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F 558 SS=E	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, facility staff failed to provide reasonable accommodations to meet the needs of the residents, when staff failed to ensure call lights were placed within reach for four residents (Resident #4, #10, #48, and #295) out of 16 sampled residents. The facility's census was 43. 1. Review of the facility's policy titled, "Call Lights: Accessibility and Timely Response", dated 01/01/25, showed the purpose of the policy is to assure the facility is adequately equipped with a call light at each resident's bedside, toilet, and bathing facility to allow residents to call for assistance, and directed staff: -All staff will be educated on the proper use of the resident's call system, including how the system works and ensuring resident access to the call light; -All residents will be educated on how to call for help using the resident call system; -Staff will ensure the call light is within reach of the resident and secured, as needed; -The call system will be accessible to the residents while in their bed or other sleeping accommodations within the resident's room. 2. Review of Resident #4's Quarterly Minimum	F 558		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Rebecca R Ley — TITLE: Administrator — (X6) DATE: 2/26/2025

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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Data Set (MDS), a federally mandated assessment tool, dated 11/22/24, showed staff assessed the resident as follows:

-Cognitive impairment;
-Partial/moderate assistance needed for transfer, and toileting, and sit to stand.

Observation on 01/28/25 at 2:00 P.M., showed the resident in his/her wheelchair next to his/her bed, the call light attached to a string on floor across the room out of his/her reach. At 2:26 P.M., the resident yelled out for help. The resident said, "I need changed."

Observation on 01/29/25 11:43 A.M., showed the resident in his/her wheelchair next to his/her bed with the call light on the floor, across the room out of his/her reach.

Observation on 01/30/25 10:20 A.M., showed the resident in bed with the call light across the room out of his/her reach.

3. Review of Resident #10's Quarterly MDS, dated 01/05/25, showed staff assessed the resident as:

-Severe cognitive impairment;
-Substantial/maximal assistance needed for toileting, and transfers.

Observation on 01/28/25 at 10:30 A.M., showed the resident in his/her recliner. At this time, the resident asked for help up and said " I don't know where the call light is." The call light was across the room at the end of the residents bed.

Observation on 01/28/25 2:31 P.M., showed the

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resident in his/her bed with the call light at the end of bed out of reach.

Observation on 01/30/25 10:15 A.M., showed the resident in his/her bed with the call light at the end of bed out of reach.

4. Review of Resident #48's Entry Tracking Record MDS, dated 01/08/25, showed the resident admitted to the facility on 01/08/25.

Review of the resident's care plan, dated 01/17/25, showed staff were directed to provide assistance with Activities of Daily Living (ADLs) as needed.

Observation on 01/27/25 at 2:44 P.M., showed the resident in bed with his/her call light secured to the wall light pull-cord, out of his/her reach. The resident repeatedly yelled, "help, I need to get up!"

During an interview on 01/27/25 at 2:44 P.M., the resident said he/she knows how to use the call light to call for help, but thinks the string might be on the bedside table, and he/she could not reach it.

During an interview on 01/27/25 at 2:46 P.M., Certified Nursing Assistant (CNA) J said the resident can use the call light if it is within his/her reach. The CNA said the string to pull the call light is a bit short and he/she secured the string to the wall light pull-cord to place it closer to the resident, but it is still difficult for the resident to reach it when in bed.

Observation on 01/29/25 at 10:31 A.M., showed the resident in bed with his/her call light secured

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to the wall light pull-cord, out of his/her reach and yelled, "Nurse! Nurse!"

During an interview on 01/29/25 at 10:31 A.M., the resident said he/she could not reach the string to pull the call light for help from staff.

Observation on 01/30/25 at 11:05 A.M., showed the resident in bed with his/her call light secured to the wall light pull-cord and out of his/her reach.

During an interview on 01/30/25 at 11:05 A.M., Licensed Practical Nurse (LPN) H said the resident should be able to reach his/her call light to call for assistance from staff if needed, but the resident is not able to reach his/her call light now because the string is too short, even when fully extended from the lever on the wall.

During an interview on 01/30/25 at 11:16 A.M., the Maintenance Director (MD) said he/she was not aware the resident's call light string was not long enough for him/her to reach it. The MD said after he/she used a tape measure to check, the call light string was two and a half feet away from the resident's reach, even with the string fully extended from the lever on the wall. He/She said he/she would go and cut a longer string for the call light.

5. Review of Resident #295's Medication Administration Record (MAR), dated 1/1/25-1/31/25, showed resident admitted to facility on 1/27/25.

Observation on 01/30/25 at 10:08 A.M., showed resident's room call light string was laying on a stack of pillows in chair next to bed. Call light string was not long enough to reach the bed up

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F 558	Continued From page 4 against the wall. During an interview on 01/30/25 at 11:16 A.M., resident said he/she is unable to reach his/her call light when in room. He/She said the call light string is not long enough to reach when he/she is laying in bed. 6. During an interview on 01/30/25 at 2:58 P.M., LPN H said call lights should be within the residents' reach at all times when staff is not with the resident in his/her room, so the resident can pull the call light to alert staff if he/she needs assistance. During an interview on 01/30/25 at 3:04 P.M., CNA K said staff should always ensure the call light is placed within the resident's reach when the resident is left inside his/her room, so he/she can pull the light if he/she needs assistance from staff. During an interview on 01/30/25 at 3:52 P.M., the Director of Nursing (DON) said he/she expects staff to educate each resident, based on his/her cognition, on how to use the call light in his/her room. He/She said staff should place the residents' call lights within his/her reach before staff step away from the resident in the room. During an interview on 01/30/25 at 4:05 P.M., the Administrator said he/she expects staff to educate each resident on how to use the call light in his/her room. He/She said staff should ensure the resident's call light is within his/her reach prior to leaving the resident in the room. During an interview on 02/06/25 at 2:56 P.M., the	F 558		

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F 558	Continued From page 5 MDS/Care Plan Coordinator said if a CNA realizes that a resident's call light string is not long enough for him/her to reach it, he/she is expected to notify the charge nurse or the MD, and if the MD is not available, the nurse should go to the maintenance office and get a longer string. He/She said there is no formal communication for that with the MD, staff just notifies him/her verbally.	F 558		
F 583 SS=E	MO00248764 Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii) §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service.	F 583		

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F 583	Continued From page 6 §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(h)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law. This REQUIREMENT is not met as evidenced by: Based on observation and interview, facility staff failed to ensure residents' personal information and privacy was protected when staff left the computer screen open in public hallways for two residents (Resident #9 and #13) of 16 sampled residents, and failed to close the privacy curtain and window blinds/curtain during incontinence care for one resident (Resident #48) out of two sampled residents observed during care. The facility's census was 43. 1. Review of the facility's policy titled, "Quality of Life-Dignity", dated 01/01/24, showed: -Each resident shall be cared for in a manner that promotes and enhances his/her sense of well-being, level of satisfaction with life, feeling of self-worth and self-esteem; -Staff protect confidential clinical information; -Staff promote, maintain and protect resident privacy, including bodily privacy during assistance with personal care and during treatment procedures. 2. Observation on 01/28/25 at 8:18 A.M., showed the medication cart across from the nurses'	F 583		

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station on the East Hall with a computer screen open with medication information for Resident #9 visible to the public while unattended. Observation showed residents and staff walked by the cart.

Observation on 01/28/25 at 12:36 P.M., showed the medication cart across from the nurses' station on the East Hall with a computer screen open with medication information for Resident #13 visible to the public while unattended. Observation showed several staff walked by the cart.

During an interview on 01/30/25 at 12:00 P.M., the Care Plan Coordinator said staff should lock the computer screen when they walk away from the cart to ensure resident privacy. He/She said he/she was just busy and did not realize he/she had left the computer screen open when he/she stepped into the medication storage room.

During an interview on 01/30/25 at 11:45 A.M., Licensed Practical Nurse (LPN) H said staff should always minimize or lock the computer screen on the medication cart when he/she walks away from the cart to ensure privacy of the residents' medical information.

3. Review of Resident #48's Entry Tracking Record Minimum Data Set (MDS), a federally mandated assessment, dated 01/08/25, showed the resident admitted to the facility on 01/08/25.

Review of the resident's Physician's Order Sheet (POS), dated 01/08/25 through 01/29/25, showed an order to provide colostomy (an opening in the abdomen to the intestines) care every shift for ileostomy (a surgical procedure that creates an

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opening in the abdomen to excrete poop from the body).

Observation on 01/29/25 at 10:37 A.M., showed Certified Nursing Assistant (CNA) K provided incontinence care to the resident and attempted to empty the resident's colostomy bag, the resident's window blinds raised and open, with clear view of vehicles parked in the front parking lot of the building. The CNA did not pull the privacy curtain and did not close the window blinds/curtain to provide privacy during incontinence care.

During an interview on 01/29/25 at 10:38 A.M., the resident said he/she did not like that you could see the cars in the parking lot while being changed.

During an interview on 01/29/25 at 10:46 A.M., the CNA said he/she should have pulled the privacy curtain and the window curtain to provide privacy during care but he/she was nervous and did not think about it.

During an interview on 01/30/25 at 11:45 A.M., LPN H said staff should pull the privacy curtain and close window curtains when they provide incontinence care to the resident to ensure privacy, and particularly if there is a clear view of the parking lot.

4. During an interview on 01/30/25 at 3:52 P.M., the Director of Nursing (DON) said he/she expects staff to minimize or lock the computer screen when he/she steps away from the medication cart. The DON said he/she expects staff to close doors and pull/close curtains in the room to provide privacy during incontinence care.

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F 583	Continued From page 9 During an interview on 01/30/25 at 4:05 P.M., the administrator said he/she expects staff to lock the computer screen when he/she steps away from the medication cart. The administrator said staff should close doors, privacy curtains, and window curtains in the room to provide privacy to the resident during incontinence care.	F 583		
F 625 SS=E	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy	F 625		

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described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by:
Based on interview and record review, facility staff failed to provide written notification information to the resident and/or the resident's representative of the bed hold policy at the time of transfer to the hospital, or therapeutic leave for four (Resident #3, #14, #20, and #26) out of four sampled residents. The facility's census was 43.

1. Review of the facility's policies showed the facility did not provide a policy for Bed Hold.

2. Review of Resident #3's medical record showed:

-Discharged from the facility on 11/19/24 and readmitted to the facility on 11/22/24;
-Did not contain written documentation staff notified the resident or the resident's responsible party of the facility's bed-hold policy.

3. Review of Resident #14's medical record showed:

-Discharged from the facility on 12/31/24 and readmitted to the facility on 01/04/25;
-Did not contain written documentation staff notified the resident or the resident's responsible party of the facility's bed-hold policy.

4. Review of Resident's 20's medical record showed:

-Discharged from the facility on 11/27/24 and readmitted to the facility on 12/17/24;
-Did not contain written documentation staff notified the resident or the resident's responsible

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F 625	Continued From page 11 party of the facility's bed-hold policy. 5. Review of Resident's #26's medical record showed: -Discharged from the facility on 10/24/24 and readmitted to the facility on 10/28/24; -Did not contain written documentation staff notified the resident or the resident's responsible party of the facility's bed-hold policy. During an interview on 01/30/25 at 3:40 P.M., the Director of Nursing (DON) said he does not know about the bed hold requirement or process. During an interview on 01/30/25 at 4:09 P.M., the administrator said she is aware of the bed hold paperwork in the admission packet but not aware of the requirement or process for bed hold at the time of the residents transfer and discharge.	F 625		
F 636 SS=E	Comprehensive Assessments & Timing CFR(s): 483.20(b)(1)(2)(i)(iii) §483.20 Resident Assessment The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. §483.20(b) Comprehensive Assessments §483.20(b)(1) Resident Assessment Instrument. A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following: (i) Identification and demographic information	F 636		

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(ii) Customary routine.
(iii) Cognitive patterns.
(iv) Communication.
(v) Vision.
(vi) Mood and behavior patterns.
(vii) Psychological well-being.
(viii) Physical functioning and structural problems.
(ix) Continence.
(x) Disease diagnosis and health conditions.
(xi) Dental and nutritional status.
(xii) Skin Conditions.
(xiii) Activity pursuit.
(xiv) Medications.
(xv) Special treatments and procedures.
(xvi) Discharge planning.
(xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS).
(xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and nonlicensed direct care staff members on all shifts.

§483.20(b)(2) When required. Subject to the timeframes prescribed in §413.343(b) of this chapter, a facility must conduct a comprehensive assessment of a resident in accordance with the timeframes specified in paragraphs (b)(2)(i) through (iii) of this section. The timeframes prescribed in §413.343(b) of this chapter do not apply to CAHs.
(i) Within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section,

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F 636	Continued From page 13 "readmission" means a return to the facility following a temporary absence for hospitalization or therapeutic leave.) (iii)Not less than once every 12 months. This REQUIREMENT is not met as evidenced by: Based on interview and record review, facility staff failed to complete the required Minimum Data Set (MDS), a federally mandated resident assessment, within the required time frame for three residents (Residents #20, #24 and #48) of six sampled residents. The facility's census was 43. 1. Review of the facility's policy titled, "MDS Completion and Submission Timeframes", dated July 2017, showed staff are directed: -The Assessment Coordinator or designee is responsible for ensuring the resident assessments are submitted to Centers for Medicare and Medicaid Services (CMS) Quality Improvement and Evaluation Service (QIES) Assessment Submission and Processing (ASAP) system in accordance with the current federal and state guidelines; -Timeframes for completion and submission of assessments is based on the current requirements published in the Resident Assessment Instrument (RAI) Manual; -Submission of MDS records to the QIES ASAP is electronic. A hard copy of each record submitted is maintained in the resident's clinical record for a period of 15 months from the date submitted. Review of the RAI manual version 3.0 RAI Omnibus Budget Reconciliation Act (OBRA)-required Assessment Summary showed assessment time frames as follows:	F 636		

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F 636	Continued From page 14 -Entry MDS completion date no later than the 7th calendar day from the resident's entry into the facility and submitted no later than 14 days from the date of entry into the facility; -Admission (Comprehensive) MDS completion date no later than 14th calendar day of the resident's admission and submitted no later than 14 calendar days from the care plan completion date; -Quarterly assessment for a resident must be completed at least every 92 days following the previous OBRA assessment of any type. 2. Review of Resident #20's Entry Tracking Record MDS, dated 12/17/24, showed the resident admitted to the facility on 12/17/24. Review of the resident's MDS record, dated 12/17/24 through 01/30/25, showed the record did not contain an in-process, completed, or submitted admission assessment within the required time frame. During an interview on 01/30/25 at 3:08 P.M., the MDS Coordinator said the resident should have a completed Admission MDS, and he/she was not sure why he/she doesn't have one completed. 3. Review of Resident #24's Quarterly MDS, dated 10/17/24, showed the resident admitted to the facility on 04/03/24. Review of the resident's MDS record, dated 10/18/24 through 01/30/25, showed the record did not contain an in-process, completed, or submitted quarterly assessment within the required time frame.	F 636		

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4. Review of Resident #48's Entry Tracking Record MDS, dated 01/08/25, showed the resident admitted to the facility on 01/08/25.

Review of the resident's Admission MDS, dated 01/21/25, showed the assessment in process and not submitted within the required time frame. Review showed 16 of 18 sections "in progress" and without information.

During an interview on 01/29/25 at 11:06 A.M., the MDS Coordinator said the resident's admission MDS was currently eight days overdue for submission, and he/she was still working on gathering information for the assessment.

5. During an interview on 01/30/25 at 3:07 P.M., the MDS Coordinator said he/she is responsible to complete residents' MDS and the DON or an assigned Registered Nurse (RN) signs the MDS and submits electronically once completed. He/She said the admission MDS should be submitted within two weeks after admission, and then a quarterly MDS should be submitted at least every three months. He/She said he/she is behind on completing MDSs because he/she is being pulled to work the floor often. He/She said currently, no one double checks the MDSs are completed within the required time frame.

During an interview on 01/30/25 at 3:52 P.M., the Director of Nursing (DON) said he/she was new to the facility and was not sure of the required time frames for MDS submissions. He/She said the MDS Coordinator is responsible to ensure the residents' MDSs are completed within the required time frames.

During an interview on 01/30/25 at 4:05 P.M., the

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F 636	Continued From page 16 administrator said the MDS Coordinator is responsible to complete the residents' MDS within the required time frames, and the DON is reponsible to monitor for completion. He/She said the residents' admission MDS should be completed within seven to 14 days after admission, and then at least quarterly.	F 636		
F 655 SS=E	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of	F 655		

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F 655	Continued From page 17 this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on interviews and record review, facility staff failed to complete a baseline care plan within 48 hours of admission for five residents (Resident #20, #43, #45, #46, and #48) out of 16 sampled residents. The facility census was 43. 1. Review of the facility's policy titled, "Care Plans-Baseline', dated December 2016, showed a baseline plan of care to meet the resident's immediate needs shall be developed for each resident within 48 hours of admission. 2. Review of Resident #20's electronic medical record (EMR), showed staff documented the resident admitted to the facility on 01/22/25. The EMR did not contain documentation staff completed a baseline care plan within 48 hours of admission. 3. Review of Resident #43's EMR, showed staff documented the resident admitted to the facility on 11/15/24. The EMR did not contain documentation staff completed a baseline care	F 655		

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plan within 48 hours of admission.

During an interview on 01/30/25 at 2:35 P.M., the Care Plan Coordinator said he/she was not sure why the resident did not have a baseline care plan in chart. He/She said resident should have had a baseline care plan within 48 hours of admission.

