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F 568 SS=C	Accounting and Records of Personal Funds CFR(s): 483.10(f)(10)(iii) §483.10(f)(10)(iii) Accounting and Records. (A) The facility must establish and maintain a system that assures a full and complete and separate accounting, according to generally accepted accounting principles, of each resident's personal funds entrusted to the facility on the resident's behalf. (B) The system must preclude any commingling of resident funds with facility funds or with the funds of any person other than another resident. (C)The individual financial record must be available to the resident through quarterly statements and upon request. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to maintain a system to ensure the resident trust fund account was managed in accordance with proper accounting principles by not maintaining an accurate accounting of all monies held in the resident trust fund petty cash box. This had the potential to affect all residents residing in the facility. The facility census was 74. Review of the facility policy titled, "Management of Residents' Personal Funds," revised March 2021, showed: - The facility manages the personal funds of residents who request the facility to do so; - Should the facility manage the resident's funds, the facility acts as a fiduciary of the resident funds and holds, safeguards, manages and accounts for the personal funds of the resident. No service charge is levied against the resident for the management of personal funds; - Should the facility be appointed the resident's representative payee, and directly receive	F 568		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Melissa Bollinger	Administrator	11/8/24

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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monthly benefits to which the resident is entitled, such funds are managed in accordance with established policies and federal/state requirements.

Review of the facility admission packet, "Attachment C Resident's Legal Rights," undated, showed:
- The facility shall hold, safeguard, manage and account for the personal funds of the resident deposited with the facility in the following manner;
- Funds less than $50.00 - the facility may maintain a resident's personal funds that do not exceed $50.00 in an interest-bearing account or petty cash fund;
- The facility must establish and maintain a system which assures a full, complete, and separate accounting, according to generally accepted accounting principles, of each resident's personal funds entrusted to the facility on the resident's behalf.

Observation of the resident petty cash box count on 10/23/24 at 9:36 A.M., showed the Human Resources/Business Office Manager (BOM) counted a total of $526.65.

Review of the facility maintained resident petty cash log on 10/23/24 at 9:36 A.M., showed the balance listed as $532.55, for a discrepancy of $5.90.

During an interview on 10/23/24 at 9:36 A.M., the Human Resources Manager/BOM said he/she knew they made an error at some point and the count was off by around $5.00. He/She tried to reconcile the cash box every day, but couldn't always get to it every day.

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F 568	Continued From page 2 During an interview on 10/24/24 at 7:50 A.M., the Administrator said the cash box was reconciled almost every day. She was aware the count was off a little yesterday.	F 568		
F 658 SS=D	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, the facility failed to follow physician's orders for four residents (Residents #5, #9, #19, and #68) out of 20 sampled residents. The facility's census was 74. The facility did not provide a policy regarding following physician's orders. 1. Review of Resident #5's medical record showed: - Admitted on 02/25/05; - Diagnoses of chronic obstructive pulmonary disorder (COPD - a debilitating, progressive lung disease), respiratory failure (insufficient oxygen carried to the blood), pneumonia (infection in the lungs), major depressive disorder (low mood), and heart failure (heart does not pump correctly). Review of the resident's Physician Order Sheet (POS), dated October 2024, showed an order for daily weights, contact the healthcare provider if a gain of 2 to 3 pounds a day or 5 pounds a week for heart failure (CHF), dated 09/28/24.	F 658		

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Review of the resident's weights summary, dated September 2024-October 2024, showed no documentation of weights for 09/28/24-10/01/24, 10/03/24-10/07/24, 10/09/24-10/11/24, 10/13/24, 10/14/24, 10/15/24-10/20/24.

Review of the resident's Treatment Administration Record (TAR), dated September 2024-October 2024, showed:
- For September 2024, one missed out of three opportunities for daily weights;
- For October 2024, nine missed out of 23 opportunities for daily weights.

2. Review of Resident #9's medical record showed:
- Admitted on 05/23/06;
- Diagnoses of acquired kidney absence, COPD, and vascular disorder of the intestine (blood flow is reduced or blocked to the intestine).

