Cancer; -The resident has a condition or disease may result in a life expectancy of less than six months. Review of the facility matrix list, dated 10/2024, showed staff identified the resident received hospice services. Review of the facility's hospice binder, showed the binder did not contain a plan of care, or communication documentation for the resident between the facility and the hospice provider. Review of the resident's medical record, showed the record did not contain a plan of care, or communication documentation for the resident between the facility and the hospice provider. 3. Review of Resident's #82's Significant change MDS, dated 02/22/24, showed: -Received hospice care; -Diagnosis of Kidney Disease. Review of the facility matrix list, dated 10/2024,	F 849		

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F 849	Continued From page 34 showed staff identified the resident received hospice services. Review of the facility's hospice binder, showed the binder did not contain a plan of care, or communication documentation for the resident between the facility and the hospice provider. Review of the resident's medical record, showed the record did not contain a plan of care, or communication documentation for the resident between the facility and the hospice provider. 4. During an interview on 10/10/24 at 2:54 P.M., Licensed practical nurse (LPN) A said the expectation would be the binder kept at the nurses station would have hospice communication and a plan of care. He/She is not sure why there is not documentation in the hospice binder. During an interview on 10/10/24 at 4:37 P.M., the Assistant Director of Nursing (ADON) said he/she would expect there to be an order for Hospice, a care plan, and communication between the hospice provider and the facility. He/She said they are not sure why this does not get done, and that the facility has met and spoken with hospice about this in the past, but not sure why it hasn't changed. During an interview on 10/10/24 at 5:19 P.M., the administrator said the expectation is that there be documentation when hospice comes in the building to see the resident, any change in condition and a plan of care should be documented and in the hospice binder at the nurses station.	F 849		

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F 880	Continued From page 35	F 880		
F 880 SS=F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections;	F 880		

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F 880	Continued From page 36 (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, facility staff failed to develop and implement complete policies and procedures for the inspection, testing and maintenance of the facility's water systems to inhibit the growth of waterborne pathogens and reduce the risk of an outbreak of Legionnaire's Disease (LD- a serious type of pneumonia (lung infection) caused by Legionella bacteria, which places all residents of	F 880		

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F 880	Continued From page 37 the facility at risk of exposure which could lead to illness. The facility census was 84. 1. Review of the Centers for Medicare and Medicaid Services (CMS) Survey and Certification (S&C) letter 17-30, dated 06/02/17 and revised on 06/09/17, showed: -The bacterium Legionella can cause a serious type of pneumonia called LD in persons at risk. Those at risk include persons who are at least 50 years old, smokers, or those with underlying medical conditions such as chronic lung disease or immunosuppression. Outbreaks have been linked to poorly maintained water systems in buildings with large or complex water systems including hospitals and long-term care facilities. Transmission can occur via aerosols from devices such as shower heads, cooking towers, hot tubs, and decorative fountains; -Facilities must develop and adhere to policies and procedures that inhibit microbial growth in building water systems that reduce the risk of growth and spread of Legionella and other opportunistic pathogens in water; -CMS expects Medicare certified healthcare facilities to have water management policies and procedures to reduce the risk of growth and spread of Legionella and other opportunistic pathogens in building water systems. An industry standard calling for the development and implementation of water management programs in large or complex building water systems to reduce the risk of legionellosis was published in 2015 by American Society of Heating, Refrigerating, and Air Conditioning Engineers (ASHRAE). In 2016, the Centers for Disease Control and Prevention (CDC) and its partners developed a toolkit to facilitate implementation of	F 880		