4. Review of Resident #45's EMR, showed staff documented the resident admitted to the facility on 01/17/25. The EMR did not contain documentation staff completed a baseline care plan within 48 hours of admission.

During an interview on 01/30/25 at 2:35 P.M., the Care Plan Coordinator said he/she was still trying to get information about the resident for the baseline care plan. He/She said resident should have had a cmpleted baseline care plan within 48 hours of admission.

5. Review of Resident #46's EMR, showed staff documented the resident admitted to the facility on 01/22/25. The EMR did not contain documentation staff completed a baseline care plan within 48 hours of admission.

6. Review of Resident #48's EMR, showed staff documented the resident admitted to the facility on 01/08/25. The EMR did not contain documentation staff completed a baseline care plan within 48 hours of admission.

During an interview on 01/29/25 at 11:06 A.M., the Care Plan Coordinator said he/she did not have an explanation for why the resident's baseline care plan was still incomplete.

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F 655	Continued From page 19 7. During an interview on 01/29/25 at 11:06 A.M., the Care Plan Coordinator he/she is responsible to complete baseline care plans after a resident is admitted. He/She said the baseline care plan should be completed within 48 hours, but he/she tries to complete them within the first week after a resident is admitted. During an interview on 01/30/25 at 3:52 P.M., the Director of Nursing (DON) said he/she was not sure of the timeframe in which a resident's baseline care plan should be completed. He/She said the Care plan Coordinator is currently responsible to complete the baseline care plans. The DON said he/she was new to the facility and was not sure if anyone was double checking that baseline care plans were completed timely. During an interview on 01/30/25 at 4:05 P.M., the administrator said baseline care plans should be initiated by the nurse who initially admits the resident, and completed within seven days by the care plan coordinator. He/She said the coordinator and the DON are responsible to monitor for the completion of base line care plans.	F 655		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive	F 656		

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assessment. The comprehensive care plan must describe the following -
(i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and
(ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6).
(iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.
(iv)In consultation with the resident and the resident's representative(s)-
(A) The resident's goals for admission and desired outcomes.
(B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.
(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.
§483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-
(iii) Be culturally-competent and trauma-informed.
This REQUIREMENT is not met as evidenced by:
Based on observation, interview and record review, facility staff failed to develop a

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comprehensive person-centered care plan to meet the resident's medical, nursing, mental and psychosocial needs for three residents (Resident #1, #15, and #16) out of 16 sampled residents. The facility's census was 43.

1. Review of the facility's policy titled, "Care Plans, Comprehensive Person-Centered", dated 01/01/24, showed:

-A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident;
-The care plan interventions are derived from a thorough analysis of the information gathered as part of the comprehensive assessment;
-The comprehensive, person-centered care plan is developed within seven days of the completion of the required comprehensive assessment;
-Assessments of residents are ongoing and care plans are revised as information about the residents' condition change.

2. Review of Resident #1's Significant change Minimum Data Set (MDS), a federally mandated assessment, dated 12/05/24, showed staff assessed the resident as follows:

-Moderate cognitive impairment;
-Diagnoses of Non-Traumatic Brain Dysfunction, Dementia and heart failure;
-Hospice care.

Review of the resident's hospice contract, dated 11/27/24, showed the resident started hospice services.

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Review of the resident's care plan, dated 12/21/24, showed the care plan did not contain direction for hospice services.

During an interview on 01/30/25 at 11:20 A.M., the Social Services Director (SSD) said the resident admitted to the facility on hospice services, and directions for the hospice care and services should be documented on his/her care plan. He/She said the Care Plan Coordinator was responsible to document hospice information on the resident's care plan.

During an interview on 01/30/25 at 3:05 P.M., the MDS/Care Plan Coordinator said he/she was not sure why there were not directions for hospice services on the resident's comprehensive care plan, but there should be. He/She said although the hospice company has their own care plans for each resident, the resident should still have directions/interventions for hospice services on his/her comprehensive care plan.

3. Review of Resident #15's annual MDS, dated 12/14/24, showed staff assessed the resident as:

-Cognitively intact;
-Independent with bed mobility, toileting, and transfers.

Review of resident's care plan, dated 08/23/24, showed the care plan did not contain direction of use of bed rails.

Observation on 1/27/25 at 11:13 A.M., showed the resident in bed with bilateral U-Bars (a bed rail) in upright position.

Observation on 1/28/25 at 9:06 A.M., showed the

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F 656	Continued From page 23 resident in bed with bilateral U-Bars in upright position. Observation on 1/29/25 at 9:45 A.M., showed the resident in bed with bilateral U-Bars in upright position. Observation on 1/30/25 at 10:07 A.M., showed the resident laying in bed with bilateral U-Bars in upright position. During an interview on 1/30/25 at 2:35 P.M., the MDS/Care Plan Coordinator said he/she thought the resident's bed rails were on the care plan. He/She said bed rails should be on the care plan. 4. Review of Resident #16's Quarterly MDS, dated 11/05/24, showed staff assessed the resident as: -Severe cognitive impairment; -Diagnoses of Non-Traumatic Brain Dysfunction, Dementia, and Alzheimer's Diease -Impairment on both side upper and lower extremities; -Dependant of staff bed mobility, tolieting, eating, dressing, and transfers. Review of the resident's care plan, dated 11/27/24, showed the care plan did not contain direction for bilateral upper and lower extremity contractures (a condition of shortening and hardening of muscles, tendons, or other tissue, often leading to deformity and rigidity of joints). Observation on 1/27/25 at 11:15 A.M., showed the resident in a broda chair (a reclined wheelchair that helps with body positioning) with both hands contracted. The resident did not have	F 656		

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F 656	Continued From page 24 intervention in place with his/her hands. Observation on 1/28/25 at 9:07 A.M., showed the resident in a broda chair with with both hands contracted. The resident did not have intervention in place with his/her hands. Observation on 1/28/25 at 2:02 P.M., showed the resident in a broda chair with both hands contracted. Observation showed the resident's left hand finger nail indent in palm. The resident did not have interventions in place for his/her contracted hands. Observation on 1/29/25 at 9:54 A.M., showed the resident in bed with both hands contracted. The resident did not have interventions in place for his/her contracted hands. During an interview on 01/30/25 at 2:35 P.M., the MDS/Care Plan Coordinator said he/she thought there was something on the care plan about the resident's contractures. He/She said staff are supposed to be putting wash cloths in the resident's hands. He/She said he/she is unsure why it is not on the care plan, but it should be. During an interview on 01/30/25 at 3:07 P.M., the MDS/Care Plan Coordinator said he/she is responsible for completing the residents' comprehensive care plans, and usually has the care plan completed within the first week of admission. He/She said he/she updates care plans as needed, and after each completed MDS assessment. He/She said the comprehsnive care plan should address each resident's specific medical, nursing, mental and psychosocial needs. During an interview on 01/30/25 at 3:40 P.M., the	F 656		

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F 656	Continued From page 25 Director of Nursing (DON) said care plans should contain things like side rails and hospice. The DON said if these thing are not care planned they may have got missed. He/She said the person responsible does get pulled away often for other duties. During an interview on 01/30/25 at 4:05 P.M., the administrator said the MDS/Care plan Coordinator is responsible to complete the residents' comprehensive care plan within 14 days of the MDS assessment, and make updates to the care plan at least quarterly and as needed with any changes. The administrator said it is the MDS/Care plan Coordinator's responsibility to get things on the care plan and the DON to over see this. The current DON is has been here a little over a week, and the past DON was simply not doing it.	F 656		
F 658 SS=E	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, facility staff failed to follow professional standards of practice when staff failed to obtain physician's orders for water flushes/flush medications with water per facility policy, failed to administer medications as directed by the physician and the medication administration record (MAR), and failed to ensure a licensed staff member documented medication	F 658		

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administration via Gastric Tube (G-Tube), a surgically inserted tube which provides nutrition, hydration, or medicine directly into the stomach, for one resident (Resident #20) of one sampled resident. Licensed staff failed to perform colostomy (an opening in the abdomen to the intestines) care as directed by the physician for one resident (Resident #48) of one sampled resident. The facility census was 43.

1. Review of the facility's policy titled, "Administering Medications through and Enteral Tube", dated November 2018, showed:

-Verify that there is a physician's medication order for the procedure;
-Dilute crushed medication with at least 30 milliliters (ml) of purified water (or prescribed amount);
-Dilute liquid medication with 30 ml or more (depending on viscosity (thickness)) purified water;
-If administering more than one medication, flush with 15 ml warm purified water (or prescribed amount) between medications.

2. Review of Resident #20's Physician's Order Sheet (POS), dated 01/01/25 through 01/27/25, showed the physician ordered Levothyroxine (for low thyroid levels), Midodrine (for low blood pressure), Vitamin D, Cyclobenzaprine (for muscle spasms), Eliquis (for blood thinner), Fludrocortisone (to treat low levels of adrenal gland hormones), Gabapentin (for nerve damage), Fluoxetine oral solution (for depression), and Prenatal tablet (vitamins with iron and folic acid), to be administered via G-Tube. Review of the POS showed it did not contain documentation of an order for water

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F 658	Continued From page 27 flushes with medication administration via G-tube. Review of the resident's MAR, dated 01/20/25 through 01/26/25, showed the MAR contained documentation of the administration of Levothyroxine, Midodrine, Vitamin D, Cyclobenzaprine, Eliquis, Fludrocortisone, Gabapentin, Prenatal, and Fluoxetine to the resident via his/her G-tube on: -01/20/25 at 10:08 A.M.; -01/21/25 at 8:39 A.M.; -01/22/25 at 9:23 A.M.; -01/23/25 at 7:54 A.M., -01/24/25 at 7:41 A.M.; -01/25/25 at 8:20 A.M.; -01/26/25 at 8:42 A.M. -Review showed the MAR did not contain direction for staff to flush the G-tube with water. Observation on 01/27/25 at 12:15 P.M. showed Licensed Practical Nurse (LPN) G crushed Levothyroxine, Midodrine, Vitamin D, Cyclobenzaprine, Eliquis, Fludrocortisone, Gabapentin, and Prenatal tablets together, emptied the mixture into a cup with the liquid Fluoxetine, and added 60 cubic centimeters (cc) of water to the cup. Observation on 01/27/25 at 12:20 P.M. showed LPN G did not flush the resident's G-tube with water before or after he/she administered the crushed and liquid medications. During an interview on 01/27/25 at 12:24 P.M., LPN G said the resident's G-tube should be flushed with 60 cc water, so he/she just added the 60 cc water to the medications and administered together.	F 658		

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F 658	Continued From page 28 During an interview on 01/30/25 at 11:45 A.M., LPN H said the resident had an order for water flushes and should have one for medication administration but does not have a current order. He/She said the nurses are responsible to obtain an order from the physician. During an interview on 01/30/25 at 1:27 P.M., the Nurse Practitioner (NP) O said he/she was not aware there wasn't an order for water flushes, and he/she expects staff to reach out to him/her for an order. 3. Review of the facility's policy titled, "Administering Medications", dated 01/01/24, showed medication administration times are determined by resident need and benefit, not staff convenience. Factors to consider include enhancing optimal therapeutic effect of the medication, and preventing potential medication or food interactions. 4. Review of Resident #20's MAR, dated 01/20/25 through 01/23/25, showed staff were directed to administer one Levothyroxine 75 micrograms (mcg) tablet via G-tube every morning on an empty stomach, do not give with any other medication. Review of the resident's MAR, dated 01/20/25 through 01/26/25, showed the MAR contained documentation of the administration of Levothyroxine at the same time as the administration of Midodrine, Vitamin D, Cyclobenzaprine, Eliquis, Fludrocortisone, Gabapentin, Prenatal, and Fluoxetine on 01/20/25 at 10:08 A.M., 01/21/25 at 8:39 A.M., 01/22/25 at 9:23 A.M., 01/23/25 at 7:54 A.M., 01/24/25 at	F 658		

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F 658	Continued From page 29 7:41 A.M., 01/25/25 at 8:20 A.M., and 01/26/25 at 8:42 A.M. Observation on 01/27/25 at 12:20 P.M. showed LPN G administered the Levothyroxine with Midodrine, Vitamin D, Cyclobenzaprine, Eliquis, Fludrocortisone, Gabapentin, Prenatal, and Fluoxetine to the resident. The LPN did not administer the Levothyroxine separately, as directed on the MAR. During an interview on 01/27/25 at 12:43 P.M., LPN G said Levothyroxine is usually administered by the night shift nurse early in the morning before breakfast, so he /she did not pay close attention to the directions on the MAR prior to administering the medication to the resident. The LPN said if the Levothyroxine is not given as directed, it may not work like it should. During an interview on 01/27/25 at 12:49 P.M., NP O said Levothyroxine is ordered to be given in the morning, and should be administered separate from other medications to increase the medication's effectiveness. 5. Review of the facility's policy titled, "Administering Medications", dated 01/01/24, showed only persons licensed or permitted by this state to prepare, administer and document administration of medications may do so, and the individual administering the medication initials the resident's MAR on the appropriate line after giving each medication. 6. Review of Resident #20's MAR, dated 01/20/25 through 01/23/25, showed staff documented the administration of Levothyroxine, Midodrine, Vitamin D, Cyclobenzaprine, Eliquis,	F 658		

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F 658	Continued From page 30 Fludrocortisone, Gabapentin, Prenatal, and Fluoxetine administered via G-tube: -01/20/25 at 10:08 A.M. by Certified Medication Technician (CMT) L; -01/21/25 at 8:39 A.M. by CMT L; -01/22/25 at 9:23 A.M. by CMT L; -01/23/25 at 7:54 A.M. by "agencycmt". During an interview on 01/30/25 at 11:45 A.M., LPN H said only nurses are allowed to administer the resident's medications via G-tube and the CMTs do not administer the resident's medications via G-tube. He/She said he/she did not know why the CMTs signed the MAR at those times, and he/she always signs the MAR him/herself when he/she administers the medications via G-tube. During an interview on 01/30/25 at 3:07 P.M., the MDS/Care Plan Coordinator said when he/she pulled the MAR report to show the documented medication administration times, he/she noticed there were days signed by a CMT, but he/she does not think the CMT actually administered the medications via G-tube because they are not trained or authorized to do so. During an interview on 01/30/25 at 3:52 P.M., the Director of Nursing (DON) said the CMTs are not authorized to administer medications via G-tube, and he/she did not know the CMTs were documenting administration on the resident's MAR. He/She said only nurses are responsible to administer medications via G-tube and he/she expects the nurse to document the administration on the MAR once completed. He/She said he/she is new to the facility and is not sure if anyone is responsible for auditing the MARs.	F 658		

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During an interview on 01/30/25 at 4:05 P.M., the administrator said the facility did not have a DON for about a month, and some things were just not being monitored.

During an interview on 02/04/25 at 2:22 P.M., LPN G said the CMTs do not administer the resident's medications via G-tube. The LPN said when he/she is the charge nurse, he/she prepares the medications with the CMT at the medication cart, and the CMT signs the MAR, but he/she (the nurse) administers the medications. He/She said the person who signs the MAR is attesting that he/she administered the medications, but that is not always the case with the resident.

7. Review of the facility's policy titled, "Colostomy/Ileostomy care", dated October 2010, showed staff are directed to document in the resident's medical record:

-The date and time the colostomy/ileostomy care is provided;
-The name and title of the individual (s) who provided the colostomy/ileostomy care;
-Any breaks in resident's skin, signs of infection (purulent discharge (pus), pain, redness, swelling, temperature) or excoriation of skin;

8. Review of Resident #48's POS, dated 01/08/25 through 01/30/25, showed an order to change colostomy appliance every three days on the day shift for ileostomy (a surgical procedure that creates an opening in the abdomen to excrete feces from the body) care, effective 01/17/25.

Review of the resident's Treatment Administration

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Record (TAR), dated 01/08/25 through 01/30/25, showed licensed staff were directed to change the colostomy appliance every three days on the day shift for ileostomy care, effective 01/18/25. Review showed the colostomy bag was scheduled to be changed on 01/30/25.

During an interview on 01/30/25 at 9:44 A.M., LPN H said the Certified Nurse Aides (CNAs) change the resident's colostomy bag, tell the nurse they completed it, and then the nurse signs the TAR. The LPN said he/she did not change the resident's colostomy bag earlier as directed on the TAR, but one of the CNAs did, and he/she signed the TAR that he/she completed the treatment. The LPN said when the nurse signs the TAR, he/she is attesting that he/she completed the ordered treatment, which sometimes is not accurate, but the CNA cannot sign the TAR. He/She said the nurses are expected to follow the physician's orders all the time.

During an interview on 01/30/25 at 3:52 P.M., the DON said he/she expects staff to always follow the physician's orders. He/She said the charge nurse is responsible to complete treatments listed on the TAR and sign the TAR that he/she completed the treatment. The DON said he/she is new to the facility and is not sure if anyone is responsible for checking the MARs/TARs.