Review of the resident's POS, dated October 2024, showed an order for weekly weights one time a day every Friday, dated 08/30/24.

Review of the resident's weights summary, dated September 2024-October 2024, showed no documentation of weights for 09/13/24, 09/20/24, 10/04/24, and 10/11/24.

Review of the resident's (TAR), dated September 2024-October 2024, showed:
- For September 2024, two missed out of four opportunities for weekly weights;
- For October 2024, two missed out of three opportunities for weekly weights.

3. Review of Resident #19's record medical

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showed:
- Admitted on 12/10/23;
- Diagnoses of dementia (thinking and social symptoms that interfere with daily function), hypothyroidism (the thyroid doesn't produce enough thyroid hormone), and hyperlipidemia (high level of fat participles in the blood).

Review of the resident's POS, dated October 2024, showed an order for weekly weights every day shift every Friday, dated 06/04/24.

Review of the resident's weights summary, dated September 2024-October 2024, showed no documentation of weights for 09/13/24, 09/20/24, 09/27/24, 10/04/24, and 10/11/24.

Review of the resident's TAR, dated September 2024-October 2024, showed:
- For September 2024, three missed out of four opportunities for weekly weights;
- For October 2024, two missed out of three opportunities for weekly weights.

During an interview on 10/24/24 at 10:15 A.M., Certified Nurse Assistant (CNA) E said the the CNAs weigh the residents and chart it in the computer. They knew who needed to be weighed and how often by the shift report or if the nurse told them.

During an interview on 10/24/24 at 12:05 P.M., Registered Nurse (RN) D said the restorative aide was responsible for completing the weights on residents. He/She didn't know if they were being completed. He/She would expect the restorative aide to following the physician orders when completing the weights.

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During an interview on 10/24/24 at 12:52 P.M., CNA F said he/she was responsible for getting and charting the weekly and monthly weights. The CNA's were responsible for getting the daily weights. He/She learned who needed weights by going to the daily meetings, charts, or if people like the dietitian told him/her about someone needing weighed.

4. Review of Resident #68's medical record showed:
- Admitted on 05/01/24;
- Diagnoses of anemia (low number of red blood cells), orthostatic hypotension (a sudden drop in blood pressure when rising from sitting or lying down), diabetes mellitus (a chronic condition that affects the way the body processes glucose), and dementia (a condition characterized by progressive or persistent loss of intellectual functioning, especially with impairment of memory and abstract thinking).

Review of the resident's POS, dated October 2024, showed an order for insulin lispro inject per the sliding scale subcutaneously (an injection under the skin) before meals and at bedtime for diabetes with blood sugar checks before meals and at bedtime, dated 06/06/24.

Review of the resident's Medication Administration Record (MAR), dated August 2024-October 2024, showed:
- For August 2024, 20 missed out of 124 opportunities for insulin administration and blood sugar checks;
- For September 2024, 19 missed out of 120 opportunities for insulin administration and blood sugar checks;
- For October 2024, nine missed out of 65

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F 658	Continued From page 6 opportunities for insulin administration and blood sugar checks. During an interview on 10/25/24 at 8:00 A.M., Resident #68 said staff checked his/her blood sugar three or four times a days every day and they must have forgotten to write it down. During an interview on 10/25/24 at 8:30 A.M., Licensed Practical Nurse (LPN) G said Resident #68 frequently refused blood sugar checks and insulin administration, but his/her refusal should be documented on his/her MAR. During an interview on 10/24/24 at 8:25 A.M., the Director of Nursing (DON) and the Administrator said they would expect staff to follow physician orders.	F 658		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure physician's orders for oxygen with the use of a bilevel positive airway pressure (BIPAP - a noninvasive ventilation device that helps people breathe by delivering pressurized air into the airways) was	F 695		

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followed for two residents (Residents #5 and #75) out of two sampled residents. The facility census was 74.

