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	265665	A. BUILDING _____ B. WING _____	01/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILL CREST MANOR	801 SOUTH COLBY HAMILTON, MO 64644

(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 550 SS=E	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the	F 550		

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

Bill Buchmann LNHA 2/12/2025

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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exercise of his or her rights as required under this subpart.
This REQUIREMENT is not met as evidenced by:
Based on observation, interview, and record review the facility failed to honor the resident's right to a dignified existence (Resident #11), and additionally when staff failed to assure residents rights to privacy was maintained for five (Resident # 8, #11, #12, #19, #21) of the 15 sampled residents. The facility census was 58.

Review of the facility's policy titled, "Resident Rights," revised February, showed:
- Employees shall treat all residents with kindness, respect, and dignity;
-Staff will maintain a residents right to privacy;
-Federal and state laws guarantee certain basic rights to all residents of this facility.

1. Review of the Resident #12's Face Sheet., showed:
- Diagnoses included: Stroke and muscle weakness;
- Do not resuscitate (No chest compressions for life saving).

Review of Resident #12's, undated care plan., showed;
- Resident was alert and oriented;
- Required assistance of 1 person for showers and transfers;
- Independent with mobility while in wheelchair;
- The care plan did not address how many showers a week the resident prefers;
- Resident requires 1 person assist for personal hygiene and grooming;
- Staff are to anticipate and meet the needs of the residents;

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- The right to privacy and knocking prior to entry of room was not care planned.

Observation of CNA A on 1/26/25 at 10:05 A.M., entered the residents room without knocking or announcing self.

Observation of CNA D on 1/27/25 at 2:15 P.M.,entered the resident's room without knocking or announcing self.

During at interview on 1/28/25 at 1:01 P.M., the resident said, staff never knock, they just walk in like the own the place.

2. Review of Resident #19's Face Sheet showed:
- Responsible for self;
-Diagnoses: Pneumonia (infection of the lungs that impacts breathing), Diabetes, (a condition in which the body does not process blood sugar properly, depression, and restless leg syndrome (twitching of the legs).

During an Interview on 1/26/25 at 1:32 P.M. the resident said nursing staff did not knock on his/her door before entering his/her room and staff talk about him/her in the hall way.

Observation 01/27/25 at 08:38 A.M. showed: Nursing staff came out of the resident's room in the hallway and yelled out to the DON (Director of Nursing) that Resident #19 was getting sick, and throwing up, then the DON yelled to to then Nurse, the resident was getting sick. All in view of other staff and residents in the hallway.

Observation on 01/28/25 at 07:08 A.M. showed: CNA's walking out of Resident #19's room discussing the current condition of the resident to

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other staff in front of other resident's.

Review of facility policy titled, "Dignity," revised February 2021, showed:
-Residents are treated with dignity and respect at all times;
-Individuals needs and preferences of the resident are identified through the assessment process;
-Staff are expected to knock and request permission before entering residents' rooms;
-Staff inform and orient residents to their environment;
-Staff promote, maintain and protect resident privacy, including bodily privacy during assistance with personal care and during treatment procedures.

Review of the facilty policy titled, "Personal Conduct," undated, showed employees are expected to be courteous and to treat everyone with dignity and respect.

3. Review of Resident #8's quarterly MDS (Minimum Data Set), a federally mandated assessment tool completed by facility staff, dated 11/15/24, showed:
-They had moderate impaired cognition;
-They had impairment to one side of upper and lower extremity;
-They were dependent on a wheelchair;
-They were dependent for transfers from sitting to lying, lying to sitting on side of bed, chair to bed transfers, and shower transfers;
-He/She required substantial/maximal assistance rolling left and right;
-Diagnoses included stroke (condition that occurred when blood flow to part of the brain was disrupted causing damage to brain tissue due to

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blocked blood vessel), hip fracture, anxiety, depression (persistent feelings of sadness, hopelessness, and loss of interest or pleasure in activities that previously enjoyed), schizophrenia (a mental health condition that affects a persons thoughts, perceptions, and behaviors), acute pain (a sudden pain that is short-lived and caused by an injury, illness, or medical procedure), restless leg syndrome, and generalized weakness (decreased muscle strength or lack of physical energy in most parts of the body).

Review of care plan, revised 12/19/24, showed:
-They will be treated with dignity and respect;
-Communication: Use my preferred name. Identify yourself at each interaction. Face them when speaking and make eye contact. Reduce any distractions by turning off television, radio, close door, etc. They understood consistent, simple, directive sentences. Provide them with necessary cues and stop and return if agitated.

Review of physicians orders, dated 1/27/25, showed an order dated 1/1/25 to readmit to hospice.

Observation on 1/26/25 9:36 A.M., showed CMT A and CNA B burst into resident's room and did not knock or announce self prior to entering resident's room.

Observation on 1/27/25 at 7:49 A.M. showed resident was laying in their bed with a gown half on and their chest exposed. Resident's room door was open and resident was visible from the hallway.

During an interview on 1/29/24 at 2:04 P.M., CNA C said staff should knock and announce

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themselves prior to entering a resident room.

During an interview on 1/29/24 at 2:22 P.M., CNA D said staff should always knock and announce themselves when entering a residents room.

During an interview on 1/29/25 at 2:34 P.M., CMT A said staff should knock prior to entering resident room and announce themselves.

During an interview on 1/29/24 at 4:16 P.M., Director of Nursing said she expected staff to knock and announce themselves prior to entering a resident room.

During an interview on 1/29/24 at 4:16 P.M., Administrator said she expected staff to knock and announce themselves prior to entering a resident room.

4. Review of Resident #16's Quarterly MDS, dated 12/14/24 showed:
- Cognitive skills intact;
- Required substantial to maximum assistance with toilet use, showers, personal hygiene and transfers;
- Always incontinent of bowel and bladder;
- Diagnoses included high blood pressure, stroke, anxiety, depression, and atrial fibrillation (A-fib, an irregular, often rapid heart rate that commonly causes poor blood flow).

Observation and interview on 1/26/25 at 12:26 P.M., showed:
- CNA B opened the resident's door and did not knock or announce him/herself first;
- The resident said he/she would prefer the staff knock and announce themselves before they enter his/her room.

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During an interview on 1/29/25 at 10:27 A.M., CNA B said:
- He/She should have knocked and announced him/herself before entering the resident's room;
- He/She was not aware of any staff being rude, yelling or rough with residents and has not had any residents complain about it to him/her.

5. Review of Resident #21's Annual MDS, dated 11/5/24 showed:
- Cognitive skills moderately impaired;
- Required substantial to maximum assistance with toilet use and showers;
- Frequently incontinent of urine;
- Occasionally incontinent of bowel;
- Diagnoses included diabetes mellitus, high blood pressure, anxiety, depression, high blood pressure, and schizophrenia (a mental disorder characterized by disruptions in thought processes, perceptions, emotional responsiveness, and social interactions).

During an interview on 1/26/25 at 2:33 P.M., the resident said staff do not knock and announce themselves before they enter the room and the resident would prefer they knock announce themselves before entering the room.

During an interview on 1/26/25 at 2:33 P.M., Resident #21 said:
- He/She had reported staff being rough with him/her. He/She had reported it to the previous Administrator and the previous DON but they did not do anything about it;
- CNA A has yelled at him/her before during one of his/her spells. He/She reported it to the previous Administrator and the previous DON and they said it was natural and not to worry about it

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and they did not do anything about it.

6. Review of Resident #11's quarterly MDS, dated 1/13/25, showed:
-They were moderately cognitively impaired;
-He/She had clear speech;
-He/She was able to make self-understood and usually understood -missing some or part/intent of message but comprehends most of conversation;
-They had severely impaired vision;
-They were dependent on a wheelchair;
-They had no impairment to upper or lower extremities;
-They were independent with mobility-rolling left and right, sit to lying, lying to sitting;
-They required supervision or touching assistance with chair to bed transfers, toilet transfers, tub/shower transfers;
-Diagnoses included: glaucoma (condition affecting the eye that can lead to vision loss if left untreated), high blood pressure, dementia (group of brain disorders that cause a decline in cognitive abilities, such as memory, thinking, reasoning, and judgement), anxiety, depression, psychotic disorder (a disconnection from reality), polyarthritis (condition affecting multiple joints without specifying location of inflammation), idiopathic neuropathies (nerve damage that can cause pain, numbness, tingling, or weakness in the body), and muscle spasms.

Review of care plan, revised 11/21/24, showed:
-They will be treated with dignity and respect;
-They can verbally express their wants and needs. Educate staff to provide resident with opportunities to do so;
-They required assistance with activities and meals related to decreased visual function

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secondary to diagnosis of glaucoma;
-They had visual impairment, place their meal plate in reach and letting her know what is on plate.
-Approach them from the front speak before touching or providing care etc for resident;
-Tell them where you are placing items, be consistent;
-They liked to call for help on a regular basis. Assist them with their needs and reassure them.

Review of physician's orders, dated 1/27/25, showed an order dated 1/17/25 for occupational therapy to evaluate for activities of daily living, cognitive skills, functional mobility and safety awareness, low vision, and compensatory techniques.

Observation on 1/26/24 at 12:50 P.M. showed resident was at lunch sitting with two aids and had received no assistance from CNA A who was sitting beside resident. Resident had food all over their left hand. CNA A did not provide verbal prompts or cues to resident.

Observation on 1/27/25 at 10:08 A.M., showed CNA A entered resident's room without knocking on door. CNA A did not introduce self to resident and did not say anything to resident. CNA A did not tell resident what they were doing with resident prior to moving resident out of their room at 10:11 A.M. in their wheelchair.

During an interview on 1/29/24 at 2:04 P.M., CNA C said:
-Resident #11 was independent with meals but required verbal cues;
-Staff provided resident with verbal cues by telling resident where their food was located by using

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the orientation of the clock method;
-Resident #11 got scared a lot so staff have to provide a lot of verbal reassurances.

During an interview on 1/29/24 at 2:22 P.M., CNA D said:
-Resident #11 staff tell residents what food was in front of them and take their hand to guide them and showing them where there meat is, vegetable, dessert, and so on;
-For resident #11, you have to verbally talk through everything with them due to their visual impairments.

During an interview on 1/29/25 at 2:34 P.M., CMT A said:
-Resident #11 required explanation of every step due to their visual impairments;
-Staff should explain location of Resident #11's wheelchair prior to assisting in a transfer and orient to items around room such as when assisting in bathroom describing location of grab bar, or call light, or bedside table;
-Staff would explain meals to resident #11 by describing where food is located in front of them on their plate and the location of their drink cup items;

During an interview on 1/29/24 at 4:16 P.M., Director of Nursing said she expected staff to explain what they were doing with visually impaired residents prior to providing cares and assisting with meals.

During an interview on 1/29/24 at 4:16 P.M., Administrator said she expected staff to announce themselves to visually impaired residents, and provide activity of daily living cares and meal service according to their care plan.

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7. Review of Resident #32's significant change MDS, dated 12/6/24, showed:
-Severe cognitive impairment;
-They had no impairment in upper or lower extremities;
-Diagnoses included: heart disease, Alzheimer's Disease (progressive neurodegenerative disorder that primarily affects memory, thinking, and behavior), and depression (mood disorder that causes a persistent feeling of sadness and loss of interest).

Review of care plan, dated 12/19/24, showed the resident requires staff assistance with ADL's (activities of daily living).

Observation on 1/27/25 at 4:39 P.M. showed the resident's hair was frizzy, uncombed and was longer than resident traditionally wears their hair. Their hair was standing straight out and unmanaged.

During an interview on 1/27/25 at 12:41 P.M., Resident's Responsible Party said the staff had not brushed the reisdent's hair on 1/10/25 and it looked like the resident "stuck their finger in a light socket".

During an interview on 1/28/25 at 3:26 P.M., Resident #32's family member said:
-The resident had not had a hair cut or perm in months;
-The resident was to have a haircut on 1/24/25 but did not receive a haircut.

During an interview on 1/29/25 at 11:48 A.M., Activities Director said:
-The facility had been without a beautician for a

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F 550	Continued From page 11 couple of months; -The resident had hair set by the beautician on 1/24/25, but did not receive a haircut or perm; -There were no set timelines for when residents haircuts were scheduled; -The staff would set up a haircut appointment for residents when they requested a cut or when residents hair looked shaggy. During an interview on 1/29/25 at 4:16 P.M., Administrator said: -Residents should receive haircuts regularly; -Residents hair should be clean and combed. MO248475	F 550		
F 561 SS=E	Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in	F 561		

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community activities both inside and outside the facility.

