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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265383	A. BUILDING _____ B. WING _____	08/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOUNTAINBLEAU LODGE	2001 NORTH KINGSHIGHWAY CAPE GIRARDEAU, MO 63701

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 607 SS=D	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(5)(ii)(iii) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, §483.12(b)(4) Establish coordination with the QAPI program required under §483.75. §483.12(b)(5) Ensure reporting of crimes occurring in federally-funded long-term care facilities in accordance with section 1150B of the Act. The policies and procedures must include but are not limited to the following elements. §483.12(b)(5)(ii) Posting a conspicuous notice of employee rights, as defined at section 1150B(d)(3) of the Act. §483.12(b)(5)(iii) Prohibiting and preventing retaliation, as defined at section 1150B(d)(1) and (2) of the Act. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure that Nurse Aide (NA) Registry checks were completed prior to the employment start date for seven employees out of a sample of ten employees and failed to ensure their policy addressed checking the NA Registry for all	F 607		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Kizzma King | TITLE: RN LNHA | (X6) DATE: 8/28/24

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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employees prior to employment. The facility also failed to follow their policy to ensure the Criminal Background Check (CBC), Employee Disqualification List (EDL) or Family Care Safety Registry (FCSR) were completed prior to the employment date for one employee out of a sample of ten employees. The facility's census was 29.

Review of the facility's Compliance and Ethics-Screening Employees, Contractors and Volunteers policy, dated December 2020, showed:
- Employees, contracted individuals and volunteers are screened for violations of fraud, abuse and/or ethics violations prior to employment or engagement;
- Background screening and investigations are conducted prior to employment or engagement to ensure that employees, contractors and/or volunteers meet at least the following criteria: Competency evaluations have been met (through the state nurse aide registry for nurse aides).

Review of the facility's Licensure, Certification, and Registration of Personnel policy, revised April 2007, showed:
- Our facility conducts employment background screening checks, reference checks, license verification and criminal conviction investigation checks in accordance with current federal and state laws;
-The policy did not address checking the nurse aide registry for employees other than nurse aides.

1. Review of Certified Medication Technician/Certified Nurse Aide (CMT/CNA) B's

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personnel file showed:
- Hire date of 09/22/23;
- The facility failed to check the NA Registry for CMT/CNA B prior to hire date.

2. Review of Housekeeper C's personnel file showed:
- Hire date of 11/15/23;
- The facility failed to check the NA Registry for Housekeeper C.

3. Review of Licensed Practical Nurse (LPN) D's personnel file showed:
- Hire date of 11/28/23;
- The facility failed to check the NA Registry for LPN D.

4. Review of Dietary Aide E's personnel file showed:
- Hire date of 12/01/23;
- The facility failed to check the CBC and EDL list prior to hire date, and failed to check the NA Registry for Dietary Aide E.

5. Review of Registered Nurse (RN) F's personnel file showed:
- Hire date of 12/28/23;
- The facility failed to check the NA Registry for RN F.

6. Review of LPN G's personnel file showed:
- Hire date of 01/03/24;
- The facility failed to check the NA Registry for LPN G.

7. Review of Dietary Aide H's personnel file showed:
- Hire date of 02/23/24;
- The facility failed to check the NA Registry for

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F 607	Continued From page 3 Dietary Aide H prior to hire date. During an interview on 08/07/24 at 3:35 P.M., the Director of Nursing (DON) said Human Resources (HR) checks the NA Registry and employees can't work until they are cleared. During an interview on 08/08/24 at 5:00 P.M., the Administrator said she would expect the NA Registry to be checked for all employees prior to hire and all employees to have a background check before they are hired.	F 607		
F 623 SS=D	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged.	F 623		

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(ii) Notice must be made as soon as practicable before transfer or discharge when-
(A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section;
(B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section;
(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;
(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or
(E) A resident has not resided in the facility for 30 days.

§483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:
(i) The reason for transfer or discharge;
(ii) The effective date of transfer or discharge;
(iii) The location to which the resident is transferred or discharged;
(iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;
(v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;
(vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for

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the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and
(vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act.

§483.15(c)(6) Changes to the notice.
If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available.

§483.15(c)(8) Notice in advance of facility closure
In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l).
This REQUIREMENT is not met as evidenced by:
Based on interview and record review, the facility failed to notify the resident and/or the resident's representative in writing of a transfer to the hospital, including the reason for transfer, and failed to notify the Office of the State Long-Term Care Ombudsman for two residents (Resident #1 and Resident #15) out of 12 sampled residents

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and one resident (Resident #13) outside the sample. The facility's census was 29.

Review of the facility's Transfer/Discharge policy, dated October 2022, showed:
- Residents who are sent emergently to an acute care setting, such as a hospital, are permitted to return to the facility;
- The Transfer/Discharge notice is given as soon as practicable but before the transfer or discharge when the health and/or safety of the individuals in the facility would be endangered due to the clinical or behavioral status of the resident, or an immediate transfer or discharge is required by the resident's urgent medical needs;
- Notices are provided in a form and manner that the resident can understand;
- Notices of Transfer are provided to the resident and/or resident's representative as soon as practicable before the transfer, and to the long-term care (LTC) Ombudsman when practicable.