During an interview on 01/30/25 at 4:05 P.M., the administrator said he/she expects staff to always follow the physician's orders. He/She said the charge nurse is responsible to complete any treatment listed on the TAR and sign the TAR after he/she completes the treatment. He/She said the facility did not have a DON for about a

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F 658	Continued From page 33 month, and some things were just not being monitored.	F 658		
F 677 SS=E	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, facility staff failed to provide care to meet basic hygiene needs for four residents (Resident #24, #32, #35, and #48) out of six sampled residents. The facility census was 43. 1. Review of the facility's, "Bath, Shower/Tub Policy", dated February 2018, showed staff are directed: -The purpose of this procedure is to promote cleanliness, provide comfort to the resident and to observe the condition of the resident's skin; -Document the date and time the shower/bath was performed; -If the resident refused the shower/tub bath, the reason(s) why and the intervention taken; -Notify the supervisor if the resident refuses the shower/tub bath. 2. Review of Resident #24's Quarterly Minimum Data Set (MDS), a federally mandated assessment, dated 10/17/24, showed staff assessed the resident as follows: -Mild cognitive impairment; -Did not reject care (such as Activities of Daily	F 677		

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Living (ADL) assistance);
-Required partial assistance from staff with personal hygiene, transfers, and to shower/bathe.

Review of the resident's care plan, dated 04/12/24, showed staff were directed to assist the resident with ADLs as needed.

Review of the resident's shower sheets, date 10/01/24 through 01/29/25, showed staff documented showers were provided on 11/6/24, 11/11/24, 11/13/24, 11/20/24, and one resident refusal on 11/28/24.

Observation on 01/28/25 at 9:21 A.M., showed the resident laid in bed with greasy hair.

Observation on 01/29/25 at 9:49 A.M., showed the resident in the dining room with greasy hair protruding from under his/her baseball cap.

3. Review of Resident #32's Quarterly MDS, dated 12/06/24, showed staff assessed the resident as follows:

-Cognitively intact;
-Did not reject care;
-Independent with transfers, ambulation, personal hygiene, but required supervision to shower/bathe.

Review of the resident's care plan, dated 01/18/25, showed the care plan did not contain directions for assistance with ADLs.

Review of the resident's shower sheets, dated 10/01/24 through 01/29/25, showed staff documented showers were provided on 11/19/24, 11/26/24, 12/10/24, 12/27/24, 01/10/25 and one

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resident refusal on 12/31/24.

Observation on 01/27/25 at 3:27 P.M., showed the resident in the dining room with greasy hair.

During an interview on 01/27/25 at 3:28 P.M., the resident said he/she has not had a shower in several weeks. He/She said staff does not even offer him/her a shower anymore, and it makes him/her feel left out and not cared for. He/She said he/she can do his/her own facial and oral hygiene, but has not asked staff recently for help with a shower, because they don't seem to have enough help.

4. Review of Resident #35's Quarterly MDS, dated 12/22/24, showed staff assessed the resident as follows:

-Cognitively intact;
-Requires supervision or touching assistance with showers, and personal hygiene and transfers;
-Does not reject care.

Review of the resident care plan, dated 12/01/24, showed the care plan did not contain directions for assistance with ADLs.

Review of the resident shower sheets, dated 10/2024 through 01/2025 showed staff documented showers were provided on 11/05/24, 11/08/24, 11/15/24, 11/22/24, 12/11/24, 12/19/24. 12/21/24 and 01/13/25.

Observation on 01/27/25 at 1:30 P.M., showed the resident in his/her bed with greasy hair, and long fingernails with a dark substance underneath.

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F 677	Continued From page 36 Observation on 01/28/25 at 10:20 A.M., showed the resident in his/her chair with greasy hair, and long fingernails with a dark substance underneath. During an interview on 01/28/25 at 10:21 A.M., the resident said it had been a while since they had a shower, he/she can't remember the last time. The resident said it does not make him/her feel very good to not get showers. 5. Review of Resident #48's Entry Tracking Record MDS, dated 01/08/25, showed the resident admitted to the facility on 01/08/25. Review of the resident's care plan, dated 01/17/25, showed staff were directed to assist the resident with ADLs as needed. Review of the resident's shower sheets, dated 01/08/25 through 01/30/25, showed the sheets did not contain documentation of a bath/shower since his/her admission, and did not documentation the resident refused any baths/showers. Observation on 01/27/25 at 2:45 P.M., showed the resident in his/her bed with greasy hair. Observation on 01/28/25 at 9:10 A.M., showed the resident in his/her bed with greasy hair, and his her teeth covered with food debris. During an interview on 01/28/25 at 9:10 A.M., the resident said he/she needed help from staff to take a shower, and he/she had not had one since admission. Observation on 01/29/25 at 10:44 A.M., during	F 677		

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incontinence care, the resident asked Certified Nursing Assistant (CNA) K, "can one of you wash my hair or something, my hair is really dirty?" The CNA responded that he/she thought the resident was scheduled to get a shower that day.

During an interview on 01/30/25 at 3:04 P.M., CNA K said he/she did not assist the resident with a shower the day prior.

6. During an interview on 01/30/25 at 2:58 P.M., Licensed Practical Nurse (LPN) H said residents are offered showers twice per week by the CNAs. He/She said the CNA documents on the shower sheet when he/she offers a resident a shower, and gives the completed shower sheet to the nurse to review and sign. The LPN said if a resident refuses a shower, the CNA is expected to document the refusal on the shower sheet and give to the nurse for follow up, the nurse should re-approach the resident, and if he/she she still refuses, then the nurse is expected to document a nurse's note regarding the resident's refusal. He/She said the previous DON would update the shower schedule, but the facility was without a DON for a while,

During an interview on 01/30/25 at 3:04 P.M., CNA K said the CNAs are responsible to offer/assist residents with a shower per the shower schedule and document on the shower sheet once completed. He/She said if a resident refused his/her shower, the CNA is expected to document the resident's refusal on the shower sheet and give to the charge nurse for follow up. He/She said if there wasn't a completed shower sheet, the resident likely was not offered a shower.

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F 677	Continued From page 38 During an interview on 01/30/25 at 4:05 P.M., the administrator said he/she expects the CNAs to offer and assist residents with showers per schedule at least twice per week or more often if the resident prefers. He/She said if the resident refuses, the CNA should let the nurse know so he/she can follow up with the resident. He/She said the facility did not have a DON for about a month and some things were just not being monitored.	F 677		
F 700 SS=E	Bedrails CFR(s): 483.25(n)(1)-(4) §483.25(n) Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. §483.25(n)(1) Assess the resident for risk of entrapment from bed rails prior to installation. §483.25(n)(2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. §483.25(n)(3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. §483.25(n)(4) Follow the manufacturers' recommendations and specifications for installing and maintaining bed rails. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record	F 700		

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review, facility staff failed to obtain signed consents for side rails and failed to complete side rail assessments for four residents (Resident #3, #15, #20 and #46), out of four sampled residents. The facility census was 43.

1. Review of the facility's Proper use of Side Rails Policy, undated, showed:

-Examples of bedrails include, but are not limited to side rails, bed side rails, safety rails, grab bars, and assist bars;
-The resident assessment must assess the resident's risk from using bed rails such as entrapment;
-The resident assessment should assess the resident's risk of entrapment between the mattress and bed rail or in the bed rail itself;
-Informed consent from the resident or resident representative must be obtained after appropriate alternative have been attempted prior to installation and use of bed rails;
-Upon receiving informed consent, the facility will obtain a physician's order for the use of the specified bed rail and medical diagnosis, condition, symptom, or functional reason for the use of the bed rail;
-A nurse assigned to the resident will complete reassessments in accordance with the facility's assessment schedule, but not less than quarterly, upon significant change in status, or a change in the type of bed/mattress/rail.

2. Review of Resident #3's Admission Minimum Data Set (MDS), a federally mandated assessment tool, dated 12/05/24, showed staff assessed the resident as follows:

-Severe cognitive impairment;

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F 700	Continued From page 40 -Substantial/maximal with toileting, and transfers. Review of the resident's medical record showed the record did not contain a signed informed consent from the resident or resident representative for the use of bed rails or a quarterly bed rail assessment. Observation on 1/28/25 at 10:00 A.M., showed resident in bed with the left side rail in the upright position. Observation on 1/30/25 at 2:45 P.M., showed resident in bed with the left side rail in the upright position. 3. Review of Resident #15's annual MDS, dated 12/14/24, showed staff assessed the resident as: -Cognitively intact; -Independent with bed mobility, toileting, and transfers. Review of the resident's medical record showed the record did not contain a signed informed consent from the resident or residnet representative for the use of bed rails or a quarterly bed rail assessment. Observation on 1/27/25 at 11:13 A.M., showed the resident in bed with bilateral side rails in the upright position. Observation on 1/28/25 at 9:06 A.M., showed the resident in bed with bilateral side rails in the upright position. Observation on 1/29/25 at 9:45 A.M., showed the	F 700		

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F 700	Continued From page 41 resident in bed with bilateral side rails in the upright position. Observation on 1/30/25 at 10:07 A.M., showed the resident in bed with bilateral side rails in the upright position. 4. Review of Resident #20's Entry Tracking Record MDS, dated 12/17/24, showed the resident admitted to the facility on 12/17/24. Review of the resident's medical record showed the record did not contain a signed informed consent from the resident or resident representative for the use of bed rails or a physician's order, as directed by the policy. Observation on 01/27/25 at 3:24 P.M., showed the resident in bed with side rails on both sides in the upright position. Observation on 01/29/25 at 1:38 P.M., showed the resident in bed with side rails on both sides in the upright position. During an interview on 01/27/25 at 11:43 A.M., the resident said he/she uses the side rails to help with bed mobility. 5. Review of Resident #46'', showed staff documented the resident admitted to the facility on 01/22/25. Review of the Resident #46's medical record showed the record did not contain a signed informed consent from the resident or resident representative for the use of bed rails, a side rail assessment, or a physician's order, as directed	F 700		

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F 700	Continued From page 42	F 700		

by the policy.

Observation on 01/27/25 at 11:55 A.M., showed the resident in bed with side rails on both sides in the upright position.

Observation on 01/27/25 at 2:41 P.M., showed the resident in bed with side rails on both sides in the upright position.

Observation on 01/29/25 at 2:13 P.M., showed the resident in bed with side rails on both sides in the upright position.

6. During an interview on 01/30/25 at 2:58 P.M., Licensed Practical Nurse (LPN) H said the charge nurse is responsible to complete a side rail assessment as a part of the resident's admission process, so he/she did not know why one was not done. He/She said he/she has never seen a side rail consent so he/she is not sure who is responsible to obtain a signed consent from the resident or resident representative.

During an interview on 01/30/25 at 2:44 P.M., LPN H said asking the resident if they want bed rails is part of the admission process. He/She said he/she is unsure if there is a consent form for bed rails. He/She said a bed rail assessment is done upon admission and quarterly. He/She said the charge nurses are responsible for ensuring bed rail assessments are completed. He/She is unsure why the bed rail assessments are not being done quarterly.

During an interview on 01/30/25 at 3:26 P.M., the Director of Nursing (DON) said bed rail forms are all together upon admission and consent is

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F 700	Continued From page 43 obtained upon admission. He/She said he/she is unsure if the bed rail assessments. He/She said the charge nurses do the assessments. He/She said he/she is unsure of the regulation but believes assessments should be done every six months. During an interview on 01/30/25 at 3:56 P.M., the administrator said charge nurses are responsible for completing bed rail assessments quarterly to ensure the resident still needs the bed rails. He/She said bed rail consent should be obtained and signed before bed rails are put onto bed. He/She is unsure why assessment are not being done quarterly.	F 700		
F 725 SS=E	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.71. §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and	F 725		

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F 725	Continued From page 44 (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to provide staff in accordance with their Facility Assessment to meet the needs of the residents. Staff failed to provide care to meet basic hygiene needs for four residents (Resident #24, #32, #35, and #48) out of six sampled residents. The facility census was 43. 1. Review of the Facility Assessment, dated 01/07/25, showed direct care staff required to care for their facility census: -Days- Five nurse aides with census above 43 or three-four nurse aides with census lower than 40; -Evenings- Four nurse aides with census above 43 or two-three nurse aides with census below 40; -Nights- Two nurse aides; -Staffing plan is to ensure that facility has sufficient staff to meet the needs of the residents at any given time. Review of the employee schedule, dated August 2024, with average census of 42, showed: -Thursday 08/01/24: one nurse aide on day shift; -Friday 08/02/24: one nurse aide on night shift; -Saturday 08/03/24: two nurse aides on day shift; -Sunday 08/04/24: two nurse aides on day shift	F 725		

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F 725	Continued From page 45 and one nurse aide on night shift; -Monday 08/05/24: two nurse aides on evening shift; -Wednesday 08/07/24: two nurse aides on evening shift; -Tuesday 08/08/24: two nurse aides on evening shift; -Friday 08/09/24: two nurse aides on day shift; -Saturday 08/10/24: two nurse aides on evening shift and one nurse aide on night shift; -Sunday 08/11/24: two nurse aides on evening shift; -Friday 08/23/24: two nurse aides on evening shift; -Saturday 08/24/24: two nurse aides on day shift; -Sunday 08/25/24: two nurse aides on evening shift and one nurse aide on night shift; -Monday 08/26/24: two nurse aides on day shift and two nurse aides on evening shift; -Saturday 08/31/24; two nurse aides on day shift and two nurse aides on evening shift. Review of the employee schedule, dated September 2024, with average census of 40, showed: -On Wednesday 09/04/24: two nurse aides on day shift, one nurse aide on evening shift, one nurse aide on night shift; -Saturday 09/07/24: one nurse aide on day shift; -Sunday 09/08/24: two nurse aides on day shift; -Thursday 09/12/24: one nurse aide on night shift; -Monday 09/16/24: two nurse aides on day shift and one nurse aide on evening shift. -Saturday 09/21/24: two nurse aides on day shift; -Saturday 09/28/24: two nurse aides on day shift. Review of the employee schedule, dated October 2024, with average census of 43, showed:	F 725		

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F 725	Continued From page 46 -On Thursday 10/03/24: two nurse aides on evening shift; -Friday 10/04/24: two nurse aides on evening shift; -Saturday 10/05/24: two nurse aides on evening shift; -Sunday 10/06/24: two nurse aides on evening shift. Review of the employee schedule, dated November 2024, with average census of 42, showed Saturday 11/23/24: two nurse aides on day shift. Review of the employee schedule, dated December 2024, with average census of 42, showed: -On Sunday 12/01/24: two nurse aides on day shift and two nurse aides on evening shift; -Saturday 12/14/24: two nurse aides on evening shift; -Sunday 12/15/24: two nurse aides on evening shift; -Friday 12/20/24: two nurse aides on evening shift; -Saturday 12/28/24: two nurse aides on day shift and two nurse aides on evening shift; -Sunday 12/29/24: two nurse aides on evening shift. 2. Review of Resident #24's Quarterly Minimum Data Set (MDS), a federally mandated assessment, dated 10/17/24, showed staff assessed the resident as follows: -Mild cognitive impairment;	F 725		

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F 725	Continued From page 47 -Did not reject care (such as Activities of Daily Living (ADL) assistance); -Required partial assistance from staff with personal hygiene, transfers, and to shower/bathe. Review of the resident's care plan, dated 04/12/24, showed staff were directed to assist the resident with ADLs as needed. Review of the resident's shower sheets, from 10/01/24 through 01/29/25, showed staff documented showers on 11/6/24, 11/11/24, 11/13/24, 11/20/24, and one resident refusal on 11/28/24. Observation on 01/28/25 at 9:21 A.M., showed the resident in bed with greasy hair. Observation on 01/29/25 at 9:49 A.M., showed the resident in the dining room with greasy hair protruding from under his/her baseball cap. 3. Review of Resident #32's Quarterly MDS, dated 12/06/24, showed staff assessed the resident as follows: -Cognitively intact; -Did not reject care; -Independent with transfers, ambulation, personal hygiene, but required supervision to shower/bathe. Review of the resident's care plan, dated 01/18/25, showed the care plan did not contain directions for assistance with ADLs. Review of the resident's shower sheets, from 10/01/24 through 01/29/25, showed staff documented showers on 11/19/24, 11/26/24,	F 725		

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F 725	Continued From page 48 12/10/24, 12/27/24, 01/10/25 and one resident refusal on 12/31/24. Observation on 01/27/25 at 3:27 P.M., showed the resident in the dining room with greasy hair. During an interview on 01/27/25 at 3:28 P.M., the resident said he/she has not had a shower in several weeks. He/She said staff does not even offer him/her a shower anymore, and it makes him/her feel left out and not cared for. He/She said he/she can do his/her own facial and oral hygiene, but has not asked staff recently for help with a shower, because they don't seem to have enough help. 4. Review of Resident #35's Quarterly MDS, dated 12/22/24, showed staff assessed the resident as follows: -Cognitively intact; -Requires supervision or touching assistance with showers, and personal hygiene and transfers; -Does not reject care. Review of the resident care plan, dated 12/01/24, showed the care plan did not contain direction for assistance with ADLS. Review of the resident shower sheets, from October 2024 through January 2025 showed staff documented showers for the following dates, 01/13/25, 12/11/24, 12/19/24. 12/21/24, 11/05/24, 11/08/24, 11/15/24, and 11/22/24. Observation on 02/27/25 at 1:30 P.M., showed the resident in his/her bed with greasy hair, and long fingernails with a dark substance underneath.	F 725		

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F 725	Continued From page 49 Observation on 02/28/25 at 10:20 A.M., showed the resident in his/her chair with greasy hair, and long fingernails with a dark substance underneath. During an interview on 02/28/25 at 10:21 A.M., the resident said it had been a while since they had a shower, he/she can't remember the last time. The resident said it does not make him/her feel very good to not get showers. 5. Review of Resident #48's Entry Tracking Record MDS, dated 01/08/25, showed the resident admitted to the facility on 01/08/25. Review of the resident's care plan, dated 01/17/25, showed staff were directed to assist the resident with ADLs as needed. Review of the resident's shower sheets, from 01/08/25 through 01/30/25, showed staff did not document they assisted the resident with a bath/shower since his/her admission, and did not document the resident refused any baths/showers. Observation on 01/27/25 at 2:45 P.M., showed the resident in his/her bed with greasy hair. Observation on 01/28/25 at 9:10 A.M., showed the resident in his/her bed with greasy hair, and his her teeth covered with food debris. During an interview on 01/28/25 at 9:10 A.M., the resident said he/she needed help from staff to take a shower, and he/she had not had one since admission.	F 725		

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F 725	Continued From page 50	F 725		

Observation on 01/29/25 at 10:44 A.M., during incontinence care, the resident asked Certified Nursing Assistant (CNA) K, "can one of you wash my hair or something, my hair is really dirty?" The CNA responded that he/she thought the resident was scheduled to get a shower that day.