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F 880	Continued From page 38 this ASHRAE Standard (https://www.cdc.gov/legionella/maintenance/wmp-toolkit.html). Environmental, clinical, and epidemiological considerations for healthcare facilities are described in this toolkit; -Surveyors will review policies, procedures, and reports documenting water management implementation results to verify that facilities: -Conduct a facility risk assessment to identify where Legionella and other opportunistic waterborne pathogens (e.g. Pseudomonas, Acinetobacter, Burkholderia, Stenotrophomonas, nontuberculous mycobacteria, and fungi) could grow and spread in the facility water system; -Implement a water management program that considers the ASHRAE industry standard and the CDC toolkit, and includes control measures such as physical controls, temperature management, disinfectant level control, visual inspections, and environmental testing for pathogens; -Specify testing protocols and acceptable ranges for control measures, and document the results of testing and corrective actions taken when control limits are not maintained. Review of the facility's Water Management Program, showed the program did not contain policies related to water management. Review showed the program did not contain control measures or corrective actions. Review showed the facility will not test the water or the resident's water unless there is a positive case of Legionnaire's disease within the facility. Review of the facility's water system description showed eight water heaters were identified as temperature permissive areas where Legionella could grow and special considerations for healthcare. Review of the annual water	F 880		

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F 880	Continued From page 39	F 880		

management checklist showed the monitoring procedure for water heaters was to maintain temperatures at 110-120 degrees Fahrenheit (F) and observe for signs of biofilm or sediment. Review showed the water heaters were cleaned on 12/12/23.

Review of the facility's water system description showed sinks and showers were identified as areas of possible stagnation. Review showed the system description did not identify system dead legs (areas where water may pool). Review showed the water management plan did not include policies, control measures or corrective actions related to areas of possible stagnation.

Review of Water Management Program Meeting minutes for June, July, August and September of 2024 showed the minutes included educational topics monthly. Review showed the minutes did not include information related to facility specific water systems or facility specific monitoring.

Review of the Bureau of Environmental Health Services Sanitation Observation, dated 10/10/24, showed the facility does not have a water management plan specific to the facility addressing the facility's water distribution system and controls. The water temperature at the water heaters were approximately 117 degrees F. Thermometers at water heaters were observed to be nonfunctional and/or painted to cover the face. Cold water lines were run to resident rooms and capped and not actively in use which result in multiple dead leg cold water lines throughout the facility.

During an interview on 10/08/24 at 3:15 P.M. the administrator said he/she was just notified the

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	265251	A. BUILDING _____ B. WING _____	10/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VILLA AT BLUE RIDGE, THE	701 BLUE RIDGE ROAD COLUMBIA, MO 65201

(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 40 resident in room 104, who was sent to the hospital on 10/06/24 with respiratory distress, tested positive for Legionella. During an interview 0n 10/08/24 at 2:45 P.M., the maintenance director said he/she tested the facility water for coliform every March. The maintenance director said he/she did not document the results of the March 2024 test. The maintenance director said he/she never tested the water for Legionella. The maintenance director said he/she checked water temperatures weekly to ensure the temperature was kept between 105 and 120 degrees Fahrenheit (F). During an interview on 10/10/24 at 9:20 A.M., Housekeeper Q said housekeepers clean the bathrooms daily and run water for about 15 seconds every other day. Housekeeper Q said when he/she cleaned a shower head he/she would hang the head up which created a hanging loop in the shower hose. Housekeeper Q said he/she never performed water flushing beyond routine daily cleaning. During an interview on 10/10/24 at 2:00 P.M., the maintenance director said the administrator or corporate staff were responsible for writing policy. The maintenance director said he/she was not aware of any specific water management policies. The maintenance director said he/she cleaned the exterior and flushed the water heaters annually. The maintenance director said housekeeping staff runs the water in resident rooms but he/she did not know how long. The maintenance director said the facility did not have a policy related to flushing resident use sinks or showers. The maintenance director said he/she created the facility's water system description on	F 880		