Review of the facility's "Discharge to Hospital Protocol," undated, showed:
- Obtain order to send to the hospital of choice for evaluation. Write a telephone order and order in the computer to send to emergency room (ER) for evaluation;
- Under resident profile in electronic health record, print the transfer/discharge record to send to the hospital;
- Under orders, print medication review sheet with current orders to send to hospital;
- Send a purple copy of the purple cardstock "Out of Hospital Do Not Resuscitate (DNR)" form from the chart;
- Have resident sign a copy of the "Bed Hold Policy." If the resident is unable to sign this form,

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contact the responsible party and inform them of this policy. Please document on the form and in the nurses notes that the resident and/or responsible party were notified of this policy. A copy of the signed policy needs to go with the resident and a copy needs to be placed in the chart under admission records.

1. Review of Resident #1's medical record showed:
- Transferred to the hospital on 02/25/24, and readmitted to the facility on 03/04/24;
- No documentation that the resident or resident's responsible party had been notified in writing.

2. Review of Resident #13's medical record showed:
- Transferred to the hospital on 03/04/24, and readmitted to the facility on 03/08/24;
- Transferred to the hospital on 05/23/24, and readmitted to the facility on the same day;
- No documentation that the resident or resident's responsible party had been notified in writing.

3. Review of Resident #15's medical record showed:
- Transferred to the hospital on 08/01/24, and readmitted to the facility on 08/02/24;
- No documentation that the resident or resident's responsible party had been notified in writing.

During an interview on 08/08/24 at 10:38 A.M., Licensed Practical Nurse (LPN) A said when a resident is hospitalized, nursing staff complete a bed hold form for the family to sign and print out a transfer/discharge form from the electronic record to go to the hospital with them. Nursing staff also call the family and tell them the resident is being sent out.

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F 623	Continued From page 8 During an interview on 08/08/24 at 2:20 P.M., the Social Services Designee said the nurse should fill out the Skilled Nursing Facility Holding Room policy, which shows the transfer reason and bed hold policy. She will then look in the chart for documentation to make sure the nurse notified the family. She will then send a letter to the family within seven days which includes the transfer reason and bed hold policy. During an interview on 08/08/24 at 5:00 P.M., the Administrator said he/she would expect notification of transfers to be sent per regulation.	F 623		
F 625 SS=D	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.	F 625		

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§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 described in paragraph (d)(1) of this section.
This REQUIREMENT is not met as evidenced by:
Based on interview and record review, the facility failed to inform the resident and/or resident's representative, in writing, of the facility's bed hold policy at the time of transfer to the hospital for one resident (Resident #1) out of 12 sampled residents and one resident (Resident #13) outside the sample. The facility's census was 29.

Review of the facility's Bed-Hold and Return policy, dated October 2022, showed:
- Residents/Representatives are provided written information regarding the facility and state bed-hold policies, which address holding or reserving a resident's bed during periods of absence;
- Residents are provided written notices about these policies in advance of any transfer (admission) and at the time of transfer (if an emergency, within 24 hours);
- The written bed-hold notices provided to residents/representatives, explain in detail, the duration of the state bed-hold policy, if any, during which the residents permitted to return and resume residence in facility.

Review of the facility's "Discharge to Hospital Protocol," undated, showed:
- Obtain order to send to the hospital of choice for evaluation. Write a telephone order and order in the computer to send to emergency room (ER)

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for evaluation;
- Under resident profile in electronic health record, print the transfer/discharge record to send to the hospital;
- Under orders, print medication review sheet with current orders to send to hospital;
- Send a purple copy of the purple cardstock "Out of Hospital Do Not Resuscitate (DNR)" form from the chart;
- Have resident sign a copy of the "Bed Hold Policy." If the resident is unable to sign this form, contact the responsible party and inform them of this policy. Please document on the form and in the nurses notes that the resident and/or responsible party were notified of this policy. A copy of the signed policy needs to go with the resident and a copy needs to be placed in the chart under admission records.

1. Review of Resident #1's medical record showed:
- Transferred to the hospital on 02/25/24 and readmitted to the facility on 03/04/24;
- No documentation the Resident or Resident's Representative was informed in writing of the facility's bed hold policy at the time of transfer.

2. Review of Resident #13's medical record showed:
- Transferred to the hospital on 03/04/24 and readmitted to the facility on 03/08/24;
- Transferred to the hospital on 05/23/24 and readmitted to the facility on 05/23/24;
- No documentation the Resident or Resident's Representative was informed in writing of the facility's bed hold policy at the time of transfer.

During an interview on 08/08/24 at 10:38 A.M., Licensed Practical Nurse (LPN) A said when a

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F 625	Continued From page 11 resident is hospitalized, nursing staff complete a bed hold form for the family to sign and print out a transfer/discharge form from the electronic record to go to the hospital with them. Nursing staff also call the family and tell them the resident is being sent out. During an interview on 08/08/24 at 2:20 P.M., the Social Services Designee said the nurse should fill out the Skilled Nursing Facility Holding Room policy, which shows the transfer reason and bed hold policy. She will then look in the chart for documentation to make sure the nurse notified the family. She will then send a letter to the family within seven days which includes the transfer reason and bed hold policy. During an interview on 08/08/24 at 5:00 P.M., the Administrator said he/she would expect residents discharging to the hospital to have the bed hold papers sent per the regulations.	F 625		
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 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	F 656		

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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 interview and record review, the facility failed to implement a care plan with specific interventions to meet individual needs for one resident (Resident #26) out of 12 sampled residents. The facility's census was 29.