Review of the facility's policy titled, "Oxygen Administration," revised October 2010, showed:
- Verify that there is a physician's order for this procedure;
- Review the physician's orders or facility protocol for oxygen administration;
- Review the resident's care plan to assess for any special needs of the resident;
- Assemble the equipment and supplies as needed.

1. Review of Resident #5's medical record showed:
- Admission date of 02/25/05;
- Diagnoses of acute and chronic respiratory failure, pneumonia (infection in lungs which can make it harder to breathe), heart failure (heart not pumping as it should), chronic obstructive pulmonary disease (COPD - a debilitating, progressive lung disease), and morbid obesity (excessive weight).

Review of the resident's Physician Order Sheet (POS), dated October 2024, showed:
- An order for a bipap with settings of 20/8 with 2 liters per minute (LPM) of oxygen bled (to add oxygen directly into a ventilator circuit) into the bipap at bedtime for COPD, dated 09/27/24;
- An order for oxygen at 2 liters per minute by nasal cannula (NC) continuous, dated 06/04/24.

Observation on 10/24/24 at 9:23 A.M., and 10/25/24 at 8:15 A.M., showed no connector piece to bleed in oxygen and no oxygen attached to Resident #5's bipap.

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During an interview on 10/25/24 at 8:15 A.M., Resident #5 said staff removed his/her oxygen and the nasal cannula when they applied the bipap mask every night. He/She didn't know if oxygen was hooked up to the bipap but relied on the staff to do everything related to the bipap.

2. Review of Resident #75's medical record showed:
- Admitted on 06/13/24;
- Diagnoses of dyspnea (difficulty breathing), hypoxemia (low oxygen levels in the blood), respiratory failure, lymphedema (chronic condition that occurs when lymph fluid builds up causing swelling, and pneumonia (lung infection that makes it difficult to breathe).

Review of the resident's detailed physician order, dated 08/13/24, showed:
- Oxygen 2 LPM via NC with activity;
- Oxygen 2 LPM via bled in with bipap at bedtime.

Review of the resident's plan of care, last revised 10/22/24, showed:
- Required bipap at night and during naps during the day;
- Ensure bipap is on the correct setting;
- Ensure that bipap is worn correctly.

Observation of the resident showed:
- On 10/22/24 at 11:10 A.M., and 10/23/24 at 2:53 P.M., the resident sat on the side of the bed with oxygen at 2 LPM via NC. The bipap sat at the bedside without an adapter piece to allow for oxygen to be bled in and no oxygen attached.

During an interview on 10/23/24 at 2:54 P.M., the resident said he/she believed the bipap was not

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F 695	Continued From page 9 operating correctly and didn't feel like he/she was receiving enough air with it on. He/She wore the nasal cannula with the bipap but was told by staff not to wear the nasal cannula with the bipap because the mask wouldn't seal correctly. He/She did attempt to wear the nasal cannula with the bipap mask for about 20 minutes one night and became very short of breath. During an interview on 10/23/24 at 3:15 P.M., the Assistant Director of Nursing (ADON) said the company who supplied the resident with the bipap supplies was here last week and checked it. During an interview on 10/24/24 at 3:28 P.M., the ADON said she was not aware of an order to bleed in oxygen with the bipap for Residents #5 and #75 and had cared for the residents during the night shifts. During an interview on 10/24/24 at 8:25 A.M., the Director of Nursing (DON) and the Administrator said they expect staff to follow physician orders. If the nurses apply a bipap at night, they should check the mask to make sure it was airtight, no kinks in the tubing, the settings were correct, monitor for complaints of air hunger, and check the resident's oxygen saturation level (the level of oxygen in a person's blood).	F 695		
F 759 SS=D	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced	F 759		

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by:
Based on observation, interview, and record review, the facility failed to maintain an error rate of less than five percent (%) when medications were administered. There were 28 opportunities with three errors made, for an error rate of 11% which affected one resident (Resident #8) outside the sample of four residents. The facility census was 74.