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F 880	Continued From page 41 his own based on a model in the CDC Toolkit. The maintenance director said he/she did not know what the term "temperature permissive" meant. The maintenance director said he was unsure what "special consideration for healthcare facilities" meant. The maintenance director said the facilities water management control measures were water temperature and visual inspections. The maintenance director said he/she did not document corrective actions. During an interview on 10/10/24 at 3:00 P.M., the Infection Preventionist (IP) said he/she was not really familiar with the water management program but there should be policies. The IP said water management education was reviewed during monthly department head meetings. The IP said he/she thought the water heaters were repaired in the previous month but he/she did not know what work was done. During an interview on 10/10/24 at 4:45 P.M., the administrator said he/she was aware of the requirements for a water management program. The administrator said the facility's control measures included water temperatures and he/she could not think of anything else. The administrator said maintenance and housekeeping flush sinks for three to five minutes every couple of weeks but he/she had never seen documentation of flushing. The administrator said he/she had not looked in depth at the water management program. The administrator said he/she was not aware the water management plan did not include facility specific policies, control measures or corrective actions.	F 880		
F 883 SS=E	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2)	F 883		

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F 883	Continued From page 42 §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is	F 883		

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F 883	Continued From page 43 medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is not met as evidenced by: Based on interview and record review, facility staff failed to follow policies and procedures for immunization of residents against Pneumococcal disease in accordance with national standards of practice and/or failed to assess and vaccinate two residents (Resident's #73 and # 92) of five sampled residents (over 65 years old) with doses of the Pneumococcal and/or influenza vaccine, as recommended by the Center for Disease control and prevention. Facility census was 83. 1. Review of the facility policy, Immunizations, undated, shows the following: -The resident's physician will be consulted and determine the level of risk and need for the vaccinations. A physician order is required to administer any medication/vaccination; -Pneumococcal vacinations in Persons aged 65 and older years, unless contraindicated, will be asministered according to the following guidelines when determining vaccination status:	F 883		

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F 883	Continued From page 44 -Adults 65 years or older who have not received any pneumococcal vaccination should receive Pneumococcal Conjugate Vaccine (PCV) 15 followed by a dose of pneumococcal polysaccharide vaccine (PPSV) 23 (one year later, or a single dose of PCV 20). If PCV 20 is administered, a dose of PPSV 23 is not indicated. Review of Centers for Disease Control (CDC) Vaccine Guidelines for Adults, 09/12/24, states: -Adults >65 who have not received any pneumococcal vaccine should receive PCV20 or PCV21; or PCV15 followed by a dose of PPSV23 a year later; -Adults >65 years with prior PCV 13 only vaccination should be given the option of PCV 20, PCV 21 or PCV 23;-Adults 65 years or older who have not already received a pneumococcal conjugae vaccine may receive either a single dose of PCV 15 followed by a dose of PPSV 23 one year later; or a single dose of PCV 20. 2. Review of Resident #73's medical record showed: -Admission date of 6/24/24; -Signed pneumococcal vaccination consent on 6/24/24; -Staff did not document the resident offered, recieved or refused the pneumococcal vaccine. 3. Review of Resident #92's medical record showed: -Admission date of 8/16/24; -Resident recieved PCV13 on 5/8/16;	F 883		

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F 883	Continued From page 45 -Signed pneumococcal vaccination consent on 8/16/24; -Staff did not document the resident was offered, recieved or refused the PCV20, PCV21or PCV23 pneumococcal vaccine. 4. During an interview on 10/9/24 at 3:30 P.M., the Assistant Director of Nursing (ADON)/ Infection Preventionist (IP) said he/she was responsible for the immunization program, but has not kept up with offering pneumococcal boosters since assuming the role. He/She does not know why some residents did not get an opportunity to be vaccinated. During an interview on 10/9/2024 at 4:00 P.M., the administrator said the IP is responsible for the vacciniation program right now. The expectation is the immuniztion policy would be followed. He/She does not know why PCV20 or PCV21 vaccines have not been offered to eligible residents, but agrees it should be done.	F 883		

Missouri Department of Health and Senior Services

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	01706	A. BUILDING: _____ B. WING _____	10/10/2024