During an interview on 01/30/25 at 3:04 P.M., CNA K said he/she did not assist the resident with a shower the day prior.

6. During an interview on 1/27/25 at 11:31 A.M., Resident #30 said he/she feels the facility is short staffed on all shifts. He/She said showers are supposed to be twice a week, but he/she is lucky if he/she gets a shower once a week because of short staffing.

During an interview on 01/27/25 at 3:09 P.M., Resident #47 said he/she admitted about a week prior for therapy and had not been offered a shower yet. He/She said the facility did not have enough staff. He/She said a female staff told him/her over the weekend that he/she "looked like he/she needed a shower" but did not offer to assist him/her with a shower, and it made him/her feel like he/she was not being cared for.

During an interview on 01/28/25 at 10:21 A.M., Resident #7 said the facility does not have enough staff. He/She said they are short on nurse aides all shifts, but more on the weekends. He/She said he/she only gets about one bath a week if that because they don't have enough staff to give us a bath twice a week.

During an interview on 01/30/25 at 2:58 P.M., Licensed Practical Nurse (LPN) H said residents are offered showers twice per week by the CNAs.

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F 725	Continued From page 51	F 725		

He/She said the CNA documents on the shower sheet when he/she offers a resident a shower, and gives the completed shower sheet to the nurse to review and sign. The LPN said if a resident refuses a shower, the CNA is expected to document the refusal on the shower sheet and give to the nurse for follow up, the nurse should re-approach the resident, and if he/she she still refuses, then the nurse is expected to document a nurse's note regarding the resident's refusal.

During an interview on 01/30/25 at 3:04 P.M., CNA K said the CNAs are responsible to offer/assist residents with a shower per the shower schedule and document on the shower sheet once completed. He/She said if there wasn't a completed shower sheet, the resident likely was not offered a shower.

During an interview on 01/30/25 at 3:34 P.M., the Director of Nursing (DON) said he/she is unsure of the facility assessment. He/She said should be about three-four nurse aides on day shift and two nurse aides on evening and night shift.

During an interview on 01/30/25 at 4:05 P.M., the administrator said he/she expects the CNAs to offer and assist residents with showers per schedule at least twice per week or more often if the resident prefers. He/She said if the resident refuses, the CNA should let the nurse know so he/she can follow up with the resident. He/She said the facility did not have a DON for about a month and some things were just not being monitored. He/She tries to ensure there is enough staff in facility to meet fire code. He/She said one person per 10 residents during day shift, one staff per 15 residents on evening shift, and one staff per 20 residents on night shift. He/She

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F 725	Continued From page 52 said he/she was not going off of facility assessment but using fire code regulation.	F 725		
F 727 SS=E	RN 8 Hrs/7 days/Wk, Full Time DON CFR(s): 483.35(b)(1)-(3) §483.35(b) Registered nurse §483.35(b)(1) Except when waived under paragraph (e) or (f) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. §483.35(b)(2) Except when waived under paragraph (e) or (f) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis. §483.35(b)(3) The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. This REQUIREMENT is not met as evidenced by: Based on interview and record review, facility staff failed to provide the services of a Registered Nurse (RN), for at least eight consecutive hours per day, seven days a week. The facility census was 43. 1. Review of the facility's policy titled, "Nursing Services-Registered Nurse (RN)," dated 01/01/24, showed the facility will utilize the services of a Registered Nurse for at least eight consecutive hours per day, seven days per week. 2. Review of the facility's RN staff schedule, dated July 2024, showed the facility did not have an RN, eight consecutive hours a day, in the building for the dates of:	F 727		

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F 727	Continued From page 53 -Monday, 07/01/24; -Tuesday, 07/02/24; -Wednesday, 07/03/24; -Thursday, 07/04/24; -Monday, 07/08/24; -Tuesday, 07/09/24; -Wednesday, 07/10/24; -Thursday, 07/11/24; -Friday, 07/12/24; -Saturday, 07/13/24; -Sunday, 07/14/24; -Monday, 07/15/24; -Tuesday, 07/16/24; -Wednesday, 07/17/24; -Thursday, 07/18/24; -Monday, 07/22/24; -Wednesday, 07/24/24; -Thursday, 07/25/24; -Monday, 07/29/24; -Tuesday, 07/30/24; -Wednesday, 07/31/24. 3. Review of the facility's RN staff schedule, dated August 2024, showed the facility did not have an RN, eight consecutive hours a day, in the building for the dates of: -Sunday, 08/04/24; -Monday, 08/05/24; -Tuesday, 08/06/24; -Wednesday, 08/07/24; -Thursday, 08/08/24; -Friday, 08/09/24; -Saturday, 08/10/24; -Sunday, 08/11/24; -Monday, 08/12/24; -Tuesday, 08/13/24; -Wednesday, 08/14/24; -Thursday, 08/15/24;	F 727		

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F 727	Continued From page 54 -Monday, 08/19/24; -Tuesday, 08/20/24; -Wednesday, 08/21/24; -Thursday, 08/22/24; -Friday, 08/23/24; -Saturday, 08/24/24; -Sunday, 08/25/24; -Monday, 08/26/24; -Tuesday, 08/27/24; -Wednesday, 08/28/24; -Thursday, 08/29/24; -Friday, 08/30/24; -Saturday, 08/31/24. 4. Review of the facility's RN staff schedule, dated September 2024, showed the facility did not have an RN, eight consecutive hours a day, in the building for the month of September. 5. Review of the facility's RN staff schedule, dated October 2024, showed the facility did not have an RN, eight consecutive hours a day, in the building for the month of October. 6. Review of the facility's RN staff schedule, dated November 2024, showed the facility did not have an RN, eight consecutive hours a day, in the building for the dates on: -Saturday, 11/02/24; -Sunday, 11/03/24; -Saturday, 11/09/24; -Sunday, 11/10/24; -Saturday, 11/16/24; -Sunday, 11/17/24; -Saturday, 11/23/24; -Sunday, 11/24/24; -Saturday, 11/30/24.	F 727		

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F 727	Continued From page 55	F 727		

7. Review of the facility's RN staff schedule, dated December 2024, showed the facility did not have an RN, eight consecutive hours a day, in the building for the dates of:

-Sunday, 12/01/24;
-Saturday, 12/07/24;
-Sunday, 12/08/24;
-Saturday, 12/14/24;
-Sunday, 12/15/24;
-Sunday, 12/22/24;
-Sunday, 12/29/24.

8. Review of the facility's RN staff schedule, dated January 2025, showed the facility did not have an RN, eight consecutive hours a day, in the building for the dates of:

-Saturday, 01/04/25;
-Sunday, 01/05/24;
-Saturday, 01/11/24;
-Sunday, 01/12/24;
-Thursday, 01/16/24.

9. During an interview on 01/30/25 at 3:30 P.M., the Director of Nursing (DON) said he/she was unsure of the regulation for RN coverage in the facility. He/She said he/she would have to look at the policy. He/She said the importance of having an RN in the facility eight consecutive hours daily is expertise advice and RN's have more knowledge about nursing with their license.

During an interview on 01/30/25 at 4:05 P.M., the administrator said the facility should have an RN in the facility at least eight consecutive hours daily. He/She said he/she was aware that there were several months that they just didn't have an RN. He/She the importance of having an RN in

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F 727	Continued From page 56 the facility is having more knowledge.	F 727		
F 732 SS=E	Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of	F 732		

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F 732	Continued From page 57 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, facility staff failed to complete the required nurse staffing information, which included the facility census, the actual hours worked by both licensed and unlicensed nursing staff directly responsible for resident care, per shift, on a daily basis in an area readily accessible to residents and visitors. The facility census was 43. 1.Review of the facility's policy titled, "Posting Direct Care Daily Staffing Numbers," dated 07/2016, showed: -Within two hours of the beginning of each shift, the number of licensed nurses and the number of unlicensed nursing personnel directly responsible for resident care will be posted in a prominent location (accessible to residents and visitors) in a clear and readable format; -Shift staffing information shall be recorded on the Daily Staffing form for each shift, the information recorded on the form shall include: -The name of the facility; -The date for which the information is posted; -The resident census at the beginning of the shift for which the information is posted; -Twenty-four hour shift schedule operated by the facility; -The shift for which the information is posted; -Type and category (licensed or non-licensed) of nursing staff working during that shift; -The actual time worked during that shift for each category and type of nursing staff; -Total number of licensed and non-licensed	F 732		

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F 732	Continued From page 58 nursing staff working for the posted shift. 2. Review of facility's daily staffing sheets, dated November 2024 and December 2024, showed the daily staffing sheets did not contain facility census or actual hours worked for licensed and non-licensed staff. 3. Review of facility's daily staffing sheets, dated 1/1/2025 through 1/30/2025, showed the daily staffing sheets did not contain facility census or actual hours worked for licensed and non-licensed staff. Observation on 01/27/25 at 12:32 P.M., showed the facility staff posting did not contain a facility census or actual hours worked by licensed and non-licensed staff and not readily accessible to residents and visitors. Observation on 01/28/25 at 09:21 A.M., showed the facility staff posting did not contain a facility census or actual hours worked by licensed and non-licensed staff and not readily accessible to residents and visitors. Observation on 01/29/25 at 10:06 A.M., showed the facility staff posting did not contain a facility census or actual hours worked by licensed and non-licensed staff and not readily accessible to residents and visitors. Observation on 01/30/25 at 10:21 A.M., showed the facility staff posting did not contain a facility census or actual hours worked by licensed and non-licensed staff and not readily accessible to residents and visitors. 4. During an interview on 02/03/25 at 10:00 A.M.,	F 732		

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F 732	Continued From page 59 the Director of Nursing (DON) said daily staff posting should include actual hours not scheduled hours for nurses and certified nurses aides. He/She said the facility census should be listed on daily shift. He/She said it is the charge nurses responsibilty to make sure daily staffing sheet is completed. He/She said he/she was not aware the daily staffing sheets did not include facility census or actual hours worked. He/She said daily staff posted should be accessible to all residents and visitors. During an interview on 02/03/25 at 10:10 A.M., the administrator said daily staff posting should include facility census and actual hours worked for licensed and non-licensed staff in the building. He/She said it is the night charge nurse who is responsible for filling out the daily staffing sheet and posting it daily. He/She was not aware that the daily staff sheets did not contain facility census or actual hours worked by staff. He/She said there is no reason why the daily staff posting was not readily available for residents or visitors, but it should be.	F 732		
F 759 SS=E	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, facility staff failed to ensure a medication error rate of less than five percent (5%). Out of 32 opportunities observed, nine errors occurred,	F 759		

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resulting in a 28.13% error rate, which affected one resident (Resident #20) out of four sampled residents. The facility's census was 43.

1. Review of the facility's policy titled, "Medication Errors", dated 01/01/24, showed the facility must ensure that it is free of medication error rates of 5% or greater.

Review of the facility's policy titled, "Administering Medications", dated April 2019, showed:

-Medications are administered in a safe and timely manner, and as prescribed;
-Medications are administered within one hour of their prescribed time, unless otherwise specified (for example, before and after meal orders);
-The individual administering the medication checks the label three times to verify the right resident, right medication, right dosage, right time, and right method (route) of administration before giving the medication.

Review of the facility's Medication Pass times, provided by the administrator showed morning (A.M.) medication pass from 8:00 A.M. - 9:00 A.M. with allowance of an hour before or after (7:00 A.M. - 10:00 A.M.)

2. Review of Resident #20's Physician's Order Sheet (POS), dated 01/01/25 through 01/27/25, showed the physician ordered medications to be administered via Gastric Tube ((G-Tube) a surgically inserted tube which provides nutrition, hydration, or medicine directly into the stomach) as follows:

-Levothyroxine 75 micrograms (mcg) tablet, give one tablet in the morning for Hypothyroidism (low

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levels of thyroid hormones in the body);
-Midodrine 2.5 milligrams (mg) tablet, give 2.5 mg one time a day for low blood pressure;
-Cholecalciferol tablet 1000 units (to treat low vitamin D), give one tablet in the morning and at bedtime for supplement;
-Cyclobenzaprine 5 mg tablet, give one tablet in the morning for muscle spasms;
-Eliquis 5 mg tablet, give 5 mg twice per day for blood thinner;
-Fludrocortisone Acetate tablet 0.1 mg (to treat Addison's disease (low hormone levels produced by the adrenal glands)), give half tablet one time a day for supplementation;
-Gabapentin 300 mg capsule, give 300 mg three times a day for neuropathy (nerve damage resulting in numbness or weakness);
-Fluoxetine oral solution 20 mg/5 milliliters (ml), give 7.5 ml one time a day for depression;
-Prenatal 27-.08 mg tablet (vitamins with iron and folic acid), give one tablet one time a day for supplementation.

Review of the Resident's Medication Administration Record (MAR), dated 01/01/25 through 01/27/25, showed staff were directed to administer the medications during the A.M. med pass times as follows:

-Levothyroxine 75 mcg tablet, give every morning on an empty stomach, do not give with any other medication;
-Midodrine 2.5 mg tablet;
-Cholecalciferol tablet 1000 units;
-Cyclobenzaprine 5 mg tablet;
-Eliquis 5 mg tablet;
-Fludrocortisone Acetate tablet 0.1 mg, give half tablet;
-Gabapentin 300 mg capsule;

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F 759	Continued From page 62 -Fluoxetine oral solution 20 mg/5 ml, give 7.5 ml; -Prenatal 27-.08 mg tablet. During an interview on 01/27/25 at 12:02 P.M., the resident said his/her main concern was not getting his/her medications as scheduled in the mornings. He/She said it was already noon and he/she had not received any medications as yet for the day. Observation on 01/27/25 at 12:15 P.M. showed Licensed Practical Nurse (LPN) G crushed Levothyroxine, Midodrine, Vitamin D, Cyclobenzaprine, Eliquis, Fludrocortisone, Gabapentin, and Prenatal tablets together, emptied the mixture into a cup with the liquid Fluoxetine, and added water to the cup. Observation on 01/27/25 at 12:20 P.M. showed LPN G administered the Levothyroxine, Midodrine, Vitamin D, Cyclobenzaprine, Eliquis, Fludrocortisone, Gabapentin, Prenatal, and Fluoxetine to the resident via his/her G-tube. The LPN administered the medications two hours and twenty minutes after the scheduled administration time. During an interview on 01/27/25 at 12:24 P.M., LPN G said the nurse is responsible to administer the resident's medications via G-tube, and he/she forgot to check and administer the resident's medications earlier. . During an interview on 01/27/25 at 12:43 P.M., LPN G said he/she administered the resident's medications late, and medications given that late was a medication error. The LPN said the resident has a few medications ordered to be administered two to three times daily that should	F 759		

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F 759	Continued From page 63 be reviewed so they are not given too close together, to prevent side effects or overdose. He/She said he/she should notify the Director of Nursing, and the resident's physician of the late medications and med error for further directions, and he/she had not notified anyone as yet but he/she would. During an interview on 01/27/25 at 12:49 P.M., Nurse Practitioner (NP) O said he/she expects to be notified if the resident's medications are administered late so he/she could give staff further directions. During an interview on 01/30/25 at 3:52 P.M., the Director of Nursing (DON) said staff have from 7:00 A.M. to 10:00 A.M. for the morning medication pass, so medications administered after 10:00 A.M. are late and considered a medication error. He/She said to address a medication error, staff should complete an incident report, notify the charge nurse, DON, and the physician for further instructions. During an interview on 01/30/25 at 4:05 P.M., the administrator said late medications are considered a med error, and he/she would expect the nurse to notify the DON and the physician for further instructions after a medication error.	F 759		
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.	F 812		

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F 812	Continued From page 64 (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: Based on observation, interview and record review, facility staff failed to ensure the dish washing machine operated according to manufacturer's instructions in a manner adequate to prevent cross contamination of kitchen wares. Facility staff failed to properly sanitize soiled kitchen wares to prevent cross-contamination. Facility staff failed to maintain an ice machine drain air gap. The facility census was 43. 1. Review of the facility's Dishwashing: Machine Operation policy, dated 2020, showed staff were instructed to: -Operate dishwashing machines according to manufacturer recommendations; -Record log documents twice daily for either final rinse temperature (high temperature machine) or sanitizer concentration (low temperature machine with chemical sanitizer); -If the machine is found to be out of the acceptable range for either final rinse temperature or proper chemical sanitizing concentration, do not proceed to wash dishes;	F 812		

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F 812	Continued From page 65 -After troubleshooting, if the dish washing machine is not functioning, the employee should contact the Dining Services Manager or maintenance or outside vendor per facility guidelines to coordinate repair. The dish machine should be labeled out of service and not utilized until the dishwashing machine is repaired; -If the dishwashing machine cannot be repaired in a timely manner, the facility will utilize the manual dishwashing procedure or paper goods may be used as a temporary measure until the dishwashing machine is repaired. 2. Observation on 01/28/25 at 9:45 A.M., showed the front of the dish machine contained a label which indicated minimum wash and rinse temperatures of 120 degrees Fahrenheit (F). Observation on 01/28/25 at 9:35 A.M., showed Dietary Aide (DA) F ran a load of dirty dishes through the dish machine. Observation showed the machine wash temperature was 108 degrees F. Observation on 01/28/25 at 10:07 A.M., showed Dietary Aide (DA) F ran a load of dirty dishes through the dish machine. Observation showed the machine wash temperature was 104 degrees F and the machine rinse temperature was 112 degrees F. Observation showed a sanitizer test strip did not change color, which indicated a sanitizer concentration level below detection. Observation showed the Dietary Manager (DM) removed the clean dishes from the clean side of the machine and placed the dishes on a cart to dry. Observation on 01/28/25 at 1:55 P.M., showed DA F ran a load of dirty dishes through the dish	F 812		

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machine. Observation showed the machine reached a wash temperature of 90 degrees F and a rinse temperature of 110 degrees F. Observation showed a sanitizer test strip did not change color, which indicated a sanitizer concentration level below detection.