Review of the facility's policy, Comprehensive

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Person-Centered Care Plans, revised March 2022, showed:
- The interdisciplinary team (IDT), in conjunction with the resident and his/her family or legal representative, develops and implements a comprehensive, person-centered care plan 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 includes measurable objectives and timeframes, describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental and psychosocial well-being;
- Care plan interventions are chosen only after date gathering, proper sequencing of events, careful consideration of the relationship between the resident's problem areas and their causes and relevant clinical decision making;
- When possible, interventions address the underlying sources of the problem areas, not just the symptoms or triggers;
- Assessments of residents are on-going and care plans are revised as information about the residents and the resident's conditions change.

1. Review of Resident #26's medical record showed:
- Admission date of 12/08/23;
- Diagnoses of: hemaplegia (paralysis on one side of the body) and hemiparesis (muscle weakness or partial paralysis on one side of the body that can affect the arms, legs and facial muscles) following nontraumatic intracerebral hemorrhage (bleeding in the brain) affecting right dominate side, cerebral infarction (disruptive bloodflow in the brain) acute kidney disease, (a

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F 656	Continued From page 14 condition in which the kidneys suddenly can not filter waste from the blood), and chronic kidney disease (long standing disease of the kidneys leading to renal failure); - Physician's Order Sheet (POS), dated 07/02/24, showed an order for dialysis, gather face sheet, POS and dialysis communication form, every night shift, on Tuesdays, Thursdays and Sundays. Review of Resident # 26's care plan, last revised 07/10/24, did not address dialysis. During an interview on 08/08/24 at 5:00 P.M., the Administrator and Director of Nursing said they would expect care plans to include treatments and any changes that may occur with orders or plan of care.	F 656		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional	F 812		

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standards for food service safety.
This REQUIREMENT is not met as evidenced by:
Based on observation, interview, and record review, the facility failed to store and distribute food under sanitary conditions, increasing the risk of cross contamination and food-borne illnesses. This deficient practice had the potential to affect all residents. The facility's census was 29.

Review of the facility's policy, Preventing Foodborne Illness-Employee Hygiene and Sanitary Practices, revised November 2022, showed:
- Food and nutrition service employees follow appropriate hand hygiene and sanitary procedures to prevent the spread of food borne illnesses;
- All employees who handle, prepare or serve food are trained in the practices of safe food handling and preventing food-borne illnesses;
- Employees must wash their hands whenever entering or re-entering the kitchen;
- Before coming in contact with any food surfaces;
- After handling soiled equipment or utensils;
- After engaging in other activities that contaminate hands;
- The use of disposable gloves does not substitute for proper handwashing;
- Gloves are not required when distributing food to residents at dining tables or when assisting residents to eat, unless touching ready-to-eat food;
- Did not address covering and labeling of food.

Observations made on 08/06/24 and 08/08/24 between 11:50 A.M. and 12:40 P.M. showed:
- Staff wore gloves and with the same gloves,

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touched door handles, residents' plates, and utensils;
- Staff did not sanitize/wash hands between glove changes;
- No sanitizer observed on counters or on walls;
- Certified Nurse Aide (CNA) I assisted resident with eating, got up from the table, walked around the dining room and refilled other residents' cups, sat back down and continued to assist/feed resident without washing or sanitizing hands;
- CNA O and CNA M received trays through the kitchen door, passed them while wearing gloves, returned for more trays, removed gloves, and did not sanitize/wash hands;
- CNA M carried bowls with bare hands, with his/her thumbs tucked inside of the bowls;
- Dietary Aide P, with gloved hands, took two trays (one in each hand), from the kitchen to the dining room, returned to obtain two more trays, wearing the same gloves, until told by another staff member to wash hands;
- CNA N picked up a utensil from the floor, placed it on the bottom of the drink cart, did not wash or sanitize hands, obtained a clean utensil and provided it to the resident;
- With bare hands, CNA N touched multiple residents' drink cups by the rim and touched the rim of the cups to the spout of the drink pitcher;
- With bare hands, CNA N scooped ice from the ice bucket into multiple residents' cups for refills, touching the cups with the scoop.

Observations on 08/07/24 at 3:50 P.M. showed:
- A container of sliced tomatoes and onions in the refrigerator with no cover, label or date;
- A squeeze bottle of red colored substance in the refrigerator with no label or date;
- Two large pans of cooked bratwurst patties placed on top of the warmer, uncovered, with a fly

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F 812	Continued From page 17 buzzing over the top of them; - Two large trays of fruit cups, in the refrigerator, covered, but not labeled. During an interview on 08/08/24 at 10:30 A.M., the Maintenance Director, who said he/she helped in other areas when needed, said the food that had been placed on top of the warmer should have been covered. During an interview on 08/08/24 at 4:00 P.M., CNA M said there was no hand sanitizer in the dining room and if a resident would drop utensil on the floor, he/she would pick it up, put it away and get a new utensil. During an interview on 08/08/24 at 4:05 P.M., CNA N said there was only hand sanitizer on the walls, there was none in the dining room, but they wore gloves. He/She said that if a resident would drop a utensil on the floor, he/she would pick it up and get a new one. During an interview on 08/08/24 at 5:00 P.M., the Director of Nursing and Assistant Director of Nursing said they would expect hand sanitizer to be available for staff in dining room. The Administrator said staff should perform hand hygiene prior to passing trays, should not cross contaminate, when gloves are removed, hands should be washed before putting on clean gloves and food should be covered, labeled and food preparation area free from pests.	F 812		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an	F 880		

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infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.

§483.80(a) Infection prevention and control program.
The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:

§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) 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

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(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.
(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and
(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.

§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.

§483.80(e) Linens.
Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.