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VILLA AT BLUE RIDGE, THE	701 BLUE RIDGE ROAD COLUMBIA, MO 65201

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A4018	19 CSR 30-85.042(18)(A) Criminal History -Facility Policy/Procedure The facility must develop and implement written policies and procedures which require that persons hired for any position which is to have contact with any patient or resident have been informed of their responsibility to disclose their prior criminal history to the facility as required by section 660.317.5, RSMo. The facility- (A) Shall also develop and implement policies and procedures which ensure that the facility does not knowingly hire, after August 28, 1997, any person who has or may have contact with a patient or resident, who has been convicted of, plead guilty or nolo contendere to, in this state or any other state, or has been found guilty of any A or B felony violation of Chapter 565, 566 or 569, RSMo, or any violation of subsection 3 of section 198.070, RSMo, or of section 568.020, RSMo, unless the person has been granted a good cause waiver by the division; II/III This regulation is not met as evidenced by: Refer to F607 Class II	A4018		
A4040	19 CSR 30-85.042(35)(B) SNF RN-Day Shift, LPN/RN eve/nights Licensed Nursing Requirements; Skilled Nursing Facility. (B) A registered nurse shall be on duty in the facility on the day shift. Either a licensed practical nurse (LPN) or a registered professional nurse (RN) shall be on duty in the facility on both the evening and night shifts. II This regulation is not met as evidenced by: Refer to F727	A4040		

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A4040	Continued From page 1 Class II	A4040		
A4055	19 CSR 30-85.042(46) Safe/Effective Medication System There shall be a safe and effective system of medication distribution, administration, control, and use. I/II This regulation is not met as evidenced by: Class II See F759	A4055		
A4064	19 CSR 30-85.042(55) Medication Storage Facilities shall store all external and internal medications at appropriate temperatures in a safe, clean place and in an orderly manner apart from foodstuffs and dangerous chemicals. A facility shall secure all medications, including those refrigerated, behind at least one (1) locked door or cabinet. Facilities shall store containers of discontinued medication separately from current medications. II/III This regulation is not met as evidenced by: Refer to F761 Class III	A4064		
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	A4086		

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A4086	Continued From page 2 Regulations pertaining to communicable diseases, specifically 19 CSR 20-20.020, as amended. I/II This regulation is not met as evidenced by: Refer to F880 and F883 Class II	A4086		
A4105	19 CSR 30-85.042(96) Medical Record-Physician Documentation Facility staff shall include physician entries in the medical record with the following information: admission diagnosis, admission physical and findings of subsequent examinations; progress notes; orders for all medications and treatment; orders for extent of activity; orders for restraints including type and reason for restraint; orders for diet; and discharge diagnosis or cause of death. II/III This regulation is not met as evidenced by: Class III See F698	A4105		
A4116	19 CSR 30-85.042(102) Clinical Records Accurate/Accessible The facility must maintain clinical records on each 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: Refer to F658	A4116		

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A4116	Continued From page 3 Class II	A4116		

and

PLAN OF CORRECTION		
Provider/Supplier Name:	The Villa at Blue Ridge	
Street Address, City, Zip:	701 Blue Ridge Road Columbia, MO 65201	
Date of Survey:	Exit 10/10/2024	
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
	This Plan of Correction (POC) is submitted under State and Federal Law. The submission of this POC does not constitute an admission on the part of The Villa at Blue Ridge (the facility) as to the accuracy of the surveyor's findings or the conclusions drawn therefrom. The Facility's submission of this POC does not constitute the submission of The Villa at Blue Ridge that the findings cited are accurate, constitute a deficiency, or that the scope and severity regarding the deficiencies cited are correctly applied. The POC is intended to constitute the facility's credible letter alleging compliance. Compliance has been and will be achieved no later than the last completion date listed in the POC. Compliance will be maintained as provided in the POC. Date of Alleged Compliance: November 21, 2024	11/21/2024
F 607	The facility will check the Certified Nurse Assistant (CNA) Registry all employees prior to hire to ensure they do not have a Federal Indicator for all employees, including Dietary Aide D, Nurse Aide E, Housekeeping F, Dietary Cook G and Registered Nurse H. Facility staff will complete thorough investigations of all injuries of unknown origin, including resident #61. All residents are considered at risk of the alleged deficient practice. The Assistant Business Office Manager (ABOM) has been inserviced regarding completing a CNA registry check on all employees prior to hire. All personnel files have been audited and all employees have been checked on the CNA registry. The ABOM will complete background checks prior to hire and will provide a completed checklist of completed checks to the Administrator for review to ensure compliance is achieved and	11/21/2024