§483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility.
This REQUIREMENT is not met as evidenced by:
Based on interview and record review the facility failed to assure that three residents (Resident #12, #25, and #42) had the right to self-determination through support of resident choice, when staff did not honor one resident's request for specific menu food items that had been encouraged by the facility's dietician (Resident # 42) but not not provided to the resident, and additionally failed to honor resident choice for showers for two residents (Resident #12, #25) out of the sampled 15 residents. The facility census was 58.

Review of the facility's policy titled, "Resident Rights," revised February, showed:
- All residents have the right to choice, and self determination, respect, and dignity;
- Federal and state laws guarantee certain basic rights to all residents of this facility.

1. Review of the Resident #12's Face Sheet., showed diagnoses included a stroke and muscle weakness.

Review of Resident #12's, undated care plan., showed;
- Resident was alert and oriented;
- Required assistance of 1 person for showers and transfers;

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- Independent with mobility while in wheelchair;
- The care plan does not address how many showers a week the resident prefers.

Review of the Resident's shower sheets provided, showed:
- The week of 11/4/24, the resident received only 1 shower;
- The week of 11/24/24, the resident received only 1 shower;
- The week of 1/3/25, the resident received only 1 shower.

During an interview at 12:46 P.M. on 01/28/25 the resident said he/she doesn't feel that he/she has a say about when he/she receives a shower and would like a shower at least twice a week. He/She does not feel clean, and it upsets him/her.

2. Review of Resident #25's face sheet., showed diagnoses included Diabetes (a condition in which the body does not process blood sugar properly), obesity, depression, swelling in the legs and feet.

Review of Care Plan, dated 11/19/24., showed:
-Resident prefers showers in the day time;
-The care plan does not address how many showers a week the resident prefers;
-Resident has depression and staff should encourage resident to maintain independence.

Review of the Residents Shower Sheets., showed;
- Week of 12/20/24- One shower was documented;
- Week of 12/26/24-One shower was documented;
- Week of 1/11/25- One shower was documented.

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	265665	A. BUILDING _____ B. WING _____	C 01/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILL CREST MANOR	801 SOUTH COLBY HAMILTON, MO 64644

(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
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During an interview on 01/26/25 10:39 AM., the resident said he/she did not get a shower this week, or last week. He/she would like a shower twice a week. " I feel dirty when I don't get a shower."

During an interview on 1/26/25 at 2:15 P.M., Certified Nurses Aide (CNA) A said staff complete the showers when we can. Resident's should have a shower at least twice a week.

During an interview with the Administrator and Director of Nursing (DON) on 1/25/25 at 4:05 P.M., stated:
-Resident's who wish to have a shower twice a week, should be able to;
-Resident's are allowed choice in their daily care;
-Showers are to be documented on the shower sheets and signed by the nurse they are completed when the CNA/Bath CNA completes them.

3. Review of Resident #42's Annual MDS assessment, (A mandatory assessment completed by facility staff).,dated 12/21/24 showed:
-Cognitive skills were intact;
-Diagnoses included: Heart disease, pneumonia (infection of the lungs), diabetes, thyroid disorder, arthritis, anxiety, depression, and asthma (chronic lung disease).

Review of physician's orders showed on 7/30/24 orders were entered for regular diet, texture and consistency.

Review of care plan, dated 10/14/24, showed:
-Resident had a potential for weight loss;

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-If resident consumed less than 50% of their meal, an alternative should have been offered;
-Snacks or supplements should have been offered when resident asked for or needed them.

During an interview on 1/27/25 at 9:59 A.M., Resident #42 said:
-They did not get enough fresh fruit;
-Meals were repetitive (always the same foods);
-When they were admitted to the facility, they told the dietician about their food preferences such as yogurt, fresh fruit, or cheese but they have not been offered these items.

During an interview on 1/29/25 at 8:58 A.M., Resident #42 said:
-They felt "defeated" because there were no healthy food options;
-They did not like that they had to ask their family for fresh fruit and other preferred food items;
-They had given up on getting to eat the food they enjoyed.

During an interview on 2/4/24 at 4:33 P.M., the Dietician said:
-They entered resident food preferences in their system and Dietary Manager should have followed up on resident preferences;
-Residents could have obtained their desired food items if the facility had the budget to provide those foods.

During an interview on 2/5/25 at 8:34 A.M., Dietary Manager said residents needed to ask kitchen staff for specific foods so they could put in an order.

During an interview on 2/5/25 at 10:56 A.M., Administrator said:

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F 561	Continued From page 16 -Residents should have been able to get their preferred food within reason; -Facility should have had fruit, yogurt and cheese on hand; -They have not always had fresh fruit available.	F 561		
F 565 SS=E	Resident/Family Group and Response CFR(s): 483.10(f)(5)(i)-(iv)(6)(7) §483.10(f)(5) The resident has a right to organize and participate in resident groups in the facility. (i) The facility must provide a resident or family group, if one exists, with private space; and take reasonable steps, with the approval of the group, to make residents and family members aware of upcoming meetings in a timely manner. (ii) Staff, visitors, or other guests may attend resident group or family group meetings only at the respective group's invitation. (iii) The facility must provide a designated staff person who is approved by the resident or family group and the facility and who is responsible for providing assistance and responding to written requests that result from group meetings. (iv) The facility must consider the views of a resident or family group and act promptly upon the grievances and recommendations of such groups concerning issues of resident care and life in the facility. (A) The facility must be able to demonstrate their response and rationale for such response. (B) This should not be construed to mean that the facility must implement as recommended every request of the resident or family group. §483.10(f)(6) The resident has a right to participate in family groups. §483.10(f)(7) The resident has a right to have	F 565		

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family member(s) or other resident representative(s) meet in the facility with the families or resident representative(s) of other residents in the facility.
This REQUIREMENT is not met as evidenced by:
Based on interview and record review, the facility failed to act promptly and resolve resident grievances voiced during the resident council meetings concerning issues of resident care and life in the facility and failed to communicate how the issues were resolved. The facility census was 58.

Review of the facility's policy titled, "Grievances/Complaints, Recording and Investigating," revised April 2017, showed:
- All grievances and complaints filed with the facility will be investigated and corrective action will be taken to resolve the grievances;
- The Administrator has assigned the responsibility of investigating grievances and complaints to the grievance officer;
- Upon receiving a grievance and complaint report, the grievance officer will begin an investigation into the allegations;
- The investigation and report will include, as applicable: the date and time of the alleged incident; the circumstances surrounding the alleged incident; the location of the alleged incident; the names of any witnesses and their accounts of the alleged incident; the resident's account of the alleged incident; accounts of any other individuals involved and recommendations for corrective action;
- The grievance officer will record and maintain all grievances and complaints on the "Resident Grievance Complaint Log". The following information will be recorded and maintained in the

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log: the date the grievance /complaint was received; the name and room number of the resident filing the grievance/complaint (if available); the name and relationship of the person filing the grievance/complaint on behalf of the resident (if available); the date the alleged incident took place; the name of name of the person investigation the incident; the date the resident or interested party, was informed of the findings and the disposition of the grievance;
- Copies of all reports must be signed and will be made available to the resident or person acting on behalf of the resident.

1. Review of the resident council minutes, dated 11/16/24 showed:
- New Business: Issues: Dietary - could residents be offered seconds on both sides? Nursing- staff is rude to residents that can't feed themselves; aides are loud at night; not answering call lights very promptly; beds not made. Laundry - missing blankets and clothes. The area for action taken and who the person responsible was left blank.

2. Review of the resident council minutes, dated 1/18/25 showed:
New Business: Issues: Can residents get Internet in their rooms? Need more sheets, bigger bed; Laundry - missing clothes. Housekeeping - not always cleaning rooms. The area for action taken and who the person responsible was left blank.

3. During a group meeting with the residents on 1/27/25 at 1:07 P.M., the residents said:
- When concerns are brought up at their resident council meetings, the staff do not tell them what has been done to correct the issues brought up from the previous meeting.
- During the resident council meeting on 1/27/25

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F 565	Continued From page 19 at 1:07 P.M., nine out of the 11 residents at the meeting said CNA A is rude, and rough with them. They have reported it to the previous Administrator and DON and nothing was ever done. During an interview on 1/27/25 at 4:37 P.M., the Activity Director said: - When a resident brings up a concern at the resident council meeting, he/she made copies and passed them out to all the department heads and also gave one to he previous Administrator and Director of Nursing (DON); - He/she is unable to discuss the results with the residents because he/she did not get any feedback from the department heads to know how the issues were handled. During an interview on 1/29/25 at 8:56 A.M., the Administrator and the DON said she was not aware of any issues being reported by the resident council about a specific aide. During an interview on 1/29/25 at 4:16 P.M., the Administrator said: - Staff yelling at residents, residents being rough with cares or cursing should be reported to administration for action. - She would expect the manager to work the process, then discuss it with administration. - The manager should go back to the resident council and notify the residents how issues were to be resolved.	F 565		
F 570 SS=E	Surety Bond-Security of Personal Funds CFR(s): 483.10(f)(10)(vi) §483.10(f)(10)(vi) Assurance of financial security. The facility must purchase a surety bond, or	F 570		

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otherwise provide assurance satisfactory to the Secretary, to assure the security of all personal funds of residents deposited with the facility.
This REQUIREMENT is not met as evidenced by:
Based on record review and interviews, the facility failed to maintain a surety bond that was equal or greater than one and one-half times the average monthly balance for the residents trust fund (RTF) account for the last 12 consecutive months from January 2024-December 2024. This had the potential to affect all residents who had funds held in the RTF account. The facility census was 58.

Review of facility policy, resident trust fund management, revised June 2022, showed:
-Transactions are to be handled and records are to be kept in accordance with established directives and in conformance with state and federal requirements.
-Facility will have a bond that equals at least one and one-half times the annual average of the fund account. This bond amount must also cover any credit balances on the facility accounts receivable (credit balances in PVT, PVA, and PVB accounts should be transferred to the RTF promptly).
-The bookkeeper will keep a copy of the bond with the resident trust fund records. The bookkeeper will perform quarterly reviews and increase or decrease the bond as necessary.

Record review on 1/27/25 of the RTF account for the last 12 consecutive months from January 2024 to December 2024 showed:
-The facility's current approved bond amount equaled $58,000;
-The average monthly balance for the RTF account equaled $39,259.28 (which was

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F 570	Continued From page 21 determined using the total of each ending balance for the last 12 months bank statements plus the petty cash ending balances and divided by 12 months); -An average monthly balance of $39,000 required a bond of at least $58,500; -Surety Bond #LSF032677 dated December 15, 2009 bond amount was changed from $65,000 to $58,000 on 12/15/2024; -Department of Health & Senior Services approved the surety bond adjustment #LSF032677 to $58,000 on December 17, 2024. During an interview on 1/27/25 at 3:57 P.M., Business Office Manager said: -Surety bond should be sufficient to cover 1.5x the average amount held in accounts; -Facility had a larger surety bond but had decreased the bond amount in December from $65,000 to $58,000. During an interview on 1/29/25 at 4:16 P.M., Administrator said: -He/She expected the surety bond held by the facility to be sufficient by equaling 1.5x times the average monthly account total held in the resident trust accounts.	F 570		
F 572 SS=E	Notice of Rights and Rules CFR(s): 483.10(g)(1)(16) §483.10(g) Information and Communication. §483.10(g)(1) The resident has the right to be informed of his or her rights and of all rules and regulations governing resident conduct and responsibilities during his or her stay in the facility. §483.10(g)(16) The facility must provide a notice	F 572		

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of rights and services to the resident prior to or upon admission and during the resident's stay.
(i) The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility.
(ii) The facility must also provide the resident with the State-developed notice of Medicaid rights and obligations, if any.
(iii) Receipt of such information, and any amendments to it, must be acknowledged in writing;
This REQUIREMENT is not met as evidenced by:
Based on interviews and record review, the facility failed to annually inform the resident's of their rights. This affected 11 of the 11 residents in the group interview. The facility census was 58.

Review of the facility's policy titled, "Resident Rights," revised February, showed:
- Employees shall treat all residents with kindness, respect, and dignity;
- Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to: be informed about his/her rights and responsibilities.

1. Review of the resident council minutes, dated 11/16/24 showed the section for resident rights reviewed was left blank.