Review of the facility's policy titled, "Insulin Administration," dated 2001, showed:
- Only appropriately licensed or certified personnel shall draw and administer insulin;
- The type of insulin, dosage requirements, strength, and method of administration must be verified before administration, to assure that it corresponds with the order on the medication sheet and the physician's order;
- The nursing staff will have access to specific instructions (from the manufacturer if appropriate) on all forms of insulin delivery system(s) prior to their use.

Review of the insulin glargine manufacture guidelines for administration, revised 11/2018, showed:
- To prime an insulin pen, follow these steps: turn the dosage selector to select a dose of two units; hold the pen with the needle pointing upwards; tap the insulin reservoir so that any air bubbles rise up towards the needle; press the injection button all the way in; check if insulin comes out of the needle tip; if no insulin comes out, repeat the safety test up to two more times, if still no insulin comes out, the needle may be blocked. Change the needle and try again; check for insulin flow, ensure that insulin is coming out of the needle tip to confirm that the pen is primed and ready for

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use;
- By following these steps, you ensure that the pen and needle are working properly and that any air bubbles are removed, which helps in delivering an accurate dose of insulin.

Review of the Humalog manufacture guidelines for administration, revised 07/2023, showed:
- Prime the pen before each injection;
- Priming Directions of Insulin Pen: turn the dose knob to select two units; hold the pen with the needle pointing up; tap the cartridge holder gently to collect air bubbles at the top; push the dose knob in and continue holding the pen with the needle pointing up; push the dose knob in until it stops, and zero is seen in the dose window. Hold the dose knob in and count to five slowly; check for insulin at the tip of the needle; if insulin wasn't present, repeat the priming steps one to three, no more than four times; if insulin still not present, change the needle, and repeat the priming steps;
- Priming the pen means removing the air from the needle and cartridge that may collect during normal use and ensures the pen is working correctly;
- If the pen isn't primed before each injection, the patient may get too much or too little insulin.

1. Review of Resident #8's Physician Order Sheet (POS), dated October 2024, showed:
- An order for insulin glargine 20 unit subcutaneously (an injection under the skin) two times a day for diabetes (a disease that occurs when the blood sugar is too high), dated 09/30/24;
- An order for Humalog (a type of insulin) 18 unit subcutaneously before meals for diabetes, dated 09/30/24;
- An order for Humalog per sliding scale for

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F 759	Continued From page 12 blood sugar of 151 - 200 = 2 units; 201 - 250 = 4 units; 251 - 300 = 6 units; 301 and above = 8 units subcutaneously before meals for diabetes, dated 09/30/24. Observations of the resident's insulin administration on 10/24/24, showed: - At 8:30 A.M., Registered Nurse (RN) D administered Humalog and insulin glargine to the resident as ordered. RN D failed to prime the Humalog and glargine insulin pens prior to the administration of the insulins; - At 11:55 A.M., RN administered Humalog insulin to the resident as ordered. RN D failed to prime the Humalog insulin pen prior to the administration of the insulin. During an interview on 10/24/24 at 2:21 P.M., the Assistant Director of Nursing (ADON) said he/she didn't prime insulin pens prior to administering insulin and hadn't educated the nursing staff to prime insulin pens prior to insulin administration. During an interview on 10/24/24 02:25 P.M., RN D said he/she didn't prime insulin pens prior to administering insulin for any resident. During an interview on 10/24/24 at 2:40 P.M., the Director of Nursing (DON) said he/she would expect nursing staff to prime insulin pens prior to administering medications if indicated.	F 759		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the	F 761		

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	265503	A. BUILDING _____ B. WING _____	10/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 761	Continued From page 13	F 761		

appropriate accessory and cautionary instructions, and the expiration date when applicable.

§483.45(h) Storage of Drugs and Biologicals

§483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.

§483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.
This REQUIREMENT is not met as evidenced by:
Based on observation, interview, and record review, the facility failed to ensure drugs and biologicals were labeled in accordance with currently accepted practices. The facility also failed to ensure one resident (Resident #22) outside of the 20 sampled residents had a physician's order to keep medications at the bedside. This had the potential to affect all residents. The facility census was 74.