and

	maintained. The DON/ADON will ensure a complete investigation is completed for injuries of unknown origin. The DON/ADON have been inserviced by the Administrator related to completing required abuse investigations for injuries of unknown origin, including formal reporting to DHSS. The Administrator will ensure all reports of resident injury of unknown origin are properly investigated. The facility staff will continue reporting any unknown injury to charge nurses and administrative staff as per prior procedure. The DON/ADON/Administrator will ensure proper paperwork is filled out for each investigation to ensure a thorough investigation has been completed. The Administrator will provide a quarterly resident abuse report to the QAA committee and will make any adjustments as needed for problems identified. Date of Alleged Compliance: November 21, 2024	
F 638	The facility will assess residents using the quarterly Minimum Data Set (MDS) for all residents, including Resident #6, #9, #20, #26, #28, #29, #31, #32m #33, #41, #44, #46, #51, #57, #63, #69, #70 and #71. Resident #12 has been discharged. All residents are considered at risk of the alleged deficient practice. **The MDS coordinator and DON have been inserviced regarding the requirement to complete an assessment on all residents using the quarterly Minimum Data Set (MDS)** An audit has been completed and all residents have current MDS within the required 92-day timeframe. The DON will complete a weekly audit of MDS progress to ensure timeliness completion of all MDS assessments to ensure compliance is achieved and maintained. Non-compliance will be immediately addressed if and when discovered. The MDS Coordinator will provide a quarterly MDS Assessment report to the QAA committee and will follow recommendations and guidance as given by the DON and Administrator. Date of Alleged Compliance: November 21, 2024	11/21/2024
F 658	The facility will meet professional standards of care for all residents with treatment orders, including resident #31 and code status for all residents, including resident #3. Resident #30 has been discharged from the facility. All residents are considered at risk of the alleged deficient	11/21/2024

and

	practice. The charge nurses have been in serviced regarding completing treatment orders per physician orders on the Treatment Record (TAR) daily as ordered. If residents refuse treatments the physician will be notified and refusal will be documented. All resident code status has been audited to ensure the face sheet, physician orders and code sticker match. The ADON or DON will audit treatment completion a minimum of once per week to ensure treatments are completed per order and compliance is achieved and maintained. Non-compliance will be immediately addressed if/when discovered. The Social Service designee will complete a monthly audit of all resident code status located on face sheet, physician order, code sticker on door and resident care plan to ensure compliance is achieved and maintained. Any discrepancies will be corrected at this time of discovery. The DON will provide a quarterly TAR audit report to the QAA committee and will follow recommendations and guidance as given by the Administrator and Medical Director. The Social Service designee will provide a quarterly resident code status report to the QAA committee and will follow recommendations and guidance as given by the Administrator and DON. Date of Alleged Compliance: November 21, 2024	
F 661	The facility staff will complete a comprehensive discharge summary or post discharge plan of care for all residents. All discharged residents are considered at risk of the alleged deficient practice. The Social Service designee will continue completing the discharge summaries for all discharged residents, at the time of discharge. Once monthly the Social Service designee will reconcile all discharged residents with discharge summaries to ensure completion of the discharge summary, per the regulation. Non-compliance will be corrected at that time, if identified. The Social Service designee will give the Administrator a copy of monthly audit to ensure compliance is achieved and maintained. The Administrator will complete a minimum of 1 random discharge audit per month to ensure the process is being completed. The Social Service designee will provide a quarterly discharge	11/21/2024