2. Review of the resident council minutes, dated 12/4/24 showed the section for resident rights reviewed was left blank.

3. Review of the resident council minutes, dated 1/8/25 showed the section for resident rights

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F 572	Continued From page 23 reviewed was left blank. 4. During a group meeting on 1/27/25 at 1:07 P.M., 11 of the 11 residents who attended the meeting said they did not discuss their rights during their monthly resident council meeting. During an interview on 1/27/25 at 4:37 P.M., the Activity Director said: - He/she helped the residents set up for their meetings; - He/she was not aware how often the facility must provide a notice of rights and services to the resident. During an interview on 1/29/25 at 4:16 P.M., the Administrator said the resident's rights should be discussed at their resident council meetings.	F 572		
F 574 SS=E	Required Notices and Contact Information CFR(s): 483.10(g)(4)(i)-(vi) §483.10(g)(4) The resident has the right to receive notices orally (meaning spoken) and in writing (including Braille) in a format and a language he or she understands, including: (i) Required notices as specified in this section. The facility must furnish to each resident a written description of legal rights which includes - (A) A description of the manner of protecting personal funds, under paragraph (f)(10) of this section; (B) A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment of resources under section 1924(c) of the Social Security Act. (C) A list of names, addresses (mailing and email), and telephone numbers of all pertinent	F 574		

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State regulatory and informational agencies, resident advocacy groups such as the State Survey Agency, the State licensure office, the State Long-Term Care Ombudsman program, the protection and advocacy agency, adult protective services where state law provides for jurisdiction in long-term care facilities, the local contact agency for information about returning to the community and the Medicaid Fraud Control Unit; and

(D) A statement that the resident may file a complaint with the State Survey Agency concerning any suspected violation of state or federal nursing facility regulations, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, non-compliance with the advance directives requirements and requests for information regarding returning to the community.

(ii) Information and contact information for State and local advocacy organizations including but not limited to the State Survey Agency, the State Long-Term Care Ombudsman program (established under section 712 of the Older Americans Act of 1965, as amended 2016 (42 U.S.C. 3001 et seq) and the protection and advocacy system (as designated by the state, and as established under the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (42 U.S.C. 15001 et seq.)

(iii) Information regarding Medicare and Medicaid eligibility and coverage;

(iv) Contact information for the Aging and Disability Resource Center (established under Section 202(a)(20)(B)(iii) of the Older Americans Act); or other No Wrong Door Program;

(v) Contact information for the Medicaid Fraud Control Unit; and

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(vi) Information and contact information for filing grievances or complaints concerning any suspected violation of state or federal nursing facility regulations, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, non-compliance with the advance directives requirements and requests for information regarding returning to the community. This REQUIREMENT is not met as evidenced by:
Based on interview and record review, the facility failed to provide accessible information on the location of the State Long-Term Care Ombudsman program that was readily available and could be read by all residents in the facility without assistance. The census was 58.

Review of the facility's policy titled, "Resident Rights," revised February 2024, showed:
- Employees shall treat all residents with kindness, respect, and dignity;
- Federal and state laws guarantee certain basic rights to all residents of the facility. These rights include the resident's right to communicate with outside agencies regarding any matter.

1. During a resident group meeting on 1/27/25 at 1:07 P.M., 11 of the 11 residents who attended the meeting did not know what the Ombudsman was, what they did or where to find information about the Ombudsman program in the facility.

Observation on 1/27/25 at 4:50 P.M., showed the Ombudsman information was located in the hall by living room area.

During an interview on 1/27/25 at 4:37 P.M., the Activity Director said:

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F 574	Continued From page 26 - He/she helps the residents set up their resident council meetings; - He/she has gone over the Ombudsman information in the past, but has not recently discussed the information with the residents or the Ombudsman's contact information. During an interview on 1/29/25 at 4:16 P.M., the Administrator said staff should inform residents of who the Ombudsman is, what the role of the Ombudsman is and contact information.	F 574		
F 576 SS=E	Right to Forms of Communication w/ Privacy CFR(s): 483.10(g)(6)-(9) §483.10(g)(6) The resident has the right to have reasonable access to the use of a telephone, including TTY and TDD services, and a place in the facility where calls can be made without being overheard. This includes the right to retain and use a cellular phone at the resident's own expense. §483.10(g)(7) The facility must protect and facilitate that resident's right to communicate with individuals and entities within and external to the facility, including reasonable access to: (i) A telephone, including TTY and TDD services; (ii) The internet, to the extent available to the facility; and (iii) Stationery, postage, writing implements and the ability to send mail. §483.10(g)(8) The resident has the right to send and receive mail, and to receive letters, packages and other materials delivered to the facility for the resident through a means other than a postal service, including the right to: (i) Privacy of such communications consistent	F 576		

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HILL CREST MANOR	801 SOUTH COLBY HAMILTON, MO 64644

(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
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with this section; and
(ii) Access to stationery, postage, and writing implements at the resident's own expense.

§483.10(g)(9) The resident has the right to have reasonable access to and privacy in their use of electronic communications such as email and video communications and for internet research.
(i) If the access is available to the facility
(ii) At the resident's expense, if any additional expense is incurred by the facility to provide such access to the resident.
(iii) Such use must comply with State and Federal law.
This REQUIREMENT is not met as evidenced by:
Based on interviews, the facility failed to deliver Saturday mail to facility residents. The facility census was 58.

Review of the facility's policy titled, "Resident Rights," revised February 2024, showed:
- Employees shall treat all residents with kindness, respect, and dignity;
- Federal and state laws guarantee certain basic rights to all residents of the facility. These rights include the resident's right to access to a telephone, mail and electronic mail (e-mail).

1. During the resident group meeting on 1/27/25 at 1:07 P.M., 11 of the 11 residents who attended the meeting said the mail is not passed out to the residents on Saturdays.

During an interview on 1/27/25 at 4:37 P.M., the Activity Director said:
- In the past, a resident used to go out and get the mail out of the mailbox and put it in the office but that has stopped;

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F 576	Continued From page 28 - The mail is delivered to the facility on Saturdays, but it does not get passed out to the residents until on Mondays. During an interview on 1/29/25 at 4:16 P.M., the Administrator said the on call managers should pass the mail out to the residents on Saturdays.	F 576		
F 585 SS=E	Grievances CFR(s): 483.10(j)(1)-(4) §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay. §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. §483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident. §483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include:	F 585		

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(i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system;
(ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations;
(iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated;
(iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and

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as required by State law;
(v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued;
(vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and
(vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision.
This REQUIREMENT is not met as evidenced by:
Based on interviews and record review, the facility failed to ensure 11 of 11 residents who participated in a group meeting, knew how to file a grievance in writing, file anonymously, and obtain a written decision regarding a grievance. The facility census was 58.

Review of the facility's policy titled, "Grievances/Complaints, Recording and Investigating," revised April 2017, showed:
- All grievances and complaints filed with the facility will be investigated and corrective action will be taken to resolve the grievances;
- The Administrator has assigned the

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responsibility of investigating grievances and complaints to the grievance officer;
- Upon receiving a grievance and complaint report, the grievance officer will begin an investigation into the allegations;
- The investigation and report will include, as applicable: the date and time of the alleged incident; the circumstances surrounding the alleged incident; the location of the alleged incident; the names of any witnesses and their accounts of the alleged incident; the resident's account of the alleged incident; accounts of any other individuals involved and recommendations for corrective action;
- The grievance officer will record and maintain all grievances and complaints on the "Resident Grievance Complaint Log". The following information will be recorded and maintained in the log: the date the grievance /complaint was received; the name and room number of the resident filing the grievance/complaint (if available); the name and relationship of the person filing the grievance/complaint on behalf of the resident (if available); the date the alleged incident took place; the name of name of the person investigation the incident; the date the resident or interested party, was informed of the findings and the disposition of the grievance;
- Copies of all reports must be signed and will be made available to the resident or person acting on behalf of the resident.

1. Review of the resident's council meeting minutes, dated 11/16/24 showed the minutes did not indicate if the residents knew how to file a grievance.

2. Review of the resident's resident council minutes, dated 12/14/24 showed the minutes did

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F 585	Continued From page 32 not indicate if the residents knew how to file a grievance. 3. Review of the resident's resident council minutes, dated 1/18/25 showed the minutes did not indicate if the residents knew how to file a grievance. 4. During an group meeting on 1/27/25 at 1:07 P.M., 11 of the 11 residents said they were not for sure how to file a grievance. During an interview on 1/27/25 at 4:37 P.M., the Activity Director said he/she had not gone over how to file a grievance, where the paperwork is located or who the residents should talk to. During an interview on 1/19/25 at 4:16 P.M., the Administrator said the grievance would go to the interdisciplinary team (IDT) and they would work on it and let the residents know how it was resolved.	F 585		
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,	F 607		

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§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 record review and interview, the facility failed to implement their own Abuse and Neglect policy, when they did not verify through the employee disqualification list (EDL) verification checks prior to the hire dates of five out of eight employees (Dietary Aide A, Nurse Aide (NA) A, NA B, Cook A, Maintenance Director) and additionally failed to check the Certified Nurses' Assistant (CNA) Registry for all staff to ensure they did not have a Federal Indicator (a marker given by the Federal government to individuals who have committed abuse/neglect) for one of the eight sampled staff (Registered Nurse (RN) A). The facility census was 58.

Review of facility policy, Employee Disqualification List (EDL), revised 2/2022, showed:
-The employee designated by the administrator to complete the EDL background check will access the EDL website and complete the access to

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automatic system.
-At the time of consideration of employment, the designated employee shall access the EDL website indicated and check EDL. Any candidate for employment whose name is on the list is not eligible for hire;
-Print off the notice returned by email to indicate that the EDL had been checked. Make sure it included the date and the initial of the person making the request.

Review of facility policy, Abuse Prevention Program, Revised Sept 2021, showed:
Background checks will be done at the time of hire in accordance with the facility background check policy. staff will not be hired who have been found guilty, or plead no contendere, of abuse, neglect, mistreatment of resident or misappropriation of resident property by a court of law.
-The nurse aide registry will be checked prior to employment for each state where a nurse aide has shown to have worked, or has listed certification. Nurse aides will not be hired who name is on any state abuse registry.
-Verification of background checks, nurse aide registry checks and reference checks will be maintained in the personnel file of each employee. A notation by facility staff member of telephone contacts for registry check and previous employer checks would constitute verification.

Review of the six sampled employee files showed:
1. Dietary Aide A, Date of Hire (DOH) 8/1/24, had no EDL check;
2. Nurse Aide (NA), DOH 6/25/24, had no EDL check;

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F 607	Continued From page 35 3. NA B, DOH 9/30/24, had no EDL check; 4. Cook A, DOH 12/16/23, had an EDL check completed on 1/29/25 (1 year, 1 month, and 13 days from their initial DOH); 5. Maintenance Director, DOH 1/16/25, had an EDL check completed 1/29/25 (13 days after their DOH). 6. Registered Nurse A, DOH 12/6/23, had no nurse aide registry check. During an interview on 1/29/25 at 1:25 P.M., Business Office Manager said: -They just checked EDL for employees upon hire and not on a routine basis; -They were to check nurse aide registry for all employees; -Dietary Aide A's first day of work was 8/4/24; -They did not locate an EDL on Cook A so they completed a new one on 1/29/25; -Maintenance Director was just hired 1/16/25, so they just completed an EDL check on 1/29/25. During an interview on 1/29/25, the Regional Accounting person said EDL checks were to be completed quarterly on all employees. During an interview on 1/29/25 at 4:16 P.M., the Administrator said she expected EDL and CNA registry checks to be completed per facility policy and upon hire.	F 607		
F 640 SS=D	Encoding/Transmitting Resident Assessments CFR(s): 483.20(f)(1)-(4) §483.20(f) Automated data processing requirement- §483.20(f)(1) Encoding data. Within 7 days after a facility completes a resident's assessment, a facility must encode the following information for	F 640		

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each resident in the facility:
(i) Admission assessment.
(ii) Annual assessment updates.
(iii) Significant change in status assessments.
(iv) Quarterly review assessments.
(v) A subset of items upon a resident's transfer, reentry, discharge, and death.
(vi) Background (face-sheet) information, if there is no admission assessment.

§483.20(f)(2) Transmitting data. Within 7 days after a facility completes a resident's assessment, a facility must be capable of transmitting to the CMS System information for each resident contained in the MDS in a format that conforms to standard record layouts and data dictionaries, and that passes standardized edits defined by CMS and the State.

§483.20(f)(3) Transmittal requirements. Within 14 days after a facility completes a resident's assessment, a facility must electronically transmit encoded, accurate, and complete MDS data to the CMS System, including the following:
(i)Admission assessment.
(ii) Annual assessment.
(iii) Significant change in status assessment.
(iv) Significant correction of prior full assessment.
(v) Significant correction of prior quarterly assessment.
(vi) Quarterly review.
(vii) A subset of items upon a resident's transfer, reentry, discharge, and death.
(viii) Background (face-sheet) information, for an initial transmission of MDS data on resident that does not have an admission assessment.