§483.80(f) Annual review.
The facility will conduct an annual review of its IPCP and update their program, as necessary.
This REQUIREMENT is not met as evidenced by:
Based on observation, interview, and record review, the facility failed to maintain infection control practices to prevent the development and transmission of infection during incontinent care for two residents (Resident #22 and #24) out of two sampled residents. The facility failed to develop and implement a risk management process specific to Legionnaires disease (a type of pneumonia caused by Legionella bacteria), which had the potential to affect all residents, staff and visitors. The facility's census was 29.

Review of the facility's policy, "Standard Precautions", revised September 2022, showed:

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F 880	Continued From page 20 - Standard precautions apply to the care of all residents in all situations regardless of suspected or confirmed presence of infectious disease; - Hand hygiene is performed with alcohol-based hand rub (ABHR) or soap and water before and after contact with resident; - Before moving from work on a soiled body site to a clean body site, on same resident; - After contact with items in resident rooms; - After removing gloves; - Hands are washed with soap and water when visibly soiled with dirt, blood or body fluids; - Gloves are worn when handling or touching resident-care equipment visibly soiled or potentially contaminated with blood, body fluids or infectious organisms; - Gloves are changed and hygiene performed before moving from a contaminated body site to a clean body site during resident care; - Gloves are removed promptly after use, before touching non-contaminated items and environmental surfaces and before going to another resident; - After gloves are removed, hands are washed immediately to avoid transfer of microorganisms to other residents or environment. 1. Observation of Resident #22 on 08/08/24 at 1:44 P.M. showed: - Certified Nurse Aide (CNA) I and CNA J gathered a container of wipes and a clean brief, entered the Resident's room, and donned gloves without washing hands; - CNA I cleaned the resident's perineal area and placed the used wipe in a plastic bag; - While wearing the same gloves, CNA I reached into the wipes container and obtained another wipe, cleaned bowel movement (BM) off of the resident's buttocks and placed the wipe in the	F 880		

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soiled brief;
- With the same soiled gloves, CNA I obtained another wipe from the wipes container, cleaned the resident's buttocks area again, placed the used wipe in the soiled brief and folded the brief up;
- CNA I rolled up the bed pad and soiled brief, tucked under the resident and did not wash hands or change gloves;
- CNA J leaned over the resident with his/her long hair dangling down, touching the resident's legs and bed pad;
- With the same soiled gloves, CNA I obtained a wipe from the wipes container, and cleaned the resident's perineal area again and his/her right leg fold;
- With the same soiled gloves, CNA I picked up a tube of cream from the resident's table and applied the cream to the inner thighs of the resident;
- With the same soiled gloves, CNA I and CNA J rolled the resident onto his/her right side. CNA J pulled out the soiled bed pad and brief, handed them to CNA I to place in bag, removed gloves, and did not wash hands;
- With the same soiled gloves, CNA I and CNA J with bare hands, placed a clean brief on the resident and straightened the clean bed pad;
- CNA I removed gloves and did not wash hands;
- CNA I and CNA J left the room with a bag of soiled linens, trash and did not wash hands until placing in the shower room.

During an interview on 08/08/24 at 2:10 P.M., CNA I said he/she would change gloves if they are soiled, if BM gets on them, and when finished with a soiled brief. He/She will change gloves when putting a clean brief on, and wash/sanitize hands before and after care.

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During an interview on 08/08/24 at 2:10 P.M., CNA J said he/she performs peri care, places clean linens if necessary, redresses resident, throws away trash, removes gloves, and washes/sanitizes hands.

2. Observation of Resident #24 on 08/08/24 at 10:50 A.M. showed:
- CNA K gathered wipes and a clean brief, did not wash or sanitize hands prior to entering the room, and donned gloves;
- CNA K removed blankets, lowered the resident's pants and folded down the soiled brief;
- With the same soiled gloves, CNA K picked up the trash can and moved it closer to the bed;
- With the same soiled gloves, CNA K removed four wipes from the container and laid them on the fitted sheet;
- With the same soiled gloves, CNA K picked up a wipe from the bed, cleaned the resident's perineal area, repeated steps two more times, then tucked the used wipes into the soiled brief;
- As CNA K leaned over the resident wearing a gait belt (a device used for assistance with transfers and walking), the strap was hanging loose and dangled onto the soiled brief on the bed during the duration of incontinent care;
- CNA K removed his/her soiled gloves, did not wash or sanitize hands and donned clean gloves;
- CNA K rolled the resident onto his/her left side, tucked the soiled brief down, reached for a wipe in the wipes container, cleaned BM off of the resident's buttocks, and reached back into the wipe container two more times to clean the resident's buttocks area;
- CNA K tucked the used wipes into the soiled brief, rolled the brief up and placed in the trash can;

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- CNA K removed gloves, did not wash or sanitize hands, donned clean gloves, then placed a clean brief on the resident;
- With the same gloves, CNA K pulled up the resident's pants, bagged the trash, touched the resident's shirt, and pulled the blankets up around his/her chest before washing hands.

During an interview on 08/08/24 at 2:20 P.M., CNA K said when providing peri care, he/she puts gloves on and would change gloves after wiping the front, after wiping the back, and before putting on clean clothes.

During an interview on 08/08/24 at 5:00 P.M., the Administrator and Director of Nursing said they would expect staff to change gloves and wash hands between dirty and clean and before leaving resident rooms.