and

	report to the QAA committee and will follow recommendations and guidance as given by the Administrator. Date of Alleged Compliance: November 21, 2024	
F 698	The facility will ensure all residents receive care and services for the provision of hemodialysis consistent with professional standards of practice. Staff will provide orders, ongoing assessments of resident's condition and monitor for complications after dialysis treatments for all residents that receive dialysis, including resident #55. All residents that receive hemodialysis are considered at risk of the alleged deficient practice. All licensed nurses will be inserviced regarding the facility dialysis policy. The staff will be trained to feel for thrill daily, inspect access site for redness, swelling or warmth, monitor for bleeding after dialysis, monitor for s/s of infection. Site to be checked once per shift. The Dialysis Communication Record will be completed and sent with resident to each dialysis visit. The DON will contact the Dialysis center and express importance of clinic filling out and returning the completed form with resident, including weight prior to and after dialysis, labs completed, medications given and any new physician orders. The care plan will be updated to include monitoring of resident on dialysis. The physician order will be updated to include an order for dialysis and care of the right-side shunt. The facility staff will document an assessment prior to and return from dialysis appointments, daily vital signs, skin assessment for infection, monitoring of shunt, monitoring of intake and output and daily weights. The communication forms will be uploaded to EMR after each dialysis visit. The DON will audit the daily charting a minimum of once daily, when scheduled x 2 weeks to ensure compliance is achieved and a minimum of once weekly thereafter to ensure compliance is maintained. The DON will provide a quarterly dialysis compliance report to the QAA committee and will follow recommendations and guidance as given by the Administrator and Medical Director. Date of Alleged Compliance: November 21, 2024	11/21/2024
F 727	The facility will schedule a Registered Nurse (RN) for at least 8 consecutive hours a day, 7 days a week. All residents are considered at risk of the alleged deficient practice.	11/21/2024

and

	The DON has been removed from the charge nurse schedule. **The DON and ADON have been inserviced in regards to the requirement to have an** **RN for 8 hours a day and the DON cannot serve as a charge nurse with a census of 60 or more residents.** The facility has hired an additional RN. The facility will ensure RN 8 hour per day coverage. The Administrator will ensure the facility staffing meets the federal requirement. The DON will provide a quarterly staffing report to the QAA committee and will follow recommendations as given by the Administrator. Date of Alleged Compliance: November 21, 2024	
F 759	The facility will ensure a medication error rate of less than 5%. All residents that are administered extended-release medication and eye drops are considered at risk of the alleged deficient practice. Resident #60 medications will be administered as ordered. All nurses and certified medication technicians (CMT's) have been inserviced by the DON regarding not crushing extended-release medications and following orders for eye drop instillation for all residents including resident #60. The charge nurses will notify physician if a resident is unable to take medication as ordered (ie – if medication can not be swallowed and needs to be crushed) to obtain an order change as needed. The DON or ADON will make a random, unannounced medication audit a minimum of 2 times per week to ensure medications are being administered as ordered to ensure compliance is achieved and once monthly thereafter to ensure compliance is maintained. Non-compliance will be immediately addressed at the time of occurrence. The DON will provide a quarterly medication error report to the QAA committee and follow recommendations and guidance as given by the Administrator and Medical Director. Date of Alleged Compliance: November 21, 2024	11/21/2024
F 761	The facility will store medications and biologics in a safe manner. The treatment carts will remain locked in public areas when nurse or CMT is away from cart. All residents are considered at risk of the alleged deficient	11/21/2024