§483.20(f)(4) Data format. The facility must

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transmit data in the format specified by CMS or, for a State which has an alternate RAI approved by CMS, in the format specified by the State and approved by CMS.
This REQUIREMENT is not met as evidenced by:
Based on interviews and record review, the facility failed to ensure they transmitted all Minimum Data Set (MDS, a federally mandate resident assessment tool) assessments within the federally mandated timeframe for one of the 15 sampled residents, (Resident #49). The facility census was 58.

The facility did not provide a policy regarding MDS assessment transmittals.

1. Review of Resident #49's medical record showed:
- Admission date: 7/27/24;
- Discharge assessment completed on 8/15/24;
- No transmission accepted date listed for the assessment.

During an interview on 1/28/25 at 3:16 P.M., the MDS/Care Plan Coordinator said:
- He/she had been in the current position for two years but worked on the floor a lot during the first year;
- The resident was discharged to home on 8/15/24;
- He/she did not know why the MDS said, "export ready" unless it had to do with insurance'
- He/she was not able to print a transmission report.

During an interview on 1/29/25 at 4:16 P.M., the Administrator said MDS should be submitted timely and a Registered Nurse (RN) would have

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F 640	Continued From page 38 to review it.	F 640		
F 657 SS=E	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on interviews, and record review, the facility failed to hold care plan meetings on a quarterly basis or when a resident's significant change in condition occurred. The facility additionally failed to involve residents and/or their	F 657		

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representatives in the care planning process for five residents (#24, #32, #42, #16, #21) of the 15 residents sampled. The facility census was 58.

Review of the facility's Care Planning Policy, dated 3/2022, showed:
-The interdisciplinary team (IDT), in conjunction with the resident and their family or legal representative, developed and implemented a comprehensive, person-centered care plan for each resident;
-Each resident's comprehensive person-centered care plan was consistent with the resident's rights to participate in the development and implementation of their plan of care, including the right to:
- Participate in the planning process;
-Identify individuals or roles to be included;
-Request meetings;
-Request revisions to the plan of care;
-See the care plan and sign it after significant changes were made.

Review of facility's Resident Rights policy, undated showed the Resident had the right to be informed of and participate in their care plan and treatment.

1. Review of Resident #24's Significant Change MDS (Minimum Data Set), a federally mandated assessment tool completed by the facility staff for care planning), dated 10/18/24, showed:
-Cognitive skills were intact;
-Diagnoses included: kidney disease, diabetes (a condition resulting in too much sugar in the blood), arthritis (joint pain and swelling), depression, anxiety (feeling of dread and fear), fractures, and thyroid disorder (condition that effects the thyroid gland).

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During an interview on 1/28/25 at 3:15 P.M., Resident #24 said he/she was upset he/she was not involved in their own care planning because they did not know what was going on or what they needed to do in regards to their care.

2. Review of Resident #32's Significant Change MDS, dated 12/6/24, showed:
-Severe cognitive impairment;
-They had no impairment in upper or lower extremities;
-Diagnoses included: heart disease, Alzheimer's disease (progressive neurodegenerative disorder that primarily affects memory, thinking, and behavior), and depression (mood disorder that causes a persistent feeling of sadness and loss of interest).

During an interview on 1/28/25 at 3:33 P.M., Resident #32's DPOA (durable power of attorney) said that the facility staff told them the resident can no longer use a walker, because staff was afraid the resident would fall, however there was no care plan meeting held to address the change in the resident's mobility.

During an interview on 1/29/25 at 8:40 A.M., Certified Medication Technician (CMT) A said:
-Resident #32 was ambulatory but was not feeling well a few weeks ago;
-Resident #32 became weaker after being sick so the resident was transitioned to a wheelchair.

During an interview on 1/29/25 at 9:30 A.M., Physical Therapy Assistant (PTA) A said:
-Resident #32 had been in therapy three times a week since 1/9/25;
-At the end of December, 2024, nursing staff

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asked PTA A if Resident #32 could switch from using a walker to a wheelchair because the resident was now unsafe when they used a walker;
- PTA A told staff to transition Resident #32 to a wheelchair;
-MDS Coordinator was responsible for updating the care plan.

3. Review of Resident #42's Annual MDS assessment, dated 12/21/24., showed:
-Cognitive skills were intact;
-Diagnoses included: heart disease, pneumonia (infection of the lungs), diabetes, thyroid disorder, arthritis, anxiety, depression, and asthma (chronic lung disease).

During an interview on 1/27/25 at 9:49 A.M., Resident #42 said they were frustrated that they have only been invited to one care plan meeting and had not been kept up-to-date with changes in their plan of care.

Review of Resident #42's face sheet and record review showed admission date of 12/14/23. No documentation regarding scheduling or having care plan meetings since admission to the current date.

During an interview on 1/29/25 at 10:16 A.M., Registered Nurse (RN) A said:
-Care plan meetings should be conducted every 90 days and when there was a significant change in a resident's condition;
-Resident #32's care plan should have been updated when their status changed from ambulating with a walker to only using a wheelchair.
4. Review of Resident #16's face sheet showed:

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F 657	Continued From page 42 - Admission date - 3/20/24; - The resident was his/her own responsible party. Review of the resident's Quarterly MDS, dated 12/14/24 showed: - Cognitive skills intact; - Diagnoses included stroke, anxiety, high blood pressure and depression. Review of the resident's care plan, revised 12/26/24 showed it did not address if the resident was invited or attended his/her care plan meeting. During an interview on 1/26/25 at 12:15 P.M., the resident said he/she has not been invited to his/her care plan meeting and has not attended a care plan meeting and would like to. 5. Review of Resident #21's face sheet showed: - Admission date - 1/20/20; - The resident was his/her own responsible party. Review of the resident's Annual MDS, dated 11/5/24 showed: - Cognitive skills moderately impaired; - Diagnoses included diabetes mellitus, anxiety, depression, high blood pressure, schizophrenia (a mental disorder characterized by disruptions in thought processes, perceptions, emotional responsiveness, and social interactions). Review of the resident's care plan, revised 12/27/24 showed it did not address if the resident was invited or attended his/her care plan meeting. During an interview on 1/26/25 at 2:41 P.M., the resident said he/she has not been invited to his/her care plan meeting and has not attended a care plan meeting.	F 657		

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During an interview on 1/29/25 at 1:37 P.M., the MDS Coordinator said:
-Care plan meetings were held at a minimum on a quarterly basis;
-Socials Services Director made appointments for care plan meetings with the residents and the family;
-Social services, MDS Coordinator, DON, charge nurse, CNA, activities, dietary, family, or resident were invited to care plan meetings;
-MDS Coordinator, Social Services Director, DON (director of nursing), and the Administrator had the ability to update care plans;
-Care plan updates were triggered when a resident had significant changes, hospitalizations, an update from CNA's or nurses, or quarterly due dates or annual assessment occurred;
-Social Services Director was responsible for keeping records of the invitees and attendees of care plan meetings.

During an interview on 1/29/25 at 3:05 P.M., the Social Services Director said:
-They were responsible for coordinating care plan meetings;
-They talked to residents to notify them of their care plan meetings;
-Care plan meetings were expected to be held quarterly or if there was a significant change;
-They did not have any record of care plan meeting invitations or attendance.

During an interview on 1/29/25 at 4:16 P.M., the Administrator said:
-Care plans should be completed upon admission, updated quarterly, and when a resident had a significant change;
-A significant change would be when a resident

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F 657	Continued From page 44 transitioned from a walker to a wheelchair and should have been care planned.	F 657		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure staff obtained routine orders for prothrombin time (PT, a blood test to measure how long it takes blood to clot) and international normalized ratio (INR, a standardized measure of the clotting ability of blood, used to monitor the risk of bleeding when taking anticoagulation medication). Staff continued to administer the the anticoagulant medication in the absence of orders to monitor the effect of the medication. This affected one of the 15 sampled residents, (Resident #16). The facility census was 58. Review of the facility's undated policy titled, "Coumadin Use," showed: - A Coumadin (Warfarin) policy for long-term care facility would typically outline guidelines and procedures to ensure the safe and effective use of this anticoagulant medication for residents; - It would address issues such as monitoring, dosing, administration, and communication among healthcare teams;	F 684		

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- Indications for Coumadin use: criteria for prescribing Coumadin, such as atrial fibrillation (A-fib, an irregular, often rapid heart rate that commonly causes poor blood flow), pulmonary embolism (PE, a blood clot that develops in a blood vessel in the body and then travels to a ling artery where it suddenly blocks blood flow) and stroke prevention;
- Monitoring and dosing: regular INR testing to monitor the effectiveness of the anticoagulant therapy, ensuring the INR stays within a therapeutic range (usually 2.0 - 3.0 for most indications). Frequency of INR checks are completed per the direction of the primary physician direction. Primary physician will be adjusting the dose based on INR results and clinical condition. Primary physician will monitor thresholds for modifying the dose or holding the medication in response to INR results;
- Medication administration: guidelines for accurate administration of Coumadin, including ensuring proper timing and consistency with ordered laboratory tests. Special consideration for dosing in elderly residents, those with liver or kidney disease, or those on interacting medications;
- Communication and documentation: clear documentation of INR results, dose adjustments, and changes in treatment plans. Communication between healthcare providers, including physicians, pharmacists, and nursing staff, about dosage adjustments and potential drug interactions. In cases of emergency or unexpected bleeding, protocols for notifying the healthcare team and managing the situation;
- Dietary considerations: educating staff and residents about the importance of consistent Vitamin K intake, as it can affect Coumadin levels. Noting any significant dietary changes or

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the introduction of foods rich in Vitamin K that may require dose adjustments;
- Bleeding and adverse event management: Notification of primary care physician (PCP) when recognizing and managing bleeding complications, including internal bleeding, excessive bruising or blood in the urine/stool. Emergency procedures for cases of major bleeding, such as administering Vitamin K, stopping the medication, or utilizing blood products. Educating staff and residents about the sings and symptoms of bleeding or clotting complications;
- Resident education and consent: providing residents and/or their families with information on Coumadin therapy, including risks, benefits, and the importance of adherence;
- Quality assurance and auditing: tracking any adverse events or near-miss incidents related to Coumadin therapy for continuous improvement. Tracking dose and INR results as laboratory results received.

1. Review of Resident #16's PT/INR Coumadin (Warfarin) Flow sheet, showed:
- Date: 10/1/24 - PT results - 24.2; INR results - 2.4; Current dose: 3 milligrams (mg.) on Monday, Tuesday, Wednesday, Thursday, Friday and Saturday, 4 mg. on Sunday; physician notified - yes; dose change: no change; date next PT/INR scheduled: left blank; family/representative notified of change: resident;
- Date: 10/16/24; PT results - 21.7; INR results - 2.1; Current dose: 3 milligrams (mg.) on Monday, Tuesday, Wednesday, Thursday, Friday and Saturday, 4 mg. on Sunday; physician notified - yes; dose change: no change; date next PT/INR scheduled: left blank; family/representative notified of change: resident;

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- Date: 10/31/24; PT results - 27.6; INR results - 2.4; Current dose: 3 milligrams (mg.) on Monday, Tuesday, Wednesday, Thursday, Friday and Saturday, 4 mg. on Sunday; physician notified - yes; dose change: no change; date next PT/INR scheduled: left blank; family/representative notified of change: resident.

Review of the PT/INR lab results, 10/31/24 showed:
- PT - 27.8; INR - 2.46. Staff wrote 10/17/24 - PT - 21.7; INR - 2.1. Currently taking Coumadin 3 mg. daily except Sundays, takes 4 mg. No change, recheck in two weeks.

Review of the PT/INR lab results, 11/14/24 showed:
- PT - 34.1; INR - 3.03. Staff wrote 10/31/24 - PT - 27.6; INR - 2.46. Currently taking Coumadin 3 mg. daily except Sundays, takes 4 mg.

Review of the fax form, dated 11/15/24 showed:
- INR - 3.03. Per the physician, hold Coumadin for one day then resume current order for Coumadin 3 mg. every day except Sundays, 4 mg. Recheck in two weeks.
- No further PT/INR results noted.

Review of the resident's Quarterly Minimum Data Set (MDS), a federally mandated assessment completed by facility staff, dated 12/14/24 showed:
- Cognitive skills intact;
- Required substantial to maximum assistance with toilet use, showers, personal hygiene and transfers;
- Always incontinent of bowel and bladder;
- Diagnoses included high blood pressure, stroke, anxiety, depression, and atrial fibrillation (A-fib, an

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irregular, often rapid heart rate that commonly causes poor blood flow).