The facility did not provide a policy regarding residents keeping at the bedside/self-administering medications.

Review of the facility policy titled "Medication Labeling and Storage," revised February 2023,

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showed:
- Compartments (including, but not limited to, drawers, cabinets, rooms, refrigerators, carts, and boxes) containing medications and biologicals are locked when not in use, and trays or carts used to transport such items are not left unattended if open or otherwise potentially available to others.

1. Review of Resident #20's Physician Order Sheet (POS), dated October 2024, showed:
- An order for Muro (used to reduce swelling of the cornea) 128 ophthalmic solution instill one drop in both eyes three times a day for dry eyes, dated 06/05/24;
- An order for Pataday (treats itchy and red eye caused by allergies) ophthalmic solution instill one drop in both eyes one time a day for allergies, dated 06/05/24;
- No documentation of an order for the resident to self-administer and keep the Muro and Pataday ophthalmic solutions at the bedside.

Review of the resident's medical record showed no assessments the resident's ability to self-administer and keep the Muro and Pataday ophthalmic solutions at the bedside.

Review of resident's care plan, dated 09/22/23, showed it did not address the resident's ability to self-administer and keep the Muro and Pataday ophthalmic solutions at the bedside

During an interview on 10/24/24 at 11:11 A.M., Resident #20 said he/she did administer his/her own eye drops when he/she feels like it and nursing administered them if he/she requested. He/She kept both the Muro and the Pataday at his/her bedside daily.

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F 761	Continued From page 15 During an interview on 10/24/24 at 11:25 A.M., the Assistant Director of Nursing (ADON) said he/she would not expect any resident to have medications of any kind at bedside unless there was a physician order in place. During an interview on 10/24/24 at 12:50 P.M., the Director of Nursing (DON) said he/she would not expect resident's to have medications at bedside without a physician order.	F 761		

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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. Based on interview and record review, the facility failed to correctly screen employees for Tuberculosis (TB - an infectious disease characterized by the growth of nodules in the tissues, especially the lungs) required by state regulation 19 CSR 20-20.100, for two employees (Employees B and C) out of ten sampled employees. The facility census was 74. Review of 19 CSR 20-20.100 Tuberculosis Testing for Residents and Workers in Long-Term Care Facilities showed: - Long Term Care Employees and Volunteers: All new long-term care facility employees and volunteers who work 10 or more hours per week are required to obtain a Mantoux Purified Protein Derivative (PPD) (Mantoux, tuberculin skin test, TB skin test, and PPDs are often used interchangeably. Mantoux refers to the technique for administering the test. Tuberculin (also called PPD) is the solution used to administer the test) two-step tuberculin test within one month prior to	A4031		

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A4031	Continued From page 1 starting employment in the facility. If the initial test is zero to nine millimeters (mm), the second test should be given as soon as possible within three weeks after employment begins, unless documentation is provided indicating a Mantoux PPD test in the past and at least one subsequent annual test within the past two years. It is the responsibility of each facility to maintain documentation of each employee's and volunteer's tuberculin status. Employees and volunteers with an initial zero to nine mm Mantoux PPD two-step test shall be one-step tuberculin tested annually and the results recorded in a permanent record; - Employees and volunteers with a documented history of a positive Mantoux PPD test shall not be required to be retested. In the absence of documentation, a repeat test shall be required. Review of the facility's policy titled, "Tuberculosis, Employee Screening for," revised 03/2021, showed: - All employees are screened for latent tuberculosis infection (LTBI) and active TB disease, using tuberculin skin test (TST) or interferon gamma release assay (IGRA) and symptom screening prior to beginning employment; - Screening includes a baseline test for LTBI using either a TST or IGRA, individual risk assessment and symptom evaluation; - If the baseline test is negative and the individual risk assessment indicates no risk factors for acquiring TB, then no additional screening is indicated; - If the baseline test is positive, but the individual risk assessment is negative and the individual is asymptomatic, a second test (either TST or IGRA) is conducted.	A4031		