Observation on 01/28/25 at 1:58 P.M., showed DA F removed a load of clean dishes and ran a load of dirty dishes through the dish machine. Observation showed the wash temperature was 90 degrees F and the rinse temperature was 110 degrees F.

During an interview on 01/28/25 at 2:00 P.M., the DM said if the dish machine was not functioning correctly staff should use a bleach and water solution to sanitize dishes for at least 10 seconds. The DM said when the dish machine first started it did not always reach the correct temperature. The DM said the dish machine temperature should be 125 to 130 degrees F. The DM said the dish machine sanitizer concentration should be greater than 50. The DM said he/she was not aware the dish machine was not reaching the proper temperature or sanitizer concentration.

3. Review of the facility's Manual Warewashing-3 Compartment Sink policy, reviewed 1/1/25, showed the facility utilizes a 3-compartment sink to wash, rinse and sanitize pots, pans and other utensils to prevent the spread of bacteria that may spread food borne illness. Review showed staff were instructed to sanitize utensils with either hot water (at least 170 degrees Fahrenheit) for 30 seconds or a chemical sanitizing solution used according to manufacturer's instructions.

Review of the sanitizing solution manufacturer's

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F 812	Continued From page 67 instructions showed: -Prior to application, remove gross food particles and soil by a pre flush, scrape or when necessary, a pre soak; -Thoroughly wash or flush objects with a good detergent followed by a potable water rinse; -Apply a use solution of 1.04-2.72 ounces of sanitizer per four gallons of water (150-400 parts per million active solution); -Expose all surfaces to the sanitizing solution for a period of not less than one minute. Review of the January 2025 Low Temperature Chemical Sanitation Log, which was mounted above the three-compartment sink, showed staff recorded sanitizer concentrations three times per day. Review showed 79 entries were recorded for the period of 01/01/25 through breakfast on 01/27/25. Review showed all 79 sanitizer concentration entries recorded as 50 or 100 ppm (parts per million). Observation on 01/28/25 at 10:04 A.M., showed DA N manually cleaned a large pan and strainer. DA N rinsed the pan and strainer and placed the items in the sanitizer sink. DA N removed the pan and strainer after one minute and placed the items on the drain board. Observation showed a sanitizer test strip indicated a sanitizer concentration of 100 ppm. Observation on 01/28/25 at 12:15 P.M., showed the DM washed food processor parts and placed the parts in the sanitizer sink. Observation showed the DM allowed the processor parts to soak for one minute then removed the parts and placed them on the drain board to dry. Observation showed a sanitizer test strip	F 812		

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indicated a sanitizer concentration of 100 ppm.

Observation on 01/28/25 at 12:33 P.M., showed DA N washed and rinsed food processor parts. DA N placed the processor parts in the sanitizer sink for 30 seconds then removed the parts and placed them on the drain board.

Observation on 01/28/25 at 1:50 P.M., showed DA N placed two cutting boards and four steam able pans in the sanitizer solution. DA N removed the cutting boards and steam table pans from the sanitizer sink and placed the items on the drain board to dry. Observation showed a sanitizer test strip indicated a sanitizer concentration of 100 ppm.

During an interview on 01/28/25 at 10:14 A.M., DA N said the log sheet on the cabinet door was for documenting the three compartment sink sanitizer concentration. DA N said the sanitizer concentration should be 50 ppm or higher.

During an interview on 01/28/25 at 12:19 P.M., Cook M said the sanitizer concentration should be 50 to 100 ppm. Cook M said kitchen staff check the sanitizer concentration every time the sanitizer sink is filled and every hour after filling to ensure proper strength.

During an interview on 01/28/25 at 9:50 A.M., the DM said the dietician was at the facility four days ago and said the sanitizer tested okay. The DM said the sanitizer concentration was running around 100 ppm. The DM said he/she had never read the sanitizer directions for use.

During an interview on 01/29/25 at 9:15 A.M., the maintenance director said the facility vendor took

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F 812	Continued From page 69 care of the dish machine and the sanitizer pump at the three-compartment sink. The maintenance director said there were issues with water temperatures in the past but he/she was not aware of any current issues. 4. Observation on 01/29/25 at 8:50 A.M., showed the facility had one ice machine, which was located in a room on the east resident hall. Observation showed the ice machine contained a black drain hose, which was connected to a metal flange, which was connected directly to the floor drain. Observation showed the hose and flange were secured to the floor drain and there was not an air gap. During an interview on 01/29/25 at 8:50 A.M., the maintenance director said he/she did not know the ice machine drain required an air gap. During an interview on 01/30/25 at 12:00 P.M., the administrator said the DM was responsible for ensuring the dish machine was working correctly. The administrator said the dish machine should reach 120 degrees F and the machine sanitizer should be at least 50 ppm. The administrator said the three compartment sink sanitizer concentration should be in accordance with facility policy. The administrator said all kitchen staff were responsible for checking the dish machine and three-part sink to ensure kitchen wares were correctly disinfected. The administrator said the maintenance director was responsible for the ice machine and he/she was not aware the ice machine did not contain the required air gap.	F 812		
F 867 SS=E	QAPI/QAA Improvement Activities CFR(s): 483.75(c)(d)(e)(g)(2)(i)(ii)	F 867		

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F 867	Continued From page 70 §483.75(c) Program feedback, data systems and monitoring. A facility must establish and implement written policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring. The policies and procedures must include, at a minimum, the following: §483.75(c)(1) Facility maintenance of effective systems to obtain and use of feedback and input from direct care staff, other staff, residents, and resident representatives, including how such information will be used to identify problems that are high risk, high volume, or problem-prone, and opportunities for improvement. §483.75(c)(2) Facility maintenance of effective systems to identify, collect, and use data and information from all departments, including but not limited to the facility assessment required at §483.71 and including how such information will be used to develop and monitor performance indicators. §483.75(c)(3) Facility development, monitoring, and evaluation of performance indicators, including the methodology and frequency for such development, monitoring, and evaluation. §483.75(c)(4) Facility adverse event monitoring, including the methods by which the facility will systematically identify, report, track, investigate, analyze and use data and information relating to adverse events in the facility, including how the facility will use the data to develop activities to prevent adverse events.	F 867		

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F 867	Continued From page 71 §483.75(d) Program systematic analysis and systemic action. §483.75(d)(1) The facility must take actions aimed at performance improvement and, after implementing those actions, measure its success, and track performance to ensure that improvements are realized and sustained. §483.75(d)(2) The facility will develop and implement policies addressing: (i) How they will use a systematic approach to determine underlying causes of problems impacting larger systems; (ii) How they will develop corrective actions that will be designed to effect change at the systems level to prevent quality of care, quality of life, or safety problems; and (iii) How the facility will monitor the effectiveness of its performance improvement activities to ensure that improvements are sustained. §483.75(e) Program activities. §483.75(e)(1) The facility must set priorities for its performance improvement activities that focus on high-risk, high-volume, or problem-prone areas; consider the incidence, prevalence, and severity of problems in those areas; and affect health outcomes, resident safety, resident autonomy, resident choice, and quality of care. §483.75(e)(2) Performance improvement activities must track medical errors and adverse resident events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the	F 867		

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F 867	Continued From page 72 facility. §483.75(e)(3) As part of their performance improvement activities, the facility must conduct distinct performance improvement projects. The number and frequency of improvement projects conducted by the facility must reflect the scope and complexity of the facility's services and available resources, as reflected in the facility assessment required at §483.71. Improvement projects must include at least annually a project that focuses on high risk or problem-prone areas identified through the data collection and analysis described in paragraphs (c) and (d) of this section. §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (iii) Regularly review and analyze data, including data collected under the QAPI program and data resulting from drug regimen reviews, and act on available data to make improvements. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility staff failed to develop and implement an effective Quality Assurance (QA)/Quality Assurance Performance Improvement (QAPI) program which included documentation and	F 867		

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F 867	Continued From page 73 implementation of on-going systemic issues with resolution. The facility census was 43. 1. Review of the facility's policies showed the facility did not provide a policy for QA/QAPI program. During an interview on 01/30/25 at 10:23 A.M., the administrator said the department heads come together quarterly and discuss different items within the facility, however there is no documentation to provide about these meetings or issues and resolutions. The administrator said she was not aware the information needed to be documented and maintained.	F 867		
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment	F 880		

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F 880	Continued From page 74 conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of	F 880		

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infection.

§483.80(f) Annual review.
The facility will conduct an annual review of its IPCP and update their program, as necessary.
This REQUIREMENT is not met as evidenced by:
Based on observation, interview and record review, facility staff failed to ensure the two-step purified protein derivative ((PPD) skin test for Tuberculosis (TB)) were completed in accordance with their policy for six employees (Licensed Practical Nurse (LPN) A, Nurse Aide (NA) B, NA C, NA D, Certified Nurse Aide (CNA) E, and Dietary aide F) out of ten employee files reviewed. Facility staff failed to implement the Enhanced Barrier Precautions (EBP) policy when they did not educate, or alert staff of residents who required EBP, and failed to place appropriate personal protective equipment (PPE) in close proximity for three residents (Resident #20, #45, and #48) of three sampled residents. The facility's cenus was 43.

1. Review of the Facility's Employee Screening for TB, revised August 2019, showed:

-All employees are screened for latent tuberculosis (LTBI) and active TB disease, using tuberculin skin test (TST) or interferon gamma release assay (IGRA) and symptom screening prior to beginning employment;
-Each newly hired employee is screened for LTBI and active TB disease after an employment offer has been made but prior to the employee's duty assignment.

Review of the Facility's TB Screening-Administration and Interpretation of TST policy,

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revised October 2019, showed:

-Inject 0.1 ml (milliliter) of PPD intradermally on the inner surface of the forearm;
-Interpret the TST forty-eight to seventy-two hours after administration;
-Unless otherwise indicated, administer a booster of 0.1ml of PPD one to two weeks after the initial TST for individuals with less that 10mm of induration.

Review of the Center for Disease Control and Prevention's, Clinical Testing Guidance for TB: TB Skin Tests, Dated May 14, 2024, showed:

-Two-Step testing;
-If the first skin test is negative, a second TB skin test should be done one to three weeks later;
-If the second TB skin test result is positive, it is probably a boosted reaction;
-Interpreting test results;
-The skin test reaction should be read between 48-72 hours after administration by a health care worker trained to read TB skin results.

2. Review of LPN A's employee file showed:

-Hire date of 11/22/24;
-First step PPD administered on 11/21/24 and read on 11/23/24;
-Second step PPD administered on 11/26/24 and read on 11/28/24;
-Staff did not wait seven -21 days after the first dose to administer the second step PPD.

3. Review of NA B's employee file showed:

-Hire date of 10/10/24;
-First step PPD administered on 10/08/24 and

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read on 10/10/24;
-The file did not contain documentation staff administered the second step PPD.

During an interview on 01/28/25 at 1:54 P.M., the Minimum Data Set (MDS) Coordinator said he/she is not sure why the employee did not have a two-step TB completed.

4. Review of NA C's employee file showed:

-Hire date of 09/30/24;
-First step PPD administered on 09/27/24 and read on 09/29/24;
-Second step PPD administered on 10/04/24 and read on 10/06/24;
-Staff did not wait seven-21 days after the first dose to administer the second step PPD.

5. Review of NA D's employee file showed:

-Hire date of 12/18/24;
-First step PPD administered on 12/13/24 and read on 12/16/24;
-Second step PPD administered on 12/20/24 and read on 12/22/24;
-Staff did not wait seven-21 days after the first dose to administer the second step PPD.

6. Review of CNA E's employee file showed:

-Hire date of 06/20/24;
-First step PPD administered on 06/20/24 and read on 06/22/24;
-Second step PPD administered on 06/27/24 and read on 06/29/24;
-Staff did not wait seven -21 days after the first dose to administer the second step PPD.

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F 880	Continued From page 78 7. Review of Dietary Aide F's employee file showed: -Hire date of 06/11/24; -First step PPD administered on 06/10/24 and read on 06/12/24; -Second step PPD administered on 06/17/24 and read on 06/19/24; -Staff did not wait seven -21 days after the first dose to administer the second step PPD. 8. During an interview on 01/28/25 at 1:54 P.M., the MDS Coordinator said he/she is responsible for ensuring all new employee two-step TBs are completed accurately. He/She said he/she believes the facility policy is to perform the second step five days after reading the first-step TB. He/She said if the TB's were too close together it is either because he/she had something going on or the staff member was scheduled to be off. He/She said he/she does not like to ask staff to come in for TBs on their days off. During an interview on 01/28/25 at 2:08 P.M., Social services (SS) said the MDS coordinator is responsible for ensuring staff TBs are completed timely. He/She was not aware they were not being completed accurately and timely. He/She said he/she notifies the MDS coordinator when they have a new hire and staff get their first step TB done that day. He/She said after it is the MDS coordinators job to ensure it is read and that the second step TB is completed. During an interview on 01/28/25 at 2:29 P.M., the Director of Nursing (DON) said the MDS coordinator is responsible for new employee two step TB's. He/She said he/she is new to the	F 880		

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F 880	Continued From page 79	F 880		

facility and was not aware they were not being done timely. He/She said time frames are to administer them upon hire, read the TB 48-72 hours after, and then the facility policy is to do the second step one to two weeks after reading the first step. He/She said staff should never do second step less than seven days after reading the first step.

During an interview on 01/28/25 at 2:48 P.M., the administrator said when an employee is hired, SS takes them to any nurse that is working, and they administer the First step TB. He/She said it is the MDS coordinators job to ensure the TB is read and the second step TB is done timely. He/She said TBs are read within 48 hours and that the second step is done one to two weeks after it is read. He/She was not aware they were not being done correctly and he/she is not sure why.

9. Review of the facility's policy titled, "Enhanced Barrier Precautions (EBP)", dated 03/23/24 showed:

-All staff receive training on enhanced barrier precautions upon hire and at least annually and are expected to comply with all designated precautions;
-The facility will have the discretion on how to communicate to staff which residents require the use of EBP, as long as staff are aware of which residents require the use of EBP prior to providing high-contact care activities;
-An order for enhanced barrier precautions will be obtained for residents with any of the following:
    -Wounds;
    -Indwelling medical devices (central lines, urinary catheters, feeding tubes);
-Make gowns and gloves available immediately

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F 880	Continued From page 80 near or outside of the resident's room; -Position a trash can inside the residents room and near the exit for discarding Personal Protective Equipment (PPE) after removal; -Provide education to residents and visitors; -PPE for enhanced barrier precautions is only necessary when performing high-contact care activities such as: -Dressing; -Bathing; -Transferring; -Providing Hygiene; -Changing Linens; -Changing briefs or assisting with toileting; -Device care or use: central lines, urinary catheters, and feeding tubes; -Wound Care: any skin opening requiring a dressing. 10. Review of Resident #20's Entry Tracking Record MDS, dated 12/17/24, showed the resident admitted to the facility on 12/17/24. Review of the resident's Physician's Order Sheet (POS), dated 01/01/25 through 01/27/25, showed the physician ordered medications to be administered via Gastric Tube ((G-Tube) a surgically inserted tube which provides nutrition, hydration, or medicine directly into the stomach). Observation on 01/27/25 at 12:19 PM., showed the resident's room did not contain a sign to alert staff on the use of EBP or PPE in close proximity of the room. Observation on 01/27/25 at 12:20 PM., showed LPN G did not wear a gown when he/she administered the resident's medications via his/her G-tube.	F 880		

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F 880	Continued From page 81 During an interview on 02/04/25 at 2:22 P.M., the LPN said he/she was not familiar with any extra PPE required for EBP when administering medications via the resident's G-tube. He/She said he/she could not recall attending an in-service at the facility regarding EBP. 11. Review of Resident #45 Entry tracking record, dated 01/17/25, showed the resident admitted to the facility on 01/17/25. Observation on 1/27/25 at 11:05 A.M., showed the resident's room did not have PPE in close proximity outside the door as directed per the facility EBP policy. Observation on 1/27/25 at 03:02 P.M., showed the resident's room did not have PPE in close proximity outside the door. LPN G administered a supplement feeding via feeding tube wearing only gloves. During an interview on 01/27/25 at 3:10 P.M. LPN G said he/she was administering a supplement feeding via feeding tube that is done three times a day to help with nutrition. He/She said resident can eat and take medication orally. He/She said staff only wears gloves when administering feedings. He/She said they do not wear gowns while caring for the resident. He/She said he/she is not aware of other precautions besides wearing gloves. Observation on 1/28/25 at 09:23 A.M., showed the resident's room did not have PPE in close proximity outside the door as directed per the facility EBP policy.	F 880		

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Observation on 01/28/25 at 9:28 A.M., showed CNA K did not wear a gown when he/she provided incontinence care to the resident.