Review of the facility's policy, "Legionella Water Management Program", revised September 2022, showed:
- As part of the infection prevention and control program (IPCP), our facility has a water management program which is overseen by the water management team, including The Infection Preventionist (IP), Administrator, Medical Director, Maintenance Director, and Director of Environmental Services;
- The purposes of the water management program are to identify areas in the water system where Legionella bacteria can grow and spread, and to reduce the risk of Legionnaire's Disease;
- The identification of situations that can lead to Legionella growth are such as construction, water main breaks, changes in municipal water quality, presence of biofilm, scale or sediment, water temperature fluctuations, water stagnation and

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inadequate disinfection;
- Specific measures used to control the introduction and/or spread of Legionella such as temperatures and disinfectants;
- Control limits or parameters that are unacceptable and are monitored;
- A diagram where control measures are applied;
- A system to monitor control limits and effectiveness;
- A plan for when control limits are not met and/or control measures are not effective.

Review of the facility's water temperature log, dated April 2023 through July 2024, showed:
- On 07/01/23, water temperature in room 207 was 97.2 degrees (°) Fahrenheit (F) and room 220 was 100.9 °F, with no intervention documented;
- On 08/01/23, water temperature in room 201 was 100.8°F, room 207 was 97.6°F and room 220 was 100.3°F, with no intervention documented;
- In September 2023, water temperature in room 201 was 100.8°F, room 207 was 97°F and room 220 was 100.3°F, with documentation of "got it adjusted";
- In October 2023, water temperature in room 207 was 104°F, with no intervention documented;
- On 11/14/23, water temperature in room 207 was 104°F, with no intervention documented;
- On 12/14/23, water temperature in room 207 was 104°F, with no intervention documented;
- On 01/12/24, water temperature in rooms 201 and 207 were 104°F, with no intervention documented;
- On 06/14/24, water temperature in room 201 was 103°F, room 207 was 104°F and room 220 was 103.1°F, with no interventions documented;
- On 07/14/24, temperatures in room 201 was

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F 880	Continued From page 25 97.4°F, room 207 was 98.4°F and room 220 was 98.5, with no interventions documented. During an interview on 08/07/24 at 10:25 A.M., the Maintenance Director said he didn't know he was supposed to check for Legionella since the facility was on city water, but the temperatures should be no higher than 122 degrees (°) Fahrenheit (F) and no lower than 95° F. When asked about the lower temperature ranges, he/she said he/she thought it was ok since they had been above 95 °F. During an interview on 08/07/24 at 10:55 A.M., the Maintenance Director said he just found out the range should be 105-120°F. During an interview on 08/08/24 5:00 P.M., the Administrator said she would expect the facility to follow the Water Management and Legionella policies, and the water temperatures, in resident areas, should be between 105 and 115°F.	F 880		
F 925 SS=D	Maintains Effective Pest Control Program CFR(s): 483.90(i)(4) §483.90(i)(4) Maintain an effective pest control program so that the facility is free of pests and rodents. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to maintain an effective pest control program. This practice affected three residents (Resident #10, #17 and #19) out of 12 sampled residents and had the potential to affect all residents in the facility. The facility's census was 29.	F 925		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265383	A. BUILDING _____ B. WING _____	08/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOUNTAINBLEAU LODGE	2001 NORTH KINGSHIGHWAY CAPE GIRARDEAU, MO 63701

(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 925	Continued From page 26	F 925		

Review of the facility's policy, "Pest Control", revised May 2008, showed:
- The facility shall maintain an effective pest control program;
- The facility maintains an on-going pest control program to ensure that the building is kept free of insects and rodents;
- Only approved insecticides are permitted in facility and stored in areas away from food storage;
- Maintenance services assist, when appropriate and necessary, in providing pest control services.

Observation on 08/06/24 at 10:50 A.M. of Resident #17's room showed a fly landed on the resident's hand, bedspread, and nose.

During an interview on 08/06/24 at 10:50 A.M., Resident #17 said the flies were always bad.

Observation of the dining room on 08/06/24 at 12:29 P.M. showed a fly buzzed around, landing on a window and a gnat flying around near the doors in the dining room.

Observation of the dining room on 08/07/24 at 12:10 P.M. showed two flies buzzed around a table while residents were eating, landing on the residents and on the table.

Observation of the dining room during the resident council meeting on 08/07/24 at 3:00 P.M. showed two flies buzzed around residents and had to be swatted away.

During the resident council meeting on 08/07/24 at 3:15 P.M., Resident #10 said he/she wished for a fly swatter and Resident #19 said he/she kept one in his/her room.

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	265383	A. BUILDING _____ B. WING _____	08/08/2024

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F 925	Continued From page 27 Observations on 08/08/24 between the hours of 8:50 A.M. and 2:23 P.M. showed: - A fly on a resident's table in the dining room; - A fly crawling on the table in front of Resident #17 while eating lunch; - Three flies on the center light/chandelier in the dining room; - A fly on a resident's wheelchair in the dining room; - Three flies buzzed around the nurses station; - A fly buzzed around in the common area by the therapy room, while residents were watching television; - A fly buzzed around a resident in a wheelchair in the hallway near the nurses station on the therapy hall; - A fly buzzed around in the hall outside of room 206; - A fly buzzed around in the hall outside of room 214; - A fly buzzed around in room 217. During an interview on 08/08/24 at 09:30 A.M., Licensed Practical Nurse (LPN) A said the facility has issues with flies and spiders. During an interview on 08/08/24 at 5:00 P.M., the Administrator said she would expect the facility to be free of pests.	F 925		

Missouri Department of Health and Senior Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	12751	A. BUILDING: _____ B. WING _____	08/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOUNTAINBLEAU LODGE	2001 NORTH KINGSHIGHWAY CAPE GIRARDEAU, MO 63701