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A4031	Continued From page 2 1. Review of Employee B's employee file showed: - Hire date of 10/02/24; - The employee received step one of the TB screening on 10/01/24, with the test read on 10/02/24, and no result documented; - The employee received step two of the TB screening on 10/08/24, with test read and results documented on 10/10/24. 2. Review of Employee C's employee file showed: - Hire date of 08/03/24; - The employee received step one of the TB screening on 07/30/24, with test read on 08/01/24, and no result documented; - The employee received step two of the TB screening on 08/12/24, with test read on 08/14/24, and no result documented. During an interview on 10/25/24 at 9:15 A.M., the Administrator said the Infection Preventionist (IP) was responsible for employee TB testing, but the current IP has not been in that role for very long. She expects TB testing to be completed per policy and results to be documented.	A4031		
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. Refer to F759.	A4055		

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A4059	Continued From page 3	A4059		
A4059	19 CSR 30-85.042(50) Self-Administration of Medication Self-administration of medication is permitted only if approved in writing by the resident's physician, and it is in accordance with the facility's policy and procedures. II This regulation is not met as evidenced by: Class II Refer to F761.	A4059		
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 F695.	A4075		
A9005	19 CSR 30-88.020(5) Petty Cash up to $50 per Res, Separate Funds A petty cash fund of up to fifty dollars ($50) for each resident for whom the facility is holding funds may be kept in the facility and shall be maintained separately from the facility's funds. II/III This regulation is not met as evidenced by: Class III. Refer to F568.	A9005		

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F568 SS=C	Accounting and Records of Personal Funds CFR(s): 483.10(f)(10)(iii)	
	The facility failed to maintain a system to ensure the resident trust fund account was managed in accordance with proper accoutning principles by not maintianing an accurate accounting of all monies held in the resident trust fund petty cash box. This had the potential to affect all residents. The petty cash showed a discrepancy of $5.90 The facility deposited $5.90 in the petty cash box to reconcile the difference. The Administrator will conduct daily audits for 2 weeks to ensure the accuracy of residents' petty cash fund. The administrator will then monitor weekly for 4 months. Any issues of non-compliance will be addressed upon discovery and in the monthly Quality Assurance Performance Improvement meeting.	December 8, 2024

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F658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i)	
	Based on observation, interview, and record review, the facility failed to follow physician's orders for four residents (Residents #5, #9, #19, and #68) out of 20 sampled residents. Resident #5 – Daily weights were immediately implemented. The Director of Nursing or designee will monitor daily weights daily Monday – Friday for two weeks, then weekly for two weeks and monthly for two months to ensure physician orders are followed. Resident #9 – The resident was weighed on 10/25/24 and every Friday (weekly) as ordered by the provider. The Director of Nursing or designee will monitor weekly weights daily Monday – Friday for two weeks, then weekly for two weeks and monthly for two months to ensure physician orders are followed. Resident #19 - The resident was weighed on 10/25/24 and weekly as ordered by the provider. The Director of Nursing or designee will monitor weekly weights daily Monday – Friday for two weeks, then weekly for two weeks and monthly for two months to ensure physician orders are followed. The Director of Nursing or designee will provide education to the nursing staff on the policy for weighing residents and to include the significance of resident weights. Resident #68 – Resident had numerous occasions of missed blood sugar checks. The Director of Nursing or designee will provide education on blood glucose checks, sliding scale insulin and documentation.	December 8, 2024

	The Director of Nursing or designee will monitor all resident who have blood sugars ordered daily Monday – Friday for 2 weeks, weekly for 4 weeks and monthly for 2 months, Any issues of non-compliance will be addressed upon discovery and in the monthly Quality Assurance Performance Improvement meeting.	