During an interview on 01/28/25 at 9:45 A.M., CNA K said he/she is not aware of any enhanced barrier precautions to use besides gloves while caring for resident. He/She said he/she has not been to any in-services regarding enhanced barrier precautions.

Observation on 1/29/25 at 10:03 A.M., showed the resident's room did not have PPE in close proximity outside the door as directed per the facility EBP policy.

Observation on 1/30/25 at 10:21 A.M., showed the resident's room did not have PPE in close proximity outside the door as directed per the facility EBP policy.

12. Review of Resident #48's Entry Tracking Record MDS, dated 01/08/25, showed the resident admitted to the facility on 01/08/25.

Review of the resident's POS, dated 01/08/25 through 01/29/25, showed an order to provide colostomy (an opening in the abdomen to the intestines) care every shift for ileostomy (a surgical procedure that creates an opening in the abdomen to excrete poop from the body).

Review of the resident's care plan, dated 01/17/25, showed staff were directed to educate the resident to empty his/her colostomy pouch when it is one third to half full.

Observation on 01/27/25 at 2:45 P.M., showed the resident in bed with a colostomy bag

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approximately one-third full to his/her right abdomen. The resident's room did not contain a sign to alert staff on the use of EBP or PPE in close proximity of the room.

Observation on 01/29/25 at 10:33 A.M., showed the resident's room did not contain a sign to alert staff on the use of EBP or PPE in close proximity of the room.

Observation on 01/29/25 at 10:37 A.M., showed CNA K did not wear a gown when he/she provided incontinence care to the resident and attempted to empty the resident's colostomy bag.

During an interview on 01/29/25 at 10:46 A.M., CNA K said he/she did not know what EBP was or that extra PPE was required when performing incontinence care or emptying the resident's colostomy bag. The CNA said he/she had not received any in-service at the facility regarding EBP.

13. During an interview on 01/30/25 at 10:05 A.M., the Corporate Registered Nurse (RN) said EBP education was shared with each Director Of Nursing (DON) at each facility when it came out initially. He/She said the education was given again to this facilities DON at the beginning of December, however there was no over site by the previous DON so nothing was being done here with regard to EBP. He/She said there is a new DON who has been here for about a week, so the facility is in need of more education.

During an interview on 1/30/245 at 3:30 P.M., the DON said he/she is aware that EBP was not being done. He/She said the previous DON did not know what they were doing and that's why it

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F 880	Continued From page 84 was not getting done. He/She said EBP should be implemented on residents with feeding tubes, catheters, and wounds. He/She said the importance of EBP is infection control. During an interview on 1/30/25 at 4:05 P.M., the administrator said EBP should be done on residents with colostomy's, ileostomy, feeding tubes, and catheters. He/She said EBP supplies should be readily accessible to use. He/She said the charge nurse should give report at the beginning of the shift on who requires EBP. He/She said the EBP precautions have not been getting done. He/She said there is no reason why it hasn't been getting done. He/She said the importance of EBP is infection control.	F 880		
F 881 SS=E	Antibiotic Stewardship Program CFR(s): 483.80(a)(3) §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(3) An antibiotic stewardship program that includes antibiotic use protocols and a system to monitor antibiotic use. This REQUIREMENT is not met as evidenced by: Based on interview and record review, facility staff failed to implement an Antibiotic Stewardship Program with antibiotic use protocols and a system to monitor and track antibiotic use within the facility. The facility census was 43. 1. Review of the facility's policies showed the	F 881		

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F 881	Continued From page 85 facility did not provide a policy for Antibiotic Stewardship. Review of the facility's antibiotic stewardship program showed facility staff did not have a process in place to track and trend antibiotic usage. During an interview on 01/28/25 at 8:30 A.M., the Director of Nursing (DON) said he has the Infection Preventionist but has only been employed at the facility for eight days. He said he is unsure what was being done before he came, but unfortunately he does not have an antibiotic stewardship program to provide. During an interview on 01/28/25 at 9:30 A.M., Corporate Nurse said the previous DON did not track and trend antibiotic use in the facility. He/She said "To be honest, no one has been doing it and we will use this as a learning experience." During an interview on 01/30/25 at 4:09 P.M., the administrator said the Infection Preventionist is responsible for the antibiotic stewardship program. This would have been the previous DON, and over site of the DON is done by the corporate nurse(s). The administrator said she was unaware it was not completed and does not know why it wasn't.	F 881		
F 909 SS=E	Resident Bed CFR(s): 483.90(d)(3) §483.90(d)(3) Conduct Regular inspection of all bed frames, mattresses, and bed rails, if any, as part of a regular maintenance program to identify areas of possible entrapment. When bed rails	F 909		

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and mattresses are used and purchased separately from the bed frame, the facility must ensure that the bed rails, mattress, and bed frame are compatible.
This REQUIREMENT is not met as evidenced by:
Based on observation, interview, and record review, facility staff failed to complete regular inspections of all bed frames, mattresses, and bed rails as part of a regular maintenance program to identify areas of possible entrapment for four residents (Residents #3, #15, #20, and #46) out of four sampled residents. The facility census was 43.

1. Review of the facility's policies showed staff did not provide a policy for Entrapment Risk Assessments.

Review of the facility's policy titled, "Proper Use of Side Rails," undated, showed the facility will assure the correct installation and maintenance of bed rails prior to use ensuring that the beds dimensions are appropriate for the resident by:

-Confirming the bed rails are appropriate for the size and weight of the resident using the bed;
-Inspecting and regularly checking the mattress and bed rails for ares of possible entrapment;
-Ensuring the bed frame, bed rail, and mattress do not leave a gap wide enough to entrap a resident's head or body, regardless of mattress width, length, and/or depth;
-Checking bed rails regularly to make sure they are still installed correctly, and have not shifted or loosened over time;
-The maintenance director, or designee, is responsible for adhering to a routine maintenance and inspection schedule for all bed frames,

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F 909	Continued From page 87 mattresses, and bed rails. Review of the facility's policy titled, "Bed Safety," revised 12/07, showed to try and prevent death/injury from the beds and related equipment (including the frame, mattress, side rails, headboard, footboard, and bed accessories), the facility shall promote the following approaches: -Inspection by maintenance staff of all beds and related equipment as part of our regular bed safety program to identify risks and problems including potential entrapment risks; -Review that gaps within the bed system are within the dimensions established by Food and Drug Administration (FDA) (Note: the review shall consider situations that could be caused by the resident's weight, movement or bed position). 2. Review of Resident #3's Admission Minimum Data Set (MDS), a federally mandated assessment tool, dated 12/05/24, showed staff assessed the resident as follows: -Severe cognitive impairment; -Substantial/maximal with toileting, and transfers. Review of the resident's electronic medical record (EMR), showed the record did not contain an entrapment risk assessment for the use of side rails, or a maintenance inspection to ensure the side rails were properly secured to the resident's bed. Observation on 1/28/25 at 10:00 A.M., showed the resident in bed with the left side rail in the upright position. Observation on 1/30/25 at 2:45 P.M., showed the	F 909		

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F 909	Continued From page 88 resident in bed with the left side rail in the upright position. 3. Review of Resident #15's Annual MDS, dated 12/14/24, showed staff assessed the resident as: - Cognitively intact; -Independent with bed mobility, toileting, and transfers. Review of the resident's EMR, showed the record did not contain an entrapment risk assessment for the use of side rails, or a maintenance inspection to ensure side rails were properly secured to the resident's bed. Observation on 1/27/25 at 11:13 A.M., showed the resident in bed with bilateral side rails in the upright position. Observation on 1/28/25 at 9:06 A.M., showed the resident in bed with bilateral side rails in the upright position. Observation on 1/29/25 at 9:45 A.M., showed the resident in bed with bilateral side rails in the upright position. Observation on 1/30/25 at 10:07 A.M., showed the resident in bed with bilateral side rails in the upright position. 4. Review of Resident #20's Entry Tracking Record MDS, dated 12/17/24, showed the resident admitted to the facility on 12/17/24. Review of the resident's EMR showed the record did not contain an entrapment risk assessment for the use of side rails, or a maintenance	F 909		

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F 909	Continued From page 89 inspection to ensure the side rails were properly secured to the resident's bed. Observation on 01/27/25 at 3:24 P.M., showed the resident in bed with side rails on both sides in the upright position. Observation on 01/29/25 at 1:38 P.M., showed the resident in bed with side rails on both sides in the upright position. 5. Review of Resident #46's EMR, showed staff documented the resident admitted to the facility on 01/22/25. Review of the resident's EMR showed the record did not contain an entrapment risk assessment for the use of side rails, or a maintenance inspection to ensure the side rails were properly secured to the resident's bed. Observation on 01/27/25 at 11:55 A.M., showed the resident in bed with side rails on both sides in the upright position. Observation on 01/29/25 at 2:13 P.M., showed the resident in bed with side rails on both sides in the upright position. 6. During an interview on 01/29/25 at 3:00 P.M., the Maintenance Director said he/she only puts the bed rails on the bed and takes them off. He/She said there is one sheet that has the measurements on it and that how he/she knows how to put the bed rails on the bed. He/She said he/she does not do any measurements regularly of the bed rails once the bed rails have been put on the bed. He/she said no measurements are ever done with the resident in the bed. He/She	F 909		

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F 909	Continued From page 90 said he/she was not aware of any regulation about doing regular measurements of the bed rails after they are on the bed. During an interview on 01/30/25 at 3:26 P.M., the Director of Nursing (DON) said he/she believes that the MDS coordinator does bed rail measuring. He/She said he/she is not aware of regulation for bed rails and believes entrapment assessment should be done every six-twelve months. During an interview on 01/30/24 at 3:56 P.M., the administrator said the maintenance director has a sheet with measurements and that is how they know where the bars are to be placed on the bed. He/She said entrapment assessment should be done quarterly. He/She said he/she was not aware entrapment assessments were not being done quarterly. He/She said the importance of doing an entrapment assessment is so the resident does not get stuck.	F 909		

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A4031	19 CSR 30-85.042(27) Communicable Disease-Employees The facility must develop and implement policies and procedures which ensure employees are screened to identify communicable diseases and ensure that employees diagnosed with communicable diseases do not expose residents to such diseases. The facility's policies and procedures must comply with the Missouri Department of Health's regulations pertaining to communicable diseases, specifically 19 CSR 20-20.010 through 19 CSR 20-20.100, as amended. II This regulation is not met as evidenced by: Class II Refer to F880	A4031		
A4033	19 CSR 30-85.042(29) Employee Hours Documented Facilities shall maintain written documentation on the premises showing actual hours worked by each employee. III This regulation is not met as evidenced by: Class III Refer to F732	A4033		
A4046	19 CSR 30-85.042(37) Nursing Staff Sufficient/Qualified All facilities shall employ nursing personnel in sufficient numbers and with sufficient qualifications to provide nursing and related services which enable each resident to attain or maintain the highest practicable level of physical, mental and psychosocial well-being. Each facility	A4046		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FULTON MANOR CARE CENTER	520 MANOR DRIVE FULTON, MO 65251

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A4046	Continued From page 1 shall have a licensed nurse in charge who is responsible for evaluating the needs of the residents on a daily and continuous basis to ensure there are sufficient, trained staff present to meet those needs. I/II This regulation is not met as evidenced by: Class II Refer to F725 and F727	A4046		
A4055	19 CSR 30-85.042(46) Safe/Effective Medication System There shall be a safe and effective system of medication distribution, administration, control, and use. I/II This regulation is not met as evidenced by: Class II See F759	A4055		
A4074	19 CSR 30-85.042(65) Protective Oversight, Voluntary Leave Each resident shall receive twenty-four- (24-) hour protective oversight and supervision. For residents departing the premises on voluntary leave, the facility shall have, at a minimum, a procedure to inquire of the resident or resident's guardian of the resident's departure, of the resident's estimated length of absence from the facility, and of the resident's whereabouts while on voluntary leave. I/II This regulation is not met as evidenced by: Class III Refer to F700 and F909	A4074		

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A4075	Continued From page 2	A4075		
A4075	19 CSR 30-85.042(66) Nursing Care per Res Condition Each resident shall receive personal attention and nursing care in accordance with his/her condition and consistent with current acceptable nursing practice. I/II This regulation is not met as evidenced by: Class II Refer to F658 and 558	A4075		
A4076	19 CSR 30-85.042(67) Clean, Dry, Odor Free Each resident shall be clean, dry, and free of body and mouth odor that is offensive to others. I/II This regulation is not met as evidenced by: Class II See F677	A4076		
A4086	19 CSR 30-85.042(77) Infection Control/Communicable Disease Residents shall be cared for by using acceptable infection control procedures to prevent the spread of infection. The facility shall make a report to the division within seven (7) days if a resident is diagnosed as having a communicable disease, as determined by the Missouri Department of Health and listed in the Code of State Regulations pertaining to communicable diseases, specifically 19 CSR 20-20.020, as amended. I/II This regulation is not met as evidenced by: Class II	A4086		

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A4086	Continued From page 3 See F880	A4086		
A4108	19 CSR 30-85.042(98)(B) Clinical Records - assessment/interventions Facilities shall ensure that the clinical record contains sufficient information to- (B) Reflect the initial and ongoing assessments and interventions by each discipline involved in the care and treatment of the resident; and II/III This regulation is not met as evidenced by: Class III See F655	A4108		
A8030	19 CSR 30-88.010(29) Dignity/Privacy Each resident shall be treated with consideration, respect, and full recognition of his or her dignity and individuality, including privacy in treatment and care of his or her personal needs. All persons, other than the attending physician, the facility personnel necessary for any treatment or personal care, or the department or Department of Mental Health staff, as appropriate, shall be excluded from observing the resident during any time of examination, treatment, or care unless consent has been given by the resident. II/III This regulation is not met as evidenced by: Class III Refer to F583	A8030		

PLAN OF CORRECTION

Provider/Supplier Name:	Fulton Manor Care Center
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Date of Survey:	01/30/2025

PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER		265760
ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION: (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLETION DATE
F 558	Immediate actions taken for the residents to have been affected :	
A4075	The call light for resident #4, #10, #48, and #295 was placed within easy reach.	
	Identification of other residents having the potential to be affected by the same deficient practice:	
	The facility has determined that all residents have the potential to be affected.	
	What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recure:	
	The Director of Nursing and/or designee provided an in-service for all direct care personnel addressing policies and procedures as well regulations and facility expectations to staff to assure call lights are within the reach of residents while in their room.	

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	How the corrective action(s) will be monitored to ensure the practice will not reoccur:	

	The Director of Nursing and/or designee will make rounds 2 times daily for 1 week, then daily for 1 week to ensure call lights are within reach of the resident. Random checks will be made on 5 residents 3 times per week for 4 weeks or until compliance is met.	
	Concerns will be discussed by the QA committee and monitoring will be adjusted as determined by the QA committee.	
	The QA committee will review this plan of correction until such time substantial compliance has been met as determined by the QA committee.	
	Date of corrective action being completed:	3114/2025

Rebecca R Bey Administrator
2/26/25

PLAN OF CORRECTION		
Provider/Supplier Name:	Fulton Manor Care Center	
Street Address, City, Zip:	520 Manor Drive, Fulton, Missouri 65251	
Date of Survey:	01/30/2025	
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	SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	
F 583	Immediate actions taken for the residents to have been affected:	
A8030	The private information for resident #9 and #13 has been protected b using the privacy mode on the computer.	
	The privacy of resident #48 has been maintained by closing the privacy curtain during care.	
	Identification of other residents having the potential to be affected by the same deficient practice:	
	The facility has determined that all residents have the potential to be affected.	
	What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recure:	
	The Director of Nursing and/or designee provided an inservice for all direct care staff regarding the use of privacy mode on computers when not in use to protect residents' private information and to ensure privacy curtains and/or window blinds/curtains are closed while providing care to residents.	
	How the corrective action(s) will be monitored to ensure the practice will not reoccur:	
	The Director of Nursing and/or designee will make rounds 2 times daily for 1 week, then daily for 1 week to ensure privacy mode is being utilized during med pass and privacy curtains and/or window blinds/curtains are closed while providing care to residents. Random checks will be made on 5 residents 3 times er week for 4 weeks or until compliance is met.	

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	Concerns will be discussed by the QA committee and monitoring will be adjusted as determined by the QA committee.	
	The QA committee will review this plan of correction until such time substantial compliance has been met as determined by the QA committee.	
	Date of corrective action being completed:	3/14/2025

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F 625	Immediate actions taken for the residents to have been affected:	
	Resident #3, #14, #20, and #26 record was reviewed for notification of Bed Hold. The resident and/or legal representative has been notified of the facility 's bed hold policy	
	Identification of other residents having the potential to be affected by the same deficient practice:	

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	The facility has determined that all residents have the potential to be affected.	
	What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recure:	
	An audit on residents who have discharged in the last 30 days have been reviewed for notification of bed hold policy. Any notification missing was rectified by notifying the resident and/or le al representative of the facility's bed hold policy	
	An in-service has been conducted by the Director of Nursing with all licensed nursing staff addressing the facilities' notification of bed hold policy. The Charge Nurse is responsible for providing the Transfer/Discharge paperwork to the residents upon departure. If the resident refuses to sign the document the nurse will annotate that on the form. A copy will be placed in the SSD door file pocket upon completion.	