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A4017	19 CSR 30-85.042(17) Criminal Background Check Request Effective August 28, 1997, each facilily shall, not later than two (2) working days of the date an applicant for a position to have contact with residents is hired, request a criminal background check, as provided in sections 43.530, 43.540 and 610.120, RSMo. Each facility must maintain in its record documents verifying that the background checks were requested and the nature of the response received for each such request. The facility must ensure that any applicant who discloses prior to the check of his/her criminal records that he/she has been convicted of, plead guilty or nolo contendere to, or has been found guilty of any A or B felony violation of Chapter 565, 566 or 569, RSMo, or any violation of subsection 3 of section 198.070, RSMo, or of section 568.020, RSMo, will not be allowed to work in contact with patients or residents until and unless a check of the applicant ' s criminal record shows that no such conviction occurred. II/III This regulation is not met as evidenced by: Class III Refer to F607.	A4017		
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	A4086		

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A4086	Continued From page 1 diseases, specifically 19 CSR 20-20.020, as amended. I/II This regulation is not met as evidenced by: Class II Refer to F880.	A4086		
A6039	19 CSR 30-87.020(39) Inspect/Rodent Control Effective measures intended to minimize the presence of rodents, flies, cockroaches and other insects on the premises shall be utilized. The premises shall be kept in such condition as to prevent the harborage or feeding of insects or rodents. II/III This regulation is not met as evidenced by: Class III Refer to F925.	A6039		
A7015	19 CSR 30-87.030(13) Food-Protected, Temp, Need to Contact DHSS At all times, including while being stored, prepared, displayed, served or transported to or from the facility, food shall be protected from potential contamination, including dust, insects, rodents, unclean equipment and utensils, unnecessary handling, coughs and sneezes, flooding, drainage and overhead leakage or overhead drippage from condensation. The temperature of potentially hazardous food shall be forty-five degrees Fahrenheit (45°F) or below or one hundred forty degrees Fahrenheit (140°F) or above at all times, except as otherwise provided in this section. In the event of a fire, flood, power outage or similar event that might	A7015		

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A7015	Continued From page 2 result in the contamination of food, or that might prevent potentially hazardous food from being held at required temperatures, the person in charge shall immediately contact the Department of Health and Senior Services (the department). Upon receiving notice of this occurrence, the department shall take whatever action that it deems necessary to protect the residents. II/III This regulation is not met as evidenced by: Class III Refer to F812.	A7015		
A7019	19 CSR 30-87.030(17) Food Stored in Identifying Containers Unless its identity is unmistakable, bulk food, such as cooking oil, syrup, salt, sugar or flour not stored in the product container or package in which it was obtained, shall be stored in a container identifying the food by common name. III This regulation is not met as evidenced by: Class III Refer to F812.	A7019		
A8008	19 CSR 30-88.010(8) Informed Services/Charges - Alz Disclosure Prior to or at the time of admission and during his or her stay in the facility, each resident and/or his or her next of kin, legally authorized representative or designee shall be fully informed, in writing, of services available in the facility and of related charges, including any charges for services not covered by the facility's basic per	A8008		

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A8008	Continued From page 3 diem rate or federal or state programs. Information shall include procedures to be followed by the facility in cases of medical emergency, including transfer agreements and costs. All residents who receive treatment in an Alzheimer's special care program or unit and their next of kin, legally authorized representatives or designees shall be given a copy of the Alzheimer's Special Care Services Disclosure Form at the time of admission. Residents also shall be informed of services outside the facility which may reasonably be made available to the resident and of any reasonable estimate of any foreseeable costs connected with those services. II/III This regulation is not met as evidenced by: Class III Refer to F625.	A8008		
A8018	19 CSR 30-88.010(18) Emergency Discharges In emergency discharge situations the facility shall submit to the resident and his or her next of kin, legally authorized representative or designee a written notice of discharge. The written notice of discharge shall be given as soon as practicable and advise the resident of the right to request an expedited hearing. In the event that there is no next of kin, legally authorized representative or designee known to the facility, the facility shall send a copy of the notice to the appropriate regional coordinator of the Missouri State Ombudsman's office. II/III This regulation is not met as evidenced by: Class III	A8018		

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A8018	Continued From page 4 Refer to F623.	A8018		

PLAN OF CORRECTION

Provider/Supplier Name:	Fountainbleau Lodge
Street Address, City, Zip:	2001 North Kings Highway Cape Girardeau, Mo. 63701
Date of Survey:	~~08/09/2024~~ 08/08/2024 JH

PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	**265383**

ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION: (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLETION DATE
	This Plan of Correction (POC) is being submitted as required under State and Federal Law. The submission of this POC does not constitute an admission on the part of Fountainbleau Nursing Center (FBNC). FBNC's submission of this POC does not constitute an admission that the Surveyor's findings were accurate, nor that the deficiencies cited were correct and/or the scope and severity was merited. This POC is solely intended to ensure compliance within State and Federal regulatory guidelines. **Compliance will be achieved no later than 09/23/2024.**	
F607	• The facility will ensure that Nurse Aide (NA) Registry checks are completed prior to the employment start date. • The facility will ensure its policy addresses checking the NA Registry for all employees prior to employment. • The facility will ensure the Criminal Background Check (CBC), Employee Disqualification List (EDL), or the Family Care Safety Registry (FCSR) is completed prior to the employment date. 1) The facility's policy "Background Screening Investigations" was updated on 8/23/2024 to address all employees having the NA Registry check prior to employment. 2) An employee-wide audit was completed on 8/9/2024 by the Human Resources Director checking that all staff had the (NA) Registry checked and a CBC, EDL, or FCSR checked. All staff were brought up to date with having the NA registry checked and a CBC, EDL, or FCSR checked. 3) The Director of Human Resources was educated by the administrator on 8/9/2024 on F607 to include having the NA registry checked on all employees and a CBC, EDL, or FCSR checked prior to start of employment. 4) The Director of Human Resources or designee will complete 5 random staff file audits per month to ensure all staff have the NA registry check and a CBC, EDL, or	~~09/23/2024~~ 09/22/2024 JH

	FCSR check completed prior to employment until substantial compliance is met.	