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F695 SS=C	Respiratory/Tracheostomy Care and Suctioning CFR(s):483.25(i)	
	The facility failed to ensure physician's orders for oxygen with the use of a bilevel positive airway pressure (BIPAP - a noninvasive ventilation device that helps people breathe by delivering pressurized air into the airways} was followed for two residents (Residents #5 and #75). Resident #5- the connective piece for the oxygen was attached to the BI-PAP and the oxygen connected to the BI-PAP to ensure administration per physician orders. Resident #75 – the oxygen was connected to the BI-PAP to with the appropriate adapter and setting validated to ensure administration per physician orders. The DON or designee reviewied 100% or residents on BI-PAP to ensure orders accurately implented and settings correct. DON or designee scheduled training by a registerd respiratory therapist to train nursing personnel on appropriate administration of respiratory modalites of treament. The DON or designee will monitor all BI-PAPs in the building for accuracy of settings three times weekly for two weeks and weekly or 6 weeks. Any issues of non-compliance will be addressed upon discovery and in the monthly Quality Assurance Performance Improvement meeting.	December 8, 2024

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F759 SS=D	Free of Medication Error Rts 5 Prent or More CFR(s): 483.45(1)(1)	
	The facility failed to maintain an error rate of less than five percent (%) when medications were administered. There were 28 opportunities with three errors made, for an error rate of 11% which affected one resident (Resident #8) outside the sample of four residents. Resident #8- The error could not be corrected. The following administrations of insulin were administered correctly with the insulin pen being primed according to standards of practice and manufacturers recommendations. . The DON or designee will educate all nurses on proper administration of insulin via an insulin pen. The DON or designee will monitor each nurse a minimum of one time within a two week period to ensure proper administration of insulin via pen and then complete random audits twice weekly -- once on day shift and once on night shift for 6 weeks to ensure appropriate administration via standards of practice and manufacturers recommnedations. Any issues of non-compliance will be addressed upon discovery and in the monthly Quality Assurance Performance Improvement meeting.	December 8, 2024

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F761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2)	
	Based on observation, interview, and record review, the facility failed to ensure drugs and biologicals were labeled in accordance with currently accepted practices. The facility also failed to ensure one resident (Resident #22) outside of the 20 sampled residents had a physician's order to keep medications at the bedside. This had the potential lo affect all residents. Resident #20- the resident was educated on why the facility did not allow the ophthalmic solutions to be kept at the bedside. The ophthalmic solutions were removed and placed on the treatment cart. The DON or designee will educate all nurses on the policy realated to medications at bedside. The DON or designee will monitor each resident room daily (Monday-Friday) for two weeks to ensure no medications at the bedside, then weekly time four weeks and monthly times two months. Any issues of non-compliance will be addressed upon discovery and in the monthly Quality Assurance Performance Improvement meeting.	December 8, 2024

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A4031	19 CSR 30-85.042(27) Communicable Disease Employees	
	The facility failed to correctly screen employees for Tuberculosis (TB - an infectious disease characterized by the growth of nodules in the issues, especially the lungs) required by state regulation 19 CSR 20-20.100, for two employees (Employees B and C) out of ten sampled employees.	December 8, 2024
	The Administrator will educate the Infection Control Nurse and DON on correctly screening employees for Tuberculosis. The Administrator will monitor 100% of TB screenings for a period of one month and then 50% of TB screenings for 3 months.	December 8, 2024
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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.	December 8, 2024
	Please refer to F759	
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A4059	19 CSR 30-85.042(50) Self-Administration of Medication	
	Self-administration of medication is permitted only if approved in writing by the resident's physician, arid it is in accordance with the facility's policy and procedures. II	December 8, 2024
	Please refer to F761	
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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. 1/11	December 8, 2024
	Please refer to F658 & F695	
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A9005	19 CSR 30-88.020(5) Petty Cash up to $50 per Res, Separate Funds	
	A petty cash fund of up to fifty dollars ($50) for each resident for whom the facility is holding funds may be kept in the facility and shall be maintained separately from the facility's funds.	December 8, 2024
	Please refer to F568	
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