	How the corrective action(s) will be monitored to ensure the practice will not reoccur:	
	The Director of Nursing will monitor daily all transfers to the hospital to ensure a completed bed hold form has been signed and dated for each transfer.	
	Concerns will be discussed by the QA committee and monitoring will be adjusted as determined by the QA committee.	
	The QA committee will review this plan of correction until such time substantial compliance has been met as determined by the QA committee.	
	Date of corrective action being completed:	3/14/2025

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F 636	Immediate actions taken for the residents to have been affected:	
	The Comprehensive Minimum Data Set (MDS) has been completed for Resident #20, #24, and #48	

	Identification of other residents having the potential to be affected by the same deficient practice:	
	The facility has determined that all residents have the potential to be affected.	
	What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recure:	
	The facility IDT team, including the MDS coordinator, has been educated regarding the timely completion of the MDS assessment according to the timeframe outlined in the MDS manual.	

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	An audit was completed on all current residents in the facility to ensure the MDS was completed according to the timeframe outlined in the MDS manual.	
	How the corrective action(s) will be monitored to ensure the practice will not reoccur:	
	The MDS Coordinator and/or designee will review the MDS schedule to ensure the timely completion schedule of residents' assessment weekly for 4 weeks, then 2 times a month for 1 month, and monthly for 4 months or until compliance is met. Any deficiency found will be corrected immediately.	
	Concerns will be discussed by the QA committee and monitoring will be adjusted as determined by the QA committee.	
	The QA committee will review this plan of correction until such time substantial compliance has been met as determined by the QA committee.	
	Date of corrective action being completed:	3114/2025

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F 655	Immediate actions taken for the residents to have been affected:	
A4108	Resident #20, #43, #45, #46, and #48 baseline care plan has been completed.	
	Identification of other residents having the potential to be affected by the same deficient practice:	
	The facility has determined that all residents have the potential to be affected.	
	What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recure:	
	All interdisciplinary care plan team members responsible for writing baseline care plans will be educated on the facility's policy and procedure for developing Baseline Care Plan, which includes procedures for providing the residents with a written summary of their baseline care Ian.	
	An audit was completed on all admissions from the past 30 days to ensure a baseline care Ian was completed.	

	How the corrective action(s) will be monitored to ensure the practice will not reoccur:	

	The MDS Coordinator and/or designee will complete an audit on all admissions to ensure a baseline care plan has been developed weekly for 4 weeks, then 2 times a month for 1 month, and monthly for 4 months or until compliance is met. Any deficiency found will be corrected immediately	
	Concerns will be discussed by the QA committee and monitoring will be adjusted as determined b the QA committee.	
	The QA committee will review this plan of correction until such time substantial compliance has been med as determined by the QA committee.	
	Date of corrective action being completed:	3/14/2025

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F 656	Immediate actions taken for the residents to have been affected:	
	The comprehensive care plan for residents 1 , #15, and #16 have been reviewed and u dated as indicated.	
	Identification of other residents having the potential to be affected by the same deficient practice:	

	The facility has determined that all residents have the potential to be affected.	
	What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recure:	

	All interdisciplinary care plan team members responsible for writing care plans will be educated on the facility's policy and procedure for developing Comprehensive Care Plans to include hospice services, use of bed rails (u-bars, assist bars), and/or have contractures.	
	An audit was completed for all residents who currently receive hospice, utilize bed rails (u-bars, assist bars), and/or have contractures to ensure their care plans have been reviewed and updated accordingly.	
	How the corrective action(s) will be monitored to ensure the practice will not reoccur:	
	Care plans will be reviewed weekly in accordance with the care plan review schedule by the MDS coordinator. All care plans will be updated as indicated.	
	The Director of Nursing and/or designee will complete 5 random care plans weekly audits of care plans for 4 weeks then 1 random care plan weekly for 1 month or until compliance is met. Any deficiency found will be corrected immediately	
	Concerns will be discussed by the QA committee and monitoring will be adjusted as determined by the QA committee.	
	The QA committee will review this plan of correction until such time substantial compliance has been met as determined by the QA committee.	
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F 658	Immediate actions taken for the residents to have been affected:	
A4075	Resident #20 physician orders have been reviewed and updated accordingly as well as changed to the licensed eMAR	
	The levothyroxine order has been reviewed and updated.	
	Identification of other residents having the potential to be affected by the same deficient practice:	
	The facility has determined that all residents have the potential to be affected by deficient practice.	
	What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recure:	
	An audit has been completed to identify residents who have a g tube, colostomy, and/or receive levothyroxine. Physician orders have been reviewed and u dated if indicated.	

	The Director of Nursing and/or designee provided an inservice to all licensed nurses regarding follow physician orders regarding g-tube flushing, proper documentation in the eMAR, and proper care of a colostomy. All licensed nurses and medication aides have been educated on proper administration of levothyroxine.	
	How the corrective action(s) will be monitored to ensure the practice will not reoccur:	
	The Director of Nursing and/or designee will perform weekly audits x 3 months for new admissions and those residents on the MDS assessment schedule to ensure orders have been obtained for those residents who have a G-tube, Colostomy, and/or receive levothyroxine. All deficiencies will be corrected immediately, and 1 on 1 education will be provided.	
	The Director of Nursing and/or designee will conduct random medication administration audits for 1 nurse weekly on each	
	shift for 4 weeks, then 1 nurse weekly x 4 weeks, the 1 random medication audit monthly until compliance is met. All deficiencies will be corrected immediately, and 1 on 1 education will be provided.	
	Concerns will be discussed by the QA committee and monitoring will be adjusted as determined by the QA committee.	
	The QA committee will review this plan of correction until such time substantial compliance has been met as determined by the QA committee.	
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F 677	Immediate actions taken for the residents to have been affected:	
A4076	Basic hygiene care was provided to resident #24, #32, #35, and	
	Identification of other residents having the potential to be affected by the same deficient practice:	
	The facility has determined that all residents have the potential to be affected by deficient practice.	
	What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recure:	
	All direct care staff have been educated on appropriate adl care to be provided to resident to include hygiene care and showers.	

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	The Director of Nursing has reviewed and updated the facility shower schedule.	
	How the corrective action(s) will be monitored to ensure the practice will not reoccur:	

	The Director of Nursing and/or designee will complete walking rounds and review the shower schedule 5 times a week for 4 weeks then weekly for 1 monthly to ensure residents have received the necessary services to maintain good personal hygiene. All deficiencies will be corrected immediately	
	Concerns will be discussed by the QA committee and monitoring will be adjusted as determined by the QA committee.	
	The QA committee will review this plan of correction until such time substantial compliance has been met as determined by the QA committee.	
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F 700	Immediate actions taken for the residents to have been affected:	
A4074	The side rail assessment has been reviewed and consents obtained if indicated for resident #3, #15, #20, and #46.	
	Identification of other residents having the potential to be affected by the same deficient practice:	

	The facility has determined that all residents have the potential to be affected.	
	What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recure:	
	An audit was completed to identify residents who have a side rail/assist bar on their bed. An updated side rail assessment was completed and consent obtained if indicated.	
	The Director of Nursing and/or designee provided an inservice for all direct care staff regarding the proper use of side rails, completing the side rail assessment, and obtaining consents.	
	How the corrective action(s) will be monitored to ensure the practice will not reoccur:	
	The Director of Nursing and/or designee will monitor the utilization of bed rails during rounds that will occur weekly x 4weeks, then monthly x 3 months, then quarterly following the MDS schedule.	
	Concerns will be discussed by the QA committee and monitoring will be adjusted as determined by the QA committee.	

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	The QA committee will review this plan of correction until such time substantial compliance has been met as determined by the QA committee.	
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F 725	Immediate actions taken for the residents to have been affected:	
	Basic hygiene care was provided to resident #24, #32, #35, and	
	Identification of other residents having the potential to be affected by the same deficient practice:	
	The facility has determined that all residents have the potential to be affected by deficient practice.	
	What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recure:	
	All direct care staff have been educated on appropriate adl care to be provided to residents to include hygiene care and showers.	

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	The Director of Nursing has reviewed and updated the facility shower schedule.	
	The Administrator reviewed the Facility Assessment to ensure sufficient staffing is appropriately reflected based on the needs of the facility	
	How the corrective action(s) will be monitored to ensure the practice will not reoccur:	
	The Director of Nursing and/or designee will complete walking rounds and review the shower schedule 5 times a week for 4 weeks then weekly for 1 monthly to ensure residents have received the necessary services to maintain good personal hygiene. All deficiencies will be corrected immediately	

	The Director of Nursing and/or designee will review the daily staffing schedule to ensure sufficient staffing based on the facility needs.	
	Concerns will be discussed by the QA committee and monitoring will be adjusted as determined by the QA committee.	
	The QA committee will review this plan of correction until such time substantial compliance has been med as determined by the QA committee.	
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F 727	Immediate actions taken for the residents to have been affected:	
A4046	No residents were found to be affected	
	Identification of other residents having the potential to be affected by the same deficient practice:	
	The facility has determined that all residents have the potential to be affected by deficient practice.	
	What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not reoccur:	
	The facility is utilizing agency RN's to cover needed shifts until an RN can be hired. The facility continues to advertise for RN's on Indeed to include a sign-on bonus.	
	All residents will be screened prior to admission to ensure all needs can be met by current nursing staff.	

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	How the corrective action(s) will be monitored to ensure the practice will not reoccur:	
	The Director of Nursing and/or designee will continue to monitor Indeed for applicants and schedule interviews as applicants come available. The Administrator will monitor the monthly schedule to ensure an RN is scheduled 7 days a week.	
	Concerns will be discussed by the QA committee and monitoring will be adjusted as determined by the QA committee.	
	The QA committee will review this plan of correction until such time substantial compliance has been met as determined by the QA committee.	
	Date of corrective action being completed:	311412025

PLAN OF CORRECTION

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ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION: (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLETION DATE
F 732	Immediate actions taken for the residents to have been affected:	
A4033	No residents were found to be affected	

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	Identification of other residents having the potential to be affected by the same deficient practice:	
	The facility has determined that all residents have the potential to be affected by deficient practice.	
	What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recure:	
	The Director of Nursing and/or designee provided an inservice to all staff regarding the requirements of posting nurse staffing information.	
	How the corrective action(s) will be monitored to ensure the practice will not reoccur:	
	The Director of Nursing and/or designee will audit the staff posting daily for 4 weeks then weekly for 4 weeks to assure compliance with the posting requirement.	
	Concerns will be discussed by the QA committee and monitoring will be adjusted as determined by the QA committee.	
	The QA committee will review this plan of correction until such time substantial compliance has been met as determined by the QA committee.	
	Date of corrective action bein com leted:	3/1412025

PLAN OF CORRECTION

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ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION: (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLETION DATE
F 759	Immediate actions taken for the residents to have been affected :	
A4055	The physician orders have been reviewed and updated for resident #20.	
	Identification of other residents having the potential to be affected by the same deficient practice:	
	The facility has determined that all residents receiving medications have the potential to be affected by deficient practice.	
	What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not reoccur: The charge nurse will periodically monitor the eMar to ensure there are no med errors and the nurse will help the Med Tech if they are running behind to ensure timely dispensing of meds to the residents.	
	The Director of Nursing and/or designee provided an inservice to all nurses and medication aides on preventing medication errors.	
	How the corrective action(s) will be monitored to ensure the practice will not reoccur:	
	The Director of Nursing and/or designee will conduct random medication administration audits for 1 nurse weekly on each shift for 4 weeks, then 1 nurse weekly x 4 weeks, the 1 random medication audit monthly until compliance is met. All deficiencies will be corrected immediately, and 1 on 1 education will be provided.	

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	Concerns will be discussed by the QA committee and monitoring will be adjusted as determined by the QA committee.	
	The QA committee will review this plan of correction until such time substantial compliance has been med as determined by the QA committee.	
	Date of corrective action being completed:	3/14/2025

PLAN OF CORRECTION

Provider/Supplier Name:	Fulton Manor Care Center
Street Address, City, Zip:	520 Manor Drive, Fulton, Missouri 65251
Date of Survey:	01/30/2025

PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER		265760
ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION: (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLETION DATE
F 867	Immediate actions taken for the residents to have been affected:	
	No residents were found to be affected	

	Identification of other residents having the potential to be affected by the same deficient practice:	
	The facility has determined that all residents have the potential to be affected by deficient practice.	
	What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recure:	

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	The facility quality assurance committee has been in-serviced related to the appropriate functioning of the QA/QAPI Committee and the importance of providing documentation of developing and implementing appropriate plans of action for identified facility concerns.	
	How the corrective action(s) will be monitored to ensure the practice will not reoccur:	
	The Administrator will review quarterly compiled QAPI report information, review trends, and review corrective actions taken and the dates of completion. The administrator will be responsible for ensuring QAPI committee concerns are addressed through further training and other interventions.	
	The QA committee will review this plan of correction until such time substantial compliance has been met as determined by the QA committee.	
	Date of corrective action being completed:	3/14/2025

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PLAN OF CORRECTION

Provider/Supplier Name:	Fulton Manor Care Center
Street Address, City, Zip:	520 Manor Drive, Fulton, Missouri 65251
Date of Survey:	01/30/2025

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ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION: (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLETION DATE
F 880	Immediate actions taken for the residents to have been affected:	
A4031	Enhanced Barrier Precautions have been implemented for resident #20, #45, and #48.	
A4086		
	Identification of other residents having the potential to be affected by the same deficient practice:	
	The facility has determined that all residents have the potential to be affected by deficient practice.	
	What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recure:	
	An audit has been conducted to determine residents who would require enhanced barrier precautions (EBP). EBP has been implemented for any resident found to meet the requirement.	

	The Director of Nursing and/or designee provided an inservice to all staff regarding the facility's policy on Enhanced Barrier Precautions and expectations. An audit was performed to ensure the facility's policy on two-step PPD skin test is completed within the policy 's time frame for all new hires and that current employees have the PPD skin test completed annually.	
	How the corrective action(s) will be monitored to ensure the practice will not reoccur:	

	The Director of Nursing and/or designee will make rounds 2 times daily for 1 week, then daily for 1 Enhanced Barrier Precautions are being followed. Random checks will be made on 5 residents 3 times per week for 4 weeks or until compliance is met.	
	The Administrator and/or designee will review all new hires to ensure a two-step PPD test has been completed according to policy weekly x 4 weeks, then 2 times a month x 1 month or until compliance is met.	
	Concerns will be discussed by the QA committee and monitoring will be adjusted as determined by the QA committee.	
	The QA committee will review this plan of correction until such time substantial compliance has been met as determined by the QA committee.	
	Date of corrective action being completed:	3/1412025

PLAN OF CORRECTION

Provider/Supplier Name:	Fulton Manor Care Center
Street Address, City, Zip:	520 Manor Drive, Fulton, Missouri 65251

Date of Survey:	01/30/2025	
PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER		265760
ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION: (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLETION DATE
F 881	Immediate actions taken for the residents to have been affected:	
	No residents were found to be affected	
	Identification of other residents having the potential to be affected by the same deficient practice:	
	The facility has determined that all residents have the potential to be affected by deficient practice.	

	What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recure:	
	The Corporate Nurse educated the Administrator and Director of Nursing on the Antibiotic Stewardship Pro ram policy	
	The facility has placed an ad on Indeed with the goal of hiring a full-time Infection Control Nurse to help oversee the Antibiotic Stewardship Program.	
	How the corrective action(s) will be monitored to ensure the practice will not reoccur:	

	The Director of Nursing and/or designee will conduct auditing and monitoring of the Antibiotic Stewardship program 5 times weekly to ensure the key elements of the Antibiotic Stewardship program are being implemented to include monitoring infections and antibiotic usage, monitoring residents on antibiotics for potential adverse outcomes, ensuring a McGeer's assessment is completed following an order received to initiate an antibiotic, if an antibiotic is started that the antibiotic time-out (ATO) was completed 72 hours after the antibiotic was started to determine continued appropriateness of the antibiotic. Monitoring for determined approaches to ensure effective implementation and ongoing sustainment. After four weeks of monitoring and demonstrating expectations are being met, monitoring may be reduced to twice monthly for one month.	
	Concerns will be discussed by the QA committee and monitoring will be adjusted as determined by the QA committee.	
	The QA committee will review this plan of correction until such time substantial compliance has been met as determined by the QA committee.	
	Date of corrective action being completed:	3/14/2025

PLAN OF CORRECTION

Provider/Supplier Name:	Fulton Manor Care Center
Street Address, City, Zip:	520 Manor Drive, Fulton, Missouri 65251
Date of Survey:	01/30/2025

PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER		265760
ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION: (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLETION DATE
F 909	Immediate actions taken for the residents to have been affected:	

A4074	The bed frames, mattresses, and bed rails have been inspected for Resident #3, #15, #20, and #46.	
	Identification of other residents having the potential to be affected by the same deficient practice:	
	The facility has determined that all residents have the potential to be affected by deficient practice.	
	What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recure:	
	An audit was completed to identify beds that have bedrails and/or assist rails. The maintenance director has completed an entrapment assessment on those beds while residents were in their bed to ensure proper placement for the assist bars.	
	The maintenance director has been educated on the facility's policy on Bed Safety and the expectation of routine monitoring for potential entrapment risks.	
	How the corrective action(s) will be monitored to ensure the practice will not reoccur:	
	The maintenance director will monitor side rails weekly for proper use for 4 weeks, then 2 times a month x 1 month, and then he will do monthly checks on all beds with assist rails. The Administrator /or Director of Nursing will ensure all entrapment assessments are being completed.	
	Concerns will be discussed by the QA committee and monitoring will be adjusted as determined by the QA committee.	
	The QA committee will review this plan of correction until such time substantial compliance has been met as determined by the QA committee.	