Review of the resident's care plan, revised 1/15/25, showed:
- The resident is at risk for bleeding related to anticoagulant therapy of Coumadin related to A-fib. Administer anticoagulant medications as ordered by the physician. Monitor for side effects and effectiveness. Labs including PT/INR as ordered. Report abnormal lab results to the physician. Educate the resident to report any incidents or falls promptly to staff.

During an interview on 1/26/25 at 12:24 P.M., the resident said he/she was on Coumadin and has not had a PT/INR drawn in forever.

Review of the Physician's Order Sheet (POS), dated January, 2025, showed:
- Start date: 8/14/24. Warfarin tablet 3 mg. one tablet daily every Monday, Tuesday, Wednesday, Thursday, Friday and Saturday for A-fib;
- Start date: 8/14/24. Warfarin tablet 4 mg. every Sunday for A-fib;
- Did not have a standing order for a PT/INR lab draw.

Review of the Medication Administration Record (MAR), dated January, 2025 showed:
- Warfarin tablet 3 mg. daily on every Monday, Tuesday, Wednesday, Thursday, Friday and Saturday for A-fib. Staff documented it was administered as ordered 1/1/25 through 1/24/25.
- Warfarin tablet 4 mg. every Sunday for A-fib. Staff documented it was administered as ordered from 1/1/25 through 1/24/25.

During an interview on 1/26/25 at 3:08 P.M., the

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F 684	Continued From page 49 resident said he/she refused the Coumadin because the staff have not checked his/her PT/INR recently. During an interview on 1/27/25 at 7:46 A.M., the Director of Nursing (DON) said the resident has been scheduled to have a PT/INR drawn. During an interview on 1/29/25 at 4:16 P.M., the DON said: - If a resident was on Coumadin, there should be a physician's order for labs to check the PT/INR; - If there was an order to recheck the PT/INR in two weeks, then it should have been completed.	F 684		
F 685 SS=D	Treatment/Devices to Maintain Hearing/Vision CFR(s): 483.25(a)(1)(2) §483.25(a) Vision and hearing To ensure that residents receive proper treatment and assistive devices to maintain vision and hearing abilities, the facility must, if necessary, assist the resident- §483.25(a)(1) In making appointments, and §483.25(a)(2) By arranging for transportation to and from the office of a practitioner specializing in the treatment of vision or hearing impairment or the office of a professional specializing in the provision of vision or hearing assistive devices. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to provide quality of care by assisting one resident (Resident #32) out of the 15 sampled residents when the facility failed to replace their prescription eyeglasses that had been reported missing for several weeks by the	F 685		

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family representative. The facility census was 58.

Review of facility undated Resident Rights policy showed residents have the right to services and/or items included in plan of care.

1. Review of Resident #32's Significant Change MDS, dated 12/6/24, showed:
-Severe cognitive impairment;
-They had no impairment in upper or lower extremities;
-Impaired vision;
-Required corrective lenses;
-Diagnoses included: Heart disease, Alzheimer's disease (progressive neurodegenerative disorder that primarily affects memory, thinking, and behavior), and depression (mood disorder that causes a persistent feeling of sadness and loss of interest).

Review of Resident's electronic medical record did not show any documentation of communication to the resident's representative regarding the appointment for the replacement of the missing eyeglasses.

Review of Resident's revised care plan, dated 1/15/25, showed:
-Resident wears glasses and forgets where they were placed;
-When needed, assist Resident with finding eyeglasses.

Observation on 1/27/25 at 4:38 P.M. showed the resident was not wearing eyeglasses.

During an interview on 1/27/25 at 11:45 A.M., resident's representative said:
-The resident's glasses were lost a few weeks

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ago;
-The Social Services Director informed him/her that the resident's eyeglasses were found;
-The glasses that were found were reading glasses and not the resident's prescription eyeglasses;
-He/she notified the Social Services Director on 1/20/25 that the eyeglasses on the resident did not belong to the resident.

During an interview on 1/28/25 at 3:20 P.M., the Resident's Representative said the Social Services Director told him/her on 1/25/25 that she would ask the Transportation Aid to make an appointment for residents eyeglasses replacement.

During an interview on 1/29/25 at 8:36 A.M., CMT A said the resident sometimes wore eyeglasses.

During an interview on 1/29/25 at 9:07 A.M., CNA B said if a resident was missing eyeglasses, they would notify the Social Services Director.

During an interview on 1/29/25 at 2:26 P.M., the Social Services Director said:
-The resident wore eyeglasses;
-The resident's eyeglasses were lost;
-Staff found reading glasses on 1/20/25 and resident said the reading eyeglasses were theirs;
-She gave a communication form to the Transportation Aid on 1/20/25 for an appointment to be scheduled for replacement of the residents eyeglasses;
-She was not sure who was responsible to provide communication to the resident representative about the appointment.

During an interview on 1/29/25 at 2:48 P.M., the

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F 685	Continued From page 52 Transportation Aid said: -He/she would expect Social Services Director to create a communication form for Transportation Aid if a resident needed an appointment for eyeglasses; -He/she would then make the appointment; -He/she would expect the Social Services Director to notify the resident representative. During an interview on 1/29/25 at 4:16 P.M., Administrator said: -The Social Services Director should notify resident representative of missing eyeglasses; -The Social Services Director should make an appointment to replace resident's missing eyeglasses; -The Social Services Director should notify the resident's representative appointments; -The Social Services Director should document the notification to the resident representative.	F 685		
F 689 SS=E	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility staff failed to ensure residents remained free from accident hazards when staff did not follow the manufacturer's guidelines when transferring one (Resident # 8) in a mechanical	F 689		

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F 689	Continued From page 53 lift and while pushing residents in their wheelchairs without foot pedals for two (Resident #11 and #30) residents. This affected three (Resident #8, #11, and #30) of the fifteen sampled residents. The facility census was 58. Review of facility policy, Resident Rights, undated, showed: -Safe Environment: Resident have the right to a safe, clean, comfortable, and homelike environment, including while receiving treatment and supports for daily services. Review of facility policy, Resident Handling Policy, Revised in 2000, showed: -Resident handling policy exists to ensure a safe working environment for resident handlers; -Resident transfer status will be reviewed via care-plan time frame and on an as needed basis; -Resident transfer status will be documented in the resident's chart and care plan. Review of facility policy, wheelchair policy, undated, showed: -Facility allows the resident the use of wheelchairs for mobility under their own propulsion or with assistance of staff. Residents may utilize wheelchairs without leg rests under their choice to allow for greater independence; -Movement within the chair may be under the residents' own means or with staff assistance at the resident's decision; -Residents may choose not to utilize leg rests on wheelchairs to improve their freedom to peddle chairs to and from, rest feet on the floor, increase ability to get closer to items such as meals, or other deemed appropriate reasons; -Wheelchair use and resident choices will be care planned as needed.	F 689		

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HILL CREST MANOR	801 SOUTH COLBY HAMILTON, MO 64644

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Review of manufacturer guidelines for use dated 2018, showed:
-When transferring a resident/lifting the patient:
-Warning: The legs of the patient lift must be in the maximum open position for optimum stability and safety.

1. Review of Resident #8's Quarterly MDS (Minimum Data Set), A federally mandated assessment tool completed by facility staff, dated 11/15/24, showed:
-They had moderate impaired cognition;
-They had impairment to one side of upper and lower extremity;
-They were dependent on a wheelchair;
-He/She was dependent for transfers from sitting to lying, lying to sitting on side of bed, chair to bed transfers, and shower transfers;
-He/She required substantial/maximal assistance rolling left and right;
-Diagnoses included: Stroke (condition that occurred when blood flow to part of the brain was disrupted causing damage to brain tissue due to blocked blood vessel), hip fracture, anxiety, depression (persistent feelings of sadness, hopelessness, and loss of interest or pleasure in activities that previously enjoyed), schizophrenia (a mental health condition that affects a persons thoughts, perceptions, and behaviors), acute pain (a sudden pain that is short-lived and caused by an injury, illness, or medical procedure), restless leg syndrome, and generalized weakness (decreased muscle strength or lack of physical energy in most parts of the body).

Review of care plan, revised 11/13/24 showed the resident required assist of two staff for transfers with a mechanical lift.

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Review of physician's orders, dated 1/28/24, showed and order revised 1/26/24 may use mechanical lift for transfers.

During an observation on 1/27/25 at 10:26 A.M. resident was transferred from their chair to their bed in resident room by Certified Nurse Aide (CNA) A and CNA B . Observation showed CNA B raised Resident #8 from their chair and CNA B assisted from behind chair stabilizing the patient. As Resident #8 was being transferred from the chair to the bed the mechanical lift legs remained closed and were not spread as CNA B mobilized resident in the lift from their chair to their bed.

During an interview on 1/29/25 at 2:04 P.M., CNA C said when using a mechanical lift the legs should be spread while transferring a resident.

During an interview on 1/29/25 at 2:22 P.M., CNA D said when transferring a resident they should move residents with the mechanical lift legs closed.

During an interview on 1/29/25 at 2:34 P.M., CMT A said:
-While transferring a resident with the mechanical lift the legs should be open;
-The legs of the mechanical lift should never be closed when somebody is in the lift because the lift could topple over.

During an interview on 1/29/25 at 4:16 P.M., Director of Nursing said she expected the mechanical lift to be used according to manufacturers guidelines.

During an interview on 1/29/25 at 4:16 P.M.,

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Administrator said she expected the mechanical lift to be used according to manufacturers guidelines.

2. Review of Resident #11's Quarterly MDS, dated 1/13/25, showed:
-They were moderately cognitively impaired;
-They had severely impaired vision;
-They were dependent on a wheelchair;
-They had no impairment to upper or lower extremities;
-They were independent with mobility-rolling left and right, sit to lying, lying to sitting, ;
-They required supervision or touching assistance with chair to bed transfers, toilet transfers, tub/shower transfers;
-Diagnoses included: Glaucoma (condition affecting the eye that can lead to vision loss if left untreated), high blood pressure, dementia (group of brain disorders that cause a decline in cognitive abilities, such as memory, thinking, reasoning, and judgement), anxiety, depression, psychotic disorder (a disconnection from reality), polyarthritis (condition affecting multiple joints without specifying location of inflammation), idiopathic neuropathies (nerve damage that can cause pain, numbness, tingling, or weakness in the body), and muscle spasms.

Review of care plan, revised 11/21/24, showed the reisdent used a wheelchair for mobility and could propel self and may need assistance with the task at time due to visual impairments.

Review of physician's orders, dated 1/27/25, showed:
-Start 1/17/25, occupational therapy to evaluate for activities of daily living, cognitive skills, functional mobility and safety awareness, low

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vision, and compensatory techniques

Observation on 1/26/25 at 10:11 A.M. showed CNA A wheeled resident out of his/her room without any foot pedals on resident's chair. CNA A was stopped by DON at common area of 300 halls. CNA A then applied a blanket to resident's legs and wheeled resident down to administrative office by front entry of building where CNA A was observed applying foot pedals to resident's wheelchair.

Observation on 1/27/25 at 10:32 A.M. showed Resident had a wheelchair foot pedal sitting on floor at foot of their bed in their room.

3. Review of Resident #30's Quarterly MDS, dated 12/11/24, showed:
-They were cognitively intact;
-They had impairment on one side of upper and lower extremities;
-They were dependent on a wheelchair;
-They were independent with wheeling self 50-150 feet in a manual wheelchair;
-Diagnoses included: aftercare following joint replacement surgery, muscle weakness, muscle spasms, hemiplegia and hemiparesis following stroke affecting left non-dominant sides (condition that causes weakness or paralysis on one side of the body), cognitive communication deficit (condition affecting a person's ability to speak, listen, read, write, and interact socially).

Review of care plan revised 1/27/25, showed:
-They used wheelchair for mobility and could propel self short distances. They relied on staff and family to propel them at times. They would propel themselves backwards in their wheelchair, ensure theirs and other residents safety is

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monitored.

Observation on 1/28/25 at 9:59 A.M. showed CNA D pushed resident #30 with no right side foot pedal on his/her wheelchair when pushing out of bathroom back to their room. Resident had a foot pedal on left side foot rest of wheelchair with foot on pedal but right foot was observed on the floor on right side of chair.

4. During an interview on 1/29/25 at 2:04 P.M., CNA C said he/she was not allowed to push residents in wheelchairs without foot pedals because it could result in injury.

During an interview on 1/29/25 at 2:22 P.M., CNA D said residents should not be pushed without foot pedals on their wheelchairs.

During an interview on 1/29/25 at 2:34 P.M., CMT A said residents being pushed in wheelchairs should have foot pedals on their wheelchairs.