and

	practice. All nurses and CMT's have been inserviced by the DON/ADON regarding the treatment carts remaining locked when unattended by staff. The DON/ADON will monitor the carts daily when scheduled during facility rounds for a minimum of 2 weeks to ensure compliance is achieved and a minimum of once weekly thereafter to ensure compliance is maintained. Non-compliance will be addressed immediately if/when discovered. The DON will provide a quarterly staff compliance report to the QAA committee and will follow recommendations and guidance as given by the Administrator. Date of Alleged Compliance: November 21, 2024	
F 849	The facility will document collaboration of care with hospice providers for development and implementation of a coordinated plan of care and communication between the facility and local hospice provider for all residents on hospice service, including resident #49 and #82. All residents on hospice service are considered at risk of the alleged deficient practice. The facility has contacted the hospice agency for resident #49 and #82 to ensure the hospice record contains a plan of care or communication between the facility and hospice binder or uploaded to the EMR. The hospice agency nurse will be invited to all care plan meetings for residents on hospice service to ensure continuity of care. The DON/ADON will monitor the hospice record a minimum of once monthly to ensure compliance is maintained. The DON will provide a quarterly hospice report to the QAA committee and will follow recommendations as given by the Medical Director and Administrator. Date of Alleged Compliance: November 21, 2024	11/21/2024
F 880	**The facility will develop and implement complete policies and procedures for the inspection, testing and maintenance of the facility's water systems to inhibit the growth of waterborne pathogens and reduce the risk of an outbreak of Legionnaire's Disease (LD) caused by Legionella bacteria.** **All residents are considered at risk of the alleged deficient practice.** **The facility's Water Management Program will contain policies related to water management, possible stagnation**	**11/21/2024**

and

	and dead leg cold water lines, including corrective actions. **Water heaters will be maintained at 110-120 degrees Fahrenheit (F).** **The Maintenance Director will routinely observe for signs of biofilm or sediment. The Maintenance Director will ensure thermometers at water heaters remain functional.** **The facility is following environmental health services recommendations. The shower fixture has been changed out with the recommended fixture with filters and the water retested on 10/24/2024 with no legionella detected. Water lines with possible stagnation and dead leg cold water lines will be flushed weekly until the low flow faucets have been replaced.** **The Facilities Water Management Committee which includes the Maintenance Director, Housekeeping Supervisor, Director of Nursing, Assistant Director of Nursing and Dietary Manager have been inserviced by the Administrator on the water management program and the prevention of legionella. The Maintenance Director will complete monthly testing of the water heater temperatures, assess for biofilm and sediment in hot water heaters. Water lines with possible stagnation and dead leg cold water lines will be flushed weekly.** **Any issues outside the normal parameters will be addressed immediately at the time of discovery.** **The Maintenance Director will provide a quarterly Water Management Report to the QAA committee and will follow recommendations and guidance as given by the Administrator.** **Date of Alleged Compliance: November 21, 2024**	
F 883	The facility will follow policies and procedures for immunization of residents against Pneumococcal disease in accordance with the national standards of practice. Staff will assess and vaccinate all residents that consent for the Pneumococcal vaccine including resident #73, & #92. All residents are considered at risk of the alleged deficient practice. The ADON has audited all resident records to ensure any resident that has consented for a Pneumococcal vaccine that is eligible for a Pneumococcal vaccine has received the vaccine. The ADON will maintain record of all resident Pneumococcal	11/21/2024

and

	immunizations and next dose due date to ensure all vaccines are received timely. The ADON will provide a quarterly immunization report to the QAA committee and will follow recommendations and guidance as given by the Administrator and Medical Director. Date of Alleged Compliance: November 21, 2024	

and

A 4018	Refer to F 607	11/21/2024
A 4040	Refer to F 727	11/21/2024
A 4055	Refer to F 759	11/21/2024
A 4064	Refer to F 761	11/21/2024
A 4086	Refer to F 880 and F 883	11/21/2024
A 4105	Refer to F 698	11/21/2024
A 4116	Refer to F 658	11/21/2024

and

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.