PLAN OF CORRECTION

Provider/Supplier Name:	Fulton Manor Care Center
Street Address, City, Zip:	520 Manor Drive, Fulton MO 65251
Date of Survey:	1/30/2025

PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER		265760
ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION: (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLETION DATE
F812	Immediate actions taken for the residents to have been affected	
	The DM educated the DA on the importance of ensuring the temperature on the dish machine reaches its proper temperature before dishes are removed from the machine.	
	The DM had the DC to bring the chemical in the three compartment sink to the listed manufacture recommendations and the dishes were rewashed and sanitized.	
	Identification of other residents having the potential to be affected by the same deficient practice:	
	The facility has determined that all residents have the potential to be affected by the deficient practice.	
	What measures will be put into place or what systemic changes will be made to ensure the deficient practice does not occur: The DA will ensure the dishwashing machine reaches the correct operating temperature for every load washed in the machine. They will alert the DM if the machine fails to reach the proper temperature, and she will call for service immediately if she cannot correct the deficiency herself. The DC will ensure they properly test the sanitizer solution on the three compartment sink prior to washing dishes in them and no dishes will be washed or sanitized until the correct sanitizer strength has been achieved.	
	The DM has in-serviced all staff on the correct operation of the dishwashing machine. And all DC's were educated and in serviced on the proper sanitizer strength and testin of it.	
	How the corrective action (s) will be monitored to ensure the practice does not reoccur:	

	The DM will conduct random temperature check audits twice a day for one week, then weekly for 4 weeks. The DM will periodically test the three compartment sink daily for one week, then weekly for four weeks. All deficiencies will be corrected immediately, and 1 on 1 education will be provided	
	Concerns will be discussed by the QA committee and monitoring will be determined by the QA committee.	
	The QA committee will review this plan of correction until such time substantial compliance has been met as determined by the QA committee.	
	Correction Date	3/14/25

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265760	A. BUILDING _____ B. WING _____	R-C 03/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FULTON MANOR CARE CENTER	520 MANOR DRIVE FULTON, MO 65251

(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 000	INITIAL COMMENTS	F 000		
{F 700} SS=E	Bedrails CFR(s): 483.25(n)(1)-(4) §483.25(n) Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. §483.25(n)(1) Assess the resident for risk of entrapment from bed rails prior to installation. §483.25(n)(2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. §483.25(n)(3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. §483.25(n)(4) Follow the manufacturers' recommendations and specifications for installing and maintaining bed rails. This REQUIREMENT is not met as evidenced by This deficiency is uncorrected. For previous examples, please refer to the Statement of Deficiencies dated 02/13/25. Based on observation, interview, and record review, facility staff failed to complete side rail assessments for four residents (Resident #3,	{F 700}		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Rebecca D Lee — TITLE: Administrator — (X6) DATE: 4/3/2025

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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{F 700}	Continued From page 1 #15, #20 and #46) out of four sampled residents. The facility census was 41. 1. Review of the facility's Proper use of Side Rails Policy, undated, showed: -Examples of bedrails include, but are not limited to side rails, bed side rails, safety rails, grab bars, and assist bars; -The resident assessment must assess the resident's risk from using bed rails such as entrapment; -The resident assessment should assess the resident's risk of entrapment between the mattress and bed rail or in the bed rail itself; -Informed consent from the resident or resident representative must be obtained after appropriate alternative have been attempted prior to installation and use of bed rails; -Upon receiving informed consent, the facility will obtain a physician's order for the use of the specified bed rail and medical diagnosis, condition, symptom, or functional reason for the use of the bed rail; -A nurse assigned to the resident will complete reassessments in accordance with the facility's assessment schedule, but not less than quarterly, upon significant change in status, or a change in the type of bed/mattress/rail. 2. Review of Resident #3's Admission Minimum Data Set (MDS), a federally mandated assessment tool, dated 12/05/24, showed staff assessed the resident as follows: -Severe cognitive impairment; -Substantial/maximal assistance with toileting, and transfers.	{F 700}		

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{F 700}	Continued From page 2 Review of the resident's medical record showed the record did not contain a quarterly side rail assessment. Observation on 03/21/25 at 11:00 A.M., showed the resident's bed with a left side rail in the upright postition. 3. Review of Resident #15's Annual MDS, dated 12/14/24, showed staff assessed the resident as follows: -Cognitively intact; -Independent with bed mobility, toileting, and transfers. Review of the resident's medical record showed the record did not contain a quarterly side rail assessment. Observation on 03/21/25 at 11:05 A.M., showed the resident's bed with a left side rail in the upright position. 4. Review of Resident #20's Quarterly MDS, dated 01/18/25, showed staff assesed the resident as follows: -Cognitively intact; -Substantial/maximal assistance with toileting, and bathing. Review of the resident's medical record showed the record did not contain a quarterly side rail assessment. Observation on 03/21/25 at 11:10 A.M., showed the resident's bed with bilateral side rails.	{F 700}		

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{F 700}	Continued From page 3 5. Review of Resident #46's Admission MDS, dated 02/04/25, showed staff assessed the resident as follows: -Severe cognitive impairment; -Substantial/maximal assistance with toileting and bathing. Review of the resident's medical record showed the record did not contain a quarterly side rail assessment. Observation on 03/21/25 at 11:30 A.M., showed the resident's bed with bilateral side rails. 6. During an interview on 03/21/25 at 2:00 P.M., the MDS Coordinator said he/she did not do measurements or assessments in regards to side rails on a residents bed. He/She said "If I am responsible I did not know." MDS Corrdinator said he/she believes it was the Director of Nursing (DON) responsible for the task. During an interview on 03/21/25 at 2:05 P.M., the DON said he/she is not responsible for side rail assessments, and is not sure who is responsible for the task. During an interview on 03/21/25 at 2:50 P.M., the administrator said the MDS Coordinator is responsible for quarterly side rail assessments, and she thought they were being done. The administrator said the DON is responsible for audits of the process to make sure its completed.	{F 700}		
{F 881} SS=C	Antibiotic Stewardship Program CFR(s): 483.80(a)(3) §483.80(a) Infection prevention and control	{F 881}		

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{F 881}	Continued From page 4 program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(3) An antibiotic stewardship program that includes antibiotic use protocols and a system to monitor antibiotic use. This REQUIREMENT is not met as evidenced by: This deficiency is uncorrected. For previous examples, please refer to the Statement of Deficiencies dated 02/13/25. Based on interview and record review, facility staff failed to implement an Antibiotic Stewardship Program with antibiotic use protocols and a system to monitor and track antibiotic use within the facility. The facility census was 43. 1. Review of the facility's policies showed the facility did not provide a policy for Antibiotic Stewardship. Review of the facility's antibiotic stewardship program showed facility staff did not have a process in place to track and trend antibiotic usage. During an interview on 03/21/25 at 2:00 P.M., the Director of Nursing (DON) said he/she has not had time to start the antibiotic stewardship program. The DON said they hired a new Infection Preventionist who starts at the end of March, who will be responsible for the program. During an interview on 03/21/25 at 2:45 P.M., the administrator said she is not sure why the antibiotic stewardship program is not completed,	{F 881}		

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{F 881}	Continued From page 5 and there is no reason.	{F 881}		
{F 909} SS=E	Resident Bed CFR(s): 483.90(d)(3) §483.90(d)(3) Conduct Regular inspection of all bed frames, mattresses, and bed rails, if any, as part of a regular maintenance program to identify areas of possible entrapment. When bed rails and mattresses are used and purchased separately from the bed frame, the facility must ensure that the bed rails, mattress, and bed frame are compatible. This REQUIREMENT is not met as evidenced by: This deficiency is uncorrected. For previous examples, please refer to the Statement of Deficiencies dated 02/13/25. Based on observation, interview, and record review, facility staff failed to complete regular inspections of all bed frames, mattresses, and bed rails as part of a regular maintenance program to identify areas of possible entrapment for four residents (Residents #3, #15, #20, and #46) out of four sampled residents. The facility census was 41. 1. Review of the facility's policies showed staff did not provide a policy for Entrapment Risk Assessments. Review of the facility's policy titled, "Proper Use of Side Rails," undated, showed the facility will assure the correct installation and maintenance of bed rails prior to use ensuring that the beds dimensions are appropriate for the resident by:	{F 909}		

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{F 909}	Continued From page 6 -Confirming the bed rails are appropriate for the size and weight of the resident using the bed; -Inspecting and regularly checking the mattress and bed rails for ares of possible entrapment; -Ensuring the bed frame, bed rail, and mattress do not leave a gap wide enough to entrap a resident's head or body, regardless of mattress width, length, and/or depth; -Checking bed rails regularly to make sure they are still installed correctly, and have not shifted or loosened over time; -The maintenance director, or designee, is responsible for adhering to a routine maintenance and inspection schedule for all bed frames, mattresses, and bed rails. Review of the facility's policy titled, "Bed Safety," revised 12/07, showed to try and prevent death/injury from the beds and related equipment (including the frame, mattress, side rails, headboard, footboard, and bed accessories) the facility shall promote the following approaches: -Inspection by maintenance staff of all beds and related equipment as part of our regular bed safety program to identify risks and problems including potential entrapment risks; -Review that gaps within the bed system are within the dimensions established by Food and Drug Administration (FDA) (Note: the review shall consider situations that could be caused by the resident's weight, movement or bed position). 2. Review of Resident #3's Admission Minimum Data Set (MDS), a federally mandated assessment tool, dated 12/05/24, showed staff assessed the resident as follows: -Severe cognitive impairment;	{F 909}		

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{F 909}	Continued From page 7 -Substantial/maximal assistance with toileting, and transfers. Review of the resident's Electronic Medical Record (EMR), showed the record did not contain an entrapment risk assessment for the use of side rails, or a maintenance inspection to ensure side rails were properly secured to the resident's bed. Observation on 03/21/25 at 11:00 A.M., showed the resident's bed with a left side rail in the upright position. 3. Review of Resident #15's Annual MDS, dated 12/14/24, showed staff assessed the resident as follows: -Cognitively intact; -Independent with bed mobility, toileting, and transfers. Review of the resident's EMR, showed the record did not contain an entrapment risk assessment for the use of side rails, or a maintenance inspection to ensure side rails were properly secured to the resident's bed. Observation on 03/21/25 at 11:05 A.M., showed the resident's bed with a left side rail in the upright position. 4. Review of Resident #20's Quarterly MDS, dated 01/18/25, showed staff assesed the resident as follows: -Cognitively intact; -Substantial/maximal assistance with toileting, and bathing.	{F 909}		

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FULTON MANOR CARE CENTER	520 MANOR DRIVE FULTON, MO 65251

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 909}	Continued From page 8 Review of the resident's EMR, showed the record did not contain an entrapment risk assessment for the use of side rails, or a maintenance inspection to ensure side rails were properly secured to the resident's bed. Observation on 03/21/25 at 11:10 A.M., showed the resident's bed with bilateral side rails. 5. Review of Resident #46's Admission MDS, dated 02/04/25, showed staff assessed the resident as follows: -Severe cognitive impairment; -Substantial/maximal assistance with toileting and bathing. Review of the resident's EMR, showed the record did not contain an entrapment risk assessment for the use of side rails, or a maintenance inspection to ensure side rails were properly secured to the resident's bed. Observation on 03/21/25 at 11:30 A.M., showed the resident's bed with bilateral side rails. During an interview on 03/21/25 at 2:05 P.M., the Director of Nursing (DON) said he/she is not responsible for the inspection or entrapment assessments for residents' bed, the Maintenance Director is responsible for the tasks but is unsure why they are not completed. During an interview on 03/21/25 at 2:50 P.M., the Administrator said the MD is responsible for this task, but is not sure why it was not completed. During an interview on 03/24/25 at 3:35 P.M., the	{F 909}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265760	A. BUILDING _____ B. WING _____	R-C 03/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FULTON MANOR CARE CENTER	**520 MANOR DRIVE FULTON, MO 65251**

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{F 909}	Continued From page 9 Maintenance Director said he/she is still tying to figure out what the expectation is for the side rail entrapment assessments. The Maintenance Director said he was not trained on what to do, and there is no corporate Mainte nance Director to assist in that process.	{F 909}		

PLAN OF CORRECTION

Provider/Supplier Name:	Fulton Manor Care Center
Street Address, City, Zip:	520 Manor Drive Fulton, MO 65251
Date of Survey:	3/21/2025

PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	

ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION: (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLETION DATE
F700	Immediate actions taken for the residents to have been affected:	
	The side rail assessment has been reviewed and consents obtained if indicated for resident #3, #15, #20, and #46.	
	Identification of other residents having the potential to be affected by the same deficient practice:	
	The facility has determined that all residents have the potential to be affected.	
	What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recure:	
	An audit was completed to identify resident who have a side rail/assist bar on their bed. An updated side rail assessment was completed and consent obtained if indicated.	
	The Director of Nursing and/or designee provided an in-service for all direct care staff regarding the proper use of assist bars, Nurses were educated on completing the side rail assessment on PCC and obtaining consents. The Maintenance Director was educated on how to accurately measure each resident for the use of assist bars.	
	How the corrective action(s) will be monitored to ensure the practice will not reoccur:	
	The Director of Nursing and/or designee will monitor the utilization of assist bars during rounds that will occur	

	weekly x 4weeks, then monthly x 3 months, then quarterly following the MDS schedule.	
	Concerns will be discussed by the QA committee and monitoring will be adjusted as determined by the QA committee.	
	Date Corrected	**4/4/2025**

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.

PLAN OF CORRECTION

Provider/Supplier Name:	Fulton Manor Care Center
Street Address, City, Zip:	520 Manor Drive Fulton, MO 65251
Date of Survey:	3.21.2025

PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	

ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION: (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLETION DATE
F881	Immediate actions taken for the residents to have been affected:	
	No residents were found to be affected	
	Identification of other residents having the potential to be affected by the same deficient practice:	
	The facility has determined that all residents have the potential to be affected by deficient practice	
	What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recure:	
	The Corporate Nurse educated the Administrator and Director of Nursing on the Antibiotic Stewardship Program policy	
	The facility has hired a full-time Infection Control Nurse to help oversee the Antibiotic Stewardship Program.	
	How the corrective action(s) will be monitored to ensure the practice will not reoccur:	
	The Director of Nursing and/or designee will conduct auditing and monitoring of the Antibiotic Stewardship program 5 times weekly to ensure the key elements of the Antibiotic Stewardship program are being implemented to include monitoring infections and antibiotic usage, monitoring residents on antibiotics for potential adverse outcomes, ensuring a McGeer's assessment is completed following an order received to initiate an antibiotic, if an	

	antibiotic is started that the antibiotic time-out (ATO) was completed 72 hours after the antibiotic was started to determine continued appropriateness of the antibiotic. Monitoring for determined approaches to ensure effective implementation and ongoing sustainment. After four weeks of monitoring and demonstrating expectations are being met, monitoring may be reduced to twice monthly for one month.	
	Concerns will be discussed by the QA committee and monitoring will be adjusted as determined by the QA committee.	
	The QA committee will review this plan of correction until such time substantial compliance has been met as determined by the QA committee.	
	Completed Date	**4/09/2025**

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.

PLAN OF CORRECTION

Provider/Supplier Name:	Fulton Manor Care Center
Street Address, City, Zip:	520 Manor Drive Fulton, MO 65251
Date of Survey:	3.21.25

PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	

ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION: (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLETION DATE
F909	Immediate actions taken for the residents to have been affected:	
	The bed frames, mattresses, and bed rails have been inspected for Resident #3, #15, #20, and #46.	
	Identification of other residents having the potential to be affected by the same deficient practice:	
	The facility has determined that all residents have the potential to be affected by deficient practice.	
	What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recure:	
	An audit was completed to identify beds that have assist rails. The maintenance director has completed an entrapment assessment on those beds while residents were in their bed to ensure proper placement for the assist bars	
	The maintenance director has been educated on the facility's policy on Bed Safety and the expectation of routine monitoring for potential entrapment risks.	
	How the corrective action(s) will be monitored to ensure the practice will not reoccur:	
	The maintenance director will monitor assist bars weekly for proper use for 4 weeks, then he will do monthly checks on all beds with assist bars. The administrator will ensure all entrapment assessments are being completed. The Director of Nursing will ensure all assist bar assessments	

	are completed and consents are uploaded into the PCC system. The Director of Nursing will ensure the MDS Coordinator documents the use of assist bars in the residents' care plans. The Administrator will monitor PCC monthly to ensure everything is being completed.	
	Concerns will be discussed by the QA committee and monitoring will be adjusted as determined by the QA committee.	
	The QA committee will review this plan of correction until such time substantial compliance has been met as determined by the QA committee.	
	Date Corrected	**4/09/2025**

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.