During an interview on 1/29/25 at 2:44 P.M., Social Service Designee said:
-Residents in wheelchairs could not be pushed without foot pedals;
-It would be residents preference if they were able to hold their feet up during a transfer it would be okay to push them without pedals;
-Therapy had been working on adjust foot pedals for wheelchairs.

During an interview on 1/29/25 at 4:16 P.M., Director of Nursing said she expected dependent residents who were pushed through the facility to have foot pedals on their wheelchairs.

During an interview on 1/29/25 at 4:16 P.M.,

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F 689	Continued From page 59 Administrator said she expected dependent residents pushed through the facility to have foot pedals on their wheelchairs.	F 689		
F 728 SS=E	Facility Hiring and Use of Nurse Aide CFR(s): 483.35(d)(1)-(3) §483.35(d) Requirement for facility hiring and use of nurse aides- §483.35(d)(1) General rule. A facility must not use any individual working in the facility as a nurse aide for more than 4 months, on a full-time basis, unless- (i) That individual is competent to provide nursing and nursing related services; and (ii)(A) That individual has completed a training and competency evaluation program, or a competency evaluation program approved by the State as meeting the requirements of §483.151 through §483.154; or (B) That individual has been deemed or determined competent as provided in §483.150(a) and (b). §483.35(d)(2) Non-permanent employees. A facility must not use on a temporary, per diem, leased, or any basis other than a permanent employee any individual who does not meet the requirements in paragraphs (d)(1)(i) and (ii) of this section. §483.35(d)(3) Minimum Competency A facility must not use any individual who has worked less than 4 months as a nurse aide in that facility unless the individual- (i) Is a full-time employee in a State-approved training and competency evaluation program; (ii) Has demonstrated competence through satisfactory participation in a State-approved	F 728		

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F 728	Continued From page 60 nurse aide training and competency evaluation program or competency evaluation program; or (iii) Has been deemed or determined competent as provided in §483.150(a) and (b). This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure nurse aides (NA's) met the minimum qualifications which included satisfactory participation in a State-approved nurse aide training and competency evaluation program within four months of hire. The facility census was 58. The facility did not provide a policy regarding hiring and training nurse aides. 1. Review of the facility employee list showed: - NA A was hired on 6/5/24; - NA D was hired on 12/19/22; - NA E was hired on 5/19/23. Record review of personnel files showed no documentation that NA A, NA D and NA E had been certified. During an interview on 1/29/24 at 4:16 P.M., the Administrator said they are no longer hiring NA's, but NAs should have their certification within four months of their hire date.	F 728		
F 761 SS=E	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	F 761		

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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 observations, interviews and record review, the facility failed to discard expired medications and biological's stored within the medication cart and medication room, failed to date an opened vial of tuberculin (TB) purified protein derivative (PPD, skin test used to help diagnosed tuberculosis infection), failed to ensure to insulin pens had a pharmacy label to indicate who they belonged to, failed to ensure there were no loose pills in the medication carts and failed to ensure staff did not leave medications at bedside for Resident #26. The facility census was 58.

Review of the facility's undated policy titled, "Medication Storage in the Facility," showed:
- Medications and biological's are stored safely, securely and properly following manufacturer's

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recommendations or those of the supplier;
- Outdated, contaminated, or deteriorated medications and those in containers that are cracked, soiled , or without secure closures are immediately removed form stock, disposed of according to the procedures for medication destruction, and reordered from the pharmacy, if a current order exists.

1. Observation and interview on 1/26/25 at 9:51 A.M., showed:
- The resident was in his/her room in a rocking chair;
- There were two clear medication cups on the resident's beside table;
- Staff had written the resident's first name and last initial on each clear medication cup;
- One medication cup had one pill in it;
- The second medication cup had one big round white pill, one small white pill, one white oblong pill, one dark colored pill, and one red and white capsule;
- The resident said the staff usually bring one pill in at 4:30 A.M., and just leave the other pills for him/her to take later.

During an interview on 1/27/25 at 11:46 A.M., Certified Medication Technician (CMT) A said:
- Staff should not leave medications at bedside;
- Staff should watch to make sure the residents take their pills.

During an interview on 1/29/25 at 4:16 P.M., the Director of Nursing (DON) said staff should not leave pills at bedside.

2. Observation and interview on 1/27/25 at 10:05 A.M., of the medication room showed:
- An opened vial of TB did not have a date when it

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was opened;
- Two Tresebia (fast acting insulin) flex touch pens did not have a pharmacy label to indicate who they belonged to;
- An opened bottle of Tussin cough suppressant, expired 4/24;
- Two bottles of liquid iron supplements, expired 9/24;
- Salonpas pain relieving patch, expired 5/23;
- The Regional Nurse Consultant said the insulin pens should have a pharmacy label to indicate who they belonged to. The vial of TB should have a date when it was opened. The previous DON should have been checking the medication room for expired medications. Staff should not use the expired medications and they should have been thrown away.

3. Observation and interview on 1/27/25 at 11:46 A.M., of the South medication cart showed;
- There was one white pill, three oblong white pills, one round pink pill, one oblong light pink pill, one small round white pill, two oblong light yellow pills and 1/2 of an oblong white pill loose in the drawer of the medication cart;
- CMT A said there should not be any loose pills in the medication cart. The loose pills should have been thrown away.

4. Observation and interview on 1/27/25 at 12:06 P.M., of the North CMT medication cart showed:
- One small round white pill loose in the locked narcotic box;
- There was two small round white pills, and two oblong white pills loose in the drawer of the medication cart;
- One opened bottle of melatonin (used for sleep aid), expired 4/24;
- One opened bottle of Thiamin Vitamin B1

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F 761	Continued From page 64 (supplement), expired 7/24; - There should not be any loose pills in the medication cart; - The CMT's try to check the medication carts weekly for expired medications. During an interview on 1/29/25 at 4:16 P.M., the DON said: - Pharmacy comes in once monthly to check the medication room and the medication carts for expired medications; - The CMT's should check the medication room and the medication carts for loose pills and expired medications.	F 761		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by:	F 812		

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Based on observations, interviews, and record review, the facility failed to prepare and serve food in accordance with professional standards for food service safety when staff failed to label and date all foods, seal all foods after opening, use proper hand washing, record refrigerator temperatures, properly store food storage containers and dishes, and failed to temperature check foods before serving food from steam table. The facility census was 58.

1. Facility's policy titled, "Handling Leftover Food," dated 10/23 showed:
-Leftover foods stored in the refrigerator should be wrapped and labeled with a use by date no later than 72 hours from the time of first use;
-Leftover foods stored in the freezer should be dated and labeled.

A policy regarding safe food handling was requested but not provided.

Continuous observation of the kitchen on 1/26/25 at 9:15 A.M.- 9:52 A.M., showed:
-Two packages of unlabeled, undated smoked sausage in the freezer.
-Undated sausage;
- 24-ounce white bread was undated and unsealed;
-Undated sandwich bread;
-Measuring cup stored upright on oven shelf;
-Uncovered butter bowl on oven shelf;
-Unlabeled and undated large pan of gravy in large refrigerator;
-Unbranded ranch dressing container dated 1/20 in the large refrigerator had no lid.

During an interview on 2/5/25 at 8:34 A.M., the Dietary Manager said he/she expected opened

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food items to be sealed and dated.

During an interview on 2/4/25 at 4:33 P.M., the Dietician said he/she expected food items to be sealed and dated after opening.

During an interview on 2/5/25 at 10:56 A.M., the Administrator said food items should be sealed and dated after opening.

2. Facility did not provide a policy for proper storage of dishes and containers.

Continuous observation on 1/28/25 at 8:47 A.M. - 12:45 P.M. showed:
-Four plastic cups stored upright on shelf above coffee maker;
-Plastic cover on plate cart pulled back, exposed bowls and plates stored upright;
-Dinner plates, desert bowls, and salad plates were stored face up on uncovered plate rack;
-Two large storage containers on metal table outside of pantry were stored upright;
-Metal pans on top shelf of metal rack next to the small refrigerator were stored upright;
-Dinner plates, desert bowls, and salad plates were stored face up on uncovered plate rack;
-Dinner plates, desert bowls, and salad plates were stored face up on uncovered plate rack;
-Metal pans on top shelf of metal rack next to the small refrigerator were stored upright.

During an interview on 1/28/25 at 9:28 A.M., Dietary Aid B said plates, bowls, pots, storage containers and cups should be stored upside down.

During an interview on 2/5/25 at 8:34 A.M., the Dietary Manager said:

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-He/She expected oil cup on oven shelf to be stored inverted when not in use and butter container should be covered when not in use;
-He/She expected bowls, plates, and storage containers should be upside down or covered when not in use.

During an interview on 2/4/25 at 4:33 P.M., Dietician said he/she expected the butter bowl and oil cup stored on oven shelf be covered when they are not in use.

During an interview on 2/5/25 at 10:56 A.M., Administrator said:
-She did not know how food storage containers and dishes should be stored.
-The butter bowl should be covered when not in use and the oil cup should be inverted or covered when not in use.

Observation on 1/26/25 at 12:46 P.M. showed Certified Medication Technician (CMT) A cut up food for a resident, then touched another resident's wheelchair and did not wash hands or sanitize before continuing to cut up the resident's food.

Observation on 1/28/25 at 12:27 P.M. showed Cook A leaned over steam table while serving food onto plates and their clothing touched the food on a plate that was served to a resident.

Continuous observation on 1/28/25 from 11:38 A.M. to 11:53 A.M. showed:
-Dietary Aid C did not wash hands when they came back into kitchen to add drinks to tray;
-Dietary Aid C did not wash hands upon when they entered the kitchen and started another pot of coffee and poured a glass of milk;

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HILL CREST MANOR	801 SOUTH COLBY HAMILTON, MO 64644

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F 812	Continued From page 68 -Dietary Aid C did not wash hands when they entered the kitchen, poured a cup of coffee and took to dining room; -Dietary Aid C did not was hands upon entering the kitchen, poured a glass of milk and took to dining room. During an interview on 1/29/25 at 8:37 A.M., CMT A said when cutting up food for one resident, that task should have been finished before moving on to another task or hands should have been sanitized before going back to cutting up the food. During an interview on 01/29/25 at 9:03 A.M., Dietary Aid A said staff should wash hands anytime they walk into the kitchen, even if was just to grab a cup of coffee. During an interview on 1/29/25 4:16 P.M., the Administrator said: - She expected dietary staff to have washed hands upon entering kitchen; - She expected staff, when dietary assistance was provided to wash hands or sanitize in between tasks. -She expected staff's clothing not to touch the food on plates that were served to residents. During an interview on 2/4/25 at 4:33 P.M., the Dietician said: -He/She expected staff to wash their hands when they entered the kitchen; -He/She expected staff to sanitize their hands if they are cutting up residents' food, then touch another residents wheel chair, before going back to cutting up food; -He/She expected staff's clothing not to touch food on plates on steam table prior to serving to residents.	F 812		

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F 812	Continued From page 69	F 812		

During an interview on 2/5/25 at 8:34 A.M., the Dietary Manager said:
- He/She expected staff's clothing to not touch food on plates on steam table prior to serving to residents;
-Staff should wash their hands when they enter the kitchen.

3. Facility did not provide a policy on proper food temperatures.

Observation on 1/28/25 at 12:02 P.M. showed Cook C did not take food temperature of food items on steam table before serving.

During an interview on 1/29/25 at 2:52 P.M., the Dietary Manager said he/she expected staff to check the holding temperature of the food before it was served.

During an interview on 2/4/25 at 4:33 P.M., the Dietician said:
-They expect staff to check food temperatures when they take the food out of the oven and on the steam table before serving.

During an interview on 2/5/25 at 10:56 A.M., the Administrator said temperatures of food on the steam table should be taken before food was served.

4. Facility did not provide a policy on refrigerator temperature logs.

Observation on 1/26/25 at 9:15 A.M. showed:
-Large refrigerator temperature logs missed entries for 1/22-1/26.

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F 812	Continued From page 70 During an interview on 2/5/25 at 8:34 A.M., Dietary Manager said he/she expected refrigerator temperatures to have been logged daily. During an interview on 2/4/25 at 4:33 P.M., Dietician said he/she expect refrigerator temperatures to be recorded daily. During an interview on 2/5/25 at 10:56 A.M., Administrator said refrigerator temperatures should be logged daily.	F 812		
F 908 SS=E	Essential Equipment, Safe Operating Condition CFR(s): 483.90(d)(2) §483.90(d)(2) Maintain all mechanical, electrical, and patient care equipment in safe operating condition. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to maintain resident wheelchairs in safe operating condition when resident wheelchairs had ripped and peeling arm rests. This affected three of fifteen sampled residents (Resident #11, #57, and #60). The facility census was 58. Review of facility policy, wheelchair policy, undated, showed the facility may provide residents with wheelchairs for mobility when such need is established either by evaluation or request of the resident. Review of facility policy, Resident Rights, undated, showed: -Safe Environment: Resident has right to a safe, clean, comfortable, and homelike environment, including to receiving treatment and supports for	F 908		

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F 908	Continued From page 71	F 908		

daily services;
-Facility shall exercise reasonable care for protection of resident's property from loss or theft;
-Maintenance services to maintain a sanitary, orderly, and comfortable interior.