F607	5) The Director of Human Resources or designee will report all audit findings to the QAPI committee until substantial compliance is met. 6) On 8/23/2024 the administrator added F607 and A4017 to the QAPI agenda until substantial compliance is met.	~~09/23/2024~~ 09/22/2024 JK
F623	• The facility will ensure the resident and/or resident's representative is notified in writing of a transfer to the hospital, including the reason for transfer, and will notify the Office of the State Long-Term Care Ombudsman. 1) Resident #1 was notified in writing on 8/23/2024 of 02/25/2024 transfer to the hospital, including the reason for transfer. The Office of the State Long-Term Care Ombudsman was notified on 3/4/2024. Documentation was added to resident 1's medical record on 8/23/2024 to reflect notification. 2) Resident #13's Responsible Party was notified in writing on 8/23/2024 of 03/04/2024 and 05/23/2024 transfers to the hospital, including the reason for transfers. The Office of the State Long-Term Care Ombudsman was notified on 4/1/2024 of 03/4/2024 transfer to the hospital and on 8/28/2024 of 05/23/2024 transfer to the hospital. Documentation was added to resident 13's medical record on 8/23/2024 and 8/28/24 to reflect notifications. 3) Resident #15 was notified in writing on 8/23/2024 of 08/01/2024 transfer to the hospital, including the reason for transfer. The Office of the State Long-Term Care Ombudsman was notified on 8/28/2024 of 08/01/2024 transfer to the hospital. Documentation was added to resident 15's medical record on 8/23/24 and 8/28/24 to reflect notification. 4) All licensed Nurses and were educated by the DON on 8/28/24 to notify residents and/or resident's representatives in writing of all transfers to the hospital, including reason. All Administrative staff were educated by the DON on 8/28/2024 to notify, in writing, the Office of the State Long-Term Care Ombudsman of all transfers to the hospital, including reason. 5) A facility-wide audit was completed on 8/28/2024 by the DON looking back 60 days to determine if resident and/or resident's representative was notified in writing of transfer to the hospital and if the Office of the State Long-Term Care Ombudsman was notified. All concerns identified were addressed by notifying the resident and/or resident's representative in writing of the transfer to the hospital, notifying the Office of the State Long-Term care Ombudsman in writing of the transfer to the hospital, and/or documentation reflecting notification added to the medical record. 6) The Social Services Representative or designee will complete 2 random chart audits per month to determine if the resident and/or resident's representative was	~~09/23/2024~~ 09/22/2024 JK

	notified in writing of the transfer to the hospital and Office of the State Long-Term Care Ombudsman was notified until substantial compliance is met.	
F623	7) The Social Services Representative or designee will report audit findings to the QAPI Committee until substantial compliance is met. 8) On 8/28/2024 the Administrator added F623 and A8018 to the QAPI agenda until substantial compliance is met.	~~9/23/2024~~ 09/22/2024
F625	• The facility will ensure the resident and/or resident's representative is informed, in writing, of the facility's bed hold policy at the time of transfer to the hospital. 1) Resident #1 was supplied a copy of the facility's bed hold policy on 8/23/2024 with review of 02/25/2024 transfer to the hospital. Documentation was added to resident 1's medical record on 8/23/2024 to reflect bed hold policy was supplied to resident. 2) Resident #13's Representative was supplied a copy of the facility's bed hold policy on 8/23/2024 with review of 03/04/2024 and 05/23/2024 transfer to the hospital. Documentation was added to resident 13's medical record on 8/23/2024 to reflect bed hold policy was supplied to resident's representative. 3) A facility-wide audit was completed on 8/28/2024 by the DON looking back 60 days to determine if resident and/or resident's representative was informed in writing of the facility's bed hold policy. All concerns identified were addressed by notifying the resident and/or resident's representative in writing of the facility's bed hold policy and documentation reflecting notification added to the medical record. 4) The Social Services Representative or designee will complete 2 random chart audits per month to determine if the resident and/or resident's representative was informed in writing of the facility bed hold policy until substantial compliance is met. 5) The Social Services Representative or designee will report audit findings to the QAPI Committee until substantial compliance is met. 6) On 8/23/2024 the Administrator added F625 and A8008 to the QAPI agenda until substantial compliance is met.	~~09/23/2024~~ 09/22/2024
F656	• The facility will implement a care plan with specific interventions to meet individual needs for all residents. 1) All Licensed Nurses were educated on 8/23/2024 by the DON regarding F656 implementing care plans with specific interventions to meet individual needs for all residents. 2) Resident #26's care plan was updated by the MDS Coordinator on 8/9/2024 to address dialysis. 3) A facility-wide audit was completed on 8/9/2024 by the MDS Coordinator to ensure all residents on dialysis had dialysis addressed on their care plan. The MDS Coordinator will ensure all residents have specific interventions on their care plans.	~~09/23/2024~~ 09/22/2024