Review of facility policy, maintenance service, revised December 2009, showed the maintenance department was responsible for maintaining equipment in safe and operable manner at all times.

1. Review of Resident #11's quarterly MDS (Minimum Data Set), a federally mandated assessment tool completed by facility staff, dated 1/13/25, showed:
-They were moderately cognitively impaired;
-They had severely impaired vision;
-They were dependent on a wheelchair;
-They had no impairment to upper or lower extremities;
-They were independent with mobility-rolling left and right, sit to lying, lying to sitting;
-They required supervision or touching assistance with chair to bed transfers, toilet transfers, tub/shower transfers;
-Diagnoses included: glaucoma (condition affecting the eye that can lead to vision loss if left untreated), high blood pressure, dementia (group of brain disorders that cause a decline in cognitive abilities, such as memory, thinking, reasoning, and judgement), anxiety, depression, psychotic disorder (a disconnection from reality), polyarthritis (condition affecting multiple joints without specifying location of inflammation), idiopathic neuropathies (nerve damage that can cause pain, numbness, tingling, or weakness in the body), and muscle spasms.

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Review of the residents care plan, revised 11/21/24, showed they used a wheelchair for mobility and could propel self and may need assistance with the task at time due to visual impairments.

Review of physician's orders, dated 1/27/25, showed 1/17/25, occupational therapy to evaluate for activities of daily living, cognitive skills, functional mobility and safety awareness, low vision, and compensatory techniques.

Observation on 1/26/25 at 9:52 A.M. showed the resident's wheelchair arm was taped with tape on the left side of the arm rest pad.

2. Review of Resident #57's admission MDS, dated 11/13/24, showed:
-They were cognitively intact;
-They were dependent on a walker and wheelchair for mobility;
-They required supervision or touching assistance for mobility of rolling left and right, sitting to lying transfers, and lying to sitting on side of bed transfers;
-They required partial to moderate assistance when transferring from a sitting to stand, chair to bed, toilet transfers, and walking up to 10 feet;
-Diagnoses included cellulitis of the left and right lower limbs (painful swelling of the skin), high blood pressure, anxiety.

Review of care plan, revised 1/17/25, showed the resident utilized a wheelchair for mobility outside of their room but will use a walker at times, assist them with these tasks as needed.

Observation on 1/29/25 at 11:09 A.M. showed resident's wheelchair arm rests were taped with

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F 908	Continued From page 73	F 908		

white tape.

3. Review of Resident #60's admission MDS, dated 1/8/25, showed:
-They were cognitively intact;
-They had impairment on one side of lower extremity;
-They were dependent on a wheelchair for mobility;
-They had a fracture related to a fall in past 6 months prior to admission;
-They had a orthopedic surgery repair for a bone;
-Diagnoses included fracture of the left talus sequela (healed fracture of the left ankle bone with lasting complications or effects from a previous injury), anxiety , manic depression (a mental illnesses causing extreme mood swings).

Review of care plan, revised 1/16/25, showed the resident used a wheelchair for mobility, can propel themselves and directed staff to assist the resident with this task as needed.

Review of physician's orders, dated 1/29/25, showed started 12/26/24, non weight bearing to lower left extremity.

Observation on 1/29/25 at 11:21 A.M., showed the resident's left wheelchair arm rest was wrapped in white tape.

During an interview on 1/29/24 at 4:16 P.M., Maintenance said he/she was aware of several wheelchairs that needed repairs and it was on his/her list to complete these items.

During an interview on 1/29/24 at 4:16 P.M., Director of Nursing said they expected residents wheelchairs to be in good repair and free of torn

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F 908	Continued From page 74 arm rests. During an interview on 1/29/24 at 4:16 P.M., Administrator said he/she expected residents wheelchairs to be in good repair and free of torn arm rests.	F 908		

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A3038	19 CSR 30-85.032(38) Furniture/Equip, Provide Comfort & Safety The facility shall maintain furniture and equipment in good condition and shall replace it if broken, torn, heavily soiled or damaged. Rooms shall be designed and furnished so that the comfort and safety of the residents are provided for at all times. II/III This regulation is not met as evidenced by: Class II Please refer to F908 * The higher classification merited due to the extent of the violation.	A3038		
A4023	19 CSR 30-85.042(21)(A) NA Training Complete In 4 mos All nursing assistants shall successfully complete the entire basic course (including passing the final examination) of the nursing assistant training program and be certified within four (4) months of employment. II/III This regulation is not met as evidenced by: Class II 1. Refer to F728 * The higher classification merited due to the extent of the violation.	A4023		
A4064	19 CSR 30-85.042(55) Medication Storage Facilities shall store all external and internal medications at appropriate temperatures in a	A4064		

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A4064	Continued From page 1 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: Class II 1. Refer to F761 * The higher classification merited due to the extent of the violation.	A4064		
A4075	19 CSR 30-85.042(66) Nursing Care per Res Condition Each resident shall receive personal attention and nursing care in accordance with his/her condition and consistent with current acceptable nursing practice. I/II This regulation is not met as evidenced by: Class II 1. Refer to F684 and F689	A4075		
A7001	19 CSR 30-87.030(1) Employees Clean & Good Hygiene Employees shall maintain a high degree of personal cleanliness and shall conform to good hygienic practices during all working periods. II/III This regulation is not met as evidenced by: Class III	A7001		

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A7001	Continued From page 2 Please see F812.	A7001		
A7034	19 CSR 30-87.030(32) Metal Steam-Type Thermometers Used Metal stem-type numerically scaled indicating thermometers, accurate to plus or minus two degrees Fahrenheit (±2°F), shall be provided and used to assure the attainment and maintenance of proper internal cooking, holding or refrigeration temperatures of all potentially hazardous foods. II/III This regulation is not met as evidenced by: Class III Please see F812.	A7034		
A7089	19 CSR 30-87.030(87) Glasses/Cups/Utensils Storage Glasses and cups shall be stored inverted. Other stored utensils shall be covered or inverted, wherever practical. Facilities for the storage of knives, forks and spoons shall be designed and used to present the handle to the employee or consumer. Unless tableware is prewrapped, holders for knives, forks and spoons at self-service locations shall protect these articles from contamination and present the handle of the utensil to the consumer. III This regulation is not met as evidenced by: Class III Please refer to F812.	A7089		
A8001	19 CSR 30-88.010(1) Required Info Available for Public Inspection	A8001		

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A8001	Continued From page 3 The facility shall retain and make available for public inspection at the facility to facility personnel, residents, their next of kin, legal representatives or designees and the general public, a list of names, addresses and occupations of all individuals who have a property interest in the facility as well as a complete copy of each official notification from the Department of Health and Senior Services (the department) of violations, deficiencies, licensure approval, disapprovals, or a combination of these, and responses. This includes, as a minimum, statements of deficiencies, copies of plan(s) of correction, acceptance or rejection notice regarding the plan(s) of corrections and revisit inspection report. II/III This regulation is not met as evidenced by: Class III. 1. Refer to F574	A8001		
A8004	19 CSR 30-88.010(4) Resident Rights-Admission/Annual Review Each resident admitted to the facility, or his or her next of kin, legally authorized representative or designee, shall be fully informed of the individual's rights and responsibilities as a resident. These rights shall be reviewed annually with each resident, and/or his or her next of kin, legally authorized representative or designee, either in a group session or individually. II/III This regulation is not met as evidenced by: Class II 1. Refer to F572	A8004		

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A8004	Continued From page 4 * The higher classification merited due to the extent of the violation.	A8004		
A8013	19 CSR 30-88.010(13) Right to Plan Care/Refuse Treatment Each resident shall be afforded the opportunity to participate in the planning of his or her total care and medical treatment, to refuse treatment and to participate in experimental research only upon his or her informed written consent. If a resident refuses treatment, this refusal shall be documented in the resident's record and the resident, his or her legally authorized representatives or designees, or both, shall be informed of possible consequences of not receiving treatment. II This regulation is not met as evidenced by: Class II 1.Refer to F657	A8013		
A8020	19 CSR 30-88.010(20) Exercise Rights/Voice Grievances Each resident shall be encouraged and assisted, throughout his or her period of stay, to exercise his or her rights as a resident and as a citizen and to this end a resident may voice grievances and recommend changes in policies and services to facility personnel or to outside representatives of his or her choice. A staff person shall be designated to receive grievances and the residents shall be free to voice their complaints and recommendations to the staff designee, an ombudsman or to any person outside the facility. Residents shall be informed of and provided a	A8020		

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A8020	Continued From page 5 viable format for recommending changes in policy and services. The facility shall assist residents in exercising their rights to vote. II/III This regulation is not met as evidenced by: Class II 1. Refer to F565 and F585 * The higher classification merited due to the extent of the violation and when combined with other deficiencies.	A8020		
A8023	19 CSR 30-88.010(23) Develop/Implement A/N Policies The facility shall develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of any resident and misappropriation of resident property and funds, and develop and implement policies that require a report to be made to the department for any resident or to both the department and the Department of Mental Health for any vulnerable person whom the administrator or employee has reasonable cause to believe has been abused or neglected. II/III This regulation is not met as evidenced by: Class III Please refer to F607	A8023		
A8030	19 CSR 30-88.010(29) Dignity/Privacy Each resident shall be treated with consideration, respect, and full recognition of his or her dignity and individuality, including privacy in treatment and care of his or her personal needs. All	A8030		

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A8030	Continued From page 6 persons, other than the attending physician, the facility personnel necessary for any treatment or personal care, or the department or Department of Mental Health staff, as appropriate, shall be excluded from observing the resident during any time of examination, treatment, or care unless consent has been given by the resident. II/III This regulation is not met as evidenced by: Class II Refer to F550 * The higher classification merited due to the extent of the violation. MO248475	A8030		
A8035	19 CSR 30-88.010(34) Mail If the resident cannot open mail, written consent by the resident or his or her legally authorized representative shall be obtained to have all mail opened and read to the resident. II/III This regulation is not met as evidenced by: Class III. 1. Refer to F576	A8035		
A9023	19 CSR 30-88.020(14) Resident Fund Bond Requirements The bond required by section 198.096, RSMo, for operators holding personal funds of residents shall be in a form approved by the department and shall provide that residents who allege that they have been wrongfully deprived of moneys	A9023		

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HILL CREST MANOR	801 SOUTH COLBY HAMILTON, MO 64644

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A9023	Continued From page 7 held in trust may bring an action for recovery directly against the surety. The bond shall be in an amount equal to at least one and one-half (1 1/2) times the average monthly balance of the residents ' personal funds, including residents ' petty cash, or the average total of the monthly balances for the preceding twelve (12) months. The average monthly balance(s) or the average total of the monthly balance(s) shall be rounded to the nearest one thousand dollars ($1,000). One (1) bond may be used to cover the residents ' funds in more than one (1) facility operated by the same operator, if the facility is a multilicensed facility on the same premises. If not on the same premises, then one (1) bond may be used if the bond specifies the amount of coverage provided for each individual facility and the coverage for each facility is a minimum of one thousand dollars ($1,000). II/III This regulation is not met as evidenced by: Class III Please refer to F570	A9023		

PLAN OF CORRECTION

Provider/Supplier Name:	HILLCREST MANOR
Street Address, City, Zip:	801 SOUTH COLBY HAMILTON, MO. 64644
Date of Survey:	01/29/2025

PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	265665

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 is prepared and executed because it is required by the provisions of the state and federal regulations and not because Hillcrest Manor agrees with the allegations and citations listed on the statement of deficiencies. Hillcrest Manor maintains that the alleged deficient practices do not, individually and collectively, jeopardize the health and safety of the residents nor are they of such character as limit our capacity to render adequate care as prescribed by the regulation. This plan of correction shall operate as Hillcrest Manor's written credible allegation of compliance. By submitting this plan of correction, Hillcrest Manor does not admit to the accuracy of the deficiencies. This plan of correction is not meant to establish any standard of care, contract, obligation, or position and Hillcrest Manor reserves all rights to raise all possible contentions and defenses in any civil or criminal claim, action or proceeding.	
F550	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. Residents # 8, 11, 12, 19 and 21 will receive cares from staff in a dignified manner to include knocking on doors, announcing self, providing privacy and not speaking of other residents in front of other residents.	3/12/25
	All residents are at risk of this alleged deficient practice. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur. Administrator will provide in-service to DON regarding expectations of providing care in a dignified manner and preserving HIPPA compliance.	