	4) The MDS Coordinator or designee will complete 2 random chart audits per week x 4 weeks and then 5 random chart audits per month until substantial compliance is met to ensure all residents have a care plan with specific interventions to meet individual needs.	
F656	5) The MDS Coordinator or designee will report the audit findings to the QAPI Committee until substantial compliance is met. 6) On 8/23/2024 the Administrator added F656 to the QAPI agenda until substantial compliance is met.	~~9/23/2024~~ 09/22/2024 JK
F812	• The facility will store and distribute food under sanitary conditions, decreasing the risk of cross contamination and food-borne illnesses. 1) All Dietary and Nursing Staff were educated on 8/26/2024 by the Administrator and DON regarding F812 on how to store and distribute food under sanitary conditions including when to wash hands and change gloves and how to hold food-ware to avoid cross contamination. 2) On 8/9/2024 a kitchen audit of all foods being stored was completed with all foods not stored correctly disposed of. 3) On 8/9/2024 hand sanitizer dispensers were added to the wall in the kitchen and in the dining room. 4) The Dietary Manager or designee will complete an audit weekly x 4 weeks and then monthly on all food being stored to ensure food is stored under sanitary conditions until substantial compliance is met. 5) The Dietary Manager or Designee will report the audit findings to the QAPI committee until substantial compliance is met. 6) The DON or designee will audit staff distributing food under sanitary conditions at 1 random meal 5 days x 1 week, 1 random meal x 1 week, and then monthly until substantial compliance is met. 7) The DON or Designee will report the audit findings to the QAPI Committee until substantial compliance is met. 8) On 8/23/2024 the Administrator added F812, A7019, and A7015 to the QAPI agenda until substantial compliance is met.	~~9/23/2024~~ 09/22/2024 JK
F880	• The facility will maintain infection control practices to prevent the development and transmission of infection during incontinent care. 1) Resident #22 was assessed on 8/13/2024 and no signs and symptoms of infection were noted. 2) Resident #24 was assessed on 8/13/2024 and no signs and symptoms of infection were noted. 3) All CNAs and CMTs were educated on 8/21/2024 by the DON and all Licensed Nurses were educated on 8/28/2024 by the DON regarding infection control practices to prevent development and transmission of infection during incontinent care.	~~9/23/2024~~ 09/22/2024 JK

	4) All nursing staff will have incontinent care competencies completed by 9/23/2024. 5) The DON or designee will audit incontinent care by completing incontinent care competencies on random Nursing Staff 5 a week x 4 weeks and then monthly until substantial compliance is met. 6) The DON or Designee will report audit findings to the QAPI Committee until substantial compliance is met.	
F880	7) On 8/23/2024 the administrator added F880 and A4086 to the QAPI agenda until substantial compliance is met. • The facility will develop and implement a risk management process specific to Legionnaires disease. 1) On 8/28/2024 the maintenance department, environmental services, Infection Preventionist, and Administrator were educated by the Administrator and DON on the facility's Legionnaires disease risk management process including what to do when water temperatures are out of range. 2) A facility-wide audit was completed by the Maintenance Director on 8/28/2024 to ensure all water faucets supplied water in the correct temperature range. 3) The Maintenance Director or Designee will complete facility-wide audits on water temperatures including what interventions are done if the temperature is out of range weekly x 4 weeks and then monthly. 4) The Maintenance Director or Designee will report audit findings to the QAPI Committee until substantial compliance is met. 5) On 8/23/2024 the administrator added F880 and A4086 to the QAPI agenda until substantial compliance is met.	~~9/23/2024~~ 09/22/2024
F925	• The facility will maintain an effective pest control program. 1) On 8/1/2024 the facility's contracted pest control expert, Bug Zero, provided pest control treatment. They are scheduled to provide another treatment on 9/3/2024. 2) On 8/9/2024 the administrator obtained a letter from the facility's contracted pest control expert outlining the chemical application for control of flies and gnats. 3) On 8/28/2024 all staff were educated by the Administrator and/or DON regarding the effective pest control program to keep the facility free of pests and rodents. 4) The administrator or designee will complete facility-wide surveillance audits checking for flies and gnats 3 times a week x 4 weeks and then monthly until substantial compliance is met. 5) The administrator or designee will report audit findings to the QAPI Committee until substantial compliance is met. 6) On 8/23/2024 the administrator added F925 and A6039 to the QAPI agenda until substantial compliance is met.	~~9/23/2024~~ 09/22/2024

The Administrator signing and dating the first page of the CMS-2567/State Form is indicating their approval of the plan of correction being submitted on this form.

PLAN OF CORRECTION

Provider/Supplier Name:	Fountainbleau Lodge
Street Address, City, Zip:	2001 North Kings Highway Cape Girardeau, Mo. 63701
Date of Survey:	~~08/09/2024~~ 08/08/2024 JR

PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	**265383**

ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION: (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLETION DATE
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A4017	See F 607	~~9/23/2024~~ 09/22/2024 JR
A4086	See F880	~~9/23/2024~~ 09/22/2024 JR
A6039	See F 925	~~9/23/2024~~ 09/22/2024 JR
A7015	See F 812	~~9/23/2024~~ 09/22/2024 JR
A7019	See F 812	~~9/23/2024~~ 09/22/2024 JR
A8008	See F 625	~~9/23/2024~~ 09/22/2024 JR
A8018	See F 623	~~9/23/2024~~ 09/22/2024 JR

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