	DON and\or designee will in-service nursing staff of expectations of providing care in a dignified manner and preserve HIPPA compliance. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur. DON and\or designee will perform walking rounds daily and provide re-education as needed 5x/wk x 2 wks, then 3x/wk x 2 wks, then weekly on-going. How the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that corrections achieved are sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system. The Director of Nurses and\or designee will report findings to the QAA committee to review monthly and augment review process as necessary to maintain compliance.	
F561	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. Res # 12 and 25 will be interviewed for their preference of showers and/or hygiene. Res # 42 will be interviewed for food preference and educated regarding food availability. All residents are at risk of this alleged deficient practice. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur. Director of Nurses and\or designee will monitor the completion of showers/hygiene daily 5x/weekly on-going. The Dietary manager will interview and educate res # 42 and report findings/needs/request to Administrator. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur. Monthly Resident council meeting will review the satisfaction of residents regarding showers/hygiene and food choice monthly x 3 months then quarterly on-going. How the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that corrections achieved are sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system.	3/12/2025

	The Director of Nurses and the Dietary Manager will report findings to the QAA committee monthly, then, QAA committee to review monthly and augment review process as necessary to maintain compliance.	
	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. All residents are at risk of this alleged deficient practice. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur.	
	What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur. How the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that corrections achieved are sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system. The Director of Nurses and/or Administrator will monitor completion of showers/hygiene 5 times a week during clinical meeting for 3 weeks, then 3 times weekly for 3 weeks then weekly on-going, then, QAA committee to review monthly and augment review process as necessary to maintain compliance.	
F565	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. All residents are at risk of this alleged deficient practice. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur. The Administrator will provide an in-service to the Activity Director and the grievance coordinator related to the appropriate resident council and grievance protocol and follow up information required to complete the process by the date of compliance. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur. The activity director and the grievance coordinator will meet with the administrator weekly x4 weeks to discuss resident council	03/12/2025

	concerns and resolutions. The Administrator will review all grievance and resident council forms monthly on-going. How the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that corrections achieved are sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system. The grievance coordinator and the Activity director will report findings to the QAA committee monthly, then, QAA committee to review monthly and augment review process as necessary to maintain compliance.	
F570	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. All residents are at risk of this alleged deficient practice. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur. The Administrator will in-service the business office manager regarding the surety bond. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur. The Administrator will review the RTF balance and the surety bond quarterly and adjust as needed. How the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that corrections achieved are sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system. The Business Office Manager will report the findings of the surety bond quarterly to the QAA committee then, QAA committee to review quarterly and augment review process as necessary to maintain compliance.	03/12/2025
F572	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. All residents are at risk of this alleged deficient practice. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur.	03/12/2025

	The Activity Director will be in-serviced by the Administrator regarding the need to review resident rights monthly in the resident council meeting by the date of compliance. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur. The Administrator will review resident council meeting notes monthly on-going and provide re-education to the Activity director as identified. How the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that corrections achieved are sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system. The Activity director will report the reviewed rights monthly to the QAA committee then, QAA committee to review monthly and augment review process as necessary to maintain compliance.	
F574	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. All residents are at risk of this alleged deficient practice. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur. The Administrator and/or designee will place new resident rights posters in obvious locations that contain the Ombudsman's contact information in the facility by the date of compliance. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur. The Administrator will provide an in-service to the activity director to include Ombudsman role and contact information quarterly to the resident council. How the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that corrections achieved are sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system. The activity director will report completion to the QAA committee quarterly then, QAA committee to review quarterly and augment review process as necessary to maintain compliance.	03/12/2025

F576	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. All residents are at risk of this alleged deficient practice. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur. The Administrator will assign a staff member to deliver mail on Saturday when delivered from the post office. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur.	03/12/2025
	The Activity Director will address Saturday mail delivery monthly during resident council and report findings to the Administrator monthly x 2 months, then quarterly on-going. How the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that corrections achieved are sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system. The Activity Director will report to the QAA committee monthly x 2 months then quarterly on-going, then, QAA committee to review monthly and augment review process as necessary to maintain compliance.	
F585	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. All residents are at risk of this alleged deficient practice. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur. The Administrator will provide an in-service to the Activity Director regarding how to file a grievance, which will include during normal business hours and after hours and weekends and receiving responses.	03/12/2025
	What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur. The Activity Director will educate resident council members on how to file a grievance during normal business hours, after hours and on weekends and receiving responses quarterly on-going. How the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring	

	that corrections achieved are sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system. The Activity Director will report completion of resident education regarding filing a grievance with follow up communication quarterly and on-going, then, QAA committee to review quarterly and augment review process as necessary to maintain compliance.	
F607	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.	
	All residents are at risk of this alleged deficient practice. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur. The Administrator will provide an in-service to Business Office Manager regarding EDL and nurse aide registry checks on all new hires and EDL checks on all employees quarterly. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur. The Business Office Manager will utilize a new hire check list in each employee file and submit it for review to the Administrator on-going. The Administrator to provide re-education as needed. How the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that corrections achieved are sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system. The Business Office Manager will complete the new hire check list and report to the QAA committee monthly on-going, then, QAA committee to review monthly and augment review process as necessary to maintain compliance.	
F640	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. Resident #49 will have corrected and/or updated transmission accepted dates. All residents are at risk of this alleged deficient practice.	03/12/2025

	What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur. The Regional Nurse and/or designee will in-service MDS coordinator regarding regulatory guidelines related to MDS transmission requirements for Insurance policies. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur. The Regional Nurse and/or designee will monitor facility MDS submissions weekly x 3 weeks then weekly x 2 weeks then quarterly on-going.	
	How the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that corrections achieved are sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system. The MDS coordinator will report monthly to the QAA committee of assessments completed and/or corrected on-going, then, QAA committee to review monthly and augment review process as necessary to maintain compliance.	
F657	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. Residents # 24, 32, 42, 16 and 21 will have care plan meetings scheduled and invitation to attend provided to residents and responsible parties by the date of compliance. All residents are at risk of this alleged deficient practice. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur. The Administrator will in-service the interdisciplinary team on care plan meeting regulatory requirements by the date of compliance.	03/12/2025
	What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur. The interdisciplinary team will report to the administrator weekly on care plan meeting schedule and invitations sent to attend, the facility will maintain care plan invitations and attendance records. How the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that corrections achieved are sustained. This plan must be	

	implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system. The interdisciplinary team will report to the QAA committee the weekly care plan meetings and attendance monthly and ongoing, then, QAA committee to review monthly and augment review process as necessary to maintain compliance.	
F684	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. Resident # 16 will have a doctor's order to routinely obtain a PT/INR level or document physicians direction related to use of Coumadin,	03/12/2025
	All residents are at risk of this alleged deficient practice. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur. The Administrator and\or designee will in-service licensed and registered staff on the need to monitor PT/INR results for residents on coumadin and notification of resident, family and physician of results or changes to medication regimen. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur. The Director of nurses and\or designee will audit all coumadin use and PT/INR results weekly and ongoing. How the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that corrections achieved are sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system. The Director of Nurses and\or designee will report coumadin use and PT/INR orders to QAA committee monthly and on-going, then, QAA committee to review monthly and augment review process as necessary to maintain compliance.	
F685	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. Resident # 32 will have an appointment for eyeglasses by the date of compliance. All residents are at risk of this alleged deficient practice. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur.	03/12/2025

	The Administrator to provide an in-service to the SSD and transportation aide regarding making appointments and notification of residents and responsible parties. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur. The SSD and transportation aide will inform Administrator daily of all appointments and notifications made 5x/weekly ongoing. How the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that corrections achieved are sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system. The SSD and/or transportation aide will report to the QAA committee monthly regarding resident needs, appointments and notifications on-going, then, QAA committee to review monthly and augment review process as necessary to maintain compliance.	
F689	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. Resident # 8 was transferred in a safe manner and per manufacture guidelines of use. Resident # 11 and 30 have had pedals placed onto their wheelchairs. All residents are at risk of this alleged deficient practice. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur. The Director of Nurses and\or designee will provide an in-service to staff who propel residents in wheelchairs to include the use of foot pedals by the date of compliance. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur. The Director of Nurses and\or designee will audit the use of wheelchair pedals 2x/wkly for 3 weeks, then weekly x 3 weeks and provide re-education as needed. How the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that corrections achieved are sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system.	03/12/2025

	The Director of Nurses and\or designee will report findings to the QAA committee monthly, then, QAA committee to review monthly and augment review process as necessary to maintain compliance.	
F728	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. NA A, NA D and NA E will be enrolled in a state approved nurse aide program and competencies completed by the date of compliance. All residents are at risk of this alleged deficient practice. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur. The Director of Nurses and\or designee will perform competencies on NA A, D and E. The Administrator will coordinate and validate enrollment in state approved nurse aide program of NA A, D and E. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur. The facility will no longer hire nurse aides. How the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that corrections achieved are sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system. The Director of Nurses and/or Administrator will monitor completion of competencies and enrollment of nurse aides monthly and report findings to the QAA committee, then, QAA committee to review monthly and augment review process as necessary to maintain compliance.	03/12/2025
F761	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. Vial of tuberculin was discarded. Unlabeled insulin pens were discarded. Loose pills in the medication cart have been removed. Resident # 26 has been monitored taking medications and no longer being left at bedside. All residents are at risk of this alleged deficient practice. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur.	03/12/2025

	The Director of Nurses and\or designee will provide an in-service to all certified, licensed and registered staff regarding labeling and dating regulatory practices required for safe label and storage of drugs. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur. The director of Nurses and\or designee will audit medication carts, refrigerators weekly for any discrepancies of regulatory practices required for safe labeling and storage of drugs and provide re-education when needed weekly x 3 weeks, then monthly on-going.	
	How the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that corrections achieved are sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system. The Director of Nurses and\or designee will report findings to the QAA committee monthly and on-going, then, QAA committee to review monthly and augment review process as necessary to maintain compliance.	
F812	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. The unlabeled and undated sausage, smoked sausage, white bread, pan of gravy and ranch dressing have been discarded. The bowl of butter has been replaced, cleansed and covered. The dishes, storage containers and measuring cups have been cleaned and stored inverted. The metal pans have been cleaned and stored inverted. All residents are at risk of this alleged deficient practice. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur. The Director of Nurses and\or designee will provide an in-service to employees that provide food service or assistance in the dining room regarding not allowing clothing to touch food, when to wash hands. The Administrator and/or designee will in-service the dietary manager and cooks on when to take food temperatures and refrigerator temperatures and documentation required to maintain regulatory compliance. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur.	03/12/2025

	The dietary manager will report to the Administrator weekly regarding food temps and refrigerator temps weekly and provide the logs for review. The administrator will provide re-education as needed to dietary staff. How the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that corrections achieved are sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system. The Director of Nurses and the dietary manager will report educations and findings of temperature logs to the QAA committee monthly, then, QAA committee to review monthly and augment review process as necessary to maintain compliance.	
F908	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. Resident # 11, 51 and 60 wheelchairs will be in safe operating condition by the date of compliance. All residents are at risk of this alleged deficient practice. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur. The Administrator and\or designee will provide an in-service to staff regarding the need to identify and request wheelchair repairs to maintain equipment in a safe operating manner. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur. Maintenance and/or designee will perform wheelchair repairs as needed. How the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that corrections achieved are sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system. The Maintenance Director will report wheelchair repairs to the QAA committee monthly, then, QAA committee to review monthly and augment review process as necessary to maintain compliance.	03/12/2025
A3038	Refer to F908	03/12/2025
A4023	Refer to F728	03/12/2025

A4064	Refer to F761	03/12/2025
A4075	Refer to F684 and F689	03/12/2025
A7001	Refer to F812	03/12/2025
A7089	Refer to F812	03/12/2025
A8001	Refer to F574	03/12/2025
A8004	Refer to F572	03/12/2025
A8013	Refer to F657	03/12/2025
A8020	Refer to F565 and F585	03/12/2025
A8023	Refer to F607	03/12/2025
A8030	Refer to F550	03/12/2025
A8035	Refer to F576	03/12/2025
A9023	Refer to f570	03/12/2025

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.